Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Hanover Hill Health Care Center
(CCN: 30-5009),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-13-671 (on remand)

Decision No. CR3745

Date: March 31, 2015

DECISION

Petitioner, Hanover Hill Health Care Center (Petitioner or facility), is a long-term care facility located in Manchester, New Hampshire, that participates in the Medicare program. Following a survey completed on February 11, 2011, the New Hampshire Department of Health and Human Services (state agency) determined that the facility was not in substantial compliance with Medicare participation requirements, and that the facility's noncompliance posed immediate jeopardy to the health and safety of facility residents. Specifically, even though staff recognized that one of its demented residents tended to "shovel peanut butter" into his mouth and had recently exhibited difficulties swallowing, they left him alone and unsupervised with crackers covered in peanut butter. He choked to death, with "large amounts" of the peanut butter lodged in his throat.

Based on the state agency's findings, the Centers for Medicare & Medicaid Services (CMS) imposed a per-instance civil money penalty (CMP) of $7,500. Petitioner appealed, and, in a decision dated September 20, 2012, I found that the facility was not in substantial compliance with Medicare participation requirements and that the penalty imposed was reasonable. *Hanover Hill Health Care Ctr.*, DAB CR2617 (2012).

The matter is back before me on remand from an appellate panel of the Departmental Appeals Board. *Hanover Hill Health Care Ctr.*, DAB No. 2507 (2013). The Board instructed me "to consider or explain evidence not fully addressed" in my initial decision. *Id.* at 23.

Having reviewed the record in this case in light of the Board's comments, I find that Petitioner was not in substantial compliance with Medicare participation requirements and that the penalty imposed is reasonable.

I. Background

The Social Security Act (Act) sets forth requirements for nursing facility participation in the Medicare program, and authorizes the Secretary of Health and Human Services to promulgate regulations implementing those statutory provisions. Act § 1819. The Secretary's regulations are found at 42 C.F.R. Part 483. To participate in the Medicare program, a nursing facility must maintain substantial compliance with program requirements. To be in substantial compliance, a facility's deficiencies may pose no greater risk to resident health and safety than "the potential for causing minimal harm." 42 C.F.R. § 488.301.

The Secretary contracts with state survey agencies to conduct periodic surveys to determine whether skilled nursing facilities are in substantial compliance. Act § 1864(a); 42 C.F.R. § 488.20. The regulations require that each facility be surveyed annually, with no more than fifteen months elapsing between surveys. Facilities must be surveyed more often, if necessary, to ensure that identified deficiencies are corrected. Act § 1819(g)(2)(A); 42 C.F.R. §§ 488.20(a), 488.308.

The state agency surveyed the facility between February 9 and 11, 2011, and cited deficiencies related to the care provided to a resident referred to as "Resident 17" (R17). Among other deficiencies, the state agency cited two at the immediate jeopardy level, concluding that the facility did not address sufficiently R17's demonstrated swallowing difficulties nor adequately protect him from harm:

- 42 C.F.R. § 483.13(c) (Tag F-224) (prohibit neglect), for failing to ensure that the facility implemented policies and procedures to prohibit neglect of R17; and

- 42 C.F.R. § 483.25 (Tag F-309) (quality of care), for failing to provide a comprehensive assessment to determine the appropriate interventions for R17's swallowing difficulties.[1]

[1] The state agency cited the facility for five related deficiencies that did not cause actual harm, with the potential for more than minimal harm: 42 C.F.R. §§ 483.13(c)(1)(ii)-(iii), (c)(2)-(4) (failing to report the results of an allegation of neglect within five days);

The state agency also determined that the immediate jeopardy had abated at the time of the survey, and that the facility achieved substantial compliance as of March 9, 2011. CMS adopted the state agency's findings and imposed a $7,500 per-instance CMP.

In the original proceedings in this case, I admitted into evidence CMS Exs. 1-14 and P. Exs. 1-28. I convened a hearing by video teleconference on January 23, 2012. Ms. Jill Steinberg appeared on behalf of CMS, and Mr. Joseph Bianculli appeared on behalf of Petitioner.

II. Issues

This case presents the following issues:

1. Was the facility in substantial compliance with 42 C.F.R. § 483.13(c) (Tag F-224 – staff treatment of residents, abuse/neglect policies) and 42 C.F.R. § 483.25 (Tag F-309 – quality of care); and

2. If the facility was not in substantial compliance, is the penalty imposed – $7,500 per-instance – reasonable.

I am not authorized to review CMS's immediate jeopardy determination. An administrative law judge may review CMS's scope and severity findings (which include a finding of immediate jeopardy) only if a successful challenge would affect the range of the CMP or if CMS has made a finding of substandard quality of care that results in the loss of approval of a facility's nurse aide training program. 42 C.F.R. § 498.3(b)(14); 42 C.F.R. §§ 498.3(b)(14), 498.3(d)(10); *Cedar Lake Nursing Home*, DAB No. 2344 at 9 (2010); *Evergreen Commons*, DAB No. 2175 (2008); *Aase Haugen Homes*, DAB No. 2013 (2006). For a per-instance penalty, the regulations provide only one range ($1,000 to $10,000), so the level of noncompliance here does not affect the range of the CMP. 42 C.F.R. § 488.438(a)(2).

The facility apparently does not operate a nurse aide training program. CMS Ex. 14 at 1. Even if it did, CMS's scope and severity finding would not affect approval of such a program. By statute and regulation, if, as here, CMS imposes a penalty of $5,000 or

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483.13(c) (failing to report its investigation results within five days); 483.20(d)(3) (failing to update R17's comprehensive care plan); 483.75 (failing to administer the facility in a manner that enabled it to provide residents with their highest practicable well-being); and 483.75(i) (medical director's failing to ensure adequate care and services be provided to R17, who had a history of choking). CMS did not impose any remedies for these deficiencies, however, expressly limiting the penalty to those deficiencies cited at the immediate jeopardy level.

more, the state agency cannot approve the program, so the facility would lose its approval without regard to the immediate jeopardy finding. Act § 1819(f)(2)(B); 42 C.F.R. § 483.151(b)(2)(iv).

