Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Appellate Division

In the Case of:	DATE: April 24, 2007
Britthaven of Havelock,	
Petitioner,	Civil Remedies CR1341 App. Div. Docket No. A-06-62
- v. -	Decision No. 2078
Centers for Medicare & Medicaid Services.	

FINAL DECISION ON REVIEW OF ADMINISTRATIVE LAW JUDGE DECISION

Britthaven of Havelock (Britthaven or Petitioner), a North Carolina nursing facility certified to participate in Medicare and Medicaid, appealed a January 23, 2006 decision by Administrative Law Judge (ALJ) Richard J. Smith. Britthaven of Havelock, DAB CR1392 (2006) (ALJ Decision). The appeal involves the care provided to Resident 5, a 45-year old quadriplegic who died at the facility on September 2, 2002.

At issue before the ALJ was a civil money penalty (CMP) imposed by the Centers for Medicare & Medicaid Services (CMS) on Britthaven for alleged noncompliance with two Medicare/Medicaid participation requirements: (1) 42 C.F.R. § 483.10(b)(11), which requires a nursing facility to notify a physician about "significant changes" in a resident's condition, and (2) 42 C.F.R. § 483.13(c), which requires a nursing facility to "develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents[.]" The ALJ concluded that from September 1 through September 2, 2002, Britthaven was not in substantial compliance with section 483.10(b)(11) and that from August 10 through September 2, 2002 Britthaven was not in substantial compliance with section 483.13(c). He concluded the noncompliance posed immediate

jeopardy to Resident 5 and upheld CMS's imposition of a $5,000 per day CMP from August 10 through September 2, 2007.

Britthaven excepts to the ALJ's conclusion that it was not in substantial compliance with 42 C.F.R. § 483.13(c) during the period August 10 through August 31. Request for Review (RR) at 11. Britthaven also excepts to the ALJ's conclusion that its noncompliance posed immediate jeopardy during that time period. Britthaven does not except to any of the ALJ's findings for the time period September 1 and 2, 2002.

For the reasons explained below, we uphold the ALJ Decision in full.

Legal Background

To participate in the Medicare and Medicaid programs, a nursing facility must comply with the requirements for participation in 42 C.F.R. Part 483, subpart B. Compliance with these participation requirements is verified by surveys performed by state health agencies. See 42 C.F.R. Part 488, subpart E.

A survey's findings are reported in a Statement of Deficiencies (SOD). A "deficiency" is a "failure to meet a [Medicare/Medicaid] participation requirement." 42 C.F.R. § 488.301. Each deficiency finding in the SOD includes a determination of the deficiency's level of "seriousness." See 42 C.F.R. § 488.404.

The level of seriousness is determined by assessing the deficiency's scope (whether the deficiency is isolated or widespread) and severity (the degree or magnitude of harm - or potential harm - to resident health and safety resulting from the deficiency). 42 C.F.R. § 488.404. The highest level of severity is "immediate jeopardy." 42 C.F.R. § 488.301. Immediate jeopardy is defined as "a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment or death to a resident." 42 C.F.R. § 488.301.

CMS may impose enforcement remedies on a nursing facility, including a CMP, if the nursing facility is not in "substantial compliance" with Medicare participation requirements. 42 C.F.R. § 488.402(b), (c). A nursing facility is not in substantial compliance if it has one or more deficiencies severe enough to create at least the potential for more than minimal harm to resident health and safety. See 42 C.F.R. § 488.301 (defining substantial compliance as "a level of compliance . . . such that

any identified deficiencies pose no greater risk to resident health or safety than the potential for causing minimal harm"). The regulations (and we) use the term "noncompliance" to refer to "any deficiency that causes a facility to not be in substantial compliance. 42 C.F.R. § 488.301.

A nursing facility found not to be in substantial compliance is subject to various enforcement remedies, including CMPs. 42 C.F.R. §§ 488.402(c), 488.408. CMS may impose CMPs ranging from $50-$3,000 per day for one or more deficiencies that do not constitute "immediate jeopardy" but that either cause actual harm or create the potential for more than minimal harm, and from $3,050-$10,000 per day for deficiencies constituting immediate jeopardy. 42 C.F.R. §§ 488.438(a), 488.301. CMS's determination concerning the seriousness of a nursing facility's noncompliance must be upheld unless it is "clearly erroneous." 42 C.F.R. § 498.60(c)(2).

Case Background[1]

On September 5, 2002, the North Carolina State Survey Agency (state survey agency) conducted a survey and subsequently issued a SOD citing Britthaven under tag F157 at the immediate jeopardy level for violating 42 C.F.R. § 483.10(b)(11). The basis for the state survey agency finding was that Britthaven failed to notify Resident 5's physician of an allegedly significant change in Resident 5's condition after administering a powerful laxative solution at 2400 hours on August 31, 2002.[2] On October 2, 2002, CMS notified Britthaven that, in accordance with the state survey agency's recommendation, it was imposing a $10,000 per instance CMP with an "effective date" of September 5. 2002. P. Ex. 3, at 2.

Almost one year later, CMS informed Britthaven that it was issuing a revised SOD. P. Ex. 4, at 2. In addition to tag F157, the revised SOD cited Britthaven under tag F224 for noncompliance with section 483.13(c), which concerns neglect and facility policies and procedures. P. Ex. 5, at 6-11; CMS Ex. 1, at 6-11

[1] The information in this section is drawn from the ALJ Decision and the record before the ALJ, and is presented to provide a context for the discussion of the issues raised on appeal. Nothing in this section is intended to replace or modify the ALJ's findings of fact or conclusions of law.

[2] We use 24-hour time notation because this appears to be the notation used in the nursing notes. See P. Ex. 11, at 68-70.

CMS asserted that Britthaven's care of Resident 5 from August 10, 2002, through September 5, 2002 posed immediate jeopardy. P. Ex. 4, at 2. Based on its revised determination, CMS withdrew the $10,000 *per instance* CMP and imposed a $5,000 *per day* CMP that ran from August 10 through September 5, 2002.[3] Id.

Britthaven requested and received a hearing before the ALJ to contest CMS's enforcement action.[4] Based on the exhibits and testimony submitted by the parties, the ALJ found the following facts:

Resident 5 was admitted to Britthaven on June 25, 2002 for short-term respite care while his mother underwent surgery. ALJ Decision at 6. As a quadriplegic, Resident 5 had multiple conditions that required care. One of these conditions was a neurogenic bowel, i.e., his nervous system was unable to control his bowel function. Id. at 9.

Prior to his admission in June 2002, Resident 5 was under the care of Dr. Christopher Delaney for his bowel condition. ALJ Decision at 10. The treatment prescribed by Dr. Delaney was a three-day regimen of medication which was intended to prevent incontinence and to give Resident 5 the ability to evacuate his bowels on a regular schedule. Id.

Resident 5's attending physician at Britthaven was Dr. Donald Reece. Id. at 10. On June 29, 2002, Dr. Reece adopted the three-day cycle of medication used by Resident 5 prior to his admission, including Lomotil (an anti-diarrheal agent that has a

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[3] CMS also revised the tag F157 citation (notification of the doctor) by alleging a period of noncompliance (August 10 through September 5, 2002). P. Ex. 5, at 1; P. Ex. 4, at 2. As to tag F157, the ALJ concluded that Britthaven was not in substantial compliance with 42 C.F.R. § 483.10(b)(11) upon administering GoLytely on September 1, 2002. ALJ Decision at 17-20. Since neither party appealed this determination, CMS's 2003 expansion of the period of noncompliance under tag F157 is not at issue on appeal. Therefore, we do not address whether the ALJ's analysis of the duration of noncompliance under tag F157 was correct.

