Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

In the Case of:	)	
	)	
Jennifer Matthew Nursing & Rehab Center, (CCN: 33-5439),	)	Date: December 27, 2007
	)	
Petitioner,	)	
	)	
- v. -	)	Docket No. C-06-671
	)	Decision No. CR1717
Centers for Medicare & Medicaid Services.	)	
	)	

DECISION

Until recently, Jennifer Matthew Nursing & Rehabilitation Center (Petitioner or facility) was a skilled nursing facility located in Rochester, New York, that participated in the Medicare program. The Centers for Medicare & Medicaid Services (CMS) determined that from July 13 through September 15, 2005, it was not in substantial compliance with Medicare conditions of participation, and that, from July 13 through 20, 2005, its conditions posed immediate jeopardy to resident health and safety. Petitioner did not appeal many of CMS's findings, which are therefore final. In a ruling dated February 15, 2007, which I attach and incorporate into this decision, I decided that, from July 13 through 20, the facility was not in substantial compliance with 42 C.F.R. § 483.15(h)(6) – which requires that facilities maintain safe and comfortable temperature levels – because facility residents were exposed to high humidity and to temperatures reaching well into the 90's. I now consider the remaining issues: whether facility staff appropriately cared for residents exposed to excessive heat and humidity; the facility's accountability for the apparent choking death of one of its residents; and whether its deficiencies posed immediate jeopardy to resident health and safety.

I find that from July 13 through 20, 2005, the facility was not in substantial compliance with 42 C.F.R. § 483.13(c) (staff treatment of residents), 42 C.F.R. § 483.25 (quality of care), and 42 C.F.R. § 483.75 (administration). I also find that the facility's deficiencies posed immediate jeopardy to resident health and safety, and find reasonable the $10,000 per day civil money penalty.

I. Background[1]

The Social Security Act (Act) sets forth requirements for nursing facility participation in the Medicare program, and authorizes the Secretary of Health and Human Services to promulgate regulations implementing those statutory provisions. Act, section 1819. The Secretary's regulations are found at 42 C.F.R. Part 483. To participate in the Medicare program, a nursing facility must maintain substantial compliance with program requirements. To be in substantial compliance, a facility's deficiencies may pose no greater risk to resident health and safety than "the potential for causing minimal harm." 42 C.F.R. § 488.301.

The Secretary contracts with state survey agencies to conduct periodic surveys to determine whether skilled nursing facilities are in substantial compliance with program participation requirements. Act, section 1864(a); 42 C.F.R. § 488.20. The regulations require that each facility be surveyed once every twelve months, and more often, if necessary, to ensure that identified deficiencies are corrected. Act, section 1819(g)(2)(A); 42 C.F.R. §§ 488.20(a); 488.308.

In this case, an anonymous caller advised the New York State Department of Health (State Agency) that a facility resident had choked to death while staff failed to provide him appropriate assistance. CMS Ex. 22, at 1; CMS Ex. 52, at 2 (Francis Decl. ¶ 5); Tr. 248. No one from the facility had reported such an incident. On June 17, 21, and 24, 2005, state surveyors went to the facility to investigate. The State Agency subsequently consolidated that investigation with the facility's annual survey, and, from July 11 through 18, 2005, surveyors returned to complete the annual survey. CMS Ex. 52, at 4 (Francis Decl. ¶ 8). During this latter period, temperatures and the air quality in Rochester were at unhealthy levels. The facility was not air-conditioned, and, according to the surveyors, facility staff did not monitor and assess vulnerable residents, nor respond appropriately when certain residents exhibited heat-related symptoms. *See*, discussion, *infra*.

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[1] My February 15, 2007 ruling and order summarizes this case's procedural history up until that point.

Based on the survey findings, CMS determined that, from July 13 through 20, 2005, the facility was not in substantial compliance with the following program requirements (among others which Petitioner has not appealed):

- 42 C.F.R. § 483.13(c) (Tag F224 – failure to implement policies and procedures that prohibit mistreatment, neglect and abuse of residents, at scope and severity level L – widespread immediate jeopardy);

- 42 C.F.R. § 483.75 (Tag F493 – failure to administer the facility in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, at scope and severity level L);

- 42 C.F.R. § 483.15(h)(6) (Tag 257 – Quality of Life - failure to provide comfortable and safe temperature levels, at scope and severity level L); and

- 42 C.F.R. § 483.25 (Tag 309 - Quality of Care, at scope and severity level J – isolated instance of immediate jeopardy).

CMS Ex. 63. CMS also determined that these deficiencies reflected "substandard quality of care" and posed immediate jeopardy to resident health and safety. CMS has imposed a $10,000 per day CMP for eight days of immediate jeopardy.

After partially granting CMS's motion for summary judgment, I held a hearing in Rochester, New York on June 13 and 14, 2007. Joseph L. Bianculli appeared on behalf of Petitioner and Fernando Morales appeared on behalf of CMS. I admitted into evidence CMS Exs. 1-64 and Petitioner (P) Exs. 1-93. Tr. 3.[2]

[2] Petitioner objects to provisions of my initial pre-hearing order directing each party to submit, in writing and under oath, the testimony of its proposed witnesses. In rulings dated October 15, 2007, Judge Kessel carefully considered the issues Petitioner raises. Based on the reasoning set forth in those rulings, I overrule Petitioner's objections. Rulings Denying Motion to Permit Oral Examination of Witnesses, *Sunbridge Care and Rehabilitation For the Triad*, Docket N. C-07-608; *Golden Living Center – North Little Rock*, Docket No. C-07-676 (October 15, 2007) (copy attached).

II. Issues

The facility did not appeal CMS's determination that, from July 13 through September 15, 2005, it was not in substantial compliance with the following:

- 42 C.F.R. § 483.13(c)(1)(ii) (Tag F225 – staff treatment of residents, at scope and severity level D – isolated instance presenting no actual harm, with the potential for more than minimal harm;

- 42 C.F.R. § 483.15(a) (Tag F241 – quality of life, at scope and severity level D);

- 42 C.F.R. § 483.20(k)(3)(i) (Tag F281 – resident assessment, at scope and severity level D);

- 42 C.F.R. § 483.25(a)(3) (Tag F312 – quality of care, at scope and severity level D);

- 42 C.F.R. § 483.25(j) (Tag F327 – quality of care, at scope and severity level G – isolated instance of actual harm that is not immediate jeopardy);

- 42 C.F.R. § 483.35(h)(2) (Tag F371 – dietary services, at scope and severity level F – widespread deficiency, presenting no actual harm with the potential for more than minimal harm);

- 42 C.F.R. § 483.75(b) (Tag 492 – administration, at scope and severity level E – pattern of noncompliance that presents no actual harm, with the potential for more than minimal harm).

Hearing Request (September 20, 2005), *see* n.2; CMS Ex. 63. The facility was therefore not in substantial compliance with these un-appealed program requirements from July 13 through September 15, 2005. I have also concluded that, from July 13 through 20, 2005, the facility was not in substantial compliance with 42 C.F.R. § 483.15(h)(6) (safe and comfortable temperatures). *See* Ruling and Order (February 15, 2007).

The following issues remain:

- Whether, from July 13 through 20, 2005, the facility was in substantial compliance with 42 C.F.R. § 483.13(c) (staff treatment of residents); 42 C.F.R. § 483.25 (quality of care); and 42 C.F.R. § 483.75 (administration);

- If the facility was not in substantial compliance, did its deficiencies pose immediate jeopardy to resident health and safety; and

- If the facility was not in substantial compliance, is the $10,000 per day penalty reasonable?

III. Discussion

A. From July 13 through 20, 2005, the facility was not in substantial compliance with 42 C.F.R. §§ 483.13(c), 483.25, and 483.75.[3]

"Neglect" means failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. 42 C.F.R. § 488.301. A facility must develop and implement written policies and procedures that prohibit resident neglect. 42 C.F.R. § 483.13(c). This regulation governing staff treatment of residents "addresses a deficiency related to lack of an effective policy as opposed to one directed at the occurrence of neglect itself." *Emerald Oaks*, DAB No.1800, at 12 (2001). However, the drafters of the regulation characterized as "inherent in § 483.13(c)" the requirement that "each resident should be free from neglect as well as other forms of mistreatment." 59 Fed. Reg. 56,130 (Nov. 10, 1994). The drafters also deliberately rejected the suggestion that the regulations require evidence of a negative outcome to support the finding of neglect:

> We do not accept this comment because neglect may be determined even if no apparent negative outcome has occurred. The potential for negative outcome must be considered.

Id.

Under the statute and the "quality of care" regulation, each resident must receive, and the facility must provide, the necessary care and services to allow a resident to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the resident's comprehensive assessment and plan of care. Act, section 1819(b); 42 C.F.R. § 483.25.

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[3] My findings of fact and conclusions of law are set forth, in italics and bold, in the discussion captions.

