Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Putnam Center
(CCN: 51-5070),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-15-1693

Decision No. CR4769

Date: January 10, 2017

DECISION

Putnam Center (Petitioner or the facility) challenges the Centers for Medicare & Medicaid Services' (CMS) determination that it was not in substantial compliance with Medicare program participation requirements. Petitioner also challenges CMS's imposition of a civil money penalty (CMP) of $5,100 per day from February 17, 2014 through October 15, 2014, based on a finding of immediate jeopardy, and a $250 per day CMP from October 16, 2014 through December 16, 2014.

For the reasons discussed below, I affirm CMS's determination that Petitioner was not in substantial compliance. However, I find that the period of Petitioner's substantial noncompliance at the immediate jeopardy level did not begin until July 25, 2014. Therefore, I modify the duration of the $5,100 per-day CMP that CMS imposed on Petitioner to July 25, 2014 through October 15, 2014, which is 83 days. I affirm CMS's imposition of a $250 per day CMP from October 16, 2014 through December 16, 2014. Therefore, the total amount of the CMP is $438,800.00.

I. Background

The Social Security Act (Act) sets forth participation requirements for a skilled nursing facility (SNF) in the Medicare program and authorizes the Secretary of Health and

Human Services (the Secretary) to promulgate regulations implementing those statutory provisions. 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, an SNF must maintain substantial compliance with program participation requirements. To be in substantial compliance, an SNF'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. "Noncompliance" means "any deficiency that causes a facility to not be in substantial compliance." *Id*.

The Secretary contracts with state agencies to conduct periodic surveys to determine whether SNFs are in substantial compliance. 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 are not in substantial compliance with the program participation requirements. 42 U.S.C. § 1395i-3(h)(2). The regulations specify the enforcement remedies that CMS may impose. 42 C.F.R. § 488.406. Among other enforcement remedies, CMS may impose a per-day CMP for the number of days a SNF is not in substantial compliance or a per-instance CMP for each instance of the SNF's noncompliance. 42 C.F.R. § 488.430(a). A per-day CMP 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). "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. The authorized range for a per-instance CMP is $1,000 to $10,000. 42 C.F.R. § 488.438(a)(2). 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. 42 U.S.C. §§ 1320a-7a(c)(2), 1395i(h)(2)(B)(ii)); 42 C.F.R. §§ 488.408(g), 488.434(a)(2)(viii), 498.3(b)(13).

Petitioner is an SNF located in Hurricane, West Virginia, which participates in the Medicare program. The West Virginia Department of Health and Human Resources, Office of Health Facility Licensure and Certification (state survey agency) completed an annual survey of Petitioner's facility on October 21, 2014, and issued a Statement of Deficiencies (SOD). *See* CMS Exs. 1, 31, 32. In a January 8, 2015 initial determination, CMS stated that, based on the October 21, 2014 survey, it found that Petitioner was not in substantial compliance with 14 Medicare participation requirements, including one deficiency cited at a scope and severity (s/s) level of "J," constituting immediate jeopardy to resident health and safety.[1] CMS Ex. 31 at 1-2. CMS found that immediate jeopardy

[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, and is 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). A scope and severity level of A, B, or C indicates a deficiency that has the potential for no actual harm and has the

no longer existed on October 15, 2014, but that Petitioner remained out of substantial compliance. CMS Ex. 31 at 2. CMS listed the deficiencies as follows:

- 42 C.F.R. § 483.25, F309 (Quality of Care) at a s/s level of "J";
- 42 C.F.R. § 483.10(c)(7), F161 (Surety Bond – Security of Personal Funds of Residents) at a s/s level of "E";
- 42 C.F.R. § 483.13(c)(1)(ii)-(iii), (c)(2)-(4), F225 (Investigation/Report Allegations of Mistreatment, Neglect, Abuse, Misappropriation of Resident Property) at a s/s level of "F";
- 42 C.F.R. § 483.15(a), F241 (Dignity and Respect of Individuality) at a s/s level of "D";
- 42 C.F.R. § 483.15(b), F242 (Self-Determination – Right to make choices) at a s/s level of "D";
- 42 C.F.R.§ 483.20(b)(1), F272 (Comprehensive Assessments) at a s/s level of "D";
- 42 C.F.R. § 483.20(g) - (j), F278 (Assessment Accuracy/Coordination/Certification) at a s/s level of "D";
- 42 C.F.R. § 483.20(k)(3)(ii), F282 (Services by Qualified Persons/per Care Plan) at a s/s level of "D";
- 42 C.F.R. § 483.25(a)(3), F312 (ADL Care Provided for Dependent Residents) at a s/s level of "D";
- 42 C.F.R. § 483.35(d)(1) – (2), F364 (Food) at a s/s level of "E";
- 42 C.F.R. § 483.35(i), F371 (Sanitary Conditions) at a s/s level of "F";
- 42 C.F.R. § 483.55(b), F412 (Routine/Emergency Dental Services in NFs) at a s/s level of "G";
- 42 C.F.R. § 483.75(*l*)(1), F514 (Resident Clinical Records – Complete/Accurate/Accessible) at a s/s level of "D";
- 42 C.F.R. § 483.75(o)(1), F520 (Quality Assessment and Assurance Committee) at a s/s level of "E.

CMS Ex. 31 at 1-2. CMS imposed a CMP of $5,100 per day from February 17, 2014 through October 15, 2014, and a CMP of $250 per day beginning October 16, 2014, which would continue until the facility regained compliance. CMS Ex. 31 at 2.

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potential for no more than minimal harm. A scope and severity level of D, E, or F indicates a deficiency that presents no actual harm but has the potential for more than minimal harm that does not amount to immediate jeopardy. A scope and severity level of G, H, or I indicates a deficiency that involves actual harm that does not amount to immediate jeopardy. A scope and severity level of J, K, or L indicates a deficiency that constitutes immediate jeopardy to resident health or safety. The matrix, which is based on 42 C.F.R. § 488.408, specifies which remedies are required and optional at each level based upon the frequency of the deficiency. *See* State Operations Manual ch. 7, § 7400E.

The state survey agency completed a revisit survey on December 21, 2014. CMS Ex. 33. By letter dated December 23, 2014, the state survey agency notified Petitioner that it had corrected all the deficiencies by December 17, 2014. CMS Ex. 33; *see* CMS Ex. 31 at 7. By letter dated January 15, 2015, CMS notified Petitioner that the revisit survey had determined that all deficiencies were corrected and, therefore, the total CMP was as follows: a CMP of $5,100 per day for 241 days, from February 17, 2014 through October 15, 2014, for a total of $1,229,100.00; and a CMP of $250 per day for 62 days from October 16, 2014 through December 16, 2014, for a total of $15,500.00. CMS Ex. 31 at 7.

Petitioner timely requested a hearing. In its hearing request, Petitioner stated that it was "addressing only the 'immediate jeopardy' allegations" under the F309 citation relating to a single resident, Resident 87 (R87).

The case was assigned to me, and I issued an Acknowledgment and Pre-hearing Order. In compliance with my Pre-hearing Order, CMS filed a pre-hearing brief and 62 exhibits (CMS Ex. 1-62). Petitioner filed a pre-hearing brief along with 20 proposed exhibits (P. Exs. 1-20). Both parties submitted written direct testimony for its witnesses. CMS Exs. 58-60; P. Exs. 13-20. CMS requested to cross-examine all of Petitioner's witnesses, and Petitioner requested to cross-examine four of CMS's witnesses.

Before the hearing, I denied CMS's motion for summary judgment, but sustained CMS's objection to P. Ex. 12. On September 22, 23, and 28, 2015, I held a video teleconferenced hearing at which I received testimony on cross-examination from the following witnesses: R87, the resident who is the focus of the deficiency under F309 (P. Ex. 13); John Adam Skeens, Petitioner's Director of Nursing since April 2014 (P. Ex. 15); Leslie Baylous, R.N. (P. Ex. 19), a nurse at Petitioner's facility; Angela Hodges, R.N., a Unit Manager at Petitioner's facility (P. Ex. 16); Justine McCray, M.S.W., Petitioner's Director of Social Services (P. Ex. 17); Dr. Christopher Skaggs, Petitioner's Medical Director and R87's attending physician (P. Ex. 14); Katherine Craig, Surgical Assistant/Hospital Scheduling Coordinator for Mountain State Oral & Maxillofacial Surgeons in Hurricane, West Virginia (CMS Ex. 59); Rebecca Lucas, M.S.W., surveyor from the state survey agency (CMS Ex. 60 at 1-16); Joyce Settle, R.N., surveyor from the state survey agency (CMS Ex. 60 at 44-65); and Dr. Ira Cheifetz, an oral surgeon who was CMS's expert witness (CMS Ex. 58). At the hearing, I admitted CMS Exs. 1-62, P. Exs. 1-11, and P. Exs. 13-20. Hearing Transcript (Tr.) 7-9. After the hearing, CMS and Petitioner filed post-hearing briefs (CMS Br.; P. Br.) and reply briefs (CMS Reply; P. Reply).

II. Issues

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.

III. Jurisdiction

I have jurisdiction to hear and decide this case. 42 U.S.C. §§ 1320a-7a(c)(2), 1395i(h)(2)(B)(ii)); 42 C.F.R. §§ 488.408(g), 488.434(a)(2)(viii), 498.3(b)(13).

IV. Findings of Fact

1. R87 was a 62-year-old male at the time of the October 2014 survey.

2. In February 2013, prior to his admission to Petitioner's facility, R87 underwent a procedure to remove cervical osteophytes at Thomas Memorial Hospital (Thomas Memorial). On February 28, 2013, following the surgery, he developed shortness of breath, dyspnea, and aspiration pneumonia, and required intubation. *See* P. Ex. 3 at 1. On March 7, 2013, R87 underwent a tracheostomy. On March 11, 2013, R87 was transferred to Select Specialty Hospital (Select Specialty) for further pulmonary and medical management. P. Ex. 3 at 1. In the history and physical report, the attending physician noted, among other things, that R87 had lost 100 pounds in the last eight months. P. Ex. 3 at 1. The physician also noted that R87 "is partially edentulous with poor dentition of remaining teeth." P. Ex. 3 at 2.

3. Resident 87 was admitted to Petitioner's facility on April 11, 2013. P. Ex. 1 at 1. Resident 87's diagnosed ailments included, among other things, generalized muscle weakness, dysphagia, type II diabetes, unspecified protein-calorie malnutrition, atrial fibrillation, cirrhosis of liver, weight loss, congestive heart failure, and hypertension. See P. Ex. 1 at 2, 4.

4. According to the nursing assessment completed by Petitioner's staff at the time of R87's admission, he was 6'3" and 133.8 pounds. P. Ex. 1 at 9. The assessment noted, among other things, that he had a feeding tube, no mouth pain, and all his teeth were in "poor" condition. P. Ex. 1 at 10. The assessment indicated that in the previous five days, R87 had been on a scheduled pain medication regimen and had experienced pain. P. Ex. 1 at 11.

