Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Bedford Care Center of Hattiesburg, LLC,
(CCN: 25-5158),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-11-25

Decision No. CR2523

Date: April 3, 2012

DECISION

Petitioner Bedford Care Center of Hattiesburg, LLC, challenges the determination of the Centers for Medicare & Medicaid Services (CMS) that it was not in substantial compliance with program participation requirements. Petitioner also challenges CMS's imposition of a per day civil money penalty (CMP) of $3,550 per day from July 25 through 30, 2010, and $150 per day from July 31 through August 30, 2010, for a total CMP of $25,950. For the reasons discussed below, I sustain CMS's determination and imposition of the $25,950 CMP.

I. Background

Petitioner is a long-term care facility located in Hattiesburg, Mississippi. Petitioner participates in the Medicare and Medicaid programs. The Mississippi Department of Health (state agency) completed a recertification survey of the facility on July 31, 2010, and a revisit survey on October 12, 2010. Based on the findings of the July 31, 2010 survey, Petitioner was found out of substantial compliance with seven participation requirements. CMS Exhibit (Ex.) 2; Petitioner Exhibits (P. Exs.) 1, 2. By letter dated August 13, 2010, CMS notified Petitioner that it was imposing the remedies of a CMP of

$3,550 per day effective July 25 through July 30, 2010, and $150 per day effective July 31, 2010 until substantial compliance was achieved or Petitioner's provider agreement terminated; a discretionary denial of payment for new admissions (DPNA) effective August 28, 2010; and mandatory termination on January 31, 2010, if Petitioner was still out of substantial compliance on that date. Petitioner was also notified that as a result of the extended survey, it might lose its authority to conduct a nurse aide training program (NATCEP). CMS Ex. 6. By letter dated October 18, 2010, CMS notified Petitioner that following a survey on October 12, 2010, it had been found in substantial compliance as of August 31, 2010. CMS Ex. 7.

By letter dated October 12, 2010, Petitioner requested a hearing. I held a hearing in this case in Jackson, Mississippi, on July 19 and 20, 2011. A 333-page transcript (Tr.) was prepared. Testifying were: Toni Gray, a state agency surveyor (Surveyor Gray); Janet Johnston, a state agency surveyor (Surveyor Johnston); Gussie Conner, Petitioner's Director of Nursing (DON Conner); Julia Edwards, Petitioner's Administrator at the relevant time (Administrator Edwards); Tambra L. Robbins, a registered dietitian (Ms. Robbins); Diane Akins, a speech language pathologist (Ms. Akins); A. Louise Ridgway, certified nursing assistant (CNA) supervisor at Petitioner's facility (Ms. Ridgway); and Daniel R. Blackledge, Director of Corporate Compliance and Human Resources for the company managing Petitioner's facility (Mr. Blackledge). I admitted CMS Exs. 1-40. I admitted P. Exs. 1-14 at hearing, and now admit P. Ex. 16.[1] Tr. at 311-12, 314. Both parties filed pre-hearing briefs (CMS and P. Pre-hearing Br.); post-hearing briefs (CMS and P. Br.); and post-hearing answer briefs (CMS and P. Ans. Br.).

II. Issues

The issues before me are:

1. Whether Petitioner was in substantial compliance with participation requirements in the Medicare and Medicaid programs; and

2. Whether the remedies imposed are reasonable.[2]

III. Controlling Law

Sections 1819 and 1919 of the Social Security Act (Act) and the regulations at 42 C.F.R. Part 483 govern Petitioner's participation in Medicare and Medicaid. Sections 1819 and 1919 of the Act provide the Secretary of Health and Human Services (Secretary) with

[1] P. Ex. 16 consists of an August 2, 2010 report of an investigation conducted by Mr. Blackledge, which Petitioner filed on August 18, 2011.

[2] Petitioner has not challenged the DPNA or the NATCEP**,** but only the imposition and reasonableness of the CMP. P. Pre-hearing Br. at 18, 20; P. Br. at 23; P. Ans. Br. at 6.

authority to impose remedies, including CMPs, against long-term care facilities for failure to comply with participation requirements.

