Department of Health and Human Services
DEPARTMENTAL APPEALS BOARD
Appellate Division

The Peaks Care Center
Docket No. A-15-52
Decision No. 2564
September 3, 2015

FINAL DECISION ON REVIEW OF ADMINISTRATIVE LAW JUDGE DECISION

The Centers for Medicare & Medicaid Services (CMS) requests review of the January 6, 2015 decision by an Administrative Law Judge (ALJ) finding no basis for CMS's imposition of a $6,500 per-instance civil money penalty (CMP) on The Peaks Care Center (Peaks, Petitioner), a skilled nursing facility (SNF) located in Longmont, California. *The Peaks Care Center*, DAB CR3551 (2015) (ALJ Decision). Based on a June 2012 survey, CMS found that Peaks failed to comply substantially with the Medicare participation requirement at 42 C.F.R. § 483.75(m)(1). That regulation states that a "facility must have detailed written plans and procedures to meet all potential emergencies and disasters, such as fire, severe weather, and missing residents." The ALJ concluded following an evidentiary hearing that CMS did not make a prima facie case of noncompliance based on a violation of section 483.75(m)(1). The ALJ further concluded that even assuming CMS had made a prima facie case, Peaks' evidence was sufficient to rebut it and there is no basis for imposition of the per-instance CMP. In its request for review of the ALJ Decision, CMS contends that it did make a prima facie case and that Peaks did not prove by a preponderance of evidence that it was in substantial compliance with section 483.75(m)(1). Request for Review dated 3/13/15. Peaks did not respond to the request for review.

For reasons explained below, we reverse the ALJ Decision and uphold the $6,500 per-instance CMP.

Legal Background

To participate in the Medicare program, a long-term care facility, including a SNF, must be in "substantial compliance" with the requirements in 42 C.F.R. Part 483. 42 C.F.R. §§ 483.1, 488.400. Under agreements with the Secretary of Health and Human Services, state survey agencies conduct onsite surveys of facilities to verify compliance with the Medicare participation requirements. *Id.* §§ 488.10(a), 488.11; *see also* Social Security Act (Act) §§ 1819(g)(1)(A), 1864(a).

A state survey agency reports any "deficiencies" it finds in a Statement of Deficiencies (SOD), which identifies each deficiency under its regulatory requirement and the corresponding "tag" number. A "deficiency" is any failure to comply with a Medicare participation requirement, and "substantial compliance" means "a level of compliance with the requirements of participation such that any identified deficiencies pose no greater risk to resident health or safety than the potential for causing minimal harm." 42 C.F.R. § 488.301 (also defining "noncompliance" as "any deficiency that causes a facility to not be in substantial compliance").

CMS may impose one or more remedies on noncompliant facilities, including per-day and/or per-instance CMPs. 42 C.F.R. §§ 488.402(b)-(c), 488.406, 488.408(d)(1)(iii)-(iv), (e)(1)(iii)-(iv), 488.430(a). When CMS imposes a per-instance CMP, it chooses an amount within the $1,000-$10,000 range designated for per-instance CMPs. *Id.* §§ 488.408(d)(1)(iv), (e)(1)(iv). This range applies to a per-instance CMP regardless of the level of noncompliance found by CMS. *Id.*; *compare* 42 C.F.R. §§ 488.408(d)(1)(iii) and 488.408(e)(1)(iii) (for per-day CMPs, providing an upper range for noncompliance that CMS determines constitutes immediate jeopardy and a lower range for lower levels of noncompliance).

Case Background

CMS notified Peaks by letter dated July 17, 2012 that it was imposing enforcement remedies for noncompliance with Medicare participation requirements, including sections 483.25(h) and 483.75(m)(1), found on the June 2012 survey of Peaks. The remedies included a $10,000 per-instance CMP for the noncompliance with section 483.25(h). Following informal dispute resolution (IDR), CMS revised its June 17, 2012 determination and imposed a $6,500 per-instance CMP for noncompliance with section 483.75(m)(1).[1] ALJ Decision at 2.

