Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

In the Case of:	)	
	)	Date: December 3, 2007
Topeka Presbyterian Manor (CCN: 17-5297),	)	
	)	Docket No. C-05-438
Petitioner,	)	Decision No. CR1707
v.	)	
Centers for Medicare & Medicaid Services.	)	

DECISION

Petitioner, Presbyterian Manors, Inc., d/b/a Topeka Presbyterian Manor, violated 42 C.F.R. § 483.10(b)(11)[1] (Tag F157) between about January 4, 2005 and January 10, 2005. A per instance civil money penalty of $7000 is reasonable.

I. Background

Petitioner is a long-term care facility located in Topeka, Kansas. Petitioner is certified to participate in the federal Medicare program as a skilled nursing facility (SNF) and in the Kansas Medicaid program as a nursing facility (NF). From April 25 through April 28, 2005, the Kansas Department of Aging (the state agency) conducted a survey of Petitioner's facility finding violations of 42 C.F.R. § 483.10(b)(11) (Tag F157) and 42 C.F.R. § 483.13(c)(1)(i), as reported in the Statement of Deficiencies (Form CMS-2567) (SOD) dated May 5, 2005. CMS Exhibit (CMS Ex.) 1. The state agency forwarded the survey to the Centers for Medicare & Medicaid Services (CMS). CMS notified Petitioner by letter dated May 25, 2005, that based on the deficiencies found by the state agency, CMS was imposing a per instance civil money penalty (CMP) of $7000, a denial of

[1] Citations are to the version of the regulation in effect at the time of the survey.

payment for new admissions (DPNA) effective May 27, 2005, and termination of Petitioner's provider agreement on November 5, 2005, if substantial compliance was not achieved before that date. CMS further advised Petitioner that it was ineligible to offer a nurse aide training competency evaluation program (NATCEP) for a period of two years from the date of the survey.

On or about July 7, 2005, the state agency conducted a revisit survey of Petitioner's facility and determined that Petitioner achieved substantial compliance with regulatory requirements effective May 27, 2005. As a result of finding Petitioner had returned to substantial compliance, the DPNA and termination remedies were not effectuated. Transcript page (Tr.) 273.

Petitioner filed a request for hearing by an administrative law judge (ALJ) on July 8, 2005. The case was assigned to me for hearing and decision on August 2, 2005. I convened a hearing in Topeka, Kansas on February 8 and 9, 2006. CMS offered exhibits 1 through 9. CMS exhibits 1 through 4, 8, and 9 were admitted, but CMS agreed with Petitioner that CMS exhibits 5, 6, and 7 were not relevant and they were not admitted. Petitioner offered exhibits (P. Exs.) 1, 4, 5, 6, 9, and 10-17, which were admitted. Tr. 18 and 381. Petitioner's exhibits 2, 3, 7, and 8, were not offered at hearing. Audrey Sunderraj and James E. Beery testified for CMS. Petitioner elicited testimony from Tom Bechtel, Linda M. Finch, Dr. Kevin Sundbye, Tanya Stewart-Vann, and Nancy Pearl Denham. The parties submitted post hearing briefs and post hearing reply briefs.

II. Discussion

A. Findings of Fact

The following findings of fact are based upon the exhibits admitted and the parties stipulations of fact. Citations to exhibit numbers related to each finding of fact may be found in the analysis section of this decision if not indicated here.

1. Resident 900, the resident who is the subject of the deficiencies alleged, was admitted to Petitioner's SNF on January 25, 2003. Joint Stipulation of Undisputed Facts (Jt. Stip.) at 2.

2. Kevin Sundbye, M.D., was Petitioner's Medical Director and Resident 900's primary care physician at the time of the events that form the basis for the allegations from the survey. Jt. Stip. at 2.

3. Resident 900 was an 83-year-old, wheelchair-bound male, with diagnoses of chronic obstructive pulmonary disease (COPD), hypertension, dementia, depression, post-polio syndrome, cataracts, and glaucoma, who was moderately impaired for decision-making, had difficulty finding words or finishing thoughts, displayed a depressed mood, was verbally abusive, resisted care, needed extensive assistance or was totally dependent for activities of daily living, required transfers with a mechanical lift, was at risk for impaired skin integrity because of urinary and bowel incontinence, and was placed on psychotropic drugs because of agitation, delusions, and physical and verbal abusive behaviors.[2] P. Ex. 10-16.

