Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Life Care Center of Jefferson City
(CCN: 44-5275),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-08-345

Decision No. CR2115

Date: April 20, 2010

DECISION

Petitioner, Life Care Center of Jefferson City, challenges the decision of the Centers for Medicare and Medicaid Services (CMS) that it was not in substantial compliance with program participation requirements and CMS's imposition of remedies, including: a civil money penalty (CMP) totaling $1,410,000; a denial of payment for new admissions (DPNA) from January 30, 2008 through February 3, 2008, and loss of Petitioner's ability to operate a nurse aide training and competency evaluation program (NATCEP) for two years. For the reasons discussed below, I find that Petitioner was not out of substantial compliance with participation requirements during the relevant period and, thus, the record does not support CMS's determination to impose the stated remedies.

I. Background

On January 22, 2008, the Tennessee State Survey Agency (state agency) completed a complaint investigation at Petitioner's Jefferson City, Tennessee facility, which resulted in CMS notifying Petitioner by letter, dated January 28, 2008, that it had been found out of substantial compliance with participation requirements. As a result, CMS imposed remedies, including: a CMP of $10,000 per day effective September 17, 2007, which was to continue until immediate jeopardy was removed or Petitioner was terminated; a DPNA effective when notice requirements could be met; loss of NATCEP; and

discretionary termination on February 14, 2008, if the immediate jeopardy was not removed by that date. CMS Exhibit (CMS Ex.) 15; Petitioner Exhibit (P. Ex.) 2. On February 8, 2008, CMS notified Petitioner that it was back in substantial compliance with participation requirements as of February 4, 2008 and noted that the DPNA was in effect from January 30, 2008 through February 3, 2008. CMS Ex. 11; P. Ex. 3. It is uncontested that the amount of the CMP, as of that date, amounted to $1,410,000. P. Br. at 1, 45; CMS Br. at 4.

Petitioner requested a hearing by letter, dated March 11, 2008. The case was assigned to me for hearing and decision on March 20, 2008. I initially scheduled a hearing to commence December 9, 2008. I agreed to postpone that hearing pending a state administrative law judge (ALJ) decision in a parallel state proceeding, as the parties indicated a possibility existed that the case would settle following issuance of that decision.[1] On January 7, 2009, in the absence of settlement, I rescheduled the hearing. I held the hearing in Knoxville, Tennessee from June 16-18, 2009. A 409-page transcript of the hearing (Tr.) was prepared. Testifying for CMS was Beverly Cox, Registered Nurse (R.N.) (Surveyor Cox), a surveyor for the state agency. Testifying for Petitioner were: Karen Moceri, R.N., Petitioner's Assistant Director of Nursing (ADON Moceri); Brandy Klein, Licensed Practical Nurse (L.P.N.) (LPN Klein); Teresa Williams, R.N., Petitioner's Director of Nursing (DON Williams); Shirley Miller, L.P.N. (LPN Miller); Annette O'Brien, R.N., an expert witness in matters involving long term care nursing[2] (Ms. O'Brien); and Warren Stinson, D.D.S. (Dr. Stinson). I admitted CMS Exs. 1-39 and P. Exs. 1-43. CMS submitted a post-hearing brief (CMS Br.), and Petitioner submitted a post-hearing brief (P. Br.) and a post-hearing reply brief (P. Reply).

II. Issues

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

2. If Petitioner was out of substantial compliance with participation requirements, whether the remedies imposed are reasonable.

III. Applicable Law

The statutory and regulatory requirements for Medicare participation by a long-term care facility are found at sections 1819 (skilled nursing facility or SNF) and 1919 (nursing facility or NF) of the Social Security Act (Act), and at 42 C.F.R. Part 483. Section

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[1] I have not been provided with a copy of a decision from that proceeding.

[2] CMS did not object to the designation of Ms. O'Brien as an expert witness in long term care nursing. Tr. 337.

1819(h)(2) of the Act vests the Secretary of the Department of Health and Human Services (Secretary) with authority to impose enforcement remedies against a SNF for failure to comply substantially with federal participation requirements established by sections 1819(b), (c), and (d) of the Act (section 1919(h)(2) of the Act gives similar enforcement authority to the states). Included among these remedies are: termination of a noncompliant facility's participation in Medicare; imposition of a DPNA; CMPs; and appointment of temporary management. Act § 1819(h)(2)(B). The Secretary has delegated authority to CMS and the states to impose remedies against a long-term care facility that is not complying substantially with federal participation requirements. "*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 (emphasis in original). A deficiency is a violation of a participation requirement established by sections 1819(b), (c), and (d) of the Act, or the Secretary's regulations at 42 C.F.R. Part 483, Subpart B. Facilities that participate in Medicare may be surveyed on behalf of CMS by state survey agencies to determine whether the facilities are complying with federal participation requirements. 42 C.F.R. §§ 488.10-.28, 488.300-335.

The regulations specify the enforcement remedies that CMS may impose if a facility is not in substantial compliance with Medicare requirements, including imposition of CMPs. 42 C.F.R. § 488.406. CMS may impose a CMP for each day a facility is not in substantial compliance, or for each instance of noncompliance. The regulation provides that a CMP that is imposed against a facility on a per day basis will fall into one of two ranges of penalties. 42 C.F.R. §§ 488.408, 488.438. The upper range of a CMP, from $3,050 per day to $10,000 per day, is reserved for deficiencies that pose immediate jeopardy to a facility's residents and, in some circumstances, for repeated deficiencies. 42 C.F.R. §§ 488.438(a)(1)(i), (d)(2). "*Immediate jeopardy* means a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident." 42 C.F.R. § 488.301 (emphasis in original). The lower range of a CMP, from $50 per day to $3,000 per day, is reserved for deficiencies that do not constitute immediate jeopardy, but either cause actual harm to residents or cause no actual harm but have the potential for causing more than minimal harm. 42 C.F.R. § 488.438(a)(1)(ii). CMS is authorized to impose a per instance CMP (PICMP) from $1,000 to $10,000, whether or not immediate jeopardy is identified. 42 C.F.R. § 488.438(a)(2).

The Act and regulations make a hearing before an ALJ available to a long-term care facility against which CMS has determined to impose an enforcement remedy. Act § 1128(A)(c)(2); Act § 1866(h); 42 C.F.R. §§ 488.408(g), 498.3(b)(13). The hearing before an ALJ is a *de novo* proceeding. *Anesthesiologists Affiliated,* DAB CR65 (1990), *aff'd*, 941 F.2d 678 (8th Cir. 1991); *Emerald Oaks*, DAB No. 1800 at 11 (2001); *Beechwood Sanitarium*, DAB No. 1906 (2004); *Cal Turner Extended Care Pavilion*, DAB No. 2030 (2006); *Residence at Salem Woods*, DAB No. 2052 (2006). A facility has a right to appeal a "certification of noncompliance leading to an enforcement remedy."

See 42 C.F.R. § 488.408(g)(1); *see also* 42 C.F.R. §§ 488.330(e), 498.3. However, CMS's choice of remedies, or the factors CMS considered when choosing remedies, are not subject to review. 42 C.F.R. § 488.408(g)(2). A facility may only challenge the scope and severity level of noncompliance that CMS finds, if a successful challenge would affect the range of the CMP that CMS could impose or impact the facility's authority to conduct a NATCEP. 42 C.F.R. §§ 498.3(b)(14), 498.3(d)(10)(i). The CMS determination as to the level of noncompliance "must be upheld unless it is clearly erroneous" (42 C.F.R. § 498.60(c)(2)), including the finding of immediate jeopardy. *Woodstock Care Ctr. v. Thompson*, 363 F.3d 583 (6th Cir. 2003). The Departmental Appeals Board (Board) has long held that the net effect of the regulations is that a provider has no right to challenge the scope and severity level assigned to a noncompliance finding, except in the situation where that finding was the basis for an immediate jeopardy determination. *See, e.g., Ridge Terrace*, DAB No. 1750 (2000). ALJ review of a CMP is subject to 42 C.F.R. § 488.438(e).