The SOD issued by the State survey agency, as revised after IDR, found that the requirement at 483.75(m)(1) "is not met" on the ground that "the facility failed to have detailed written plans and procedures to meet all resident emergencies, including those involving seven of 31 sample residents . . . ." CMS Ex. 8, at 94. In particular, the SOD found that: "the facility failed to have a sufficient plan explaining if and where emergency power could be located in the building and how resident care equipment would be powered in the event of a power outage"; the plan the facility had in place "did not include where to locate details about residents with special needs or who depend on

[1] CMS further advised Peaks that it was ineligible to conduct a nurse aide training and competency evaluation program (NATCEP) for two years. A state may not approve and must withdraw any prior approval of a NATCEP offered by a SNF that has been assessed a CMP of not less than $5,000. *See* 42 C.F.R. § 483.151(b)(2) and (f). The notice does not specifically state that the previously imposed $10,000 per-instance CMP was rescinded, but the ALJ concluded "based on the context" that it was rescinded. ALJ Decision at 3. We have no reason to conclude otherwise.

electrically powered care equipment" or "detail what was powered by the back-up generator"; one resident in the facility, R102, "required chronic suctioning due to severe dysphagia"[2]; the "facility's failure to ensure an emergency power source was available to enable the suction device for [R102] created a situation of immediate jeopardy for serious harm"; and six other residents of the 31 residents sampled were "at risk" due to the facility's noncompliance because they, like R102, had been identified by the facility's clinical coordinator as "being at risk for choking." *Id*. at 94-95, 99, 106-108.

There were two power outages at the facility in the year preceding the survey, both due to snowstorms: one on October 12, 2011 that lasted six hours and one on December 13, 2011 that lasted two hours. CMS Ex. 8, at 100. During the power outage on October 12, a "back-up generator did come on, but after four hours it became evident that the generator was not heavy enough to keep the facility at a proper temperature[.]" *Id*. (quoting e-mail from Peaks' Administrator). Peaks' "Electrical Outage" plan, revised shortly after the December power outage, states in relevant part that: there is an "Alternate Power supply" that will activate emergency lighting in the hallways in the event of an electrical outage; "If outage will be above and beyond the alternate power source, backup generator will be used"; "Nursing staff will be directed to move patients that have O2 to the O2 portable tanks from the concentrators"; and if the temperature in resident rooms "drops below 60^{o}f then residents should be evacuated to any areas in the building that are still maintaining heat[.]" *Id*. at 98-99; *see also* P. Ex. 13 (titled "Electrical Outage").[3]

Nurses' notes documented suctioning R102 on three dates: on March 23, 2012, R102 was suctioned six times for "[i]ncreased secretions" and a "[f]requent cough" that was "non-productive"; on March 24, 2012, R102 was suctioned five times for four hours "due to increased secretion," and approximately "150 mL of secretion is on collector," i.e., the collection container for the suction machine; and on March 27, 2012, when R102 was suctioned when staff heard him coughing while his wife was giving him thin liquids. CMS Ex. 8, at 103. On June 6, 2012, surveyors saw on the bedside table in R102's room a suction machine that was plugged into a standard wall outlet. Surveyors saw three other suction machines elsewhere in the facility (other than in resident rooms). *Id*. at 104.

[2] Dysphagia is characterized in part by difficulty swallowing. *See* CMS Ex. 15, at 3 (speech therapy evaluation identifying characteristics of R102's "profound dysphasia[.]")

[3] The SOD states that this plan was "updated on 12/27/12" (CMS Exhibit 8, at 98) but appears to have misstated the year since the ALJ found, and CMS does not dispute, that the plan was "revised on or about December 27, 2011." ALJ Decision at 27, citing P. Ex. 13. The "Electrical Outage" plan was part of Peaks' "Emergency Disaster Plan." Tr. at 418 (testimony of Peaks' Administrator).

As we discuss in detail in the first section of our analysis, Peaks' environmental director took the surveyors on "an environmental tour of the facility" on June 13, 2012 at about 4:00 p.m. during which the surveyors asked if there was an emergency power system in place and how resident care equipment would be powered in the event of a power outage. CMS Ex. 8, at 104. As also discussed in that section, the surveyors interviewed several other facility personnel, including Peaks' Administrator, about these matters on June 13, 2012 after the environmental tour and on June 14, 2012. *Id*. at 105-106, 108-110.