Regulations define the term "substantial compliance" to mean:

> [A] level of compliance with the requirements of participation such that any identified deficiencies pose no greater risk to resident health or safety than the potential for causing minimal harm.

42 C.F.R. § 488.301.

The Secretary has delegated to CMS and the states the authority to impose remedies against long-term care facilities not complying substantially with federal participation requirements. The applicable regulations at 42 C.F.R. Part 488 provide that state survey agencies, on behalf of CMS, may survey facilities participating in Medicare and Medicaid to ascertain whether the facilities are complying with participation requirements. 42 C.F.R. §§ 488.10-488.28. The regulations contain special survey conditions for long-term care facilities. 42 C.F.R. §§ 488.300-488.335. Under Part 488, a state or CMS may impose a CMP against a long-term care facility if a state survey agency ascertains that the facility is not complying substantially with participation requirements. 42 C.F.R. §§ 488.406, 488.408, and 488.430. The CMP may begin to accrue as early as the date that the facility was first substantially out of compliance or may continue to accrue until the date the facility achieves substantial compliance, or until CMS terminates the facility's provider agreement. 42 C.F.R. § 488.440.

The regulations specify that if a CMP is imposed against a facility based on an instance of noncompliance, the CMP will be in the range of $100 to $10,000 per instance. 42 C.F.R. § 488.438(a)(2). When a CMP is imposed against a facility on a per-day basis, it must fall into one of two broad ranges of penalties. 42 C.F.R. §§ 488.408, 488.438. The upper range of CMP, 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). "Immediate jeopardy" is defined as:

> [A] situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident.

42 C.F.R. § 488.301.

Sections 1819(f)(2)(B) and 1919(f)(2)(B) of the Act prohibit approval of a NATCEP if within the last two years the facility has been subject to, among other things, an extended or partial extended survey; imposition of a CMP of not less than $5,000; or imposition or a DPNA.

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 an enforcement remedy. Act, section 1128A(c)(2), 1866(h); 42 C.F.R. §§ 488.408(g), 498.3(b)(13). The hearing before an ALJ is a *de novo* proceeding. *The Residence at Salem Woods,* DAB No. 2052 (2006); *Cal Turner Extended Care,* DAB No. 2030 (2006); *Beechwood Sanitarium,* DAB No. 1906 (2004); *Emerald Oaks,* DAB No. 1800, at 11 (2001); *Anesthesiologists Affiliated,* DAB CR65 (1990), *aff'd,* 941 F.2d 678 (8th Cir. 1991). A facility has the right to appeal a certification of noncompliance leading to an enforcement remedy. 42 C.F.R. § 488.408(g)(1); 42 C.F.R. §§ 488.430(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 challenge the scope and severity that CMS cites only if a successful challenge would affect the range of CMP amounts that CMS imposed or would affect the facility's NATCEP. 42 C.F.R. § 498.3(b)(14), (d)(10)(i). CMS's determination as to the scope and severity 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 (2000), *aff'd, Woodstock Care Center v. U.S. Department of Health and Human Services,* 363 F.3d 583 (6th Cir. 2003). The Departmental Appeals Board (Board) has long held that the net effect of these regulations is that a provider has no right to challenge the scope and severity assigned to a noncompliance finding except in the situation where that finding is the basis for an immediate jeopardy determination. *See, e.g., Ridge Terrace,* DAB No. 1834 (2002); *Koester Pavilion,* DAB No. 1750 (2000). ALJ review of a CMP is subject to 42 C.F.R. § 488.438(e).