[4] Britthaven appealed the original CMP, and that appeal was docketed as C-03-149. Britthaven subsequently appealed the revised CMP. That appeal was docketed as C-04-53 and consolidated with C-03-149. Thereafter, the case was referred as C-04-53. ALJ Order dated March 8, 2004.

constipating effect), Senekot (a laxative), and Dulcolax suppositories (a laxative). Id. at 11; CMS Ex. 15, at 9; Transcript of ALJ Hearing (Tr.) at 692. The purpose of this medication regimen was to establish a schedule for evacuating Resident 5's bowels every third day. ALJ Decision at 11. The medication would help Resident 5 become constipated over the first two days of the cycle. ALJ Decision at 11. On the third day, he would receive a Dulcolax suppository to trigger bowel evacuation. Id.

On or about July 12, 2002, the facility finalized a Comprehensive Care Plan, required under 42 C.F.R. § 483.20(k), for Resident 5. Id. at 11, citing CMS Ex. 36. While the care plan addressed numerous problems or conditions, it did not address Resident 5's bowel care needs. Id.

The bowel medication regime did not produce the two-day no bowel movement, third day bowel movement pattern it was designed to produce. Id. at 12-13.[5] For example, from August 1 to August 9, Resident 5 experienced repeated unplanned bowel movements. Id. at 12; see also Tr. at 319-325.

On August 9, Resident 5 went to see Dr. Delaney for his bowel problem. ALJ Decision at 12, citing P. Ex. 14, at 19. Dr. Delaney's progress note (which returned with Resident 5 to Britthaven) indicated that Dr. Delaney thought Resident 5 "is not fully evacuating" and questioned whether he had a "high impaction." Dr. Delaney ordered an x-ray and suggested medication changes. Id., citing CMS Ex. 4, at 4.

On August 9, Petitioner's medication regime was changed. Senekot, an oral laxative, was discontinued and Dulcolax tablets (a laxative) were prescribed every day as needed if Resident 5 did not have a bowel movement. ALJ Decision at 12, citing CMS Ex. 15, at 11; P. Ex. 11, at 28, 30.

In accordance with Dr. Delaney's order, Resident 5 had an x-ray on August 9, which was transcribed on August 10. ALJ Decision at 12. The x-ray report stated Resident 5 had evidence of colon fecal impaction and "some degree of small bowel obstruction."

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[5] The ALJ Decision details the medication and bowel movement records for August. The bowel movement records for June and July also show repeated unplanned bowel movements. P. Ex. 11, at 105-106.

Id. quoting CMS Ex. 6, at 1.[6] Britthaven did not receive a copy of the x-ray until after Resident 5's death. Tr. at 1208-1209.

Thereafter, no pattern of bowel movements was established. ALJ Decision at 13. As of August 28, Resident 5 had gone without a bowel movement for five days. Id.

On August 28, Dr. Reece examined Resident 5 and found him to be "medically stable." ALJ Decision at 13. He ordered a three step sequence of enemas, and "if no results" an oral laxative, and "if no results in 2 days give GoLytely prep." Id., citing P. Ex. 11, at 30. GoLytely's intended use is to completely clean out the bowel in anticipation of a colonoscopy, but it is also used, off-label, for resistant constipation. Id., citing Tr. at 930. [7]

Resident 5 refused both the enemas and the oral laxative. At 2400 hours August 31, the nursing staff began administering GoLytely. Id. at 15.

No bowel movement occurred as a result of this treatment until, about 7:40 a.m. on September 2, when Resident 5 was found in a supine position covered with liquid stool. Id. at 16. His respiration was labored, and the nurse could not find his blood

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[6] Impaction "refers to the stool being overly compressed and overly distending a portion of the colon." Tr. at 208, also 297-298. A high impaction is an impaction "way up in the colon . . . the right or ascending colon." Tr. at 208. An obstruction "is any mechanical filling of the bowel anywhere from the stomach down to the end of the colon." Id. The obstruction can be partial or complete and created by something in the bowel, like an impaction, or something outside the bowel putting pressure on it. Tr. at 208-209. The CMS expert, Dr. Steven A. Stiens, testified that people with spinal cord injury are at risk for impaction because they have "significant decrease of peristalsis and do not have bowel movements on a regular basis on their own." Tr. at 210.

[7] A GoLytely prep involves drinking almost a gallon of a solution that induces diarrhea. CMS Ex. 8, at 1. When used for a colonoscopy, a person drinks 8 ounces every ten minutes, which produces bowel movements within an hour. CMS Exs. 8, 9; Tr. at 234, 861. Here 8 ounces was given to Resident 5 every thirty minutes. ALJ Decision at 15. At the slower rate, the GoLytely should have begun producing bowel movements within 4 hours. Tr. at 1034. GoLytely is contraindicated for people with gastrointestinal obstructions. CMS Ex. 8, at 1; Tr. at 260.

pressure or pulse. Id. CPR was administered but Resident 5 died a few minutes later. Id. The Office of the Chief Medical Examiner, North Carolina Department of Health and Human Services, determined that the cause of Resident 5's death was "cardiorespiratory arrest due to treatment for constipation."[8] Id. at 17, citing CMS Ex. 13, at 1.

The ALJ determined that Britthaven was not in substantial compliance with section 483.13(c) on the ground that it had neglected Resident 5 by failing to provide Resident 5 with the goods and services he needed to avoid physical harm. Id. at 20. The ALJ also upheld CMS's determination that the noncompliance posed immediate jeopardy from August 10 through September 2, 2002, the date of Resident 5's death.[9] Because the ALJ shortened the period of noncompliance from an end date of September 5 to September 2, he reduced the amount of the CMP accordingly. Id. at 24-25.

Standard of Review

We review a disputed finding of fact to determine whether the finding is supported by substantial evidence, and a disputed conclusion of law to determine whether it is erroneous. Guidelines for Appellate Review of Decisions of Administrative Law Judges Affecting a Provider's Participation in the Medicare and Medicaid Programs, http://www.hhs.gov/dab /guidelines/ prov.html; see, e.g., Golden Age Nursing & Rehabilitation Center, DAB No. 2026 (2006).

Discussion

Britthaven appeals the ALJ's conclusion that it was not in substantial compliance with section 483.13(c) from August 10 through August 31, 2002. Britthaven also appeals the ALJ's

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[8] Before the ALJ, Britthaven questioned the finding of the Medical Examiner. ALJ Decision at 17, n.11. While the ALJ accepted the Medical Examiner's finding, he also indicated that a contrary finding would not change his decision in the case. Id. On appeal, Britthaven does not challenge the ALJ's acceptance of the Medical Examiner's finding as to the cause of death.

[9] CMS did not appeal the ALJ's conclusion that the immediate jeopardy existed only through the date of Resident 5's death, September 2, 2002, as opposed to through September 5. Since CMS did not appeal the ALJ's conclusion, we do not address here whether the ALJ's analysis of that issue is correct.

conclusion upholding CMS's determination that immediate jeopardy existed during this period.

1. The ALJ's conclusion that Britthaven was not in substantial compliance with 42 C.F.R. § 483.13(c) from August 10 through August 31, 2002 is supported by substantial evidence and free of legal error.

Section 483.13(c) requires a nursing facility to "develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property." 42 C.F.R. § 483.13(c). "Neglect" is defined as a "failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness." 42 C.F.R. § 488.301. First, we discuss the scope of the legal issue presented on appeal, and then we discuss why we uphold the ALJ Decision.

a. Under the circumstances presented by this case, the issue on appeal is whether Britthaven neglected Resident 5.

Under tag F224, the SOD cited the language of 42 C.F.R. § 483.13(c), i.e., "the facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents . . . ." CMS Ex. 1, at 6.[10] Decisions involving citations under section 483.13(c) have typically addressed whether there was neglect and whether that neglect was related to a failure to develop and implement policies and procedures.[11] See Emerald Shores, DAB No. 2072

[10] We note that, while the SOD used the language of section 483.13(c) for tag F224, it cited subsection 483.13(c)(1)(i) rather than section 483.13(c). Section 483.13(c)(1)(i) prohibits the use of verbal, mental, sexual or physical abuse of residents. The ALJ noted this discrepancy in the decision. He concluded that Britthaven had not been prejudiced because "at no time has Petitioner shown that the notice that it received was not clear that CMS's contention is that Petitioner failed to comply with section 483.13(c), not subsection 483.13(c)(1)(i)." ALJ Decision at 2, n.1.