The standard of proof or quantum of evidence required is a preponderance of the evidence. CMS has the burden of coming forward with evidence and making a prima facie showing of a basis for imposition of an enforcement remedy. Petitioner bears the burden of persuasion to show by a preponderance of the evidence that it was in substantial compliance with participation requirements or any affirmative defense. *See Hillman Rehab. Ctr.*, DAB No. 1611 (1997), *aff'd,* No. 98-3789, 1999 WL 34813783 (D.N.J. May 13, 1999); *Cross Creek Health Care Ctr.,* DAB No. 1665 (1998); *Emerald Oaks*, DAB No. 1800; *Batavia Nursing & Convalescent Ctr.,* DAB No. 1904 (2004), *aff'd, Batavia Nursing & Convalescent Ctr. v. Thompson*, 129 F. Appendix 181 (6th Cir. 2005); *Batavia Nursing & Convalescent Inn,* DAB No. 1911 (2004).

IV. Discussion

My conclusions of law are set forth in bold, followed by a statement of facts and my analysis.

1. Petitioner was in substantial compliance with participation requirements.

This case involves the care that Petitioner provided to a gravely ill resident, Resident 1, who died at Petitioner's facility on September 17, 2007. The state agency completed a complaint survey, along with Petitioner's annual survey, in October 2007, shortly after Resident 1's death. The state agency reviewed Resident 1's chart and a surveyor, or surveyors, talked to employees, after which it was determined that the complaint was unsubstantiated, and no deficiencies concerning Resident 1's care were cited. Tr. 239, 243. The state agency returned on January 22, 2008 to reexamine the case, after Resident 1's daughter lodged a complaint. Tr. 95-96. Following that second complaint survey,

which Surveyor Cox conducted,[3] Petitioner was found out of compliance with participation requirements, and the above-noted remedies were imposed.

The January 22, 2008 statement of deficiencies recites that Petitioner,

> [F]ailed to document and medicate for pain, assess the resident's vital signs, notify the physician of the resident's complaints of pain, and the resident's request for a transfer to the hospital, prevent neglect, and failed to thoroughly investigate an allegation of neglect placing resident (#1) in Immediate Jeopardy.

P. Ex. 1 at 1. The statement of deficiencies asserts that due to Petitioner's deficiencies, Petitioner was out of compliance with the following participation requirements at the level of immediate jeopardy[4]: 42 C.F.R. § 483.10(b)(11) (F Tag 157, SS-J); 42 C.F.R. § 483.13(c) (F Tag 224, SS-J); 42 C.F.R. § 483.13(c) (F Tag 226, SS-J); 42 C.F.R. § 483.20(k)(3)(i) (F Tag 281, SS-J); 42 C.F.R. § 483.25 (F Tag 309, SS-J); and 42 C.F.R. § 483.75 (F Tag 490, SS-J). In addition, the statement of deficiencies asserts that Petitioner was out of compliance with other requirements at a non-immediate jeopardy level: 42 C.F.R. § 483.10(b)(4) (F Tag 155, SS-D);[5] 42 C.F.R. §§ 483.20, 483.20(b) (F Tag 272, SS-D); 42 C.F.R. § 483.75(l)(1) (F Tag 514, SS-D). Below, I do not discuss the

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[3] It is unclear whether other surveyors participated in this survey. The only surveyor to testify and that CMS refers to, however, is Surveyor Cox.

[4] Scope and severity levels are used by CMS and a state when selecting remedies. The scope and severity level is designated by an alpha character, A through L, selected by CMS or the state agency from the scope and severity matrix published in section 7400E of the State Operations Manual (SOM). *See* 42 C.F.R. § 488.408. A scope and severity level of A, B, or C indicates a deficiency that presents no actual harm but has the potential for minimal harm. Facilities with deficiencies of a level no greater than C remain in substantial compliance. 42 C.F.R. § 488.301. A scope and severity level of D, E, or F indicates a deficiency that presents no actual harm but has the potential for more than minimal harm that does not amount to immediate jeopardy. A scope and severity level of G, H, or I indicates a deficiency that involves actual harm that does not amount to immediate jeopardy. Scope and severity levels J, K, and L are deficiencies that constitute immediate jeopardy to resident health or safety. The matrix, which is based on 42 C.F.R. § 488.408, specifies which remedies are required and optional at each level based upon the frequency of the deficiency, i.e., whether a deficiency is isolated, part of a pattern, or widespread. *Id.* The immediate jeopardy level deficiencies under review here were found to be at a level J, which indicates that they are isolated.

[5] This Tag includes a reference both to Resident 1 and to another resident, Resident 10. CMS presented no argument or evidence with regard to Resident 10, and I do not address Resident 10 in this decision. The Tag involves the "advance directives" citation under

(continued…)

lower level deficiencies (other than 42 C.F.R. §§ 483.20, 20(b) (F Tag 272), which CMS discusses with 42 C.F.R. § 483.20(k)(3)(i) (F Tag 281)). CMS did not submit any argument, or evidence, specifically regarding them and, other than the example of Resident 10 (see n.5), they relate solely to Petitioner's care of Resident 1. Instead, I discuss Resident 1's baseline condition, the events of the night in question upon which the deficiencies were based, and then specifically reference each of the regulatory citations cited as immediate jeopardy above, in finding that Petitioner was in compliance with participation requirements.

a. Resident 1's complicated medical history and its impact on her baseline condition during her stay at Petitioner's facility.

Resident 1's medical history included diverticular disease, atrial fibrillation, hypertension, reflux disease, anxiety, osteoarthritis, hyperlipidemia, chronic back pain, multiple knee surgeries, open cholecystectomy, and hysterectomy. P. Ex. 7 at 2. Resident 1 suffered a perforated duodenal ulcer in May 2007. P. Ex. 6, P. Ex. 7. A perforated ulcer is a life-threatening condition, and there is a high mortality rate associated with it. Tr. 348. Resident 1 had surgery in an attempt to repair the perforation, but the surgery was unsuccessful and complications developed. Tr. 109, 353-54; P. Ex. 6, P. Ex. 7; CMS Ex. 23 at 11. Over the course of the next few months, Resident 1 was transferred between two hospitals, St. Mary's Hospital and Select Specialty Hospital (a long term acute care hospital). P. Ex. 6, P. Ex. 7; Tr. 102. An August 2, 2007 entry from Resident 1's physical examination notes, compiled at Select Specialty Hospital, recites that "[t]he patient is reasonably stable, but she is very fatalistic, obviously quite depressed and may have a mixture of dementia and so-called hospital psychosis as well given the fact that she has been here for months now." CMS Ex. 23 at 13.

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[5] (…continued)

the regulation. CMS asserts that Resident 1's husband, not the resident herself, signed a Tennessee advance directive document known as a "Physician Orders for Scope of Treatment (POST)" that included a do not resuscitate provision. With regard to Resident 1, Surveyor Cox asserted that she cited a deficiency, because it made the person doing Resident 1's admission paperwork uncomfortable discussing advance directives with residents upon admission. In addition, she determined that Resident 1 was competent to sign the form for herself. Tr. 85; P. Ex. 5. But, the family and resident questionnaire completed upon Resident 1's admission notes that the resident was not physically able to complete the questionnaire, which included a question referencing whether the advanced directive had been signed. P. Ex. 4 at 1-2. And, the POST form itself provides that a surrogate may sign if the surrogate is aware of the patient's wishes. P. Ex. 5. I do not find this citation to constitute a deficiency.

