**Department of Health and Human Services**
**DEPARTMENTAL APPEALS BOARD**
**Appellate Division**

White Sulphur Springs Center
Docket No. A-13-45
Decision No. 2520
June 26, 2013

# FINAL DECISION ON REVIEW OF ADMINISTRATIVE LAW JUDGE DECISION

White Sulphur Springs Center (WSS, Petitioner), a West Virginia skilled nursing facility (SNF), appeals the February 14, 2013 decision of an Administrative Law Judge (ALJ), *White Sulphur Springs Center*, DAB CR2706 (2013) (ALJ Decision). The ALJ concluded that WSS was not in substantial compliance with the Medicare participation requirement at 42 C.F.R. § 483.25(h)(2) regarding prevention of accidents and sustained a per-instance civil money penalty (CMP) of $10,000.

For the reasons discussed below, we sustain the ALJ Decision.

## Legal Background

To participate in Medicare, a SNF must at all times be in "substantial compliance" with the requirements in 42 C.F.R. Part 483. The Secretary contracts with state survey agencies to conduct periodic onsite surveys to assess compliance with those requirements. Act §§ 1819(g), 1864(a); 42 C.F.R. Part 488, subpart E. Survey findings are reported in a Statement of Deficiencies (SOD). A "deficiency" is a "failure to meet a participation requirement specified in the Act or [42 C.F.R. Part 483]." 42 C.F.R. § 488.301. "Substantial compliance" is "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." *Id.* "Noncompliance" is "any deficiency that causes a facility to not be in substantial compliance." *Id*. "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." *Id*.

CMS may impose various remedies on a facility that is found not to comply substantially with the participation requirements, including a per-day CMP for the number of days that the facility is not in substantial compliance or a per-instance CMP for a single instance of noncompliance. 42 C.F.R. § 488.408(d), (e). For noncompliance determined to pose

immediate jeopardy, CMS may impose per-day CMPs in amounts ranging from $3,050-$10,000 per day. 42 C.F.R. § 488.438(a)(1)(i). For noncompliance at less than the immediate jeopardy level, CMS may impose per-day CMPs in amounts ranging from $50-3,000 per day. 42 C.F.R. § 488.438(a)(1)(ii). A per-instance CMP must be in the range of $1,000 to $10,000. 42 C.F.R. § 488.438(a)(2).

A facility is required to "develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment." 42 C.F.R. § 483.20(k)(1). The care plan must describe the "services that are to be furnished to attain or maintain the resident's highest practicable physical, mental and psychosocial well-being as required under § 483.25" and "[a]ny services that would otherwise be required under § 483.25 but are not provided due to the resident's exercise" of various rights, including "the right to refuse treatment." 42 C.F.R. § 483.20(k)(1)(i), (ii).

The quality of care regulations in 42 C.F.R. § 483.25 contain the overarching requirement that—

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

The Medicare participation requirement at issue here is part of 42 C.F.R. § 483.25(h), which provides:

> *Accidents*. The facility must ensure that-
>
> (1) The resident environment remains as free of accident hazards as is possible; and
>
> (2) Each resident receives adequate supervision and assistance devices to prevent accidents.

**Case Background**

CMS imposed the CMP based on the findings in the SOD regarding the care of one resident, R14, observed by a surveyor during the State survey agency's annual survey of WSS. The following facts are undisputed.

R14, a 68-year-old male, had resided in the facility since having a stroke at age 60.[1] ALJ Decision at 2. His diagnoses included Alzheimers disease, vascular dementia resulting from stroke, late effects of a cerebrovascular accident with left-sided hemiplegia, and severe dysphagia.[2] *Id.* R14 was identified as at high risk of choking or aspirating due to impaired swallowing function. *Id*. A quarterly minimum data set dated April 6, 2011 found that he required the extensive physical assistance of two or more persons for bed mobility and required the extensive physical assistance of one person with eating. *Id.*; CMS Ex. 1, at 11.

R14's April 2011 care plan identified as a "Focus" that "Resident has impaired swallowing due to dysphagia and is endentulous [*sic*] – Resident at risk for aspiration, chokes easily."[3] CMS Ex. 11, at 16.[4] Under "Goals" for this "Focus," the care plan states, "The resident will be free from signs and symptoms of possible aspiration thru next review" and gives a "Target Date" of 7/10/2011. *Id.* The care plan lists the following "Interventions" for this "Focus":

· Honor food preferences within meal plan.
· Provide diet as ordered (family aware of choking,waiver was signed).
· Provide thickened consistency liquids as ordered.
· Place resident in 90$^{o}$ upright position/out of bed when swallowing food or drink.
· Encourage resident to take small sips/bites.
· Observe for signs/symptoms of aspiration.
· Place call light within reach at all times.
· Supervise/cue/assist as needed with meals.

*Id*.

At about 8:30 a.m. on May 11, 2011, a nurse assistant brought R14's breakfast tray to his room, where he was in bed, and left the room. ALJ Decision at 9; CMS Ex. 1, at 10. About five minutes after serving R14 breakfast, the nurse assistant returned to R14's room after hearing him cough, saw that he had slipped down in his bed, and repositioned

[1] To protect the privacy of individuals mentioned in this decision, we use either the abbreviations in the SOD or their last initial.

[2] WSS identified "dysphagia" as a "swallowing disorder." RR at 3.

[3] "Edentulous" is commonly defined as "toothless." *See, e.g.*, http://www.merriam-webster.com/dictionary/edentulous.