4. On January 3, 2005,[3] at approximately 7:17 p.m., Resident 900 was found lying face down on the floor in his room, with a small skin tear on his left elbow and a large hematoma or bruise on the left side of his forehead and face. CMS Ex. 4, at 2; P. Ex. 1, at 1.

5. Resident 900 reported to Petitioner's staff that he fell forward out of his wheelchair when he reached down to put his foot back on the wheelchair foot rest. CMS Ex. 4, at 2; P. Ex. 1, at 1.

6. At 7:20 p.m. on January 3, 2005, Resident 900 was assessed by the Licensed Practical Nurse (LPN) who found among other things that his oxygen saturation on room air was low at 82 percent, respiration rate was 44 breaths per minute, and he was breathing with his accessory muscles; also his pupils were constricted and non-reactive to light. CMS Ex. 4, at 2; P. Ex. 1, at 1.

---

[2] Linda Finch, Petitioner's Director of Nursing (DON), testified that Resident 900 had a history of stroke which continued to impact his right side, yet there is nothing in his medical records presented to me that indicates that fact or lists that in his history. Tr. 176-77. The quarterly Minimum Data Set (MDS) assessment done on this resident with and assessment reference date of December 1, 2004, has only "depression" checked under section I1. "Cerebrovascular accident (stroke)" is not checked off as an active diagnosis. Furthermore, rather than a limitation of range of motion on the right side, he was assessed as having a bilateral loss of range of motion in the arms, legs and feet with a partial loss of voluntary movement in one leg. P. Ex. 10, at 4.

[3] The parties stipulated that the fall occurred on February 3, 2005 (Jt. Stip. at 3), clearly in error as there is no question Resident 900 expired on January 10, 2005. Jt. Stip. at 5.

7. At 7:30 p.m. on January 3, 2005, Resident 900 was assessed again by the LPN after being placed on oxygen and, among other things, his oxygen saturation level was up to 86 percent but still low, his respiration rate had dropped to 40 breaths per minute, his breathing was labored, and he was using accessory muscles to breath. CMS Ex. 4, at 2; P. Ex. 1, at 1.

8. Petitioner's nursing notes indicate that at 7:40 p.m. the LPN paged Dr. McKee, the physician on call for Dr. Sundbye. Jt. Stip. at 2.

9. Petitioner's nursing notes show that Dr. McKee returned the LPN's call at 7:45 p.m. and Dr. McKee authorized ambulance transport of Resident 900 to the local hospital emergency room. CMS Ex. 4, at 2-3; P. Ex. 1, at 1-2.

10. Petitioner's nursing notes show that Resident 900 left Petitioner's facility en route to the emergency room at 8:05 p.m. CMS Ex. 4, at 3, P. Ex. 1, at 2.

11. The nursing notes show that when Resident 900 left the facility, he was complaining of left chest pain and a headache. CMS Ex. 4, at 3, P. Ex. 1, at 2.

12. The nursing notes indicate that Resident 900 was returned by ambulance from the hospital approximately four hours later, at 1:00 a.m. on January 4, 2005; Petitioner's staff began doing regular neurologic checks; the resident had a urinary or Foley catheter from the hospital; and he was receiving oxygen via nasal cannula at a rate of three liters. CMS Ex. 4, at 3; P. Ex. 1, at 2.

13. A nursing note at 2:00 a.m. on January 4, 2005, shows that neurologic checks that had been conducted every 15 minutes over the past hour were within normal limits. CMS Ex. 4, at 3; P. Ex. 1, at 2.

14. The 2:00 a.m. nursing note also shows that the orders received from the hospital specified the administration of oxygen at the rate of two liters to maintain an oxygen saturation of greater than 90% but to otherwise continue current orders and follow-up with Dr. Sundbye in the coming week. CMS Ex. 4, at 1, 3; P. Ex. 1, at 2, 9, 13; Jt. Stip. at 4.

15. A nursing note at 3:00 a.m. shows that the LPN and a nursing assistant (CNA) did a "head to toe" assessment, electrocardiogram leads were removed, the resident was alert and oriented and commented that he had a big adventure, he was cold on return due to weather conditions, his breath sounds were clear with oxygen in place, but the hospital had noted worsening COPD. P. Ex. 1, at 14.

16. A nurse note at 5:00 a.m. on January 4, 2005, records that the resident slept periodically and responded to voice and touch. P. Ex. 1, at 14.

17. A nurse note at 6:00 a.m. on January 5, 2005, states "[r]esident is much less responsive at this time;" his vital signs remained in normal limits; his pupils were noted to be equal, round, and reactive to light and accommodation (PERRLA); but his breath sounds were wheezy bilaterally and he had a "very red face." P. Ex. 1, at 14.