Resident 1 was admitted to Petitioner's facility on August 31, 2007, with drains for waste removal and acid drainage, a gastric tube in her stomach that could be unclamped when necessary to relieve discomfort, and a jejunostomy tube to permit tube feeding. Tr. 103, 107-08, 110, 354; CMS Ex. 23 at 56. Her admission documentation noted that she was not physically able to complete the family and resident questionnaire and that the responsible party filling it out was her husband. It also noted that she had acute stomach pain that resolved with medication. P. Ex. 4 at 1-2.

Petitioner's staff assessed Resident 1 upon admission and during her residence at the facility. P. Exs. 8-15. The assessments note her history of unsuccessful surgeries and reflect that she was on a feeding tube. The minimum data set (MDS), which is a comprehensive assessment done upon admission and periodically throughout a resident's stay in a facility, notes that the resident had persistent anger, a sad, pained, worried facial expression, and had periods of crying and tearfulness, and had repetitive health complaints. Her mood was documented as not being easily altered. P. Ex. 8 at 5. A September 4, 2007 Resident Assessment Protocol (RAP) worksheet for behaviors notes that "[t]he resident was recently admitted to the facility. Since admission she has been easily upset/irritated, experiences anxious health concerns, insomnia, exhibits sad/pained affect at times, tearful episodes and resistant to care." P. Ex. 8 at 22. A September 4, 2007 RAP worksheet for cognitive loss and dementia notes that she is "alert/oriented, but has impaired short term memory." P. Ex. 8 at 19. A September 4, 2007 Mood State RAP notes "[s]ince admission she has been easily upset/irritated, experiences anxious health concerns, insomnia, exhibits sad/pained affect at times, tearful episodes and resistant to care." P. Ex. 8 at 30; Tr. 246-55.

The resident's history of persistent pain, nausea, and vomiting was addressed. Her MDS noted moderate pain. P. Ex. 8 at 7, 14. A pain assessment noted "internal stomach pain related to perforated ulcer" for which Lortab and Darvocet were prescribed. P. Ex. 10. An activities assessment noted that she was currently on comfort measures and a feeding tube and had "uncontrolled vomiting." P. Ex. 11. A physician's telephone order from September 4, 2007, noted that her "G-tube [was to] remain clamped – unclamp for nausea/vomiting," and the instruction was placed in the medication record. P. Ex. 19 at 3; P. Ex. 20 at 5; *see* CMS Ex. 23 at 63. A physician's telephone order from September 2, 2007, noted that she was to receive Phenergan intramuscularly every six hours as needed, and the order was placed in the medication record. P. Ex. 19 at 2; P. Ex. 20 at 9. Physician orders also note that she had an as needed (PRN) order for oxygen, which was never administered. CMS Ex. 23 at 20, 24, 71.

Resident 1's nurse's notes, from August 31, 2007 to September 16, 2007, reveal: complaints of pain or discomfort or taking pain medication; complaints of nausea and/or vomiting; and complaints of crying and anxiety. P. Ex. 20 at 1-2, 10; CMS Ex. 23 at 47-56. Nurse's medication notes, and the medication record between September 4 through September 16, indicate that Phenergan was given for nausea, and Lortab and Darvocet were given for pain. *Id.*

Nurse's notes and physician telephone orders indicate that on September 1, 2007, Resident 1 was sent to St. Mary's Hospital for evaluation. Physician's telephone orders note that Resident 1 was sent to the emergency room (ER) on September 1 to be evaluated. P. Ex. 19 at 1; CMS Ex. 23 at 41, 55. On September 3, 2007, she was sent to St. Mary's Hospital by LPN Miller because she was vomiting brown liquid, and Phenergan was not effective. Her husband was notified, and EMS was called. CMS Ex. 23 at 54. Nurse's notes prepared by ADON Moceri on September 4, 2007, state:

> Telephone Call to Brenda Gauzet @ Select Specialty . . . . Stated nausea/vomiting chronic problem for months. Prognosis for this resident is good. However will be continual issue [with nausea and vomiting].

CMS Ex. 23 at 53. ADON Moceri testified that she placed the call, because Resident 1's husband stated that he preferred that the resident not be sent to the hospital for nausea and vomiting because it was a chronic condition. He provided the names of the nurse at the transferring facility and the physician who had performed Resident 1's surgery to ADON Moceri, so that she could call them for confirmation of Resident 1's condition. The nurse at the transferring facility confirmed to ADON Moceri that Resident 1's condition was chronic. ADON Moceri understood by the nurse's use of the term "good" to describe Resident 1's prognosis that the resident was "stable" and that her condition was "as good as it gets," not that the resident would get better (a view also held by Surveyor Cox). Tr. 116-17; 199-203; *see* Tr. 105-10, 359-62, 375. ADON Moceri also spoke to the resident's surgeon, who told her that to deal with nausea and vomiting they were "to leave the tube clamped, the gastric tube clamped. And were she to become nauseated or start vomiting we were to unclamp the tube to relieve the pressure." Tr. 201-03. ADON Moceri noted in the Medication Administration Record (MAR) that Resident 1's husband had requested she not be sent to the hospital for just nausea and vomiting, because it was a chronic condition. In addition, she referred the nurses to the physician telephone order, which indicated the gastric tube was to remain clamped; however, the tube should be unclamped for nausea and vomiting and then flushed with water. Tr. 202-03; P. Ex. 19 at 3; *see* Tr. 293, 313. Ms. O'Brien testified that documenting such advice on the MAR represents a customary method of assuring that nursing staff is aware of it. Tr. 362; *see* Tr. 107-08, 115, 118-19.

On September 10, 2007, Resident 1 was sent to the hospital to have a stitch replaced in her gastric tube. CMS Ex. 23 at 50. Nurses who interacted with Resident 1 during her stay, ADON Moceri, LPN Klein, and LPN Miller, testified credibly and consistently with regard to Resident 1's baseline condition. ADON Moceri, who was familiar with the resident, testified that she was chronically ill, had chronic nausea and vomiting, some confusion, anxiety, and would often call out. She wanted people to stay with her and calm her down. She was basically bed bound. While she was aware of her surroundings, she was unrealistic in her expectations of getting better. Instead of using the call light, she would "holler" for help. She would speak in an anxious, consistently loud voice. Tr. 195-97, 209, 216-17.

LPN Klein, who cared for Resident 1 on the day shift, testified that Resident 1 was on her call light with a lot of complaints. She was very sick. She complained that her stomach and back hurt. She complained of nausea and vomiting daily. She would receive pain and nausea medication. And, if she was complaining of abdominal pain and nausea, they would unclamp her drainage tube to let the gastric fluid come out and then clamp it back. This would relieve the gas pressure. The clamping and unclamping was done multiple times per day. LPN Klein stated that when the resident was nauseous she would be highly anxious and push her call light more often than usual – even before the nurse left the door. Her anxiety level was high. She also got confused. She would think she was at home. She would ask for her husband to visit her when he could have left five minutes before. She did not appear to be aware of the seriousness of her condition. She would ask to go home and, five minutes later, she would "be saying she's sick and she needs to go to the hospital." It was typical of her to ask to go to the hospital or to say she was dying. Her tone of voice changed throughout the day. She would call out in a loud voice. She would scream, "[c]ome here. Come here." And, if she saw LPN Klein going down the hall, she would say in a loud voice, when upset, "[h]elp me, I'm sick." LPN Klein once grabbed Resident 1's hand, because Resident 1 kept saying "come here," when LPN Klein was right beside her to let Resident 1 know she was there. Tr. 220-24. LPN Klein testified that Resident 1 required a lot of attention and was very vocal. Tr. 225. LPN Klein gave her pain medications. Tr. 229. LPN Klein testified that Resident 1 was the loudest patient on her unit. Tr. 231.