A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. 42 C.F.R. § 483.75. A finding of substantial noncompliance in the facility's administration may derive from findings of substantial noncompliance in other areas.

> [W]here a facility has been shown to be so out of compliance with program requirements that its residents have been placed in immediate jeopardy, the facility was not administered in a manner that used its resources effectively to attain the highest practicable physical, mental, and psychosocial well-being of each resident.

Asbury Center at Johnson City, DAB No. 1815, at 11 (2002).

1. Staff delayed in providing critical assistance to a choking resident.

Over time, the facility has generated multiple conflicting statements as to the events leading up to the death of Resident (R) 17 on June 9, 2005. However, in their contemporaneous notes describing those events – which I consider the most reliable evidence – the staff members with first-hand knowledge were reasonably consistent.

R17 was an 81-year-old facility resident. He suffered from a multitude of problems, including end-stage dementia. His muscle memory was impaired. He was aphasic (loss of ability to produce or comprehend language). He had also forgotten how to move his fork from plate to mouth; he had difficulty moving food from the front of his mouth to the back to swallow. He chewed, but then left the food where it was, or "pocketed" it in his cheeks. According to his care plan, staff were supposed to feed him his meals. CMS Ex. 22, at 79; P. Ex. 76; Tr. 40, 218, 419.

For reasons not adequately explained, this man who was forgetting how to eat was given a hot dog for dinner. Hot dogs are known to present choking hazards. Tr. 108, 223- 224.[4]

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[4] Based on the testimony of the Director of Nursing (DON), who was not at the facility at the time, Petitioner claims that R17 was given an Italian sausage, not a hot dog. Petitioner also claims, based on no evidence, that an Italian sausage presents less of a choking risk than a hot dog. P. Posthearing Br. at 35, n.17, *citing* Tr. 420. The Certified Nurse Assistant (CNA) and the Licensed Practical Nurse (LPN), who were in the dining room and observed the meal, told the surveyors that R17 was eating a hot dog. CMS Ex. 22, at 2, 3, 28. In any event, I am not aware of any support for the proposition that an Italian sausage presents less of a choking risk than a hot dog, particularly for someone who has forgotten how to eat.

Notwithstanding the directive in R17's care plan that staff feed him his meals, they did not do so. He regularly fed himself, and was feeding himself on the evening of June 9. CMS Ex. 22, at 2, 3, 28 ("most days he fed himself, but on some days staff had to finish feeding him.")

At the time of the incident, Certified Nurse Assistant (CNA) Pat Brooks was responsible for R17's care, and she was in the dining room when the incident occurred. She told Surveyors Judith Carpenter and Stephanie Sulyma-Mauro that she gave R17 his tray. His food was cut up and he started feeding himself. She then passed out trays to other residents, periodically looking back at R17. At one point, she saw that he was staring at his tray; his complexion changed to bluish; he was not making any sounds; he was clammy and his eyes were rolled back. CNA Brooks asked Licensed Practical Nurse (LPN) Sara Jacobs, who was standing by the door, to check on him. CMS Ex. 48, at 8 (Carpenter Decl. ¶¶ 28, 29); CMS Ex. 49, at 6 (Sulyma-Mauro Decl. ¶ 20); Tr. 29, 107.

CNA Brooks then helped to transfer R17 from his dining room chair to his wheelchair, and they took him back to his room. In his room, he turned "completely blue," was "bent over backwards in the wheelchair, almost tilting out of the chair." Registered Nurse (RN) Judi Buckalew, who was the facility's development coordinator, and a social worker were in the room, and RN Mary Charles, who was the supervising nurse on the evening shift, arrived. R17 could not stand so they put him on the floor "and worked on him" until the Emergency Medical Technicians (EMTs) arrived. CMS Ex. 48, at 8 (Carpenter Decl. ¶ 30); CMS Ex. 22, at 4; Tr. 36, 385.

LPN Jacobs wrote a contemporaneous nursing note that is wholly consistent with CNA Brooks' statement to the surveyors. The signed note, dated June 9, 2005, at 6:20 p.m., says that the resident was in the dining room, eating supper, "chewing food, pocketing food, lips blue, resident not swallowing, encouraged resident to spit it out, unable to do." She does not say that she checked his airway, nor does she say that he was breathing. She describes R17 as sweating and writes "placed resident in the chair taken to room. Called supervisor. Placed resident on the floor." Oxygen was started "3-L, suctioned and *Heimlich maneuver started* by in-service coordinator (Judy)." (Emphasis added). Some undigested food was removed from his mouth. He was not responding well. 911 was called and a team arrived at 6:30 p.m. At 6:45 p.m. they pronounced him dead. CMS Ex. 22, at 73; P. Ex. 80, at 2; Tr. 114-115. I recognize that LPN Jacobs later changed her version of events, but I accord greater weight to her contemporaneous notes, particularly since Petitioner did not produce her as a witness to explain her discrepant accounts.

Virtually every other contemporaneous account of the incident comports with these statements.

In nursing notes written on June 9, between 6:25 p.m. and 8:30 p.m. Shift Supervisor RN Mary Charles records that R17 was in the dining room at supper time "being fed by a CNA."[5] The CNA called out to the nurse that he was pocketing food in his mouth and had difficulty swallowing. The nurse went to assess and noted that R17 "looked like he was choking," and his color "appeared bluish." According to the note, he was "immediately taken to his room" and laid on the floor. Oxygen was started "and Heimlich maneuver." The education coordinator [Judi Buckalew] "was present and helping." Undigested food was removed from the resident's mouth. The resident was still not breathing. Someone called 911 "for choking resident." The 911 team arrived, but found no vital signs and at 6:45 p.m., he was declared dead. CMS Ex. 22, at 74; P. Ex. 80, at 3; Tr. 110-111.

In a statement dated June 12, 2005, Judi Buckalew, R.N., writes that she met the ambulance crew at the front door to direct them to R17's room. She told them that R17 "apparently choked while eating supper but that following intervention resulting in removal of food from oral cavity there was no breathing and he had no pulse." CMS Ex. 22, at 67.[6]

The EMT report confirms that R17 began choking while eating and that staff initially attempted the Heimlich maneuver, although it suggests that staff gave the EMTs the impression that they attempted the Heimlich *before* they moved R17 back to his room (which would have been the proper procedure). According to the EMT report:

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[5] Since Supervisor Charles was not present in the dining room, and, inasmuch as the CNA responsible, Pat Brooks, and the LPN present, Sara Jacobs, both said that R17 was feeding himself, and that he regularly fed himself, I conclude that he was feeding himself dinner on June 9, contrary to the instructions in his care plan. CMS Ex. 22, at 74.

[6] Although not at issue here, RN Buckalew also writes about the problems staff had in locating R17's DNR (do not resuscitate) order. Staff told the EMT that R17 had a DNR order, but when he insisted on seeing it, the Nurse Supervisor told him that staff had taken it to photocopy. RN Buckalew showed the EMT the doctor's order sheet, which the EMT said was "not adequate." RN Buckalew was not able to find a document acceptable to the EMTs, who continued their efforts to resuscitate. When the "needed order" was finally located, the EMTs stopped their resuscitation efforts. CMS Ex. 22, at 67.

> RN reports that [patient] was eating dinner when he began to choke and lost consciousness. RN relates staff performed Heimlich maneuver but [patient] lost pulses. RN relates staff quickly moved [patient] to his room away from other residents and began to perform CPR.

CMS Ex. 22, at 13, 19.

Petitioner did not produce as witnesses any employee with first-hand knowledge of the events of June 9, and, considering the seriousness of the incident, the facility's documentation is minimal (*see*, discussion below). Nevertheless, the nursing notes and the surveyors' interviews with staff overwhelmingly establish that R17 began choking while he was feeding himself a hot dog. His lips were turning blue and he was sweating. CNA Brooks called to LPN Jacobs, who told him to spit out his food, but he was unable to do so. CMS Ex. 22, at 73. The documentation does not suggest that LPN Jacobs so much as checked for an airway, much less performed any life-saving efforts until critical minutes later, after staff transferred him from chair to wheelchair and returned him to his room. There, they put him on the floor, and attempted the Heimlich maneuver (also referred to as abdominal thrusts) with no success.

CMS argues that this response did not meet professionally-recognized standards of care. I agree.

Gregory Young, M.D., is a physician, Board-certified in emergency medicine and internal medicine, with twenty-two years experience in emergency medicine. He is a clinical associate professor of emergency medicine at S.U.N.Y. Buffalo, and is the medical director of the EMT training program at Erie Community College. CMS Ex. 58, at 1, 2 (Young Decl. ¶¶ 2, 3, 4).