[11] It would not be necessary to find actual neglect in order to uphold a finding that a facility failed to substantially comply with section 483.13(c). For example, if a facility had no general abuse and neglect policy, it could be found to be

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(2007); Liberty Commons Nursing and Rehab Center-Johnston, DAB No. 2031 (2006); Barn Hill Care Center, DAB No. 1848 (2002), Emerald Oaks, DAB No. 1800 (2001).

Britthaven's position before the ALJ was that the sole issue under tag F224 was whether it had neglected Resident 5 and that its policies and procedures were irrelevant. Britthaven represented that it inquired in a pre-hearing conference call about how the ALJ wished to handle its objections to CMS's attempt to raise issues Britthaven regarded as irrelevant and was instructed to raise them at the hearing. P. Post-hearing Br. at 46. When CMS sought to cross-examine Britthaven's Director of Nursing (DON) about policies and procedures, Britthaven objected that this line of inquiry was not relevant. Tr. at 1175-1176. The ALJ stated that the question of relevancy should be addressed in the post-hearing briefs. Tr. at 1176-1179.

In its post-hearing brief, Britthaven objected to CMS's allegations about policies/procedures as "improper, untimely, and irrelevant" to a citation under tag F224. P. Post-hearing Br. at 46-49. It argued as follows.

- Britthaven stated that, under tag F224, the surveyors concluded that "the facility failed to provide the necessary care and services in order to prevent the neglect" of Resident 5 and that the facts listed by the surveyors in support of this conclusion never mentioned the absence of or failure to implement policies/procedures. Id. at 46-47, citing CMS Ex. 1, at 7.

- Britthaven pointed out that the SOM and the SOD state that F224 is to be used "for deficiencies concerning mistreatment, neglect, or misappropriation of resident property" while they state that F226 should be used "for deficiencies concerning the facility's development and implementation of policies and procedures." Id. at 47-48, citing P. Ex. 9, at 3.

- Finally, Britthaven argued that if the facility's policies/procedures were relevant, CMS had failed to make a prima facie case. Id. at 48.

[11](...continued)
noncompliant.

In the decision, the ALJ quoted the language of the regulation, the SOD, and the definition of neglect. He then wrote, "As Petitioner frames the issue, my inquiry here is to determine whether it 'failed to provide or withheld goods and services necessary to avoid physical harm, mental anguish, or mental illness, such that Resident 5 was neglected.'" ALJ Decision at 20, citing Britthaven Post-hearing Reply Br. at 3. Thereafter, he treated neglect as the only issue before him and concluded that Britthaven was deficient under tag F224 because it "failed in its provision of services to Resident 5 in order to avoid physical harm." Id.

Before the Board, Britthaven continues to argue that it did not neglect Resident 5. However, it no longer argues that its policies and procedures are irrelevant. Instead, it argues that the ALJ erred in concluding it was noncompliant without first finding that any deficient care resulted from Britthaven's failure to adopt or implement neglect policies or procedures. RR at 12, 13, 17, 19, and 23-25; P. Reply Br. at 12, 14-16.

We reject this argument. The ALJ made no findings or conclusions about the relationship between the neglect he found and Britthaven's implementation of policies and procedures because he adopted Britthaven's argument below that its policies/procedures were not at issue under tag F224. Britthaven may not now allege error on the ground that the ALJ adopted its position below. Indeed, the ALJ could reasonably conclude that Britthaven conceded that it was not in substantial compliance with section 483.13(c) if the ALJ found neglect, regardless of whether it had adopted and implemented policies and procedures prohibiting neglect.

b. Britthaven failed to show that it had adopted and implemented policies and procedures to prevent the neglect Resident 5 suffered.

Even if we were to reach the question whether Britthaven had adopted and implemented appropriate policies and procedures, we would uphold the ALJ's determination that Britthaven was not in substantial compliance with section 483.13(c). As discussed below, the circumstances on which the ALJ relied (failure to plan, to follow up on the doctor's note and x-ray, and to notify the doctors of the change in orders and Resident 5's response to the GoLytely) support a reasonable inference that Britthaven did not have or had not implemented policies/procedures to prevent

the type of neglect suffered by Resident 5.[12] Britthaven did not proffer evidence that would rebut such an inference, even though CMS gave notice to Britthaven that it regarded neglect policies/procedures to be at issue by citing the text of section 483.13(c) in the SOD (CMS Ex. 1, at 6-7) and by raising the issue in its pre-hearing brief (CMS Pre-hearing Br. at 8). Additionally, in its Plan of Correction, Britthaven adopted procedural changes related to bowel management and physician notification and performed in-service training on existing policies/procedures – measures that were plainly intended to prevent the type of neglect suffered by Resident 5. CMS Ex. 1, at 11. Thus, Britthaven understood the type of additional measures that CMS concluded were needed and could have presented evidence or argument before the ALJ as to the lack of any relationship between its pre-existing policies/procedures and the neglect suffered by Resident 5.

c. Substantial evidence in the record as a whole supports the ALJ's finding that Britthaven failed to provide Resident 5 with goods and services necessary to avoid physical harm.

The ALJ determined Britthaven was deficient under tag F224 because it neglected Resident 5 by failing to develop a plan of care for his neurogenic bowel condition, by failing to follow up on Dr. Delaney's note and the x-ray of August 9, by failing to inform his doctor that it skipped the first two steps of the three step order issued on August 28, and by failing to consult with the doctor when, after administering the third step,

[12] The Board has held that it is not error for an ALJ to infer from multiple or sufficient examples of neglect that a facility has failed to adequately implement its anti-neglect policy. See, e.g., Liberty Commons Nursing & Rehab – Johnston (upholding inference from failure of shift nurse to notify CNA about resident's allergy to latex before she provided care, failure of staff to maintain latex warning signs and failure of CNA to review resident's medical record when caring for resident for the first time); Emerald Oaks, (upholding inference where facility delayed contacting resident's physician about sudden changes in resident's condition and abnormal vital signs until a second episode occurred); Barn Hill Care Center, (upholding inference based on substantial evidence showing medication errors and untimely medication passes by one nurse on a single day).

GoLytely, Resident 5 had not produced a timely bowel movement.[13] ALJ Decision at 22. Below we discuss the first three bases; the fourth occurred during the time period covered by the CMP that Britthaven does not contest.

(1) Neglect resulting from failure to plan care for Resident 5's neurogenic bowel condition

The Social Security Act (the Act) and implementing regulations require nursing facilities to "provide services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, in accordance with a written plan of care which . . . describes the medical, nursing, and psychosocial needs of the resident and how those needs will be met." Section 1819(b)(2)(A) of the Act; see also 42 C.F.R. §§ 483.20(k); 483.25.

On or about July 12, 2002, Britthaven finalized its "Comprehensive Care Plan" for Resident 5. ALJ Decision at 11, citing CMS Ex. 36. The plan did not mention Resident 5's neurogenic bowel condition. Id.

The ALJ concluded that Britthaven neglected Resident 5 because it never "care-planned" for Resident 5's neurogenic bowel condition. ALJ Decision at 22. The ALJ wrote,

> Without planning for Resident 5's bowel care, there was no way to ensure that repetitive daily care was delivered in such a way to ensure that care was being appropriately rendered. An accruing problem could become life threatening.

Id. (emphasis added).

These findings are supported by the testimony of Dr. Steven A. Stiens, CMS's expert witness.[14] Dr. Stiens testified that, to

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[13] CMS also argued that other aspects of Britthaven's care of Resident 5 constituted neglect; the ALJ did not address these assertions because he concluded that the four factors on which he relied were a sufficient basis for the deficiency finding. ALJ Decision at 22.