LPN Miller testified that she took care of Resident 1 on the night shift. She described the resident as constantly nauseated and vomiting. Resident 1 complained about her stomach (that it hurt, mostly gas). She had trouble sleeping and was confused at times. By confused, LPN Miller means she would not always know that she was in a nursing home and would think she was at the hospital. She wanted a lot of attention and was more comfortable when someone was with her. She wanted LPN Miller to be with her. She had a drain tube and a feeding tube (with which LPN Miller testified that she had experience). Tr. 289-291.

LPN Miller testified that on the night of September 2 and 3, 2007,[6] Resident 1 started vomiting what looked like the substance that was in her drain tube. LPN Miller thought something was backing up. LPN Miller testified she believed that the vomiting in this instance was a change in Resident 1's condition necessitating a call to her physician. She then called Resident 1's physician[7] who told her to send the resident to St. Mary's Hospital in Knoxville, where Resident 1 had her surgery, because he felt they would know more about her condition. The following day ADON Moceri put a note in the

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[6] Night refers to two days, in that the night shift starts at 11:00 p.m. on one day and goes to 7:00 a.m. the next.

[7] LPN Miller did not call Resident 1's husband. Tr. 312.

medication record telling the nurses not to send Resident 1 to the hospital for nausea and vomiting, because that was to be expected (unless the nausea and vomiting was uncontrollable). The resident continued to complain about nausea, vomiting, and pain every night. LPN Miller would give her a Phenergan shot intramuscularly in the hip to treat the nausea and vomiting and unclamp her drain tube, which brought her more relief than anything else. LPN Miller was aware that Resident 1 had orders for the pain medication Lortab (also known as Hydrocodone) and Darvocet. As well as relieving nausea, Phenergan can make an individual sleepy. Tr. 291-95, 312-13. Although she testified that Resident 1 could have more than one pain medication at a time, LPN Miller's experience with Resident 1 was that burping her bag gave her more relief than pain medication. Tr. 302. The resident might not ask for pain medication every night, but she did ask for Phenergan. It was normal for her to be nauseous, vomiting, and experiencing pain as gas on her stomach, which was better alleviated by unclamping the gastric tube than by pain medication. Tr. 319.

Surveyor Cox testified at hearing that LPN Miller is entitled as a nurse to make a judgment as to the effectiveness of the interventions she takes to address a resident's pain. Tr. 137. Surveyor Cox also testified that any analysis of a resident's change of condition must take into account that resident's clinical baseline. Tr. 99-100.

b. The care that was provided to Resident 1 by Petitioner's staff during the night of September 16 – 17, 2007.

CMS's deficiency citations involve the care provided to Resident 1 by Petitioner's staff on the night of September 16-17, 2007. Surveyor Cox's testimony was that the citations were even more narrowly focused on the last few hours of Resident 1's life on September 17, 2007. Tr. 40-41, 120. Specifically, CMS asserts that beginning at 12:00 a.m. on September 17, 2007, Resident 1 was observed to be nauseous and vomiting. She was given a shot of Phenergan. An hour later, she was still vomiting and requested her husband be called and that she possibly be sent to the ER. The husband requested that she be observed to allow the Phenergan to work but requested that the facility call back if her condition did not improve. While Resident 1's vomiting subsided, she continued to complain of nausea for the next several hours. At 3:00 a.m., she was found in bed with no heartbeat. She was not breathing and was later pronounced dead. CMS Br. at 10; CMS Ex. 23 at 47, 49. Her death certificate lists her cause of death as failure to thrive due to, or as a consequence of, a perforated duodenal ulcer with sepsis. P. Ex. 22.

Nursing notes beginning at 12:00 a.m. on September 17, 2007, prepared by LPN Miller, relate that:

> 12A c/o nausea & vomiting. Gave Phenergan I.M. Resident laying in bed [with] head [up]. Will cont. to monitor.

> 1:00 A Resident still c/o vomiting & nausea. Wants me to call husband and maybe send to JMH ER. Talked to Gene, husband, says "let's give the phenergan a little longer and see if it helps." Asked me to call back if I need him or if she doesn't get to feeling better. Told him I would.
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> 1:30 AM Resident still c/o nausea. Not vomiting as much. Anxious, gave PRN med for anxiety and restlessness. Husband called back to see how she was. Told him she was still c/o nausea but not vomiting as much. Resident trying to go to sleep.
>
> 2:00 AM Resident not vomiting any more. Still shows anxiety, wants someone in room [with] her. Told her we would keep checking on her.
>
> 2:00 AM Assured her we would be here all night and that I was just down the hall. If she put her light on I could see it.
>
> 2:15 AM Warren Stinson DDS here visiting [with] Resident.
>
> 2:40 AM Resident still c/o nausea. No vomiting. Seems to be calmer. Asks for cold wash cloth for her head. Told her I would keep checking on her.
>
> 3:00 AM Resident found in bed [with] no heart beat and no respirations.

CMS Ex. 23 at 47, 49.

Earlier that evening, at 8:00 p.m., prior to LPN Miller's shift, Resident 1 had been given Hydrocodone for pain. It is not disputed that the resident could not receive more Hydrocodone for six hours. Tr. 131. It is also not disputed that Petitioner was visited by Warren K. Stinson, D.D.S., on the night in question. Dr. Stinson was in the facility to care for another resident.[8] Dr. Stinson knew Resident 1 socially and had visited her at least three times in the facility. Tr. 392-93. Dr. Stinson testified that he and his wife visited her that night for "at least 15 minutes." Tr. 394. Dr. Stinson testified that Resident 1 spoke to him and told him "[w]hy don't you hush?" when he was talking to her. *Id.* Dr. Stinson testified that she was not screaming, but she was nauseated and vomited. Tr. 395. Dr. Stinson did not hear her begging to go to the hospital. She asked for a "cold rag" for her head, and she received it. She told the staff "[t]hat's not cold enough. Make it colder." Staff wet the washcloth again. Dr. Stinson held the vomit pan for her. After she "got through throwing up," he stayed for a few more minutes and left. Dr. Stinson testified that Resident 1 told him her stomach hurt. He also testified that Resident 1 was asking for pain medication (Lortab, which is also known as

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[8] Dr. Stinson testified that he visits the facility late at night, stating, "I pay $8,000 a month in alimony, so I work day and night to pay all that." Tr. 394.

Hydrocodone), and LPN Miller told her she had received Hydrocodone and could not have more at that time. Dr. Stinson testified that he could not believe she had lived as long as she had. She had tubes with green drainage coming out of her. He understood the tubes could be opened up if she got sick. He testified, "I didn't know she was going to die 10 minutes later, no." Tr. 395-97, 398.