Dr. Young sees no medical justification for removing R17 from the dining room rather than immediately taking emergency measures. CMS Ex. 58, at 14. (Young Decl. ¶ 39). According to Dr. Young, staff should first have ascertained whether R17's airway was clear. If his airway were clear, staff could rule out choking; if not, they should have performed the Heimlich maneuver without delay. CMS Ex. 58, at 3 (Young Decl. ¶ 10); Tr. 219-220, 222-223. They had about four minutes in which to provide meaningful assistance. After four minutes of oxygen deprivation, the chances of survival are "virtually nil." Tr. 219; CMS Ex. 58, at 13-14 (Young Decl. ¶ 38); CMS Ex. 60, at 1; CMS Ex. 46, at 10. Moreover, blue lips signify a medical emergency. At that point, according to Dr. Young, staff no longer had even four minutes in which to act; "you need to deal with it right then and there." Tr. 225, 232 (While a public environment is not ideal, you don't have much time to respond to a choking event. "It's a matter of just minutes.")

Dr. Young also reasonably pointed out that it is much easier to perform the Heimlich maneuver when the resident is still conscious and able to be upright, and the likelihood of positive outcome is greater if performed when the individual is still conscious. Tr. 229.

R17 was nonverbal and demented, so he was not able to tell staff that he was choking (or anything else). Nor could he be expected to remember the universal choking sign (clutching the neck).[7] Staff therefore should have looked for signs of an obstructed airway. Inasmuch as R17 had food in his mouth, and was neither speaking nor coughing, Dr. Young opined that he most likely had an airway obstruction. CMS Ex. 58, at 13 (Young Decl. ¶ 37).

And R17 plainly had an airway obstruction, because, after staff returned him to his room, they performed the Heimlich maneuver, and they swept, suctioned, and removed food from his mouth. They wrote notes in which they characterized the incident as R1''s "choking." CMS Ex. 22, at 67, 74. They also told the paramedics that R17 had choked and that they had attempted the Heimlich maneuver. CMS Ex. 22, at 13, 19, 67. Based on this compelling evidence, I conclude that R17's airway was obstructed and that staff realized it, but delayed providing him the assistance he needed.

In Dr. Young's view, this was most likely not a cardiac event. CMS Ex. 58, at 14 (Young Decl. ¶ 41); Tr. 220. However, even if R17 had suffered a heart attack while eating, staff should have suspected that food was obstructing his airway (sometimes referred to as a "café coronary") and immediately cleared the airway, "otherwise you're going to have a dead patient." Lack of oxygen worsens the cardiac event. CMS Ex. 58, at 11 (Young Decl. ¶ 32); Tr. 228 ("Any time someone is eating and there's an event associated with it, you have to assume airway until proven otherwise.")

In reaching my conclusion, I have also considered the testimony of Petitioner's expert witness, Richard A. Hodder, M.D. Dr. Hodder also has impressive credentials, although not in emergency medicine. He is currently a nursing facility medical director. P. Ex. 91, at 1 (Hodder Decl.). The main problem with Dr. Hodder's opinion is that it is based on a factual scenario for which there is virtually no reliable support. For example, Dr. Hodder says that if the choking "victim is breathing and coughing, the proper procedure is to encourage the person to continue to cough to dislodge the partial blockage." P. Ex. 91, at 11 (Hodder Decl.); *accord* CMS Ex. 60, at 1. I find no fault with this opinion as a general proposition, but R17 was probably not breathing, or was barely breathing, and

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[7] If someone clutches his neck, he is likely choking; however, not everyone who is choking will make the sign. *See*, e.g., CMS Ex. 46, at 10. ("The victim *may* clutch the neck, demonstrating the universal choking sign.") Dr. Young described an incident in which he, himself, experienced an episode of choking, became quite agitated, and neglected to put his hands to his neck. Tr. 217.

unquestionably *he was not coughing* so he could not possibly have dislodged the blockage through coughing. Not one note mentions coughing, and not one witness came forward to suggest that he was coughing.

According to Dr. Hodder, R17 was not choking. In reaching this opinion Dr. Hodder says that he "reviewed the case" and "obtained pertinent excerpts of the Resident's medical record." Unfortunately, Dr. Hodder does not disclose exactly which documents he reviewed. P. Ex. 91, at 7 (Hodder Decl.). And his testimony suggests that he did not review the critical documents describing the circumstances surrounding R17's death.

First, Dr. Hodder disregards R17's care plan. He says that CNA Brooks "reported that the Resident had no history of swallowing problems," but he seems unaware that R17 had forgotten how to eat. P. Ex. 91, at 9 (Hodder Decl.).[8] R17 was not able to move food to the back of his mouth to swallow. As a result, he needed staff to feed him his meals. CMS Ex. 22, at 79. But it seems that CNA Brooks – the individual responsible for feeding him – was not aware of the risk or her responsibility.

Dr. Hodder also claims that, even though in distress, R17 stood and "got into the wheelchair by his own power." Dr. Hodder characterizes this finding as "very significant" and says that it reinforces "in my mind that the Resident did not have a complete tracheal obstruction." P. Ex. 91, at 9. But R17 did not independently transfer to the wheelchair. He required assistance. CMS Ex. 48, at 8 (Carpenter Decl. ¶ 30). In fact, even when he was not undergoing a medical emergency, R17 would not have been able to stand and transfer himself to a wheelchair. Under the best of circumstances, he required a 2+ person physical assist. CMS Ex. 22, at 77; P. Ex. 76, at 3.

Inasmuch as R17 died, I do not fully understand Dr. Hodder's claim that performing the Heimlich maneuver would have caused "even greater injury." P. Ex. 91, at 11. But Dr. Hodder seems completely unaware that staff, in fact, performed the Heimlich maneuver; they just did not perform it soon enough.

The facility's Director of Nursing (DON), Mary Crosby, also "strongly" disagrees with the argument that staff should have performed the Heimlich maneuver in the dining room if they suspected that R17 was choking. According to DON Crosby, "the Heimlich maneuver should be performed only when the person about to do so is *sure* that the airway is completely blocked." (Emphasis added). P. Ex. 92, at 14. She argues that Nurse

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[8] Petitioner has not produced actual testimony from any of its employees who witnessed the events of June 9. I find inherently unreliable and accord no weight to Petitioner's hearsay evidence as to what transpired. Not only were the employees not available for cross-examination, but, as discussed below, this record is riddled with inconsistent and self-serving accounts, generated by staff well after the event occurred.

Jacobs' failure to do the Heimlich maneuver was justified because staff had been instructed to do the Heimlich "only if they could verify that no air was moving." Tr. 410-411. So, according to DON Crosby, unless staff can establish that an airway is completely blocked, they should not attempt the Heimlich.

If I believed that the facility policy actually put the burden on staff to establish total airway blockage before intervening, I would find it deeply disturbing. DON Crosby misunderstands the standard of care. If a foreign body obstruction is *mild*, and the victim is coughing forcefully, staff should not interfere with the victim's spontaneous coughing and breathing efforts. But, the rescuer *should* intervene if the choking victim has signs of "severe" – note, "severe" does not mean "complete" – airway obstruction. These include "signs of poor air exchange and increased breathing difficulty, such as a silent cough, cyanosis (which R17 unquestionably demonstrated), or inability to speak or breathe. CMS Ex. 46, at 10; Tr. 225, 232.

I am therefore satisfied that, because staff did not provide R17 the emergency care he needed when he needed it, the facility did not provide necessary care to allow him to maintain the highest practicable physical well-being, as required by the statute and quality of care regulation. Act, section 1819(b); 42 C.F.R. § 483.25.[9]

CMS also points out that, in delaying implementation of the Heimlich maneuver, staff were not following the facility's own policies. The policy, which is dated June 16, 2004, provides that "all employees . . . will be trained to initiate abdominal thrusts for a conscious adult choking victim." CMS Ex. 15, at 2. When observing that a resident is choking, staff are directed to call out for assistance, *begin choking intervention for conscious adult*, instruct other staff to call 911, and continue the intervention until the EMS arrives. The policy also requires that an accident/incident report be completed.

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[9] I find disturbing Petitioner's apparent dismissal of the quality-of-care regulation as a "catch-all." P. Posthearing Br. at 55. First, the requirement was specifically mandated by Congress. Act, section 1819(b). Second, as I pointed out in a recent decision, providing necessary care and services is central to a facility's Medicare participation. Medicare pays for placement in skilled nursing facilities specifically so that residents can receive the care they need. *See The Laurels at Forest Glenn*, DAB CR1681, at 14, n.15 (October 30, 2007).

CMS Ex. 15, at 1, 2. CMS has no problem with the written policy itself, but argues persuasively that, in failing to follow it, staff denied R17 the services he needed to avoid physical harm. This is neglect (42 C.F.R. § 488.301), and violates the requirement that the facility implement its policy prohibiting staff neglect.[10]

2. The facility neither investigated nor reported the incident, and it deliberately provided to the State Agency and to this tribunal false and misleading accounts.

The facility's actions following R17's death are deeply troubling.

First, although required to do so, the facility did not report the incident to the State Agency. The State Agency only learned of it from an anonymous caller. CMS Ex. 48, at 3 (Carpenter Decl. ¶ 11); Tr. 31, 249.

