Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

White Sulphur Springs Center,
(CCN: 51-5100),

Petitioner,

v.

Centers for Medicare and Medicaid Services.

Docket No. C-11-577

Decision No. CR2706

Date: February 14, 2013

DECISION

White Sulphur Springs Center (Petitioner or facility), challenges the determination of the Centers for Medicare and Medicaid Services (CMS) that it was not in substantial compliance with Medicare program requirements for accident prevention and adequate supervision for one of its residents on May 11, 2011. Petitioner also challenges CMS's imposition of a per-instance civil money penalty (CMP) of $10,000. For the reasons discussed below, I sustain CMS's imposition of the CMP.

I. Procedural History

Petitioner is a skilled nursing facility, located in White Sulphur, West Virginia, that participates in the Medicare and Medicaid programs. The West Virginia state survey agency conducted a survey of Petitioner from May 11 through May 19, 2011. Based on the survey results, CMS determined Petitioner to not be in substantial compliance with program participation requirements.

By notice dated June 24, 2011, CMS advised Petitioner that it was imposing a $10,000 per-instance CMP for an instance cited on May 11, 2011 that involved Petitioner's

supervision of a resident while he ate and drank. Petitioner timely filed its request for hearing on June 30, 2011, challenging the deficiency findings and the related per-instance CMP.

I presided over a hearing held in Beckley, West Virginia, from January 18 through 19, 2012. At a prehearing telephone conference, I admitted into evidence CMS Exhibits (Exs.) 1-37 and Petitioner Exhibits (P. Exs.) 1-52. Summary of Prehearing Conference and Order Establishing Procedures for Hearing (December 7, 2011); *see also* Transcript (Tr.) at 7-8. At hearing, I also admitted into evidence a revised CMS Ex. 37. Tr. at 9. I excluded the written direct testimony of one of Petitioner's witnesses (P. Ex. 46), in accordance with my July 8, 2011 Prehearing Order, because Petitioner was unable to produce the witness for cross-examination. Tr. at 436-37.

A transcript of the proceedings was prepared, and I afforded the parties an opportunity to review the transcript and file post-hearing briefs and replies. CMS filed its suggested errors and proposed corrections on March 8 and April 3, 2012. In its post-hearing brief Petitioner (P. Br.) advised me of errata. P. Br. at 2 n.3. There being no objections, the transcript is amended to reflect the noted errors.

II. Background

This case involves one resident, referred to as "R14" for privacy reasons, and the events that occurred on the morning of May 11, 2011, during an annual survey of the facility. R14 was 68-years-old at the time and had been at the facility since July of 2003, following a stroke at age 60. He suffered from several severe medical conditions that included Alzheimers, vascular dementia resulting from a stroke, late effects of a cerebrovascular accident with left-sided hemiplegia, and severe dysphagia, which posed a risk for choking and aspiration. He was edentulous, had a history of choking when he ate, and was identified as at high risk of choking or aspirating due to impaired swallowing function. CMS Ex. 11, at 16; *see also* CMS Exs. 10, at 34; 37, at 8. An April 6, 2011 Minimum Data Set (MDS) assessment noted that R14 required the extensive physical assistance of one staff member to eat. CMS Ex. 12, at 11.

On May 11, 2011, a nurse assistant served R14 breakfast in bed and then left the room while he ate. CMS Ex. 7, at 1, 2; P. Ex. 43, at 2-4. The facility claimed it provided "distant supervision" consisting of a nurse nearby in the hallway auditorily monitoring R14 while administering medications to other residents whose rooms were also along the hallway. Tr. at 405-06; P. Exs. 34, at 4; 43, at 2; P. Br. at 18; *see also* CMS Ex. 9 (floor plan of Petitioner's facility).

While conducting a routine survey at Petitioner's facility this same morning, at approximately 9:15 a.m., a state surveyor, Jackie Lee Wickline, R.N., was in the hallway corridor outside of R14's room when she looked into the room and noticed R14 eating

breakfast. She reported his meal was on a bed tray situated above his abdomen, there was no staff in or near his room, and she found him slumped sideways with his head, right arm, and right shoulder pressed against the side-rail of his bed. When she approached R14, she reported that he told her "I choked on my eggs." She noticed that there were partially chewed eggs on the front of his shirt and on his chin. The surveyor also reported that R14 told her that he did not know where his call light was, and she noticed that the call light was wedged between the air mattress and the side-rail of the bed. She observed that he was unable to position himself upright upon her cueing. After discovering R14 in that position, the surveyor requested assistance from a nursing assistant who came and repositioned R14 away from the side-rail. CMS Exs. 1, at 23, 25; 22, ¶¶13, 14; Tr. at 27.