CMS bases the deficiencies in this case not on what is documented in the nursing notes, but on, what Surveyor Cox asserts, was not documented that night. Principally, CMS bases the deficiencies on the care LPN Miller provided to Resident 1, and the assertion that Resident 1 was screaming and begging to go to the hospital but was not sent out. Tr. 130, 140. Surveyor Cox based her opinions regarding Resident 1's condition and experiences that night almost entirely on her interviews of a Certified Nurse Assistant (CNA) caring for Resident 1 that night, Ashley Samples, and an LPN, Robin Campbell, who was not assigned to care for the resident and who it is not clear ever actually saw the resident. Tr. 122-23. Ms. Cox also based her opinion on the fact that a 911 call was made to emergency services that night by another resident. The interviews with CNA Samples and LPN Campbell took place several months after the incident in question, and the interview with CNA Samples was by telephone only. Petitioner has portrayed CNA Samples as a young, inexperienced CNA who was not competent to assess whether a resident was suffering a change in condition. She had never witnessed a resident die, and she quit Petitioner's employ the day after the incident in question for reasons that remain unclear.[9] Surveyor Cox does not dispute this, responding to a question regarding CNA Samples' credibility by asserting only that "any person, be them trained or not, would know enough to know if a resident is crying, screaming, and begging to go to the hospital." Tr. 125-28. LPN Campbell was not responsible for Resident 1's care, and Surveyor Cox does not know whether she actually observed Resident 1 on the night in question. Tr. 122-23. As neither CNA Samples nor LPN Campbell testified before me, I have no way to gauge the credibility of their statements to Surveyor Cox. Although hearsay is admissible in administrative hearings, I must weigh whether the hearsay is corroborated by other evidence in the record as a whole to determine the weight I should give it. *Gateway Nursing Ctr.*, DAB No. 2283 at 5-7 (2009). As discussed below, I give the hearsay statements of CNA Samples and LPN Campbell little or no weight.[10]

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[9] CMS's assertion that she quit because she was afraid of retribution from LPN Miller is not persuasive, as there is nothing in the record to suggest that an active investigation of the incident in question had been undertaken at the time CNA Samples quit.

[10] Petitioner offered the transcript of a state administrative hearing in this case as P. Ex. 36. CNA Samples testified at this hearing, as did other witnesses who testified before me. I do not rely on the state administrative hearing transcript. CMS did not cite to the state transcript to point out inconsistent statements, or otherwise discuss the transcript in its brief.

Surveyor Cox also relied on the fact that a review of a local emergency call log recorded a 911 call from another resident of Petitioner's facility at 11:34 p.m. on September 16, 2007. See surveyor notes at CMS Ex. 21 at 33. It is unclear why the other resident made the call. Petitioner offered to submit a tape of the call in evidence, to which CMS objected. As the tape was offered at hearing, long after the date for the parties to have exchanged exhibits, I sustained CMS's objection and did not admit the tape as an exhibit. Tr. 403. Thus, I do not know what the resident actually told the 911 operator. The fact that the call was made, however, does not indicate that the resident was not receiving care, or that her condition substantially changed. The call does not establish or bolster CMS's case.

CMS asserts, however, that the resident who made the telephone call to emergency services stated that Resident 1 had been screaming for a nurse (although, as noted, since I have not heard the tape, I have no ability to know exactly what the resident who made the call actually said). *See* Tr. 403. It is undisputed that the 911 operator subsequently contacted the facility and spoke with LPN Campbell. CMS references Surveyor Cox's testimony that LPN Campbell walked over to Resident 1's unit to investigate. Tr. at 58. Surveyor Cox testified that LPN Campbell told her Resident 1 was complaining of stomach pain, crying, and begging to go to the hospital. CMS Br. at 10, 13; Tr. 58. CMS references a written statement drafted by LPN Campbell on January 16, 2008, at Surveyor Cox's request, and written in the surveyor notes, in which LPN Campbell relates,

> I told Shirley 2 or 3 times that she needed to send the resident to the hospital. One time in particular was when Shirley came down to Unit 1 and said "She is getting on my [expletive deleted] nerves" and I told her well if nothing else send her out so you don't have to hear her. Shirley also waited until Karen Moceri came in that morning to chart on resident. I read the chart after the documentation had been put in that morning and it did not reflect what had truly happened . . . Shirley did not relate fully what was going on to the resident's husband or he would probably have sent her out. When Shirley documented that the resident was trying to get to sleep that was not true. She was crying and screaming the whole time I was down there. Shirley had not wrote down the times of anything because I asked her about it and she said she hadn't that she was waiting on Karen to come in that morning.

CMS Ex. 21 at 45. However, as noted above, LPN Campbell did not testify. LPN Campbell did not tell DON Williams any of this at the time. Tr. 279-80. I give LPN Campbell's written statement no weight. While she indicates she "told" LPN Miller to send the resident to the hospital, the evidence does not establish that she saw or treated the resident or was ever in the room with the resident. While she indicates that the charting done the next day on the resident's chart did not reflect what truly happened, she did not testify to what "truly" happened. Moreover, there is no evidence that at the time of the incident LPN Campbell related what "truly" happened to anyone at the facility. Tr. 279-80.

CMS asserts that the CNA assigned to Resident 1 on the night of her death, CNA Samples, stated in a telephone interview with Surveyor Cox that Resident 1 was on her call light for the whole night, complained of pain in her stomach, and was vomiting. CMS Ex. 21 at 30; CMS Br. at 10; Tr. 45. Surveyor Cox related that CNA Samples told her that the resident complained of trouble breathing, but the CNA could not get an oxygen saturation level. Her fingers were turning blue. LPN Miller told CNA Samples that Resident 1 could not have oxygen, because they could not obtain her oxygen saturation level. *Id.* CNA Samples stated she told LPN Miller that the resident wanted to go to the hospital and wanted her husband to be called. CNA Samples asked LPN Miller whether she should check Resident 1's vital signs, but was told it was unnecessary. *Id.* CNA Samples attempted to report her concerns to the DON and ADON but was rebuffed, because they were too busy to speak with her. CMS Br. at 10-11; CMS Ex. 21 at 30. CNA Samples left her job shortly after Resident 1's death. CMS Br. at 11; CMS Ex. 21 at 31. As noted above, CNA Samples did not testify, so I have no way to gauge the credibility of the statements she made by telephone to Surveyor Cox several months after the event in question. Although CNA Samples allegedly indicated to Surveyor Cox that she attempted to report her concerns to the DON and ADON, there is no evidence that if she was so concerned about what happened that night that she persisted in doing so. CMS asserts that LPN Miller, who was assigned to care for Resident 1 on the night of her death, called Resident 1's husband on September 17, 2007, and asked if he wanted the resident sent to the hospital. Resident 1's husband did not want her sent to the hospital, and he asked LPN Miller to wait and see if Phenergan relieved Resident 1's nausea. Resident 1 had been sent to the hospital the week before and the husband did not want her to be sent back for nausea and vomiting. CMS Ex. 21 at 36-37; CMS Br. at 11; Tr. 53. Surveyor Cox testified that LPN Miller told her it was not uncommon for the resident to be vomiting and nauseous and that if she had taken vital signs they would be in the nursing notes. *Id.* LPN Miller did not give the resident pain medication, despite her complaints of pain. LPN Miller admitted that DON Williams should be contacted regarding a request to go to the hospital. Resident 1's physician was not contacted regarding her complaints of pain, vomiting, and nausea, as well as a transfer request. *Id.* Surveyor Cox testified that nurse's notes from that night did not list any vital signs or documentation regarding vital signs. Tr. 57.