5. On April 15, 2013, a nurse practitioner examined R87 and, among other things, noted his prior surgery, his bout of aspiration pneumonia, his tracheostomy, and that he continued with tube feedings. The nurse practitioner also stated that she had reviewed R87's hospital records. P. Ex. 9 at 1.

6. The Minimum Data Set (MDS) assessment for R87, with an assessment reference date of April 18, 2013, indicated that he was 75 inches tall and weighed 139 pounds. CMS Ex. 62 at 12. On the MDS, in the diagnoses section, Petitioner's staff indicated that R87 had anemia, atrial fibrillation, coronary artery disease, heart failure, hypertension, cirrhosis, malnutrition, and respiratory failure. Pneumonia was not checked as one of R87's diagnoses. CMS Ex. 62 at 9-11. The MDS noted that R87 was on a scheduled pain medication regimen. CMS Ex. 62 at 11. According to the MDS, R87 did not have any cavities, broken natural teeth, inflamed/bleeding gums, loose teeth, abnormal mouth tissue, or mouth pain. CMS Ex. 62 at 13.

7. Resident 87's attending physician was Dr. Christopher Skaggs, who was also Petitioner's Medical Director. P. Ex. 1 at 1; P. Ex 14 at 1.

8. Petitioner's staff conducted a pain evaluation on April 11, 2013, which indicated that R87 reported severe back pain and pain in his left foot. P. Ex. 1 at 15-16. The evaluation form noted that R87 was on morphine and dilaudid. P. Ex. 1 at 16.

9. On April 14, 2013, Dr. Skaggs completed a form titled "Physician Determination of Capacity," in which he found that Resident 87 had "sufficient mental or physical capacity to appreciate the nature and implication of health care decisions." P. Ex. 1 at 5.

10. On October 8, 2013, Petitioner's staff noted that R87 had experienced occasional acute pain in his teeth over the last five days and that he was receiving scheduled pain medication. A staff notation appears to indicate that R87 requested a dental appointment. P. Ex. 1 at 27-28; CMS Ex. 13, Part H at 13-14.

11. An interdisciplinary progress note dated October 8, 2013, documents that R87 requested a dental appointment because he was experiencing tooth pain. The note stated: "[t]eeth appear brownish, no open areas noted. No bleeding noted." According to the note, R87 had an appointment with "Dr. Bowels [sic] DDS" on October 9, 2013. CMS Ex. 13, Part C at 36; *see* P. Ex. 2 at 1.

12. Dr. Bowles, a dentist, examined R87 on October 9, 2013. In his treatment notes, Dr. Bowles stated that R87 required extraction of his remaining teeth, which was to be performed by an oral surgeon. He noted that R87 was "just off antibiotics & not having pain" and stated "[m]aking arrangements for med clearance." P. Ex. 2 at 2; CMS Ex. 13, Part D at 61, 62.

13. On October 16, 2013, Dr. Skaggs wrote an order for R87 that stated he "may have teeth extractions with local or minimal twighlight [sic] sedation only." P. Ex. 2 at 3; CMS Ex. 13, Part D, at 60.

14. On November 23, 2013, Petitioner was admitted to Thomas Memorial and treated for pneumonia. *See* CMS Ex. 13, Part H at 56-58; P. Ex. 5 at 4.

15. In a Thomas Memorial hospitalist progress note dated November 28, 2013, a physician's assistant stated, among other things, that R87 "needs full dental extraction;" "will see if SW can determine if this could be done at Select, or if he will need to be assessed in NH." P. Ex. 4 at 2.

16. On November 29, 2013, R87 was discharged from Thomas Memorial and returned to Petitioner's facility. CMS Ex. 13, Part H at 56-58; *see* P. Ex. 4 at 4. The discharge report stated, in relevant part, that R87 "needs full dental extraction because he has multiple infected teeth." CMS Ex. 13 Part H at 58.

17. Dr. Bowles' treatment notes show that on December 3, 2013, he wrote an entry stating "Nursing Home Request Referral for Mt. State – Mailed Pano [panographic x-ray] and referral to Mt. State." P. Ex. 2 at 2. Further, on December 3, 2013, Dr. Bowles' office faxed a completed form to Mountain State Oral & Maxillofacial Surgeons (Mountain State or oral surgeon's office), which contained information that Mountain State required in advance of an appointment; on this document, Dr. Bowles wrote "Ext teeth marked with I.V. sedation," and, for "Type of Anesthesia Requested," he circled "IV." P. Ex. 2 at 4; CMS Ex. 13, Part D at 37.

18. On January 28, 2014, Mountain State faxed documents to Petitioner that needed to be completed and returned before R87's evaluation for oral surgery. P. Ex. 2 at 5-13; CMS Ex. 13, Part D at 47-55. The documents consisted of forms for providing health history information, a form titled "Request for Medical Clearance," a consent form for anesthesia and extraction of teeth, and a consent form for intravenous sedation/anesthesia. The "Request for Medical Clearance" form had the following comments: "Patient needs to have multiple teeth extracted under IV anesthesia. Requesting recent H & P and medical clearance." P. Ex. 2 at 7; CMS Ex. 13, Part D, at 36, 49.

19. Angela Hodges, who was a nurse and unit manager at the facility, and R87 completed the forms together, and Nurse Hodges sent them back to Mountain State on January 28, 2014. P. Ex. 16 at 3. On the health history form, R87 stated that the "main problem" which brought him to Mountain State was "frequent infection, rotting of teeth." CMS Ex. 13, Part D at 52.

20. R87 originally had an appointment with Mountain State for February 13, 2014, but Mountain State canceled the appointment due to weather conditions and rescheduled it for February 17, 2014. CMS Ex. 13, Part C at 30; CMS Ex. 13, Part D at 35.

21. On February 13, 2014, Dr. Grey, a pulmonologist, examined R87 and noted that R87 was there for a "routine follow up regarding recurrent infections and currently is feeling worse. Since last visit, [R87] has had no recent infection. He has had no new symptoms . . . ." and that R87 "has an appt to see a dental surgeon." CMS Ex 13, Part H at 59.

22. On February 17, 2014, Dr. Krajekian, an oral surgeon with Mountain State, examined R87. P. Ex. 2 at 17-18. Dr. Krajekian's examination report notes that R87 was "here from Dr. Bowles for removal of remaining maxillary and mandibular teeth, decayed" and that "[w]e will try to obtain clearance from his physician, coordinate his care and see if he is a candidate for either mach or general anesthesia in a hospital setting. P. Ex. 2 at 18; CMS Ex. 13, Part D at 46.

23. On March 28, 2014, Dr. Grey examined R87. P. Ex. 10 at 7; *see* CMS Ex. 13, Part H at 16. In his progress note, Dr. Grey reported that R87 was there "for a routine follow up regarding pneumonia and currently is feeling about the same." Dr. Grey noted that R87 was experiencing chest pains and that "[R87] saw a dental surgeon about extraction and states they are working on it." P. Ex. 10 at 7.

24. On April 29, 2014, a licensed social worker assessed R87 and noted that R87 "needs teeth removed but due to current health status Dr. unwilling to do under anesthesia." P. Ex. 1 at 12.

25. On June 4, 2014, Dr. Grey examined R87 to "follow up regarding pneumonia and currently is feeling about the same." In his report, Dr. Grey described R87 as a "[p]atient with chronic aspiration pneumonia who has a stoma from trach still and peg [feeding tube] but still having problems. [H]e is supposed to have dental extraction but they are waiting on his breathing." P. Ex. 10 at 9.

26. On June 8, 2014, R87 went to Thomas Memorial's emergency room and, on June 9, 2014, was admitted as an inpatient at Thomas Memorial with the diagnosis of aspiration pneumonia and a noted comorbidity of sepsis. CMS Ex. 51, Part A at 1-2, 52; *see* P. Ex. 5 at 1, 2. On June 9, 2014, Dr. Modi performed a consultation examination of R87 and stated in his report that R87 "was last admitted here in November and was treated for pneumonia at that time . . . He does have a history of recurrent aspiration. He also has very severe periodontal disease. There has been discussion about a full dental extraction; however, his underlying medical condition limits anesthetic options." P. Ex. 5 at 4.

27. R87 was discharged from Thomas Memorial on June 19, 2014, and transferred to Select Specialty. P. Ex. 5 at 1; P. Ex. 6 at 1. The Thomas Memorial discharge summary report shows that R87 had four consulting physicians: "Dr. Grey of Pulmonary Associates . . . Dr. Modi of infectious disease . . . Dr. Beasley of ENT [and] Dr. Gharib of cardiology." P. Ex. 5 at 1. According to the discharge summary:

> In terms of the patient's sepsis and pneumonia, he was treated with broad-spectrum antibiotics and seen by Dr. Modi. He did grow MRSA from his tracheal aspirates. At the current time, he remains on Vancomycin and Invanz. He did develop

> an acute episode of respiratory failure related to his pneumonia that required mechanical ventilation via tracheostomy tube for less than 96 hours.
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> * * *
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> Because the patient has had multiple recurrent episodes of aspiration pneumonia and has severe periodontal disease, efforts were made to contact dental surgery for tooth extraction. Dr. Martin is now on staff at Thomas Memorial Hospital and is awaiting the appropriate radiographic machinery to be able to do this procedure in our surgical suite and has agreed to see the patient as an outpatient for dental extraction once the appropriate device is in place.
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> * * *
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> Currently, the patient will be transferred to Select Specialty Hospital for long-term acute care. His medical power of attorney is agreeable with this plan of care. His overall prognosis is guarded in reference to his multiple comorbidities and his generally declining health over the course of the past 12 to 18 months.

P Ex. 5 at 2-3, 5. The physicians who were cc'd on this report included R87's attending physician, Dr. Skaggs.

28. R87 was admitted to Select Specialty on June 19, 2014, and a physician who examined R87 noted that R87 has "very, very poor dentition." P. Ex. 6 at 1-3.

29. An infectious diseases progress note dated July 4, 2014, shows that R87 was examined and his list of diagnoses included, among other things: aspiration pneumonia with severe periodontal disease and MRSA; respiratory failure which required tracheostomy revision and mechanical ventilation (noted to be "[b]etter);" severe sepsis (noted to be "[b]etter);" and severe periodontal disease and dental caries. P. Ex. 6 at 9.

