Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

In the Case of:	)	
	)	
Sheridan Health Care Center	)	
(CCN: 14-5665),	)	Date: August 24, 2007
	)	
Petitioner,	)	
	)	Docket No. C-04-315
- v. -	)	Decision No. CR1641
	)	
Centers for Medicare & Medicaid	)	
Services.	)	

DECISION

For the reasons discussed below, I find Petitioner, Sheridan Health Care Center, to have been in substantial compliance with program participation requirements at all relevant times, and find, further, that the Centers for Medicare & Medicaid Services (CMS) is not authorized to impose remedies against Petitioner.

I. Background

Petitioner is a skilled nursing facility located in Zion, Illinois. This case arose out of the survey cycle that began with a January 29, 2004 complaint survey. In a letter to Petitioner dated April 23, 2004, CMS advised the facility that as a result of the January 29, 2004 survey, the Illinois Department of Public Health (IDPH or state agency) determined that Petitioner was not in substantial compliance with participation requirements. CMS stated that the IDPH conducted a subsequent complaint survey on February 26, 2004, which found that Petitioner continued not to be in substantial compliance and that immediate jeopardy existed from February 3, 2004 through February 10, 2004. CMS advised Petitioner that a revisit survey on April 5, 2004, determined that Petitioner achieved substantial compliance on February

27, 2004. CMS's letter also advised Petitioner of the following: a denial of payment for new Medicare and Medicaid admissions, imposed effective March 25, 2004, was rescinded; a civil money penalty (CMP) of $3,050 per day from February 3, 2004 through February 10, 2004, and $200 per day from February 11, 2004 through February 26, 2004, would be imposed, for a total CMP of $27,600; and termination of Petitioner's Medicare and Medicaid provider agreement would not be imposed. CMS advised Petitioner further that directed in-service training was to be completed by March 25, 2004, and that it was prohibited from conducting a Nurse Aide Training and/or Competency Evaluation Program for two years from February 26, 2004 due to the finding of substandard quality of care.

By letter dated May 3, 2004, Petitioner requested a hearing challenging the findings of the state agency and the enforcement remedies imposed by CMS. The case was assigned to me for hearing and decision.

The parties executed a prehearing stipulation on January 4, 2005, in which they agreed that Petitioner was not challenging the January 29, 2004 survey, and that only F-tags F309, F325, and F327 cited in the February 26, 2004 survey were being contested, and only to the extent that those tags related to Resident 2 (R2). I conducted a hearing in this case on January 10-12, 2005, in Chicago, Illinois.

At the hearing, CMS offered as evidence, and I admitted, CMS Exhibits (CMS Exs.) 1, 7 through 12, 42 through 73, 112, 114 through 120, and 122 through 124. Petitioner offered as evidence, and I admitted, Petitioner Exhibits (P. Exs.) 1 through 20.

CMS presented testimony of the following witnesses: Paula Brennan and William Schubert. Petitioner presented testimony of the following witnesses: Dr. James Monahan, Paul Ross Zeller, Nancy Johnson, Marie Greathouse, Alysson Sward, Julie Stangel, and Marla Benson.

At the close of the CMS case-in-chief, Petitioner moved for "a directed finding." Tr. 295. I understood this motion to argue that CMS had not made its prima facie case, and took the motion under advisement. For purposes of clarity in this decision, I now deny the motion, since I believe that assuming that a prima facie case was made by CMS, it was successfully rebutted by Petitioner's evidence.

The parties filed posthearing briefs (CMS Posthearing Br. and Petitioner Posthearing Br.) and posthearing reply briefs (CMS Posthearing Reply and Petitioner Posthearing Reply).

Based on the applicable law and regulations, the documentary evidence, and the testimony taken at hearing, the preponderance of the evidence shows that Petitioner was in substantial compliance with federal participation requirements governing nursing homes, and therefore, CMS is not authorized to impose remedies against Petitioner.

II. Applicable Law and Regulations

The Social Security Act (Act) sets forth requirements for long-term care facilities (Medicare skilled nursing facilities (SNFs) and Medicaid nursing facilities (NFs)) participating in the Medicare and Medicaid programs, and authorizes the Secretary of Health and Human Services (Secretary) to promulgate regulations implementing the statutory provisions. Act, sections 1819 and 1919. The Secretary's regulations governing long-term care facilities participating in the Medicare program are found at 42 C.F.R. Parts 483, 488, 489, and 498.

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

If a facility is not in substantial compliance with program requirements, CMS has the authority to impose one or more of the enforcement remedies listed in 42 C.F.R. § 488.406, which include imposing a CMP. *See* Act, section 1819(h). CMS may impose a CMP for the number of days that the facility is not in substantial compliance with one or more program requirements, or, for each instance that a facility is not in substantial compliance. 42 C.F.R. §§ 488.430(a), 488.440.

In situations where deficiencies constitute immediate jeopardy, CMS may impose a CMP of between $3050 and $10,000 per day. 42 C.F.R. § 488.438(a)(1)(i). In situations where deficiencies do not constitute immediate jeopardy, but have caused actual harm or have the potential for causing more than minimal harm, CMS may impose a CMP of $50 to $3000 per day. 42 C.F.R. § 488.438(a)(1)(ii). An administrative law judge (ALJ) must uphold CMS's determination as to the level of noncompliance unless it is clearly erroneous. 42 C.F.R. § 498.60(c).

The Act and regulations make a hearing before an ALJ available to a long-term care facility against which CMS has determined to impose a CMP. Act, § 1128A(c)(2); 42 C.F.R. §§ 488.408(g); 498.3(b)(13). The hearing before an ALJ is a *de novo* proceeding. *Anesthesiologists Affiliated, et al*, DAB CR65 (1990), *aff'd*, 941 F.2d 678

(8th Cir. 1991); *Emerald Oaks*, DAB No. 1800, at 11 (2001); *Beechwood Sanitarium*, DAB No. 1906 (2004); *Cal Turner Extended Care*, DAB No. 2030 (2006)*; The Residence at Salem Woods*, DAB No. 2052 (2006). A facility has a right to appeal a "certification of noncompliance leading to an enforcement remedy." 42 C.F.R. § 488.408(g)(1); *see also* 42 C.F.R. §§ 488.330(e) and 498.3. However, the choice of remedies by CMS or the factors CMS considered when choosing remedies are not subject to review. 42 C.F.R. § 488.408(g)(2). A facility may only challenge the scope and severity level of noncompliance found by CMS if a successful challenge would affect the amount of the CMP that could be collected by CMS or impact upon the facility's nurse aide training program. 42 C.F.R. §§ 498.3(b)(14) and (d)(10)(i). CMS's determination as to the level of noncompliance "must be upheld unless it is clearly erroneous." 42 C.F.R. § 498.60(c)(2). This includes CMS's finding of immediate jeopardy. *Woodstock Care Center*, DAB No. 1726, at 9, 38 (2000), *aff'd, Woodstock Care Center v. Thompson*, 363 F.3d 583 (6th Cir. 2003).

When a penalty is proposed and appealed, CMS must make a prima facie case that the facility has failed to comply substantially with federal participation requirements. "Prima facie" means that the evidence is "(s)ufficient to establish a fact or raise a presumption unless disproved or rebutted." *Black's Law Dictionary* 1228 (8th ed. 2004); *see also*, *Hillman Rehabilitation Center*, DAB No. 1611, at 8 (1997), *aff'd, Hillman Rehabilitation Center v. U.S. Dept. of Health and Human Services*, No. 98-3789 (GEB), slip op. at 25 (D.N.J. May 13, 1999). To prevail, a long-term care facility must overcome CMS's showing by a preponderance of the evidence. *Batavia Nursing and Convalescent Center*, DAB No. 1904 (2004); *Batavia Nursing and Convalescent Inn*, DAB No. 1911 (2004); *Emerald Oaks*, DAB No. 1800 (2001); *Cross Creek Health Care Center*, DAB No. 1665 (1998); *Hillman Rehabilitation Center*, DAB No. 1611.

III. Issues

1. Whether Petitioner was out of substantial compliance with participation requirements.

2. Whether the CMPs imposed by CMS against Petitioner are reasonable.

IV. Findings of Fact and Conclusions of Law

I am obliged by the terms of 42 C.F.R. § 498.74(a) to set out numbered findings and conclusions in this Decision. I announce four: they appear below, identified by arabic numerals and set out in boldface.

V. Discussion

The three alleged deficiencies at issue in this case (Tags F309, F325, and F327) arise out of the care and treatment of one resident, R2. With respect to Tag F309, CMS alleges that Petitioner's noncompliance was at the immediate jeopardy level.

1. Petitioner was in substantial compliance with the participation requirement at 42 C.F.R. § 483.25 (Tag F309).

At Tag F309 of the Statement of Deficiencies (SOD) from the February 26, 2004 survey, the surveyors alleged that Petitioner failed to comply substantially with the requirement at 42 C.F.R. § 483.25 (Quality of Care). CMS Ex. 7, at 1-14. This regulation requires that:

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

42 C.F.R. § 483.25.

CMS alleged in the SOD that Petitioner violated the quality of care requirement with respect to R2 by failing to: (1) assess and monitor a change in R2's medical/psychiatric condition; (2) immediately notify the physician of a change in R2's behavior and an increase in R2's frequency of refusing meals; (3) immediately notify the physician of R2's significant weight loss; (4) accurately document R2's food intake; and (5) have R2 assessed by a Registered Dietitian. CMS Ex. 7, at 1.