LPN Miller, the only individual who testified before me that actually had direct contact with the resident that night (other than Dr. Stinson), testified credibly and consistently on both direct and cross-examination. She testified consistently with the nurse's notes she prepared that night. LPN Miller testified that she worked the 11:00 p.m. to 7:00 a.m. shift five days a week while Resident 1 was at the facility and had 60 residents under her care the night of September 16-17, 2007. Tr. 289, 319. She testified that on the night in question she came on duty around 11:00 p.m. At about 11:30 p.m. or 12:00 a.m., the CNA came to tell her Resident 1 was vomiting. LPN Miller went to see her, and she

appeared "[a]bout the same as she was every day."[11] Tr. 295. She appeared mentally about the same as she was every day. LPN Miller asked the resident if she wanted a Phenergan shot and gave the shot to her. She gave the resident a cold rag to put on her head (because a cold rag makes a person feel better when vomiting). Phenergan can make a person sleepy, and the resident was having trouble sleeping. Resident 1 was not expressing different complaints of pain, or of pain in parts of her body, other than those that she usually complained about. She was not complaining of chest pain, did not have trouble breathing, and her fingers were not turning blue. Her hands were cold, but that was not unusual. When the resident complained of discomfort in her stomach, LPN Miller unclamped her drain tube a couple of times, burping the bag once to let the gas out of the bag. This gave the resident some relief. Tr. 294-98, 313, 319.

LPN Miller testified that Resident 1 asked her to call her husband and see if maybe he would send her to the hospital. LPN Miller had been told not to send the resident out for nausea and vomiting. The resident was not begging to go to the hospital or screaming in pain. LPN Miller called the husband about Resident 1's request to go to the hospital, and Resident 1's husband asked LPN Miller to give the Phenergan time to work. LPN Miller testified that seemed like a reasonable suggestion. The Phenergan did seem to work. The resident calmed down. She was resting and trying to go to sleep. The husband later called back and LPN Miller told him that she was still complaining of nausea, but was not throwing up like she had been and was resting better. The husband seemed satisfied. LPN Miller testified that in her opinion the resident "was doing a whole lot better." Tr. 298-99; *see* Tr. 281-82.

LPN Miller testified that LPN Campbell came to her unit to report that a resident across the hall had called 911. LPN Campbell relayed to her that apparently the resident heard someone hollering for help, and no one was answering her. LPN Miller testified that she was coming out of Resident 1's room when LPN Campbell arrived. LPN Campbell let LPN Miller know that the call had been made and that LPN Miller needed to call "dispatch back." LPN Campbell did not express alarm or concern over the resident's condition, and LPN Miller does not recall LPN Campbell going into the resident's room. The resident was not screaming at the time. The resident was saying "help," but that was

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[11] During cross-examination, CMS counsel asked LPN Miller whether it was "not a big deal that [Resident 1] was complaining of nausea, vomiting, and pain." Tr. 319. In its brief, CMS counsel asserted that LPN Miller thought the resident's complaints were "no big deal" and inferred as a result of that phrase that LPN Miller grossly failed in her care and allowed Resident 1 to needlessly suffer in severe pain during her last hours of life. CMS Br. at 18. The terminology of "no big deal" was CMS counsel's, and the question, in context, refers more to LPN Miller's testimony that it was normal for the resident to be nauseous, vomiting, and experiencing pain "as the gas on her stomach" than it does to whether or not LPN Miller was callous towards Resident 1's complaints on the night in question. Tr. 319.

normal for her, as was testified to also by LPN Klein. LPN Miller returned the 911 call to tell them that she was in the resident's room at the time the other resident placed the call. LPN Miller let the resident who placed the call (who could not see into Resident 1's room as the door was shut) know that the resident was just upset, wanted someone with her, and LPN Miller was there. Tr. 224, 299-301, 315-18, 320.

LPN Miller testified that she spoke with Dr. Stinson in Resident 1's room. He was talking to Resident 1 about their past relationship. He did not express any concern or alarm to LPN Miller about the resident's condition or appearance. Tr. 301-02.

LPN Miller testified that Resident 1 did ask her for pain medication. LPN Miller checked the MAR and saw it was not time for that pain medicine. While Resident 1 could have had two medications, she had the stronger one, and it was not helping. LPN Miller stated she could have had more than one medication at a time. However, it was LPN Miller's experience that burping the resident's bag brought her more relief than the pain medicine. And, she had already had pain medication, and it was not really helping. So LPN Miller burped the bag, which appeared to help, and gave Resident 1 Phenergan, which appeared to also help. LPN Miller did this, because it was "something we done just about every night." Tr. 302-03. LPN Miller testified that at no point during the night did she feel the resident should be sent to the hospital. LPN Campbell told her to send the resident to the hospital, "[b]ecause she was on her light so much that night keeping us busy in her room all night. She said it would be easier just to send her out and get rid of her." LPN Miller said she could not do that, since they are not supposed to do that. Tr. 303.

LPN Miller testified that CNA Samples had not been a CNA very long and had never had "anybody pass away while she was working." CNA Samples did not tell LPN Miller that she saw symptoms she considered to be new, unusual, or very serious. Tr. 304

LPN Miller testified that they tried to take the resident's oxygen saturation level, but Resident 1 did not keep her hands still long enough for them to get it. For the monitor to register, an individual must keep his or her hands still so the device can be clamped on the individual's finger. LPN Miller testified that she was only trying to measure the Resident 1's oxygen saturation level to calm her down, as the resident was not exhibiting symptoms of a lack of oxygen. LPN Miller was just doing different things to show the resident she was there. Tr. 304-05.

LPN Miller charted the events of the night in question at the end of her shift. Tr. 324. She did not chart that vital signs were checked. She noted that she gave the resident Phenergan, and she also gave the resident something for anxiety. *Id.*

LPN Miller testified that she let ADON Moceri know that the resident had passed away and that there had been a 911 call. LPN Miller does not recall telling her the resident had requested to go to the hospital. LPN Miller did not mention that the resident was expressing some pain, because LPN Miller did not consider it a change of condition.

LPN Miller testified that the nursing administrators reviewed Resident 1's chart and found nothing unusual. She was not threatened with disciplinary action;[12] and there was no reason for her to make any threats against CNA Samples. LPN Miller testified that she did not have a good reputation with the CNAs, because she wanted them to do their jobs and some were "kind of lazy." Tr. 306-07. LPN Miller testified she quit after her suspension after the January Survey, because she was upset, needed to make a living, and the suspension was without pay. Tr. 307-09, 325.

c. Petitioner was in substantial compliance with 42 C.F.R. § 483.10(b)(11) (F Tag 157).

The regulation at 42 C.F.R. § 483.10 governs resident rights. Subsection 483.10(b)(11)(B) requires that a facility must: immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative, or an interested family member, when there is significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications). As the Board noted:

> . . . the regulation does not limit the term "significant change in . . . status: to mean only a "life threatening condition," nor does it equate the term "significant change" with "medical emergency." . . . Rather the regulation directs the facility to consult with the physician immediately not only where a resident's "significant change" is in a "life-threatening" condition, but also when the change involves non-emergency clinical complications such as the development of a stage II pressure sore, the onset of delirium, or a need to alter treatment significantly.

Laurels at Forest Glenn, DAB No. 2182 at 12 (2008). The Board also observed that the preamble introducing the final rule, as well as prior Board decisions, addressed the role of professional nursing judgment

> The regulatory history acknowledges that nursing judgment may be involved in evaluating what is significant for a particular resident, gives examples of "life threatening conditions" (heart attack and stroke), and supports a conclusion that the potential need for physician intervention in whether notice is required."

Id. at 13-14, *quoting Park Manor Nursing Home*, DAB No. 2005 at 29 (2005), *aff'd*, *Park Manor, Ltd. v. U.S. Dep't of Health & Human Servs.,* 495 F. 3d 433 (7th Cir. 2007); *see also Park Manor Nursing Home*, DAB No. 1926 (2004).

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[12] I note that LPN Miller received disciplinary warnings. The warnings do not impeach the credibility of her testimony, nor does testimony concerning action against her nursing license as a result of this incident. Tr. 322-23, 326; CMS Ex. 18.