30. On or around July 17, 2014, R87 was discharged from Select Specialty. P. Ex. 6 at 4-6; CMS Ex. 13, Part C at 21-24 (pp. 23-24 are duplicates of p. 22). In the section describing R87's "Hospital Course," the Select Specialty discharge report stated, in relevant part:

> During his stay at Thomas Memorial Hospital, it was deduced that the reason behind the patient's multiple recurrent episodes of aspiration pneumonia was secondary to his severe periodontal disease. Dr. Martin, dentist, was consulted and in

the very near future will do a complete tooth extraction of all the patient's teeth when Thomas Memorial Hospital is able to obtain the appropriate radiographic machinery, in order to do this procedure in their surgical suite. The patient was transferred to Select Specialty Hospital for continued medical treatment of his pneumonia as well as medical management of his other comorbidities.

On admission, the patient was on a tracheostomy collar requiring high-flow oxygen and Dr. Kayi, pulmonologist, was consulted. Dr. Modi, infectious disease physician, who followed the patient at Thomas Memorial Hospital, also followed the patient at Select Specialty Hospital. The patient has completed his course of antibiotics for his aspiration pneumonia and currently is afebrile with a normal white count. He has been successfully weaned down to room air but still has a tracheostomy that is capped. He has been evaluated by speech therapy but will continue to be nothing-by-mouth status on percutaneous endoscopic gastrostomy tube feedings. He has worked with physical therapy and occupational therapy, and it is recommended perhaps he continue to do so at the skilled nursing facility. The patient is now stabilized and ready to be transferred back to the skilled nursing facility.

CONDITION ON DISCHARGE
The patient is stable in no acute distress.

* * I*

FOLLOWUP INSTRUCTIONS:
1. The patient will be transferred to Cedar Ridge nursing home until Monday. After that he will be transferred to Putnam Care Home.
2. The patient will be returning to Thomas Memorial Hospital in the very near future, as previously noted, for a complete dental extraction by Dr. Martin. Further arrangement for this will be made through the skilled nursing facility.
3. All medical decisions regarding this patient's care will be the responsibility of the attending at the skilled nursing facility.

> 4. The patient will need to follow up with a pulmonologist regarding the tracheostomy collar. At this time, the patient remains with the tracheostomy collar capped secondary to poor lung function. He with [sic] will need continued tracheostomy care.

P. Ex. 6 at 4-6.

31. On July 23, 2014, Katie Craig, the Surgical Assistant/Hospital Scheduling Coordinator for the oral surgeon's office, sent a letter directly to R87 to inform him that, as of that date, the oral surgeon's office had not received the medical clearance from his physician. The letter requested that R87 obtain the medical clearance "in order to move forward with scheduling" the teeth extraction procedure. CMS Ex. 59 at 3; P. Ex. 2 at 25; Tr. 275-76.

32. Nurse Hodges became aware of the letter sent by Ms. Craig, and she called the oral surgeon's office, informing them that R87 was hospitalized and not currently a resident, and therefore, they needed to call Thomas Memorial to get clearance from his current physician. Tr. 177-81.

33. R87 was readmitted to Petitioner's facility on July 24, 2014. P. Prehearing Br. at 16; P. Ex. 1 at 13.

34. On July 31, 2014, a registered dietician conducted a nutritional assessment of R87 following his readmission to the facility. P. Ex. 1 at 13-14. Among other things, she noted that R87 weighed 117.6 lbs. on July 28, 2014, and had weighed in the 130's prior to his hospitalization. P. Ex. 1 at 13. The dietician made recommendations regarding R87's tube feedings and his nutritional supplements. She stated that R87 "appears malnourished, cachectic, and current [recommendations] would be made [related to] maintenance vs any significant improvement based on overall poor prognosis." P. Ex. 1 at 14. The dietician also noted that R87 was "awaiting complete dental extraction." P. Ex. 1 at 13.

35. On September 20, 2014, an LPN conducted an oral assessment of R87. CMS Ex. 13, Part H at 8; *see* P. Ex. 1 at 71. In her assessment report, the LPN documented that R87 experienced pain in his mouth, jaw, or tongue; his teeth were decayed; and more than three teeth were missing. The LPN noted that R87 was "awaiting dental procedure." CMS Ex. 13, Part H at 8.

36. According to the progress notes, on September 23, 2014, R87, who was having breathing problems, was transported to the Thomas Memorial's emergency room for an

evaluation of his lungs. A chest x-ray was negative for pneumonia, but R87 was started on IV antibiotics. Later that day, R87 returned to Petitioner's facility from the emergency room with new orders for IV antibiotics. *See* P. Ex. 1 at 68, 71.[2]

37. In a Social Service progress note dated September 26, 2014, social worker Justine McCray stated that she called Thomas Memorial and left a message with their social work department "pertaining to [R87's] teeth extraction. Currently awaiting a call back." P. Ex. 1 at 63.

38. On September 27, 2014, R87 experienced a fever and was admitted to Thomas Memorial's emergency room for evaluation. P. Ex. 7 at 1; *see* P. Ex. 1 at 62. Among other things, the history and physical report stated the following: R87 had recently been seen in the emergency room on September 23, 2014; R87 stated he had pneumonia several times over the last year or so; R87 "has a tracheostomy and had difficulty expectorating his secretions;" R87 ambulates with a walker; and R87 had MRSA pneumonia in June 2014. P. Ex. 7 at 1, 2, 5.

39. On September 27, 2014, a consulting physician, Dr. Eggleston, examined R87 and stated in his report that R87 had a regular cardiac rate and rhythm, and his lungs were "significantly diminished bilaterally." He noted that R87 "has multiple decayed teeth in his oropharynx." With respect to his cardiovascular and pulmonary systems, Dr. Eggleston stated that R87 had a regular cardiac rate and rhythm, and his lungs were "significantly diminished bilaterally." P. Ex. 7 at 12. His plan for R87 including continuing intravenous antibiotics and nebulizers. P. Ex. 7 at 13.

40. Another consulting physician, Dr. Modi, examined R87 on September 29, 2014. P. Ex. 7 at 7-10; CMS Ex. 13, Part H at 1-4. In his report, Dr. Modi noted that R87 had "been admitted to the hospital on several occasions for aspiration pneumonia and acute respiratory failure." P. Ex. 7 at 7, 9; CMS Ex. 13, Part H at 1, 3. Dr. Modi noted that R87 had been at Teays Valley Rehabilitation and "reports walking up to 500 feet with a walker." P. Ex. 7 at 7; CMS Ex. 13, Part H at 1. He stated that R87's "symptoms are severe in nature and present at rest and made worse with exertion. He is requiring oxygen." P. Ex. 7 at 7; CMS Ex. 13, Part H at 1. Among his findings, Dr. Modi stated that R87 "has very poor dentition" and that his "[t]eeth are in extremely poor condition with caries." P. Ex. 7 at 7, 9; CMS Ex. 13, Part H at 1, 3. Dr. Modi's report indicates he sent a copy to Dr. Skaggs. P. Ex. 7 at 10; CMS Ex. 13, Part H at 4.

41. On October 4, 2014, R87 was discharged from Thomas Memorial and was readmitted to Petitioner's facility. P. Ex. 7 at 14-15; *see* P. Ex. 1 at 62. Under "Hospital Course and Treatment," the Thomas Memorial discharge report stated, in relevant part:

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[2] The hospital records from the Thomas Memorial emergency room are inconsistent because a September 27, 2014 record states that R87 was previously diagnosed on September 23 with pneumonia "[a]t that time." P. Ex. 7 at 1.

> Overall his lung condition improved even though we did not see much improvement in the x-ray. He did have a lot of secretions which needed suctioning. He does require bronchodilator therapy and his body pain is controlled with morphine liquid . . . . He does have chronic atrial fibrillation. Rate is controlled. He will be discharged back to Putnam Rehabilitation Center.

P. Ex. 7 at 14-15. The discharge report was sent to two consulting physicians (Dr. Modi and Dr. Wade, a pulmonologist) and Putnam Rehabilitation Nursing Home. P. Ex. 7 at 14-15.

42. During the state survey on October 15, 2014, Nurse Hodges contacted Mountain State to follow up on R87's teeth extraction procedure. P. Ex. 1 at 57. Nurse Hodges stated in a progress note that Mountain State requested "current medical clearance for extraction," and she noted that she would obtain the clearance from Dr. Skaggs and that "[R87]" is aware." P. Ex. 1 at 57.

43. On October 15, 2015, Mountain State faxed a Request for Medical Clearance form for R87 to Petitioner's facility. According to the handwritten comments, Mountain State needed Petitioner to provide a "Medical Clearance [with] Current H & P [history and physical] and also labwork. P. Ex. 2 at 20; CMS Ex. 13, Part D at 58.

44. On October 15, 2014, Dr. Skaggs wrote on the Request for Medical Clearance form that he would refer R87 to his pulmonologist for the medical clearance. P. Ex. 2 at 26; *see* P. Ex. 1 at 53. It appears that Petitioner's facility then faxed the form back to the oral surgeon's office that same day. P. Ex. 2 at 26.

45. A progress note written by the nurse practitioner, dated October 16, 2014, states, in relevant part,

> Discussed dental extraction, resident is very high risk if undergoes sedation, and resident understands that finding a dentist willing to do the procedure given the risks is very difficult. Resident reports that while he does want his teeth removed he is still weighing the risks and benefits of the procedure and will decide definitively if a surgeon is found and medical clearance is given by his pulmonologist for sedation. Denies oral pain.

P. Ex. 1 at 54.

46. In a Social Service progress note dated October 16, 2014, Social Worker McCray stated that she had spoken to Tami Handley, Ombudsman, on October 15, 2014, regarding R87's teeth "and other resources in the community that might assist with teeth removal." According to Ms. McCray, Ms. Handley said she "was not aware of any other resources that could help him" with his teeth removal and that she had "spoken to [R87] several times since his admission to this facility and at no time did he speak with her or voice any concerns to her about the removal of his teeth or issues with facility staff." P. Ex. 1 at 53. Ms. McCray's progress note also stated:

> On 10/16/14 LSW spoke with [R87] about the removal of his teeth to ensure he felt the facility was adequately meeting his needs. [R87] stated he felt the facility had done everything possible to assist him with his oral needs and voiced no complaints related to our attempts in assistance. [R87] was able to voice why he could not obtain medical clearance and stated that Dr. Skaggs was very clear in explaining why he would not give [R87] clearance for oral surgery. [R87] appeared very informed and educated in regards to what the facility has done to assist him in this process. He stated he was very happy with Dr. Skaggs care and did not wish to seek primary care from another physician.

P. Ex. 1 at 53.

47. On October 20, 2014, Pulmonary Associates faxed Nurse Hodges a document signed by Dr. Grey which provided medical clearance for R87's teeth extraction procedure. P. Ex. 2 at 27-28. In the document, Dr. Grey stated, in relevant part:

> [R87] is a 62 y/o male with recurrent Pneumonia who has horrible dental carries [sic] in need of total dental extraction. He has a Permanent trache which can be utilized for mechanical ventilation if needed. He has high risk from a pulmonary standpoint but would be able to have surgery if warranted.