Thus, because the immediate jeopardy finding here does not affect the range of the CMP or cause the facility to lose approval of its nurse aide training program (if it has one), the finding is not reviewable.

III. Discussion

A. *Petitioner was not in substantial compliance with 42 C.F.R § 483.13(c) and 42 C.F.R. § 483.25 because the facility did not implement its policy prohibiting resident neglect and did not provide the necessary assessment, care, and services to R17 to address his exhibited swallowing difficulties and to keep him safe and free from neglect.*[2]

The deficiencies cited under sections 483.13(c) and 483.25 stem from a common set of facts. *Compare, e.g.*, CMS Ex. 1 at 2-6 *with* CMS Ex. 1 at 12-18. This is neither surprising nor uncommon. After all, if a facility does not "provide goods and services necessary" for a resident to avoid harm (42 C.F.R. §§ 483.13(c), 488.301), it necessarily fails to provide the "care and services" necessary to allow the resident "to attain or maintain the highest practicable physical, mental, and psychosocial well-being." 42 C.F.R. § 483.25. For this reason, and to avoid an unnecessarily lengthy and redundant decision, I do not repeat the facts for each of the deficiencies cited, but, as appropriate, I discuss how those facts put the facility out of substantial compliance with each of the cited regulations. *See, e.g.*, *Liberty Health & Rehab of Indianola, LLC*, DAB No. 2434 at 12 (2011) ("Although Liberty objects that the ALJ relied on the same analysis to support his conclusion on noncompliance with all three cited requirements, the Board has held that, in appropriate circumstances, a finding of noncompliance with section 483.75 may be derived from findings of noncompliance with other participation requirements."); *Van Dunn Home & Hosp.*, DAB No. 2368 at 17 n.5 (2011) ("We also uphold the ALJ's conclusion that the same facts demonstrate noncompliance with 42 C.F.R. § 483.74 (administration) and 42 C.F.R. § 483.75(i) (medical director), given the fundamental responsibilities of the administration and the medical director to ensure systems and policies protect residents' safety from foreseeable risks."); *Jennifer Matthew Nursing & Rehab. Ctr.*, DAB No. 2192 at 50 (2008) ("Jennifer Matthew can demonstrate no prejudice since the ALJ determined after [a] hearing (and we agree) that, based on its care of R17 and of other residents during the heat wave, Jennifer Matthew was not in substantial compliance with sections 483.13(c), 483.25, and 483.75.").

[2] My findings of fact and conclusions of law are set forth, in bold and italics, as captions in the discussion section of this decision.

In reaching my conclusions here, I have considered the evidence and arguments that Petitioner raised – essentially, that it was not required to address R17's risk of choking, because he was not at risk; rather, his problems stemmed from behavioral issues, and, to the extent that staff changed his care plan, they did so to address his behaviors, not his ability to swallow. In accordance with the Board's instructions, I have also considered arguments that Petitioner did not raise – that some evidence (not relied on by Petitioner and not "fully discussed" in my decision) might (or might not) suggest that the facility addressed the swallowing issue.

Program Requirements. Facilities must develop and implement written policies and procedures that prohibit resident neglect. 42 C.F.R. § 483.13(c). "Neglect" means the failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. 42 C.F.R. § 488.301.

Section 483.13(c) "addresses a deficiency related to lack of an effective policy as opposed to one directed at the occurrence of neglect itself." *Emerald Oaks*, DAB No. 1800 at 12 (2001). However, the drafters of the regulation characterized as "inherent in [section] 483.13(c)" the requirement that "each resident should be free from neglect as well as other forms of mistreatment," 59 Fed. Reg. 56,130 (Nov. 10, 1994). The regulation requires that the facility "implement" its anti-neglect policies. 42 C.F.R. § 483.13(c). Implementing a policy requires more than drafting and maintaining documents. Staff must carry out and follow the policy. The Board has recognized that examples of neglect can demonstrate that the facility has not implemented its policies. *Barn Hill Care Ctr.*, DAB No. 1848 at 9-12 (2002); *Emerald Oaks*, DAB No. 1800 at 18; 59 Fed. Reg. 56,130; *see also The Cottage Extended Care Ctr.*, DAB No. 2145 at 4 n.4 (2008); *Liberty Commons Nursing & Rehab. Ctr.-Johnston*, DAB No. 2031 at 7-17 (2006), *aff'd, Liberty Nursing & Rehab. Ctr.-Johnston v. Leavitt*, 241 F. App'x 76 (4th Cir. 2007).

In addition, under the Act and "quality of care" regulation, each resident must receive, and the facility must provide, the necessary care and services to allow a resident to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the resident's comprehensive assessment and plan of care. Act § 1819(b); 42 C.F.R. § 483.25. To this end, the facility must eliminate or reduce a known or foreseeable risk of accident "to the greatest degree practicable." *Del Rosa Villa*, DAB No. 2458 at 7 (2012) (quoting *Clermont Nursing & Convalescent Ctr.*, DAB No. 1923 at 9-10 (2004)), *aff'd, Clermont Nursing & Convalescent Ctr.*, 142 F. App'x 900 (6th Cir. 2005)).

The Facility's Policies and Procedures. The facility's "Abuse Prohibition" policy provides that the facility would "make every effort to prevent patient/resident . . . neglect . . . by employing the seven components of prevention: screening, training, prevention, identification, investigation, protection and reporting/response." CMS Ex. 5 at 19. In the

"prevention" component, the policy says that the facility would, among other things, "identify, correct, and intervene in situations in which . . . neglect . . . is more likely to occur" and "[a]ssess, care plan for and monitor residents with needs and behaviors which may lead to . . . neglect . . . ." CMS Ex. 5 at 19-20.