The parties do not dispute that R14 required supervision during meals due to his choking and aspiration risks. Rather, the parties disagree as to the level of supervision that Petitioner was required to provide to ensure an environment that would make it as safe as possible for R14 to consume food and liquids. CMS argues that Petitioner failed to provide R14 with the supervision he required to be as safe as possible while eating and drinking in his bed, which included visually supervising him while he ate to ensure he practiced safe swallowing strategies, positioning him in a 90 degree angle, and ensuring he had access to his call light. Petitioner argues, however, that its staff did monitor R14 and that he only required "distant supervision" while he ate in his room. Petitioner maintains that this level of supervision allowed the facility to maintain a proper balance between R14's safety and his autonomy. CMS Post-hearing Brief (CMS Br.) at 1; P. Br. at 2.

III. Issues

a. Whether Petitioner was in substantial compliance with adequate supervision requirements at 42 C.F.R. § 483.25(h) (Tag F323) considering its level of supervision of R14's eating and drinking situation on May 11, 2011; and,

b. Whether the $10,000 per-instance CMP that CMS imposed was reasonable.

I have no authority to review CMS's determination that Petitioner's noncompliance constituted immediate jeopardy. *See, e.g., Hanover Hill Health Care Ctr.*, DAB No. 2617, at 3-4 (2012) *citing* Social Security Act § 1819(f)(2)(B); 42 C.F.R. § 483.151(b)(2)(iv) (explaining that with the imposition of a penalty of $5,000 or more, a state agency cannot approve a nurse aid training program regardless of any immediate jeopardy finding, which ultimately precludes administrative law judge (ALJ) review of CMS's immediate jeopardy finding that involves a per-instance CMP). Further, a finding of actual harm to a resident is not necessary to conclude that Petitioner was not in substantial compliance. *See* 42 C.F.R. § 488.301. Therefore, in order to substantiate that Petitioner was not in substantial compliance with federal requirements, I need only find

that Petitioner's violation resulted in *the potential for more than minimal harm* to R14. *Id.*

A facility must ensure that each resident receives adequate supervision and assistance devices to prevent accidents. 42 C.F.R. § 483.25(h)(2). In *Meridian Nursing Ctr.*, DAB No. 2265, at 3 (2009), the Board interpreted the requirements of this subsection, stating:

> Section 483.25(h)(2) requires that a facility take "all reasonable steps to ensure that a resident receives supervision and assistance devices that meet his or her assessed needs and mitigate foreseeable risks of harm from accidents." *Briarwood Nursing Center*, DAB No. 2115, at 11 (2007), *citing Woodstock Care Ctr*. v. Thompson, DAB No. 1726 (2000) (facility must take "all reasonable precautions against residents' accidents"), *aff'd, Woodstock Care Ctr. v. Thompson*, 363 F.3d 583 (6th Cir. 2003).

The Board has also held that facilities "have the 'flexibility to choose the methods of supervision' to prevent accidents so long as the methods chosen are adequate in light of the resident's needs and ability to protect himself or herself from a risk." *Briarwood Nursing Ctr.*, DAB No. 2115, at 5, *citing Liberty Commons Nursing & Rehab – Alamance*, DAB No. 2070, at 3 (2007). A facility is not required by 42 C.F.R. § 483.25(h)(2) to ensure that its residents never sustain accidents, thus the regulation does not impose a strict liability standard on a facility.

IV. Findings of Fact and Conclusions of Law

a. R14 had impaired swallowing, breathing, cognition, and mobility.

It is undisputed that R14 had several medical conditions that affected his swallowing, breathing, cognition, and mobility. CMS Ex. 10, at 1. As for his mobility challenges, R14 had partial paralysis of one side of his body, and his April 2011 MDS noted that he required extensive assistance with his activities of daily living (ADLs) with one, and at times two, staff assisting him. CMS Exs. 10, at 1; 12, at 1; *see also* CMS Ex. 11, at 5 (R14's plan of care).