Dr. Grey stated "[R87] needs total dental extraction which I believe is warranted." P. Ex. 2 at 28.

48. Consistent with the receipt of Dr. Grey's faxed document, Nurse Hodges documented in a progress note dated October 20, 2014, that medical clearance had been obtained from Dr. Grey's office "for IV sedation for teeth extraction." Her note further states: "Clearance states resident is high risk. Surgical clearance and coumadin plan

faxed to Mountain state oral surgeons. Resident is aware of facility obtaining clearance and that Mountain State has all documentation needed to schedule surgery. Resident states verbal understanding." P. Ex. 1 at 52.

49. Dr. Skaggs wrote a letter dated October 20, 2014, which states the following:

> To Whom It May Concern:
>
> I am caring for [R87] as his primary care physician at Putman Care and Rehab. [R87] has a long list of significant medical problems including chronic respiratory failure as well as severe dysphasia and protein calorie malnutrition requiring a peg tube. It is my professional medical opinion that he has not been medically stable to undergo complete dental extraction from February 2014 through June 2014.

CMS Ex. 13, Part C at 25.

49. According to her progress note dated October 23, 2014, Nurse Hodges spoke with an employee at Mountain State to follow up on R87's tooth extraction procedure and was informed that Petitioner's facility "[had] provided all documentation and surgical clearance . . . to schedule surgery" and would be contacted by Mountain State when they had scheduled a surgery date. P. Ex. 1 at 50.

50. On November 6, 2014, Dr. Grey examined R87. Among the findings in his consultation report, Dr. Grey stated, "Pt with trach who needs total extraction of [his] teeth to hopefully prevent recurrence of ASP Pneumonia. . . . Extraction hopefully will help." P. Ex. 2 at 29.

51. According to a progress note dated December 3, 2014, Mountain State informed Petitioner's nurse that, as of that date, R87's surgery was scheduled for January 15, 2015, and they would follow up with a definite time and date. P. Ex. 1 at 44; *see* CMS Ex. 55, Part B at 18, 41.

52. Progress notes dated December 4, 2014, indicate that Petitioner's nurse informed R87 of his January 15, 2015, surgery date, and R87 stated he was aware of the risks but "looking forward to getting it done." R87 stated that he "believes it will be worth it" and "thinks once teeth are out he will have no more pneumonia." P. Ex. 1 at 44.

53. On January 15, 2015, Dr. Krajekian performed the full dental extraction procedure on R87 as outpatient surgery at Teays Valley Hospital. P. Ex. 1 at 33; CMS Ex. 55, Part B at 23, 29, 42-43. The anesthesia record and the perioperative record show that R87 underwent the surgery under general anesthesia. CMS Ex. 55, Part B at 26-27, 32.

Also, on the "Pre-Anesthesia Evaluation" form, "GA" [General Anesthesia] is checked off under "Anesthesia Plan of Care." CMS Ex. 55, Part B at 40. In his operative report, Dr. Krajekian indicated that R87 received anesthesia "via monitored anesthesia care." CMS Ex. 55, Part B at 29.

V. Conclusions of Law and Analysis

My conclusions of law are set forth in bold font below.

1. **Petitioner was not in substantial compliance with 42 C.F.R. § 483.25 because Petitioner's staff failed to provide necessary care and services to R87 to address his severe periodontal disease.**

The quality of care regulation, 42 C.F.R. § 483.25, requires that "[e]ach resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care." A failure to follow a resident's plan of care that is based on the comprehensive resident assessment is a clear case of failing to meet the requirements of 42 C.F.R. § 483.25. *Cedar Lake Nursing Home*, DAB No. 2288, at 6-7, 10 (2009), *aff'd, Cedar Lake Nursing Home v.U.S. Dep't of Health & Human Servs.*, 619 F.3d 453 (5th Cir. 2010); *Spring Meadows Health Care Ctr.*, DAB No. 1966, at 17 (2005). The language of 42 C.F.R. § 483.25 not only requires skilled nursing facilities to furnish the care and services set forth in a resident's care plan but also to implement physicians' orders, monitor and document the resident's condition, and follow its own policies. *See, e.g., Alexandria Place*, DAB No. 2245 (2009).

In its March 2, 2015 request for hearing and July 31, 2015 pre-hearing brief, Petitioner indicates that, although the SOD alleged that Petitioner had violated several participation requirements, it is only challenging the alleged violation of 42 C.F.R. § 483.25 (Tag F309), S/S J, relating to R87. CMS alleged in the SOD that Petitioner violated 42 C.F.R. § 483.25 because R87 "was not sent to an oral surgeon for extraction of all remaining natural teeth due to severe periodontal disease." CMS Ex. 1 at 21. In explaining Petitioner's deficient care in addressing R87's dental needs, the SOD stated, in relevant part:

> The facility failed to provide evidence of any attempts made to obtain medical clearance from any physician . . . . Review of the medical director/attending's progress notes, after the consult with the oral surgeon on 02/17/14, found no indication of medical clearance for oral surgery. . . . The DON could not provide any noted attempts to assist the resident in getting medical clearance for the extraction of the

> resident's remaining natural teeth. . . . [R87's] need for medical clearance for the removal of his remaining natural teeth due to severe periodontal disease and continuing pain and discomfort from his broken and decayed teeth was not addressed until brought to the attention of the facility during the survey. Based on these findings, [R87] was found to be in an immediate jeopardy situation.

CMS Ex. 1 at 21, 26-27.

Petitioner argues that its staff did not fail to provide necessary dental services to R87 and that "in the context of his many medical problems, he *did* attain and maintain his highest practicable status." P. Br. at 3. In explaining why R87 did not have his teeth extracted until more than a year after his dentist's recommendation, Petitioner argues that R87's treating physician determined that R87 "was too ill during 2014 to undergo general anesthesia and oral surgery." P. Reply at 21; *see* P. Br. at 14-15. Petitioner points out that R87 "understood that the reason for the delay was that he was too sick" to have the teeth extraction procedure. P. Br. at 3-4. Petitioner contends further that any supposed delay in the scheduling of the procedure is also attributable to the logistics involved to arrange it. Finally, Petitioner challenges the credibility of CMS's expert witness, Dr. Cheifetz, asserting that, notwithstanding his impressive resume, he had neither the knowledge nor the experience to render opinions regarding Petitioner's care of R87. P. Br. at 1.

I find that neither the SOD's allegations nor Petitioner's arguments are entirely accurate. Therefore, while I conclude that Petitioner failed to provide R87 with the necessary dental care and services he required, I also conclude that Petitioner's noncompliance did not begin until July 25, 2014, the day after R87 was readmitted to the facility following an extended hospitalization.

Between February 17, 2014 and July 2014, R87's health was greatly compromised and he would not have been a suitable candidate for oral surgery during this time frame. The record reflects that during this period, R87's condition deteriorated and he was hospitalized for an extended time beginning in June 2014 with aspiration pneumonia, MRSA, and sepsis. P. Ex. 5 at 1-3, 5; P. Ex. 6 at 4-5, 9. However, by July 25, 2014, R87's condition had improved and stabilized such that Petitioner's staff should have moved expeditiously forward with arranging for his teeth extraction procedure. Instead, neither Dr. Skaggs, who is R87's attending physician and Petitioner's Medical Director, nor the nursing staff took any action to ensure that R87 received oral surgery. It was not until October 2014, when the state surveyors were on site and brought the issue of R87's severely decayed teeth and the long-delayed oral surgery to their attention that Petitioner's staff, including Dr. Skaggs, was finally prompted to take action and move forward on R87's surgery.

There is no dispute that R87 suffered from severe periodontal disease for many years and needed all his teeth removed. P. Ex. 13; P. Ex. 14 at 1-2; Tr. 22. There is also no doubt that, besides having dental problems, R87 suffered from other serious medical issues, including, among other things, dysphagia, protein-calorie malnutrition, severe weight loss, atrial fibrillation, recurrent pneumonia. R87 also had a gastrostomy tube (feeding tube). Before he was admitted to the facility in April 2013, R87 underwent a spinal surgical procedure at Thomas Memorial in February 2013 and a tracheostomy in March 2013. When R87 was transferred to Select Specialty on March 11, 2013, the history and physical report stated that R87 had lost 100 pounds in the last eight months and described him as "partially edentulous with poor dentition of remaining teeth." P. Ex. 3 at 2. At the time of his admission to Petitioner's facility, the assessment by Petitioner's staff indicated, among other things, that R87's teeth in all four quadrants were in "poor" condition. P. Ex. 1 at 10; CMS Ex. 29 at 10.

As support for its position that R87 was too ill to have had the teeth extraction procedure in 2014, Petitioner relies on the testimony of R87's attending physician, Dr. Skaggs. Dr. Skaggs acknowledges that R87 "had poor teeth for a long time" but states that he "did not consider [R87's] dental issues to be one of his more significant medical problems" since "his teeth were not interfering with his quality of life." P. Ex. 14 at 1; *see* Tr. 492-93. Dr. Skaggs expressed his opinion that he "[did] not believe that [R87] was strong enough to tolerate elective dental surgery in late 2013 and through 2014." P. Ex. 14 at 2; *see* Tr. 471-72.

According to Dr. Skaggs, his October 16, 2013 order giving medical clearance for R87 was intended to serve as written clearance for R87's teeth extraction procedure, but with the qualification that R87 could undergo the procedure under "local or minimal twilight sedation only." P. Ex. 14 at 2. Dr. Skaggs testified that he considered R87's overall condition and "was not sure [R87] could survive general anesthesia for the surgery." P. Ex. 14 at 2. Dr. Skaggs testified that at that time, he believed that the only form of anesthesia R87 would have been able to tolerate was twilight anesthesia. Tr. 491. Dr. Skaggs stated that he "made the medical judgment that the risks of anesthesia far outweighed any potential benefit." P. Ex. 14 at 2.

In Dr. Skaggs' opinion, the "low point" of R87's illness was during the period "between early June and late July, 2014 when [R87] was hospitalized." P. Br. at 15; *see* Tr. 495; CMS Ex. 13, Part C at 25. On cross-examination, when asked if he "ever recalibrate[d] a plan to figure out when [R87's] teeth extraction procedure was going to be done" after R87 returned to the facility in July 2014, Dr. Skaggs responded as follows:

> There was never any distinctive time line on which it was going to be done because his health status was always so unstable or labile even after returning to the facility.

Tr. 480. Dr. Skaggs opined that he did not believe that there were "other windows of time during that entire year between October of 2013 and October of 2014 when [R87] could have had the procedure done under MAC [monitored anesthesia care] anesthesia." Tr. 491.[3]

On re-direct examination, however, Dr. Skaggs conceded that R87 began to improve after his hospitalization in June. Tr. 495. He admitted further that R87's overall condition started to improve "between the end of July and the survey in October." Tr. 497. Dr. Skaggs testified:

> I mean, he was slowly improving. You know, I think again the trach[eostomy] helped so he could clear secretions again. He was in pretty poor condition in the summer. Therefore, I certainly wouldn't have expected him to rebound within, you know, several days, week, two weeks, you know, probably a few months. But he was starting to show improvement.

