Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Legend Healthcare and Rehabilitation - Euless,
(CCN: 67-6029),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-13-471

Decision No. CR3415

Date: October 9, 2014

DECISION

Following a complaint investigation survey, the Texas Department of Aging and Disability Services (state agency) determined that Legend Healthcare and Rehabilitation - Euless (Petitioner or the facility) was not in substantial compliance with Medicare participation requirements for long-term care facilities and that its noncompliance posed immediate jeopardy to the health and safety of its residents. The Centers for Medicare & Medicaid Services (CMS) agreed with the state agency's determination and imposed a $6,650 per-day civil money penalty (CMP) against Petitioner for nine days of immediate jeopardy and a $1,000 per-day CMP for 47 days of substantial noncompliance that was not immediate jeopardy, for a total penalty of $106,850. Petitioner now appeals.
As explained below, I find Petitioner was not in substantial compliance with Medicare participation requirements, CMS's determinations of immediate jeopardy to resident health and safety were not clearly erroneous, and the CMPs CMS imposed are reasonable in amount and duration.

I. Background

The parties do not dispute the following facts unless otherwise noted. Petitioner is a long-term care facility located in Euless, Texas, that participates in the Medicare program as a skilled nursing facility. The facts giving rise to this case involve an 83-year-old male resident admitted to Petitioner's facility on June 24, 2011, referred to during the survey and these proceedings as "Resident 1." Resident 1 had a medical history of non-Alzheimer's dementia, anemia, heart failure, hypertension and diabetes mellitus. CMS Ex. 8, at 1, 4. Resident 1 was also severely cognitively impaired and was totally dependent upon nursing staff for assistance with eating, mobility, bathing, dressing, and personal hygiene. CMS Ex. 4, at 4. Resident 1 also had dysphagia, a swallowing disorder, and he received the majority of his food and nutrition through a feeding tube; however, his family wanted Resident 1 to have to option to attempt to eat pureed food by mouth. P. Pre-hrg. Br. at 5; CMS Ex. 4, at 4-5; CMS Ex. 8, at 10.

On April 19, 2012, Resident 1's physician referred him to speech and swallowing therapy after a nurse reported "pocketing [and] mucus production during meals." CMS Ex. 8, at 24. The speech therapist assessed Resident 1's oral motor function at a moderate to severe degree of impairment, and the speech therapy swallowing evaluation noted that Resident 1 had some difficulty managing bolus, including some residue. CMS Ex. 8, at 24. Resident 1's physician reviewed the speech therapist's plan of treatment and certified that the assessment was medically necessary. CMS Ex. 8, at 25. The speech therapist noted that Resident 1 was at risk for aspiration and alerted nursing staff and the physician assistant to the possibility of aspiration and that continued speech therapy was needed "to treat continued oral residue issues [and] signs of aspiration, e.g. watering eyes, wet vocal quality." CMS Ex. 8, at 26-27. The speech therapist also noted that Resident 1 coughed and had a wet vocal quality and watery eyes and that "CNA [certified nursing assistant] aware of these signs of aspiration" and spoke to the charge nurse regarding checking Resident 1's lung sounds reporting any signs and symptoms of aspiration (wet cough and watering eyes) to the physician assistant. CMS Ex. 8, at 26-27.

On the morning of November 22, 2012, the Thanksgiving holiday, a facility employee who routinely provided care to Resident 1, CNA C, noted that Resident 1 coughed up and discharged phlegm from his mouth, which she did not find particularly unusual. P. Closing Br. at 2; P. Ex. 2, at 1. Resident 1 did not eat breakfast that morning, and CNA C removed him from the dining room and took him to his room. P. Closing Br. at 2. Resident 1 was given a bolus tube feeding later that morning. P. Ex. 2, at 1. After the feeding, CNA C checked on Resident 1 and again observed phlegm discharging from Resident 1's nose and mouth. P. Closing Br. at 2-3; P. Ex. 2, at 1. Petitioner's staff took Resident 1 to the dining room for lunch, but because he was discharging phlegm, another CNA, CNA B, asked N.O., a floor tech, to take Resident 1 out of the dining room and deliver him to CNA C before lunch concluded. P. Ex. 2, at 1; P. Closing Br. at 3. Surveyor notes reflect that at approximately 12:40 p.m., CNA B observed Resident 1

coughing with his mouth closed and noticed "copious amounts of phlegm" draining from the side of his mouth. CMS Ex. 5, at 4. CNA B stated that Resident 1 "sometimes ha[d] runny nose, cough; but not like that[,] it was too much phlegm that day." CMS Ex. 5, at 4. The surveyor also noted that around this time the CNAs told the assistant director of nursing (ADON) that Resident 1 "was coughing and they were going [to] take him out." CMS Ex. 5, at 5.

After N.O. brought Resident 1 back to his room after lunch, CNA C "found that the phlegm had significantly increased and was coming from his mouth and it seemed to be getting worse." P. Ex. 2, at 1. CNA C wiped a moderate to large amount of phlegm from Resident 1's face with a towel and then went to the nurses' station to show her supervisor, LVN A, the towel's contents. P. Closing Br. at 3; P. Ex. 2, at 2. CNA C told LVN A "how this had come on over the last couple or three hours and seemed to be getting progressively worse" and "all of a sudden he had a lot of phlegm . . . [i]t came up quickly . . . it was really thick . . ." P. Ex. 2, at 2; CMS Ex. 5, at 8. According to CNA C, LVN A instructed her to "take [Resident 1] and clean him up." CMS Ex. 5, at 8. CNA C also states that LVN A told CNA C that it was time for another bolus feeding and she would see Resident 1 momentarily and assess him, however, LVN A "did not react with . . . urgency". P. Ex. 2, at 2; P. Closing Br. at 3. CNA C then went back to working on her other duties. P. Ex. 2, at 2; P. Closing Br. at 3.