The SOD alleges that Petitioner's failures placed R2 in immediate jeopardy, causing him to be transferred to the hospital on February 3, 2004. The SOD notes that R2, who was 52 years old, was diagnosed as having gastrointestinal bleeding, and had secondary diagnoses of dehydration and cachexia. R2 died 12 hours later of respiratory failure secondary to cachexia and malnutrition. CMS Ex. 7, at 1-2.

R2 was admitted to Petitioner's facility on August 31, 1998. P. Ex. 3; CMS Ex. 55. Prior to his admission, he had spent approximately six and one-half years at another nursing home in Chicago. P. Ex. 2; Tr. 380. Prior to March 1992, R2 had been at a State facility for the mentally ill. P. Ex. 1, at 5, 6; Tr. 379.

According to the SOD, R2 had diagnoses of blindness in both eyes and schizophrenia. CMS Ex. 7, at 2; P. Ex. 3; CMS Ex. 55. His minimum data sets (MDS) dated September 2, 2003 and December 2, 2003, documented that R2 was moderately impaired in cognitive skills for decision-making. CMS Ex. 7, at 2; CMS Ex. 64, at 2, 8. These MDSs also stated that he was independent with eating. CMS Ex. 7; CMS Ex. 64, at 2, 8. The SOD notes that the most recent Resident Assessment Protocol (RAP) Summary dated September 2, 2003, documented that R2 "displays moderately impaired decision-making skills due to delusions and paranoid ideations . . . requires supervision and cues to ensure safety" and "he has been without psychotropic medications since 10/00 because of refusal to take them." CMS Ex. 7, at 2; CMS Ex. 65, at 8.

The SOD notes further that R2's Psychiatric Assessment dated October 1, 2003, stated that he "is obsessed with his religious views. Has delusions – talking to God."[1] According to the assessment, R2 had hallucinations, and impaired perception, judgment, and insight. CMS Ex. 7, at 2; CMS Ex. 57. In a Social Service Assessment dated September 2, 2003, staff wrote, "Resident may not make correct decisions for self at times by refusing treatments/meds, stating God will heal him. Res. displays delusional behavior mentioning he's son of God . . . . " CMS Ex. 7, at 2; CMS Ex. 56, at 1. A Specialized Services Progress Note dated December 2, 2003, documented that "[r]esident exhibits delusional/hallucinotic behavior (stares in altered state/talking to self or non-existing being) and will relate he had communication with God . . . will frequently refuse care or act against healthful recommendations . . . refuses showers/shaves/meds/meals . . . ." CMS Ex. 7, at 2-3; CMS Ex. 59, at 5. A Social Service Quarterly Progress Note dated December 2, 2003, stated, "[r]es. displays poor choices by refusing meds/treatments stating 'God will heal me.'" CMS Ex. 7, at 3; CMS Ex. 59, at 7.

The SOD goes on to relate incidents and events involving R2 that occurred on January 24, 2004, January 27, 2004, and February 3, 2004. I describe these incidents below:

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[1] The SOD misstated the Psychiatric Assessment, which stated that R2 "is obsessed with his religious ideas." CMS Ex. 57, at 1.

Incident of January 24, 2004

According to the SOD, a nursing note dated January 24, 2004, at 6:45 a.m., documented that R2 told a nurse that he was not feeling well and needed to see a doctor.[2] R2 was "[n]oted to be cold & clammy but not in resp. distress." CMS Ex. 7, at 3; CMS Ex. 60, at 8. The next nursing note entry is dated February 3, 2004, and documented, "found res in bed weak appearance emaciated unable to obtain vital signs. page MD stat." CMS Ex. 7, at 3; CMS Ex. 60, at 8. The SOD states that the assistant director of nursing confirmed in a telephone interview on February 24, 2004, that there were no other entries in the nursing 24-hour log regarding R2 from January 19, 2004 to February 2, 2004. CMS Ex. 7, at 3.

The SOD notes that there are several "late entry" notes in R2's record that were written after the February 3, 2004 nursing note. According to the Administrator, staff wrote these notes on February 4, 2004. CMS Ex. 7, at 3.

Incident of January 27, 2004

The SOD states that the Assistant Director of Social Services (Diane Lee) wrote a late entry nursing note which documented that previously, on January 27, 2004, at 10:00 a.m., she observed R2 come in the building from outside and enter the elevator. The note stated that it was very cold outside, and R2 was not wearing a coat. CMS Ex. 7, at 3; *see* CMS Ex. 60, at 9. Ms. Lee touched R2's arm, and it felt "very clammy." She asked a nurse (Nurse Salinas) to go to R2's room with her because he "was clammy and not looking very well." CMS Ex. 7, at 3; *see* CMS Ex. 50, at 21, 25; CMS Ex. 60, at 9-10. In another late entry for January 27, 2004, Nurse Salinas noted that she was told that R2 "appears to have a change in LOC [level of consciousness], more delusional." She also noted that R2 refused to let her examine him, and he stated, "Get away! I don't need you to touch me. I'm fine! God takes care of me." CMS Ex. 7, at 4; CMS Ex. 60, at 10.

In another late entry referring back to January 27, 2004, the licensed practical nurse (LPN) stated that she "[w]as made aware of resident having SOB [shortness of breath]" and "did go check on resident & he informed me he was fine & God took care of him . . . ." The LPN noted that the "resident appeared pale." CMS Ex. 7, at 4;

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[2] When the nurse asked why he needed to see a doctor, R2 stated that "he's afraid of something but don't know what." CMS Ex. 60, at 8.

CMS Ex. 60, at 10. The LPN continued her late entry for January 27, 2004, and wrote that, at 12:00 p.m., the "[r]esident refused to eat anything today – said he was fasting unable to get him to eat. Will cont to monitor." CMS Ex. 7, at 4; CMS Ex. 60, at 11.

Paul Ross Zeller, Petitioner's Assistant Administrator who is also an ordained pastor, also saw R2 on the morning of January 27, 2004. He wrote a late entry nursing note referring back to January 27, 2004, in which he stated "[r]esident indicated he was fine, but that someone was trying to kill him." CMS Ex. 7, at 4; CMS Ex. 60, at 11. Mr. Zeller also wrote a late entry referring back to January 30, 2004, in which he stated that the Administrator had informed him that R2 "looked too thin" and "had been fasting." Mr. Zeller noted further that R2 "indicated he was fasting per religious beliefs 2 days a week" and that R2 stated that God told him to fast. CMS Ex. 7, at 4; CMS Ex. 60, at 9.

Events of February 3, 2004

On February 3, 2004, an LPN found R2 in bed looking very weak and short of breath, with his bed and clothes soiled. CMS Ex. 7, at 8. R2 was admitted to the hospital emergency room with a primary diagnosis of gastrointestinal bleed and secondary diagnoses including dehydration and cachexia. CMS Ex. 7, at 2, 10. A hospital assessment dated February 3, 2004, documented that R2 was "very emaciated, cachetic . . . very thin, skin is dry and flaky . . . very weak . . . unable to ambulate steady." CMS Ex. 7, at 10. R2 died later that night. R2's physician (Dr. Suescun) was interviewed on February 11, 2004, and he stated that R2's cause of death was "respiratory failure secondary to cachexia and malnutrition." CMS Ex. 7, at 11. Dr. Suescun stated that he was first notified of R2's significant weight loss and refusal to eat on the day R2 was transferred to the hospital (2/3/04). CMS Ex. 7, at 11.

In its posthearing brief, CMS characterizes the allegations somewhat differently than in the SOD:

> [Petitioner] did not care plan regarding Resident 2's fasting behavior. It did not accurately monitor his food and fluid intake, or promptly enter important information in the nurses [sic] notes. [Petitioner] failed to follow its own care plans for Resident 2 and its policies on meal monitoring and refusal of treatment in several respects. Finally, [Petitioner] did not notify Resident 2's physician of important changes

> in his condition that occurred in January 2004, including changes in his behavior, a change in his physical appearance, and his loss of over ten percent of his body weight in under a month.

CMS Posthearing Brief at 3.

In its posthearing brief, Petitioner contends that CMS is holding it to a strict liability standard and asserting that, regardless of what caused R2's decline, Petitioner is accountable. P. Posthearing Brief at 34-36. To show that CMS has taken a flawed approach, Petitioner points to the decision in *Crestview Parke Care Center v. Thompson*, 373 F.3rd 743 (6th Cir. 2004), in which the Sixth Circuit held that 42 C.F.R. § 483.25 does not impose a strict liability standard. Petitioner contends that, in R2's case, the highest practicable level was achieved, and there is no basis for me to find that it was deficient in the areas of assessment and monitoring, charting, and physician notification.