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

IV. Discussion

I make numbered findings of fact and conclusions of law (Findings) to support my decision. I set them forth below as separate headings, in bold and italic type, and discuss each in detail.[3]

Although the July 31, 2010 survey cited seven deficiencies, Petitioner is only contesting the two deficiencies cited at a level J,[4] which CMS alleges violated 42 C.F.R. § 483.10(b)(11) (Tag F-157)[5] which sets forth a facility's duty to notify physicians and family of significant changes in a resident's condition, and 42 C.F.R. § 483.25 (Tag F-309) which requires a facility to provide a resident the necessary care and services to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, in accordance with the resident's comprehensive assessment and plan of care. Both cited deficiencies are based on a series of events involving the use of a syringe in feeding one resident. Below, I address only the alleged violation of 42 C.F.R. § 483.25 (Tag F-309) because it is not necessary for me to address the alleged violation of 42 C.F.R. § 483.10(b)(11) (Tag F-157) to support the CMP imposed. *Plott Nursing Home,* DAB No. 2426, at 24 (2011); *see also Residence at Salem Woods,* DAB No. 2052, at 11 (2006).

1. Petitioner was out of substantial compliance with the participation requirement at 42 C.F.R. § 483.25 (Tag F-309).

The regulation at 42 C.F.R. § 483.25 requires that each resident receive and the facility 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 Board has found that while the regulation does not impose a strict liability standard on facilities, or make facilities "unconditional guarantors

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[3] I have reviewed the entire record, including all the exhibits and testimony. Because the Federal Rules of Evidence do not control the admission of evidence in proceedings of this kind (*see* 42 C.F.R. § 498.61), 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 are not supported by the weight of the evidence or by credible evidence or testimony.

[4] A scope and severity citation of J describes an isolated deficiency constituting immediate jeopardy.

[5] An F-Tag designation refers to the section of the state operations manual (SOM), Appendix PP, which gives guidance to state agency surveyors regarding specific regulatory requirements and the investigation of compliance with those requirements. The statement of deficiencies (SOD) sets out deficiencies by F-Tag.

of favorable outcomes," it does impose an affirmative duty to provide services designed to achieve those outcomes to the highest practicable degree. A facility must take such "reasonable steps" and "practicable measures" to achieve that end. *Sheridan Health Care Center*, DAB No. 2178, at 13-15, *citing Woodstock Care Center*, DAB No. 1726, at 25 (2000), *aff'd, Woodstock Care Ctr. v. Thompson*, 363 F.3d 583 (6th Cir. 2003); *Clermont Nursing & Convalescent Ctr.*, DAB No. 1923, at 21 (2004), *aff'd, Clermont Nursing & Convalescent Ctr. v. Leavitt*, 142 Fed. App. 900 (6th Cir. 2005).

The SOD alleges that Petitioner fell short of its obligation to meet this requirement with respect to Resident 5, an individual totally dependent on staff to feed her. The SOD charges that Resident 5 did not receive "the necessary care and services to prevent possible aspiration due to being syringe fed by a private sitter." CMS Ex. 2, at 24. CMS alleges further that because Petitioner's staff failed to follow the explicit orders of Resident 5's physician, Dr. Gillespie, Resident 5's care did not meet professionally recognized standards of care. I agree.

Upon re-admission to the facility on September 25, 2007, Resident 5, then an 88-year-old woman, was noted to have diagnoses including dementia, dehydration, atrial fibrillation, and dysphagia, oropharyngeal phase. CMS Ex. 21; P. Ex. 6. A social history taken during a hospital admission on April 5, 2010 noted that Resident 5 was "dependent upon others for all her needs. She has to be fed. She has to be turned. She has to be cleaned. She has a history of dysphagia and [a] feeding tube has been recommended in the past but the family has refused." P. Ex. 13, at 3. Minimum Data Set (MDS) assessments from November 16, 2009, April 21, 2010, and May 3, 2010, noted that Resident 5 was totally dependent on staff for assistance with eating. CMS Ex. 23, at 2; CMS Ex. 24, at 3; CMS Ex. 25, at 2; CMS Ex. 28, at 1. A nursing Kardex care card dated May 4, 2010, noted she was to be fed a pureed diet with nectar thickened liquids, and positioned at an upright 90 degree angle while wearing a soft neck collar. CMS Ex. 33, at 1; *see* CMS Ex. 30, at 22, 50, 61.