18. The 6:00 a.m. nursing note also states that the nurse asked Resident 900 whether he wished to return to the hospital but the note does not state why she asked the resident the question except the note includes that she could not tell whether he truly could not do hand grasps, nodding, and blinking or whether he was just deliberately withholding. P. Ex. 1, at 14.

19. The 6:00 a.m. note records that the nurse knew that one of the hospital diagnosis was a closed-head injury, but despite the nurse's question about whether the resident should be returned to the hospital, the nurse elected to continue oxygen and continue other medications as ordered and to wait for Dr. Sundbye to appear at the facility later in the day as scheduled. P. Ex. 1, at 14.

20. A nursing note at 6:45 a.m. on January 4, 2005, shows that the resident was alert and oriented to person, but he was no longer oriented to date, time, or place, which is a decline from his status compared to the 3:00 a.m. nursing note. P. Ex. 1, at 14.

21. The nursing note at 6:45 a.m. also shows that Resident 900's face was flushed and his neurologic checks revealed that his left grip strength was "considerably weaker" than his right, his left pupil was pinpoint and nonreactive, his right pupil was sluggish but reactive, he was not answering questions appropriately at times, all reflecting a decline from his neurologic checks reported at 2:00 a.m., 3:00 a.m. and 6:00 a.m. P. Ex. 1, at 14-15.

22. The nursing note at 8:45 a.m. on January 4, 2005, records that on neurologic check, Resident 900's left pupil remained pinpoint and his right eye was still sluggish. P. Ex. 1, at 15.

23. The nursing note at 10:50 a.m. on January 4, 2005, shows improvement, with the resident up in bed reading the newspaper, pupils equal and reactive to light, bilateral grip strength equal, and he answered questions appropriately, but continued on oxygen via nasal cannula. P. Ex. 1, at 15.

24. Around 11:00 a.m. on January 4, 2005, the nurse records that she spoke to Resident 900's brother who holds the resident's durable power of attorney,[4] and he advised that he wished for the resident to be sent back to the hospital if necessary. P. Ex. 1, at 15.

25. The last nursing note on January 4, 2005 at 8:15 p.m. is a summary of the remainder of the day and includes that the resident's oxygen saturation was 94 percent on 2 liters of oxygen via nasal cannula, he was not responding to verbal stimuli but did respond to physical, his neurologic checks every four hours showed a sluggish right pupil and the left was pinpoint, around 3:00 p.m. staff discontinued the urinary catheter when they realized that the order from the hospital did not call for it to be continued. P. Ex. 1, at 15-16.

26. The nursing notes for January 4, 2005, do not show that Resident 900's primary care physician, Dr. Sundbye, was contacted or consulted by Petitioner's staff and there is no other evidence Dr. Sundbye was consulted. Tr. 373-74.

27. The three nursing notes from January 5, 2005, show that in the early morning Resident 900 responded to verbal stimuli, his pupils were equal, round, and reactive to light and accommodation (PERRLA), his vital signs were within normal limits; in the early afternoon his neurologic signs were normal but his oxygen saturation was only 84 percent; the note from 11:00 p.m. shows that he was non-verbal and mumbling responses, he was engaging in abdominal breathing, was on continuous oxygen at 2 liters with saturation of 91 percent, and was in no apparent pain. P. Ex. 1, at 16-17.

28. The nursing notes for January 5, 2005, do not show that Resident 900's primary care physician, Dr. Sundbye, was contacted or consulted by Petitioner's staff and there is no other evidence Dr. Sundbye was consulted. Tr. 373-74.

---

[4] It is not specified in the nursing notes whether the durable power of attorney was for health care decisions however the parties stipulated that it was. Jt. Stip. at 4. Petitioner has not presented evidence that tells me why the durable power was in effect if the resident was alert and oriented or whether there was a guardianship or other legal status determination that affected who could make health care decisions for Resident 900. Tr. 248. However, the absence of this fact does not affect my decision.