Then, on the first day of the survey, June 17, 2005, when Surveyor Carpenter asked the facility's administrator, Mark Walker, and its DON, Mary Crosby, for the incident and accident report, and the report of the facility's investigation of the incident, DON Crosby told her that there were no such documents and that there had been no investigation "because the resident had died." CMS Ex. 48, at 5 (Carpenter Decl. ¶ 19); CMS Ex. 22, at 2; Tr. 32-33, 102. In her testimony, DON Crosby confirmed that, when Surveyor Carpenter asked her for the investigation, she replied that they did not complete one because "the judgment was he died of natural causes." Tr. 421, 435.

This raises a question as to how the facility could have made such a determination without investigating the incident. But more troublesome, DON Crosby admits that on the day after the incident, she reviewed RN Charles' note that described R17 as choking; she also reviewed LPN Jacob's note that describes R17's chewing and pocketing food, his blue lips, inability to swallow or to spit the food out, and the staff's placing him in his wheelchair and taking him back to his room before attempting the Heimlich maneuver. Yet, she told the surveyor that an investigation was not necessary because R17 died naturally from a heart attack. Tr. 389, 423.

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[10] I note also that, in failing to complete an accident/incident report, the facility's supervisory and administrative staff failed to follow the facility policy. *See* discussion, *infra*.

But it gets worse. When the surveyors returned to the facility on June 21, DON Crosby gave them two typed statements, which she said represented statements from CNA Brooks and RN Buckalew. CMS Ex. 48, at 5-6 (Carpenter Decl. ¶ 21); Tr. 33, 103-104. One of these documents is the June 12, 2005 statement signed by RN Buckalew, which is described above. CMS Ex. 22, at 67.

The other is labeled "Conversation with Pat Brooks" and dated 6/13/05. DON Crosby claimed that she spoke to CNA Brooks on June 10, and typed the document on June 13. The statement is signed by DON Crosby; it is not signed by CNA Brooks. It says that Pat was assigned to care for R17 on June 12, 2005.[11] Pat was feeding him, and had cut up his food into bite-size pieces. She turned to assist another resident. When she turned back she observed R17 "in distress." She called the nurse and

> the Heimlich maneuver was performed. There were no results and, as he became less responsive, they took him via [wheelchair] to his room where he was placed on the floor and the Heimlich maneuver for an unconscious person was performed. At this time he was without pulse respiration. 911 was called. She stated the whole event took maybe 5 minutes.

CMS Ex. 22, at 66.

But when Surveyor Carpenter asked CNA Brooks about the statement, CNA Brooks said that she had never seen the statement and that it was inaccurate. She said that she was not feeding the resident. She denied telling DON Crosby that anyone had performed the Heimlich maneuver while R17 was still in the dining room, and confirmed that no one had done so until later, after returning him to his room. With respect to how long the event took, CNA Brooks said that the resident's daughter had been visiting and left at about 6:00 p.m. Trays were brought into the dining room at about 6:10 p.m. and R17's tray was on the first cart. Rather than everything taking "maybe 5 minutes," CNA Brooks opined that the whole event took 15 to 20 minutes. CMS Ex. 48, at 10 (Carpenter Decl. ¶ 37); Tr. 104, 106; *See also* CMS Ex. 22, at 73 (per LPN Jacobs, the event lasted from 6:20 to 6:45 p.m.).

In her testimony before this tribunal, DON Crosby told a completely different story. She testified that she was not at the facility when the incident occurred, but that RN Charles called her shortly thereafter and reported that R17 was eating dinner when CNA Brooks "saw him become red in the face, sweating, and blue around the lips."

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[11] In addition to getting the date wrong, DON Crosby also got the resident's name wrong, referring instead to another resident with a similar name. Tr. 128, 398-399.

> According to Nurse Charles' report, CNA Brooks called a nearby nurse, Sara Jacobs, who retrieved a nearby wheelchair; the resident stood and seated himself in the wheelchair; Nurse Jacobs decided to take the Resident to his room to assess him further; someone called 911; one or more nurses started CPR when the Resident stopped breathing; but the Resident passed away quickly. According to Nurse Charles, she believed the Resident had suffered a heart attack or stroke. She never mentioned choking, and the matter seemed like a routine death of an elderly, debilitated resident that required no further inquiry.

P. Ex. 92, at 12; Tr. 387, 388. This statement is obviously inconsistent with RN Charles' note written on the night of the incident, which DON Crosby admits reading. CMS Ex. 22, at 74; Tr. 389.

DON Crosby further testified that she called RN Buckalew, the facility's development coordinator, who

> basically confirmed the rest of the story as Nurse Charles had related it and expressed the opinion that the Resident apparently had suffered a heart attack or stroke. Again, she said nothing about the Resident appearing to choke.

P. Ex. 92, at 13. But this testimony is inconsistent with RN Buckalew's June 12, 2005 statement, which DON Crosby handed to the surveyors on June 21. CMS Ex. 22, at 67.[12]

DON Crosby also testified that on the day following R17's death, she spoke to CNA Brooks who "repeated to me the same story I had heard the evening before. At no time during any of these conversations did anyone say that he or she thought that the Resident had choked." P. Ex. 92, at 13. This testimony is obviously inconsistent with the DON Crosby's own written account of her June 10 conversation with CNA Brooks. CMS Ex. 22, at 66. When asked to explain the discrepancies between that account and her testimony, DON Crosby said that she knew to be false CNA Brooks' claim that staff performed the Heimlich maneuver while R17 was still in the dining room. She didn't "recall specifically" if she told the surveyors about the conflicting information. Tr. 403.

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[12] In a June 24 telephone conversation with Surveyors Francis and Carpenter, DON Crosby claimed that, on the evening of June 9, RN Charles told her that R17 died from choking, and that the Heimlich had been performed in the dining room. CMS Ex. 52, at 3 (Francis Decl. ¶ 7).

DON Crosby testified that no one "even mentioned choking, or the Heimlich maneuver" until several weeks after R17's death, following the anonymous complaint to the State Agency leveled, according to DON Crosby, "by a staff person who had not even been present at the incident to the effect that we had killed the Resident." P. Ex. 92, at 13. DON Crosby concedes that some of the documentation created immediately following the incident used the word "choking," but suggests that a CNA confused the chest compressions of CPR with the abdominal thrusts of the Heimlich maneuver. P. Ex. 92, at 13. The problem with this claim is that LPN Jacobs, RN Charles, and RN Buckalew all said that they performed the Heimlich maneuver/abdominal thrusts. And they told the EMTs that they had done so. CMS Ex. 22, at 13, 19, 67, 73, 74.

Administrator Walker testified that he conducted an investigation of the incident (although Petitioner has produced no corresponding investigative report). He did not mention whether that investigation included reading the staff's contemporaneous notes, yet he claimed that "no one who was present in the dining room thought that the Resident was choking at the time." He testified that his senior staff had a "very brief" discussion on the morning following the event, and "no one even mentioned the possibility that he had choked to death." P. Ex. 89, at 11 (Walker Decl.).

DON Crosby complains that facility staff were not trustworthy, honest or truthful. Tr. 428. Their underlying goal "was always to get someone else in trouble." Tr. 431. I do not doubt this, but the dishonesty of her staff does not justify DON Crosby's own dissembling, and it hardly furthers Petitioner's case.[13]

Finally, DON Crosby testified that if she had to do it over again, she still would not have reported the incident to the State Agency. Tr. 434-435.

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[13] Petitioner points out that DON Crosby had filed with the State Agency "literally hundreds of [incident] reports," including the report of a recent choking death. Petitioner asserts that "it is hard to imagine why she would want to cover up this particular event, especially after she came to the conclusion that the Resident actually had died a natural death." P. Reply at 15. First, I find not credible her claim that she thought that R17 died a natural death. Second, it is not so hard to imagine that she wanted to cover up this particular incident of neglect. During this time, the facility was under investigation for criminal neglect. Fourteen of its staff were ultimately indicted, and at least eight or more of those were convicted. P. Ex. 89, at 3 (Walker Decl.); P. Ex. 92, at 2 (Crosby Decl.); CMS Exs. 12, 13, 59.

Not only did staff neglect R17, failing to provide him the care and services he needed, its administration then compounded those transgressions by failing to investigate the incident and failing to report it as required. Then, the facility's director of nursing made matters worse by knowingly providing false and misleading information to the State Agency. The evidence thus establishes the facility's substantial noncompliance with 42 C.F.R. § 483.75 (administration) as well as 42 C.F.R. §§ 483.25 and 483.13(c).