It is undisputed that Resident 5's family hired a private sitter for Resident 5. An October 12, 2009 care plan entry notes that Resident 5 had a sitter, among whose duties was to assist Resident 5 with socialization. CMS Ex. 30, at 37. The sitter also was to assist the facility in feeding Resident 5. A February 1, 2010 care plan entry regarding Resident 5's mechanically altered diet notes as an intervention that Resident 5 is to be "[h]and fed meals by staff & sitter." CMS Ex. 30, at 59, 61. There is nothing of record, however, explaining how the duty was to be shared, or how Petitioner's staff would supervise the sitter's feedings.

On May 12, 2010, Resident 5's physician, Dr. Gillespie, was making rounds at the facility. Upon entering Resident 5's room, Dr. Gillespie observed the sitter with a feeding syringe. Dr. Gillespie told the sitter that feeding syringes should not be used to feed Resident 5, because their use could result in Resident 5's aspiration of the food

material and could result in Resident 5's death. P. Pre-hearing Br. at 6. Nurse's notes from that date reflect that Dr. Gillespie faxed the facility an order regarding "family's req[uest] to use syringe to feed" Resident 5. Dr. Gillespie ordered the facility not to use feeding syringes because such syringes can cause aspiration. P. Ex. 9. The staff member who wrote the nurse's note apparently spoke with the sitter about Dr. Gillespie's order and documented in the nurse's notes that the sitter was to talk to Resident 5's family about Dr. Gillespie's order. P. Pre-hearing Br. at 6; P. Ex. 8; Tr. at 161. Facility personnel placed Dr. Gillespie's order regarding syringes on Resident 5's plan of care, with the "goal" that Resident 5 would not aspirate through the next review. P. Ex. 14, at 2 ("Do not use syringes for feeding, syringes cause aspiration."); CMS Ex. 30, at 60, 62; P. Pre-hearing Br. at 6. However, no approaches or interventions were suggested regarding how this order was to be implemented or monitored.

On May 26, 2010, DON Conner was informed that a feeding syringe had been observed on a meal tray in Resident 5's room. DON Conner documented in nurse's notes that:

> Dietary supervisor reported that there was a feeding syringe laying on overbed table. Sitter was in room. I went to room and saw the syringe but it wasn't being used while I was in room.
>
> Spoke [with] sitter regarding using syringe to feed resident. Explained that it is against facilities (sic) policy as well as state regulation. Also explained the possibility of resident aspirating when using it, voiced understanding.

CMS Ex. 38, at 1. DON Conner testified she counseled the sitter that using a syringe to feed a resident was against Petitioner's policy and state regulations.[6] Tr. at 117-19, 160. DON Conner testified that the sitter told her she would not use a syringe and DON Conner took the sitter's word for it. Tr. at 119. Petitioner asserts the sitter also explained to DON Conner that she used the feeding syringe at the instruction of Resident 5's family. P. Pre-hearing Br. at 7-8. DON Conner testified that after this incident she spoke with the RN and CNA supervisors and the CNAs and asked them to observe Resident 5, especially at feeding time, to ensure that no syringe feeding was done. Tr. at 119-20, 123-24.

The SOD notes that during a July 29, 2010 surveyor interview with Dr. Gillespie, Dr. Gillespie stated that on July 25, 2010, she again saw the sitter feeding Resident 5 with a syringe and again told her not to use the syringe. CMS Ex. 2, at 31-32. Surveyor Johnston testified that Dr. Gillespie told her she saw the sitter syringe-feeding Resident 5 two or three days prior to the survey. Dr. Gillespie told the sitter not to continue the syringe-feeding because it was dangerous and there were risks involved and told her the

[6] DON Conner later testified that her understanding that use of a syringe was prohibited by state regulation was incorrect. Tr. at 160.