29. There are four nursing notes for January 6, 2005, which show that at 6:00 a.m. the resident's vital signs were within normal limits and he was alert and oriented in three spheres, his neurologic checks showed his pupils were equal, round, and reactive to light and accommodation (PERRLA) and "all other responses are normal/better than normal," stated he felt better and smiled, but his breathing was still "labored;" but the 8:00 a.m. note shows that his breathing had become very labored with five to ten seconds of apnea (suspension of external breathing), he was nonresponsive to verbal or physical stimuli, his right pupil was pinpoint and nonreactive to light, his left pupil was sluggish but reactive; at 8:45 a.m. the nurse again called the brother with the durable power of attorney, and while what specifically was said when he called back at 9:15 a.m. is not recorded, the brother no longer wanted the resident sent to the hospital but that he just be kept comfortable; the sister was also notified, of what is not recorded, but she and her husband were at the bedside by 10:45 a.m.; the last note of the day shows that Resident 900 could respond to questions but he kept looking straight ahead, his right pupil was fixed, nonreactive and pinpoint, the left pupil was also pinpoint but there was reaction to light, he continued to use accessory muscles for breathing and was on continuous oxygen at 2 liters by nasal cannula with 90 percent saturation, he accepted water but no food. P. Ex. 1, at 17-18.

30. The nursing notes for January 6, 2005, do not show that Resident 900's primary care physician, Dr. Sundbye, was contacted or consulted by Petitioner's staff and there is no other evidence Dr. Sundbye was consulted. Tr. 373-74.

31. The parties stipulated that Petitioner's staff did notify Dr. Sundbye's nurse practitioner, Kathy Snyder on January 6, 2005, of the brother's request that Resident 900 receive only comfort care. Jt. Stip. at 5; P. Ex. 1, at 23; CMS Ex. 4, at 24.

32. Three nursing notes on January 7, 2005, show Resident 900 was awake at 3:30 a.m. and hungry, he was breathing with accessory muscles, became winded while talking, ate a peanut butter and jelly sandwich; at 10:30 a.m. his oxygen saturation was down to 87 percent with continuous oxygen at 2 liters by nasal cannula but he tried to remove the oxygen and had to be reminded to keep it on. P. Ex. 1, at 19.

33. The nursing notes for January 7, 2005, do not show that Resident 900's primary care physician, Dr. Sundbye, was contacted or consulted by Petitioner's staff and there is no other evidence Dr. Sundbye was consulted. Tr. 373-74.

34. Nursing notes from January 8, 2005, show that Resident 900 continued to use accessory muscles, he was alert with episodes of unresponsiveness, he was wheezing later in the morning, he was up in his wheelchair for at least two meals, by 9:30 p.m. he had diminished lung sounds in all fields, but he was responsive to questions. P. Ex. 1, at 19-20.

35. The nursing notes for January 8, 2005, do not show that Resident 900's primary care physician, Dr. Sundbye, was contacted or consulted by Petitioner's staff and there is no other evidence Dr. Sundbye was consulted. Tr. 373-74.

36. Nursing notes for January 9, 2005, record Resident 900 as breathing harshly from the diaphragm, he was alert and oriented in good spirits, he was in his wheelchair for breakfast but remained in bed for lunch, lung sounds were noted to be diminished in both lungs, his oxygen saturation was not noted to be below 90 percent. P. Ex. 1, at 20-21.

37. The nursing notes for January 9, 2005, do not show that Resident 900's primary care physician, Dr. Sundbye, was contacted or consulted by Petitioner's staff and there is no other evidence Dr. Sundbye was consulted. Tr. 373-74.

38. On January 10, 2005 at 5:45 a.m., Resident 900 awoke in good spirits and reportedly slept well, he was alert and oriented with an oxygen saturation of 92 percent on 2 liters via nasal cannula. P. Ex. 1, at 21.

39. At 10:00 a.m. on January 10, Resident 900's oxygen saturation was down to 83 percent with continuous oxygen at 3 liters via a mask, he ate all his breakfast but his breathing was labored and "diaphramic." P. Ex. 1, at 21.

40. At 2:00 p.m. on January 10, his condition was reported as unchanged, he was responsive to verbal stimuli, he refused lunch, and the family was in to visit. P. Ex. 1, at 21.

41. At 6:30 p.m. the nurse initiated pursuant to a standing order, Tylenol 650 mg every four hours as need for pain because she observed facial grimacing, the resident's breathing was labored, his oxygen saturation had dropped to 78 percent on 2 liters of oxygen delivered by nasal cannula and the nurse switched him to a mask to improve his oxygen saturation. P. Ex. 1, at 21.

42. A 9:20 p.m. nursing note show an absence of vital signs and that Dr. Dishman who was on call for Dr. Sundbye, was notified of Resident 900's death, as were his brother and sister.