[4] This version of the care plan specifies a revision date of 4/13/2011 in the "Focus" column. The record also includes otherwise identical care plans for this "Focus" with revision dates of 11/2/2010 and 1/20/2011 (P. Exs. 16, at 14 and 17, at 11), as well as care plans for this "Focus" with revision dates in 2008 that differ only with respect to the diet intervention (P. Exs. at 13, at 1; 14, at 11; and 15, at 14).

him with the help of a licensed practical nurse (LPN), LPN F. ALJ Decision at 9; CMS Exs. 1, at 10 and 7, at 1-2; P. Ex. 43, at 3. At about 9:15 a.m., a nurse surveyor, Surveyor W., was standing in the corridor outside of R14's room, looked into the room, and observed R14 in his bed slumped toward the right with his head, right arm, and right shoulder pressed against the siderail of his bed. ALJ Decision at 2-3; CMS Ex. 1, at 8-9. According to Surveyor W., once in the room, she observed an overbed table placed across R14's abdominal area with his breakfast tray on top. CMS Ex. 1, at 9. When she approached R14, he told her "I choked on my eggs," and she noticed that there were partially chewed eggs on the front of his shirt and on his chin. ALJ Decision at 3; CMS Ex. 1, at 9. R14 told Surveyor W. he did not know where his call light was, and she noticed that the call light was wedged between the air mattress and the side-rail of the bed. *Id*. She also observed that he was unable to position himself upright upon her cueing. *Id*.

On June 24, 2011, CMS advised WSS that it had determined that WSS was not in substantial compliance with Medicare participation requirements at the immediate jeopardy level and was imposing a $10,000 per-instance CMP. ALJ Decision at 1-2; CMS Ex. 2, at 2. WSS requested a hearing by an ALJ. After an in-person hearing, the ALJ issued a decision upholding the noncompliance determination and the per-instance CMP. WSS timely appealed to the Board.

**The ALJ Decision**

The ALJ Decision specifically identifies the following as findings of fact and conclusions of law (FFCLs):

a. R14 had impaired swallowing, breathing, cognition, and mobility.
b. Petitioner did not substantially comply with adequate supervision requirements because no one was in the room observing R14 while he ate and drank on May 11, 2011.
    1. A staff member was not present in the room to immediately intervene if he choked or aspirated.
    2. A staff member was not present in the room to ensure R14 practiced safe swallowing strategies.
c. Petitioner did not substantially comply with adequate supervision requirements on May 11, 2011 because it did not maintain R14 in a 90 degree upright position while he ate and drank alone, and it did not ensure he could reach his call light to request assistance.
d. Petitioner did not rebut, by a preponderance of the evidence, CMS's showing of an inadequate supervision deficiency.
e. The $10,000 per-instance CMP that CMS imposed is reasonable.

ALJ Decision at 4, 5, 7, 8, 10, 13.

In discussing FFCL a., the ALJ stated:

> Petitioner acknowledges that R14 was at risk when he ate and drank. In its post-hearing brief , Petitioner states: "Petitioner's witnesses testified that the Resident's attempts to eat or drink virtually any foods or beverages can cause him to aspirate foreign matter into his trachea, which can cause choking and a life-threatening condition known as aspiration pneumonia." [citations omitted] So clearly, if Petitioner did not [] take all reasonable steps to prevent R14 from choking or aspirating, it is undisputed that there was the potential for more than minimal harm to R14.

ALJ Decision at 5.

In FFCL b., the ALJ proceeded to find that WSS did not take all reasonable steps to prevent R14 from choking or aspirating because WSS did not provide the supervision required by R14's care plan. In discussing FFCL b.1., the ALJ noted that the care plan meeting summary dated April 27, 2011 states that R14 "continues to be [a] very high risk for aspiration" and that "He is to be supervised [with] eating/drinking."[5] ALJ Decision at 5, citing CMS Ex. 10, at 2.[6] The ALJ reasoned that this required staff to "observe" R14 while he ate and drank "in order to immediately assist him if he choked or aspirated." *Id*. at 5. The ALJ found that WSS failed to follow R14's care plan because WSS provided only what it described as "distant supervision" by staff outside of R14's room. On the morning in question, the ALJ found, the "distant supervision" was provided by a nurse who was administering medications to other residents whose rooms were in the same hallway as R14's room. *Id*. at 5-6.

In discussing FFCL b.2., the ALJ found that R14's care plan also provided that, to address R14's risk for aspiration and choking, "staff should supervise, cue, and assist R14 as needed with meals." ALJ Decision at 7. The ALJ stated that this intervention was supported by evidence showing "that the SLPs [speech language pathologists] who had worked with R14 confirmed that he required some cueing to implement safe swallowing strategies" such as "small bites," small sips," and "the chin tuck (positioning his head to limit aspiration)[.]" *Id*. The ALJ found that R14 "could not be effectively cued to implement safe swallowing strategies during oral intake if no one was present in his room while he ate and drank." *Id*. The ALJ also stated that "[i]t is unreasonable to expect staff

[5] The ALJ appears to have misread "with" as "while."

[6] The care plan meeting summary states: "Details are on care plan." CMS Ex. 10, at 2. As noted above, the care plan then in effect includes as an intervention "Supervise/cue/assist as needed with meals." CMS Ex. 11, at 16.

would be able to adequately supervise R14 for signs of aspiration, coughing or choking . . . while also having primary responsibility for medication passes for the other residents down the hall" or merely by "being within earshot of R14 . . . , especially in light of the evidence that R14 could choke or aspirate silently." *Id*. at 8.