Resident should be spoon-fed by staff. Surveyor Johnston did not know what Dr. Gillespie told the facility about her observations. Tr. at 91-92. In a physician's monthly progress note dated July 28, 2010, the sitter admitted to Dr. Gillespie that she knew Dr. Gillespie had told her not to use the syringes but she continued to use them anyway. CMS Ex. 29, at 40. In another physician's monthly progress note dated July 28, 2010, Dr. Gillespie documented that the sitter told Dr. Gillespie that she was aware that Resident 5 was at risk for aspiration with syringe-feeding. The sitter admitted that Resident 5's family gave her the syringes to bring to the facility to feed Resident 5. Dr. Gillespie noted that the sitter stated that she had been trained to feed patients by syringe while working at a hospital. The sitter admitted that it was her idea to syringe-feed, based on her understanding that the family was adamantly against a feeding tube and Resident 5 was losing weight. The sitter admitted her "boss" — Resident 5's son — told her to use the syringe to feed his mother knowing that it was against facility policy. Dr. Gillespie noted that the sitter was also aware that she was not to remove Resident 5's "c-collar" during feeding. CMS Ex. 29, at 41. On May 16, 2010, Dr. Gillespie had ordered that Resident 5 wear a soft cervical collar daily from 6:30 a.m. to 6:30 p.m. CMS Ex. 29, at 16. Surveyor Gray testified that Resident 5 was to have a neck collar on at mealtime to position her head and promote swallowing. Surveyor Gray did not see the collar on the resident. The sitter told Surveyor Gray that she took the collar off when feeding Resident 5 because the collar made it slower to feed her. Tr. at 41.

On July 28, 2010, during the survey, Surveyor Gray testified that she discovered the sitter in possession of feeding syringes in Resident 5's room. Tr. at 28. She reported this to DON Conner. The sitter admitted to DON Conner that she had a syringe and DON Conner brought Administrator Edwards to the room. Administrator Edwards asked the sitter for the syringes. The sitter wanted to give the syringes back to the family. After Administrator Edwards told the sitter she would not be allowed to give the syringes back to the family, the sitter complied and gave Administrator Edwards the syringes. DON Conner disposed of them. Tr. at 125-27, 177-79.

In its answer brief, Petitioner encapsulates CMS's arguments to be that: Petitioner's staff failed to follow physician's orders regarding use of a feeding syringe; Petitioner allowed the sitter to continue to feed Resident 5 despite being aware that Resident 5's care plan prohibited syringe feeding; to protect Resident 5 the only action Petitioner took was to counsel the sitter; and Petitioner did not adequately monitor the sitter. P. Ans. Br. at 3.[7]

[7] Petitioner also notes CMS's argument that Petitioner violated its own policies regarding the use of private duty sitters. Petitioner asserts it had not adopted a policy covering the use of private duty sitters at the time of the survey. I do not address the issue as it is not necessary for me to do so to support my decision in the case.

Petitioner asserts that the conduct that posed a risk to Resident 5 was covertly undertaken by the sitter, who was also a friend of Resident 5's family, not simply an employee of the family. P. Br. at 2; P. Ans. Br. at 5. Petitioner asserts that at all times the syringes were in the exclusive control of the sitter, without the facility's knowledge or approval. Petitioner argues that the fact that the sitter effectively concealed the syringes should not detract from the adequacy of the monitoring procedures undertaken by Petitioner's staff. Moreover, Petitioner argues that the sitter had every right to assist in feeding Resident 5, so long as she obeyed the directive against use of a feeding syringe. P. Ans. Br. at 3-4. Petitioner argues that it is undisputed that there was no accident caused by or injury sustained by Resident 5 due to the sitter's use of a syringe. And, after Petitioner discovered the sitter was feeding Resident 5 by syringe, Petitioner undertook "reasonable and appropriate steps and actions" to provide Resident 5 with care, including monitoring her. Specifically, Petitioner asserts that the RN supervisor immediately informed other nursing staff about the incident, requested monitoring of Resident 5's room, periodically searched Resident 5's room, and required that Resident 5's door be open unless care was being provided in a context requiring privacy. Petitioner asserts that the RN supervisor implemented personal monitoring of the room during lunch and evening meals, and only observed the sitter to use a spoon to feed Resident 5. P. Br. at 20-21; P. Ans. Br. at 4; Tr. at 119-20, 141, 150-51. Further, Petitioner consistently designated CNAs to feed Resident 5. On certain days the sitter asked to feed Resident 5 and she was permitted to do so. However, Petitioner remained responsible for insuring that her dietary needs were met. P. Ans. Br. at 5; Tr. at 146-47.