43. The nursing notes for January 10, 2005, do not show that Resident 900's primary care physician, Dr. Sundbye, was contacted or consulted by Petitioner's staff and there is no other evidence Dr. Sundbye was consulted. Tr. 373-74.

44. Prior to his fall on January 3, 2005, Resident 900 did not require administration of oxygen to maintain his oxygen saturation at or above 90 percent, which is normal; he did not use accessory muscles for breathing; and he was not noted to experience shortness of breath or labored breathing. Tr. 178-79, 192-93, 204, 369.

45. Dr. Sundbye opined at hearing that pleural effusions and possibly a heart attack, both conditions he identified from documentation from Resident 900's hospitalization on January 3, 2005, contributed significantly to the resident's decline and death. Tr. 227-29, 249-50.

46. Dr. Sundbye testified, that in his opinion, he should have been notified by Petitioner's staff the morning of January 4, 2005, regarding Resident 900's condition but for the fact he was scheduled to be at the facility that morning. Tr. 225-26.

B. Conclusions of Law

1. Petitioner violated 42 C.F.R. § 483.10(b)(11) (Tag F157) because it failed to consult Resident 900's physician about a significant change in Resident 900's condition.

2. Petitioner has failed to rebut the CMS *prima facie* showing of a violation of 42 C.F.R. § 483.10(b)(11).

3. Petitioner's violation of 42 C.F.R. § 483.10(b)(11) (Tag F157) is a sufficient basis for the imposition of a PICMP.

4. A PICMP of $7000 is reasonable under the facts of this case and considering the regulatory factors at 42 C.F.R. § 488.438(e).

C. Issues

The issues in this case are:

Whether there is a basis for the imposition of an enforcement remedy; and,

Whether the remedy imposed is reasonable.

The parties agreed at the beginning of the hearing that the only resident involved in the case before me is Resident 900 and the only alleged deficiencies are violations of 42 C.F.R. § 483.10(b)(11) (Tag F157) and § 483.13(c)(1)(i) (Tag F224). CMS alleges that the deficiencies posed immediate jeopardy for Resident 900 and Petitioner alleges that the immediate jeopardy determination is clearly erroneous.

D. Applicable Law

Petitioner is a long-term care facility participating in the federal Medicare program as a skilled nursing facility (SNF) and in the state Medicaid program as a nursing facility (NF). The statutory and regulatory requirements for participation by a long-term care facility are found at sections 1819 and 1919 of the Social Security Act (Act) and at 42 C.F.R. Part 483. Sections 1819 and 1919 of the Act vest the Secretary of Health and Human Services with authority to impose civil money penalties against a long-term care facility for failure to comply substantially with federal participation requirements.

Facilities that participate in Medicare may be surveyed on behalf of CMS by state survey agencies in order to determine whether the facilities are complying with federal participation requirements. 42 C.F.R. §§ 488.10-488.28, 488.300-488.335. Pursuant to 42 C.F.R. Part 488, CMS may impose a per-instance or per day CMP against a long-term care facility when a state survey agency concludes that the facility is not complying substantially with federal participation requirements. 42 C.F.R. §§ 488.406; 488.408; 488.430. The regulations in 42 C.F.R. Part 488 also give CMS a number of other remedies that can be imposed if a facility is not in compliance with Medicare requirements.

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, from $3050 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 $3000 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 $1000 to $10,000 for a PICMP 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 ALJ available to a long-term care facility against which CMS has determined to impose a CMP. Act, section 1128A(c)(2); 42 C.F.R. §§ 488.408(g); 498.3(b)(13). The hearing before an ALJ is a *de novo* proceeding. *Anesthesiologists Affiliated, et al*, 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*, DAB No. 2030 (2006)*; The Residence at Salem Woods*, DAB No. 2052, (2006). 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) and 498.3. However, the choice of remedies by CMS 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 found by CMS if a successful challenge would affect the amount of the CMP that could be collected by CMS or impact upon the facility's nurse aide training program. 42 C.F.R. §§ 498.3(b)(14) and (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 finding of immediate jeopardy. *Woodstock Care Center*, DAB No. 1726, at 9, 38 (2000), *aff'd, Woodstock Care Center v. Thompson*, 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. *See, e.g.*, *Ridge Terrace*, DAB No. 1834 (2002); *Koester Pavilion*, DAB No. 1750 (2000). Review of a CMP by an ALJ is governed by 42 C.F.R. § 488.438(e).