I will preface my discussion by stating that this is an extremely unusual and difficult case involving the intersection of a resident's right to certain fundamental religious and personal freedoms – including the right to fast literally to the point of death – and a facility's obligations to care for him. There can be no dispute that caring for R2 presented great challenges to Petitioner's staff. Petitioner's staff recognized that R2 was an independent-minded individual who often resisted and refused to allow care, was determined to refuse assistance, and fasted on a rather consistent basis in the exercise of his religious beliefs. As I will discuss below, I find that the evidence as a whole demonstrates that Petitioner provided necessary care and services to R2 within this context and demonstrated that it was in substantial compliance with 42 C.F.R. § 483.25.

The record is replete with notations by staff that R2 resisted and refused care and assistance. An assessment completed in September 1998 noted that "[R2] often refuses assistance – says he can do it himself. Becomes angry when told to 'be careful.' Says don't tell him that. That God watches out for him." The assessment also noted that "[r]esident refuses doctors, assessments, etc." P. Ex. 4, at 4. Another assessment completed in September 1999 noted, "[r]es. refuses assistance stating 'No thanks, I can do it myself. Res. often refers to God stating 'God will take care of all my problems.'" P. Ex. 5, at 4.

Beginning in October 1999, R2 refused to allow any physical examinations by his physician, Dr. Suescun. In his progress notes for his visits, which occurred every two to three months, Dr. Suescun noted that R2 "refused P.E." or deferred a physical

examination.[3] P. Ex. 6, at 3-10. According to Petitioner's monthly weight and vital sheets, with the exception of September 2002, R2 refused to allow his blood pressure, temperature, pulse, and respiration to be taken in 2002, 2003, and January and February of 2004. P. Ex. 13; CMS Ex. 60, at 2-7 (Nursing notes from September 2003 through January 2004 indicated that R2 refused to have his vital signs taken); *see also* P. Ex. 7, at 2, 8 (Nursing notes dated October 15, 1999 and January 24, 2000 stated that R2 refused to have his vital signs taken by staff; another nursing note dated June 18, 2001, stated that R2 had been seen by Dr. Suescun; R2 had refused a physical assessment, and received no new orders).

R2's refusals extended to the taking of medications. In a February 24, 1999 progress note, Dr. Suescun wrote that R2 stated he "doesn't believe in medicine or vaccinations." P. Ex. 6, at 2. The note indicates that Dr. Suescun prescribed Mellaril for R2's schizophrenia. According to Mr. Zeller, R2 only took one drug, Mellaril, and refused everything else. Tr. 390, 416. The record shows that R2 had been without psychotropic medications since October 2000 because he had refused to take them. P. Ex. 10, at 6.

R2 requested a double portion, high protein diet beginning in late August 1999. Dr. Suescun ordered that R2 be kept on this diet. P. Ex. 6, at 3. The registered dietician's nutrition therapy note dated August 28, 1999, stated that R2 was on a "high protein general diet w/ double portions and whole milk. Does not like supercereal." P. Ex. 12, at 1. In July 2001, R2's diet remained the same, with staff also noting that he desired "no sweets." P. Ex. 12, at 1. According to progress and nutrition notes, as well as assessments, R2 continued on this same diet in 2002 and 2003. P. Ex. 8, at 3, 6; P. Ex. 12, at 2-3; P. Ex. 20, CMS Ex. 67, at 1; *see also* P. Ex. 14, which is dated February 2004.

According to Mr. Zeller, R2 did not eat meals from the general menu. Tr. 449. R2's typical breakfast consisted of four hard-boiled eggs, four slices of toast, and juice. Tr. 449; *see* CMS Ex. 67, at 1; CMS Ex. 50, at 13, 23. For lunch, R2 usually had two bologna sandwiches made with six slices of thin bologna, or six slices of thick

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[3] For example, in his August 11, 2003 progress note, Dr. Suescun wrote, "[a]s usual, [R2] didn't want physical examination." P. Ex. 6, at 10. Dr. Suescun's notes for his February 14, 2000 and August 21, 2001 visits did not state that R2 refused a physical examination; however, nothing in his notes indicated that he performed a physical examination of R2 on those dates. P. Ex. 6, at 4, 6. R2 also refused dental exams and dental care. P. Ex. 10; CMS Ex. 65, at 8.

bologna, or twelve slices of thin bologna. Tr. 449; *see* CMS Ex. 50, at 23. R2 also received milk and juice with his lunch. For dinner, R2 generally received two bologna sandwiches made in accordance with his specifications, two soups, and a bowl of vegetables.[4] Tr. 450; s*ee* P. Ex. 12, at 3.

Mr. Zeller testified that Petitioner's staff attempted to accommodate R2's food preferences and provide him with foods that he liked and would eat. Tr. 396. Mr. Zeller stated that R2 liked "bologna, bratwurst, hot dogs, Italian sausage, pizza and Polish sausage," and staff made sure that R2 received those foods. Tr. 404. (Mr. Zeller apparently referred to P. Ex. 14, which is, as noted, dated February 2004.) If R2 requested other foods, Mr. Zeller stated that staff would accommodate his request. *See* Tr. 404-05.[5] Petitioner's staff also brought R2 food from the outside "to see if in fact that was something that . . . would please him." Tr. 396; *see* Tr. 504. When asked whether this was successful, Mr. Zeller responded that while R2 would eat the food, this approach was "not tremendously successful." Tr. 396. R2 also kept extra coffee in his room. P. Ex. 12, at 3; duplicated at CMS Ex. 67, at 2.

Petitioner's records show that R2 fasted on and off during the course of his stay at the facility. His history of sporadic fasting pre-dated his admission to the facility. P. Br. at 10; *see* Tr. 202. A nurse's note dated July 30, 1999, stated, "[r]esident verbalized to this writer his dislike of having somebody check after him concerning his appetite & that everybody should assume he is fasting when he does not eat; nurses & nsg. assts. made aware." P. Ex. 7, at 1. In a nutrition therapy note dated August 28, 1999, the registered dietician wrote, "[a]ppetite is generally good although he states he has to 'fast' at times and that is when he does not eat." P. Ex. 12, at 1; CMS Ex. 67, at 3. In another nutrition therapy note dated February 5, 2000, the registered dietician stated, "[r]esident will state he is 'fasting' on occasion – refuses to be on meal monitoring, refused to discuss appetite. No new nutritional labs. Continue plan of care as outlined by CDM. Monitor wt closely for further wt loss." P. Ex. 12, at 1; CMS Ex. 67, at 3. R2's interim care plan (most likely from January 2004) stated, "[w]ill from time to time refuse to eat. States God tells him not to in order to serve Him." P. Ex. 11, at 2; CMS Ex. 58, at 2.

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[4] A quarterly progress note dated December 2, 2003, stated, among other things, that "[r]es. cont. to make meal request of 13 slices of lunchmeat and 2 soups." P. Ex. 8, at 7.

[5] At the hearing, Surveyor Schubert acknowledged that Petitioner went to "great lengths to try to find foods that [R2] would eat." Tr. 251.

In alleging that Petitioner violated 42 C.F.R. § 483.25, CMS argues that Petitioner's staff should have notified R2's physician concerning R2's significant weight loss in January 2004, his behavioral changes, and changes in his physical condition. In CMS's view, these changes, taken together, should have put Petitioner on notice that R2's condition had undergone a significant change for the worse. CMS Posthearing Br. at 20-26. CMS asserts further, in its posthearing reply brief, that "[t]he documented weight loss that Resident 2 experienced in January, 2004, all by itself, was more than enough to constitute a significant change in condition requiring physician notification." CMS Posthearing Reply at 23.

Whether or not Resident 2 underwent a significant change in condition is a point of vigorous contention between the parties. In rebutting CMS's allegations, Petitioner contends that "CMS cannot point to, and does not point to, any single observable event or condition which constitutes an objective significant change in R2's condition prior to the morning of February 3, 2004." Petitioner's Posthearing Brief at 47. Petitioner asserts that CMS is attempting to substitute its judgment for that of its nursing staff who had dealt with R2 for years. *Id.*

The incidents of January 24 and January 27, 2004, might have suggested that R2's condition was changing in the direction of crisis, but only if that condition was viewed from a short perspective, or from the perspective of hindsight. Even granting that the incident of January 24, 2004 was not perfectly documented at the time, and even granting that some of the entries concerning the incident of January 27, 2004 were late entries, R2's behavior and appearance on those dates were not remarkable to those staff who knew him well, and over a long time. It seems fair to describe those incidents as indicative of R2's general situation, and not as significant changes giving cause for alarm.