The level of assistance required for R14's ADLs as noted in his April 2011 MDS is consistent with prior MDS assessments. *See* CMS Exs. 13-15, at 7-8. As for his cognitive ability, R14 had significant impairment due to a stroke, dementia, and schizoaffective disorder. CMS Exs. 10, at 1; 11, at 8. The record shows that R14's attending physician noted in February 2011, that R14 lacked "sufficient mental or physical capacity to appreciate the nature and implication of health care decisions," and that the duration of his incapacity was long-term. CMS Ex. 34, at 1. The record also shows that R14 had poor sitting balance and could not always maintain a 90 degree position in bed. Tr. at 204. R14 was also diagnosed with chronic obstructive pulmonary

disease (COPD), a condition that resulted in a compromised respiratory system. As of April 27, 2011, he was on continuous oxygen due to being short of breath and tiring easily. CMS Ex. 10, at 1, 2, 26.

Petitioner acknowledges that R14 was at risk when he ate and drank. In its post-hearing brief Petitioner states: "Petitioner's witnesses testified that the Resident's attempts to eat or drink virtually any foods or beverages can cause him to aspirate foreign matter into his trachea, which can cause choking and a life-threatening condition known as aspiration pneumonia." P. Br. at 5-6, *citing* P. Exs. 41, at 1; 42, at 1; Tr. at 203, 382. So clearly, if Petitioner did not to take all reasonable steps to prevent R14 from choking or aspirating, it is undisputed that there was the potential for more than minimal harm to R14.

b. Petitioner did not substantially comply with adequate supervision requirements because no one was in the room observing R14 while he ate and drank on May 11, 2011.

1. A staff member was not present in the room to immediately intervene if he choked or aspirated.

R14's care plan recognized that he was a "very high risk for aspiration," and that he "chokes easily." CMS Exs. 10, at 2; 11, at 6, 16. R14's most recent care plan meeting summary, dated April 27, 2011, stated that "[t]he resident continues to be [a] very high risk for aspiration. . . . He is to be supervised while eating/drinking." CMS Ex. 10, at 2. R14's MDS states that he requires extensive assistance of one staff with eating. CMS Exs. 12, at 11; 13, at 8; 14, at 8; 15, at 8.

However, on May 11, 2011, the record shows that a nurse assistant served R14 breakfast in bed and then left him alone to eat with what Petitioner describes as "distant supervision" being provided. The "distant supervision" consisted of a nurse nearby in the hallway monitoring R14 while administering medications to other residents whose rooms were also along the hallway. Tr. at 405-06; CMS Ex. 7, at 1, 2; P. Exs. 34, at 4; 43, at 2-3; CMS Ex. 9.

The evidence clearly shows that distant supervision was not adequate to meet R14's needs. R14's care plan did not specify that distant supervision was an adequate level of supervision to facilitate the interventions identified so R14 could safely consume food and liquids. Further, R14's MDS notes that he requires the extensive assistance of at least one staff when eating eat. CMS Ex. 12, at 11.

When considering the record as a whole, it is reasonable to expect that staff needed to observe R14 in order to immediately assist him if he choked or aspirated.

Lindsay McWilliams Day, a speech and language pathologist (SLP) who worked with R14, explained that R14 had significant swallowing problems, noted that he had a history of choking when he ate, and was at high risk of aspiration. P. Ex. 40, at 2. At hearing, SLP Day testified that it was a risk for R14 to be on an oral diet. Tr. at 200. Jennifer Groves, another SLP who worked with R14, stated in her direct testimony that "my professional judgment is that it is not safe for him to have any oral intake at all at this point." SLP Groves stated that she and her colleagues recommended that R14 receive intake via a feeding tube, but both the resident and his family insisted that he continue with a mechanical soft diet with some pureed items. P. Ex. 41, at 1-2.