In discussing FFCL c., the ALJ found that "R14's care plan also required that he be in a 90 degree upright position when he was swallowing food or drinking." ALJ Decision at 8. The ALJ noted that both SLP D. and LPN F. testified that R14 could slide down in bed and needed assistance for repositioning. *Id*. at 9. The ALJ found that WSS failed to implement this care plan intervention, as evidenced by the fact that Surveyor W. found R14 "slumped over" in bed with his breakfast tray on the overbed table. *Id*. at 9-10.

In his discussion of FFCL c., the ALJ further found that "R14's care plan also required staff to place a call light within his reach at all times." ALJ Decision at 10. The ALJ stated that if R14 was left alone in his room, he "should have at least been able to activate his call light for help if he started to choke or aspirate." *Id*. Based on Surveyor W.'s observation that R14 was not able to reach his call light on the morning of May 11, the ALJ found that WSS failed to follow this care plan intervention. *Id*.

**Analysis**

On appeal, WSS disputes all of the ALJ's FFCLs. Request for Review (RR) at 1. Below, we first discuss WSS's arguments relating to FFCLs a.-d. We then discuss WSS's arguments relating to FFCL e.

We review a disputed finding of fact to determine whether the finding is supported by substantial evidence on the record as a whole, and a disputed conclusion of law to determine whether it is erroneous. *Guidelines – Appellate Review of Decisions of Administrative Law Judges Affecting a Provider's Participation in the Medicare and Medicaid Programs*, http://www.hhs.gov/dab/divisions/appellate/guidelines/prov.html.

**I. The ALJ's conclusion that WSS did not comply substantially with section 483.25(h)(2) is supported by substantial evidence and is free of legal error.**

The Board has held that section 483.25(h)(2) requires that a facility take "all reasonable steps to ensure that a resident receives supervision and assistance devices that meet his or her assessed needs and mitigate foreseeable risks of harm from accidents." *Briarwood Nursing Ctr.*, DAB No. 2115, at 11 (2007), citing *Woodstock Care Ctr. v. Thompson*, 363 F.3d 583, 590 (6th Cir. 2003) (facility must take "all reasonable precautions against residents' accidents"); *Meridian Nursing Ctr*., DAB No. 2265, at 3 (2009), *aff'd, Fal-Meridian, Inc. v. U.S. Dep`t of Health & Human Servs.*, 604 F.3d 445 (7th Cir. 2010). The Board has also said that accident precautions contained in a resident's care plan represent a SNF's judgment about what measures are necessary to keep the resident safe

and that failure to implement such precautions supports a conclusion that the SNF did not meet its obligation under section 483.25(h)(2) to provide adequate supervision. *Cedar Lake Nursing Home*, DAB No. 2288, at 6 (2009), *aff'd, Cedar Lake Nursing Home v. U.S. Dep't of Health & Human Servs.*, 619 F.3d 453 (5th Cir. 2010). This derives from the overarching requirement of section 483.25 for the provision of care and services "in accordance with the comprehensive assessment and plan of care." *See Deltona Health Care*, DAB No. 2511, at 7-8 (2013).

Here, the ALJ concluded that WSS violated section 483.25(h)(2) because it did not implement interventions it adopted in R14's care plan to address the risk it had identified that R14 would choke on or aspirate his food or drink.

WSS disputes this conclusion, arguing principally that—

- the ALJ misread R14's care plan as requiring that facility staff be physically present while R14 ate or drank;
- the ALJ misread R14's care plan as requiring that R14 always be in a 90 degree upright position when he was eating or drinking;
- the ALJ should not have found a violation of section 483.25(h)(2) because R14 suffered no adverse outcome from his dysphagia while in the facility; and
- implementing the interventions in R14's care plan (as read by the ALJ) would have violated R14's right to refuse treatment.

Below, we discuss why we conclude that each of these arguments lacks merit.[7]

### A. The ALJ did not err in finding that WSS did not follow R14's care plan requirement for supervision because facility staff did not remain in R14's room while he was having breakfast on May 11, 2011.

WSS concedes that no facility staff remained in R14's room while R14 had breakfast on May 11, 2011. However, WSS argues that the ALJ erred in holding that the requirement for "supervision" in R14's care plan "means close one-to-one presence of a staff member *in the Resident's room* while he ate[.]" *Id*. at 19 (italics in original); *see also id*. at 20 (R14's "care plan did *not* require the physical presence of staff, or one-to-one supervision, while the Resident ate" (italics in original)).[8]

[7] Although we do not specifically discuss all of the evidence and arguments presented, we have fully considered all of WSS's exceptions to the ALJ's findings and conclusions and reviewed the entire record. We do not comment specifically on all of the many instances in which WSS cites witness testimony and other evidence which on its face does not support the proposition for which it is cited.

[8] Contrary to WSS's characterization, the ALJ did not hold that R14's care plan required "one-to-one" supervision, although it may be reasonable to assume that the staff to resident ratio would need to be "one-to-one" in order for facility staff to be present while R14 was eating or drinking in his room.

In its request for review, WSS initially seems to say that R14's care plan expressly calls for "distant supervision." *See* RR at 2. However, the April 26, 2011 care plan meeting summary uses the word "supervised" without the word "distant" or any other modifier, and the care plan itself uses the word "supervise" without the word "distant." CMS Exs. 10, at 2 and 11, at 16.

Absent language to support its position, WSS argues that the context in which the care plan was adopted shows that by "supervision," the care plan meant "distant supervision," which WSS claims to have provided. WSS points out that the term "distant supervision" was used in a speech therapy "Initial Evaluation" to describe the type of supervision recommended for R14 while eating and drinking. According to WSS, the "evidence makes clear that the care plan provision for 'supervision' was based on" that recommendation, which WSS states was made by SLP G. following an evaluation of R14 in January 2011.[9] RR at 20, citing CMS Ex. 34, at 4. The "Initial Evaluation" contains a section captioned "Recommendations" which includes the following:

> Supervision During Intake = Distant supervision (for safety and comp strats)
> Compensatory Strategies/Positions: chin tuck, small sips, alternate solid and liquids . . . .