Peaks' plan of correction to remove immediate jeopardy was presented shortly before the end of the June 14, 2012 interview with Peaks' Administrator and included the following:

> On 6/13/2012 at around 10:30 p.m., a generator to serve as an emergency power source was made available in the main courtyard, an extension cord leading into the facility made emergency power readily available in case suction machines are needed during a power outage. Staff were educated on how the emergency generator works and how it would be monitored. The generator is located in courtyard off the North hall. To use the generator, apply the choke, turn unit on, pull cord, then switch unit to "run." Use the orange extension cord to run power into the facility….All nurse staff will be in-serviced no later than 6/16/2012.

Id. at 96-97.

Peaks requested a hearing before an ALJ pursuant to 42 C.F.R. Part 498, and an evidentiary hearing was convened. ALJ Decision at 3. After CMS presented its case, Peaks moved for judgment in its favor on the ground that CMS failed to make a prima facie case of noncompliance based on a violation of section 483.75(m)(1). Tr. at 311-314; Motion for Judgment on Partial Findings dated 8/14/13. The ALJ did not rule on the motion, and Peaks then proceeded to present its case. Tr. at 316, 324. After receipt of post-hearing briefs, the ALJ issued the decision appealed here.

The ALJ Decision sets out four numbered findings of fact and conclusions of law (FFCLs):

1. CMS did not make a prima facie showing of noncompliance under Tag F517 based on a violation of 42 C.F.R. § 483.75 (m)(1) that posed a risk for more than minimal harm to any resident.
2. Petitioner did not violate 42 C.F.R. § 483.75(m)(1) (Tag F517).
3. There is no basis for the imposition of an enforcement remedy.
4. Additional issues raised by Petitioner in its hearing request are beyond my jurisdiction to hear and decide.

ALJ Decision at 8, 22, 30. Under the first FFCL, the ALJ explained his determination that Peaks' Motion for Judgment on Partial Findings "has merit." *Id*. at 8. Under the second and third FFCLs, the ALJ stated, "If I concluded that CMS made a prima facie showing of noncompliance under Tag F517 based on a violation of 42 C.F.R. § 483.75(m)(1)[,] I would conclude after consideration of Petitioner's evidence that there was no regulatory violation" and proceeded to explain why he would conclude that there was no regulatory violation. *Id*. at 22. Under the heading "Conclusion," the ALJ stated, "For the foregoing reasons, I conclude that Petitioner did not violate 42 C.F.R. § 483.75(m)(1), and there is no basis for the imposition of a $6,500 [per-instance CMP]." *Id*. at 30.

Standard of Review

The Board's standard of review on a disputed conclusion of law is whether the decision is erroneous. The Board's standard of review on a disputed finding of fact is whether the ALJ's finding is supported by substantial evidence in the record. Guidelines -- Appellate Review of Decisions of Administrative Law Judges Affecting a Provider's Participation in the Medicare and Medicaid Programs (Guidelines) (at http://www.hhs.gov/dab/divisions/appellate/guidelines/ prov.html); *South Valley Health Care Ctr.*, DAB No. 1691, at 2 (1999), *aff'd, South Valley Health Care Ctr. v. HCFA*, 223 F.3d 1221 (10th Cir. 2000).

Substantial evidence is "more than a mere scintilla. It means such relevant evidence as a reasonable mind might accept as adequate to support a conclusion." *Richardson v. Perales*, 402 U.S. 389, 401 (1971), quoting *Consolidated Edison Co. v. NLRB*, 305 U.S. 197, 229 (1938). Under the substantial evidence standard, the reviewer must examine the record as a whole and take into account whatever in the record fairly detracts from the weight of the decision below. *Universal Camera Corp. v. NLRB*, 340 U.S. 474, 488 (1951). The reviewer does not, however, reweigh the evidence nor substitute his or her judgment for that of the initial decision-maker. *Casias v. Secretary of Health & Human Servs.*, 933 F.2d 799, 800 (10th Cir. 1991). Thus, the reviewer must not displace a "choice between two fairly conflicting views," even though a different choice could justifiably have been made if the matter had been before the reviewer de novo. *Universal Camera*, 340 U.S. at 488. The reviewer must, however, set aside the initial conclusions when he or she "cannot conscientiously find that the evidence supporting that decision is substantial, when viewed in the light that the record in its entirety furnishes, including the body of evidence opposed to the [initial decision-maker's] view." *Id*.