During the survey, Surveyor Wickline interviewed SLP Day regarding the level of supervision R14 required to eat. SLP Day initially responded that R14 could be supervised by indirect supervision, i.e., by staff passing by in the hall. When Surveyor Wickline asked SLP Day if staffing were not an issue, what type of supervision would she recommend for R14, SLP Day responded that she would recommend direct supervision. CMS Exs. 1, at 24; 37, at 1; 23, ¶8. During the survey Surveyor Beverly Hissom, RN, sat in on the interview of SLP Day. Surveyor Hissom confirmed in her written direct testimony that when SLP Day was asked the level of supervision needed for R14 while eating if staffing issues were not a concern, SLP Day responded that R14 needed direct supervision, meaning staff had to be present when R14 was eating. CMS Ex. 23, ¶8.

Petitioner argues that distant supervision was adequate because a staff member would be able to hear R14 choke or aspirate and then be able to quickly enter the room and assist him. P. Reply at 6-8. However, just being within earshot of the resident was not sufficient because R14 could choke or aspirate quietly or silently, as SLP Donna Rife confirmed. Ms. Rife provided speech and language therapy to R14 and was familiar with his safety needs. She explained that when she was working with R14 she noticed that he aspirated on everything due to his severe dysphagia. P. Ex. 42, at 1. Further, SLP Rife stated that back in 2006 and 2008 when she worked with R14, he would cough and get choked up, but he had silent aspirations as well. *Id.*

I find Petitioner's failure to follow R14's plan of care interventions, the interventions that its own interdisciplinary team developed to address R14's foreseeable risk of aspirating and choking, persuasive evidence that Petitioner was not in compliance with the requirements of 42 C.F.R. § 483.25. *See Alden Town Manor Rehab.*, DAB No. 2054, at 7-8 (2006)(if a facility has identified and planned for a hazard and then failed to follow its own plan, that may be sufficient to show a lack of compliance with the regulatory requirement (quoting *Maine Veterans' Home – Scarborough*, DAB No. 1975 (2005)(footnote omitted)). Based on R14's care plan and supporting documents and testimony, I do not find credible Petitioner's claims that distant supervision outside of R14's room would suffice as adequate supervision while he ate and drank.

2. A staff member was not present in the room to ensure R14 practiced safe swallowing strategies.

R14's care plan also specified that he had "impaired swallowing due to dysphagia and is edentulous – Resident is at risk for aspiration, chokes easily." One of the interventions required to ensure R14's safety was that staff should supervise, cue, and assist R14 as needed with meals. CMS Ex. 11, at 16. R14's speech therapy progress notes confirm that he required cueing to implement safe swallowing strategies to reduce aspiration. CMS Ex. 10, at 28, 30.

Other evidence also supports this care plan intervention. SLP Day discussed safe swallowing strategies in her discharge recommendations and testified at hearing that R14 needed supervision "to implement small bites, small sips, things along those lines, to reduce the risk," and that he required "cues to demonstrate safe swallowing strategies, or to remember them all the time." She also noted that he would do the chin tuck (positioning his head to limit aspiration) if she were "sitting there telling him to do it." Tr. at 209, 212, 213, 220; CMS Ex. 10, at 29. In a therapy progress notation dated January 13, 2011, SLP Day wrote that she cued R14 to keep his chin down, and when she did, he demonstrated no more overt signs and symptoms of aspiration. P. Ex. 50, at 1. SLP Groves also testified that she cued R14 in order to encourage him to implement the chin tuck strategy. Tr. at 192. The evidence shows that the SLPs who had worked with R14 confirmed that he required some cueing to implement safe swallowing strategies. CMS Ex. 10, at 28, 30.

SLP Day also testified that although R14 had shown that he knew what was required if asked, he needed cues to demonstrate and even to remember the strategies consistently. So, while he was eating he would need to be cued at times to remember to practice the safe swallowing strategies. Tr. at 210. While R14 needed to implement small bites and small sips to swallow safely while eating, he did not have capacity to be relied upon to recall this without staff present to cue him. SLP Day testified that she provided instruction to CNAs on how to implement these strategies with R14. Tr. at 213.

Although R14's medical record shows that he required staff cues to implement safe swallowing strategies, and these strategies were also a part of his care plan requirements, on May 11, 2011, the nursing assistant served R14 served breakfast in bed and then left him alone in the room to eat and drink with "distant supervision" which entailed a nurse nearby in the hallway monitoring R14 while she administered medications to other residents along the hallway. Tr. at 405-06; CMS Ex. 7, at 1, 2; P. Exs. 43, at 2-3; 34, at 4. Clearly, R14 could not be effectively cued to implement safe swallowing strategies during oral intake if no one was present in his room while he ate and drank.