The facility's "Monitoring Residents/Patients as Having Significant or Health Altering Nutritional Issues" policy says that the facility will identify to the "Nutrition-at-Risk Committee" residents with "significant, health altering nutritional issues." CMS Ex. 5 at 2. The Nutrition-at-Risk Committee will review residents "who meet at least on[e] of the following criteria: . . . (5) Score of 10 or above on malnutrition risk assessment." CMS Ex. 5 at 2. The Committee must discuss the resident's nutritional issues, including "current weight, variances in weight, current diet order and supplements, heath status review, changes in cognitive/behavior status, and identification of co-founding factors." CMS Ex. 5 at 2.

R17's Swallowing Difficulties. R17 was a 69-year-old man who suffered from a multitude of conditions, including chronic venous insufficiency, dementia, diabetes, and heart disease. P. Ex. 2 at 3. Over a three-week period – from an August 9, 2010 choking incident until his August 29, 2010 death – R17 experienced five documented occasions of choking or difficulty swallowing:

- On August 9, the facility's nursing staff found R17 in his room, "red in face," choking on his lunch. CMS Ex. 6 at 41. A nurse performed "[two] pumps of the [H]eimlich maneuver," which dislodged the food and opened R17's airway. CMS Ex. 6 at 47; P. Ex. 18 at 3 (Bumford Decl.).

- On August 12, a nurse observed R17 "reddened in the face, attempting to cough with difficulty" while eating apple slices, which he was "able to clear with thick sputum and apple peels present in vomited remnants." CMS Ex. 6 at 48.

- On August 14, R17 took his oral medication "with much difficulty." CMS Ex. 6 at 50. The administering nurse reported that R17 "took a couple minutes to swallow each individual pill," and he "[r]efused to try taking pills with applesauce or anything to aid with swallowing." CMS Ex. 6 at 50.

- On August 15, R17 "took a significant time to swallow each individual pill with difficulty." CMS Ex. 6 at 50. The nurse explained that R17 "tossed pills around in his mouth and talk[ed] during swallowing." She directed him to "focus on swallowing during med[ication] administration to prevent choking, but [R17 is] forgetful." CMS Ex. 6 at 50. He again "refused to take pills crushed or with applesauce to assist with swallowing." CMS Ex. 6 at 50.

- On August 21, R17 had "difficulty swallowing pills," and was "pocketing them inside of [his] cheek." CMS Ex. 6 at 52. The nurse "[a]dded applesauce to whole pills," which was "helpful in assisting with swallowing." CMS Ex. 6 at 52.

August 9, 2010 Choking Episode. Nursing staff reported the August 9 choking episode to the facility's speech and language pathologist (SLP), Heather Marttila, who assessed R17's swallowing functions and "observed [R17] consuming a regular texture with thin liquids." CMS Ex. 6 at 47. SLP Marttila reported that R17 was "tolerating [food] without overt signs [or] symptoms of aspiration [or] choking," and "no coughing, throat clearing or change in subsequent vocal quality." CMS Ex. 6 at 47. She concluded that the "[c]hoking episode appears to be an isolated event" but recommended that the nursing staff monitor R17 over the "next few shifts." CMS Ex. 6 at 47.

Nursing staff notified Physician's Assistant (PA) Enieda Islamovic (covering for R17's primary care physician, Dr. Howard Suls), who issued no new orders. CMS Ex. 6 at 47. Staff also notified R17's daughter of the incident, and "reviewed and updated" R17's plan of care to include allowing "ample time for resident to swallow medication" which, it noted, was "secondary to possible swallowing issues." CMS Ex. 6 at 41; P. Ex. 5 at 23.

The facility's response to the August 9 choking incident presents no significant problems. Staff identified signs of changes in swallowing function and timely notified the appropriate personnel (SLP Marttila). SLP Marttila assessed R17's swallowing function and concluded that the incident was likely "isolated," although she recommended supervision for the "next few shifts." CMS Ex. 6 at 41, 47. Staff also notified PA Islamovic. Both SLP Marttila and PA Islamovic directed staff to monitor R17 during meals for "a few shifts," and check his vital signs and lung sounds every shift for 72 hours. CMS Ex. 6 at 42, 47.

CMS questioned the adequacy of SLP Marttila's assessment, suggesting it was a "screen" and did not meet the assessment standards described in medical literature. CMS Post-Hr'g Br. at 5 n.4. This case does not turn on the facility's response to the August 9 incident, however. As the evidence establishes, in the three weeks following that incident, facility staff made little effort to identify and address the causes of R17's swallowing difficulties despite growing evidence that those difficulties went beyond one isolated choking incident. Most important, knowing how vulnerable R17 was, *they did not keep him safe*.

August 12, 2010 Incident. On August 12, staff found R17 "reddened in the face, attempting to cough with difficulty" while eating apple slices. CMS Ex. 6 at 48.[3]

[3] Why staff gave him apples is a mystery. An April 7, 2010 entry in his care plan directed "NO APPLES per speech therapy recommendations." (emphasis in original). P. Ex. 5 at 16.

Petitioner offers no testimony from anyone who witnessed the entire episode, and it appears that no one did.[4]

Petitioner now denies that R17 choked on or had difficulty swallowing the food, but argues that he experienced a benign coughing episode, which did not merit further attention. P. Post-Hr'g Br. at 13. I reject Petitioner's position for two reasons: first, coughing while eating (including before swallowing) is itself a sign of dysphagia that merits further attention. *See* CMS Ex. 9 at 2 (Jeanie Kayser-Jones and Kathryn Pengilly, *Dysphagia Among Nursing Home Residents*, 20 Geriatric Nursing 77, 78 (No. 2 1999)); CMS Ex. 10 at 5-7 (Carol Smith-Hammond and Larry Goldstein, *Cough and Aspiration of Food and Liquids Due to Oral-Pharyngeal Dysphagia: ACCP Evidence-Based Clinical Practice Guidelines*, Chest Journal (No. 129, 2006), describing "reflexive cough" in response to presence of liquid or food in laryngeal area as a sign of possible aspiration or dysphagia).