Analysis

The ALJ Decision rests primarily on the ALJ's conclusion that CMS failed to make a prima facie showing of noncompliance with section 483.75(m)(1); the ALJ addressed whether Peaks had shown that it substantially complied with section 483.75(m)(1) only

as an alternative analysis, assuming for that purpose that CMS had made a prima facie showing. To make a prima facie case, CMS must "com[e] forward with evidence related to disputed findings that is sufficient (together with any undisputed findings and relevant legal authority)" to support a decision in its favor absent an effective rebuttal. *Evergreene Nursing Care Ctr.*, DAB No. 2069, at 7 (2007). However, the Board has held that once both parties have presented their evidence, the "ultimate question" before the ALJ is "whether a preponderance of the evidence on the record as a whole when both sides have completed their presentations shows the provider to be in substantial compliance," so that an ALJ need not determine under such circumstances whether CMS failed to make a prima facie showing. *Hanover Hill Health Care Ctr.*, DAB No. 2507, at 7 (2013). We therefore discuss below only the ALJ's alternative analysis, although it is clear that CMS did make a prima facie case of noncompliance with section 483.75(m)(1) even if one looks solely at the undisputed facts on the SOD.[4]

In his alternative analysis, the ALJ concluded, based on "the entire record as a whole," that Peaks "has shown by the preponderance of the evidence that its 'Electrical Outage' plan is sufficient and does not violate the regulation" at section 483.75(m)(1). ALJ Decision at 28. Under the applicable regulations, noncompliance exists if a facility's violation of a participation requirement poses a risk to resident health or safety that is greater than the potential for causing minimal harm. *See* 42 C.F.R. § 488.301. The ALJ concluded that there was no risk of harm to R102 or other residents cited in the SOD from a violation of section 483.25(m)(1). *Id*. at 29. As explained below, we conclude that the record lacks substantial evidence to support either of these conclusions and that the record in its entirety supports contrary conclusions.

1. The ALJ erred in concluding that Peaks did not violate section 483.75(m)(1).

Section 483.75(m)(1) requires a facility to have a detailed plan to address emergency situations. The issue presented here is whether Peaks had a sufficiently detailed plan to address a power outage, which it had identified as an emergency situation. As noted above, Peaks had an "Electrical Outage" plan that stated that a "back up generator will be used" to provide power not provided by the "alternate power source," which the plan indicated would activate emergency lighting. CMS alleged, and we agree, that this plan did not contain sufficient detail about the "back up generator" (or other emergency procedures involving electrical systems) so that when there was a power outage, facility staff would know how to power electric equipment, such as a suction machine, used to provide care to residents.

[4] The Board has held that the SOD may constitute prima facie evidence of the undisputed facts asserted in it. *See, e.g., Universal Health Care – King*, DAB No. 2383 (2011)

The ALJ acknowledged that "[t]he type of backup generator, its location, and operation are not specified in" Peaks' "Electrical Outage" plan. ALJ Decision at 29. The ALJ nevertheless found that the plan was sufficiently detailed because "[t]here is no basis to assume that [the plan] referred to any other backup generators than those Petitioner had during the outages in the fall [of] 2011 and at the time of the survey." *Id*. The ALJ noted that during the power outage in December 2011, Peaks had a generator that provided heat (albeit not enough), and that "[d]uring the survey, Petitioner's staff showed the surveyors the small portable, pull-start generator maintained in the interior courtyard" that could be used with "as many as three extension cords…to power electric devices in the facility if necessary." *Id*. Thus, in the ALJ's view, the reference to a "back up generator" in the "Electrical Outage" plan meant these two generators and it was clear that the portable generator in the courtyard could be used to power electric equipment such as suction machines.

The ALJ's view is not supported by the "Electrical Outage" plan. On its face, that plan refers to only a single generator, not two generators as the ALJ found. Moreover, as the ALJ acknowledged, the plan does not describe the "back up generator" to which it refers, where it is located or what it powered, much less specifically describe a portable generator such as the one found in the courtyard. Indeed, Peaks' staff could well read "back up generator" to be a reference to the generator used to provide heat in an emergency given Peaks' Administrator's statement in the e-mail after the October 12 power outage that the "back-up generator" "did come on but . . . was not heavy enough to keep the facility at a proper temperature." CMS Ex. 8, at 100. Staff could also read the plan provision referencing a "back up generator" as instructing them to use the generator that provided heat to also provide emergency lighting if the "alternate power source," i.e., the "Alternate Power supply," was not adequate to do so. Thus, at least absent evidence that all staff who worked in the facility understood how electric resident care equipment would be powered during a power outage, it follows that the plan was not sufficiently detailed to enable Peaks to provide care and services that required the operation of this equipment in such an emergency.