Staff's failure to provide the required cueing to R14 on May 11th does not appear to be an isolated incident either. At hearing, two of Petitioner's witnesses testified that, prior to the survey, they did not visually supervise R14 when he ate in his room. Tr. at 407-08,

426-27; P. Ex. 43, at 2. Byrda Tincher, who was related to R14 and worked as a CNA at the facility for 11 years testified that it was the aides who supervised R14 when he ate. She also testified that she was not aware of any standing instructions for the CNAs to monitor R14 when he ate in his room. CNA Tincher noted that prior to the survey R14 ate in bed by himself after staff had set him up in bed at a 90 degree angle. She stated that "he ate by himself, we didn't have to supervise." Tr. at 426-27. Judy Fogus, LPN, had worked at the facility for seven years at the time of the survey and was also related to R14. She was responsible for overseeing a total of 36 beds and supervising two to three CNAs. She acknowledged at hearing that prior to the survey when R14 was eating in his room she did not keep an eye on R14 herself, and there were no instructions that she was aware of requiring staff to watch R14 when he ate in his room. She further stated she was not aware if CNAs took any special action to watch R14 when he ate his meal in his room. Tr. at 407-08.

R14's assessments and his SLP progress notes show that he was inconsistent in his performance of the compensatory strategies required for his safety while eating. The assessments from the SLPs and his care plan required staff to supervise, cue and assist him while he ate his meals. It is unreasonable to expect staff would be able to adequately supervise R14 for signs of aspiration, coughing or choking and also cue him to use the safe swallowing strategies, including the chin tuck, while also having primary responsibility for medication passes for the other residents down the hall. Additionally, I do not find being within earshot of R14 via "distant supervision" is adequate, especially in light of the evidence that R14 could choke or aspirate silently. Clearly these quiet or silent episodes would not be detectible to staff who were attending to other resident needs in other rooms.

c. *Petitioner did not substantially comply with adequate supervision requirements on May 11, 2011 because it did not maintain R14 in a 90 degree upright position while he ate and drank alone, and it did not ensure he could reach his call light to request assistance.*

R14's care plan also required that he be in a 90 degree upright position when he was swallowing food or drinking. CMS Ex. 11, at 16.

This care plan requirement was consistent with other evidence in the record including R14's assessment to maintain a midline position in bed. R14 had poor balance while sitting and was unable to position himself in bed without the extensive assistance of two staff members. CMS Exs. 10, at 31; 12, at 11. An SLP also assessed R14 in January 2011 and determined he required a pillow to maintain midline position in bed during meals. In a note dated December 31, 2012, SLP Groves recommended that R14 sit in an upright position while in bed with "pillow positioning" under his right side to assist him in maintaining an upright position. CMS Ex. 10, at 30. A December 31, 2010 progress note states: "Swallowing Therapy (92526) to assess and modify positioning to enhance

swallow function including repositioning the patient in bed, with head of bed elevation and pillow positioning under right side of body to increase ability to sustain midline position. . . ." CMS Ex. 10, at 31. A Speech Therapy Discharge Summary for services ending January 14, 2011 notes that "Therapist provides staff education for safe swallow strat[egies], specifically for sitting upright 90 degrees in bed or [wheelchair]for meals to take small bites/sips. CMS Ex. 10, at 29. However, at hearing SLP Day testified that she was not surprised when the surveyor found R14 slumped over while eating. She explained that R14 could slip to that position even after staff had set him up in a 90 degree upright position. Tr. at 205. She testified further that once R14 fell from the 90 degree position he needed assistance for repositioning in bed. Tr. at 204. In a treatment note dated January 12, 2011, SLP Day wrote that when R14 was placed in an upright 90 degree position and drank milk he did not show any overt signs and symptoms of aspiration. P. Ex. 50, at 1. SLP Day testified that R14 needed to be supervised by staff, and that with staff assistance, he could sit upright 100 percent of the time. Tr. at 212, 215. SLP Donna Rife testified that sitting in a 90 degree angle "could reduce [R14's] risk of aspiration." Tr. at 387.