CMS Ex. 4, at 4. SLP G. testified that by "distant supervision," she meant "just somebody, maybe, in hearing distance. Not necessarily sight. They would have observed, or hear him coughing . . . ." Tr. at 187. However, SLP G. never claimed that her recommendation was adopted in R14's care plan. *See, e.g., id.* at 187, 190. Indeed, such a claim would not be plausible since the specific interventions listed in the care plan to which the care plan meeting summary refers were in place long before SLP G. made her recommendation. *See* n.4 *infra*.

WSS also asserts that the care plan requirement for "supervision" meant "distant supervision" because R14 and his family refused to have facility staff watch him while he ate or drank and WSS took into account this refusal when care planning to address R14's risk of aspirating or choking while eating or drinking. RR at 3-4, 10-11, 14; Reply Br. at 2. WSS relies in part on the written direct testimony of R14's wife and of a certified nursing assistant (CNA), CNA T. RR at 14, citing P. Exs. 38 and 39. R14's wife, who held his medical power of attorney, testified that R14—

[9] WSS also disputes that, as stated in the ALJ Decision, another SLP, SLP D., told Surveyor W. that but for staffing issues, her recommendation for R14 would be "direct supervision" rather than "indirect supervision, i.e., by staff passing by in the hall." ALJ Decision at 6; Reply Br. at 19. We need not consider whether SLP D. made this statement or not since it is immaterial to the issue of what R14's care plan provided and whether WSS followed the care plan.

> especially does not like to be watched when he eats. Even before he got sick, he did not like to eat with other people, even his family. He will sometimes allow a family member in the room while he eats, but . . . [w]e have to look away while he chews and swallows. I know the state inspector made the nursing home put a nursing assistant in the room with him when he eats, but he really does not like it.

P. Ex. 38, at 2. CNA T., who was R14's stepdaughter, similarly testified that even before R14 got sick, "he just did not like anyone watching him eat" and that R14 told her after the survey that he "cannot stand" having someone in his room watching him eat. P. Ex. 39, at 2. WSS also relies on the testimony of two SLPs and a dietician that R14 "specifically told them that he did not want anyone to sit with him or watch him while he eats." RR at 14, citing P. Ex. 43, at 2, and Tr. at 181, 186, 283, 285, 295, 298, 391.

That R14 may have sometimes expressed dislike of having anyone watch him eat or sit with him while he was eating is not evidence that he (or his wife on his behalf) actually refused to accept the mealtime positioning, supervision, cueing and assistance interventions the facility care-planned for him. The care plan does not document such a refusal, and none of the other evidence WSS cites to show the alleged refusal is even remotely relevant.[10] Moreover, the record shows that R14, despite the alleged preference for eating unobserved, sometimes ate meals in the dining room, where there was "constant supervision" and he could be observed while eating. Tr. at 274-275 (testimony of WSS's Director of Dietary Services).

Thus, substantial evidence supports the ALJ's finding that the "distant supervision" WSS allegedly provided was not sufficient to meet the care plan requirement for supervision. Even if WSS had shown that it care-planned for "distant supervision," WSS has not explained how facility staff would know that this was what was meant by "supervision" in the absence of any indication on the face of the care plan itself. *Cf. Del Rosa Villa*, DAB No. 2458, at 10 (2012)(facility must "care plan" for the level of supervision it determines the resident requires and "communicate to the staff their role and responsibility to implement the care plan.").

Moreover, as the ALJ found, the interventions in R14's care plan itself are persuasive evidence that WSS planned for facility staff to be present in R14's room while he ate or drank. The ALJ found that several of these interventions could not be implemented unless facility staff were present in R14's room. In particular, staff needed to be present in order to "immediately assist [R14] if he choked or aspirated;" "effectively [cue R14] to

[10] WSS cites its Exhibit 43 (RR at 14), but this is the testimony of an LPN who did not mention any refusal. WSS also cites its Exhibit 23, at 4, as documenting an SLP's "concern regarding the Resident's insistence on eating by himself in his room[.]" RR at 13. However, the exhibit, a 2003 speech therapy discharge summary, reflects no such concern. In addition, WSS cites to CMS Exhibit 34, at 1, for its general assertion that R14 and his family refused to have facility staff watch him while he ate or drank (RR at 11), but that document , titled "Physician Determination of Capacity," includes no relevant information.

implement safe swallowing strategies during oral intake;" and "adequately supervise R14 for signs of aspiration, coughing or choking." ALJ Decision at 5, 7, 8. In addition, the ALJ reasonably inferred that staff needed to reposition R14 if he slid down while eating in bed in order to implement the care plan strategy that R14 eat and drink while in a 90 degree upright position. *Id*. at 9.