Petitioner argues that although the SOD indicates that there is no documentary evidence that Petitioner monitored meals being administered to Resident 5 after the syringes were discovered, or any documentary evidence that Petitioner took other action to monitor her feeding activities, the absence of such documentation is not conclusive evidence regarding whether or not such monitoring occurred. Petitioner asserts it had reasonable measures in place to monitor the sitter and Resident 5's feeding activities, whether the actions were documented or not. P. Br. at 21 n.9.

Petitioner argues that it is being held to a strict liability standard, whereas the law only required it to take reasonable steps and actions to ensure that Resident 5 received the necessary care and services to attain or maintain her highest practicable physical, mental, and psychosocial well-being in accordance with her comprehensive assessment and plan of care. Petitioner asserts it met that standard in its care of Resident 5. Moreover, Petitioner asserts that I should rely on the facility's own judgment as to what must be done to attain or maintain this standard. P. Br. at 21-22.

Petitioner argues that a facility cannot control everything a sitter may do, or what family members or visitors may do when they come to the facility. I find, however, that once a facility discovers that a sitter, family member, or visitor is doing something that is likely

to place a resident at risk of serious harm, the facility has a high duty to monitor the situation to negate that risk. Petitioner failed to do so here.

I accept the view that Petitioner did not order or even condone the syringe-feeding that was going on and I acknowledge that it was the family who provided the syringes, engaged the sitter who used them, and encouraged the sitter in their use. My acknowledgment, however, does not mean that I find Petitioner compliant with participation requirements. This case does not oblige me to decide whether the regulations allow a private sitter to feed a resident. The case asks — and requires me to decide — whether after Dr. Gillespie's May 12 Order, and certainly after DON Conner's May 26 discussion with the sitter, Petitioner took reasonable steps and practicable measures to ensure that Resident 5 was not fed by syringe. I find that CMS has made a *prima facie* case, which Petitioner did not rebut, that Petitioner did not take such reasonable steps and practicable measures.

Surveyor Gray testified that Petitioner had no documentation showing how Petitioner monitored the sitter to prevent her feeding Resident 5 with a syringe. Tr. at 32. Surveyor Johnston testified that nothing was documented in Resident 5's chart to show exactly what procedures Petitioner actually put into place to monitor the sitter when feeding Resident 5. Tr. at 90-91, 94. While Petitioner's witnesses have testified that they monitored the situation, there is no contemporaneous evidence showing that they did so, and no care plan or other instruction spelling out how they should monitor the sitter when she fed Resident 5, how often they should check on her, and for how long a period of time they should continue with the monitoring.

Resident 5's sitter had shown by May 26 that she had the potential to persist in feeding Resident 5 with a syringe despite the facility's telling her not to do so and explaining to her the danger of Resident 5's aspirating if syringe-fed. Instead of simply taking the sitter's word that she would not syringe-feed, DON Conner ought to have taken proactive and not unreasonable measures to verify that the sitter was in fact not feeding Resident 5 by syringe in order to assure Resident 5's safety. DON Conner could have, for instance, placed a staff member in the room with the sitter (perhaps the CNA who was assigned to do her feeding if the sitter did not) whenever the sitter fed Resident 5, for the entire time of feeding, to ensure that no syringe-feeding was done. And the actions taken to ensure that Resident 5 was not syringe-fed ought to have been documented, either in nurse's notes or on some other form. Without documentation there is no way for a reviewer to ensure that the sitter and Resident 5 were actually observed during an entire feeding. Doing so is not unreasonable or impractical, especially here where the CNA would have been feeding Resident 5 had the sitter not been there.