At hearing LPN Fogus testified that it was important for R14 to be sitting in an upright position when he ate in a bed or in his wheelchair. As for R14's ability to maintain an upright position on his own, she stated that he was able to pull himself up with the use of side-rails – "most of the time." Tr. at 408-09. In her written direct testimony, LPN Fogus noted that R14 would tend to slide down even when bolstered with pillows and that staff were aware of this. P. Ex. 43, at 2. She further explained at hearing that when R14 does slide he is unable to reposition himself without the assistance of staff. She stated "[h]e could get the rail and pull himself over. But to pull himself up in the bed, he couldn't do that." Tr. at 410. LPN Fogus also noted that even after R14 was repositioned, he would eventually slide down given he was on an air mattress, and staff would need to upright him and place "some pillows behind him" so he could eat. She noted that these interventions would assist him in maintaining an upright position so he could eat. Tr. at 411.

The testimonial and documentary evidence, which includes R14's clinical assessments, all note that it was important for him to eat at a 90 degree angle while sitting in bed or in his wheelchair. While R14's care plan required that staff implement this strategy, on May 11, 2011, the state surveyor found R14 slumped over. Prior to Surveyor Wickline discovering R14 at 9:15 a.m., the record shows that earlier that morning at about 8:35 a.m., R14 had experienced an episode of coughing. The evidence shows that a nurse assistant brought R14 his breakfast tray that morning at around 8:30 a.m., set him up and then left. She then returned about 5 minutes later after hearing him cough. She found him leaning to the left so she then pulled him to the middle of the bed and had an LPN to assist her. P. Exs. 32, at 2; 39, at 2; CMS Ex. 7; P. Br. at 19. R14 was then left alone to continue to eat his meal until he was discovered by Survey Wickline at 9:15 a.m. in a slumped position. Although the evidence shows that a nurse propped R14 up earlier,

Petitioner does not dispute that the surveyor found him slumped over when she observed him.

The evidence also shows that it was a continuing challenge for R14 to maintain a midline balance while eating, and facility staff were specifically directed to ensure he was maintained in a 90 degree angle while he ate. CMS Exs. 10, at 31; 11, at 16; 12, at 11. To facilitate this, R14 had the option of eating his meal in the restorative nursing rehab dining room where he would be supervised. If R14 chose not to go to the restorative nursing rehab dining room, then he could have his meal in his room, either in his wheelchair or in his bed. CMS Ex. 11, 1-3; P. Exs. 26, at 1; 32, at 1. Regardless of the option R14 chose, Petitioner needed to ensure that staff provided R14 with the identified supervision and assistance that his care plan required.

R14's care plan also required staff to place a call light within his reach at all times. CMS Ex. 11, at 16. It was foreseeable that R14 could choke or aspirate while eating. Therefore, if he was left alone in his room, which was undisputed on the morning of May 11, R14 should have at least been able to activate his call light for help if he started to choke or aspirate. However, when Surveyor Wickline observed R14 that morning, she discovered him wedged into the side-rail of the bed with his forehead pressed against the side-rail. CMS Ex. 22, ¶13. When she asked him where his call light was, he told her that he did not know. She then looked for the call light and saw that it was wedged between the right side-rail and the mattress. She also noted that he was not able to reach the call light. CMS Ex. 22, ¶14.

As noted earlier, if care plan supervision requirements are not met, then that may constitute a violation of accident prevention and adequate supervision regulations. *See Alden Town Manor Rehab.,* DAB No. 2054, at 7-8. Here, on May 11, 2011, Petitioner failed to meet the supervision requirements outlined in R14's care plan – that he be in a 90 degree upright position when he swallowed food or drank liquids and that he be within reach of his call light. Considering Petitioner did not take these reasonable steps, I find R14's potential to choke or aspirate was a foreseeable risk that involved the possibility of more than minimal harm. Therefore, I do not find that Petitioner was in substantial compliance with the Medicare requirement at 42 C.F.R. § 483.25(h).

d. Petitioner did not rebut, by a preponderance of the evidence, CMS's showing of an inadequate supervision deficiency.

A sanctioned facility must prove substantial compliance by a preponderance of the evidence once CMS has established a prima facie case that the facility was not in substantial compliance with relevant statutory or regulatory provisions. *See Cross Creek Health Care Ctr.*, DAB No. 1665 (1998), applying *Hillman Rehab. Ctr.*, DAB No. 1611(1997), *aff'd*, *Hillman Rehab. Ctr. v. HHS*, No. 98-3789 (GEB), at 25 (D.N.J. May 13, 1999). The evidence CMS offers to support its arguments that Petitioner failed to

provide adequate supervision to R14 is persuasive, and Petitioner does not sufficiently rebut it.