CMS asserts that Petitioner had a policy that required nursing staff to notify a resident's physician and family member/legal representative when a resident had a significant change in physical, mental or emotional status. CMS Ex. 34 at 1-2. The policy also recorded that all changes in a resident's medical condition needed to be properly reported in the resident's medical record. *Id.* at 2. CMS asserts that because LPN Miller did not recognize Resident 1's pain complaints, ongoing nausea, and vomiting as a change in condition, she did not contact the resident's physician (although she did contact the resident's husband). Further, CMS asserts that the nurse's notes contained no information related to the significant condition change on the night of September 17, 2007, other than about the resident's death. CMS Br. at 19-20.

I find that Petitioner did not suffer a change in her baseline condition such that her physician was required to be notified. CMS asserts that what constituted Resident 1's change in condition were her complaints of pain, ongoing nausea and vomiting. However, these were the exact complaints that the nurses, who actually knew and treated Resident 1, asserted occurred daily, while testifying before me. ADON Moceri testified that the resident had chronic nausea and vomiting and wanted people to calm her down. According to LPN Klein, Resident 1 would "holler" for help. LPN Klein testified that Resident 1's stomach and back hurt and, she complained of nausea and vomiting daily. She would call out in a loud voice. LPN Miller testified she was constantly nauseous and vomiting and said her stomach hurt. LPN Miller did contact the physician and sent the resident to the hospital, when she saw what she believed to be change in Resident 1's condition on the night of September 2-3. Specifically, she noticed the resident was vomiting brown liquid, and the Phenergan was not effective. After Resident 1 was sent back to the facility, the nurses were told the resident's condition was chronic, and the best way to deal with her chronic condition was to unclamp the gastric tube. Dr. Stinson did not describe a resident who was screaming or begging to go to the hospital. The weight of this testimony, balanced against the evidence submitted by CMS on this point (surveyor notes prepared by Surveyor Cox delineating her conversations with LPN Campbell and CNA Samples several months after the survey and the written statement of LPN Campbell), leads me to conclude that Resident 1's baseline condition was unchanged on the night of September 16-17, 2007.

d. Petitioner was in substantial compliance with 42 C.F.R. §§ 483.13(c) (F Tags 224 and 226).

42 C.F.R. § 483.13 governs resident behavior and facility practices. Further, 42 C.F.R. § 483.13(c) references staff treatment of residents. It states:

> The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.

Section 488.301 defines "neglect" to be the "failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness."

The statement of deficiencies asserts that Petitioner violated F Tag 224, because it failed to assess and control the resident's pain, assess the resident's vital signs, and honor the resident's request for a transfer to the hospital. CMS also alleges that Petitioner violated F Tag 226 by failing to thoroughly investigate an allegation of neglect. As a result, both violations placed Resident 1 in immediate jeopardy. P. Ex. 1 at 8, 17.

In its briefing, CMS argues specifically that Petitioner failed to recognize that the incidents preceding Resident 1's death might indicate possible resident neglect. By applying the facility's definition of neglect within its neglect abuse policy,[13] LPN Miller failed to acknowledge or address that Resident 1's repeated ongoing complaints of severe abdominal pain and nausea constituted a failure to ensure that Resident 1 did not suffer needless hours of physical and mental anguish prior to her death. In failing to recognize the incident was one of possible resident neglect, Petitioner failed to trigger and implement its neglect investigation policy. CMS Br. at 11-14.

While CMS admits that the incident was correctly reported to the DON and ADON the day after the incident, CMS maintains that several other requirements were not implemented: the nurse's notes did not have any information related to Resident 1's vital signs; no incident report was completed, and no witness statements provided to Surveyor Cox; and Resident 1's physician was not contacted. CMS Br. at 14. Surveyor Cox's testimony indicates that the DON was not notified of any of the incidents related to Resident 1's death until after her death. *See* Tr. 64-65. CMS asserts that the extent of DON Williams' investigation was a chart review performed by DON Williams and a corporate nurse consultant. Tr. 65. No witness statements were provided when Surveyor Cox requested them. Tr. 65, 69-72.

All of CMS's arguments presuppose that the care provided by LPN Miller constituted neglect. CMS did not establish, however, that Petitioner neglected Resident 1. The evidence establishes that LPN Miller was providing the required and appropriate care in providing nausea medication, anxiety medication, and releasing the clamp to Resident 1's gastric tube to provide pain relief. Ms. O'Brien,[14] the only expert in long term nursing

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[13] Petitioner's policy and procedure manual defines resident neglect as "[t]he failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness." CMS Ex. 29 at 1.

[14] Ms. O'Brien testified that she reviewed Resident 1's medical record at the facility, as well as Tennessee regulations. She researched perforated ulcers. She was also sent the facility's plans of correction and the transcript of the state hearing. Tr. 337-38. She was not provided witness statements prepared at the time of Surveyor Cox's survey. Tr. 379-

(continued…)

care offered by the parties, testified that LPN Miller's interventions and judgments that night met the nursing standard of care. Ms. O'Brien testified that LPN Miller's care of the resident was positive. She had control of the situation, was not panicked, and had other staff around her. Tr. 344-45, 370-71. Ms. O'Brien also testified with regard to whether vital signs should have been taken. Ms. O'Brien testified that night shift vital signs are usually taken in the morning, unless there is a change of condition, which Ms. O'Brien testified Resident 1 was not experiencing. Tr. 366-67. Although Surveyor Cox testified that Petitioner's policy was to check vital signs when a resident is complaining of pain, it does not require that they be documented. Tr. 153-54. DON Williams testified that vital signs are included when there is a change of condition. Tr. 267. While the DON conceded that LPN Miller's documentation had problems, nothing in the chart, or in her conversation with LPN Miller the morning Resident 1 passed away, alarmed her. The resident had a chronic condition, and it was not shocking that she had passed away. Tr. 258-60.

Further, Petitioner did not fail to investigate an incident of neglect. Following state review after the resident's death, no citation against the facility or deficiency was found. There was no allegation of neglect and nothing to further investigate. DON Williams and ADON Moceri did a routine chart review and spoke with the nurses on duty (with the exception of CNA Samples, who chose not come back to work). The nurses told Surveyor Cox that they saw nothing suspicious. Tr. 155, 158, 258-59.

e. Petitioner was in substantial compliance with 42 C.F.R. §§ 483.20, 483.20(b), and 483.20(k)(3)(i) (F Tags 272 and 281).

42 C.F.R. § 483.20 references resident assessments and requires a facility to conduct initially and periodically a comprehensive assessment of a resident's functional capacity. 42 C.F.R. § 483.20(b) references comprehensive assessments, and 42 C.F.R. § 483.20(k)(3)(i) references comprehensive care plans. Specifically, the services provided or arranged by the facility must meet professional standards of quality. The statement of deficiencies cited the deficiency at F Tag 272 at a scope and severity level of D and asserted that Petitioner failed to assess Resident 1's complaints of pain and vital signs. The statement of deficiencies at F Tag 281 cited a deficiency at a scope and severity of level J and asserted that Petitioner failed to document and medicate for complaints of pain, assess Resident 1's vital signs, and notify Resident 1's physician of the resident's pain and request for a transfer to the hospital. P. Ex. 1 at 21-27.

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[14] (…continued)

80. However, as noted above, I have given little or no weight to the statement of LPN Campbell, which CMS relies upon to make its case.