The ALJ Decision suggests that facility staff understood that "back up generator" included the portable generator in the courtyard (notwithstanding the absence of any such description) because some staff showed that generator to the surveyors and demonstrated that it could be used to power electric equipment in the building. However, no staff member showed the portable generator to the surveyors until the evening of June 13, after the surveyors notified Peaks that they had found noncompliance with section 483.75(m)(1) that posed immediate jeopardy. *See* CMS Ex. 8, at 96-97; Tr. at 91-92 (testimony of Surveyor B.). Peaks' plan of correction stated that staff who were present that evening "were educated on how the emergency generator works and how it would be monitored" and that "[a]ll nurse staff will be in-serviced no later than 6/16/2012." CMS Ex. 8, at 96-97. If facility staff had understood from the plan that Peaks had a portable generator that could be used to power electric equipment such as suction machines, they

presumably would have communicated that to the surveyors at an earlier point in the survey, before the facility recognized that this "education" was necessary.

Although the ALJ found that staff did previously communicate an understanding that the portable generator could have been used to power electric equipment such as suction machines, the evidence on which the ALJ relied does not support his finding. That evidence includes Surveyor B.'s notes regarding what the environmental director told her during the environmental tour. The ALJ read the notes as stating that the environmental director said that in the event of a power outage, "suction equipment could be powered by a mini generator." ALJ Decision at 21, citing CMS Ex. 29, at 3. The notes show that the environmental director mentioned a "mini generator"; however, the notes do not show that he understood that the portable generator in the courtyard could be used to power a suction machine. The notes state:

> The environmental director (ED) was asked if there was an emergency power system in place in the event of a power outage. The ED stated the exit lights were illuminated as they ran off of batteries. The ED stated residents on oxygen concentrators were moved to portable tanks. When asked how other resident care equipment, such as, air mattresses or suction devices were powered in the event of a power outage, the ED said the building had a "mini generator." <u>When asked what the mini generator powered, the ED stated the generator powered some rooms in the assisted living section of the building and some of the front offices</u>. The ED was unable to identify what outlets specifically received power from the emergency generator.

CMS Ex. 29, at 3 (emphasis added).[5] Although the environmental director responded that the facility had a "mini generator" when the surveyor asked how certain resident care equipment would be powered in the event of a power outage, he then proceeded to explain that the mini generator provided power to part of the assisted living unit and Peaks' front office. Since resident care equipment would not be used in those parts of the facility, the ALJ's reading of the environmental director's statement as referring to the portable generator that Peaks demonstrated could power equipment in the skilled nursing part of the facility is not reasonable. Indeed, the environmental director's statement that the mini generator would power whole areas of the facility strongly suggests that he was referring to a generator that provided power to electrical outlets, and not to the portable generator, which provided power through extension cords that had to be plugged directly into the electric equipment. The ALJ opines that what he acknowledges was evidence of staff confusion about the "Electrical Outage Plan," ALJ Decision 21 (citing surveyor testimony and notes), is attributable to confusing questions by the surveyors, *id*. In particular, he states that "[t]he ED's responses became confused when he was asked what

[5] The SOD describes the notes using almost identical language. CMS Ex. 8, at 104. Surveyor B.'s testimony (Tr. at 84-85) is consistent with her notes. The renvironmental director did not testify at the hearing.

the mini generator powered and which outlets." *Id*. However, the ALJ points to no evidence that staff were confused by the surveyors' questions. Moreover, if the environmental director was referring to the portable generator and knew how it worked, we see no reason why he would not have provided the correct information to the surveyor even if she asked about outlets.

