Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Life Care Center of Leominster
(CCN: 22-5038),

Petitioner

v.

Centers for Medicare and Medicaid Services.

Docket No. C-09-139

Decision No. CR2207

Date: August 10, 2010

DECISION

I find that Life Care Center of Leominster (Petitioner) failed to comply substantially with 42 C.F.R. § 483.25(h)(2) by failing to provide a cognitively-impaired, 89-year old resident (Resident #1) with adequate supervision to prevent the choking accident that occurred on August 11, 2008. I therefore sustain the Centers for Medicare and Medicaid Services' (CMS) imposition of a civil money penalty (CMP) of $300 for one day of non-compliance.

I. Background

Petitioner participates in the Medicare and Medicaid programs pursuant to sections 1819, 1919, and 1866 of the Social Security Act (Act) and by its implementing regulations at 42 C.F.R. Parts 483 and 488. Its right to a hearing in this case is governed by regulations at 42 C.F.R. Part 498.

On August 20, 2008, the Massachusetts Department of Public Health, Division of Health Care Quality (the state survey agency) conducted a complaint survey and found Petitioner was not in substantial compliance with Tag F323 – accidents and supervision under the

quality of care regulation at 42 C.F.R. § 483.25(h)(2). CMS Ex. 1. Based on the survey finding, CMS imposed a $300 CMP for one day of substantial noncompliance. October 30, 2008 Letter from CMS.

I was assigned this case for hearing and decision. I conducted a hearing on December 3, 2009, and the parties received a transcript (Tr.) of the proceeding. CMS offered, and I admitted CMS Exhibits (CMS Exs.) 1–11. Tr. at 8 and 30. Petitioner offered, and I admitted Petitioner Exhibits (P. Exs.) 1–29. Tr. at 9. The parties submitted posthearing briefs and reply briefs.

II. Applicable Law

The regulatory requirements for long-term care facilities that participate in the Medicare and Medicaid programs are set forth at 42 C.F.R. Part 483. Facility compliance with the participation requirements is determined through a survey and certification process. Sections 1819 and 1919 of the Act; 42 C.F.R. Parts 483, 488, and 498. This process is performed on behalf of the Secretary of the Department of Health and Human Services (HHS) and CMS by state survey agencies.

Under Part 488, CMS may impose a CMP against a facility that is not complying substantially with participation requirements. 42 C.F.R. §§ 488.406, 488.408, 488.430. The penalty may start accruing as early as the date that the facility was first out of compliance and runs until the date substantial compliance is achieved or the provider agreement is terminated.

"Deficiency" is defined as a facility's "failure to meet a participation requirement specified in the Act" or in 42 C.F.R. Part 483. 42 C.F.R. § 488.301. The term "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." *Id.* "Noncompliance" means "any deficiency that causes a facility to not be in substantial compliance." *Id.* "Immediate jeopardy" means "a situation in which the provider's noncompliance . . . has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident." *Id.*

The regulations specify that a CMP that is imposed against a facility on a per-day basis will fall into one of two broad ranges of penalties. 42 C.F.R. §§ 488.408, 488.438. The upper range of CMP, of from $3,050 per day to $10,000 per day, is reserved for deficiencies that constitute 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). The lower range of 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). There is only a single range of $1,000 to $10,000 for a per-instance CMP that applies whether or not immediate jeopardy is present. 42 C.F.R. §§ 488.408(d)(1)(iv), 488.438(a)(2).

The Act and regulations make a hearing before an administrative law judge (ALJ) available to a long-term care facility against which CMS has determined to impose a CMP. Act § 1128A(c)(2); 42 C.F.R. §§ 488.408(g), 498.3(b)(13). The hearing before an ALJ is a de novo proceeding. *Residence at Salem Woods*, DAB No. 2052 (2006); *Cal Turner Extended Care Pavilion*, DAB No. 2030 (2006); *Emerald Oaks*, DAB No. 1800, at 11 (2001); *Beechwood Sanitarium*, DAB No. 1906 (2004); *Anesthesiologists Affiliated, et. al*, DAB CR65 (1990), *aff'd*, 941 F.2d 678 (8th Cir. 1991). A facility has a right to appeal a "certification of noncompliance leading to an enforcement remedy." 42 C.F.R. § 488.408(g)(1); *see also* 42 C.F.R. §§ 488.330(e), 498.3. However, the 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 found if a successful challenge would affect the amount of the CMP that CMS could collect or impact the facility's nurse aide training program. 42 C.F.R. §§ 498.3(b)(14), (d)(10)(i). CMS's determination as to the level of noncompliance "must be upheld unless it is clearly erroneous." 42 C.F.R. § 498.60(c)(2). This includes CMS's findings of immediate jeopardy. *Woodstock Care Ctr.*, DAB No. 1726, at 9, 39 (2000), *aff'd*, *Woodstock Care Ctr v. U.S. Dept. of Health & Human Servs.*, 363 F.3d 583 (6th Cir. 2003). The Departmental Appeals Board (the 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.[1] *See*, *e.g*., *Ridge Terrace*, DAB No. 1834 (2002); *Koester Pavilion*, DAB No. 1750 (2000). ALJ review of a CMP is governed by 42 C.F.R. § 488.438(e).