CMS asserts specifically that LPN Miller failed to meet a professional standard of care as to Resident 1 based upon her failure to address Resident 1's repeated complaints of abdominal pain and nausea on September 17, 2007. Further, CMS asserts that LPN Miller did not make any entries in Resident 1's nursing notes contemporaneously (instead, she filled them in at the end of her shift). CMS asserts that LPN Miller's LPN license was suspended as a result of her role in this incident, pending her completion of a refresher course. CMS Br. at 15-16. CMS asserts, without first establishing what the standard of care is, that LPN Miller's care fell below a professional standard of care, because she failed to properly assess Resident 1's complaints of pain and failed to provide pain control. According to CMS, her "haphazard" charting also exposed Resident 1 to substandard quality of care. CMS asserts that even with her colleagues urging her to transfer Resident 1 to the hospital, due to the resident's persistent pain complaints and cries for assistance, LPN Miller did "absolutely nothing to aid Resident 1." CMS Br. at 16.

I note initially that the deficiencies asserted by CMS do not appear to fall under F Tag 272 and that deficiency citation is only at a level D. Therefore, I do not address that section. With regard to F Tag 281, CMS appears to assert that Petitioner did not provide services that met professional standards of quality in the care that LPN Miller provided to Resident 1 on September 17, 2007.

The evidence does not support CMS's assertions, especially its assertion that LPN Miller did "absolutely nothing" to aid Resident 1. LPN Miller did address Resident 1's complaints of pain and nausea by unclamping the tube and giving the resident medications. That LPN Miller did not give pain medication at about 2:00 a.m., I accept as her nursing judgment. CMS does not assert a standard of care that an LPN's assessment must be in writing. CMS does not relate how the suspension of LPN Miller's license relates specifically to the facts of this case. I accept LPN Miller's explanation that she agreed to a suspended license and re-training, because she did not want to go to court to fight the suspension. Although CMS asserted that LPN Miller should have made nursing notes contemporaneous with Resident 1's care, as opposed to charting before or at the end of her shift, CMS does not cite to a standard of care to make its case. CMS Br. at 16. Nor does CMS explain what it means by how "haphazard" charting exposed Resident 1 to substandard quality of care and exactly what the "haphazard" charting in this case consisted of. *Id*. As previously noted, I give no weight to the hearsay statements and written note prepared by LPN Campbell - that she urged LPN Miller to transfer the resident to the hospital to aid the resident (as opposed to getting the resident out of the facility, because she was annoying to staff).

f. Petitioner was in substantial compliance with 42 C.F.R. § 483.25 (F Tag 309).

This regulation relates to a facility's quality of care, and provides that 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 comprehensive assessment and plan of care. The statement of deficiencies alleges that Petitioner failed to alleviate pain for Resident 1. P. Ex. 1 at 27-30.

CMS references its Guidance for Surveyors in asserting that three factors are to be evaluated when determining whether to cite a deficiency on the basis of pain control. These include that a caregiver: (1) recognize when the resident is experiencing pain and identify circumstances when pain can be anticipated; (2) evaluate the existing pain and the causes; and (3) manage or prevent pain, consistent with the comprehensive assessment and plan of care, current clinical standards of practice, and a resident's goals and preferences. CMS Br. at 16-17 (citing the SOM, Guidance to Surveyors at 191). CMS asserts that the SOM requires that effective pain recognition and management requires an ongoing facility-wide commitment to: resident comfort; identifying and addressing barriers to managing pain; and addressing any misconceptions that residents, families and staff may have about managing pain. CMS Br. at 17 (citing SOM at 193).

CMS asserts that Petitioner's pain management policy's stated goal was to "control comfort level by altering the perception of pain without producing confusion or sedation." CMS Ex. 33 at 8. Surveyor Cox testified that Resident 1 exhibited several of the behaviors and symptoms of pain noted in the pain management policy. CMS Br. at 18; Tr. 80. Surveyor Cox testified that LPN Cox failed to document whether Resident 1's pain was assessed and failed to provide Resident 1 with any pain medication, despite the fact that Resident 1 had physician orders for at least two pain medications. *Id.*

CMS notes that LPN Miller testified that it was normal for Resident 1 to complain of pain, and she often requested pain medication at night. Tr. 319. CMS asserts from this statement that LPN Miller minimized Resident 1's pain complaints on September 17, 2007, stating that it was not a "big deal" when the resident complained of stomach pain and asked to go to the hospital. CMS Br. at 18. CMS asserts that LPN Miller did not follow the pain management protocol, ignoring Resident 1's pain, and failed to assess it or make any additional attempts to alleviate the pain. CMS maintains that LPN Miller's gross failure to even acknowledge, or attempt to address, the resident's pain caused Resident 1 to needlessly suffer in severe pain during her last hours of life. *Id.*

As noted above, CMS counsel, not LPN Miller, introduced the use of the phrase "big deal." CMS's hyperbole aside, the evidence does not show that LPN Miller "minimized" the resident's pain. LPN Miller addressed the resident's complaints of pain, nausea, and vomiting, by unclamping the gastric tube and giving the resident Phenergan and an anti-anxiety medication. It is uncontested that the resident was provided pain medication at 8:00 p.m. and could not have more until at least 2:00 p.m. LPN Miller has credibly testified that Resident 1 had received the stronger pain killer and that it was not working. It was her testimony, based on her care of the resident, that the resident received more relief from unclamping the tube than from medication. I find LPN Miller to be credible

and accept that it was LPN Miller's nursing judgment whether and when to give more pain medication.

g. Petitioner was in substantial compliance with 42 C.F.R. § 483.75 (F Tag 490).

The regulation in question requires that a facility 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. The statement of deficiencies reflects that: Petitioner was not administered in a manner to ensure that Resident 1 was free from neglect; the resident's physician was notified of changes in the resident's condition; and the resident's request for a transfer was not honored. P. Ex. 1 at 30-31.

CMS does not address this Tag in its brief, although the Tag was found to be at a scope and severity level of J. *See* CMS Br. at 2. As I have otherwise found Petitioner to be in substantial compliance, I find Petitioner to be in substantial compliance with this F Tag as well.

2. No remedies are reasonable, because Petitioner was at all times in substantial compliance with participation requirements.

CMS has painted a lurid portrait of what happened to Resident 1 on the night of September 16-17, 2007. Specifically, CMS asserts that LPN Miller did nothing to aid Resident 1 and allowed the resident to "suffer in excruciating pain for several hours without any real assistance or relief . . .." CMS Br. at 23. Resident 1 was certainly a distressing case. The perforated ulcer she suffered, the unsuccessful surgeries, and the fact that she suffered from chronic nausea, vomiting, and pain are extremely unfortunate. In such circumstances, it is incumbent upon a facility to respond immediately and appropriately to changes in a resident's condition and to alleviate their pain. It is also incumbent upon state surveyors and CMS to robustly investigate complaints of neglect. The evidence of record in this case, however, does not show that the care provided by LPN Miller to this unfortunate woman was so deficient as to constitute immediate jeopardy under the deficiencies cited justifying a $1,410,000 CMP. CMS's case is based solely on questioning the clinical judgments that LPN Miller made on this one night. However, LPN Miller had been caring for this resident since she was admitted to Petitioner's facility. LPN Miller testified credibly with regard to the resident, her condition, and the care that the resident received. I am convinced by LPN Miller's credible testimony that the most effective response to Resident 1's complaints that night was to administer anti-nausea medicine and unclamp her gastric tube. Moreover, even if I had found a deficiency to exist, CMS has singularly failed to show how the care provided by this one LPN to this one resident over a three-hour period could in any way justify a CMP of almost one and a half million dollars.

IV. Conclusion

For the foregoing reasons, I find Petitioner was in substantial compliance with participation requirements at all relevant times and that imposition of any remedies is not supported by the record.

/s/
Alfonso J. Montaño
Administrative Law Judge