When a penalty is proposed and appealed, CMS must make a *prima facie* case that the facility has failed to comply substantially with federal participation requirements. "*Prima facie*" means that the evidence is "(s)ufficient to establish a fact or raise a presumption unless disproved or rebutted. *Black's Law Dictionary* 1228 (8th ed. 2004), *see also*, *Hillman Rehabilitation Center*, DAB No. 1611, at 8 (1997), *aff'd Hillman Rehabilitation Center v. U.S. Dept. of Health and Human Services*, No. 98-3789 (D.N.J. May 13, 1999). To prevail, a long-term care facility must overcome CMS's showing by a preponderance of the evidence. *Batavia Nursing and Convalescent Center*, DAB No. 1904 (2004); *Batavia Nursing and Convalescent Inn*, DAB No. 1911 (2004); *Emerald Oaks*, DAB No. 1800 (2001); *Cross Creek Health Care Center*, DAB No. 1665 (1998); *Evergreene Nursing Care Center*, DAB No. 2069, at 7-8 (2007).

E. Analysis

1. Petitioner violated 42 C.F.R. § 483.10(b)(11) (Tag F157).

The surveyors allege in the SOD that Petitioner violated 42 C.F.R. § 483.10(b)(11) (Tag F157) because Petitioner's staff failed to notify Resident 900's physician of the resident's declining status prior to his death, placing him in immediate jeopardy.[5] CMS Ex. 1, at 2. Section 483.10(b)(11)(i) provides:

> (11) Notification of changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative (sic) or an interested family member when there is --
>
> > (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;
> > (B) A 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);
> > (C) A need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or
> > (D) A decision to transfer or discharge the resident from the facility as specified in Sec. 483.12(a).

---

[5] The surveyors also cited Petitioner for a violation of 42 C.F.R. § 483.13(c)(1)(i) (Tag F224) based upon the same facts as those alleged under Tag F157. CMS Ex. 1, at 12. It is apparent from the face of the SOD, the evidence, and the briefs of CMS that the citation in the SOD to 42 C.F.R. § 483.13(c)(1)(i) was in error or at least superfluous. That subsection provides that "(1) The facility must-- (i) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; . . . ." None of the facts alleged in the SOD or developed by the parties suggest that there was any "physical abuse, corporal punishment, or involuntary seclusion." Rather, CMS indicates that it intended to cite Petitioner for a violation of 42 C.F.R. § 483.13(c) (Tag F224) for neglect of the patient. I need not review this Tag, however, because the deficiency under section 42 C.F.R. § 483.10(b)(11) is more than sufficient a basis for the remedy proposed by CMS.

Petitioner fails to directly address in its briefs what the regulation actually requires. Petitioner attempts to narrow the focus to whether or not it was necessary for the treating physician to be "notified" of a change in the resident's condition. Petitioner takes the additional step of arguing that any changes in Resident 900's condition were not significant within the meaning of the regulation, a position not supported by the testimony of its own witnesses.

The regulatory requirements are abundantly clear yet they are often misquoted and misconstrued. Patients in long term care facilities have certain rights. Among these are that the facility "**must immediately . . . consult with the resident's physician** . . . when there is a significant change in the resident's physical, mental, or psychosocial status" (meaning a deterioration in the resident's condition). 42 C.F.R. § 483.10(b)(11)(emphasis added). The requirement is not discretionary and it requires more than merely informing or notifying the physician, which is evident from the plain language of the regulation. The drafters chose the language carefully. The regulation is specific that the facility is required to **immediately** "**inform** the resident; **consult** the physician; and . . . **notify** the legal representative or an interested family member." *Id*. (emphasis added). The preamble to the final rule indicates the drafters specific intention that the facility should "inform" the resident of the changes that have occurred but should "consult with the physician about actions that are needed." 56 Fed. Reg. 48,826, at 48,833 (Sept. 26, 1991). Thus, it is clear from the language of the regulation and its history, that the requirement of the regulation to consult means more than to simply notify. Consultation requires a dialogue with and a responsive directive from the resident's physician as to what actions are needed; it is not enough to merely notify the physician of the resident's change in condition. Nor is it enough to leave just a message for the physician.