B. ***The facility was not in substantial compliance with 42 C.F.R. §§ 483.13(c), 483.25, and 483.75 because it did not provide it residents with necessary and appropriate care during a period of high heat and humidity.***

There is no dispute that the elderly are more susceptible to heat-related difficulties because their bodies are less able to regulate and respond to temperature changes. P. Ex. 91, at 5 (Hodder Decl.); CMS Ex. 58, at 18 (Young Decl. ¶ 52). Extreme heat can cause a variety of ailments, ranging from what Dr. Hodder characterizes as "relatively minor problems," such as muscle cramps, to heat exhaustion (excessive sweating, fatigue, headache, and nausea) to heat stroke, which is a medical emergency. Heat stroke involves hot, dry, red skin, rapid increase in temperature, loss of consciousness, and even death. P. Ex. 91, at 5 (Hodder Decl.); CMS Ex. 58, at 18 (Young Decl. ¶ 54).

Beginning July 10, 2005, the City of Rochester experienced a severe heat wave combined with unhealthy air quality. CMS Ex. 14, at 10; P. Ex. 89, at 5. Outside temperatures reached highs of 90° to 93°F, with high levels of humidity. CMS Ex. 48, at 15; CMS Ex. 14, at 11; CMS Ex. 49, at 9; CMS Ex. 51, at 3. The facility was not centrally air conditioned, and sections of it, including resident rooms, became uncomfortably hot and humid. P. Ex. 89, at 4-5; CMS Ex. 48, at 15; CMS Ex. 51, at 3. I have already ruled that housing residents in rooms this hot and humid (up to 96°F) violates the quality-of-life requirement that the facility provide comfortable and safe temperature levels. 42 C.F.R. § 483.15(h).

I now consider whether the facility provided its residents with the necessary and appropriate care during that period of excessive heat and humidity.

The surveyors described the temperatures in the facility during the July survey. According to Surveyor Gail Ajavon, "On the 11th it was hot, on the 12th it was hotter, and on the 13th it was just unbearable." Tr. 355. Surveyor Cynthia Francis said that when she entered the facility late in the day on July 13, 2005, "it hit me in the face like I walked into a sauna . . . it was hot in the facility. It was oppressive. It was hot." Tr. 285; CMS Ex. 52, at 5 (Francis Decl. ¶ 13). Facility Administrator Walker admits that it was hot,

but claims that the heat did not become "oppressive" until July 13. P. Ex. 89, at 4 (Walker Decl.). He does not explain when "hot" becomes "oppressive," but suggests that, pursuant to the facility's "heat emergency policy," certain measures (providing extra fluids, closing curtains, moving residents) would be implemented during periods of "persistent" heat and humidity. P. Ex. 89, at 4 (Walker Decl.).

The facility's written policies and procedures. Petitioner produces as its policy a document titled "High Heat/Humidity." To minimize confusion, I refer to this as "Standard Policy." "Standard Policy" says that the facility "will initiate the following measures to protect residents/patients and staff from periods of extreme heat and humidity and the associated health risks." Those measures include:

- closing draperies on the sunny side of the building;
- increasing the quantity of fluids offered to residents;
- using appropriate preventive and treatment measures such as bathing, sponge baths, and transferring to cooler areas "those residents with temperature elevations."

Staff were also directed to observe residents for: absence of perspiration; decreased urinary output; high body temperature/hot and dry skin; rapid respirations/elevated pulse; confusion. If such symptoms appeared, staff were immediately to notify the nurse or doctor. They were also instructed to notify the nurse immediately of signs/symptoms of electrolyte imbalance (confusion, nausea, cramps, unusual muscle weakness). CMS Ex. 18, at 1.

A second document is titled "Heat Wave." I refer to this document as "Emergency Policy." "Emergency Policy" says that "an *emergency* situation is created by a prolonged period of hot weather that exceeds 85 degrees with high humidity." (Emphasis added) CMS Ex. 18, at 6. Under those circumstances, the administration was to inform staff of the emergency situation, alert hospitals of the potential need to transfer residents, and notify the State Health Department and its Long Term Care Division of the situation. Among the listed procedures were the following:

- "utilize air circulating and to attain and maintain air movement and cooling, especially in resident use areas;"[14]
- close drapes and/or blinds in sun exposed areas;

[14] I believe this refers to using fans.

- provide and encourage resident fluid intake. "Provide glasses of cool water to all in addition to regular meal fluids and nourishments." Maintain a supply of fruit juices, lemonade, and ice tea on each nursing unit, and nursing staff "shall encourage and [make] available these fluids to their residents." Encourage sodium and potassium intake;

- encourage residents to stay out of direct sunlight;

- monitor temperature and other vital signs once each shift on all residents.

CMS Ex. 18, at 6.

Petitioner argues that it should not be held accountable for failing to provide the services described in this "Emergency Policy" document, because the document does not represent facility policy; it is simply a page from an inservice training session. P. Posthearing Br. at 17. But both Administrator Walker and DON Crosby refer to the facility's "heat emergency policy," reflecting the language of the "Emergency Policy" document, that is not found in the "Standard Policy" document. Administrator Walker describes a policy that requires taking action during periods of "persistent" heat and humidity. P. Ex. 89, at 4 (Walker Decl.). Similarly, DON Crosby says that, under its heat emergency policy, the facility would intervene when the weather was "persistently hot and humid." P. Ex. 92, at 3 (Crosby Decl.).[15]

The "Standard Policy" says nothing about a "heat emergency" or "persistent" or "prolonged" periods of heat. Under its provisions, the listed measures should be taken during "periods of extreme heat and high humidity." CMS Ex. 18, at 1. Only the "Emergency Policy" refers to "a prolonged period of hot weather." CMS Ex. 18, at 6. So, contrary to Petitioner's argument, the testimony of its witnesses suggest that the facility policy was reflected in the "Emergency Policy" as well as the "Standard Policy" (which requires no waiting period prior to its implementation).

[15] In DON Crosby's view, the policy would be implemented after "four or five consecutive days of unusual heat." P. Ex. 92, at 3 (Crosby Decl.). I consider it dangerously excessive to wait up to five days before monitoring vital signs, or encouraging residents to stay out of the direct sunlight. Of course, the other interventions were required by both policies, and should have been implemented during any period of extreme heat and high humidity. CMS Ex. 18, at 1.

Moreover, Petitioner has not explained why the facility would not be accountable for its instructions to staff and staff's failure to follow those instructions. In any event, the "Emergency Policy" on its face, appears to be a policy with designated procedures, which are specifically labeled "procedure." No facility witness claimed that this document did not represent the facility's policy. In this regard, Petitioner's references to the record point to arguments of counsel, not the testimony of witnesses.

Policy Implementation. CMS voices no particular objections to the contents of either the "Standard Policy" or "Emergency Policy," but argues that they were not properly implemented. The evidence supports CMS's position.

First, the facility had no way of determining when it was time to implement its *emergency* measures, because it had no thermometers for measuring room temperatures. So, even though its written policy said that it would implement its "Emergency Policy" when temperatures reached 85° or above, staff had no way of determining when that occurred. CMS Ex. 18, at 6; Tr. 336. Administrator Walker dismisses as insignificant the facility's failure to measure temperatures: "We knew it was hot, and that the rooms were hot." P. Ex. 89, at 5, 7 ("Again, these data confirmed what we already knew – it was hot and humid.") But how was the facility to determine when the hot weather "exceeded 85 degrees with high humidity" if it did not monitor the temperature? When the facility finally started to measure room temperatures on the evening of July 13, temperatures above 85° were common, and in some resident rooms, temperatures were in the 90's. CMS Ex. 35, at 3-5; CMS Ex. 43, at 28-30; CMS Ex. 51, at 11-12 (Ajavon Decl. ¶¶ 36, 37, 38, 39); CMS Ex. 48, at 16, 17 (Carpenter Decl. ¶¶ 55, 66); P. Ex. 87; *See* Ruling and Order, at 7-8 (February 15, 2007).

Next, facility policy required staff to increase the amount of fluid offered to residents during periods of heat and humidity. Everyone recognizes the importance of keeping the facility's aged and infirm residents well-hydrated. As Dr. Hodder points out, "most heat ailments result from overexertion and/or dehydration in hot conditions . . . staff ordinarily is able to keep [nursing facility residents] well hydrated in such conditions." P. Ex. 91, at 6.

But the evidence establishes that the facility was not providing the most vulnerable of its residents with sufficient hydration. The facility had in place blue carts containing ice and pitchers of juice and water – one on each floor. Staff were supposed to offer these extra drinks to the residents, but the surveyors did not observe them doing so. CMS Ex. 49, at 9 (Sulyma-Mauro Decl. ¶ 34); Tr. 92; 292, 345. Residents on the first floor were ambulatory, so, although staff were not handing out fluids to them as dictated by the policy, those residents could at least help themselves. Tr. 343-344. But the residents on the second and third floors were confined to their beds; they were not capable of purposeful movement, and many were not able to speak. CMS Ex. 48, at 15; CMS Ex. 49, at 9. Until the afternoon of July 13 (when the State Agency called immediate

jeopardy), no surveyor observed staff providing water or other drinks to residents on the second floor. Tr. 294, 343-344. Surveyor Stephanie Sulyma-Mauro testified that she and Surveyor Parrinello-Hall observed the hydration cart parked at the second floor nurses station on July 11, 12, and 13, but did not see staff handing out drinks to residents until the afternoon of the 13th. She did not personally see any resident take a drink from the hydration cart during this time. And the surveyors were specifically "keeping an eye" on the hydration cart. CMS Ex. 49, at 9-10 (Sulyma-Mauro Decl. ¶ 34); Tr. 292-293. Surveyor Wood testified that she observed hydration carts on the second and third floors near the nurses station, but did not see them used until late afternoon on the 13th. Tr. 309-310.