[14] Dr. Stiens' 23-page Curriculum Vitae is at CMS Exhibit 46. Dr. Stiens is an Associate Professor at the University of Washington Department of Rehabilitative Medicine. He is board

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prevent serious injury including death, quadriplegics require care plans for bowel and skin management that ensure that "repetitive daily care is delivered in such a way that there's no accruing or increase or magnifying effect of the daily care not being rendered appropriately." Tr. at 289-290. Dr. Stiens testified that an effective bowel plan was necessary to prevent a range of harmful complications that accrue over time. Tr. at 295-296, 300. Complications include constipation, diarrhea, distention of the colon leading to a cathartic colon, impaction of the colon, hemorrhoids, and perianal fissures or abscesses. Tr. at 295-296; 300. Dr. Stiens also testified that an over-filled colon in a quadriplegic can result in autonomic dysreflexia, a life-threatening syndrome which can rapidly drive blood pressure to very high levels and cause stroke.[15] ALJ Decision at 7, n.5, citing Tr. at 349-350. Failure to develop a plan for neurogenic bowel care, therefore, creates a risk of physical harm and, in Resident 5's case, contributed to the physical harm he suffered and to his death.

Britthaven does not dispute that an inadequate bowel care plan could result in physical harm or death for a quadriplegic, does not dispute that a neurogenic bowel is a condition that should be

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[14](...continued)
certified by the American Board of Physical Medicine & Rehabilitation (1991) and received a subspecialty certification in Spinal Cord Medicine (1998). He has published extensively in the field of neurogenic bowel and spinal cord injury. He was a member of the Neurogenic Bowel Guideline Panel of the Consortium for Spinal Cord Medicine, which developed guidelines for patients and for clinicians for the care of the neurogenic bowel. CMS Exs. 47, 48. His current practice is restricted to spinal cord medicine. Tr. at 189. He provides care for people with spinal cord injury from the time of injury and throughout their lives. Id. His patients include people living in nursing homes. Id. at 190, 291, 294, 555, 558-559, 562.

The ALJ determined that Dr. Stiens was qualified as "an expert (and so acknowledged by Petitioner) in the care of individuals with spinal cord injury, with a specialty in neurogenic bowel." ALJ Decision at 7, citing Tr. at 198; CMS Ex. 46.

[15] Autonomic dysreflexia is a response to pain stimulus such as "a colon being over-filled, any pathologic process below the level of injury that causes excessive sympathetic discharge of reflex mediated by the spinal cord." Tr. at 349-350. It can be life threatening. Id., see also ALJ Decision at 7, n.5.

included in a care plan, and does not dispute it did not address Resident 5's neurogenic bowel condition in his Comprehensive Care Plan. Rather, Britthaven argues that it implemented a care plan for Resident 5's bowel condition by following the medication regime prescribed by his doctors; that the regulations do not require the plan to be memorialized in any particular document; and that this bowel plan was documented throughout the record. RR at 14-15. Britthaven argues that the ALJ's finding was not related to the quality of the care provided to Resident 5, but "was limited to the facility's failure to document the care plan [i.e., the doctors' orders] on a specific form: the 'Comprehensive Care Plan' dated July 12, 2002." P. Reply at 3.

We reject all of these arguments. Both the Act and the regulations require care plans to include specific information. A care plan must "include[] measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment."[16] 42 C.F.R. § 483.20(k)(1). A care plan "must describe the following . . . [t]he services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under section 483.25." 42 C.F.R. § 483.20(k)(1)(i). Failure to address Resident 5's neurogenic bowel condition in his care plan transgresses both these standards.

Even if we accepted, however, Britthaven's position that the doctor's order did not have to be memorialized in the care plan or that failure to memorialize the doctor's order did not result in physical harm to Resident 5, we reject Britthaven's argument that the doctor's order constituted a care plan under section 483.20(k). A care plan is created by a nursing facility. Britthaven points to no evidence in the record that its staff considered what Britthaven, as a nursing facility, could contribute to the care of Resident 5's neurogenic bowel condition, other than administration of medications. Thus, the ALJ properly rejected Britthaven's argument that its implementation of the medication orders constituted bowel care

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[16] Comprehensive assessments must be performed pursuant to a Resident Assessment Instrument specified by the State. 45 C.F.R. § 383.20(b)(1). Because such survey instruments cannot incorporate every possible factor a facility should consider in a resident assessment, a facility's obligation to plan for a resident's care is not limited to the protocols or triggers in such instruments. Park Manor Nursing Home, DAB No. 2005 (2005); Maine Veterans' Home-Scarborough, DAB No. 1995 (2005).

planning. Rather, he concluded that, by failing to plan for Resident 5's bowel condition, Britthaven failed to take the appropriate responsibility for his care, relied too much on Resident 5 and his doctors in delivering care, and failed to provide Resident 5 with nursing services to prevent the types of physical harm he ultimately suffered. ALJ Decision 20-21. He also concluded that Britthaven failed in its duty "to understand adequately the needs of such an obviously difficult case and to understand the level of care to which it committed itself by admitting Resident 5." Id. at 19; see also id. at 8, n.5, and at 23. Both of these circumstances contributed to the physical harm suffered by Resident 5.

In making these findings, the ALJ relied on the testimony of Dr. Stiens and neurogenic bowel care guidelines issued by the Consortium for Spinal Cord Medicine.[17] Dr. Stiens testified that a bowel program for a quadriplegic should be based on a "comprehensive management plan" (Tr. at 295) that includes four components: medication, diet, activity, and bowel care. ALJ Decision at 10, citing Tr. at 294-310. Each of these components is discussed below.

As for medications, Resident 5 came to Britthaven with a medication regime, prescribed by his doctors, which was designed to constipate him for two days and produce a planned bowel movement on the third day. ALJ Decision at 11. Britthaven argues that its nurses had no authority to change the doctor's medications or to question the doctor's medications. P. Reply at 8-9. This position ignores the fact that medication is only one component of an effective bowel program. It also ignores the fact that, by the time Britthaven adopted its written care plan for Resident 5 and well before August 10, it was apparent that this medication regime, by itself, was not effective. Instead, in July and the beginning of August Resident 5 was having regular unplanned bowel movements and by the second week of August he had developed symptoms of constipation and possible intestinal

[17] The Consortium's members are identified in CMS Exhibit 47, at page 2, and include, but are not limited to, the American Academy of Orthopedic Surgeons, American Academy of Physical Medicine and Rehabilitation, American Association of Neurological Surgeons, American Association of Spinal Cord Injury Nurses, American Association of Spinal Cord Injury Psychologists and Social Workers, American Congress of Rehabilitation Medicine, American Physical Therapy Association, Association of Rehabilitation Nurses, Paralyzed Veterans of America, and U.S. Department of Veteran Affairs.

blockage. Therefore, even if Britthaven reasonably concluded at the time of his admission that Resident 5's medication regime constituted an adequate bowel program, that conclusion was not reasonable after the staff realized he was having frequent unplanned bowel movements.

In spite of the fact that Britthaven should have realized shortly after Resident 5's admission that the medication regime was not an adequate bowel program, Britthaven failed to develop or implement any changes in the program and ultimately failed to plan for any of the other three components of a bowel program. See ALJ Decision at 22, citing Tr. at 288 (Dr. Stiens stated that "a comprehensive approach is necessary" in planning bowel care). The first missing component was attention to diet and fluids. Tr. at 310. While Britthaven argues that the doctor authorized a regular diet for Resident 5, there is no indication in the record that Britthaven reviewed that diet and fluid intake in relation to Resident 5's elimination problems. Indeed, Dr. Stiens testified that, based on his review of the records, "there was not a dietary approach to this problem." Tr. at 310. Britthaven's assertion on appeal that Resident 5's diet was based on his food preferences is not responsive. P. Reply at 7. A facility can simultaneously consider a resident's food preferences and the food's relationship to the effectiveness of his bowel program, but Britthaven did not do so.