The regulation also requires consultation "immediately" upon discernment of a change in condition of the resident. The use of the term immediately in the regulatory requirement indicates that consultation is expected to be done as soon as the change is detected, without any intervening interval of time. It does not mean that the facility can wait hours or days before consulting with the physician. The preamble to the final rule indicates that originally the proposed rule granted the facility up to 24 hours in which to notify the resident's physician and the legal representative or family. However, after the receipt of comments that time is of the essence in such circumstances, the final rule amended that provision to require that the physician and legal representative or family be consulted/notified immediately. 56 Fed. Reg. 48,826, 48,833 (Sept. 26, 1991). The point of using the word "immediately" was the recognition that in such situations a delay could result in a situation where a resident is beyond recovery or dies, similar to the resident in this case. Furthermore, when we balance the relative inconvenience to a physician and the facility staff to consult about a resident's change in condition with the possibility for dire consequences to the resident if the physician is not consulted, it seems that any inconvenience certainly is inconsequential and outweighed by the potential for significant

harm if the facility fails to consult the physician.[6] This regulation is entitled "Resident rights" and the requirements of this specific regulation provide that every resident has the right to a dignified existence and access to and communication with persons and services inside and outside the facility. Therefore, the regulatory requirements make inconsequential any inconvenience under the regulation to the resident's physician or to the facility staff when compared to the protection and facilitation of the rights of the resident. *See* 56 Fed. Reg. 48,826, at 48,834 (Sept, 26, 1991).

Finally, the regulation does not allow the facility to pick and choose whom to notify and whom to consult. Rather, it requires the facility to immediately inform the resident, consult the physician **and** notify the resident's legal representative or interested family member. Merely, notifying the legal representative/family without also consulting with the physician is not enough.

The facts important to this case are set forth in the Findings of Fact above and are not restated here. I have reviewed the nursing notes and resident records submitted by the facility and CMS. Nowhere in the record is there any indication that Resident 900's physician, Dr. Sundbye, was consulted or even notified of the resident's change in condition.

There is no dispute by Petitioner that Dr. Sundbye was not consulted.[7] Petitioner has the affirmative duty under the regulation to immediately consult with the physician, a key

---

[6] Better to err on the side of consulting a physician regarding a change in a resident's condition rather than not or debating about whether the change is significant, particularly since nursing home staff may not be qualified or competent to identify the significance of signs and symptoms.

[7] The evidence shows that Dr. Sundbye's nurse practitioner was notified on January 6, 2005. Her note, dated January 6, 2005, states

> Notified by nursing staff that pts [patient's] DPOAH [Durable Power of Attorney/brother] wants comfort measures only for pt and for him to not be sent to hospital.

CMS Ex. 4, at 24. This note does not indicate that Dr. Sundbye was notified or that his nurse practitioner made any effort to contact him to examine the patient. It is also clear from the clinical record that the facility contacted the resident's brother first with respect to comfort measures and then staff reported that election to the nurse practitioner. Tr. 246-48. There is no indication that the unfortunate brother had the benefit of qualified medical advice prior to changing his earlier direction to take the resident to the hospital in the event of complications.

member of the care planning team, to ensure the physician is aware of significant changes and to obtain his or her orders, guidance, and direction to ensure the resident receives necessary care and services. Petitioner completely failed in its duty despite the fact that staff who were caring for Resident 900 believed he was declining and dying. Tr. 287-90, 304, 307-09.

Dr. Sundbye testified that the fact that Resident 900 was wheezing and had a red face on January 4, 2005, were signs and symptoms of which he should have been notified and consulted they reflected a need for medical intervention and potential change in treatment modality. Tr. 225. He offered, however, that he was scheduled to be in the facility that morning, within hours, and he did not feel additional notification was necessary. Tr. 226. Due to an intervening winter storm, Dr. Sundbye did not visit the facility and he never saw the Resident before the resident expired on January 10, 2005. However, the fact that Dr. Sundbye never showed his face in the facility the six days from January 4 through January 10, 2005, is no defense for Petitioner. It was Petitioner's duty to ensure that the doctor was immediately consulted, and this Petitioner failed to do.

Petitioner's failure in this case is made more egregious by the fact that the emergency room doctor specifically ordered that Resident 900's physician be consulted. Furthermore, Dr. Sundbye testified that pleural effusions and signs of a probable heart attack apparent to him from emergency room test results, may have significantly contributed to Resident 900's death. Thus, there is more sufficient evidence from which to infer that Petitioner's failure to consult with Dr. Sundbye about the resident and his signs and symptoms following return from the hospital, prevented Dr. Sundbye from ordering treatment necessary to prevent the untimely demise of the resident.