According to Petitioner, R2 had a history of significant weight fluctuations and his weight loss was "a gradual process, not any sudden change in condition."
P. Posthearing Brief at 53. The evidence in the record shows that, over the course of his approximately five and one-half year stay at Petitioner's facility, R2's weight fluctuated broadly, and trended downward. Because R2's weight has been the subject of much scrutiny by both parties, I have set out his weights below, as recorded in his nutritional progress notes and the monthly weight and vital sheets:

Date	Weight
8/31/98 (Admission date)	128 lbs.
8/28/99	145 lbs. (Staff noted that R2's weight ranged from 141-146 lbs. the last six months). CMS Ex. 67, at 3; P. Ex. 12, at 1.
1/00	140 lbs. (This Jan. 2000 weight is noted in a progress note dated 2/5/00). CMS Ex. 67, at 3; P. Ex. 12, at 1.
7/01	121 lbs. Staff noted that R2 had lost five pounds from the previous three months. CMS Ex. 67, at 3; P. Ex. 12, at 1.
8/19/01	121 lbs. Staff noted that R2's weight was "stable this month." CMS Ex. 67, at 3; P. Ex. 12, at 1.
9/30/01	127 lbs. Staff noted that "gradual desired weight gain continues." CMS Ex. 67, at 4; P. Ex. 12, at 2.
1/02	127 lbs. CMS Ex. 69 (duplicated at P. Ex. 13).
2/02	128 lbs. CMS Ex. 69 (duplicated at P. Ex. 13).
3/02	128 lbs. CMS Ex. 69 (duplicated at P. Ex. 13).
4/02	133 lbs. CMS Ex. 69 (duplicated at P. Ex. 13).
5/02	125 lbs. Staff noted that R2 had lost 8 lbs. in one month, and that his usual weight ranged between 127 and 130 lbs. CMS Ex. 67, at 4; P. Ex. 12, at 2; CMS Ex. 69 (duplicated at P. Ex. 13).
6/02	127 lbs. CMS Ex. 69 (duplicated at P. Ex. 13).
7/02	129 lbs. CMS Ex. 69 (duplicated at P. Ex. 13).

8/02	124 lbs. Staff noted "[R2] followed for reported 5# wt loss." CMS Ex. 67, at 4; P. Ex. 12, at 2; CMS Ex. 69 (duplicated at P. Ex. 13).
9/02	127 lbs. CMS Ex. 69 (duplicated at P. Ex. 13).
10/02	126 lbs. CMS Ex. 69 (duplicated at P. Ex. 13).
11/02	127 lbs. CMS Ex. 69 (duplicated at P. Ex. 13).
12/9/02	Staff wrote that R2 refused to have his weight taken in December, and, in the entry, noted his November 2002 weight of 127 lbs. Staff wrote "Res remains on thin side. . . .Wgt no lower desired." CMS Ex. 67, at 4 (duplicated at P. Ex. 12, at 2).[6]
1/03	126 lbs. CMS Ex. 69 (duplicated at P. Ex. 13).
2/03	129 lbs. CMS Ex. 69 (duplicated at P. Ex. 13).
3/03	136 lbs. CMS Ex. 69 (duplicated at P. Ex. 13).
4/03	130 lbs. CMS Ex. 69 (duplicated at P. Ex. 13).
5/03	130 lbs. CMS Ex. 69 (duplicated at P. Ex. 13).
6/03	128 lbs. CMS Ex. 69 (duplicated at P. Ex. 13).
7/03	126 lbs. CMS Ex. 69 (duplicated at P. Ex. 13).

[6] On the Monthly Weight and Vital Sheet, staff noted that R2 weighed 127 lbs in December 2002; however, as stated above, R2 refused to have his weight taken in December. Staff apparently recorded R2's weight from November 2002 – 127 lbs. – as his December 2002 weight. CMS Ex. 69; P. Ex. 13.

8/15/03	123 lbs. Staff noted that R2 had had weight changes, and that his body mass index (BMI) of 17.2 put him in a high risk category. Staff noted also that R2 required 2177 calories a day. CMS Ex. 67, at 1; *see* CMS Ex. 68.
9/03	121 lbs. CMS Ex. 68, 69 (CMS Ex. 69 duplicated at P. Ex. 13).
10/03	128 lbs. CMS Exs. 68, 69 (CMS Ex. 69 duplicated at P. Ex. 13).
11/03	113 lbs. Staff noted that R2's BMI was 15.8. CMS Ex. 67, at 2; P. Ex. 12, at 3; CMS Exs. 68, 69 (CMS Ex. 69 is duplicated at P. Ex. 13).[7]
12/03	127 lbs. CMS Exs. 68, 69 (CMS Ex. 69 duplicated at P. Ex. 13).
1/04	128 lbs. CMS Exs. 68, 69 (CMS Ex. 69 duplicated at P. Ex. 13).
2/1/04	115 lbs. CMS Ex. 68.

[7] On the Monthly Weight and Vital Sheet (CMS Ex. 69), R2's November 2003 weight is recorded as "113 lbs." Next to the weight, however, there is a handwritten note that states "re-weigh - 127." According to another weight sheet for R2 (CMS Ex. 68), which recorded R2's weights from August 2003 through February 2004, R2 weighed 113 pounds on November 1, 2003. A handwritten note in the margin appears to correspond with the November 2003 weight, and this note stated "triggered a C/P re-weighed on new scale at 127#." CMS Ex. 68, at 1. Nothing in the records indicates that R2's recorded weight of 113 pounds was incorrect.

2/3/04	115.6 lbs. CMS Ex. 73, at 42. (EMS notes at CMS Ex. 73, at 26, set R2's weight at 110 lbs. The "150 pounds" noted in CMS Ex. 73, at 6, is almost certainly a mistake by the medical transcriptionist who misinterpreted Dr. Suescun's orally dictated, and perhaps not clearly stated, "one hundred fifteen pounds." The typed "150" is absolutely inconsistent with all recorded weights up to February 3, 2004, and all other recorded weights on or immediately before that date.)

A review of the recorded weights above shows that R2 weighed as much as 145 pounds back in August 1999. In July 2001, R2's recorded weight was 121 pounds, and staff noted that he had lost five pounds from the previous three months. On September 30, 2001, R2 weighed 127 pounds, and continued to maintain or gain weight through April 2002, when he weighed 133 pounds. In May 2002, R2's weight declined to 125 pounds, for a loss of eight pounds in one month. From June 2002 through August 2002, R2's weight ranged between 124-129 pounds. R2 weighed between 126-127 pounds for the next three months, through November 2002. In December 2002, R2 refused to have his weight taken, and staff noted that he "remain[ed] on thin side . . . . Wgt no lower desired." CMS Ex. 67, at 4; P. Ex. 12, at 2.

R2's weight continued to fluctuate throughout 2003. In January 2003, he weighed 126 pounds. In March 2003, R2 was 136 pounds. Subsequently, his weight started to decline, and, in June 2003, he weighed 128 pounds. R2 continued to lose weight into September 2003, when he was 121 pounds. He weighed 128 pounds in October 2003, 113 pounds in November 2003, and 127 pounds in December 2003.

It is R2's weight loss in January 2004 that figures prominently in CMS's arguments. There can be no dispute that, by the end of January 2004, R2 was seriously underweight. At the beginning of the month, R2 had weighed 128 pounds. CMS Ex. 69, at 2. On January 28, 2004, staff documented in his care plan that he had lost 13 pounds. CMS Ex. 58, at 3. CMS points out that R2 lost greater than 10% of his body weight in January 2004. CMS Posthearing Br. at. 20. Petitioner's Monthly Weight and Vital Sheet shows R2's last recorded weight, taken in February 2004, was 115 pounds. CMS Ex. 69, at 2.

It is plain from the record that much of R2's weight loss can be attributed to his fasting behavior. Petitioner's records documented R2's desire to fast and indicated that he fasted on and off during the course of his stay at the facility.

Petitioner maintains that R2 had the right to fast, and that he "chose not to eat from time to time in the exercise of his religious beliefs." P. Posthearing Br. at 26. Petitioner asserts that, as a resident of a nursing facility participating in the Medicare program, R2 had certain rights under the federal regulations, including the right of self-determination, the right to refuse treatment, and the right to make choices about aspects of his life that were significant to him. 42 C.F.R. §§ 483.10, 483.10(b)(4), and 483.15(b).

Contrary to Petitioner's assertions, CMS contends that R2's fasting was "the product of mental illness." CMS Posthearing Reply at 6. CMS contends that R2 suffered from schizophrenia and religious delusions, and therefore, was in no position to be permitted to fast without interventions and monitoring. *See* CMS Posthearing Reply at 1-3, 33. CMS argues that R2's fasting should not have been considered a legitimate religious practice. CMS Posthearing Brief at 6. Moreover, because of R2's underweight status and mental condition, CMS posits that R2 had only a limited right to exercise his religious beliefs.

There can be no dispute that R2 suffered from "chronic undifferentiated schizophrenia" (CMS Ex. 62, at 1), and had religious delusions. CMS Exs. 56, 57, 58, 59; *see* CMS Ex. 65. When a nurse assessed him on September 10, 1999 (RAP Narrative), she wrote, "[h]e states that he is a very strict Christian and that others are against him due to this, that he is persecuted for his beliefs, just like Jesus Christ was." P. Ex. 10, at 1. The nurse noted that "[h]e displays moderately impaired decision making skills due to delusions and paranoid ideations." *Id.*

In a quarterly progress note dated 6/02/03, Petitioner's staff wrote, among other things, "[r]esident has had no significant change in weight for this quarter; resident is on high protein/dbl portions/whole milk/ no supercereal, or sweets diet . . . displays periods of delusions (especially of a religious nature) . . . . Resident isolates self in room the majority of time (excepting smoking, religious oriented activities, church services, Gospel singing, B-day parties). Resident spends time c Bible audio tapes." P. Ex. 8, at 4, 5.