Second, the staff's contemporaneous notes and reports consistently characterize the event as "choking" or otherwise related to R17's difficulty swallowing. Nurse Melissa O'Donnell, who witnessed at least part of the incident, left a message with PA Islamovic "regarding recent med[ication] change of [O]xycontin and *any relation to swallowing issues*." CMS Ex. 6 at 48 (emphasis added). The facility's Registered Dietician (RD), Amy Goulas, wrote that staff supervised R17 at meals due to "recent choking episodes on apples." CMS Ex. 6 at 37. RD Goulas now says "I should have been clearer in my note, and written that the resident had started coughing while eating apple slices, and that in an exercise of caution . . . I recommended replacement of that snack on his meal tray ticket."[5] I find this claim not credible. I find it more likely that RD Goulas, who was in the facility but did not witness the incident, wrote "choking episodes" because staff reported that R17 had choked on his food. *See* P. Ex. 19 at 3 (Goulas Decl.); CMS Ex. 6, at 38. *See Jennifer Matthew Nursing & Rehab. Ctr.*, DAB No. 2192 at 52 (2008) (finding that the ALJ may reasonably give more weight to contemporaneous notes than to witness testimony). Indeed, RD Goulas not only wrote that R17 is supervised at meals because of "recent choking episodes on apples," she emphasized that fact by writing an addendum:

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[4] As discussed below, the Nutrition-at-Risk Committee apparently thought that staff supervised R17 as he ate. CMS Ex. 6 at 37; *see also* CMS Ex. 7 at 3 (July 2010 assessment indicating that R17 needed a one-person physical assist with eating); *but see* CMS Ex. 7 at 9 (May 2010 assessment indicating that R17 needed set-up help only for eating). But the evidence establishes that staff did not supervise him. P. Ex. 18 at 5 (Bumford Decl.).

[5] RD Goulas admits that she ordered kitchen staff to stop providing apple slices to R17 because apple slices "can be a difficult food for some people to chew and swallow" (P. Ex. 25 at 1). CMS Ex. 6, at 37, 48.

staff were "watching resident while in room [with] meals" on all three shifts. CMS Ex. 6 at 37.

This second incident cast sufficient doubt on SLP Marttila's initial impression of a single isolated incident to compel the facility to: 1) provide R17 with additional care and services to keep him free from neglect (42 C.F.R. § 483.13(c)); and 2) identify the underlying cause and, as possible, treat his swallowing issues so that he could attain his highest practicable physical, mental, and psychosocial well-being (42 C.F.R. § 483.25). The evidence establishes that the facility fell short on both counts.

Difficulty Swallowing Medication. On August 14, August 15, and August 21, nurses documented that R17 had difficulty swallowing his medication. P. Ex. 7 at 31-33; CMS Ex. 6 at 50, 52. Petitioner dismisses these incidents as attributable to R17's behavior problems. P. Post-Hr'g Br. at 9; P. Ex. 18 at 2 (Bumford Decl.) (describing R17 as "manipulative," and claiming that "sometimes" he refused medications from certain nurses); *accord* P. Ex. 20 at 2 (Ballentine Decl.); P. Ex. 21 at 2 (Ouellette Decl.); P. Ex. 23 at 1 (Turgeon Decl.); P. Ex. 24 at 3 (Foster Decl.).

I have no doubt that R17, who suffered from dementia likely caused by organic brain syndrome (*see* CMS Ex. 6 at 1-2), was often sarcastic, rude, and socially inappropriate. CMS Ex. 6 at 11. That R17 exhibited these behaviors, however, does not preclude the very real possibility that he was developing a problem swallowing and that he had difficulty swallowing his medications. Indeed, refusing to swallow may itself signal swallowing problems; and it is not uncommon for staff to mistake genuine swallowing problems as the resident's "deliberately being difficult." *See* CMS Ex. 9 at 3 (Kayser-Jones and Pengilly, 20 Geriatric Nursing at 79). According to R17's care plan, he may have resisted taking oral medications because of his problems with swallowing. The care plan entry, dated August 9, 2010, says "Resident often takes a long time to swallow pills *secondary to possible swallowing difficulties*." CMS Ex. 6 at 24 (emphasis added); P. Ex. 5 at 23.

Even more compelling, the nurses' notes that document R17's difficulties taking oral medication describe swallowing difficulties, not behavioral issues.[6] He did not refuse to take his medication on August 14, for example. According to the note written by Nurse Kimberly Jacobson, R17 took his pills "with much difficulty," but refused to take the

[6] For this reason I finding unconvincing, at best, and deeply disturbing, at worst, Director of Nursing (DON) Heather Foster's claim that not one of her staff members ever reported that R17 had a physical problem swallowing medication. P. Ex. 24 at 3 (Foster Decl.). Moreover, none of the testimony from Petitioner's nursing staff that describes R17's behavior problems is from the nurses who documented R17's trouble swallowing medication between August 9 and August 29, 2010.

pills with applesauce or anything else "to aid with swallowing." CMS Ex. 6 at 50 (emphasis added). From this, I can reasonably infer that he was having trouble swallowing his pills.

On August 15, Nurse Jacobson again reported that R17 "took a significant time to swallow each individual pill with difficulty." CMS Ex. 6 at 50. She directed him to "focus on swallowing," but noted that he was "forgetful" and, again, would not allow the pills to be crushed or taken with applesauce "to assist with swallowing." CMS Ex. 6 at 50. The progress note plainly describes another instance – the second in two days – of R17 having "difficulty" swallowing his medication. The nurse wrote that staff would "continue to monitor for comfort and safety." CMS Ex. 6 at 50.