The second missing component is activity, such as changing position, manipulating joints for a full range of motion, or massaging the abdomen, all of which can facilitate bowel movement regularity. Tr. at 311. Resident 5 used a wheelchair, so he had some physical activity. Id. However, Dr. Stiens testified that Resident 5's activity component was inadequate in that Britthaven provided no range of motion or massaging activities which facilitate elimination. Id. Britthaven's expert witness, Dr. John Rubino, testified that, in a long term care facility, there are "exercise opportunities available for residents," including physical therapy, "if it's a more prescribed regimen that you want." Tr. at 949. He also testified that physical therapy, range of motion, and flexion extension would "typically" require a doctor's order. Id. However, the record contains no indication that Britthaven considered such services or the relationship between the purportedly available "exercise opportunities" at the facility and the effectiveness of Resident 5's bowel program. Finally, even if some of these services required a doctor's order, Britthaven could have easily requested such an order from the treating physician.

The third missing component is bowel care, i.e., providing assistance in the elimination of stool so that bowel movements that occur are efficient and effective.[18] Tr. at 295. Dr. Stiens' testimony and the guidelines published by the Consortium for Spinal Cord Medicine all speak of the critical importance of this element. According to Dr. Stiens and the literature, there are multiple strategies, to be used in combination, for achieving effective and efficient elimination. For example, bowel care should occur at a regular time. CMS Ex. 47, at 11. Bowel care may be scheduled in relation to a meal or hot drink which has a tendency to stimulate the bowel to push stool out. Id. at 9. Bowel care can include assistive techniques such as abdominal massage and proper positioning, which for a patient who must lie down involves lying on the left side. Id. at 16, 20. Finally, it includes rectal stimulation such as digital rectal stimulation, manual evacuations, and/or stimulant medications such as a suppository or mini-enema. Id. To be most effective, such a suppository must be inserted correctly, i.e., any stool that would interfere with the suppository's insertion should be removed and the suppository placed in contact with the rectal wall. Id. at 15.

Other than the stimulating suppository prescribed by the doctor, Britthaven identifies no evidence indicating that its plan of care for Resident 5 used any of these strategies for bowel care or even that it administered the suppository to maximize its effectiveness.[19] Additionally, Britthaven's "Resident Care Guide" indicates that Britthaven did not view bowel care as a service it would provide to Resident 5. The Guide is a printed form used to identify elements of care for different matters, including a resident's "toileting program." The Guide's printed choices for the "toileting program" are "Protection and Containment," "Scheduled Toileting," and "Prompted Voiding." On Resident 5's Guide, Britthaven checked only "Protection and Containment." P. Ex. 11, at 120.

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[18] Efficient means that elimination is accomplished in as short a time period as possible. Tr. at 295. Effective means that a significant quantity of stool is excreted during the bowel care period, i.e., the time when it is scheduled to be excreted. Id.

[19] As the ALJ noted, the Dulcolax suppository should have produced a bowel movement within 15 minutes to an hour. ALJ Decision at 11, n.7 citing CMS Ex. 43, at 2, 3, 6, 11, 13. However, it was repeatedly administered with no effect in the day of administration. Id.

Britthaven did not dispute Dr. Stiens' assertions that attention to diet, activity, and bowel care would result in more efficient and effective elimination for a quadriplegic. Rather, it argues that a failure to use Dr. Stiens' care methods does not necessarily constitute neglect. P. Reply at 5-8. It characterizes Dr. Stiens as presenting a program "developed in an academic setting . . . which includes all conceivable 'bells and whistles'." Id. It argues that Dr. Stiens "advocates for the use of this all-inclusive "Cadillac" bowel program for all quadriplegic individuals with neurogenic bowel issues, regardless of individual needs or circumstances or the local communities' treating physicians' level of knowledge and training." P. Reply at 5.

We reject these arguments for the following reasons.

- First, Dr. Stiens did not advocate a uniform bowel program. He was very clear that quadriplegic individuals and their care givers should adopt a comprehensive approach that produces an efficient and effective bowel program for that individual. Tr. at 212-214, 292, 294. He also maintained that in designing such a program, the individual and care givers should consider a full range of strategies that can contribute to the efficiency and effectiveness of a bowel program, particularly where a bowel program was not effective. Id. at 587-589, 681-682; see also CMS Exs. 47, 48.

- Second, Britthaven's insinuation that Dr. Stiens' "Cadillac" bowel program is based on his personal preferences is incorrect. The standards Dr. Stiens described are set forth in clinical practice guidelines for the care of neurogenic bowel issued by the Neurogenic Bowel Guideline Panel of the Consortium for Spinal Cord Medicine. See Neurogenic Bowel: What You Should Know, A Guide for People with Spinal Cord Injury (issued in March 1999) at CMS Ex. 47, and Neurogenic Bowel Management in Adults with Spinal Cord Injury (issued in March 1998) at CMS Ex. 48.

- Third, Britthaven's insinuation that these standards were appropriate only in an "academic" setting or its assertion that it was dependent on "the local communities' treating physicians' level of knowledge and training" are not correct. The elements of care described by the standards do not require sophisticated equipment or training, nor are they impractical for the

ordinary nursing facility.[20] Indeed, Dr. Stiens testified that the absence of an effective bowel program increases the work of nursing facility staff because they have to keep cleaning up the resident's accidents. Tr. at 323, 357. Further, Dr. Stiens testified that the Consortium's standards have been distributed widely and are available free on the internet. Tr. at 194, 196, 583-586.

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[20] For example, Dr. Stiens testified about the efficacy of the bowel care technique of digital rectal, which is --

> [t]he process of inserting a gloved, well-lubricated finger into the rectum and moving the finger in a circular funnel-shaped pattern, keeping contact with the rectal wall. This technique helps trigger peristalsis in people with reflexic bowel . . .

CMS Ex. 47, at 44.

Dr. Stiens characterized digital stimulation as "an age old technique for triggering a bowel movement" and stated that it would be very difficult to have an effective bowel care program for a patient like Resident 5 without using it. Tr. at 603-605.

Britthaven's DON testified that she had performed digital stimulations in the past (Tr. at 1200) and had found the technique effective (Tr. at 1200-1201), and that the use of the technique did not require a doctor's order (Tr. at 1245). On redirect, she was asked if she believed Resident 5 would have "accepted it as a treatment alternative." Tr. at 1246. The DON answered "I think as a last means, maybe. He was a proud man and if he felt that he needed it, he would have accepted it but I don't think he felt that he needed it." Id. The obvious problem with this testimony is that there is no indication that Resident 5 was aware of this alternative or that Britthaven offered digital stimulation or tried to explain its efficacy, even when Resident 5 was in extreme distress on the night before he died. This testimony supports the ALJ's finding that Britthaven relied too heavily on Resident 5 in delivering care and failed to take appropriate responsibility for Resident 5's care. Here the DON admits making an assumption about an effective treatment alternative without ever presenting the alternative to Resident 5 and ascertaining whether he was aware of the alternative and the potential benefits it offered.

- Finally, the ALJ did not conclude that Britthaven neglected Resident 5 simply because it failed to use all of Dr. Stiens' "bells and whistles." Rather, the ALJ concluded that Britthaven neglected Resident 5 because it failed to develop a care plan for his neurogenic bowel and that this failure contributed to the physical harm he ultimately suffered. ALJ Decision at 22. The ALJ reasonably relied on Dr. Stiens' testimony about care measures that Britthaven, as a nursing facility, could have contributed to Resident 5's care. Britthaven failed to present credible evidence that it ever considered and rejected these or other care options, whether for reasons unique to Resident 5 or pursuant to some other authority on neurogenic bowel care.