Dr. Sundbye's opinions that Petitioner did what it was supposed to or all it could, is entitled to no weight here. The fact that Dr. Sundbye may have found Petitioner's care and treatment of the resident satisfactory is not determinative. It is my duty to review the evidence and apply the regulatory requirements. The preponderance of the evidence shows that there was a significant change in Resident 900's condition upon his return from the hospital and that Petitioner failed to fulfill its regulatory duty to consult with Resident 900's physician immediately in order to determine what actions should be taken. Accordingly, I conclude that Petitioner violated 42 C.F.R. § 483.10(b)(11).

2. The PICMP of $7000 is reasonable.

If a facility is not in substantial compliance with program requirements, CMS has the authority to impose one or more of the enforcement remedies listed in 42 C.F.R. § 488.406, including a CMP. CMS may impose a CMP for the number of days that the facility is not in compliance or for each instance that a facility is not in substantial

compliance. 42 C.F.R. § 488.430(a). The minimum amount for a PICMP is $1000 and the maximum is $10,000. CMS imposed a per instance penalty here of $7000. I must consider whether the proposed PICMP is reasonable.

In determining whether the amount of the per instance CMP is reasonable, the following factors specified at 42 C.F.R. § 488.438(f) must be considered: (1) the facility's history of non-compliance, including repeated deficiencies; (2) the facility's financial condition; (3) the seriousness of the deficiencies as set forth at 42 C.F.R. § 488.404; and (4) the facility's degree of culpability.

I evaluate the $7000 PICMP against the regulatory factors I have mentioned. I conclude, after considering the circumstances and the regulatory factors, that $7000 is reasonable.

Strictly speaking, a determination of immediate jeopardy is irrelevant to the issue of what is reasonable as a PICMP; it is only relevant as a necessary prerequisite to imposition of a per diem CMP in excess of $3000. Therefore, while I need not consider immediate jeopardy in the context of a prerequisite to the imposition of a PICMP, the finding of immediate jeopardy is an indication of the seriousness of a deficiency, at least from the surveyors' and CMS' perspective. 42 C.F.R. § 488.404 (b). In this case, the evidence certainly supports a finding that Petitioner's failure to consult with Resident 900's physician immediately upon noticing a change in the resident's condition constituted immediate jeopardy because it "caused, or is likely to cause, serious injury, harm, impairment, or death to a resident." 42 C.F.R § 488.301. I find that the evidence in the record supports the conclusion that Petitioner's failure to consult Dr. Sundbye immediately on January 4, 2005, when the LPNs recognized a change in Resident 900's condition, was likely to cause this resident serious injury, harm, impairment or death and constituted immediate jeopardy. Moreover, I find that the overwhelming evidence supports a finding that Petitioner was culpable. All that was required was for Petitioner to consult Resident 900's physician or return the resident to the hospital at the first indication that his condition was worsening. Yet, Petitioner did nothing. One might conclude from the facts, that the staff were more concerned with disturbing Dr. Sundbye than with caring for the resident's needs or that they had the attitude that Resident 900 was dying anyway. There is also some indication from the record that the facility employees, including its Medical Director, Dr. Sundbye, were completely unaware of what was required under the regulation. But what is particularly troublesome here is how little effort it would have taken by the staff to consult with Dr. Sundbye with respect to this resident before the deterioration in his condition became too grave. I note that the record before me indicates that the facility did indeed have a means of notifying a doctor and request an urgent response, but did not do so in this case. *See* P. Ex. 14, at 1-3.

Although CMS Ex. 8 appears to show that Petitioner was cited for violation of Tag F157 in 2001, the parties stipulated that "(t)here is no relevant history of prior surveys citing the Facility for same [sic] deficiencies as those at issue in this matter. . . ." Jt. Stip. at 3. Petitioner presented no evidence and has not argued that its financial condition precludes payment of the $7000 PICMP. I find, after evaluation of all the regulatory factors, that the $7000 PICMP is reasonable.

III. Conclusion

For the foregoing reasons, I conclude that Petitioner violated 42 C.F.R. § 483.10(b)(11) and a PICMP of $7000 is reasonable.[8]

/s/
Keith W. Sickendick
Administrative Law Judge

[8] Pursuant to 42 C.F.R. § 483.151(b)(2) and (e)(1) a state may not approve and must withdraw any prior approval of a NATCEP offered by a SNF or NF that: (1) has been subject to an extended or partial extended survey under sections 1819(g)(2)(B)(i) or 1919(g)(2)(B)(i) of the Act; (2) has been assessed a CMP of not less than $5000; or (3) that has been subject to termination of its participation agreement, a DPNA, or the appointment of temporary management. The evidence shows Petitioner was previously notified and no further action appears necessary.