Consistently throughout these proceedings, Petitioner has argued that R14 did not wish to be supervised while eating and that R14 had the right to refuse this treatment. A resident does have the right to refuse treatment, choose health care, and to make choices about significant aspects of his or her life in the facility. *See* 42 C.F.R. §§ 483.10(b)(4); 483.15(b)(1); 483.15(b)(3). However, the resident's care plan must outline the services to be provided to the resident. Any services that would otherwise be required under the quality of care requirement at 42 C.F.R. § 483.25, but can not be provided due to the resident's exercise of his or her rights, including the right to refuse treatment, and the resident's right to choose health care must be identified and "consistent with his or her . . . assessments, and plans of care." *See* 42 C.F.R. §§ 483.20(k)(1)(ii), 483.15(b)(1).

In *Van Duyn Home & Hosp.,* DAB No. 2368 at 6-7 (2011) the Board noted that when a resident refuses treatment, a facility has an obligation to ensure that the refusal is an informed one, that the basis for the resident's refusal is properly addressed, and that the facility offers alternatives. Here, the record shows that Petitioner failed to specifically assess and plan for any refusal of R14 for the interventions outlined in his care plan goal that addressed his impaired swallowing and risk for aspiration and choking. Although Petitioner permitted R14 to eat in his room rather than the restorative rehab nursing dining area, staff did not provide the necessary resources R14 needed to safely effectuate that resident choice.

While there is no dispute that residents have a right to refuse treatment, Petitioner has a countervailing duty to protect the individuals under its care against accidents. Therefore, while the regulations support a resident's right to refuse care, such right is not absolute and should be consistent with the resident's interest, assessments, and plans of care. *See Innsbruck HealthCare Ctr.*, DAB No. 1948, at 7-8 (2004). Additionally, a resident's right to refuse treatment does not absolve a facility from a continuous effort to comply with the regulations by use of other means – to allow this would mean facilities could permit residents to refuse treatments to the point of injury or death. *See Koester Pavillion*, DAB No. 1750, at 28 (2000) ("It is simply unacceptable to abdicate the duty to supervise or use assistive devices to prevent falls even when the resident, for whatever reason, is resistant, noncompliant, or difficult to deal with."). A facility is entrusted with balancing necessary care and services with a resident's right to refuse treatment. *See also* 54 Fed. Reg. 5316, 5332 (Feb. 2, 1989) (preamble to the implementing regulations stating: " [w]e also think it is reasonable to require the facility to ensure that the resident does not deteriorate within the confines of a resident's right to refuse treatment and within the confines of recognized pathology and the normal aging process"); CMS's State Operations Manual, App. P (Tag F323)(the regulations do not create a right for a resident, legal surrogate or representative to demand a facility use specific medical interventions or treatments that the facility deems inappropriate).

Petitioner's claim that they were respecting R14's wishes and rights when they allowed him to eat with distant supervision while he was in his bed is not persuasive. Petitioner was still required to continue to provide adequate supervision to R14 and cannot avoid this deficiency citation by claiming to have been honoring the resident and family's wishes without modifying his care plan.

Petitioner maintains that its staff was well aware of R14's risk of choking and aspirating. P. Br. at 5, 6, 24. Petitioner also asserts that R14 has been a resident at the facility for eight years and that staff was providing exactly the level of supervision both the resident and his family demanded over the years. There is no doubt that over the years Petitioner's staff provided much care and attention to R14. As Petitioner asserts in its post-hearing brief, R14's treatment and care were without significant adverse consequences over that period of time. However, this good historical safety record for R14 cannot compensate for Petitioner's inadequate supervision of R14 on May 11, 2011, when facility staff failed to provide R14 with the interventions outlined in his care plan in order to keep him safe while eating. Further, for Petitioner to argue that R14 historically received the same level of supervision as on May 11 increases its culpability by demonstrating an ongoing disregard for R14's safety.