WSS does not point to any evidence that undercuts these findings. WSS asserts that facility staff providing "distant supervision" outside R14's room could immediately assist R14 if he choked or aspirated because they could hear him coughing. *See, e.g.*, RR at 19-20, 26 (citing testimony of LPN F.); Reply Br. at 8 n.4. However, the ALJ found, and WSS does not dispute, that WSS's "distant supervision" of R14 while he was having breakfast on May 11 "entailed a nurse nearby in the hallway monitoring R14 while she administered medications to other residents along the hallway." ALJ Decision at 7. WSS relies on LPN F.'s testimony that she was "right outside the doorway" of R14's room the entire time he was eating breakfast on May 11 while ignoring her subsequent admission that she went in and out of other residents' rooms to administer their medications. RR at 26, citing Tr. at 406. WSS does not explain how a nurse engaged in this task in other residents' rooms would be able to hear R14 coughing in his room. Although LPN F. testified that she was still "aware of what was going on" with R14, she did not state that she could hear R14 coughing from other residents' rooms. Tr. at 406. Indeed, although LPN F. was responsible for providing the "distant supervision" on the morning of May 11, it was the nurse assistant, not LPN F., who heard R14 coughing five minutes after she served him breakfast and went in his room to check on him. *See* P. Ex. 43, at 3; CMS Ex. 7, at 2. Moreover, the ALJ noted that SLP R. testified that "R14 could choke or aspirate quietly or silently[.]" ALJ Decision at 6. WSS claims that aspiration is distinguishable from choking and that "there was no way to prevent the Resident from aspirating virtually everything he ate and drank;" however, WSS does not dispute that R14 could choke quietly or silently, in which case staff outside his room would not know he needed assistance.[11] RR at 20, n.15; *see also id*. at 10 n.6, and Reply Br. at 8 n.4.

WSS also asserts that the survey supervisor "agreed that a staff person did *not* need to be physically present with the Resident at all times to implement the care plan provision for 'cueing,' and she agreed that he might not even need cueing at every meal." RR at 20 n.16 (italics in original), citing Tr. at 343, 349, 351. In fact, the survey supervisor testified that "<u>if</u> the resident would recall to" take small sips and bites after the person who delivered his food instructed him to do that, facility staff would not need to be at his bedside the entire time he was eating. Tr. at 351 (emphasis added). In effect, she

[11] If staff were present in R14's room, staff could helpR14 "clear his airway" by doing "the heimlich maneuver, or abdominal thrusts, or whatever the situation calls for[.]" Tr. at 420 (testimony of LPN F.).

testified that R14 would need cuing on such safe swallowing strategies at every meal unless he could remember them on his own. SLP D. clearly indicated that R14 was unable to do so, stating that "although R14 has shown that he knew what was required if asked, he needed cues to demonstrate and even to remember the [safe swallowing] strategies consistently." ALJ Decision at 7 (emphasis added), citing Tr. at 210.

WSS also indicates that R14 was discharged from speech therapy in January 2011 because he was not making progress in reaching goals for using safe swallowing strategies and questions how the ALJ could conclude that a CNA could effectively cue the resident regarding such strategies when the SLPs could not. RR at 20-21 n.17; *see also id.* at 17. However, the mere fact that R14's progress was not sufficient to warrant continued speech therapy does not mean it would be useless to cue him to use safe swallowing strategies. Indeed, although R14's care plan was revised after his discharge from speech therapy, it nevertheless included the interventions "Encourage to take small bites/sips," a safe swallowing strategy, and "Supervise/cue/assist as needed with meals." CMS Ex. 11, at 16. In addition, SLP D. testified that she educated the CNAs on safe swallowing strategies because staff would have to cue R14 to help him use the safe swallowing strategies she recommended when discharging him. Tr. at 213; *see also* CMS Ex. 10, at 29 (discharge summary stating "Therapist provides staff education for safe swallow strats. . . .").[12]

WSS also appears to suggest that R14 did not always need assistance to return to a sitting position after sliding down in his bed. RR at 12, citing LPN F.'s testimony at Tr. 408-412. However, LPN F. testified that if R14 slid down in his bed while eating, he "could get to the rail and pull himself over" but could not "pull himself up in the bed." Tr. at 410. This testimony supports rather than undercuts the ALJ's finding that R14 needed assistance in this respect. Moreover, LPN F. confirmed that R14 did not refuse to eat in a sitting position, stating that he "didn't mind that." Tr. at 420.

Accordingly, we find no error in the ALJ's conclusion that, in order to provide the level of "supervision" R14 needed and his care plan required, facility staff had to be present whenever R14 ate or drank, and that WSS, by its own admission, did not provide services in accordance with this care plan requirement.[13]

[12] WSS also argues that the ALJ confused "goals" with "requirements" and determined that WSS was out of compliance with section 483.25(h)(2) because R14 did not meet the goals in the discharge summary for R14's compliance with safe swallowing strategies or other interventions. *See, e.g.*, RR at 8, 18. However, it is WSS that is confused. The ALJ plainly relied on WSS's failure to implement the interventions in R14's care plan in determining that WSS was out of compliance with section 483.25(h)(2).

[13] Since WSS's own care plan required this type of supervision, WSS cannot reasonably claim that it lacked notice that it was not providing adequate supervision. *See, e.g.*¸ RR at 20, 29, 32, 34; Reply Br. at 4-5, 16.

**B. The ALJ did not err in finding that WSS did not follow the care plan requirement that R14 be in a 90 degree upright position when he was swallowing food or drink.**

FFCL 1.c. states in part that WSS "did not substantially comply with adequate supervision requirements on May 11, 2011 because it did not maintain R14 in a 90 degree upright position while he ate and drank alone[.]" ALJ Decision at 8. WSS argues that this conclusion is based on a misreading of R14's care plan as requiring that R14 "always be maintained in a 90 degree upright position while he ate." RR at 21. According to WSS, the context in which the care plan was developed shows that the facility did not intend to require its staff to ensure that R14 was always in a 90 degree upright position when he ate or drank and never slid down in his bed while eating or drinking. *Id*.