DON Crosby states "with certainty that [the cart] was circulated at least every hour, since I not only saw it, but also did so myself." P. Ex. 92, at 5. But DON Crosby has demonstrated a complete lack of credibility in this case (*see*, discussion, *supra*). Petitioner had ample notice of the surveyors' observations, but produced no other employee who claims to have taken the cart around, nor evidence of any reliable, systematic means by which the facility could verify that its (purportedly unreliable) staff circulated the cart and that they actively encouraged the residents – many of whom might not have recognized that they needed water – to drink. I found credible the surveyor testimony that they did not see the carts circulated. If, in fact, the carts were circulated hourly, at least one of the surveyors would have seen it go around at least one time.

Other evidence supports the finding that staff were not providing residents with increased fluids. For example, R24 was an 83-year old man, suffering from dementia, cerebral vascular accident, hypertension, history of hypernatremia (elevated sodium) and acute renal failure. CMS Ex. 27, at 10. On July 13, at approximately 5:15 p.m., surveyors observed him in bed. The temperature of his room was 96°F.[16] He complained that he was hot and thirsty; his lips were dry and cracked. P. Ex. 49, at 21 (Sulyma-Mauro Decl. ¶ 89). He had no water in his room, and, when Surveyor Sulyma-Mauro asked him if he wanted water, he said yes. Tr. 306-307.

R5 was tube-fed and thus completely dependent on staff for hydration. Her care plan identified her as at risk for dehydration. CMS Ex. 49, at 10-11 (Sulyma-Mauro Decl. ¶¶ 37, 39); Tr. 187, 314. She was suffering from a urinary tract infection, elevated temperature (103°F), and kept in a stiflingly hot room. Tr. 184, 296-298. With a core temperature of 103°F, a patient should be given more fluids because she is losing more

[16] Petitioner objects that this temperature exceeded the official high temperature for Rochester that day. I see nothing unusual about a temperature taken in direct sunlight registering higher than the official high.

"to insensible loss, which could cause dehydration and kidney issues." Tr. 193. Yet her physician did not order increased hydration until July 13. CMS Ex. 24, at 27; Tr. 319, 323-324. The results of her subsequent blood tests were consistent with dehydration. CMS Ex. 24, at 88; CMS Ex. 58, at 26-27 (Young Decl. ¶ 86). *See* discussion, *infra*.

Nor were staff monitoring temperatures and vital signs "once each shift on all residents," as called for by the "Emergency Policy." CMS Ex. 18, at 6. Even though Administrator Walker says that he called a heat emergency on the morning of July 13, staff did not begin taking temperatures until that evening. CMS Ex. 34; CMS Ex. 51, at 7 (Ajavon Decl. ¶ 26). As discussed below, no one took R2's temperature until July 14, at which time they learned that she had a fever.

The facility failed to implement its policies in other respects. Staff were supposed to close drapes on the sunny side of the building, and to encourage residents to stay out of direct sunlight. CMS Ex. 18, at 1, 6. But the facility apparently did not have actual draperies in the resident rooms, and the window blinds were ineffective in blocking the sun. Tr. 87, 283-285; CMS Ex. 48, at 19 (Carpenter Decl. ¶ 74); CMS Ex. 49, at 11 (Sully-Mauro Decl. ¶ 41.

R24 was found lying in his bed in the direct sunlight in a 96°F room. CMS Ex. 49, at 21 (Sulyma-Mauro Decl. ¶ 89). Leaving him in the direct sunlight "would be like leaving a child in a car." Tr. 215. Because of his dementia and history of stroke, R24 was dependent on staff for his care, and was not able to move himself out of the sun. CMS Ex. 49, at 90 (Sulyma-Mauro Decl. ¶90). DON Crosby's claim that R24 "was a native of Georgia and enjoyed hot weather" does not justify leaving him that way. P. Ex. 92, at 9 (Crosby Decl.).

Staff were also supposed to be assessing residents and responding to their heat-related symptoms. CMS cites examples of residents with high temperatures and other symptoms, who were left lying in hot rooms:[17]

[17] The circumstances of the residents discussed here (along with the other deficiencies cited) more than justify the penalty imposed, so I do not discuss every resident cited by CMS.

Resident 2. R2 was an 85-year-old woman who suffered from chronic obstructive pulmonary disease (COPD). She had histories of stroke and urinary tract infections. CMS Ex. 48, at 16 (Carpenter Decl. ¶ 57); Tr. 89, 147. High temperatures and humidity will exacerbate the symptoms of COPD. CMS Ex. 58, at 20 (Young Decl. ¶ 59); Tr. 119-120. Because of residuals from her stroke, she was completely dependent on staff for feeding and transfer.

R2 spent most of her day in her room. When measured on July 13 and 14, the temperature in her room was 90°F. CMS Ex. 48; P. Ex. 92, at 10. Surveyors saw her lying in bed with a fan blowing directly on her face. She said that she could not breathe without the fan. CMS Ex. 48, at 18 (Carpenter Decl. ¶ 67).

R2 was not capable of getting herself out of bed; she required the assistance of staff and a mechanical lift. On July 11 and 12, she apparently was left in her bed in her hot room all day. Staff finally got her out of bed and into a gerichair on July 13, "the first time in a long time [that] she had been out of bed," but she was not encouraged to leave her room to move to a cooler place. CMS Ex. 48, at 17 (Carpenter Decl. ¶¶ 60-65); Tr. 121.

According to Petitioner, R2 "typically refused to get out of bed." P. Posthearing Br. at 30. But the nursing notes from April through August 2005, cite only two instances of her refusal to get out of bed, July 12 and July 18. A July 12 nursing note says "refuses to get out of bed." P. Ex. 65, at 7. However, that is also the date that R2, who is fully alert and oriented and understands without difficulty (P. Ex. 64), told Surveyor Carpenter that the CNA had tried to get her out of bed, but was unable to do so, which does not sound like she was refusing to get out of bed. CMS Ex. 48, at 17 (Carpenter Decl. ¶ 63).[18]

Petitioner's "Standard Policy" called for transferring to cooler areas or comparably assisting residents with temperature elevations. CMS Ex. 18, at 1. Because staff did not take R2's temperature on July 11, 12, or 13, we do not know whether she should have been transferred on those dates. When someone finally took her temperature, at about noon on July 14, her axillary body temperature was 100° (suggesting a higher core temperature). CMS Ex. 34, at 27; CMS Ex. 48, at 18 (Carpenter Decl. ¶68); CMS Ex. 58, at 20-21 (Young Decl. ¶63).

[18] Ordinarily, I might not afford the resident's statement too much weight, since it is contradicted by the nursing notes. However, Petitioner has convinced me that its staff was capable of putting false information into the patient records. *See*, *e.g.* Tr. 428, 431. *See also* Tr. 237-238; CMS Exs. 12, 13 (At least eight facility employees criminally convicted of falsifying medical records and patient neglect during April and May 2005).

Petitioner claims, without citation to the record, that R2's elevated temperature was of no consequence because her temperature "normally fluctuated between 97.4 and 100.2." P. Posthearing Br. at 30. R2's clinical record does not support this assertion. Nursing notes show that in April 2005, she was on antibiotic therapy for an infection. Even then, her temperature reached 100° only once. I see three readings of 99° or above (P. Ex. 65, at 2), but, even with an infection, her temperature generally ranged between 96.7 and 98.7. P. Ex. 65, at 1-3. I see no temperatures recorded between April 23 and July 14, 2005.

Petitioner may be referring to the testimony of DON Crosby. But DON Crosby did not claim that R2's temperature "normally fluctuated between 97.4 and 100.2." She said that "*during the heat wave* R2's temperature fluctuated between 97.4 and 100.2." (Emphasis added) P. Ex. 92, at 11. Her testimony is not wholly accurate. We have no idea what R2's temperature was during the early days of the heat wave (July 11-13), when she was confined to her hot room. We only know what it was after staff started taking her to cooler areas. P. Ex. 65, at 8.

Resident 26 (R26). R26 had multiple risk factors for heat-related injury and dehydration. He had end-stage Alzheimer's disease, diabetes, and was described by his physician as "functionally quadriplegic." P. Ex. 53, at 1. He was unable to move his arms or legs or to turn himself. Tr. 118, 176. He had a gastrostomy (feeding) tube. CMS Ex. 48, at 19 (Carpenter Decl. ¶ 73.