III. Issue, Findings of Fact, and Conclusions of Law

A. Issue

The sole issue in this case is whether Petitioner failed to comply substantially with the requirements that the resident environment remain as free of accident hazards as is possible and that each resident receives adequate supervision and assistance devices to prevent accidents. 42 C.F.R. § 483.25(h)(2).

The only remedy imposed is a $300 per day CMP for one day of substantial noncompliance. Petitioner has not argued that the CMP imposed is unreasonable.

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[1] Such a challenge only applies where CMS has imposed a per-day CMP within the upper range. No such challenge is available if a per instance CMP is imposed.

B. Findings of Fact and Conclusions of Law

I make the following findings of fact and conclusions of law (Findings), set forth below as separate headings in bold and italics, to support my decision in this case.[2]

1. Petitioner was not in substantial compliance with the requirements of 42 C.F.R. § 483.25(h)(2).

This case involves a single deficiency. Specifically, CMS maintains that Petitioner violated section 483.25(h)(2) by failing to provide a cognitively-impaired, 89-year old resident, Resident #1, with adequate supervision to prevent the choking accident that resulted in Resident #1's death.

Resident #1 was admitted to the facility in April 2007, suffering from various medical and cognitive impairments, including swallowing disorders and dementia with delusions. P. Br. at 4; CMS Br. at 2. Resident #1 had difficulty chewing and swallowing, and he required a puréed diet with thin liquids. His care plans further provided that he be supervised at meals and monitored for signs and symptoms of choking or aspiration. CMS Exs. 1, 2, 4. Indeed, a few weeks before the subject incident, Resident #1 was re-assessed and again found to be at risk for choking and aspiration. The evaluation stated that Resident #1 was extremely impulsive during the meal with an increased rate of intake. Resident #1 took large bites of food and refused to open his mouth to be checked for pocketing of the food. As a result, the evaluation concluded that Resident #1 should remain on a puréed diet with thin liquids and with aspiration precautions taken. CMS Ex. 1; CMS Ex. 4.

There also is no dispute that Resident #1 was a food scavenger. CMS Ex. 11, at 8, 10; P. Ex. 16, at 4, 5. Staff was aware that Resident #1 would grab solid food within his reach from other people as he maneuvered his wheelchair through the facility. He would grab food from the food carts or from other residents/ trays, both in the dining room and in the hallways of the facility. CMS Ex. 1; CMS Ex. 11, at 8-10, 14; CMS Ex. 7 (The Health Alliance Hospital Report, dated August 11, 2008, stated "[t]he staff told [ER] nurse here by telephone later that the patient was known to take solid food from other people as he maneuvered with his wheelchair, though he was required to be on a puréed diet

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[2] I have reviewed the entire record, including all the exhibits and testimony. As I am not bound by the rules of evidence, I may admit evidence and determine later, upon a review of the record as a whole, what weight, if any, I should accord that evidence or testimony. To the extent that any contention, evidence, or testimony is not explicitly addressed or mentioned, it is not because I have not considered the contentions. Rather, it is because I find that the contentions were not supported by the weight of the evidence or by credible evidence or testimony.

himself."). Resident #1 was known to become agitated and impulsive when agitated. When this occurred, he was likely to scavenge food and to engage in other behaviors that were a danger to him and to others, as he self-propelled through the facility. Tr. at 112-13, 130, 137-38, 173.

No dispute exists that previous to the incident on August 11, 2008, there were two documented instances on June 3 and June 4, 2008 of Resident #1 scavenging food. P. Ex. 16, at 4-5; CMS Ex. 2, at 16; Tr. at 131-35. There also were increasing episodes of agitation. CMS Ex. 3, at 4-6. As a result, on June 24, 2008, Petitioner revised Resident #1's care plan to address his increased agitation and to protect him from these episodes. The care plan added a requirement for staff to "shadow resident as needed to prevent resident from encountering hazards as he self propels in w/c." [3] CMS Ex. 2, at 7; P. Ex. 12, at 5. Therefore, when Resident #1 became agitated, the nursing staff, which was supposedly aware of the various hazards to Resident #1 and others, was to keep him in their line of sight "until the agitation had gone" and until the staff knew he would not cause harm to himself or anybody else. Tr. at 150, 151, 180. Petitioner does not dispute this. P. Br. at 8.