WSS mischaracterizes the ALJ's finding regarding what R14's care plan required with respect to proper positioning while eating and drinking. In his discussion of the FFCL, the ALJ noted SLP D.'s testimony that R14 could slip down in his bed "even after staff had set him up in a 90 degree upright position" and that "once R14 fell from the 90 degree position he needed assistance for repositioning in bed." ALJ Decision at 9, citing Tr. at 204-205. The ALJ also noted LPN F.'s testimony that "R14 would tend to slide down even when bolstered with pillows" and that "staff would need to upright him and place 'some pillows behind him' so he could eat." *Id*., citing P. Ex. 43, at 2 and Tr. at 411. The ALJ then stated that LPN F. "noted that these interventions would assist him in maintaining an upright position so he could eat." *Id*., citing Tr. at 411. It is apparent from this discussion that the ALJ read R14's care plan to require that facility staff reposition R14 to an upright position whenever he slid down in his bed while eating, not to mean that staff must ensure that R14 never slid down in his bed while eating.

The record supports the ALJ's conclusion that WSS failed to comply with this care plan requirement on May 11. WSS does not dispute the testimony of its own staff, cited by the ALJ, that R14 could slide down in his bed from a 90 degree upright position and could not pull himself back up in his bed. Since it was foreseeable that R14 might be unable to maintain a 90 degree upright position on his own, staff needed to be present to reposition him as soon as he slid down in bed in order to ensure that he would be in an upright position while eating and drinking. Yet, it is undisputed that no facility staff were in R14's room between the time the nurse assistant who served R14 breakfast returned to

his room after hearing him cough and repositioned him with the help of LPN F., and thetime Surveyor W. observed R14 slumped over in his bed, about 9:15 a.m., 45 minutes after he was served breakfast.[14] ALJ Decision at 2-3, 9.

Accordingly, we find no error in the ALJ's conclusion that WSS failed to follow R14's care plan with respect to proper positioning while eating and drinking because facility staff did not provide supervision adequate to maintain R14 in an upright position while he was having breakfast in bed on May 11, 2011.[15]

### C. The ALJ did not err in concluding that although R14 suffered no adverse consequences from his dysphagia while in the facility, WSS violated section 483.25(h)(2).

WSS argues that the "bottom line in this case should have been that Petitioner kept Resident #14 safe for some eight years – during some 10,000 meals and countless drinks and snacks—notwithstanding his severe dysphagia, combined with his consistent insistence on eating what, how, and where he wanted, and his refusal to accept most recommended interventions." RR at 35. WSS states, "It may be the case that no harm need actually occur to support a violation of Section 483.25(h)(2), but neither can such a violation be entirely speculative or hypothetical[.]" *Id*. According to WSS, the ALJ should not have concluded that WSS violated section 483.25(h)(2) since "Petitioner's care planning and intervention actually was completely effective to safeguard the Resident notwithstanding his choices." *Id*. at 35-36.

[14] WSS does not dispute the ALJ's finding that the nurse assistant served R14 breakfast "around 8:30 a.m." or that she returned to R14's room "about five minutes later" and repositioned him with the LPN's assistance. *See* ALJ Decision at 9. WSS does suggest that it was possible R14 was left alone for 25 minutes rather than as much as 40 minutes (8:35 a.m. to 9:15 a.m.) if the time on the progress note written by LPN F. regarding the repositioning, "08:50," refers to when the repositioning occurred rather than when she wrote the note. P. Ex. 32, at 2; RR at 26. In either event, however, the length of time R14 was left alone while he was having breakfast was significant.

[15] In the same FFCL, the ALJ also found that WSS did not comply substantially with section 483.25(h)(2) on May 11 because "it did not ensure [R14] could reach his call light to request assistance." ALJ Decision at 8; *see also id*. at 10. The ALJ based this finding on the surveyor's observation that the call light was wedged between the side-rail and mattress and that R14 did not know where it was. *Id*. at 10. WSS questions the significance of this observation "as a nurse was readily available, and . . . already had responded, at least twice, before the Surveyor's observation." Reply Br. at 18. However, that a nurse had provided assistance to R14 earlier that morning does not change the fact that R14 was unable to use his call light to request assistance between the time he was last seen by facility staff and the time he was observed by Surveyor W. In any event, the ALJ's other findings amply support his conclusion that WSS was not in substantial compliance.

Addressing WSS's similar argument below, the ALJ stated:

> As Petitioner asserts in its post-hearing brief, R14's treatment and care were without significant adverse consequences over that period of time [the eight years R14 had been a resident at the facility]. However, this good historical safety record for R14 cannot compensate for Petitioner's inadequate supervision of R14 on May 11, 2011, when facility staff failed to provide R14 with the interventions outlined in his care plan in order to keep him safe while eating.

ALJ Decision at 12.

We find no error in the ALJ's conclusion that WSS's "good historical safety record for R14" does not excuse WSS's failure to provide the supervision required by section 483.25(h)(2).[16] As a matter of law, all that was required to support a finding of noncompliance with section 483.25(h)(2) was a finding that WSS's violation of that section had the potential for causing more than minimal harm. *See* 42 C.F.R. § 488.301 (definitions of "deficiency," "substantial compliance," and "noncompliance"). It is undisputed that R14 was at high risk of aspirating or choking on his food, which could cause serious harm, including death. ALJ Decision at 5. Even if WSS reduced the risk of harm to some extent by implementing some care plan interventions such as a modified diet, WSS's failure to implement all the care plan interventions it had determined were necessary to keep R14 safe showed that it did not eliminate the potential for more than minimal harm.