A psychiatric rehabilitation skills assessment dated September 12, 2003, noted, among other things, that R2's "delusional thoughts of being persecuted turn to persistent anger" and that he makes "impaired decisions." CMS Ex. 72, at 2. It assessed R2 as

"capable of maintaining positive diet choices," but also noted that he "refuses meals if agitated/routine varies." The assessment noted that he was "able to maintain lengthy conversation" and "can relate needs/desires appropriately." It was also noted that R2 "attends occasional religious programs." CMS Ex. 72, at 1.

When R2 underwent a psychiatric assessment on October 1, 2003, the examiner stated that R2 "is obsessed with his religious ideas" and "has delusions – talking to God." CMS Ex. 57. The assessment indicated that R2 had delusions, hallucinations, and obsessions, as well as impaired judgment and insight. It further noted that R2 had normal intellectual abilities, a normal memory, no suicidal or homicidal ideations, carried on coherent communication and maintained conversation with others. *Id.* According to a social service re-assessment dated December 2, 2003, R2 "cont. to be deeply religious." CMS Ex. 56, at 3.

Moreover, R2's psychiatrist, Dr. Baker, saw R2 in March, June, and October of 2003. In his progress note dated June 18, 2003, Dr. Baker stated, "[c]ontinues to do well & denies any problems. Not depressed & in contact c reality." CMS Ex. 63, at 2. In his progress note dated October 15, 2003, Dr. Baker wrote, "[a]lert high & continues to do well. Denies any problems." CMS Ex. 63, at 2. It is not apparent that Dr. Baker wrote any new orders for R2.

CMS suggests that R2's religious beliefs were not genuine because he had a mental illness. I am not persuaded that R2 was as mentally impaired as CMS has portrayed him to be. It is true that R2 had moderately impaired decision-making skills (P. Ex. 10, at 1; CMS Ex. 64, at 2, 8). However, there is nothing in the record that indicates or suggests that R2's mental status was such that he was found to be incompetent or incapacitated.

As stated above, the October 2003 psychiatric assessment found him to possess normal intellectual abilities. R2 was also assessed as able to maintain coherent and lengthy conversations and able to relate his needs/desires appropriately. *See* CMS Exs. 57, 72. His psychiatrist, Dr. Baker, noted that R2 was doing well. In light of such assessments, I cannot agree with CMS that R2 had only a limited right to exercise his religious beliefs. The record shows that Petitioner's staff, including R2's physician, allowed R2 to make decisions regarding his care. According to the progress notes, Dr. Suescun saw R2 approximately every two months beginning in February 1999. P. Ex. 6, at 2-10. Beginning in October 1999, R2 refused to allow any physical examinations by Dr. Suescun. In his progress notes for his visits, Dr. Suescun noted that R2 "refused P.E." or deferred a physical examination. P. Ex. 6, at 3-10. Dr. Suescun last saw R2 on December 12, 2003. P. Ex. 6, at 10; CMS Ex.

63, at 1. He stated in his progress note for that visit that R2 did not have any new complaints, and that R2 refused a physical examination. Dr. Suescun wrote that R2 was "cooperative to talk, very sensitive," and noted R2's blindness and schizophrenia. P. Ex. 6, at 10; CMS Ex. 63, at 1. Dr. Suescun did not write any new orders for R2. *See* Tr. 252. Had R2 been seriously mentally ill, it is highly unlikely that Dr. Suescun and Petitioner's staff would have yielded to his wishes and allowed him to make such decisions regarding his care.

Moreover, the record demonstrates that Petitioner's staff was aware of R2's fasting behavior. I have previously referred to nursing notes and nutrition therapy notes that referenced R2's fasting behavior. According to interview notes, one of Petitioner's certified nurse aides (CNA) stated that R2 wanted a note "saying it was ok" to fast. The CNA stated that she "wrote a note that said [R2] could fast a couple days a week for his religion & not to bother him. Would show note to other staff." CMS Ex. 50, at 15. In another interview note, Petitioner's Social Services Director stated that she felt that R2 "was capable of making his own decisions about eating and drinking, even though Res. stated he was taking his direction from God about what to eat or when to eat or when to go out or stay in his room." CMS Ex. 50, at 20.

Assistant Administrator Zeller, who is also an ordained pastor (Tr. 375), testified that he was aware of R2's fasting behavior, which began upon his admission. Tr. 386. He stated that "it was a consistent behavior . . . that he would fast sporadically, but consistently. It varied." Tr. 386. Mr. Zeller expressed concurrence with staff interview notes that indicated R2 never fasted for more than one to two days in a row at a time. Tr. 445.[8] He stated that R2 talked about fasting "no more than maybe a couple times in a week time frame." Tr. 445. Mr. Zeller added that he was uncertain as to the length of R2's fasting, whether it lasted all day or not. He stated, "I suppose it depended on his hunger, and in his mind, what God was telling him at any one given time." Tr. 446.

According to Mr. Zeller, he had had discussions with R2 regarding his fasting behavior and attempted to use Bible stories in an effort to encourage him to eat, but this approach was unsuccessful. Tr. 386-87. He stated that, in every conversation, he

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[8] According to interview notes, a CNA stated that R2 would fast several times a year for two or three days at a time for religious reasons. The CNA also stated that he would drink a little fluid -- one glass a day. CMS Ex. 50, at 6.

would advise R2 that fasting was "not a recommended approach that he ought to be taking." Tr. 497-88. Mr. Zeller stated that no approach was ever successful in getting R2 to eat when he wanted to fast. Tr. 387.

Although Mr. Zeller testified that he could not recall having written a note for R2 that permitted him to fast (Tr. 442), I note that an activity aide stated in an interview that she had seen a note on the nursing desk that stated that R2 has permission to fast two to three times a week. The aide stated that the note was signed by Mr. Zeller. CMS Ex. 50, at 4.[9]

Further, R2's physician, Dr. Suescun, was fully aware of R2's status over the years and gave no new or additional orders. The record shows that Dr. Suescun initialled R2's monthly weights from January 2002 through December 2003. P. Ex. 13 (duplicated at CMS Ex. 69).

Clearly, R2 had the right to enjoy certain personal freedoms while he was a resident of Petitioner's facility, and this included his right to exercise his religious beliefs, a fact not disputed by CMS's surveyors. Tr. 85, 251. I note that the regulation at 42 C.F.R. § 483.15(b)(3) explicitly states that R2 had the right to make choices about aspects of his life in the facility that were significant to him. R2's primary interest or hobby while he was a resident at Petitioner's facility was participating in religious activities and exercising his religious beliefs. Towards this end, Petitioner asserts that R2 had the right to make his own choices and decisions in the exercise of his religious beliefs. I agree.

In addition to activities such as listening to Bible audio tapes, R2 chose to fast on a relatively consistent basis as a way of practicing his religion. When R2 fasted, he informed Petitioner's staff that he was fasting due to his religious beliefs. Petitioner's staff, who were all aware that R2 was a strict Christian, accepted his fasting behavior and did not try to intervene. Contrary to CMS's position, I am persuaded that R2's fasting was a legitimate religious practice, and that Petitioner's staff rightly viewed it as such.

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[9] At the hearing, Mr. Zeller testified that he wrote notes for R2 to show to staff. For example, Mr. Zeller stated that he wrote notes that R2 could take out of his pocket and let staff know he didn't need their assistance with locomotion. *See* Tr. 439-40, 441, 442.

With respect to CMS's contention that Petitioner was deficient with R2's careplanning, I note that CMS concedes that, as of December 2003, Petitioner had a weight loss care plan for R2. CMS Posthearing Br. at 14; *see* CMS Posthearing Br. at 6.[10] This updated care plan, dated December 2, 2003, listed R2's current weight as 127 pounds and his BMI as 17.8. CMS Ex. 58, at 7. The plan listed his ideal body weight (IBW) as 172 pounds, and noted that his IBW range was in the 155-189 pound range. Petitioner's staff identified R2 as having weight problems, noting that he was below his IBW range, had never been heavy, and had a BMI of less than 19. Staff noted further that R2 "[r]efuses to eat at times," and "[r]efuses to eat sweets or fruits." CMS Ex. 58, at 7.

As goals for R2, the care plan stated that he "will eat at least 75% of meals" and "increase BMI to help with prevention of health problems." Also in the care plan, Petitioner's staff listed the following approaches: (a) Dietary Manager shall provide a quarterly nutritional note; (b) Registered Dietician shall provide yearly and/or PRN recommendations; (c) monitor and encourage oral intake; (d) provide tray set-up; (e) monitor monthly weights; (f) weigh as ordered; (g) inform physician of abnormal lab results – any problems; (h) encourage H20 – provide extra fluids mealtimes – Groups – 1 to 1's ; (i) provide diet Regular-High protein – Double portions whole milk Q meal; (j) provide substitutes food dislikes as requested; and (k) inform nurse if doesn't eat. CMS Ex. 58, at 7.