Tr. 498.

On cross-examination, Dr. Skaggs specifically admitted that R87's improvement was partly due to the reinstallation of his tracheostomy tube in June 2014, which "helped [R87] clear his secretions, which would have made it safer for surgery." Tr. 470. Dr. Skaggs noted further that R87 was also regaining muscle strength through therapy, and "he was stronger." Tr. 470; *see* Tr. 495, 497-98. However, when asked why R87 did not have the teeth extraction procedure sometime between June and October 2014 if the placement of the tracheostomy tube made a difference in R87's ability to tolerate the teeth extraction procedure, Dr. Skaggs could not provide a precise explanation, but stated only that R87 "needed more time to recuperate" from his hospitalization. Tr. 470-71. When asked whether he had documented anywhere in R87's clinical record that R87 needed to recuperate from his hospitalization before he underwent oral surgery, Dr. Skaggs responded, "I don't recall if that was documented or not." Tr. 471.

When asked whether he had seen R87 after his readmission to Petitioner's facility on July 24, 2014, following his hospitalization, Dr. Skaggs claims that he did see R87 at or about the time he came back to the facility. He opined that R87 was not in any shape to have oral surgery at that time. Tr. 496. Dr. Skaggs could offer no corroborating evidence to show that he examined R87 or assessed his health status, or even followed up on R87's teeth extraction procedure in any way in late July 2014.

Petitioner offered a letter written by Dr. Skaggs, which is dated October 20, 2014, and addressed "To Whom It May Concern." It is evident that Dr. Skaggs wrote this letter during the state survey of Petitioner's facility, which was completed on October 21, 2014.

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[3] Dr. Skaggs testified that monitored anesthesia care and twilight sedation are the same form of anesthesia. Tr. 479.

In the letter, Dr. Skaggs stated that it is his "professional medical opinion that [R87] has not been medically stable to undergo complete dental extraction from February 2014 through June 2014." CMS Ex. 13, Part C at 25. It is significant that in October 2014, Dr. Skaggs only thought R87's condition precluded the dental procedure from February 2014 through June 2014, and not through October 2014.

Taken as a whole, I do not find credible Dr. Skaggs' testimony that R87 was too sick from July 2014 through October 2014 to have the teeth extraction procedure. I recognize that he is R87's treating physician and thus, would be very familiar with R87's condition. However, I find that Dr. Skaggs' testimony was, at times, unconvincing, evasive, and contradictory. Significantly, Dr. Skaggs was not able to produce any contemporaneous documentation in R87's medical record to corroborate Dr. Skaggs' claims that he had not ignored R87's dental issues and had indeed made medical judgments regarding R87's health status relative to whether or not he could tolerate the teeth extraction procedure. Further, as I discuss below, the testimony of CMS's expert witness, Dr. Cheifetz, refuted Dr. Skaggs' testimony in significant respects.

Undercutting Dr. Skaggs' opinion that R87 was not stable enough to have had the teeth extraction procedure between July 2014 and October 2014 is the fact that R87's treating physicians at Thomas Memorial attempted to arrange for R87 to have the teeth extraction procedure done while he was a patient at the hospital in June 2014. The Thomas Memorial discharge summary report dated June 19, 2014, states, in relevant part:

> Because the patient has had multiple recurrent episodes of aspiration pneumonia and has severe periodontal disease, efforts were made to contact dental surgery for tooth extraction. Dr. Martin is now on staff at Thomas Memorial Hospital and is awaiting the appropriate radiographic machinery to be able to do this procedure in our surgical suite and has agreed to see the patient as an outpatient for dental extraction once the appropriate device is in place.

P. Ex. 5 at 3. Dr. Skaggs was sent a copy of this report. P. Ex. 5 at 3, 5.

Further, the discharge summary report from Select Specialty, where R87 was a patient from June 19 through July 17, 2014, states, in relevant part:

> During his stay at Thomas Memorial Hospital, it was deduced that the reason behind the patient's multiple recurrent episodes of aspiration pneumonia was secondary to his severe periodontal disease. Dr. Martin, dentist, was consulted and in

> the very near future will do a complete tooth extraction of all the patient's teeth when Thomas Memorial Hospital is able to obtain the appropriate radiographic machinery, in order to do this procedure in their surgical suite.

P. Ex. 6 at 4; CMS Ex. 13, Part C, at 21. The discharge instructions state, among other things, that R87 would "be returning to Thomas Memorial Hospital in the very near future, as previously noted, for a complete dental extraction by Dr. Martin. Further arrangement for this will be made through the skilled nursing facility." P. Ex. 6 at 6; CMS Ex. 13, Part C, at 22-24.[4]

I find that the hospital discharge reports from Thomas Memorial and Select Specialty show the expectation that R87 would eventually have the oral surgery at Thomas Memorial and that Petitioner's staff would take appropriate action and make "further arrangements" for the surgery to happen. One would have expected that, after R87 returned to Petitioner's facility, Dr. Skaggs and Petitioner's staff would have reviewed the hospital discharge reports and, in accordance with the discharge instructions, evaluated R87's dental issues with the objective of moving forward expeditiously with arranging his oral surgery.[5] However, this did not occur.

The record contains no evidence that Dr. Skaggs addressed R87's dental issues following his readmission or even acknowledged that R87 was still awaiting the teeth extraction procedure since he did not have it done at the hospital. The only assessment that appears to have occurred after R87 returned to Petitioner's facility was the registered dietician's nutritional assessment, which took place on July 31, 2014. P. Ex. 1 at 14. In her assessment, the dietician noted that R87 was "[a]waiting complete dental extraction." P. Ex. 1 at 13. Further, according to the record, R87 did receive an oral assessment on September 20, 2014; however, the assessment was conducted by a LPN, not by Dr. Skaggs or a nurse practitioner. In her assessment report, the LPN documented that R87 had pain in his mouth, jaw, or tongue; his teeth were decayed; more than three teeth were missing; and that he was "awaiting dental procedure." CMS Ex. 13, Part H at 8. Although Petitioner's staff was apparently aware that R87 was to have oral surgery, there is no evidence that Dr. Skaggs or anyone else took any action to follow up on R87's teeth extraction procedure after he returned to the facility.

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[4] Petitioner claims that a physician's assistant may have written the Select Specialty discharge summary report, and therefore, suggests that the contents may not be attributable to the hospital physicians. P. Reply at 15-16. Petitioner has offered no evidence to support this assertion.

[5] For example, after R87 was admitted to Petitioner's facility on April 11, 2013, after his hospitalization, a nurse practitioner who examined him on April 15, 2013, noted that she had reviewed his hospital records. P. Ex. 9 at 1.

Dr. Skaggs claimed on cross-examination that he addressed R87's decayed teeth between October 17, 2013, and October 15, 2014; however, I find the record contains no contemporaneous evidence in the record to corroborate his assertion. Tr. 448-50. In fact, Dr. Skaggs concedes that, in his handwritten notes focused upon by CMS, he "did not specifically mention [R87's] teeth." Tr. 452. Rather, as the record plainly shows, it was not until the surveyors brought R87's serious dental issues to Dr. Skaggs' attention during the October 2014 survey, that he and the nursing staff were finally prompted to take any action to move forward with R87's oral surgery.

Petitioner downplays the scant documentation by Dr. Skaggs, and argues that it should not be faulted for this because ultimately, R87's overall condition actually improved. *See* P. Reply at 3-5; Tr. 494-95. Petitioner asserts it is more important to focus on resident outcomes, rather than "focusing on who wrote down what when." Tr. 750. Petitioner argues that "hundreds of Board decisions," which addressed a facility's compliance with 42 C.F.R. § 483.25, have indicated that the focus should be "outcome oriented" rather than on "nit-picking 'paper compliance' " or 'process' issues." P. Reply at 4; Tr. 750.

I am unpersuaded by Petitioner's arguments on the issue of documentation. Petitioner has not cited to even one decision that supports its premise that documentation is unnecessary where the resident has not suffered a poor outcome. It is true that, in examining the legislative history of 42 C.F.R. § 483.25, that "the preamble to the final rule implementing this provision (*see*, e.g., 54 Fed. Reg. 5316, 5332) states that the wording reflects an approach that emphasizes resident care outcomes, rather than procedural and structural requirements." *Golden Living Center – Foley*, DAB No. 2625 at 16 (2012). However, the quality of care standard set forth in 42 C.F.R. § 483.25 requires, among other things, that a facility "monitor and adequately document each resident's condition." *Alexandria Place*, DAB No. 2245 at 5 (2009).

Thus, the fact that R87 may not have suffered a poor outcome does not excuse Dr. Skaggs' failure to adequately document his dental issues. Further, R87's much improved health in 2015 may be the result of the dental sugary, which, after all, was arranged to reduce R87's recurrent pneumonia.

To this point, CMS relies on the testimony of its expert witness, Dr. Cheifetz, in support of its position that Petitioner failed to provide necessary dental services to R87. Dr. Cheifetz is a Board-certified oral and maxillofacial surgeon with 35 years of experience, and he is also Board-certified by the National Dental Board of Anesthesiology. CMS Ex. 58 at 1-2. Although Petitioner argued that Dr. Cheifetz has neither the knowledge nor the experience to render opinions regarding Petitioner's care of R87, I find that Dr. Cheifetz is well-qualified to testify about R87's dental issues and the care he received from Petitioner.

Contrary to Dr. Skaggs' opinion, Dr. Cheifetz testified that R87's compromised health status would not have precluded him from undergoing the teeth extraction procedure. Dr. Cheifetz's expert opinion was that R87's condition did stabilize at a certain point between October 2013 and January 2015 and that during this time, R87 would have been able to tolerate the procedure. CMS Ex. 58 at 14. Dr. Cheifetz testified further that by failing to have R87 undergo the procedure in a more timely manner, Petitioner's staff exposed him to the risk of serious harm. CMS Ex. 58 at 14. I accept as credible and persuasive Dr. Cheifetz's expert opinions, and, as I discuss below, find that his testimony undermined the credibility of Dr. Skaggs.

In discussing R87's condition and whether he was able to tolerate oral surgery, Dr. Cheifetz acknowledged that "there were periods of time where perhaps [R87] was not medically stable or cleared to do the procedure." Tr. 707. He testified that when R87 was first admitted to the hospital in June 2014, this would not have been a "window of time" when he could not have had the oral surgery because he had "full-blown pneumonia that needed to be treated, and was and gotten under control." Tr. 707-08.