On August 11, 2008, a short time before 5:30 p.m., Resident #1 and his wife were seated in wheelchairs in the lobby area, adjacent to the main dining room, waiting for dinner. P. Br. at 8; CMS Br. at 3; P. Ex. 26, CMS. Ex. 11, at 2; Tr. at 113. Resident #1 and his wife argued, and Resident #1 became agitated. P. Br. at 8; CMS Br. at 3. When the meal truck arrived at the dining room, CNA Peterson escorted the wife into the dining room. Because he was agitated, the CNA that was supervising Resident #1 and his wife stated in the Nurses Notes—

> Prior to dinner in the main dining room [Resident #1] was agitated. So to avoid anything further we aloud [sic] him to rome [sic].

Written statement of CNA S. Peterson, P. Ex. 27, at 3. She testified that usually when he would become agitated, the staff would "just let him go propel and do his own thing until he would calm down." Tr. at 178. Although no documentation exists of this, CNA Peterson claims that after she brought the wife into the dining room, she remained in the doorway of the dining room and lobby for a few minutes until Resident #1 started to

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[3] The revised care plan addressing Resident #1's Mood/Behavior identified his mood/behavior problems as "increased agitation, AEB, striking out at staff, yelling in corridor, striking railings as he self propels in his w/c, attempting to grab [illegible] at other residents." P. Ex. 12, at 5. CMS Counsel asked the Director of Nursing (DON) what AEB meant, but she did not know. Tr. 139, 140. I would expect a DON to be familiar with abbreviations and terms used in the Care Plans developed by her staff, since the DON is ultimately responsible for supervising and advising nursing staff in the facility. 42 C.F.R. § 483.30 and 483.30(b)(2).

propel toward the A wing.[4] Tr. at 184. Resident #1 then left the lobby around 5:30 p.m., self-propelling in his wheelchair. While Petitioner's brief claims that CNA Peterson stayed with Resident #1 until he calmed down, no direct evidence exists that this is true or that she watched for more than a minute. She returned to the dining room where she was occupied with serving the evening meal to the residents. CMS Ex. 11, at 9. It is also undisputed that Resident #1 was last seen propelling himself in his wheelchair down toward the A Wing and that his movements and activities for the next 10 to 15 minutes are unknown.

During this period, two or three food carts were in the A wing corridor and at least one of the carts had an open door within reach at wheelchair level. P. Exs. 25 and 26; CMS Ex. 1, at 6; CMS Ex. 3, at 13; Tr. at 54, 56, 85, 94, and 157. The next documented sighting of Resident #1 occurred between 5:40 and 5:45 p.m. when Henry Hotin, the facility's physical therapist, who had been doing paperwork at the A wing nurses' station, observed Resident #1 coming towards the nurses' station from the end of the A wing corridor furthest away from the front lobby and the dining room. CMS Ex. 1, at 4; CMS Ex. 6, at 2; CMS Ex. 11, at 2; Tr. at 53. Mr. Hotin observed that Resident #1 had a chicken sandwich in his hand. Mr. Hotin was unaware of Resident #1's diet restrictions, and, after nodding to the resident, he returned to his paperwork. CMS Ex. 6, at 2; Tr. at 191. Shortly thereafter, an unidentified staff member parked the resident in his wheelchair up against the wall across from the nurses' station. CMS Ex. 6, at 2; CMS Ex. 11, at 12; P. Ex. 26. Mr. Hotin stood up from where he was sitting, as he was getting tired. Tr. at 191. He then looked over and saw that Resident #1 looked distressed. Tr. at 191. He was not sure what was wrong and asked "[a]re you alright?" *Id.* When Resident #1 did not respond, Mr. Hotin realized Resident #1 was choking and called out to Nurse Durrett, an LPN who was behind the nurses' station. Tr. at 192; CMS Ex. 6. Mr. Hotin performed the Heimlich maneuver a couple of times with the resident in the wheelchair, while Nurse Durrett brought over the crash cart and tried to suction the food out of his