Less than one week later, on August 21, Nurse O'Donnell reported that R17 was having "difficulty swallowing pills, pocketing them inside of cheek." CMS Ex. 6, at 52. This time he allowed her to add the whole pills to applesauce, which she described as "helpful in *assisting with swallowing*." CMS Ex. 6 at 52 (emphasis added); P. Ex. 7 at 33. Again, nothing in the progress note suggests that he was refusing to take the pills or exhibiting any other behavioral problem. The nurse wrote that staff would "continue to monitor."

Petitioner also questions whether difficulty swallowing pills bears any relationship to difficulty swallowing food. First, at least one nurse suggested that R17 had problems with his pills because he was forgetting how to swallow, which would evidence a very serious problem and require further assessment. CMS Ex. 6 at 50. Second, an adequate assessment could have shown whether his difficulties were as limited as Petitioner now suggests. Finally, R17's inability to swallow apple slices on August 12, by itself, should immediately have alerted staff to his potentially serious swallowing problems and triggered a serious reassessment pursuant to the facility's abuse prohibition policy.

I recognize that nursing staff checked and recorded R17's vital signs at least once following the August 12 incident. I also recognize that some of his nurses gave him additional time to swallow his medications. P. Ex. 7 at 30-33. I do not consider these acceptable substitutes for a qualified therapist assessing thoroughly the degree of his impairment and proposing appropriate treatment. Nor do I consider these "interventions" acceptable substitutes for proper monitoring in order to keep him safe while he ate.

<u>The facility's limited – and inadequate – response to R17's swallowing problems: 1) medication change</u>. As noted above, following the August 12 choking incident, Nurse O'Donnell left a message with PA Islamovic, who subsequently adjusted R17's medications. Whether the physician's assistant communicated directly with anyone from the facility is far from clear, but, in a telephone order, she reduced the resident's Oxycontin dosage. CMS Ex. 6 at 49. According to the medical literature, overusing medications that affect a resident's alertness *may* exacerbate swallowing difficulties, so the medication change made some sense. *See, e.g.*, CMS Ex. 10 at 3-5; CMS Ex. 11 at

14; CMS Ex. 12 at 2-4; P. Ex. 18 at 4. But no evidence suggests that SLP Marttila or any qualified person subsequently assessed R17's abilities to swallow. Indeed, no one even told SLP Marttila about the August 12 incident, which staff certainly should have done. Unless competent staff assessed and monitored the resident's swallowing following the medication change, the facility would not learn whether his swallowing difficulties were related to his medications. More important, staff knew that R17 had experienced two significant swallowing incidents and that he continued to have problems swallowing his medications. They did not know why, and, without carefully monitoring R17 while he ate, they could not guarantee his safety.

2) Nutrition-at-Risk Committee. For reasons unrelated to swallowing (abnormal lab values and pressure ulcers), R17 had been referred to the Nutrition-at-Risk Committee. The committee reviewed his status bi-weekly. CMS Ex. 6 at 37, 65, 66; P. Ex. 19 at 2 (Goulas Decl.).

On August 16, 2010, the committee, made up of RD Goulas and a nurse, completed a one-page document, titled "Nutrition-At-Risk Communication Form." The document focuses on other issues (wounds, weight gain possibly related to edema), but mentions that the resident "is supervised at meals" secondary to "recent choking episodes on apples." An undated addendum reiterates: "watching resident while in room" with meals every shift. CMS Ex. 6 at 37. However, R17's care plan does not include any instruction that staff supervise him during his meals, and the record does not reflect when the facility implemented that supervision or the means by which it instructed staff to supervise him. *See* P. Ex. 5. Indeed, RN Shauna Bumford testified that staff *did not* supervise R17 while he ate. P. Ex. 18 at 5 (Bumford Decl.). As evidenced by the August 12 incident, R17's choking death on August 29 (see discussion below), and the absence of evidence that staff ever remained with him while he ate, I conclude that they were not supervising him. He choked on his food three times (August 9, August 12, and August 29), and, each time, no one was with him when he started to choke.

The form includes a checklist of recommendations for follow-up. Only one box is checked – that the resident be weighed weekly. CMS Ex. 6 at 37. Other boxes, including medical evaluation and speech pathology consult, are left blank. The Board has suggested that the absence of a check mark "might be read as indicating that each of the listed actions was considered and only the checked ones were chosen to be implemented." *Hanover Hill Health Care Ctr.*, DAB No. 2507 at 16.

An unchecked box seems a tenuous thread by which to hang a finding of substantial compliance. Indeed, in *Brenham Nursing and Rehabilitation Center*, DAB No. 2619 (2015), a box *was* checked, but the Board recognized – correctly – that checking, or not checking, a box has little significance in the absence of underlying evidence:

> The report's bare statement that there was an "evaluation for possible cause," absent more information about the content and extent of that evaluation, is not evidence of an investigation at all, much less a thorough one. Moreover, the ALJ reasonably concluded Brenham did not rule out the possibility of abuse or neglect, notwithstanding someone's having put a check mark in the "No" box.

DAB No. 2619 at 11.