However, Dr. Cheifetz disagreed with Dr. Skaggs' opinion that R87 was too sick to undergo the teeth extraction procedure during the entire period that spanned February 17, 2014 through October 2014. Tr. 675; *see* Tr. 706-07. He testified that "there were windows of opportunity" during this time frame when R87 would have been able to have the procedure. Tr. 707; *see* CMS Ex. 58 at 14. Dr. Cheifetz expressed the opinion that R87 was "in a physical condition where he could have tolerated the surgery" at the end of July 2014 when he was readmitted to P's facility. Tr. 647 .

Dr. Cheifetz testified that a total tooth extraction could be safely performed on a patient who had a tracheostomy in place, and that he had performed such a procedure himself in the past. Tr. 742-43. Dr. Cheifetz testified that the procedure may be safer to do with a tracheostomy because "a tracheostomy is a direct route to the airway" and "the airway is always maintained in a tracheostomy patient." Tr. 743-44. In the situation where a patient does not have a tracheostomy and requires general anesthesia, Dr. Cheifetz testified that "the process is putting the patient to sleep with anesthetics, and then intubating the patient, reacquiring an airway, because when a patient has a general anesthetic, they can't maintain their own airway." Tr. 743.

Dr. Cheifetz testified that the fact that a patient has "a chronic illness or multiple co-morbidities" does not preclude the patient from having oral surgery. Tr. 705-06. He testified that a patient with pneumonia would not be precluded from having a total teeth extraction procedure, but noted that the procedure might have to be deferred depending on the severity of the pneumonia. Tr. 692. However, according to Dr. Cheifetz, "if the teeth are considered a contributing factor and causative to the pneumonia . . . you have to decide is it in the patient's best interest to remove a source of infection causing the patient to have recurrent bouts of pneumonia." Tr. 692. Dr. Cheifetz noted that a "judgment" would need to be made "as to the necessity of the surgery in the face of

pneumonia." Tr. 692. He testified further that a patient on blood thinning medication would not be precluded from having oral surgery and noted that "[t]here are methodologies available to minimize" the risks to patients who are on blood thinners. Tr. 693.

In Dr. Cheifetz's opinion, R87 "could have tolerated the surgery" at the end of July 2014 when he was readmitted to Petitioner's facility following his hospitalization. Tr. 647. In support of his assertion, Dr. Cheifetz points to the fact that R87 had a tracheostomy under general anesthesia in June 2014. Tr. 647, 707, 713; CMS Ex. 58 at 8, 14. Dr. Cheifetz testified that a tracheostomy would be "a moderate, low-risk surgical procedure in some patients," but that for R87, his physicians would likely have considered the procedure to be "high-risk," but necessary. Tr. 592. Citing R87's medical records, Dr. Cheifetz testified that R87 underwent the tracheostomy under general anesthesia, "which is the most risky . . . anesthetic protocol for any patient." Tr. 707.[6] Dr. Cheifetz noted further that R87 "tolerated the procedure and anesthesia well, and likely would have tolerated the same anesthetic technique for removal of his teeth during that same hospitalization." CMS Ex. 58 at 8. In Dr. Cheifetz's opinion, R87's tracheostomy "supports the conclusion that surgical procedures can be performed on medically compromised patients, when necessary." CMS Ex. 58 at 6; *see* Tr. 707.

As further evidence that R87's condition had stabilized enough such that oral surgery would have been possible, Dr. Cheifetz noted that R87's treating physicians at Thomas Memorial had attempted to arrange for him to undergo the teeth extraction procedure during his hospitalization in June 2014. Dr. Cheifetz testified that the physicians' actions in trying to schedule the procedure "reflected their medical opinion that [R87] was stable enough to have it." Tr. 709; *see* Tr. 713. According to Dr. Cheifetz, the hospital notes show that the Thomas Memorial physicians believed that R87's severe periodontal disease was a "contributing factor to his recurrent bouts of aspiration pneumonia." Tr. 676-77; *see* Tr. 700. Dr. Cheifetz opined that the Thomas Memorial physicians recognized that R87's teeth needed to be removed in order to "benefit his overall systemic health." Tr. 677, 700.

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[6] Dr. Cheifetz testified that there is a continuum of levels of anesthesia. He stated that the acronym "MAC" stands for "monitored anesthesia care," which means that an anesthesiologist is present in the operating room, monitoring the patient. Tr. 704. According to Dr. Cheifetz, a patient might receive local anesthesia in conjunction with MAC. CMS Ex. 58 at 4. Dr. Cheifetz explained that the lightest form of intravenous anesthesia is conscious sedation (the term "twilight sedation" is no longer used), and then next on the continuum are deep sedation and general sedation. Tr. 703-05; *see* CMS Ex. 58 at 4. With general anesthesia, the patient loses consciousness, "does not respond to pain, must have the airway maintained, possibly with a ventilator, and may have altered cardiac function." CMS Ex. 58 at 4.

Dr. Cheifetz emphasized that in stating that R87's condition had stabilized at certain points, he did not mean to imply that R87 was in good or perfect health:

> And when the patient record indicates no change from yesterday, or he's evaluated a week later, and says no change from a week prior, then you can say, in spite of his medical problems, he is stable. However, when he has episodes that require him to go to the hospital for emergency evaluation, get a chest X-ray, or be admitted for the aspiration pneumonia, clearly those are not opportunities. But I think you can review the chart and find that there are periods of time where he was stable. **Not healthy, not 100 percent but stable enough to have the procedure done.**

Tr. 724 (emphasis added).

When asked whether the teeth extraction procedure could be characterized as an elective procedure for R87, Dr. Cheifetz opined that it was "a priority procedure" for R87. Tr. 674. In explaining his answer, Dr. Cheifetz described the serious risks posed by R87's periodontal disease to his health:

> The multiple decayed teeth [R87] has are a significant risk to any patient, for that process to advance to either localized infection, or to advance to a more regional or systemic infection. And I think that risk is compounded in a patient who has some underlying medical problems, such as diabetes.

Tr. 674-75.

In his declaration, Dr. Cheifetz also testified about the serious consequences of the failure to follow up on R87's oral surgery, and his statements are consistent with his testimony at the hearing:

> Due to the severely decayed teeth, a risk existed that portions of the teeth could break off, causing a risk of aspiration, a risk magnified in the presence of dysphagia.
>
> The severely decayed teeth had the potential for an acute situation resulting in a localized dental abscess. The severe, chronic periodontitis could also become acute. Either of these occurrences would further compromise a patient's health status.
>
> In a patient with co-morbidities such as Resident 87, the localized infections could become extensive and systemic, causing a decrease in the patient's medical well-being.

CMS Ex. 58 at 9-10. As stated by Dr. Cheifetz, "the bacterial components and inflammation associated with chronic periodontal disease may increase the risk of systemic disease. . . . In the presence of dysphagia, these bacteria could be aspirated and exacerbate an already compromised pulmonary condition." CMS Ex. 58 at 10.

Dr. Cheifetz testified that when R87 finally had the teeth extraction procedure in January 2015, he received general anesthesia. Dr. Cheifetz noted that the surgery took 45 minutes, and did not require R87 to remain overnight at the hospital. Tr. 649, 707, 722; CMS Ex. 58 at 11, 14; *see* CMS Ex. 55, Part B at 26-27, 42-43.[7]

I find that Petitioner did not rebut Dr. Cheifetz's expert opinions. In fact, Dr. Cheifetz's opinion regarding R87's status is supported by Dr. Skaggs' own testimony. Dr. Skaggs himself testified that R87's condition began to improve "between the end of July [2014] and the survey in October." Tr. 497. On cross-examination, Dr. Skaggs admitted that the tracheostomy procedure was beneficial to R87 and made it safer for him to undergo the oral surgery. When Dr. Skaggs was asked why R87 did not have the procedure sometime between June 2014 and October 2014 if the placement of the tracheostomy tube made a difference in his ability to tolerate the teeth extraction procedure, Dr. Skaggs could only offer the vague response that R87 "needed more time to recuperate." Tr. 470.

Further, when asked on cross-examination whether it was "true that Resident 87 had the tracheostomy put in place under a general anesthesia procedure," Dr. Skaggs gave a non-responsive answer, stating, "I can repeat the same answer I just gave, that under those circumstances they're directly controlling the airway by putting in a trach, which would therefore make that a relatively low-risk procedure." Tr. 472-73. Inasmuch as Dr. Skaggs does not deny that R87 successfully underwent the tracheostomy under general anesthesia in June 2014, I find that Dr. Skaggs' testimony fails to rebut Dr. Cheifetz's opinion that R87 was stable enough such that he could have undergone the teeth extraction procedure at the end of July 2014. Further, I am persuaded that the fact that the Thomas Memorial physicians attempted to arrange for R87 to undergo the teeth extraction procedure during his hospitalization in June 2014 is further evidence that R87's condition had stabilized enough such that oral surgery would have been possible at the end of July 2014. Dr. Cheifetz' testimony is enhanced because he based it in part on the physicians' actions in "trying to schedule [the] procedure [which] reflected their medical opinion that [R87] was stable enough to have it." Tr. 709; *see* Tr. 713.

[7] Following the surgery, R87 experienced complications and had to go to the emergency room due to post-surgical bleeding. R87 eventually recovered. P. Ex. 2 at 34-38; *see* P. Pre-hearing Br. at 18. Progress notes dated January 29, 2015 and February 5, 2015, state that R87 "has continued without any complications from recent surgery" and that he "has had no issues following dental extraction." P. Ex. 2 at 37-38.

Petitioner downplays the Thomas Memorial physicians' efforts to schedule the oral surgery, calling it "wishful thinking" on their part. P. Reply at 16. Petitioner asserts that Thomas Memorial did not have the appropriate equipment, and notes that "nothing ever came of the proposal." P. Reply at 16; *see* P. Br. at 16.

That R87 ultimately did not have the oral surgery while he was hospitalized at Thomas Memorial does not detract from the fact that R87's consulting physicians believed he should have the surgery and attempted to schedule the procedure while he was there. Even Dr. Skaggs acknowledged that he "was aware that while [R87] was at Thomas Hospital and Select Specialty Hospital in June and July, 2014, the physicians at Thomas Hospital made an effort to arrange for the surgery in the hospital's operating room, but were unable to do so."[8] P. Ex. 14 at 2. As discussed above, according to the hospital discharge reports, R87's physicians believed there was a correlation between his aspiration pneumonia and his severely decayed teeth. The physicians informed R87 that his decaying teeth were having a negative impact on his health and needed to be removed. P.Ex. 13 at 2; Tr. 19-20. As part of its efforts to arrange for the teeth extraction procedure, Thomas Hospital consulted a dentist on staff, Dr. Martin, and he was apparently prepared to perform the procedure once the appropriate equipment was in place. I have no reason to doubt the discharge reports from Thomas Memorial and Select Specialty, and Petitioner has offered no evidence to suggest that their veracity is to be questioned.