Petitioner's assertions regarding R14's wife's desire to allow R14 to eat where he wanted do not justify why R14 was not provided with the required interventions to keep him safe while eating. Even when R14 chose to eat in his room and in his bed, there was no reason why he was not provided with the level of supervision that would have allowed staff to monitor him as necessary and to provide him with the assistance required to remain safe. Further, R14's wife's testimony and the evidence Petitioner presented simply do not support Petitioner's assertions as to R14's wife's refusals. Specifically, Petitioner has presented no evidence to show that R14's wife, as his medical power of attorney, refused permission for Petitioner to use proper positioning pillows, to remind R14 to use safe swallowing strategies, to ensure R14 remained in an upright position while eating, and to assist R14 in clearing his airway in the event his airway became blocked. CMS Ex. 7, at 5; P. Exs. 3; 22, at 2; 25, at 2; 38; P. Br. at 3.

In summary, the record shows that in spite of the concerns of R14's SLP's, his occupational therapist, and his attending physician as to his safety when consuming an oral diet, Petitioner continued to allow R14 to eat without proper supervision in his room – thus failing to take into account the recommendations of its own professionals and the concerns they continually raised over the years regarding R14's safety in regards to the risks of his consuming food orally. Although R14's wife, as his medical power of attorney, declined recommendations of a feeding tube option, Petitioner still had a duty to ensure R14 was adequately supervised while eating. The record is clear that given R14's swallowing difficulties, cognitive deficits, and limited physical functioning, he needed a staff member present while he ate and drank. If Petitioner wanted to continue to provide

residential nursing services to R14, then Petitioner was responsible to provide the level of staff needed to ensure R14's safety while in its facility.

e. The $10,000 per-instance CMP that CMS 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).

Unless a facility contends that a particular regulatory factor does not support the CMP amount, the ALJ must sustain it. *Coquina Ctr.*, DAB No. 1860 (2002). With respect to its financial condition, it would be Petitioner's responsibility to show that it cannot pay the CMP. Petitioner was free to call any witnesses to testify to its financial condition or to submit any documentary evidence regarding its financial condition. However, Petitioner provided no evidence to show that its financial condition hinders it from paying the proposed CMP.

The seriousness of the deficiency was high and had the potential of causing at least minimum harm to R14. R14's swallowing difficulties placed him at risk of choking, thus food could block his airway and if not promptly dislodged could result in death. P. Reply at 1 (stating that R14 was at high risk of choking and aspirating and that these risks could cause harm and even death); *see also* P. Br. at 5-6, *citing* P. Exs. 41, at 1; 42, at 1; Tr. at 203, 382. R14 was also at risk of aspirating when food could enter his lungs rather than his digestive system and, once there, could result in a lung infection and lead to pneumonia. This scenario was particularly disconcerting given R14's lung function was already compromised by COPD, which placed him at further risk of aspirating food and liquids. CMS Ex. 10, at 1, 2, 26.

The facility's culpability here was high. R14's record is replete with documentation that R14 needed to be directly supervised while eating. Not only did I find that Petitioner left R14 alone on May 11, 2011, but the evidence shows this was not a one-time occurrence. *See supra* Parts IV(b)(2) & (c).

Given the seriousness of the deficiency and the culpability of the facility, the CMP is reasonable. CMS imposed a penalty of a $10,000 per-instance CMP, which although at the higher range for a per-instance CMP ($1,000-$10,000), is modest considering what CMS might have imposed considering the evidence of continuing non-compliance and disregard for safety requirements in R14's care plan. 42 C.F.R. § 488.408(e)(1)(iv*); see Plum City Care Ctr*., DAB No. 2272, at 18-19 (2009) (observing that even a $10,000 per-instance CMP can be "a modest penalty when compared to what CMS might have imposed"). Further, the absence of a history of non-compliance is not a mitigating factor and not a basis to find a $10,000 per-instance CMP unreasonable. *Id.* at 19.

V. Conclusion

Petitioner did not substantially comply with 42 C.F.R. § 483.25(h)(2) because on May 11, 2011, it did not take all reasonable steps necessary, as specified in a resident's care plan, to adequately supervise the resident while eating to prevent the foreseeable risk of his choking or aspirating. Furthermore, I find the $10,000 per-instance CMP that CMS imposed is reasonable.

/s/
Joseph Grow
Administrative Law Judge