WSS also complains that the ALJ's conclusion that it failed to comply substantially with section 483.25(h)(2) is "based on extrapolation from one single incident" and that "CMS has not alleged noncompliance on any other occasion[.]" RR at 36-37. However, no such "extrapolation" occurred here; nor was it necessary. CMS imposed the CMP pursuant to regulations expressly permitting it to impose a penalty "for an instance of noncompliance." 42 C.F.R. §§ 488.438(a)(2), 488.440(a)(2). Moreover, the Board has held that a "single incident" may be sufficient to establish that a facility failed to provide adequate supervision and assistance devices. *See, e.g., Golden Oaks Medical Care Facility*, DAB No. 2470, at 6 (2012). Thus, the ALJ's finding that R14 did not receive adequate supervision while he was eating breakfast in his room on May 11 provides a

[16] CMS appears to dispute the ALJ's finding that "R14's treatment and care were without significant adverse consequences" over the eight years R14 had been in the facility (ALJ Decision at 12). *See* CMS Br. at 31. CMS did not file a request for review of the ALJ Decision, however, so any such dispute is not properly before us. *See, e.g., John J. Kane Regional Center — Glen Hazel*, DAB No. 2068, at 20 (2007) **(**declining to consider CMS's objection to ALJ finding because CMS did not request review of the ALJ decision within the 60-day period specified in 42 C.F.R. § 498.82).

sufficient basis for concluding that WSS failed to comply substantially with section 483.25(h)(2). Furthermore, WSS does not specifically dispute the ALJ's finding, discussed later, that its leaving R14 alone to eat "was not a one-time occurrence" (ALJ Decision at 14).

Accordingly, we conclude that the ALJ did not err in concluding that, although R14 suffered no adverse consequences from his dysphagia while he was in the facility, WSS failed to comply substantially with section 483.25(h)(2).

### D. The ALJ did not err in concluding that WSS did not establish that implementing the care plan interventions would have violated R14's right to refuse treatment.

WSS takes the position that it provided adequate supervision to R14 in light of the regulations at 42 C.F.R. §§ 483.10(b)(4) and (8) providing that a resident has a right to refuse treatment. WSS maintains that the ALJ erred by holding "that the requirement to keep residents safe trumps any 'resident rights' requirement[.]"[17] RR at 5; *see also id.* at 6, 30-33. According to WSS, the ALJ agreed with CMS that section 483.25(h)(2) "allows CMS to enforce [a] Hobson's choice" between "forc[ing] unwanted interventions" upon R14 or "discharg[ing] him involuntarily if he refused them." *Id.* at 6.

WSS mischaracterizes the ALJ's analysis in arguing that the ALJ concluded that the requirements of section 483.25(h)(2) "trump" a resident's right to refuse treatment. Instead, the ALJ Decision states, for example, that a "facility is entrusted with balancing necessary care and services with a resident's right to refuse treatment." ALJ Decision at 11, citing *Van Duyn Home & Hosp.*, DAB No. 2368, at 7-8 (2011) (stating in part that CMS's State Operations Manual "explains facilities' obligations to make sure that any such refusal is informed, that the basis for the refusal is addressed, and that alternatives are offered"); *see also* 54 Fed. Reg. 5316, 5321 (Feb. 2, 1989). The ALJ Decision indicates that to strike such a balance, WSS was required to "specifically assess and plan for any refusal of R14 for the interventions outlined in his care plan goal that addressed his impaired swallowing and risk for aspiration and choking." ALJ Decision at 11.

Thus, the ALJ found, in order to honor R14's preference to eat in his room, WSS was required to "provide the necessary resources R14 needed to safely effectuate that resident choice," i.e., "the interventions then outlined in his care plan[.]" ALJ Decision at 11. The ALJ also found unpersuasive WSS's claim that facility staff "were respecting R14's

[17] WSS incorrectly asserts that the ALJ "did not even mention Section 483.10(b)[.]" RR at 5. The ALJ expressly cites section 483.10(b)(4) (which states in relevant part, "The resident has the right to refuse treatment") on page 4 of his decision.

wishes and rights when they allowed him to eat with distant supervision while he was in his bed[.]" ALJ Decision at 12. As already discussed, we agree with the ALJ that WSS did not show that R14 refused the care plan interventions that required staff to be present in the room with him while he ate in bed.

Moreover, the regulations require that a resident's care plan "must describe . . .[a]ny services that would otherwise be required under § 483.25 but are not provided due to the resident's exercise of rights . . . including the right to refuse treatment under § 483.10(b)(4)." 42 C.F.R. § 483.20(k)(1)(ii). Thus, as the ALJ found, WSS "cannot avoid this deficiency citation by claiming to have been honoring the resident and family's wishes without modifying his care plan." ALJ Decision at 12; *see also id*. at 11 (citing section 483.20(k)(1)(ii)).

## II. The ALJ's conclusion that the $10,000 per-instance CMP imposed by CMS is reasonable is supported by substantial evidence and free of legal error.

In deciding whether a CMS-imposed per-instance penalty amount (which may range from $1,000 to $10,000) is reasonable, an ALJ (or the Board) may consider only those factors specified in section 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. Section 488.483(e)(3), (f). Section 488.438(f) (4) states that culpability "includes, but is not limited to, neglect, indifference, or disregard for resident care, comfort or safety." Section 488.404(b) provides that CMS considers the following factors to determine the "seriousness of deficiencies":

> (1) Whether a facility's deficiencies constitute-
> (i) No actual harm with a potential for minimal harm;
> (ii) No actual harm with a potential for more than minimal harm, but not immediate jeopardy;
> (iii) Actual harm that is not immediate jeopardy; or
> (iv) Immediate jeopardy to resident health or safety.
> (2) Whether the deficiencies-
> (i) Are isolated;
> (ii) Constitute a pattern; or
> (iii) Are widespread.