Significantly, Petitioner did not suggest that the absence of a check mark on this form was significant in any way. Petitioner argues that RD Goulas and PA Islamovic exercised their "professional judgment" by *not* assessing R17 or asking that R17 be re-assessed. P. Post-Hr'g Br. at 14. Certainly, the record shows that no one performed a meaningful assessment of R17's swallowing ability following the August 12 incident or any time thereafter. Beyond that, no reliable evidence suggests that the committee, or anyone else, seriously considered or discussed whether they should refer R17 for another assessment in light of the August 12 choking incident and his ongoing difficulties swallowing his medications. To the contrary, RD Goulas concedes that she did not consider referring R17 for an assessment. She justifies that failure by denying that R17 choked on the apple slices in the first place, claiming that she "saw no evidence of dysphagia or swallowing difficulty." P. Ex. 19 at 2, 3 (Goulas Decl.). In light the written record and RD Goulas's contemporaneous notes, I have found this claim not credible (see discussion above). Moreover, inasmuch as coughing while eating can be a sign of dysphagia, she should have recognized evidence of dysphagia.

From this, I conclude that, notwithstanding the existence of an unchecked box on a standard form, the Nutrition-at-Risk Committee did not seriously consider R17's need for a swallowing assessment.

3) Malnutrition Risk Assessment. On August 24, 2010, Nurse O'Donnell completed a document titled "Malnutrition Risk Assessment." CMS Ex. 6 at 43. The document reflects three notable changes: 1) R17's "assessment score," which is used to determine a resident's level of risk for malnutrition, nearly doubled, from 7 on July 8 to 13 on August 24; 2) R17's mental status deteriorated from "alert-oriented x 3" (i.e., oriented to person, place, and time) to "lethargic-disoriented x 2"; and 3) R17 had an additional risk factor, "difficulty swallowing/frequent choking." *Compare* CMS Ex. 6 at 65 *with* CMS Ex. 6 at 43. According to the facility's policies, the Nutrition-at-Risk Committee should have discussed these specific issues. CMS Ex. 5 at 2 (directing the committee to discuss changes in status for any resident who scores 10 or above on the malnutrition risk

assessment). But, as noted above, the committee effectively disregarded the deterioration.[7]

Petitioner has not claimed that the designated committee addressed these new issues, but instead it attacks the validity of the August 24 document. In remarkable testimony, the facility's administrator, Lori McIntire, and Director of Nursing (DON) Heather Foster claim that R17's "malnutrition risk assessment" inaccurately describes R17's "difficulty swallowing/frequent choking." P. Ex. 24 at 3 (Foster Decl.); CMS Ex. 6 at 43. According to DON Foster, "the software that generates this form automatically enters that language when the nurse completing the assessment enters *any* episode of choking . . . ." P. Ex. 24 at 3 (Foster Decl.).

These claims are belied by the medical record, with its documented incidents of swallowing problems and choking. Even the August 16 Nutrition-at-Risk Communication Form refers to "recent choking episodes," and that reference is hand-written, not computer-generated. CMS Ex. 6 at 37. Moreover, a resident's assessment is supposed to be individualized and, it should go without saying, *must accurately reflect the resident's actual condition*. 42 C.F.R. § 483.20(b)(2)(ii). An inaccurate assessment compromises the integrity of the resident's care plan, because the care plan – which is supposed to describe the "services to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under [section] 483.25" – is based on the assessment. Basing a care plan on an inaccurate assessment obviously puts the facility out of substantial compliance with the quality of care regulation, 42 C.F.R. § 483.25, and would evidence a very serious deficiency. Conversely, disregarding the assessment would also put the facility out of substantial compliance and would evidence a very serious deficiency.

In accordance with its abuse/neglect prohibition policy and the regulatory standards, the facility should have re-assessed R17's ability to swallow to determine the care and services he required and then to provide that care and those services. The policy does not require a specific type of assessment, but instructs staff to "assess, care plan for, and monitor" the resident when there is a situation that may lead to neglect. CMS Ex. 5 at 19-20.[8] Not assessing the scope of a potential swallowing problem is likely to lead to

[7] The assessment also indicates that the resident required verbal cues to feed himself. That he was left alone with his food suggests that staff could not have been providing the necessary cues.

[8] SLP Marttila testified that "elaborate swallowing studies" are not done after the "occasional occurrence" of swallowing problems, and the policy does not require a specific type of assessment. P. Ex. 25, at 2. However, the swallowing difficulties exhibited here – at least five documented incidents in three weeks, and two in a matter of three days – exceeded an "occasional occurrence." Moreover, the problem is not that the

neglect because, without an accurate assessment, the facility could not know how to address the potentially life-threatening medical problem.

Even more critical, because staff knew or should have known of R17's vulnerability, they were charged with keeping him safe. The Nutrition-at-Risk Committee may have recognized as much, claiming that he was supervised while eating. In fact, he was not. P. Ex. 18 at 5 (Bumford Decl.).

R17's Death on August 29, 2010. On August 29, R17 died while eating crackers covered in peanut butter. CMS Ex. 6 at 57; CMS Ex. 8 at 7. The contemporaneous nursing notes, reports from the emergency responders, as well as the resident's death certificate all describe his choking to death on peanut butter and crackers. We know that he had been left alone because LPN Judith Ballentine writes that he called as she was passing his room. He was coughing, had difficulty speaking, and "appeared to be choking." She attempted the Heimlich maneuver, removing a piece of peanut butter, and he started coughing again. He spoke but "appeared to have difficulty catching his breath." She attempted the Heimlich a second time, "with no effect." He became unresponsive, "no breath noted." CMS Ex. 6 at 57.

Staff told the responding paramedics that the resident liked peanut butter and had a history of "shoveling peanut butter in his mouth." The paramedics reported that he "started choking" while eating it. His airway was obstructed by peanut butter, and they removed a large amount of it but were unable to suction successfully because of the "thickness of the peanut butter." CMS Ex. 6 at 122. According to the death certificate, R17 died from "asphyxia" and "upper airway obstruction by food." CMS Ex. 8, at 1; *see* CMS Ex. 6 at 29 ("Pt. was stuffing peanut butter in his mouth when he started to choke.").