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[4] CNA Peterson mentioned during the hearing for the first time that she remained with Resident #1 for a few minutes in the lobby area, "until she realized he had calmed down" and then she went into the dining room. Tr. at 180-81. However, when Resident #1 propelled himself towards the A wing corridor, his back would have been facing CNA Peterson, and it would be difficult for her to assess whether he had calmed down. CMS Ex. 11, at 2; Tr. at 183. I do not find her testimony credible; first, she describes that she stayed with Resident #1 for a "few minutes" and then she later claims she remained with him for as long as five to seven minutes. *Id.* She also indicated that keeping an eye on Resident #1 did not require her to stop or leave her other duties. Tr. at 179. I am not sure how she could attend to her other duties and still observe the resident. She also testified that, if she knew Resident #1 was agitated, she would notify the other staff so they could keep an eye on him. Tr. at 179. But no indication exists that she notified anyone on the evening of August 11.

mouth and to perform first aid. *Id.* Nurse Durrett called a code blue and 911. While some food was removed, Resident #1 still had minimal breath sounds. CMS Ex. 6. The fire department responded within minutes, and Resident #1 was taken to the hospital where he was pronounced dead due to fatal cardiopulmonary arrest associated with solid food aspiration. CMS Ex. 7.

I find CMS's arguments to be persuasive and supported by the weight of the evidence. I am not persuaded by Petitioner's arguments and assertions that it adequately protected Resident #1. The applicable regulation has been the subject of much litigation.[5] It requires a facility to take all reasonable measures to protect its residents from accident hazards that are known or that are foreseeable. In determining whether the supervision the facility provided was adequate, I must first look at whether Petitioner provided supervision in accordance with the resident's assessment and plan of care. My inquiry need go no further. Petitioner recognized that Resident #1 was becoming increasingly agitated and aggressive and that his agitation coupled with his dementia caused impulsive behavior, which put him and others at risk. As a result, on June 24, 2008, Petitioner amended Resident #1's plan of care to respond to his agitation and to protect Resident #1 from the hazards resulting from this behavior. The care plan required that, when Resident #1 became agitated, staff give him wide birth in his personal space (noting specifically not to attempt to engage the resident by standing directly in from of him), but to **shadow** the resident to prevent him from encountering hazards. Petitioner clearly did not do that. The evidence establishes that Resident #1 became agitated, and, while CNA Peterson stayed with him for a few minutes, she returned to the dining room when he moved away from her in his wheelchair and he propelled down the corridor. Petitioner claims Resident #1was "apparently calmer" when he wheeled himself away, but there is no indication that she or anyone else performed any real assessment. Rather, she had another pressing concern—she was needed in the dining room to assist with the dinner hour—so she returned to the dining room. She did not shadow Resident #1; she did not

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[5] *See Koester Pavilion*, DAB No. 1750, at 24 (noting the regulation does not impose strict liability of unforeseeable mishaps, but requires a facility "to do everything in its power to prevent accidents"); *Windsor Health Care Ctr.*, DAB No. 1902, at 5 (2003) (holding a facility may "choose the methods it uses to prevent accidents, but the chosen methods must constitute an 'adequate' level of supervision under all the circumstances"); *Briarwood Nursing Ctr.*, DAB No. 2115, at 11 (2007) (finding the relevant inquiry is "whether the facility took 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"); and *Burton Health Care Ctr.*, DAB No. 2051, at 14 (2006) (stating that in determining whether the supervision a facility provides was adequate, the Board looks "first to whether the facility provided supervision in accordance with the resident's . . . plan of care," and a facility's failure to "provide the type of supervision that it had determined was required to meet the resident's needs" supports the finding of a deficiency under section 483.25(h)(2)).

make any other staff aware of his agitation or ask that any other staff shadow him down the hall. Her only statement immediately after the event was that Resident #1 "was agitated so to avoid anything further we aloud [sic] him to rome [sic]." CMS Ex. 3, at 14. There is no dispute that from the time he began to propel down the corridor until some 10 to 15 minutes later, when Henry Hotin looked up from his paperwork at the nurses' station, no one was supervising or shadowing this resident as his care plan required. There is also no dispute that during the time Resident #1 was left to roam the hallway unsupervised, the staff were busy as it was the dinner hour. P. Ex. 26. Giving Resident #1 wide berth does not mean to not provide supervision. Petitioner knew this. Tr. at 152-56. An intervention established to protect a resident from potential harm is useless, unless it is implemented. That failure is precisely what occurred here. No one monitored Resident #1 even from a reasonable distance. If a staff member had shadowed him, that staff member would have seen him reach for and grab a sandwich from the food cart and could have taken the sandwich from him. Given the previous incidents with this resident and food, which prompted the new intervention in his care plan, a choking accident was indeed foreseeable.

IV. Conclusion

Based on my review of all of the evidence and testimony in this case, I sustain CMS's finding of noncompliance and its imposition of a CMP of $300 for one day of substantial noncompliance.

/s/

Alfonso J. Montaño
Administrative Law Judge