This care plan was updated again on January 28, 2004. CMS Ex. 58, at 3. At this time, Petitioner's staff wrote that R2 "will show no further weight loss." The care plan documented that R2 had recently lost 13 pounds. Staff noted that he "frequently refuse[d] meals – states he is 'fasting' due to religious beliefs" and that he "displays delusional behavior about religion." CMS Ex. 58, at 3. The care plan listed the following approaches: (1) provide diet as ordered; (2) encourage resident to eat at least 75% of meals; (3) provide 1:1 intervention and counseling; (4) notify physician of further weight loss; and (5) monitor weight weekly. CMS Ex. 58, at 3.

In another document titled "Interim Care Plan," Petitioner's staff indicated that R2 "will from time to time refuse to eat. States God tells him not to in order to serve Him." CMS Ex. 58, at 2; P. Ex. 11, at 2. Moreover, the care plan noted that R2 is on

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[10] On page 14 of its posthearing brief, CMS states that "[Petitioner] had weight loss care plans for [R2]" as of December 2003, and cites to CMS Ex. 58, at 3, 7. I note, however, that CMS incorrectly cited to CMS Ex. 58, at 3, as this care planning document is dated January 28, 2004.

a high protein, whole milk, and double portions diet, and that he did not want supercereal or sweets.[11] Although this document is undated, it appeared to be part of the January 28, 2004 care plan.

Based on the foregoing, I find that Petitioner established that its staff had in place care planning documents for R2. The documents show that Petitioner's staff had assessed R2's weight loss and fasting behavior and attempted to address these issues with appropriate interventions.

With respect to documentation of R2's food intake, CMS alleges that the monitoring of his intake was inaccurate. CMS contends that the meal monitoring logs, which often showed that R2 consumed 100% of his meals, were not accurate since it was questionable whether R2 ate all of his food, and since there was no mention of food that R2 took back to his room. In addition, CMS alleges that neither the nursing notes nor the meal monitoring logs contained documentation of R2 consuming food or beverages either from Petitioner's vending machines or from outside sources. CMS Posthearing Br. at 15-17. CMS asserts that, in failing to carry out accurate monitoring, Petitioner failed to follow its own meal monitoring policy (CMS Ex. 119, at 3). CMS Posthearing Br. at 19.

Petitioner disputes CMS's claim, noting that R2 refused to allow monitoring of his meals. Petitioner points to the registered dietician's nutrition therapy note dated February 5, 2000, which stated that R2 "refuses to be on meal monitoring, refused to discuss appetite." P. Ex. 12, at 1. In spite of R2's resistance, Petitioner asserts that it made efforts to monitor R2's meals. Mr. Zeller testified that staff would do their best to monitor R2's food intake, but R2 would be resistant and eat in his own room, and also take food back to his room. *See* Tr. 403. According to interview notes with CNA staff, it was difficult to get an accurate assessment of what R2 ate or drank because he often took food (sandwiches) and drinks back to his room. *See* CMS Ex. 50, at 12, 13, 15, 20, 29, 30, 31, 33; CMS Ex. 7, at 5. One CNA stated that R2 "didn't like when you asked him what he ate. He said he wasn't a child." CMS Ex. 50, at 29. Another CNA stated that entries in the food intake logs were based on what R2 ate off his tray, and did not include sandwiches, which he always took back to his room. CMS Ex. 50, at 31.

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[11] Petitioner's records show that R2 was put on this diet by his physician in late August 1999, and continued on this same diet in 2001, 2002, and 2003. *See* P. Ex. 6, at 3; P. Ex. 12, at 1; P. Ex. 8, at 3, 6; P. Ex. 12, at 2-3; P. Ex. 20; CMS Ex. 67, at 1.

The food intake logs that are in the record cover the period August 2003 through November 2003, January 2004, and February 1-3, 2004. CMS Ex. 70, at 1, 3, 5, 7, 9, and 11; partially duplicated at P. Ex. 15. The logs note that R2's diet was "high protein/double portions/whole milk." The logs show that Petitioner's staff served three meals a day to R2.[12] Petitioner's staff tracked R2's intake of his meals by noting the percentage of the food and drink he had consumed in the corresponding boxes. There are "0" or "R" notations to indicate when R2 did not eat or drink anything or refused meals.

Looking at the last 11 days of R2's stay at Petitioner's facility, which covers the period January 24, 2003 - February 3, 2004, I find that R2 refused all meals on only two days, January 24, 2003 and February 2, 2004. CMS Ex. 70, at 1, 3. He ate at least two meals, in whole or in part, on five of the eleven days. I note that R2 ate 100% of his meals (not including milk and juice) on January 25, 2003 and January 27, 2003. Out of 31 meals served, R2 ate, in whole or in part, a total of 16 meals, or 51.6% of meals served.[13] CMS Ex. 70, at 1, 3.

I note further that, from January 1, 2004 through February 2, 2004 (33 days), R2 ate, in whole or in part, at least 70, and perhaps as many as 73, of 97 meals, or at least 72.2% of meals served. *See* P. Br. at 39.

Based on the logs, I conclude that Petitioner documented R2's food intake. It may be that the logs do not give an accurate picture of what R2 was eating. However, I find credible Petitioner's explanation that because R2 refused to be on meal monitoring and took food to his room, it was difficult for Petitioner's staff to monitor R2. I conclude that, given the difficulties that R2's resistance and eating habits presented, Petitioner's staff monitored R2's food intake to the extent it could.

Petitioner appears to concede that its staff did not follow its meal monitoring policy with respect to R2. P. Br. at 43. However, Petitioner correctly notes that a facility's failure to follow its own policy is not, in and of itself, a deficiency. *Barbourville Nursing Home*, DAB CR1135 (2004), *aff'd*, DAB No. 1962 (2005). In its defense, Petitioner contends that it followed its policy as best as it could under the

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[12] On the day R2 was sent to the hospital, February 3, 2004, he received breakfast only.

[13] R2 received three meals each day from January 24, 2003 through February 2, 2004, and he received breakfast on February 3, 2004, the day he was sent out to the hospital.

circumstances, and also points out that staff was aware that R2 would sometimes eat less than 25% of food or drinks provided. As I have stated above, I find that Petitioner's staff did track R2's food intake.

In alleging that Petitioner failed to have R2 assessed by a registered dietician, CMS points to R2's care plan, dated December 2, 2003, which directed that a dietician was to provide yearly and as-needed recommendations. CMS Ex. 58, at 7. CMS contends that the registered dietician last saw R2 in December 2002. Tr. 52; CMS Ex. 67, at 4. Petitioner argues that, based on the December 2003 care plan, a yearly review by a registered dietician would not have been due until December 2, 2004. Petitioner notes that R2 died on February 3, 2004, two months after the care plan was written. Further, Petitioner points out, a full nutritional assessment was completed on August 15, 2003 by the dietary manager. CMS Ex. 67; P. Br. at 40. Even though a dietary manager is not the same as a registered dietician, Petitioner contends that nutritional assessments were being done. CMS asserts that a quarterly evaluation by the dietary manager was a separate intervention that was also required under R2's care plan.

I find that the dietary manager's August 2003 evaluation was a comprehensive assessment of R2's nutritional status. CMS Ex. 67, at 1. According to this assessment, R2 weighed 123 pounds and was on a regular, high protein diet consisting of double portions with whole milk. His IBW range was noted to be 155-189 pounds, and his BMI was 17.2. The assessment gave calculated estimates of what R2's caloric, protein, and fluid needs were. It noted his food allergies, and his food preferences of four hard-boiled eggs, four slices of toast, and bologna. Furthermore, the assessment evaluated R2's risk in various categories, and rated him, among other things, as follows: high risk (i.e. BMI <19 or 27>) in "Weight Status"; moderate risk (i.e. intake meets 26-75% Planned meal) in "Oral/Nutrition Intake - food"; no/low risk (i.e. consumes 1500-2000 cc/day) in "Oral/Nutrition Intake-fluid"; moderate risk (noting R2's supervision while eating) in "Physical and mental functioning"; and no/low risk (i.e. skin intact) in "Skin conditions." The assessment documented that R2's overall risk was "high." CMS Ex. 67, at 1.

In addition to this assessment, the record also contains a nutritional progress note dated August 15, 2003, from the dietary manager. Her note stated the following:

> Diet meets estimated calculated needs. Is served in a form designed to meet his needs. [R2] gets his double portions – wants no fruits or sweets. wants an extra bowl of vegetables instead – Never has eaten all the food – complains if double portions on everything not sent . . . . Encourage fluids. Follow any recommendations RD may make.

The dietary manager further wrote, "Have often checked tray when comes down and wrapping from sandwiches – seems to be there. food there only picked at – at times." CMS Ex. 67, at 2.

The record shows that, after the August 2003 assessment, the dietary manager saw R2 again on November 18, 2003, and her progress note stated:

> Wt: 113 lbs. BMI: 15.8. Is on Regular – [high] Prot – Double Portions – Whole milk Q meals – 2 soups – Eats in 3rd floor dining room. Eats 25-70% of meals. Usually eats the protein – not much of the others. Still wants vegetables instead of fruit – sweets. Wants 2 bowls of soup. Encourage fluids. Follow any recommendations RD may make.

CMS Ex. 67, at 2.