The SOD also describes surveyor interviews with facility staff other than the environmental director who demonstrated they did not know how to power electric resident care equipment during a power outage. The SOD relates that a licensed practical nurse (LPN) and a certified nurse aide, both of whom were working on R102's unit on June 14, 2012, stated that in the event of a power outage, they would place residents on oxygen on portable tanks and that there were no emergency power outlets on that unit. CMS Ex. 8, at 109. Nothing in these statements indicates that these individuals understood that the portable generator would be used to power suction machines during a power outage. Since they did not even mention the portable generator, it is hardly reasonable to infer that they had such an understanding. Moreover, contrary to what the ALJ suggested, it is not plausible that they failed to mention it because they thought the surveyors were asking only about emergency power outlets since they did explain that they would use portable tanks to provide oxygen to residents during a power outage.

The SOD also recounts that the LPN working on R102's unit on June 13, 2012, "[w]hen asked what she would do in the event resident #102 or the other residents at risk for choking required suctioning during a power outage, said she would take the resident across the building to the [assisted living unit] because she was sure there were emergency outlets over there." CMS Ex. 8, at 105. Her response clearly shows that she did not know that staff were to use the portable generator during a power outage to power suction machines or other electric resident care equipment.

The SOD also describes an interview on June 13, 2014 at which Peaks' Administrator told the surveyor that the facility had no plan in place to power suction machines during a power outage. CMS Ex. 8, at 105-106.

Accordingly, the evidence cited in the ALJ's findings supports rather than rebuts CMS's finding that facility staff interviewed by the surveyors lacked any knowledge of how to power suction machines or other electric resident care equipment during a power outage.[6] We therefore conclude that Peaks' "Electrical Outage" plan did not include sufficient

[6] Even if facility staff understood that Peaks' "Electrical Outage" plan referred to the portable generator (which we find they did not), we agree with CMS that the plan was inadequate because it contained no detail about what resident care equipment would be powered by the back up generator or how to identify residents dependent on electric resident care equipment. The SOD notes that an e-mail Peaks' Administrator sent to facility staff about the power outage in October 2011 quoted a staff member's statement that "In the future I feel I need to get a roster with patients/resident special needs sooner[.]" CMS Ex. 8, at 101. Yet there is no information in the plan about how staff were to identify such resident care equipment or residents who might need it during a power outage.

detail about the referenced generator (or other electrical systems) to enable facility staff to know how to power electric equipment, such as a suction machine, used to provide care and services to residents in a power outage emergency, in violation of section 483.75(m)(1).

2. The ALJ erred in concluding that any violation of section 483.75(m)(1) posed no risk of harm to R102 or other residents.

The ALJ found that CMS's finding that Peaks' violation of section 483.75(m)(1) posed a risk to resident health or safety greater than the potential for causing minimal harm was based on the "unfounded" assumption that "[s]uction may only be done with an electric suction pump." ALJ Decision at 28. The ALJ relied on the testimony of the "licensed medical professionals" presented by Peaks that the type of suctioning R102 received, i.e., "removal of excess secretions from the mouth[] and from the back of the throat[]," can be done by "other alternative means … such as manual suction bulbs, gauze, washcloths or towels, toothettes, or a finger." *Id*. The ALJ found that the evidence shows that these alternative means "were readily available for use in the event of an emergency at Petitioner's facility, including during an electrical outage" and that use of these alternative means is "standard nursing practice[.]" *Id*. The ALJ then stated:

> The credible medical opinions expressed by Petitioner's witnesses were that there was no risk for any harm to Resident 102 if he had excess secretions and no electric suction pump was available. The witness opinions were that if no electric suction was available Resident 102's excess secretions would be handled with the readily available alternatives. I conclude that those opinions apply equally to all the other residents cited in the SOD, based on the medical evidence offered as to each of those residents.

Id. at 29.[7]

That witnesses for Peaks testified about manual means sometimes used to deal with excess secretions is undisputed. However, Peaks' witnesses' opinions that, since these other means were available, there was no risk of harm to R102 if Peaks was unable to power a suction machine during a power outage appear to be based on the assumption that R102's need for suctioning to remove excess secretions could always be met by these other means. We see nothing in the record to support that assumption. There is no evidence in the record that Peaks used any means of suctioning R102 other than a suction machine, which Peaks placed in R102's room in December 2011 and kept there until the

[7] The ALJ cited to opinion testimony of a registered nurse who was the current Director of Clinical Operations for Peaks' operator, Frontline Management (and Peaks' former Administrator); LPN B., who worked the night shift on R102's unit; and LPN R. who worked the day shift on R102's unit. ALJ Decision at 26-27.

end of the survey. Tr. at 576-577.[8] Since this was the manner in which Peaks chose to provide this care to R102, it is reasonable to infer that Peaks determined that a suction machine was required to remove R102's excess secretions in a manner that would help him attain or maintain his highest, practicable well-being. *See* 42 C.F.R. § 483.25 (stating the quality of care standard facilities must meet for each resident). Or putting it another way, it is not reasonable to infer, without evidence of any facility evaluation or use on R102 of any of the manual methods described by the witnesses, that Peaks had determined any of these other methods would meet the care needs of this resident to the level required by the regulations.