Further, I find nothing in the hospital reports that indicates that R87 was too weak or too ill to tolerate the teeth extraction procedure. Indeed, had the physicians believed that R87 was too ill and not stable enough to undergo the teeth extraction procedure, it is unlikely that they would have even considered the procedure, let alone attempted to arrange for a dentist and the proper equipment. In fact, as the reports make clear, the impediment to the scheduling of the surgery was not the status of R87's condition and whether he was sufficiently stable, but the lack of proper equipment to do the surgery at the hospital.

Further, as Dr. Cheifetz testified, Petitioner's failure to ensure that R87 received the teeth extraction procedure in a timely manner potentially subjected R87 to serious health risks. *See* CMS Ex. 58 at 9-10; Tr. 674-75, 699-700, 712. According to Dr. Cheifetz, R87's "decayed teeth are just a time bomb waiting to happen to cause infection, either localized,

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[8] At the hearing, Petitioner's social worker, Justine McCray, testified that she wrote the following Social Service note, dated September 26, 2014: "Called and left a message with Thomas Hospital social work department pertaining to [R87's] teeth extraction. Currently awaiting a call back." Tr. 206-07; CMS Ex. 13, Part D at 28. When asked to explain why she was calling Thomas Hospital several months later after R87 had been discharged to inquire about the procedure, Ms. McCray could not answer directly, and repeatedly stated that she would need to review her documentation. Tr. 207-08. Ms. McCray stated she never received a call back from Thomas Hospital. Tr. 210-11.

regionally, or systemically." Tr. 699. Even Dr. Skaggs, on cross-examination, begrudgingly admitted that R87 was susceptible to serious health risks. Dr. Skaggs conceded that with severely decayed teeth, there was a risk "that portions of the teeth could break off, causing a risk of aspiration;" he conceded that "severely decayed teeth had the potential to create an acute situation, resulting in a localized dental abscess;" and he conceded that there was a risk that if R87 "developed a localized infection in his mouth" which went untreated, the infection "could become extensive and systemic." Tr. 437-39. Dr. Skaggs admitted further that "periodontal disease could contribute to aspiration [pneumonia]" and that "oral bacteria can cause aspiration pneumonia." Tr. 440-41. He conceded that R87 "had a lot of bacteria in his mouth . . . because he had 28 to 29 rotting teeth." Tr. 441. Dr. Skaggs did not deny that it was possible for R87, with his dysphagia condition, to aspirate bacteria, which would then "exacerbate an already compromised pulmonary condition." Tr. 441. Further, Dr. Skaggs admitted that "there's an association between periodontal disease and increased mortality from pneumonia." Tr. 442. When asked if periodontal disease can exist in the absence of teeth, Dr. Skaggs testified, "[i]t generally does not." Tr. 442. As the foregoing testimony plainly indicates, Dr. Skaggs could not deny that the failure to provide the teeth extraction procedure to R87 in a timely manner made R87 more susceptible to serious, potentially life-threatening, risks and complications.

On the issue of documentation, Dr. Cheifetz testified emphatically that documentation plays a crucial role in the monitoring of a patient's condition. Dr. Cheifetz testified:

> [i]t is standard of care for any discussion about a patient, even [if] it's over the telephone, to be entered into the patient record as part of their treatment. . . . patient care, whether it takes place within the facility or in communication with another healthcare provider needs to be documented in the chart.

Tr. 732-733. According to Dr. Cheifetz, "We [the medical community] live by documentation." Tr. 735. His testimony further undermines the credibility of Dr. Skaggs, whose dismissive attitude regarding his lack of documentation on R87's dental issues and teeth extraction procedure was evident during his cross-examination.

Petitioner argues that another reason it should not be found out of compliance with 42 C.F.R. § 483.25 is that R87 himself that he never questioned Dr. Skaggs' medical judgments and expressed no dissatisfaction with the care he received from Petitioner's staff. *See* P. Br. at 24; P. Reply at 3; *see* Tr. 497; *see* P. Ex. 1 at 53. Petitioner points out that in response to my questioning, R87 testified that he had no concerns regarding the length of time it took for the teeth extraction procedure to be scheduled and understood that the reason for the delay was "that he was too sick during the pertinent interim to have the surgery." P. Br. at 3-4; *see* Tr. 33, 497.

As a competent resident, R87 was free to exercise his right to make his own medical decisions. *See* 42 C.F.R. § 483.10(c). R87 understood that he was too ill during the first half of 2014 to undergo the teeth extraction procedure. However, during his hospitalization at Thomas Memorial in July 2014, R87 was apparently ready to proceed with the teeth extraction procedure had the hospital been able to obtain the proper equipment. P. Ex. 13 at 3; Tr. 20-21. At the hearing, R87 testified that the physicians at Thomas Memorial conveyed their opinion that his decayed teeth were "having a negative impact on [his] health" and told him that "it [his teeth] was causing infections." Tr. 21. According to R87, the physicians told him that his decaying teeth were "causing infections" and that "[a]lthough none of the infections were related to it, . . . it would help the infections to combine." Tr. 21. Additionally, R87 had also been advised by his pulmonologist to have his teeth extracted because "[his] bad teeth might be making [his] lungs worse and even causing pneumonia." P. Ex. 13 at 2; *see* Tr. 26. There is nothing in R87's testimony to indicate that he had any reservations about having the oral surgery at Thomas Memorial while he was a patient there. Further, there is no indication from R87's testimony that the Thomas Memorial physicians were of the opinion that he was too ill to tolerate having oral surgery or that R87 himself questioned the physicians as to whether he was physically able to undergo the procedure.

Finally, Petitioner argues that "the logistics of arranging oral surgery for a Medicaid patient in the Charleston area – and anesthesia in a hospital operating room – is not as simple as CMS would make it seem." P. Reply at 19; *see* P. Br. at 20-21. I find nothing in the record that supports Petitioner's claim that complicated logistics hindered R87's oral surgery. After the oral surgeon examined R87 in February 2014, the oral surgeon required that R87 obtain medical clearance from his physician before the teeth extraction procedure could be scheduled. P. Ex. 2 at 16, 18. Thus, before logistics could even be considered, Petitioner's staff was obligated to take action and follow up with R87's oral surgeon regarding the request for medical clearance. According to Katie Craig, the Surgical Assistant/Hospital Scheduling Coordinator at the oral surgeon's office, Dr. Skaggs' October 16, 2013 order giving medical clearance "was not sufficient" because his signature was "not legible," "there was no printed name to indicate the identity of the signatory," and it "did not address whether [R87] was being administered blood thinner medications." CMS Ex. 59 at 2 ¶ 5; Tr. 247, 261. Therefore, Ms. Craig stated that, on February 17, 2014, her office faxed a document titled Request for Medical Clearance to Petitioner's facility to obtain medical clearance from Dr. Skaggs. *See* CMS Ex. 59 at 2-3 ¶ 6.[9]

[9] According to Ms. Craig, because she did not receive any response from Petitioner, she re-faxed the Request for Medical Clearance form to Petitioner on March 3, 2016. Ms. Craig stated that she continued to receive no response, so, in accordance with their office procedure, she faxed the Request for Medical Clearance every two weeks to Petitioner after March 3, 2014, except during the period March 17, 2014, through the beginning of June 2014, when she was out of the office on leave. CMS Ex. 59 at 3;

On July 23, 2014, Ms. Craig sent R87 a letter informing him that the office had not received the requisite medical clearance from his physician as of that date. CMS Ex. 59 at 3; P. Ex. 2 at 25. Ms. Craig stated that her letter further requested that R87 obtain the medical clearance from his physician "in order to move forward with . . . the oral surgery procedure." Nurse Hodges apparently became aware of this letter, and she called the oral surgeon's office, informing them that R87 was hospitalized and not currently a resident and so they needed to call Thomas Memorial to get clearance from his current physician. Tr. 177-80.

Inasmuch as I have determined that R87 was too ill through July 24, 2014, to have had the teeth extraction procedure, it is not necessary for me to consider whether there were multiple requests for medical clearance from the oral surgeon's office between March and July 23, 2014 which Petitioner may have ignored during this time frame. However, for the relevant time frame beginning with R87's readmission to Petitioner's facility on July 25, 2014, what the record shows is that no one on Petitioner's staff followed up with the oral surgeon's office on R87's teeth extraction procedure or sought to provide the required medical clearance until October 2014, when the surveyors intervened on behalf of R87.

According to the record, during the survey on October 15, 2014, Nurse Hodges contacted Mountain State to follow up on R87's teeth extraction procedure. The oral surgeon's office requested "current medical clearance for extraction;" and Nurse Hodges stated that she would obtain the clearance from Dr. Skaggs. P. Ex. 1 at 57. The record contains a Request for Medical Clearance from the oral surgeon's office, which was apparently faxed to Petitioner's facility on October 15, 2014. P. Ex. 2 at 20; CMS Ex. 13, Part D at 58. On October 15, 2014, Dr. Skaggs responded to this request for medical clearance by stating on the form that he would refer R87 to his pulmonologist for the medical clearance. P. Ex. 2 at 26; *see* P. Ex. 1 at 53. On October 20, 2014, Dr. Grey, R87's pulmonologist, faxed a document providing medical clearance for R87's teeth extraction procedure. P. Ex. 2 at 27-28. In a progress note dated October 20, 2014, Nurse Hodges documented that medical clearance had been obtained "for IV sedation for teeth extraction" and stated, among other things, "[s]urgical clearance and coumadin plan faxed to Mountain state oral surgeons. Resident is aware of facility obtaining clearance and that Mountain State has all documentation needed to schedule surgery." P. Ex. 1 at 52. This information is confirmed by Ms. Craig, who stated in her declaration that "[o]n October 21, 2014, over eight months after I had originally requested Medical Clearance from [Petitioner], I finally received Medical Clearance for [R87] so that the oral surgery involving the extraction of [R87's] teeth could be scheduled." CMS Ex. 59 at 3.

Tr. 246, 248. Ms. Craig testified that she did not know if anyone faxed the Request for Medical Clearance to Petitioner while she was out of the office. Tr. 248.

I note that Nurse Hodges testified that it was her "understanding" that Mountain State would obtain "their own medical and anesthesia clearance" for R87 to have the teeth extraction procedure. Tr. 161; *see* P. Ex. 16 at 3. According to Nurse Hodges, she called Mountain State "at least 15 times" to find out whether they were successful in obtaining clearance by an anesthesiologist. P. Ex. 16 at 3; *see* Tr. 162. Nurse Hodges documented her alleged phone contacts in her personal calendar for 2014 and not in R87's clinical record. *See* Tr. 162; P. Ex. 2 at 21-24. She testified, moreover, that she received only one faxed request for medical clearance from the oral surgeon's office, and was unaware of other requests that may have been faxed to the facility. Tr. 184.