The facility is ultimately responsible for Resident 5's safety, and thus it cannot evade responsibility for the care provided the resident by the sitter. Although the sitter was not Petitioner's employee, Resident 5's February 1, 2010 care plan represented that she was

feeding the resident and thus acknowledged that the facility was aware that she was. Even if I accept all of Petitioner's assertions regarding what it did to monitor the situation, this much is clear: given the threat of aspiration (which all parties understood), the measures Petitioner implemented were simply not enough to protect Resident 5. And, as a result of Petitioner's failures, the sitter continued to feed the resident via syringe, as the surveyors, Dr. Gillespie, DON Conner, and Administrator Edwards discovered in July.

The parties did not directly address in their briefs the failure to use a collar on Resident 5 during feeding. However, I find the failure to use a collar, despite physician's orders to do so, to be further evidence of Petitioner's failure to comply with this participation requirement.

2. CMS's determination that the facility's noncompliance posed immediate jeopardy to resident health and safety is not clearly erroneous.

Immediate jeopardy exists if a facility's noncompliance has caused, or is likely to cause, "serious injury, harm, impairment, or death to a resident." 42 C.F.R. § 488.301. CMS's determination as to the level of a facility's noncompliance (which includes an immediate jeopardy finding) must be upheld unless it is "clearly erroneous." 42 C.F.R. § 498.60(c). The Board has observed repeatedly that CMS's determination of immediate jeopardy is presumed to be correct and Petitioner faces a "heavy burden" to demonstrate that CMS's determination is clearly erroneous. *Owensboro Place and Rehabilitation Center,* DAB No. 2397, at 9 (2011), *citing Azalea Court*, DAB No. 2352, at 16-17 (2010) and cases cited therein.

Petitioner has not shown here that CMS's determination of immediate jeopardy was clearly erroneous. As noted above, the danger of aspiration from syringe-feeding is obvious and was known by Petitioner at the time. Surveyor Gray testified that aspiration occurs when stomach contents, fluid or food enter the respiratory system. Syringe feeding can lead to a high risk of aspiration. And aspiration can sometimes cause death. Tr. at 26-28. Resident 5 was particularly debilitated and at risk. Tr. at 40-41. Surveyor Johnston testified that the risks of syringe-feeding are "aspiration, development of pneumonia, possible choking, and could result in death." Tr. at 88. *See* P. Prehearing Br. at 6, 12. Although there is no conclusive evidence that Resident 5 ever aspirated or was otherwise harmed by the syringe feeding, the likelihood of aspiration was manifest each time she was syringe-fed.

3. The remedy imposed is reasonable.

In determining whether the CMP imposed here is reasonable, I apply the factors listed in 42 C.F.R. § 488.438(f), which include: (1) the facility's history of noncompliance; (2) the facility's financial condition; (3) the factors specified in 42 C.F.R. § 488.404; and (4)

the facility's degree of culpability, which includes neglect, indifference, or disregard for resident care, comfort, or safety. The absence of culpability is not a mitigating factor. The factors at 42 C.F.R. § 488.404 include: (1) the scope and severity of the deficiency; (2) the relationship of the deficiency to other deficiencies resulting in noncompliance; and (3) the facility's prior history of noncompliance in general and specifically with reference to the cited deficiencies.

Petitioner does not specifically iterate reasons for me to reduce the amount of the CMP or the duration of the CMP, asserting only that should I find Petitioner violated a participation requirement I should find the CMP assessed unreasonable. P. Prehearing Br. at 20, 21; P. Br. at 23, 24; P. Ans. Br. at 6.

Petitioner has a history of noncompliance with 42 C.F.R. § 483.25, Tag F-309, as it had quality of care deficiencies under this requirement during surveys conducted in 2007, 2009, and 2010. CMS. Ex. 9. Petitioner has not provided any evidence with regard to its financial condition. The deficiency is serious, constituting immediate jeopardy. Accordingly, I find the CMP imposed by CMS, totaling $25,950, is reasonable.

V. Conclusion

For the reasons set forth above, CMS is authorized to impose a $25,950 CMP.

/s/
Richard J. Smith
Administrative Law Judge