Britthaven also argues that the ALJ's finding of noncompliance "fails to account for differences in clinical judgment and approach among health care providers, particularly those treating physicians who cared for Resident #5." P. Reply at 6. It asserts that --

> healthcare providers in exercising their clinical judgment can often disagree on the appropriate parameters of care to be provided. This is particularly so when considering the bowel regime followed by the facility was created by the resident's own treating physician, who was aware of and treated the individual needs of this resident as opposed to Dr. Stiens who merely provided an after the fact analysis based on a review of the record.

Id. at 7.

This argument is not persuasive. First, as discussed above, a nursing facility has an obligation to consider care options within its professional expertise that contribute to a resident's ability to attain and maintain his/her highest practicable well-being. As discussed above, Britthaven points to nothing in the record that indicates that it exercised that professional expertise in this case. Second, Britthaven did not present the testimony of the treating physicians; consequently, there is no evidence that they considered and rejected, for reasons unique to Resident 5, the clinical practice guidelines published by the Consortium for Spinal Cord Medicine, or were relying on some other appropriate authority. Thus, the record contains no information based on which the ALJ could have compared the treating physician's exercise of his "clinical judgment" to the standards described by Dr. Stiens.

Britthaven relies on the testimony of its expert, Dr. Rubino, for the proposition that Resident 5's "bowel program implemented by Resident #5's treating physicians was appropriate and did not constitute neglect, even though it varied in certain respects from the plan outlined by Dr. Stiens." P. Reply at 7, n.2 citing Tr. at 917-918, 964. The ALJ did not err in finding Dr. Stiens more credible than Dr. Rubino on this point. Dr. Stiens was qualified as an expert in the care of individuals with spinal cord injury, with a specialty in neurogenic bowel. ALJ Decision at 7. In contrast, Dr. Rubino was qualified as "an expert in internal medicine and the primary care of adults." Tr. at 905.

Additionally, Dr. Rubino's own testimony demonstrated that he did not have sufficient experience in neurogenic bowel care to testify as credibly as Dr. Stiens. For example, when asked if he had any concern about Dr. Delaney's approach to Resident 5's care as of January 2002, he said no and that "as an internist, you know, I would defer to Dr. Delaney because he takes care of many more of the patients at any one time than I do, and has more expertise in that area." Tr. at 918.[21] Further, Dr. Rubino was not knowledgeable about autonomic dysreflexia, testifying, "Prior to this case I heard the term and had some inkling of what it referred to, but could not tell you all the details of it." Id. at 952-953.

Britthaven argues further the ALJ erroneously held the facility nurses responsible for the treating physician's allegedly ineffective care plan, "insinuating that the facility nurses

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[21] Further, when asked how confident he would be caring for someone like Resident 5, Dr. Rubino testified that he would get a specialist's help if the initial bowel program was not working. Id. at 908.

Additionally, Dr. Rubino's testimony about Resident 5's bowel program was based on the erroneous assumption that it was "working." When asked if Resident 5's bowel care was "effective and appropriate," he testified "[it] seemed to be working and meeting his needs . . . . It was ordered by a physician that would have greater expertise in the area than a primary care physician. And so, I wouldn't have any reason to question that . . . . if it seems reasonable and it's working for the patient and the patient doesn't have any complaints with it . . . ." Tr. at 945-946. However, as he testified later, he would consider "more incontinence than the patient wanted" or "more difficulty passing stool" to be indications that the plan was not working. Tr. at 980-981. Resident 5 had both of these problems and complaints.

should have known that his complicated medical regime did not constitute a 'complete' bowel program and then should have challenged the treating physicians to institute alternative treatments." P. Reply at 8.

The ALJ did not rely on any failure to challenge the doctors' orders as a basis for finding Britthaven out of compliance with section 483.13(c). Instead, the ALJ stated that a nursing facility has an "independent obligation to plan for and provide services to meet the medical needs of each resident and to help each resident maintain the highest practicable physical well-being (Act, section 1891(b)(2)) outside of any physician orders." ALJ Decision at 21, n.14, citing Beverly Health and Rehabilitation – Spring Hill, DAB No. 1696, at 39-44 (1998); Cross Creek Health Care Center, DAB No. 1665 (1998). He stated that his decision "focus[ed] solely on Petitioner's actions as a nursing facility and the responsibilities attendant to that role." Id.

Substantial evidence in the record as a whole supports the ALJ's finding that Britthaven failed to take responsibility for providing the care and services that, as a nursing facility, it should have provided to try to prevent Resident 5's suffering physical harm. As the ALJ noted, Britthaven failed in its duty to understand Resident 5's care needs and "the level of care to which it committed itself by admitting Resident 5." ALJ Decision at 19. For example, in addition to its failure to plan for regular bowel care, Britthaven failed to plan for the risk of autonomic dysreflexia, even though it was on notice that Resident 5 had a history of autonomic dysreflexia. ALJ Decision at 8, n.5.[22] We see no evidence that its staff understood the potential danger autonomic dysreflexia posed to Resident 5, how to treat it, or how to plan for it in relation to bowel care. Dr. Stiens testified it is "essential" for a registered nurse in a facility "that has chosen to accept and treat people with spinal cord injury to be fully aware of what autonomic dysreflexia is, how to recognize it, how to confirm their suspicion of it by taking a blood pressure and how to treat it." Tr. at 629.

[22] The ALJ rejected Britthaven's assertion (P. Br. before ALJ at 23-24, n.9) that it was not aware that Resident 5 had previously experienced this condition. ALJ Decision at 8, n.5, citing Britthaven medical records at P. Ex. 6, at 28, 45; P. Ex. 11, at 129.

Other evidence supports the ALJ's finding that, in failing to plan for Resident 5's care, Britthaven failed to provide the care and services that, as a nursing facility, it should have provided. As Dr. Stiens testified, "Nurses are separately trained and credentialed medical professionals that do their own assessment of patient symptoms, physical findings and make their own medical judgments . . . and interact with other health professionals in concert in patient care." Tr. at 578. As discussed above, many of the care strategies identified by Dr. Stiens, such as attention to diet/fluids, activity, or elements of bowel care, did not require a doctor's order or modification of the medical regime prescribed by the doctors. Similarly, Dr. Stiens identified other shortcomings in Britthaven's care that fall within the responsibilities of nursing staff such as communication with doctors, including reporting on the success/failure of bowel care and clarifying of test results (Tr. at 334, 342, 351-352, 367-369, 382, 643, 695-696, 719-720), monitoring and assessing vital signs (Tr. at 338), understanding the potential for harm caused by a bowel obstruction when caring for a quadriplegic (Tr. at 374, 629); and making suggestions to the patient and doctors as to how nursing care could improve bowel performance (Tr. at 323, 637, 643-644). Indeed, Britthaven's DON testified that a facility has an obligation, in planning for a resident's care, to understand the care needs of the resident and confer with treating doctors about how nursing care could improve a resident's condition.[23] Tr. at 1196.

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[23] As to a facility's role in actively planning for a resident's care, the DON testified as follows:

> Q: [A]ssuming that the doctor did not direct you to obtain further information or education about the needs of a resident with neurogenic bowel, you would not on your own have taken that initiative as Director of Nursing to obtain further information about the needs, the care needs and effective interventions for resident with neurogenic bowel?
>
> A: If there was a problem with that resident, yes, I would have sought different interventions that I could relay and ask the doctor if we could implement. I would not implement – I cannot diagnose a patient and I cannot prescribe treatment for a patient, that is for a doctor, medical doctor, to do and then we follow his or her orders. We cannot initiate a treatment plan for this – for a patient, you know, diagnose a patient, we can't do that, so – but I mean we can ask a doctor do you think this would work if we

(continued...)

For the preceding reasons, we conclude that the ALJ correctly determined that Britthaven was not in substantial compliance with section 483.13(c) because it neglected Resident 5 by failing to develop a plan of care for his neurogenic bowel condition.

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[23](...continued)
thought that there was a problem.

Tr. at 1199.