Two months later, the dietary manager saw R2 again, and documented the following in her nutritional progress note dated January 27, 2004:[14]

> [R2] has said he no longer wants bologna – wants cheese sandwiches now – but last week after he had told Diane of my staff that – he turned around and told me he wanted bologna – will check with him next week again – after all this time always wanting bologna ?

CMS Ex. 67, at 2.

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[14] The nutritional progress note is dated "1-27-03"; however, this is a typo, and the year should be "04" instead of "03."

Contrary to CMS's position, I find that the above nutritional assessment and progress notes show that Petitioner's staff did evaluate R2's nutritional status and was not indifferent to his nutritional needs. While the evidence indicates that R2 was not seen by a registered dietician after December 2002, it is clear that another qualified professional – Petitioner's dietary manager – was involved in evaluating R2's status. I find that her assessments identified concerns and risks for R2, and reflected an ongoing awareness of his situation.

I now turn to CMS's allegation that R2 underwent a significant change in condition in January 2004, and that Petitioner's staff should have notified R2's physician.[15] As stated above, R2 weighed 128 pounds at the beginning of January 2004, then lost 13 pounds by January 28, 2004. His last recorded weight, taken in February 2004, was 115 pounds.

CMS and Petitioner agree that R2 fasted in January 2004. However, the parties disagree on the time frame and the extent of his fasting in the latter part of January 2004. Petitioner points to R2's food intake logs and asserts that R2 fasted on only one day during the six-day period prior to his February 3, 2004 hospital admission. P. Br. at 52; *see* CMS Ex. 70, at 1; duplicated at P. Ex. 15, at 2. CMS, however, asserts that, for R2, "fasting" could include refusing/skipping individual meals, and that R2 refused several meals after January 27, 2004. CMS Br. at 25. As I discussed above, R2 refused all meals on only two days during the last eleven days of his stay -- January 24, 2003 and February 2, 2004. After January 27, 2004, the food intake logs indicate that R2 ate, in whole or in part, eight meals, and refused, or did not eat, 11 meals. CMS Ex. 70, at 1, 3; duplicated at P. Ex. 15.

Dr. James Monahan, Petitioner's Medical Director who was R2's attending physician in 1998 (*see* P. Ex. 6), testified that R2's weight of 115 pounds in February 2004 is "consistent with his previous pattern of weight losses and gains." Tr. 339. On cross-examination, Dr. Monahan stated that, with respect to R2, he would not have wanted to be notified by staff that R2 had loss 10 percent of his body weight even if he was not scheduled to visit R2 for another three weeks. Dr. Monahan stated that he

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[15] Although the regulation at 42 C.F.R. § 483.10(b)(11) specifically addresses a facility's duty to immediately notify a resident's physician when there is a significant change in condition, CMS did not allege that Petitioner was deficient pursuant to this regulation.

wouldn't expect weight loss reports because he would obtain this information himself when he looked at R2's chart on his next visit to the facility. *See* Tr. 353-55. When pressed on this point, Dr. Monahan gave the following response:

> This is not out of the ordinary for this gentleman, you know? This is a gentlemen [sic] who had, again, wide fluctuations in weight, serious losses of weight several times over the five years that he'd been in the institution.

Tr. 355. When asked for his understanding of R2's fasting behavior, Dr. Monahan stated that it appeared that R2 went on "fasting binges from time to time and would induce large losses of body weight from his fasts." Tr. 356. Dr. Monahan acknowledged that he hadn't reviewed the whole five years of R2's chart, but stated that "[i]t's hard to imagine that [R2] would lose eight pounds in a month, as he did in one of these earlier notes, from fasting for one or two days." Tr. 356. Dr. Monahan testified rather bluntly:

> It is not out of the ordinary for this guy, for this gentleman, to refuse a lot of meals. It's not out of the ordinary for this gentleman to fast in a self-destructive manner.
>
> * * *
>
> The problem of doing something, since you asked this, is you know, what is there to do? He won't take medication, and we can't force him to. He won't eat, and se [sic] can't force him to.

Tr. 356-57. Dr. Monahan testified further that, from his review of the records, he did not see anything in terms of a change in R2's physical condition prior to the morning of February 3rd. Tr. 363.

I find that the record supports Dr. Monahan's statement that R2 had a "history of broad weight fluctuations." Tr. 338. R2 weighed 121 pounds in September 2003, 128 pounds in October 2003, 113 pounds in November 2003, and 127 pounds in December 2003. Moreover, as I stated above, the record shows that R2's physician, Dr. Suescun, initialled R2's monthly weights from January 2002 through December 2003, and from this, I will make the inference that he was aware of R2's weight fluctuations.

Petitioner did not make R2's physician, Dr. Suescun, aware of R2's weight loss in January 2004. According to telephone interview notes, Dr. Suescun stated that he was first notified of R2's weight loss and refusal to eat on February 3, 2004, the day R2 was taken to the emergency room. CMS Ex. 50, at 27. He stated that Petitioner's nurse told him that R2 had been fasting for two weeks. Dr. Suescun stated that he was later told that R2 had been fasting for one to two days. CMS Ex. 50, at 27, 28. Dr. Suescun said that Petitioner should have notified him that R2 was "in this condition." CMS Ex. 50, at 28. Dr. Suescun described R2 as having "strong religious beliefs - extreme" and "very difficult." CMS Ex. 50, at 27, 28. He stated that R2's cause of death was respiratory failure secondary to cachexia and malnutrition. CMS Ex. 50, at 27. While there are some variances in the statements of Dr. Suescun and Dr. Monahan, I do not believe that they are material, and do not believe that they reduce the value of the statements generally.

CMS contends that Petitioner should have been on notice that R2's condition had significantly changed for the worse. CMS Posthearing Reply at 34. CMS asserts that Petitioner's "deficient practices under F309 caused serious harm by contributing to R2's death." CMS Posthearing Brief at 29.

I do not agree with CMS. I find that, with the benefit of hindsight, CMS is exercising an after-the-fact review of R2's condition based on R2's sudden "collapse" on February 3, 2004. The evidence as a whole shows that R2 exhibited no objective signs of physical distress prior to 8:00 a.m. that morning. In fact, CNA Johnson testified that, on the morning of February 3, 2004, she observed R2 outside Petitioner's facility smoking when she came into work around 6:50 a.m. Tr. 493. She stated that R2 said "good morning," and that he looked fine and expressed no complaints. Tr. 493-94. CNA Johnson saw him later between 7:30 a.m. and 8:00 a.m. when she was passing out breakfast trays. When she asked R2 whether he would like breakfast, he told her that he was fasting, but had had milk and water. She asked him if he would like more milk and water, but he declined, and continued to his room. CNA Johnson stated that she didn't notice anything out of the ordinary about R2's physical condition, nor did he express any complaints to her. Tr. 494.

In addition to CNA Johnson's observation, Ms. Greathouse, Petitioner's Social Service Assistant, also saw R2 by the elevators around 7:30 a.m. on February 3, 2004, and they said "good morning" to each other. Ms. Greathouse testified that R2 did not appear to be in any physical distress, nor did she observe anything out of the ordinary about him. Tr. 503.

The fact that R2 was up and about early in the morning of February 3, 2004, and then was later found in bed around 8:00 a.m., weak and emaciated, suggests that his sudden decline was unforeseeable. As such, I cannot hold Petitioner accountable for R2's collapse and resulting death later that night.

It may be possible to second-guess Petitioner, and state that Petitioner could perhaps have done things differently regarding notification of Dr. Suescun. In its brief, Petitioner characterizes R2's weight loss "as a gradual process, not any sudden change in condition." P. Posthearing Brief at 53. In light of what I have discussed above regarding R2's fasting behavior, I find that Petitioner's characterization is not without merit. R2 fasted on a rather consistent basis, Petitioner's staff was quite aware of this, and knew that he experienced periods of weight loss from the fasting.

Contrary to what CMS asserts, the evidence of record does not lead me to conclude that Petitioner "chose to do nothing" regarding R2's fasting and low weight status. CMS Posthearing Reply at 34. Petitioner's staff acknowledged that R2 had the right to fast in the exercise of his religious beliefs. At the same time, they were aware that his fasting resulted in weight loss and posed risks to R2's health. To encourage him to eat, Petitioner's staff accommodated his food preferences, and gave him meal substitutes to please his tastes. I find that R2's physician and other staff were involved in his careplanning and assessments, which did take into account his fasting behavior. Based on the foregoing, I conclude that the overall picture of the care that Petitioner gave to R2 is that of an attentive, not an indifferent, facility.

I conclude that Petitioner provided necessary care and services to R2 such that he maintained his highest practicable physical well-being within the context of the legitimate exercise of his religious beliefs, and was in substantial compliance with the participation requirement at 42 C.F.R. § 483.25 (Tag F309).

2. Petitioner was in substantial compliance with the participation requirement at 42 C.F.R. § 483.25(i)(1) (Tag F325).

Pursuant to the participation requirement set forth at 42 C.F.R. § 483.25(i)(1) (Tag F325) (Quality of Care – Nutrition), based on a resident's comprehensive assessment, a facility must ensure that a resident maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible.