Nursing notes show that R26 had an infection (pneumonia), so staff were monitoring his temperature prior to the survey. On July 11, 2005, they recorded temperatures of 98.4 at 6:25 a.m., 101.6 during the 7 to 3 shift, and 100.4 some unspecified time thereafter. P. Ex. 55, at 22. The following day, staff reported early morning temperatures of 100.8 and 101.4. P. Ex. 55, at 22.

R26's room was on the eastern side of the building, which was the hotter side because it had no trees. Although his window blinds were closed, they were "practically transparent" and his window had no drapes. Surveyor Carpenter described the heat in R26's room as "unbearable." Tr. 87. At 8:25 a.m. on July 13, Surveyor Carpenter observed R26 in his room. A fan was on, and he had a wet cloth on his forehead, but bright light was streaming through the blinds, and R26 was not responsive. CMS Ex. 48, at 19 (Carpenter Decl. ¶ 74). Later that morning, Surveyor Carpenter observed him lying in bed, his skin warm and dry. Again, he did not respond. CMS Ex. 48, at 20 (Carpenter Decl. ¶ 75). She asked staff to take his temperature, which was 101.3°F, axillary. Surveyor Carpenter asked that his temperature be taken rectally. Staff claimed that his rectal temperature was the same, although both Surveyor Carpenter and Dr. Young deem this highly unlikely; axillary temperatures are generally lower than rectal temperatures. The room temperature was 89°F. CMS Ex. 48, at 20 (Carpenter Decl. ¶ 76); Tr. 117; CMS Ex. 58, at 33 (Young Decl. ¶ 113).

In the late afternoon on July 13, Surveyor Francis observed R26 lying in his bed, in the sun, a plastic pillow up against his body. His room temperature was 90°F. Tr. 283.

> When I walked into the room, the resident was lying in bed. His eyes were closed. He had this long plastic body pillow against his side or back. He was sort of on his side, but he sort of wasn't.
>
> The blinds were closed, but you really couldn't tell that because there was so much sun coming through them. His wife was present. His eyes were closed. He – I tried to speak with him to see if I could get any reaction, I couldn't. His wife told us that – told me that he hadn't responded to her that day. . . [W]e . . . suggested that at least put a pillow case on the pillow.
>
> * * * *
>
> That's related to the evaporation process that needs to take place if someone's sweating. If the air can't circulate, the evaporation's not going to happen. If you've got plastic directly against the skin, there's definitely no circulation, there's no evaporation, so there's no cooling.

Tr. 283-285.

When surveyors observed R26 on July 14, he had finally been moved to an air conditioned area. He was more alert; his skin was cooler; he was smiling at his wife. CMS Ex. 48, at 21 (Carpenter Decl. ¶ 81); Tr. 87.

While I do not doubt that R26's elevated temperature was primarily caused by his underlying infection, his lying in the sun in a 90°F room also likely contributed to his fever, and to his mental confusion, and certainly caused him significant discomfort. Even DON Crosby concedes that "a person in a hot room would be expected to have a slightly elevated temperature as part of the body's normal response to heat." P. Ex. 92, at 5, *but see* P. Ex. 58, at 35 (Young Decl. ¶ 119). But without regard to the cause of his elevated temperature, R26 had conditions that made him vulnerable to heat, and was exhibiting symptoms that the facility heat policy identified as problematic (absence of perspiration, hot and dry skin). He was completely unresponsive. Yet, he was left lying in an "unbearably" hot room.

Resident 5. R5 was an 82-year old woman who had a history of stroke, and suffered from diabetes, among other ailments. She had pressure ulcers. She had decreased cognition and communication deficits related to aphasia, stroke and blindness. She had a history of urinary tract infections. As noted above, her care plan identified her as at risk for dehydration due to her gastrostomy. Staff were supposed to assess changes in her fluid needs during periods of fever, diarrhea, emesis, and hot weather. CMS Ex. 22; CMS Ex. 24, at 1, 63.

Surveyors visited R5 every day of the survey and reported that the room was very warm. Mini-blinds were pulled, but they were very thin, and bright sunlight easily came through. CMS Ex. 49, at 11 (Sulyma-Mauro Decl. ¶ 41).

Surveyor Sulyma-Mauro testified that she has been going to the facility since 2001, and R5 was well-known to her. She describes R5 as pale and listless. "She did not look like she normally did." She simply "did not look right to me." Tr. 296, 299.

On July 12, at 1:50 p.m., the temperature in R5's room was 89°F. Her hair and shoulders were wet, presumably from perspiration. At approximately 9:00 a.m. on July 13, Surveyors Sulyma-Mauro and Julie Parrinello-Hall observed R5 in bed in her very warm room, sweating. At 12:45 p.m. on July 13, her room temperature was 92°F. At Surveyor Sulyma-Mauro's request, the nurse took her body temperature, which registered 101.1°F (axillary) and 103.3° (rectal). CMS Ex. 49, at 11-12 (Sulyma-Mauro Decl. ¶ 45); CMS Ex. 50 at 5. She was no longer sweating. CMS Ex. 49, at 13.[19] The nurse administered Tylenol. CMS Ex. 49, at 12 (Sulyma-Mauro Decl. ¶ 51).

At 5:00 p.m. on July 13 the temperature in R5's room was still 92°F. Notwithstanding two doses of Tylenol, her temperature was still elevated (103.3°). CMS Ex. 49, at 13; CMS Ex. 24, at 17. She was breathing heavily, with respirations of 36 a minute, which is not normal (normal is up to 12 to 20 breaths per minute). Dr. Young characterized this as a "critical number." CMS Ex. 49, at 13 (Sulyma-Mauro Decl. ¶ 52); CMS Exs. 58, at 23 (Young Decl. ¶ 75); Tr. 185. *See also* CMS Ex. 18, at 1 (facility policy identifying rapid respiration as a heat-related symptom).

[19] For an individual experiencing prolonged exposure to excessive heat, the absence of perspiration may indicate a serious problem. *See* P. Exs. 9; 14 at 2; 15 at 4 (absence of perspiration is a symptom of heat stroke); *See also* CMS Ex. 18, at 1.

Later that evening, staff finally moved her to the nurses station and applied ice to vital areas. CMS Ex. 24, at 17. Her temperature then dropped but crept back up to 101°. The facility later learned that R5 had a urinary tract infection. Based on this, Dr. Young opined that R5's exposure to heat caused a temperature elevation of an additional couple of degrees. CMS Ex. 58, at 25-26 (Young Decl. ¶¶ 82, 83, 84); Tr. 184, 297-298.

A July 16 test for blood urea nitrogen (BUN) level of 105, and creatine level of 1.2 suggested that she was dehydrated. CMS Ex. 24, at 88; CMS Ex. 58, at 26-27 (Young Decl. ¶ 86).

Everyone agrees that the elderly are more susceptible than most to heat-related problems. Among the facility's residents were individuals whose compromised conditions made them even more vulnerable to high temperatures and humidity. Such residents should not be lying in direct sunlight. It was also critically important that they be kept well-hydrated and that their conditions be monitored. Because the facility did not do so, it was not providing necessary care to allow those residents to maintain the highest practicable physical, mental, and psychosocial well-being. It was therefore not in substantial compliance with section 1819(b) of the Act and 42 C.F.R. § 483.25.

The facility had written policies in place to meet those residents' special needs. But they did not implement the policies, which exposed their most vulnerable residents to physical harm and mental anguish. This is neglect, violating 42 C.F.R. §483.13(c).

The facility's administrators are responsible for the inadequate response to the heat emergency. It was not using its resources effectively to maintain the highest practicable physical, mental and psychosocial well-being of each resident. So the facility was not in substantial compliance with 42 C.F.R. § 483.75.

C. CMS's determination that the facility's deficiencies posed immediate jeopardy to its residents was not clearly erroneous.

I next consider whether CMS's immediate jeopardy finding was "clearly erroneous." Immediate jeopardy exists if the facility's noncompliance has caused or is likely to cause "serious injury, harm, impairment or death to a resident." 42 C.F.R. § 488.301. CMS's determination as to the level of a facility's noncompliance – which includes its immediate jeopardy finding – must be upheld unless it is "clearly erroneous." 42 C.F.R. § 498.60(c).

The Board has observed repeatedly that the "clearly erroneous" standard imposes on facilities a "heavy burden" to show no immediate jeopardy, and has sustained determinations of immediate jeopardy where CMS presented evidence "from which '[o]ne could reasonably conclude' that immediate jeopardy exists." *Barbourville Nursing Home*, DAB No. 1962, at 11 (2005); *Florence Park Care Center*, DAB No. 1931, at 27-28 (2004), *citing Koester Pavilion*, DAB No. 1750 (2000). Here, the facility has not satisfied its burden.