However, when asked whether Britthaven staff made any effort, during Resident 5's stays at Britthaven, “to obtain any information concerning the effective care, bowel care of a resident with spinal cord injuries,” the DON answered “No, not in relation to Resident 5, his program seemed to be effective for him.” Tr. at 1196.

(2) Failure to follow-up on Dr. Delaney's progress note and x-ray

The ALJ concluded that Britthaven had neglected Resident 5 because it did not "follow up" with Dr. Delaney about his progress note of August 9 and the x-ray on August 9 ordered by Dr. Delaney. ALJ Decision at 22. Absent such follow up, the ALJ concluded that Britthaven was "unable to assure that Resident 5 was provided the nursing care Resident 5 needed because it simply did not have the information to do so." Id. at 23.

The factual context for this conclusion is as follows. Resident 5 went to see Dr. Delaney on August 9 because his bowel care program was not working. ALJ Decision at 12, citing P. Ex. 14, at 19. Resident 5 returned to Britthaven with a note by Dr. Delaney stating "sounds like pt is not fully evacuating. ?High impaction. Will get x ray, try Dulcolax pills, but pt. may need full Golytely bowel prep." Id. citing CMS Ex. 4, at 4. Thereafter, Resident 5's medication was changed: the Senekot was discontinued and two Ducolax pills every day as needed were added. P. Ex. 37, at 40.

In accordance with Dr. Delaney's order, Resident 5 had an x-ray of his bowel on August 9, which was transcribed on August 10. ALJ Decision at 12. The x-ray report stated "[t]here is a large amount of fecal material throughout the colon with air filled and dilated small bowel loops proximally. This most likely represents fecal impaction and some degree of small bowel obstruction." Id., quoting CMS Ex. 6, at 1. Britthaven did not obtain a copy of this x-ray until after Resident 5's death. Tr. at 1208-1209.

The ALJ found that Britthaven, on August 12 and 19, "apparently" faxed to Dr. Delaney's office the following message:

> Resident saw Dr. Delaney on 8/9/02. Returned [with] order to [discontinue] Senokot, Dulcolax tabs . . . [Resident 5] is concerned that he is not cleaned out & progress note states he might need Go-Lytely bowel prep. Do you want Go-Lytely ordered? . . . Also he would like to know results of the x-ray that was done on 8/9/02.

ALJ Decision at 13 and 22, quoting P. Ex. 37, at 42.[24]

The ALJ also found that "there is no documentation that Dr. Delaney received or responded to the fax" (ALJ Decision at 13) and stated that Britthaven should have followed up any faxes with a phone call to clarify whether Resident 5 "may have been developing a condition that Petitioner needed to treat" (ALJ Decision at 22).

The ALJ's finding that Britthaven's failure to clarify Resident 5's medical status with Dr. Delaney and to obtain x-ray results resulted in neglect is supported by substantial evidence in the record as a whole. Dr. Stiens testified that this x-ray report showed the presence of a serious medical problem, i.e., impaction and obstruction. Tr. at 333-335. Dr. Stiens testified to the danger that Resident 5's condition and the absence of an effective bowel program by August 9 posed, particularly because his "condition could change quickly in a life threatening way without our knowing because he has no sensation or very limited sensation from the neck down ... abdominal pathology is masked . . ." Tr. at 338; see also 208-210; 337, 347-349. Dr. Stiens testified that the nursing facility should have been monitoring Resident 5's temperature, pulse and blood pressure to ensure he did not suffer life threatening conditions like autonomic dysreflexia or other pathological processes. Tr. at 338, 349. Finally, he testified that a nursing facility must maintain communication with doctors and clarify test results and that by August 10 the staff should have been clarifying Resident 5's condition with a doctor. Tr. at 334, 342, 351-352, 368-369, 382, 643, 720. As the ALJ found, without this information, Britthaven "was unable to ensure that Resident 5 was provided with the nursing care Resident 5 needed because it simply did not have the information to do so." ALJ Decision at 23. Britthaven's failure to clarify Resident 5's condition and care needs with Dr. Delaney contributed to the harm and risk of harm Resident 5 experienced

[24] The ALJ's finding that Britthaven "apparently" faxed a note to Dr. Delaney reflects the facts that no fax transmittal information appears on the note and Britthaven has no other confirmation of transmittal. See P. Ex. 37, at 42. On appeal, Britthaven points out that the handwriting on the note indicates it was also faxed August 15, but the ALJ does not mention the notation for August 15. We do not need to resolve the discrepancy because the ALJ found that Britthaven should have called Dr. Delaney to discuss his note and x-ray after he did not respond to the fax.

as of August 10 and contributed to the additional harm he ultimately suffered.

(3) Failure to inform Dr. Reece that Resident 5 had refused ordered treatment.

The third instance of neglect cited by the ALJ was Britthaven's failure to inform Dr. Reece, prior to administering Golytely on August 31, that Resident 5 had refused the enemas and Miralax (a laxative) Dr. Reece ordered on August 28. ALJ Decision at 23.

The factual context of this finding is as follows. On August 28, Dr. Reece examined Resident 5 at Britthaven and found him to be "medically stable." ALJ Decision at 13, citing P. Ex. 11, at 12. Dr. Reece issued the following order:

> 1) Milk & Molasses enema x2 at 8 p.m.;
> 2) If no results give Miralax 7 gm p.o. daily p.r.n. constipation;
> 3) If no results in 2 days give GoLytely prep.

P. Ex. 11, at 30; ALJ Decision at 13,.

Resident 5 refused to take the enemas or Miralax. ALJ Decision at 23. Britthaven did not inform Dr. Reece of this fact and began administering the Golytely at 2400 hours on August 31.

The ALJ's finding that Britthaven's administration of GoLytely without informing Dr. Reece it had skipped the first two steps of the order constituted neglect is supported by substantial evidence in the record as whole. In particular, Dr. Stiens testified that the nurses should have conferred with Dr. Reece prior to simply proceeding to give Resident 5 the GoLytely. Tr. at 368-371.[25]

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[25] Britthaven relies on the fact that Dr. Rubino testified that physician notification was not required "in between steps of the order." RR at 18, citing Tr. at 932. However, the failure at issue did not involve failing to notify the doctor "between" the steps of the order; it involved failing to notify the doctor that the first two steps of his order had been rejected by the resident. In fact, Dr. Stiens stated that, had the nurse had a conversation with Dr. Reece about why Resident 5 was resistant to the first two steps before administering the GoLytely, "I think that honestly that could have lead [sic] to a change in the course of the case." Tr. at 371.

Britthaven argues the ALJ's finding should be reversed because the text of the order did not require notification and "clearly evidences an expectation that the nurses would exercise some discretion and clinical judgment in carrying out the order." RR at 17. In support of the latter assertion, Britthaven points to the conditional language, e.g., "if no results." Britthaven reasons that use of such language indicates that the doctor "has some expectation that the nurses would assess and determine whether sufficient results, if any, been achieved." Id.

We reject this argument. Dr. Reese's three step order did not indicate that the sequence of the steps was discretionary. If the facility or the resident was going to depart from the order, Britthaven should have notified the doctor. Further, Britthaven's reading of the order is not reasonable. The fact that the nurses were given discretion to not proceed with subsequent steps if they determined the "results" of the preceding steps were sufficient does not mean they had the discretion to unilaterally dispense with the preceding steps.

We therefore uphold the ALJ's conclusion that Britthaven was not in substantial compliance with section 483.13(c) during the time period August 10 through August 31 because it failed to provide goods and services necessary to avoid physical harm to Resident 5.

2. Britthaven failed to show that CMS's determination that the deficiency posed immediate jeopardy to Resident 5 from August 10 through August 31, 2002 was clearly erroneous.

The ALJ upheld CMS's determination that Britthaven's noncompliance with section 483.13(c) presented immediate jeopardy from August 10 through September 2, 2002.[26] Britthaven appeals this determination for the period August 10 through August 31, 2002.