The witness testimony cited by the ALJ is general and ambiguous. *See* ALJ Decision at 27 (citing LPN R.'s testimony at Tr. at 596 that a suction machine "is easier and can be faster at removing secretions from the oral cavity…[w]hereas some of the other methods may be a little bit more time consuming….I think it becomes a preference and not so much a necessity."). The testimony does not address the specific issue of whether the use of a suction machine could have been a matter of necessity for R102, or at least have served to better maintain his well-being, such that the inability to power a suction machine during a power outage would have posed a risk of more than minimal harm to him. Nor does the testimony specifically address this issue with respect to any of the other residents identified in facility records as "at risk of choking" who might have needed suctioning to remove excess secretions. Moreover, Peaks' decision to use a suction machine to remove R102's excess secretions was consistent with its written policy on oral suctioning, which gives instructions for using a suction machine, not the manual methods described by the witnesses. *See* CMS Ex. 25 ("Suctioning the Upper Airway (Oral Pharyngeal Suctioning)").

Accordingly, we conclude that the opinions cited by the ALJ for his conclusion that not having an operational suction machine available during a power outage would pose no risk of more than minimal harm to R102 or the other facility residents identified in the SOD do not constitute substantial evidence in support of that conclusion.[9]

[8] LPN R. testified that the suction machine was "placed in the Resident's room for easy access in the event that it was needed" at the time R102 received an order for suctioning PRN in December 2011. The ALJ found that "[t]here is no evidence that a new physician order for suctioning was issued after Resident 102's readmission to Petitioner in February 2012." ALJ Decision at 24. Even if true, it is immaterial since Dr. M. testified that Peaks did not need an order to provide oral suctioning. *Id*., citing Tr. at 342 (stating in part that although Peaks asked him for suction orders before, the "type of suctioning at Peaks…[is] part of nursing protocol.")

[9] We note that, in addition to the risk of harm we discuss as to the specific residents present in the facility at the time of the survey who might need suctioning, the absence of any clear plan for identifying residents who might need care from equipment requiring power during an outage or instructions for what steps staff should take to provide access to power or otherwise address such needs potentially places at risk any residents with such needs who had been or would be admitted to the facility until any revision of the "Electrical Outage" plan.

Indeed, we conclude that the evidence in the record in its entirety supports a conclusion that there was a risk of more than minimal harm to R102 and the other residents. We note first that the ALJ Decision cites testimony by LPN B. that "the suction on March 23 [for R102] was just for comfort" and by LPN R. that, for R102, "[s]uction was a comfort measure" and "was not required chronically." ALJ Decision at 26-27. However, the ALJ does not explain how this testimony can be reconciled with the undisputed facts that R102 was suctioned six times on March 23, 2012 and five times (for four hours) on March 24, 2012, as well as on March 27, 2012; and that nurses notes do not describe the suctioning as being for "comfort" but rather as being for such medical issues as frequent and unproductive coughing and, on one occasion, as resulting in 150 ml of collected secretions. Nor does the ALJ explain how these statements can be reconciled with the fact that Peaks kept a suction machine in his room, by his bedside, an indicator, at least absent any evidence to the contrary (which there was not), that staff deemed R102's care needs such that it was necessary to keep a suction machine close at hand.[10] In any event, these staff statements do not directly address or rule out a risk of harm to R102 if his excess secretions were not removed.