Citing the testimony of Howard Suls, M.D., who was R17's physician and the facility's medical director, the facility maintains that R17 died, not from choking on peanut butter, but from a cardiac event that just happened to coincide with his eating (but not swallowing) a lot of peanut butter on crackers. P. Ex. 28 at 3-4. I find this highly unlikely based on all of the contemporaneous evidence. Nevertheless, this case does not rest on whether R17 choked to death on peanut butter and crackers. The facility was not in substantial compliance because, contrary to the requirements of the regulations and its own policies, it failed to assess properly and care-plan appropriately for R17 after he demonstrated repeatedly that he was experiencing difficulties swallowing. To the extent that they had a plan, it required that staff supervise him while he ate. *But see* P. Ex. 18 at

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facility failed to provide an "elaborate swallowing study," but that it did not assess R17's swallowing in any meaningful way after August 9, 2010, despite additional occurrences of swallowing difficulty.

5 (Bumford Decl.) (denying that staff supervised R17 while he ate). Instead, they left him alone with his food.

August 17 Review by Dr. Suls. Petitioner argues that Dr. Suls assessed R17 on August 17 and determined that the resident did not have swallowing issues that called for further assessment or intervention. I found Dr. Suls' testimony overall to be equivocal and not credible. He testified that he decided no intervention was necessary, based on the information he had, but he could not recall what information he had. Transcript (Tr.) 23.

- When asked, on cross-examination, whether he reviewed the progress note about the August 14 instance of difficulty swallowing medication, Dr. Suls stated that "I don't recall if I did, but I won't say that I didn't either." Tr. 17.

- When asked whether he was aware of either the August 15 or August 21 instance of swallowing problems, Dr. Suls testified that "I can't say that I was, but I can't say that I wasn't." Tr. 18.

- When asked whether he reviewed the relevant medical records pertaining to R17's swallowing difficulty, he replied "I cannot specifically recall." Tr. 23.

On redirect examination, he testified that he made his decision based on SLP Marttila's August 9 assessment.

> Q: [D]o you have a recollection that you, in fact, did make a professional judgment at some point that no intervention for that [the August 9 choking incident] was necessary?
>
> A: I – I made the decision, as you said, that no intervention was necessary, based on the information I had.
>
> Q: All right. And what caused you to draw that conclusion or make that professional judgment?
>
> A: The fact that [R17] had been seen essentially immediately by the speech therapist in the building and felt it had no clinical evidence of any kind of swallowing disorder.
>
> Q: And is that a professional judgment that, in your ordinary course of medical practice you would rely upon in making your own conclusions and judgments?
>
> A: Yes it is. These are – this – these consultants are my experts and I rely on them.

Q: And did you do so in this case?

A: I did so.

Tr. 23-24. I find two significant problems with Dr. Suls' testimony. First, he mischaracterizes SLP Marttila's assessment. As he later conceded, she performed a quick evaluation, thought the choking was probably an isolated event, which is what she reported, but also said that staff should keep an eye on the resident and (presumably) let her know if additional problems arose. Tr. 28; CMS Ex. 6 at 47. Second, Dr. Suls could not say that, in reaching his conclusion, he considered any of the post-August 9 incidents of R17's trouble swallowing, from which I conclude that he did not. At best, he based his decision on incomplete information.

Based on all of this, I conclude that the facility was not in substantial compliance with **42 C.F.R. § 483.13(c)**, the regulation aimed at prohibiting abuse and neglect. As I have already said, the regulation is couched in terms of the facility's having effective policies to prevent neglect, but its drafters left no doubt that "inherent" in the regulation is the requirement that residents be free from neglect and other forms of mistreatment. 59 Fed. Reg. 56,130 (Nov. 10, 1994). A facility with acceptable written policies violates the regulation if its staff does not carry out those policies. The Board has concluded that examples of staff neglect can demonstrate that the facility has not implemented its policies and is therefore out of substantial compliance with 42 C.F.R. § 483.13(c). *See* discussion above for case citations. Here, as the above discussion illustrates, the evidence establishes multiple examples of staff ignoring R17's serious medical problem, which led to neglect. Most important, they knew, or should have known, that his ability to swallow was deteriorating and that he was at risk of choking. According to the Nutrition-at-Risk Committee report, because of the choking episodes staff supervised him at meals (although I could find no instructions to staff as to the specifics of that supervision). Certainly, to keep him safe and free from neglect, staff should have been supervising him when he ate. But no one was supervising him on August 12, when he choked on apples. No one was supervising him on August 29, when he was left alone with peanut butter and crackers. I consider this neglect.

That the facility amended his care plan to give him extra time to swallow his pills (P. Ex. 7 at 31) may have addressed his risk of choking on or not being able to take his pills, but it did nothing to keep him safe while he was eating.

Also as noted above, the August 12 choking incident – particularly when coupled with the mounting evidence that R17 could no longer swallow his medications easily – cast significant doubt on SLP Marttila's initial impression that his inability to swallow his food on August 9 represented a single isolated incident. Yet, the facility continued to rely on that outdated assessment. *See, e.g.*, Tr. 23-24; P. Ex. 18 at 4 (testimony of Nurse

Bumford, stating "I personally did not consider another such assessment necessary [on August 12] since the [SLP] had assessed [R17] only a few days earlier and found no swallowing problem.").

Facility policies compelled staff to "make every effort" to prevent resident neglect. They were instructed to "identify, correct and intervene in situations in which . . . neglect . . . [was] more likely to occur" and to assess, care plan for, and monitor residents with needs and behaviors that could lead to neglect. CMS Ex. 5 at 19-20. Yet, following the August 12 incident, no therapist or other qualified person assessed the degree of R17's swallowing impairment, much less proposed treatment based on that updated assessment. Although one nurse speculated that his swallowing problems might have been caused by his medication, which was subsequently decreased, no evidence suggests any follow-up assessments to determine whether the medication change affected his ability to swallow.