The circumstances surrounding the death of R17, and the facility's response, by themselves, justify the immediate jeopardy finding. No one knows with certainty whether staff could have saved R17's life by immediately administering the Heimlich maneuver, instead of expending precious time taking him back to his room. However, delay in initiating a potentially life-saving procedure is unquestionably likely to cause serious injury or death, and justifies the immediate jeopardy determination.

The facility compounded its deficiencies when it failed to report or investigate the incident, and – even worse – generated inconsistent, false, and misleading accounts of it. Unless the facility honestly investigates and identifies the root cause of the deficiency, it has little hope of meaningful correction. Here, staff had supposedly attended in-service training, and were able to articulate the appropriate response to a resident's choking. Yet, when called upon to apply that training, something went seriously wrong. In its efforts to hide the deficiency, the facility lost the opportunity to identify and resolve the problem. This response leaves the residents at risk of serious harm.

Further, the survey and certification process is in place to protect the health and safety of facility residents. The integrity of that process relies on facilities' providing to the State Agency and CMS reliable information. When a facility provides false information, it undermines the entire process, again putting residents at risk.

The deficiencies cited with respect to the facility's exposing its residents to excessive heat and humidity provide a second, independent basis for finding immediate jeopardy. Petitioner seems to be under the misapprehension that the immediate jeopardy standard requires findings of actual harm that rises to the level of a medical emergency. Dr. Hodder, for example, discusses temperature levels that lead to "serious injury to the brain and organs" (about 105° in an otherwise healthy person – or less than 2 degrees higher than R5's temperature). But this is not the level of harm necessary to establish immediate jeopardy.

People live in nursing facilities because of illness or other debilitating condition, and excessive heat and humidity necessarily present the potential for negative outcomes, which is why the facility must increase its vigilance during periods of excessive heat and humidity. Tr. 211. Exacerbation of those existing conditions can constitute serious harm. In testimony that was not inconsistent with anything Dr. Hodder said, Dr. Young

explained that, by the time temperatures reach around 90°F, the body is no longer able to offload heat by means of radiation. The only chance it has to dissipate excessive heat is by evaporation, but if an individual has problems sweating, which can be caused by a myriad of drugs (e.g. antipsychotics, anticholinergics, antihistamines, some antihypertensives, diuretics), the risk of heat-related injury increases. Tr. 148. When body temperature reaches 105°F or so, there is an immediate chance of end organ damage. But temperatures of 101°F can also present the risk of serious injury depending on its duration and the individual's co-morbidities, such as COPD and cardiac disease. Tr. 150.

Here, vulnerable residents, a prolonged period of heat and humidity, combined with the facility's failure to monitor vital signs and its failure to ensure that the residents were well-hydrated, (which both Drs. Hodder and Young cited as absolutely necessary) created a likelihood of serious harm. I therefore do not find "clearly erroneous" CMS's determination that the facility's deficiencies posed immediate jeopardy to resident health and safety.

D. I find reasonable the $10,000 per day CMP for the 8 days of immediate jeopardy.

Having found a basis for imposing a CMP, I now consider whether the amount imposed is reasonable, applying the factors listed in 42 C.F.R. § 488.438(f): 1) the facility's history of noncompliance; 2) the facility's financial condition; 3) factors specified in 42 C.F.R. § 488.404; and 4) the facility's degree of culpability, which includes neglect, indifference, or disregard for resident care, comfort or safety. The absence of culpability is not a mitigating factor. 42 C.F.R. § 488.438(f). The factors in 42 C.F.R. § 488.404 include: 1) the scope and severity of the deficiency; 2) the relationship of the deficiency to other deficiencies resulting in noncompliance; and 3) the facility's prior history of noncompliance in general and specifically with reference to the cited deficiencies.

It is well-settled that, in reaching a decision on the reasonableness of the CMP, I may not look into CMS's internal decision-making processes. Instead, I consider whether the evidence presented on the record concerning the relevant regulatory factors supports a finding that the amount of the CMP is at a level reasonably related to an effort to produce corrective action by a provider with the kind of deficiencies found and in light of the other factors involved (financial condition, facility history, culpability). I am neither bound to defer to CMS's factual assertions, nor free to make a wholly independent choice of remedies without regard for CMS's discretion. *Barn Hill Care Center*, DAB No. 1848, at 21 (2002); *Community Nursing Home*, DAB No. 1807, at 22 *et seq*. (2002); *Emerald Oaks*, DAB No. 1800, at 9 (2001); *CarePlex of Silver Spring*, DAB No. 1683, at 8.

CMS has imposed a penalty of $10,000 per day, which is the maximum penalty ($3,050 – $10,000). 42 C.F.R. § 488.438(a)(1). I recognize that the maximum penalty should be reserved for the most egregious cases. This is one such case.

The facility's history of noncompliance is abysmal. The State Agency designated it a "special focus facility," which means that, based on it history of noncompliance, it had to be monitored more closely. Tr. 123; P. Ex. 6. In 2003, the facility's deficiencies posed immediate jeopardy. Residents were being abused, both physically and verbally. The facility did not investigate and did not respond to the behaviors, so the state found immediate jeopardy. Tr. 237, CMS Ex. 13. In 2004, the State Agency found substandard quality of care, citing the facility for inappropriate treatment in not responding to pressure ulcer issues, and inadequate staffing. The facility was not able to provide care and meet resident needs. Tr. 237.

In the meantime, the Attorney General for the State of New York was apparently conducting his own investigation of resident neglect. In December 2005, approximately eight facility employees (CNAs and LPNs) were criminally convicted of falsifying medical records and patient neglect. They claimed to have provided care that they had not provided. Tr. 237; CMS Exs. 12, 13; P. Ex. 89, at 2-4. The charges stemmed from conduct that occurred April-May 2005, immediately prior to the incidents cited here. Remarkably, although the State Agency was supposedly closely monitoring the facility throughout the period of the staff's wrongdoing, it imposed no remedies based on that criminal neglect. Tr. 238.

Petitioner has not argued that its financial condition affects its ability to pay the penalty.

With respect to the other factors, the scope and severity of Petitioner's deficiencies were at the highest levels and justify the most severe sanctions. The heat-related problems were cited at scope and severity level L – widespread immediate jeopardy. The circumstances surrounding R17's death were cited at scope and severity level J – an isolated instance of immediate jeopardy. And these were not the facilities only deficiencies. The facility was not in substantial compliance with seven other requirements, which included deficiencies cited at scope and severity levels E (pattern of noncompliance with potential for more than minimal harm), F (widespread noncompliance with the potential for more than minimal harm), and G (isolated instance of actual harm). CMS Ex. 63.

The facility's culpability also calls for the most severe sanction. Facility staff were guilty of widespread neglect, disregarding resident care, comfort and safety. I have discussed at length the safety issues. In addition, staff's conduct and arguments demonstrate disregard for resident comfort. Indeed, Petitioner continues to trivialize the residents' real suffering as "ordinary discomforts of life." P. Posthearing Br. at 54.

The facility is also culpable for failing to investigate the circumstances surrounding R17's death, for failing to report it to the State Agency, and for its attempts to mislead the State Agency, CMS, and this tribunal as to those events. To this day, DON Crosby declares that, if she had it to over again, she still would not report the incident. Tr. 434-435.

Finally, I find no merit to Petitioner's complaint as to the duration of the immediate jeopardy. The burden is on Petitioner to establish that it implemented an effective plan of correction. *See, Hermina Traeye Memorial Nursing Home*, DAB No. 1810 (2002). Petitioner has not established that its actions removed the immediate jeopardy any earlier than July 21, 2001. The facility's immediate jeopardy deficiencies were systemic, serious, and wide-spread, not amenable to a quick and easy fix. It's failure to report, investigate, and follow-up on the choking incident alone would justify the period of immediate jeopardy. In that regard, training alone did not ensure that the immediate jeopardy was removed. The facility should then follow-up with staff to verify that they understand and have implemented the practices taught.

Similarly, with respect to the neglect, quality of care, and administrative deficiencies surrounding the heat emergency, the problems were wide-spread. That the specific individuals were eventually removed to cooler locations resolved part of the problem, but ensuring that staff consistently monitored vital signs and attended to the hydration needs of all residents required more than the facility's declaration that it intended to do so. Particularly in light of staff's history of neglect, the facility should have been instituting safeguards guaranteeing that staff fulfilled their responsibilities.

IV. Conclusion

Facility staff delayed in providing critical assistance to a choking resident, and then neither investigated nor reported the incident. It provided false and misleading accounts of the incident to the State Agency. During a period of high heat and humidity, it did not provide its residents necessary and appropriate care. Its deficiencies put facility residents at significant risk of potentially serious injury, harm, impairment, or even death. I therefore conclude that, from July 13 through 20, 2005, the facility was not in substantial compliance with 42 C.F.R. §§ 483.13(c), 483.25, and 483.75. Its deficiencies posed immediate jeopardy to resident health and safety. I find reasonable the $10,000 per day CMP.

/s/
Carolyn Cozad Hughes
Administrative Law Judge