With respect to this tag and R2, the SOD alleges that Petitioner failed to do the following: (1) immediately notify the physician of an increase in R2's frequency of refusing meals and significant weight loss; (2) accurately document R2's food intake; and (3) have R2 assessed by a Registered Dietitian. CMS Ex. 7, at 14. I note that these allegations were previously cited under Tag F309 (42 C.F.R. § 483.25) in the SOD, and are based on the identical factual circumstances described by CMS under Tag F309. As part of my discussion of Tag F309, I have already examined these allegations. In light of my conclusion that Petitioner was not in violation of Tag F309, I conclude also that Petitioner was not in violation of Tag F325.

The arguments CMS makes in support of its position focus on R2's weight loss and Petitioner's alleged inadequate measures with respect to his food intake. CMS does concede, however, that its witness, Surveyor Brennan, testified that there was nothing wrong with the diet Petitioner offered to R2. CMS Posthearing Reply at 32; *see* Tr. 147.

As I have discussed above with respect to Tag F309, much of R2's weight loss was caused by his fasting behavior in the exercise of his religious beliefs. The evidence in the record shows that Petitioner's staff was aware that R2 would fast on a rather consistent basis, and did not interfere with his right to practice his religion in this way.

The Departmental Appeals Board (Board) addressed 42 C.F.R. § 483.25(i)(1) in *Carehouse Convalescent Hospital*, DAB No. 1799 (2001), where it held:

> The regulation does not require that a facility maintain a resident's weight at a fixed level, or hold a facility strictly liable for a resident's weight loss in all cases except where maintenance of the resident's weight is clinically impossible. By its language the regulation requires maintenance of weight only to the extent that weight is a parameter of nutritional status. Where a resident receives adequate nutrition and weight loss is due to non-nutritive factors, then weight may not be a parameter of nutritional status, and weight loss by itself does not provide a basis for a deficiency finding.

Carehouse Convalescent Hospital, DAB No. 1799 (2001), at 21.

Under 42 C.F.R. § 483.25(i)(1), Petitioner was not required to maintain R2's weight at any given weight level. Instead, it was responsible for taking all reasonable steps to ensure that R2 received nutrition adequate to his needs. *See Windsor House*, DAB No. 1942, at 18 (2004). I have determined that Petitioner provided R2 with sufficient

nutrition. Moreover, I agree with Petitioner that R2's fasting in the exercise of his religious beliefs can be considered to be a non-nutritive factor that resulted in his weight loss. Contrary to CMS's arguments, I conclude that Petitioner did have a care plan that addressed his fasting, as well as other records that noted his fasting behavior, and did monitor R2's food intake as best it could. I find that Petitioner was in substantial compliance with the participation requirement at 42 C.F.R. § 483.25(i)(1) (Tag F325).

3. Petitioner was in substantial compliance with the participation requirement at 42 C.F.R. § 483.25(j) (Tag F327).

The participation requirement set forth at 42 C.F.R. § 483.25(j) (Tag F327) (Quality of Care – Hydration) requires that a facility must provide each resident with sufficient fluid intake to maintain proper hydration and health. The SOD alleges that Petitioner failed to have a plan in place to assure that R2, who was at risk for dehydration, received the amount of fluid needed to maintain hydration and prevent dehydration. The SOD alleges further that this failure resulted in R2's admission to the hospital on February 3, 2004, where he was diagnosed with dehydration. CMS Ex. 7, at 25-26.

To support the above allegations concerning hydration, CMS relies on essentially the same facts underlying its claim that Petitioner did not comply with the quality of care regulation at 42 C.F.R. § 483.25 (Tag F309). As I discussed above, I found that Petitioner was in substantial compliance with 42 C.F.R. § 483.25. I find that Petitioner was in substantial compliance with 42 C.F.R. § 483.25(j) as well.

It is CMS's position that Petitioner never had a hydration care plan in place for R2, or made any effort to keep track of his fluid intake, "except to note whether he drank or refused the milk and juice on his meal trays, or whether he ever took beverages back to his room." CMS Posthearing Br. at 7; *see* CMS Posthearing Br. at 36; Tr. 53. CMS alleges that Petitioner did not ensure that R2 consumed an adequate amount of fluids, and, because of R2's "low body weight and poor nutrition, . . . should have been on heightened alert that any refusal of fluids would put him at even greater risk than usual for dehydration." CMS Posthearing Reply at 36.

Petitioner asserts that there is nothing in the text of 42 C.F.R. § 483.25(j) that requires a hydration plan. Petitioner contends, moreover, that it is undisputed that it provided R2 with sufficient fluids. With respect to CMS's claim that R2 was at risk for dehydration, Petitioner contends that R2 had no objective signs of dehydration before

February 3, 2004, when he was admitted to the hospital. In Petitioner's view, CMS's position that it should have been "on heightened alert" is an "exercise in hindsight." P. Posthearing Reply at 33-34.

The nutritional assessment dated August 15, 2003, documented that R2's daily fluid needs were estimated to be 1677 cc's. CMS Ex. 67, at 1. The assessment indicated that whole milk was part of his diet. In the risk assessment section, R2 was rated as "no/low risk (i.e. consumes 1500-2000 cc/day)" in the category of "oral/nutrition intake – fluid." Moreover, R2 was rated as "no/low risk" in the category of "skin conditions." The assessment noted that R2's skin was intact, with no pressure sores.

In addition to the assessment, R2's care plan (CMS Ex. 58, at 1), which appears to be dated January 2004, documented that R2's skin breakdown risk was low and that his skin condition was good. On another care plan document dated December 2, 2003, the interventions noted by staff included the following: "Monitor and encourage oral intake;" "Encourage H20 – Provide extra fluids mealtimes;" and "Provide diet Regular – High protein – Double portions whole milk Q meal." CMS Ex. 58, at 7.

Although the SOD frames the alleged deficiency in terms of Petitioner's failure to have a hydration plan in place for R2, Petitioner is correct in stating that 42 C.F.R. § 483.25(j) does not require a hydration plan. The issue is whether R2 received sufficient fluids to maintain proper hydration and health.

Based on my review of the record, I am not persuaded that Petitioner failed to provide R2 with sufficient fluid intake to maintain proper hydration and health. According to R2's food intake logs, R2 received milk and juice with each of his three meals every day. CMS Ex. 70, at 1, 3, 5, 7, 9, 11; partially duplicated at P. Ex. 15. At the hearing, Surveyor Brennan admitted that Petitioner's staff offered R2 sufficient fluids to maintain hydration. Tr. 150. While R2 often did not consume the juice and milk offered with his meals, there were also meals when R2 consumed 100% of his beverages. Moreover, as R2 was widely known to take food to his room, which made monitoring difficult, it is quite likely that R2 consumed beverages in his room.[16]

I conclude that both R2's nutritional assessment and his care plan documentation further favor a conclusion that R2 received sufficient fluids. According to the August 15, 2003 nutritional assessment, R2's estimated daily fluid need was calculated to be

[16] In an August 15, 2003 nutritional progress note, the dietary manager wrote that Petitioner "[h]as extra coffee in room – comes and gets cups to make it." CMS Ex. 67, at 2; duplicated at P. Ex. 12, at 3.

1677 cc's. The fact that he was rated as "no/low risk (i.e. consumes 1500-2000 cc/day)" in the "oral/nutrition intake – fluid" category, is persuasive evidence that R2 was receiving around 1677 cc's of fluid daily. Moreover, it is clear from the care plan that Petitioner's staff addressed R2's hydration status, for it noted that extra fluids were to be provided at meals, drinking water was to be encouraged, and his oral intake was to be monitored.

On the issue of R2's risk for dehydration, the record clearly shows that R2 had no skin integrity issues. Had R2 been at risk for dehydration, one would expect that R2 would have manifested some clinical signs of possible dehydration, such as dry skin, poor skin turgor, thirst, or abnormal laboratory values. He exhibited none of these signs. According to the nutritional assessment and care plan, R2's skin condition was good, his skin was intact, and he had no pressure sores. He was found to be a low risk for skin breakdown. I agree with Petitioner that, prior to February 3, 2004, CMS failed to point to any objective signs that R2 suffered from dehydration.

I do not agree with CMS that Petitioner should have been "on heightened alert" to guard against R2 becoming dehydrated. Up until February 3, 2004, Petitioner's staff had been monitoring R2's hydration status and taken appropriate measures. On February 3, 2004, R2 experienced a sudden turn for the worse. The fact that R2's "collapse" revealed him to be in a dehydrated state does not mean that Petitioner should have foreseen R2's dehydration. Petitioner knew from its assessments how much fluid R2 was receiving and had interventions in place that specifically addressed his hydration status. I conclude that R2 was in substantial compliance with 42 C.F.R. § 483.25(j) (Tag F327).

4. There is no basis for CMS to impose the CMPs it assessed.

As I have found Petitioner to be in substantial compliance with the participation requirements at 42 C.F.R. § 483.25 (Tag F309), 42 C.F.R. § 483.25(i)(1) (Tag F325), and 42 C.F.R. § 483.25(j) (Tag F327), CMS had no basis upon which to impose the CMPs it assessed.

/s/

Richard J. Smith
Administrative Law Judge