Moreover, the testimony of Dr. M., Peaks' Medical Director as well as R102's treating physician, supports a conclusion that there was a risk of serious harm to R102 and other residents. As noted above, the surveyors found that the lack of a plan detailing how to power electric equipment such as suction machines during a power outage put seven residents, including R102, at risk of more than minimal harm. CMS Ex. 8, at 94. On June 13, 2012, Peaks' clinical coordinator identified these residents, all of whom had a diagnosis of dysphagia or other swallowing problems, as "being at risk for choking." *Id.* at 106-108. The ALJ Decision suggests that the lack of suctioning in the event of a power outage would not put these residents at risk of more than minimal harm because the type of oral suctioning Peaks provided was not the type of suctioning that might be used for someone who was choking. ALJ Decision at 24 (citing testimony of Dr. M. that the type of suctioning ordered for R102 was oral suctioning to remove excess secretions from the "pharyngeal area," i.e., the mouth up to the back of the throat, not "nasotracheal suctioning," which a hospital or ambulance crew, but not a long term care facility, might use for someone who was choking). However, the ALJ did not address all of Dr. M.'s testimony on this subject, and his testimony as a whole supports a different conclusion. Dr. M. indicated that choking is caused by an esophageal or tracheal obstruction and that

[10] There is evidence, including testimony, that R102's physician prescribed medication to help dry up secretions. *See* P. Ex. 22, at 2-5; Tr. at 347-350. However, there is no evidence that staff ever determined (as opposed to suggesting during the hearing) that the medications eliminated all need for suctioning, and the fact that staff kept the machine in R102's room strongly suggests that no such determination occurred.

oral suctioning would not "abate choking from dysphagia."[11] Tr. at 343; *see also* Tr. at 344-345 (if a patient has a blocked airway in the trachea, oral suctioning "wouldn't make a difference"). However, Dr. M. also testified that if there were "enough" secretions of the mouth, "they would be pulled down further and that could block" the airway (Tr. at 342-343) and that suctioning "could be done to prevent an aspiration," which could occur if "pooling in the back of the throat" were to "dribble down into the trachea" (Tr. at 375). Thus, the import of Dr. M.'s testimony as a whole is that although oral suctioning would not help an individual who was already choking, oral suctioning could prevent choking that might be caused by aspiration of excess oral secretions.[12] Not suctioning a resident who had excess oral secretions would therefore pose a risk of serious harm in the form of aspiration and blockage of his airway.

Even if there were no risk of serious harm, the evidence shows that R102 was at risk of more than minimal harm. Dr. M. testified that in patients with dysphagia, oral and nasal secretions can "pool" in the back of the mouth and cause coughing if they "drip down into the trachea," and that this "would be reason to do suctioning." Tr. at 341-342. A speech therapy evaluation of R102 dated February 15, 2012 states that R102 "coughs on his secretions throughout the day . . . as he has very poor saliva management." CMS Ex. 15, at 8. In addition, the nurses' notes for March 23, 2012 reflect that R102 was experiencing "increased secretions" and a "frequent cough" that was "unproductive" before suctioning. CMS Ex. 16, at 6. That excess secretions caused R102 to cough frequently and on two dates required repeated suctioning to remove the excess secretions shows that R102, at the very least, experienced a degree of discomfort from these secretions that could reasonably be considered more than minimal harm even if the secretions did not pose a risk of serious harm through aspiration and blockage of his airway.

Accordingly, we conclude that the evidence in the record in its entirety shows that Peaks' violation of section 483.75(m)(1) posed a risk of harm to resident health or safety that was greater than the potential for more than minimal harm.[13]

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[11] Dr. M. testified that "choking" is "a pretty wide open term" although he said he associated it with "esophageal involvement," which is "a little bit" different from "aspiration," which "would be tracheal involvement." Tr. at 343.

[12] Consistent with this testimony, Peaks' policy on oral suctioning states that the "purpose of this procedure is to clear the upper airway of mucous secretions and prevent the development of respiratory distress." CMS Ex. 25, at 1.

[13] Since CMS's citation of the noncompliance at the immediate jeopardy level is not challenged, we need not address whether the evidence would support any level of noncompliance higher than the potential for more than minimal harm.

Conclusion

Based on the analysis above, we conclude that Peaks failed to comply substantially with the requirements of section 483.75(m)(1) and that there is a basis for the imposition of the $6,500 per-instance CMP. Accordingly, we reverse the ALJ Decision.

/s/
Leslie A. Sussan

/s/
Susan S. Yim

/s/
Sheila Ann Hegy
Presiding Board Member