Immediate jeopardy is present when there is "a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury,

[26] The ALJ stated that he "could [have found] the immediate jeopardy began when Petitioner failed to care plan for Resident 5's bowel problems" but that he "accepted" CMS's determination that the immediate jeopardy began when Britthaven failed to ascertain his condition after the x-ray results of August 10. ALJ Decision at 24.

harm, impairment, or death to a resident." 42 C.F.R. § 488.301. The regulations at 42 C.F.R. § 498.60(c)(2) provide that a determination by CMS concerning the level of noncompliance must be upheld unless it is "clearly erroneous." In Liberty Commons Nursing and Rehab Center – Johnston, DAB No. 2031 (2006), we held that this standard of review requires the ALJ and the Board to uphold CMS's determination of immediate jeopardy unless the nursing facility demonstrates that the determination is clearly erroneous. DAB No. 2031, at 18-19. The "clearly erroneous" standard, as discussed in the preamble to the regulations, puts a heavy burden on providers to overturn CMS's determination regarding the level of noncompliance and requires that "'survey team members and their supervisors' who make judgments about the level of noncompliance be accorded 'some degree of flexibility, and deference, in applying their expertise . . . .'" Barbourville Nursing Home, DAB No. 1962, at 11 (2005), citing 59 Fed. Reg. 56,116, 56-178-56,179 ((Nov. 10, 1994); aff'd Barbourville Nursing Home v. U.S. Dept. of Health and Human Servs., No. 05-3241 (6th Cir. April 6, 2006); see also Daughters of Miriam Center, DAB No. 2067 (2007).[27]

We uphold the ALJ's determination because we conclude that Britthaven failed to prove that CMS's determination of immediate jeopardy was clearly erroneous. Dr. Stiens, the only expert witness providing testimony in this case on the care of neurogenic bowel in spinal cord injury, testified that an effective bowel care program was necessary to prevent a range of conditions that could result in serious harm, including death. Tr. at 295-302, 349-350. By August 10, Dr. Delaney's examination of Resident 5 and the x-ray report indicated that he was developing a colon impaction and a small bowel obstruction, two of the types of serious harm identified by Dr. Steins. Tr. at 333-335.

Britthaven argues that the ALJ's determination was error "because CMS has failed to prove" that this noncompliance created or resulted in a "likelihood of serious injury or harm" during the period from August 10 through August 31, 2002. RR at 26. However, as discussed above, CMS does not have to prove immediate jeopardy. The burden is on the facility to prove the immediate jeopardy determination was clearly erroneous.

[27] Britthaven based its immediate jeopardy argument on the ALJ's decision in Daughters of Miriam, DAB CR1357. RR at 26. That decision was reversed by the Board.

Britthaven also argues that the fact that Dr. Reece examined Resident 5 on August 28 and found him "medically stable," is inconsistent with the conclusion that he was in "immediate jeopardy." RR at 29. Britthaven asserts that there is no evidence that Dr. Reece brought to the nursing staff's attention concerns or criticism of the care being rendered, nor is there evidence that Resident 5's clinical condition changed between Dr. Reece's August 28 assessment and the moment that Resident 5 received the GoLytely. Id. at 28-29. Britthaven also relies on Dr. Rubino's endorsement of Dr. Reece's care as of August 28. Id. at 29, citing Tr. at 928.

This evidence is not persuasive because it is contrary to the testimony of Dr. Stiens, the only expert witness on the care of neurogenic bowel in spinal cord injury. Dr. Stiens testified that, based on Resident 5's condition as of August 28 as documented in the hearing record, Dr. Reece's three step order was both an "old remedy" and not safe for Resident 5, indicating that Dr. Reece did not appreciate the danger of Resident 5's condition. Tr. at 337-341, 360, 372-377. Further, Dr. Reece's assessment of Resident 5 on August 28 is not persuasive because there is no evidence indicating that Dr. Reece obtained vital signs or assessed Resident 5's abdomen for tenderness, distension or bowel sounds, nor is there evidence that Dr. Reece was aware of the x-ray results, which were not in the Britthaven records as of August 28. Similarly, by endorsing Dr. Reece's care of Resident 5 both before and after August 28, Dr. Rubino demonstrated that he was unaware of the danger the care provided to Resident 5 posed to him. Thus, the ALJ reasonably relied on Dr. Stiens' opinion over those of Drs. Reece and Rubino. See ALJ Decision at 7.

Britthaven argues that the ALJ "offers absolutely no analysis or discussion of any kind," other than speculation, "explaining the causative link" between the noncompliance and the likelihood of serious harm to Resident 5. RR at 27. While the ALJ did not provide explicit analysis of the elements of immediate jeopardy in the section of the decision addressing the immediate jeopardy CMP, it is apparent from the totality of the decision that he concluded that Britthaven's neglect caused either serious harm or a likelihood of serious harm to Resident 5 at least beginning August 10.[28] The ALJ finding was based on Britthaven's failure

[28] Even if the Board had concluded that the ALJ's discussion of immediate jeopardy was not adequate to determine whether to affirm on this issue, which we have not, we would not (continued...)

to develop an effective plan of care and Resident 5's clinical condition as documented by Dr. Delaney and the x-ray by August 10. The lack of an effective care plan resulted in Britthaven's failure to ensure that "repetitive daily care [was] delivered in such a way that there's no accruing or increase or magnifying effect of the daily care not being rendered appropriately." Tr. at 289; ALJ Decision at 22. Such planning and care were required to prevent serious physical harm including impaction and obstruction, which pose increased life-threatening risks to quadriplegics because of their reduced peristaltic function, lack of sensation, and risk of experiencing autonomic dysreflexia. Tr. at 289-290; 296-302; 338, 625; see also Tr. at 208-210; 337-338, 347-349; ALJ Decision at 22. As of August 10, Resident 5 was suffering "a serious medical problem," i.e., impaction and obstruction, consequences of an ineffective bowel program. Tr. at 335; 300. Britthaven's care of Resident 5 from August 10 until Resident 5's death shows it did not understand the danger his condition posed, both because its staff was unaware of the care needs of paraplegics with neurogenic bowels and because its staff did not have full information on Resident 5's condition as of August 10.[29] As Dr. Stiens testified, based on Resident 5's condition as documented in the x-ray, the nursing staff should have been conducting abdominal examinations and monitoring Resident 5's temperature, pulse, and blood pressure to ensure he did not suffer life threatening conditions like autonomic dysreflexia or other pathological processes (Tr. at 338, 348-351) and should have initiated more frequent and comprehensive bowel care to try to clear the stool from Resident 5's colon (Tr. at 346-347). Because Britthaven was uninformed about care of neurogenic bowel and did not consult with the doctor or obtain the x-ray report results, the ALJ correctly concluded that Britthaven "simply did not have the information" it needed "to assure that Resident 5 was provided the nursing care Resident 5 needed" to avoid serious harm. ALJ Decision at 23; see also id.

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[28](...continued)
have to remand the case. Rather, we have the authority to modify this part of the decision based on the record before us. 42 C.F.R. § 498.88(f). Based on the record in this case, we conclude that Britthaven has not shown that CMS's determination of immediate jeopardy was clearly erroneous.

[29] Britthaven's lack of appreciation of the danger posed to paraplegics by intestinal impaction and obstruction is vividly demonstrated by how it cared for Resident 5 after it administered the GoLytely. Britthaven no longer contests CMS's finding that this care posed immediate jeopardy.

12, CMS Ex. 4, at 4; Tr. at 295-302; CMS Ex. 6, at 1. Moreover, Britthaven points to no credible evidence in the record to support its position that CMS's determination of immediate jeopardy was clearly erroneous.

Conclusion

For the reasons discussed above, we uphold the ALJ Decision.

/s/
Judith A. Ballard

/s/
Sheila A. Hegy

/s/
Donald F. Garrett
Presiding Board Member