The ALJ found that the "seriousness of the deficiency was high and had the potential of causing at least mini[mal] harm to R14." ALJ Decision at 13. The ALJ went on to note that WSS did not dispute that "R14's swallowing difficulties placed him at risk of choking, thus food could block his airway and if not promptly dislodged could result in death." *Id*., citing P. Reply at 1 and P. Br. at 5-6. The ALJ then found that WSS's "culpability here was high." *Id*. The ALJ explained the latter finding and his conclusion that the $10,000 per-instance CMP imposed by CMS is reasonable as follows:

> R14's record is replete with documentation that R14 needed to be directly supervised while eating. Not only did I find that Petitioner left R14 alone on May 11, 2011, but the evidence shows this was not a one-time occurrence. . . .
>
> Given the seriousness of the deficiency and the culpability of the facility, the CMP is reasonable. CMS imposed a penalty of a $10,000 per-instance CMP, which although at the higher range for a per-instance CMP ($1,000-$10,000), is modest considering what CMS might have imposed considering the evidence of continuing non-compliance and disregard for safety requirements in R14's care plan. 42 C.F.R. § 488.408(e)(1)(iv); *see Plum City Care Ctr*., DAB No. 2272, at 18-19 (2009) (observing that even a $10,000 per-instance CMP can be "a modest penalty when compared to what CMS might have imposed"). Further, the absence of a history of non-compliance is not a mitigating factor and not a basis to find a $10,000 per-instance CMP unreasonable. *Id*. at 19.

*Id*.[18]

WSS does not specifically dispute the ALJ's finding that the seriousness of the deficiency was high. Instead, WSS asks the Board to find clearly erroneous CMS's determination that WSS's noncompliance with section 483.25(h)(2) posed immediate jeopardy to R14. RR at 37-38.[19]

As the ALJ correctly concluded, however, the issue of whether CMS clearly erred in citing immediate jeopardy may not be reviewed on appeal where, as here, CMS imposes a per-instance CMP because CMS's determination regarding the level of noncompliance, i.e., its scope and severity, is appealable "only if a successful challenge on this issue would affect-(i) The range of civil money penalty amounts that CMS could collect. .. ; or (ii) A finding of substandard quality of care that results in the loss of approval for a SNF or NF [nursing facility] of its nurse aide training program [NATCEP]." ALJ Decision at 3; 42 C.F.R. § 498.3(b)(14). A per-instance CMP (as opposed to a per-day CMP) has only one range. *Compare* 42 C.F.R. § 488.438(a)(1) and (a)(2); *see, e.g. Buena Vista Care Ctr.*, DAB No. 2498, at 20 (2013). In addition, under section 483.151(b)(2)(iv) and (f)(1), the imposition of a CMP of $5,000 or more automatically results in the loss of NATCEP; thus, the fact that there was a finding of substandard quality of care in this case would not provide a basis for appealing the immediate jeopardy determination. Because CMS's determination regarding the level of noncompliance was not reviewable

[18] When CMS imposes a per-day CMP, the CMP amount may be as high as $10,000 per day for immediate jeopardy. *See* 42 C.F.R. § 488.408(e)(2)(ii).

[19] WSS also asserts that R14's risk of serious harm "was associated *entirely* with his underlying medical condition, and his refusal of safety interventions" and was not attributable to any failure by WSS to provide the supervision required by R14's care plan. RR at 37. However, WSS acknowledges that this is in effect an argument that there was no noncompliance, which is contrary to our conclusion.

as a matter of law, it was final, and the ALJ could properly consider the scope and severity reflected by that determination when assessing whether the CMP amount is reasonable. *See* 42 C.F.R. § 488.404(b) (incorporated by reference in § 488.438(f)).

With respect to the ALJ's finding that its culpability was high, WSS states:

> [T]he ALJ's apparent conclusion that Petitioner's care of the Resident violated Section 483.25(h)(2) during his entire eight year stay – and that such extended noncompliance made Petitioner especially "culpable" – goes way beyond CMS' allegations or any reasonable inference from the evidence, and Petitioner specifically requests that this extraordinary assertion be removed from the public record.

RR at 3 n.1; *see also* RR at 37 (stating "it turns the burdens of proceeding and proof . . . on their heads to suggest, as does the ALJ, that Petitioner may be sanctioned if it cannot persuade him that its staff adequately monitored the Resident on every single occasion he ate in bed over a period of more than seven years").

The ALJ did not need to find that WSS's noncompliance with section 483.25(h)(2) lasted for an extended period of time in order to find WSS highly culpable. The ALJ did infer from testimony by CNA T. and LPN F., long-time employees of WSS, that what happened on May 11 was not "an isolated incident." ALJ Decision at 7-8, citing Tr. at 407-408, 426-427, and P. Ex. 43, at 2; *see also* ALJ Decision at 14 ("this was not a one-time occurrence"). This is a reasonable inference. The ALJ also noted WSS's argument that "R14 historically received the same level of supervision as on May 11" and stated that this "increases its culpability by demonstrating an ongoing disregard for R14's safety." *Id*. at 12. WSS does not deny that, prior to May 11, facility staff left R14 alone in his room while he ate and drank. In light of the staff testimony and WSS's admissions to repeated failures to provide the supervision required by R14's care plan, the ALJ could reasonably find WSS highly culpable.

Accordingly, we conclude that the ALJ's conclusion that the $10,000 per-instance CMP imposed by CMS is supported by substantial evidence in the record and free from legal error.

**Conclusion**

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

/s/
Judith A. Ballard

/s/
Constance B. Tobias

/s/
Sheila Ann Hegy
Presiding Board Member