Facility policy also dictated that members of the Nutrition-at-Risk Committee address the changes in his swallowing abilities, which neither member of that committee claims to have done. CMS Ex. 5 at 2. In fact, RD Goulas has maintained that she did not have to address R17's swallowing issues because she "saw no evidence of dysphagia or swallowing difficulty." P. Ex. 19 at 2, 3. But the record is replete with examples of R17 displaying symptoms of dysphagia: choking while eating or drinking, as R17 did on August 9, 2010, is a sign of dysphagia; coughing before, during, or after swallowing, as R17 did on August 12, is a sign of dysphagia; difficulty swallowing, as R17 displayed on August 14 and August 15, is a sign of dysphagia. Retention of food or medication in the mouth, as R17 did on August 21, is a sign of dysphagia. *See* CMS Ex. 9 at 2 (Kayser-Jones and Pengilly, 20 Geriatric Nursing at 79, Tbl. 2, listing the "signs and symptoms of dysphagia"). Because staff did not follow the facility's policies for preventing neglect, the facility was not in substantial compliance with 42 C.F.R. § 483.13(c).

For similar reasons the facility was not in substantial compliance with **42 C.F.R. § 483.25**, the quality-of-care regulation. To be safe and achieve the highest practicable well-being, R17 needed to be supervised while eating. He was not. When mounting evidence established that his swallowing problems were more serious than a single, isolated occurrence, he needed a professional assessment and treatment plan so that he could attain his highest practicable level of well-being. The facility did not provide that assessment or adequately plan for his care based on an up-to-date and accurate assessment. Instead, the facility continued to rely on the out-of-date August 9 assessment to justify its failure to identify and provide the care and services he needed. For this reason, the facility was not in substantial compliance with 42 C.F.R. § 483.25. *See Spring Meadows*, DAB No. 1966 at 16 ("The statute and the regulations as a whole are based on the premise that the facility has (or can contract for) the expertise to first assess what each resident's needs are (in order to attain or maintain the resident's highest practicable functional level) and then to plan for and provide care and services to meet the goal.").

B. *The penalty imposed is reasonable.*

To determine whether a CMP is reasonable, I apply the factors listed in 42 C.F.R. § 488.438(f): (1) the facility's history of noncompliance; (2) the facility's financial condition; (3) factors specified in 42 C.F.R. § 488.404; and (4) the facility's degree of culpability, which includes neglect, indifference, or disregard for resident care, comfort or safety. The absence of culpability is not a mitigating factor. The factors in 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.

I consider whether the evidence supports a finding that the amount of the CMP is at a level reasonably related to an effort to produce corrective action by a provider with the kind of deficiencies found, and in light of the section 488.438(f) factors. I am neither bound to defer to CMS's factual assertions nor free to make a wholly independent choice of remedies without regard for CMS's discretion. *Barn Hill Care Ctr.*, DAB No. 1848, at 21 (2002); *Cmty. Nursing Home*, DAB No. 1807 at 22 *et seq*. (2002); *Emerald Oaks*, DAB No. 1800 at 9 (2001); *CarePlex of Silver Spring*, DAB No. 1638 at 8 (1999).

Here, CMS imposed a penalty of $7,500 per-instance, which is in the middle-to-higher range for a per-instance CMP ($1,000-$10,000) and is modest considering what CMS might have imposed. 42 C.F.R. § 488.408(e)(1)(iv); *see Plum City Care Ctr.*, DAB No. 2272 at 18-19 (2009) (observing that even a $10,000 per-instance CMP can be "a modest penalty when compared to what CMS might have imposed").

Petitioner does not claim that its financial condition affects its ability to pay this relatively small CMP.

The facility has a significant history of substantial noncompliance. In 9 out of 10 surveys since 2001, CMS has found substantial noncompliance. "Quality of care" (42 C.F.R. § 483.25) deficiencies have been cited repeatedly. CMS Ex. 4. For example:

- In 2001, the facility was not in substantial compliance with "resident assessment" (Tags F-282 and F-279) and "quality of care" requirements (Tag F-316); the deficiencies were isolated but with a potential for more than minimal harm;

- In 2003, the facility was not in substantial compliance with "quality of care" requirements (Tags F-309 and F-324), and its deficiencies caused actual harm; it was not in substantial compliance with "resident assessment" requirements (Tag F-281), and those deficiencies were widespread with a potential for more than minimal harm;

- In 2004, the facility was not in substantial compliance with "quality of care" requirements (Tag F-316); the deficiencies were isolated with the potential for more than minimal harm;

- In 2006, the facility was not in substantial compliance with the requirements governing "staff treatment of residents" (Tags F-225 and F-226); CMS found a pattern of noncompliance with the potential for more than minimal harm; the facility was not in substantial compliance with "quality of care" requirements (Tag F-309); those deficiencies were isolated but caused actual harm;

- In 2007, the facility was not in substantial compliance with the requirements for "comprehensive assessments" (Tag F-272), and those deficiencies were isolated but with the potential for more than minimal harm; and

- In 2008, the facility was not in substantial compliance requirements governing "staff treatment of residents" (Tag F-226); those deficiencies were isolated with a potential for more than minimal harm. CMS Ex. 4, at 2-5.

The facility history alone justifies the relatively low penalty.

With respect to the remaining factors, multiple staff did not recognize or chose to ignore symptoms of a potentially serious condition – the inability to swallow – which put the resident in immediate jeopardy. The facility is culpable for their inaction.

For these reasons, I find that the $7,500 per-instance CMP is reasonable.

IV. Conclusion

For the reasons set forth above, Petitioner was not in substantial compliance with Medicare participation requirements, 42 C.F.R. §§ 483.13(c) and 483.25. The relatively small penalty imposed – $7,500 per-instance – is reasonable.

/s/
Carolyn Cozad Hughes
Administrative Law Judge