I give little weight to Nurse Hodges' testimony. Nothing in the record supports her claim that obtaining medical clearance for R87's teeth extraction procedure was the responsibility of the oral surgeon's office. It is clear that the medical clearance requested by the oral surgeon's office was always to have been provided by R87's physician. And, in fact, this is exactly what occurred – after the oral surgeon's office faxed another request for medical clearance to Petitioner's facility on October 15, 2014, Dr. Skaggs responded to it by referring the request to R87's pulmonologist, who did provide the medical clearance a few days later.

The cause of the protracted delay in arranging for R87's teeth extraction procedure thus had nothing to do with logistics, but can be entirely attributed to Petitioner's staff, including Dr. Skaggs. At the time of the survey in October 2014, R87 still had not had the teeth extraction procedure. Although eight months had passed since R87's appointment with the oral surgeon, there was no evidence that anyone on Petitioner's staff, including Dr. Skaggs, had taken any action to follow up on the oral surgery so that it could move forward and be scheduled. In fact, when questioned as to whether any plan existed in October 2014, Dr. Skaggs admitted that, at the time of the October survey, the facility had no plan in place to get medical clearance for R87 or to move forward with the procedure. Tr. 481. Had it not been for the surveyors intervening on behalf of R87, one wonders how many more months would have passed before Petitioner's staff took any meaningful action with regard to moving forward with R87's teeth extraction procedure. *See* CMS Ex. 1 at 26-27.

2. 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 violation of 42 C.F.R. § 483.25 amounted to a scope and severity level of "J," constituting immediate jeopardy to resident health and safety. As discussed above, the evidence in this case supports a conclusion that Petitioner violated 42 C.F.R. § 483.25. 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).

There is no question that Petitioner placed R87's health in immediate jeopardy. As the timeline of events shows, Petitioner and its staff neglected to manage R87's dental issues. Following R87's readmission to Petitioner's facility on July 24, 2014, it was Petitioner's and Dr. Skaggs' responsibility to evaluate R87, follow up on his dental issues, and ensure that his oral surgery moved forward, especially given that his condition had improved. Dr. Skaggs testified that he was aware that the physicians at Thomas Memorial had unsuccessfully attempted to arrange for R87 to have the oral surgery while he was hospitalized. However, neither Dr. Skaggs nor anyone else on Petitioner's staff took any action after R87 was readmitted to follow up on his dental issues or teeth extraction procedure. In fact, it was only after the surveyors brought the issue of R87's severely decayed teeth and the delayed oral surgery to Petitioner's attention during the October 2014 survey, that Dr. Skaggs and the nursing staff were finally prompted to take any action to move forward with the procedure. The fact that Dr. Skaggs himself admitted that there were no plans in place regarding R87's oral surgery in October 2014 is further evidence of the complete lack of follow up and involvement by Petitioner's staff with respect to R87's teeth extraction procedure.

By failing to ensure that R87 had the teeth extraction procedure performed in a timely manner, Petitioner's staff placed him at risk of serious injury, harm, impairment or death as R87 could have developed potentially life-threatening infections or complications due to his severely decayed teeth. I note that R87 experienced actual harm in the form of pain in his teeth in October 2013, and that it was this pain that prompted R87 to request a dental appointment in the first place. The record shows that R87 also experienced pain in his mouth, jaw, or tongue in September 2014. As CMS's expert witness, Dr. Cheifetz, testified, R87's decayed teeth put him at risk of suffering serious consequences, such as a localized mouth infection that could become extensive and systemic, or aspiration pneumonia caused by oral bacteria. R87's treating physician, Dr. Skaggs, himself admitted on cross-examination that R87 was susceptible to such consequences by not having the teeth extraction procedure. Further, the possibility that he could face serious

health risks due to his severely decayed teeth was not lost on R87, who, after his surgery was finally scheduled, expressed his hope that once his teeth were extracted, he would no longer have pneumonia. P. Ex. 1 at 44.

As a result of its complete lack of responsive concern regarding R87's serious dental issues over several months, Petitioner put R87 in a situation of immediate jeopardy. I conclude that Petitioner has failed to meet its burden to show that the declaration of immediate jeopardy was clearly erroneous.

3. I modify the duration of Petitioner's noncompliance at the level of immediate jeopardy and find that Petitioner's immediate jeopardy level noncompliance began on July 25, 2014, instead of February 17, 2014, and extended through October 15, 2014.

As discussed above, I find that the evidence supports that Petitioner's immediate jeopardy level noncompliance did not begin on February 17, 2014, but began on July 25, 2014, which is the day after R87 was readmitted to Petitioner's facility following his hospitalization. From February 17, 2014 through July 24, 2014, R87 experienced serious health issues and he would not have been a suitable candidate for oral surgery during this time frame. However, the record shows that around July 25, 2014, R87's condition had improved and stabilized enough such that Petitioner's staff should have moved forward with his teeth extraction procedure. Instead, no one took any action regarding R87's procedure for months. It was not until October 15, 2014, during the survey, that Nurse Hodges contacted the oral surgeon's office to follow up on R87's teeth extraction procedure, and the oral surgeon's office again requested that Petitioner provide a current medical clearance. According to CMS, Petitioner submitted a plan to abate the immediate jeopardy on October 15, 2014, which was accepted by the state survey agency that same day. I do not find that Petitioner has offered any affirmative evidence to show that it abated the immediate jeopardy level noncompliance with 42 C.F.R. § 483.25 on any date that is earlier than October 15, 2014.

4. Petitioner's noncompliance that was less than immediate jeopardy extended from October 16, 2014 through December 16, 2014.

CMS found that Petitioner's noncompliance at the non-immediate jeopardy level began on October 16, 2014 and continued through December 16, 2014. The record shows that the state survey agency completed a revisit survey of Petitioner's facility on December 21, 2014. CMS Ex. 33. By letter dated December 23, 2014, the state survey agency notified Petitioner that it had corrected all the deficiencies. CMS Ex. 33; *see* CMS Ex. 31 at 7. Petitioner has not offered any affirmative proof to show that its non-immediate jeopardy level noncompliance ended earlier than December 16, 2014. Accordingly, I do not disturb CMS's finding that Petitioner's non-immediate jeopardy level noncompliance extended from October 16, 2014 through December 16, 2014.

5. I conclude that a CMP of $5,100 per day for the period of immediate jeopardy from July 25, 2014 through October 15, 2014, is reasonable, and that a CMP of $250 per day for the period of non-immediate jeopardy from October 16, 2014 through December 16, 2014, is 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. Unless a facility contends that a particular regulatory factor does not support the CMP amount, the administrative law judge must sustain it. *Coquina Ctr.*, DAB No. 1860 at 32 (2002).

My review of the reasonableness of the CMP is de novo and based upon the evidence in the record before me. I am not bound to defer to the CMS determination of the reasonable amount of the CMP to impose, but my authority is limited by the regulations. The limitations as set forth in the regulations are: (1) I may not set the CMP at zero or reduce it to zero; (2) I may not review the exercise of discretion by CMS in selecting to impose a CMP; and (3) I may only consider the factors specified by 42 C.F.R. § 488.438(f) when determining the reasonableness of the CMP amount. I am to determine whether the amount of any CMP proposed is within reasonable bounds considering the purpose of the Act and regulations. *Emerald Oaks*, DAB No. 1800 at 10 (2001); *CarePlex of Silver Spring*, DAB No. 1683 at 14-18 (1999); *Capitol Hill Cmty. Rehab. & Specialty Care Ctr.*, DAB No. 1629 (1997).

In the present case, CMS imposed a CMP of $5,100 per day for 241 days, from February 17, 2014 through October 15, 2014, for a total of $1,229,100.00; and a CMP of $250 per day for 62 days from October 16, 2014 through December 16, 2014, for a total of $15,500.00. CMS Ex. 31 at 7. However, based on my findings and conclusions above, I modify the commencement date of the per-day CMP imposed for the period of immediate jeopardy from February 17, 2014 to July 25, 2014. I find that there is no basis to impose a CMP from February 17, 2014 through July 24, 2014.

In its request for hearing, Petitioner states that it "challenges the amount and duration of the CMP." RFH at 5. After considering the factors in the regulations, I conclude that the CMP amounts, modified as I have indicated, are reasonable. CMS has not submitted any documentation that shows that Petitioner has a significant history of noncompliance, and

Petitioner does not argue that its financial condition affects its ability to pay the penalty. In its motion for an expedited hearing, Petitioner acknowledged that "its ultimate parent, Genesis HealthCare, had the resources to pay the entire CMP if the Board were to sustain it." P. Motion for Expedited Hearing at 7.

In considering the remaining factors, I have concluded that Petitioner's noncompliance under 42 C.F.R. § 483.25 was very serious, resulting in a situation of immediate jeopardy for R87. I also conclude that Petitioner is highly culpable. As discussed above, after R87's condition had stabilized to a point where he would have been able to have the teeth extraction surgery, for several months, no one on Petitioner's staff, including R87's attending physician, Dr. Skaggs, took any action to ensure that arrangements for R87's teeth extraction procedure moved forward. By doing nothing for months, Petitioner's staff placed R87 at the risk of suffering serious harm, for his decayed teeth made him susceptible to potentially life-threatening consequences. It was only after the surveyors brought R87's dental issues to Dr. Skaggs' attention during the survey in October 2014, that Petitioner's staff, including Dr. Skaggs, was finally prompted to follow up on the teeth extraction procedure with the oral surgeon's office.

In regard to the scope and severity of the deficiency, as indicated above, I agree that CMS properly determined that Petitioner's deficiency was at the immediate jeopardy level. I also believe that CMS properly continued to penalize Petitioner at a non-immediate jeopardy level from October 16, 2014 through December 16, 2014.

The $5,100 per day CMP that CMS imposed is in the lower half of the CMP range for immediate jeopardy level deficiencies ($3,050 per day to $10,000 per day). 42 C.F.R. § 488.438(a)(1)(i), (d)(2). As discussed above, I modified the period of immediate jeopardy, and I conclude, based on the factors above, that a $5,100 per day CMP from July 25, 2014 through October 15, 2014, is reasonable. Further, I find that the $250 per day CMP from October 16, 2014 through December 16, 2014, is at the low end of the CMP range for non-immediate jeopardy level deficiencies ($50 per day to $3,000 per day), and is also reasonable. 42 C.F.R. § 488.438(a)(1)(ii).

VI. Conclusion

I conclude that Petitioner was not in substantial compliance with 42 C.F.R. § 483.25. Further, I conclude that a $5,100 per day CMP from July 25, 2014 through October 15, 2014, and a $250 per day CMP from October 16, 2014 through December 16, 2014, is reasonable.

_____/s/_____
Scott Anderson
Administrative Law Judge