After receiving the report from CNA C regarding Resident 1, LVN A either "ignored it or decided to delay acting upon it . . . ." P. Pre-hrg. Br. at 7; CMS Ex. 5, at 2-3. It appears that LVN A did not assess Resident 1 at this time, but she instead left Resident 1 unattended in his room. *See* CMS Ex. 5, at 2-3. LVN A reported that she did not see Resident 1 until 1:30 p.m., as she passed his door while "taking care of [other] residents." CMS Ex. 5, at 2. LVN A told the state surveyors that she walked by Resident 1's door and noted "he was in [his] geri-chair" and "appeared to be comfortable." CMS Exs. 5, at 2; 18 at 4. Petitioner admits that this walk-by visual assessment from outside of Resident 1's room occurred approximately 45 minutes after LVN A received the report of Resident 1's increasing production of phlegm from CNA C. CMS Ex. 5, at 2-3, P. Pre-hrg. Br. at 7. LVN A also told state surveyors that fifteen minutes later she passed back by Resident 1's room and she "saw him with stuff on his face, [she] went in, and there were no signs of life." CMS Exs. 5, at 3; 18 at 4-5. At 1:45 p.m., the nurses' notes indicate that Resident 1 had a moderate amount of "frothy phlegm on his face and chin" and required a full code. CMS Ex. 8, at 34. LVN A administered CPR before Petitioner's staff transferred Resident 1 to the hospital where he died two days later, on November 24, 2012. CMS Ex. 5, at 2-3. A hospital physician diagnosed Resident 1 with aspiration pneumonia prior to his death. CMS Ex. 9, at 8. Petitioner does not dispute that its staff did not call Resident 1's physician "until 2:20 p.m. on November 22, 2012, but by that time the resident was being treated in an emergency room and no consultation with the physician was necessary for the care of the resident." P. Closing Br. at 9.

On November 23, 2012, Petitioner's director of nursing (DON) reviewed Resident 1's chart after learning of his hospitalization. P. Ex. 3, at 1. According to her declaration, the DON noticed LVN A's "failure to chart her assessment of Resident 1 the day before". P. Ex. 3, at 1. The DON confronted LVA A about the issue, and she "shrugged [the DON] off". P. Closing Br. at 3. The DON then began to initiate termination procedures. P. Ex. 3, at 1. The DON also stated that during the investigation of the events surrounding Resident 1 on November 22, 2012, she learned "for the first time that not only did [LVN A] fail to chart an assessment of Resident 1 . . . but she failed to perform an assessment . . . after being told by [CNA C] of the residents change in condition during the late morning and early afternoon of November 22, 2012." P. Ex. 3, at 1. Immediately upon learning this new information, the DON received authority to terminate LVA's employment with Petitioner, which she did on November 30, 2012. P. Closing Br. at 3; P. Ex. 3 at 1-2.

After receiving a complaint about the incident, the state agency inspected the facility from November 29, 2012 through November 30, 2012. On December 18, 2012, a state surveyor returned to inform the facility of an immediate jeopardy determination to the health and safety of its residents. CMS Exs. 1, 3. During the survey, state surveyors conducted staff interviews and reviewed the facility's records. As a result of the survey, the state agency determined that Petitioner was not in substantial compliance with the following Medicare participation requirements:

- 42 C.F.R. § 483.10(b)(11) (Tag F-157) — (Notification of changes) a facility must immediately inform the resident, consult with the resident's physician, and if known, notify the resident's legal representative or an interested family member when the resident has a significant change in physical, mental, or psychosocial status;

- 42 C.F.R. § 483.13(c) (Tags F-224 and 226) — (Staff treatment of residents) a facility must develop and implement written policies and procedures prohibiting mistreatment, neglect, and abuse of residents; and

- 42 C.F.R. § 483.25 (Tag F-309) — (Quality of care) a facility must provide residents 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 state agency determined that Petitioner's noncompliance was at a scope and severity level "K," meaning the noncompliance demonstrated a pattern of immediate jeopardy. On December 17, 2012, the state agency then determined that the facility had not yet attained substantial compliance but that its noncompliance no longer posed immediate jeopardy.

By letter dated January 16, 2013, CMS accepted the state agency's findings and imposed a $6,650 per day CMP from November 22, 2012 through November 30, 2012 and a $1,000 per day CMP continuing until further notice. CMS Ex. 1. CMS also imposed enforcement remedies of termination of Petitioner's Medicare provider agreement, denial of payment for new Medicare admissions, and directed in-service training. CMS Ex. 1. By letter dated February 20, 2013, CMS notified Petitioner that the facility achieved substantial compliance with the requirements for Medicare participation on January 17, 2013, and the $6,650 per day CMP for nine days would remain in effect. CMS Ex. 2. CMS also imposed a $1,000 per day CMP, beginning December 1, 2012 and continuing through January 16, 2013 (47 days), contending that Petitioner did not achieve substantial compliance with all participation requirements until the completion of a directed in-service training conducted on January 16, 2013. CMS Closing Br. at 1-2; CMS Ex. 2, at 1. CMS rescinded all other proposed enforcement remedies. CMS Ex. 2.

On February 22, 2013, Petitioner requested a hearing to challenge the noncompliance findings and enforcement remedies. Following my prehearing order, CMS submitted a prehearing brief (CMS Pre-hrg. Br.) and 19 proposed exhibits (CMS Exs. 1-19). Petitioner then submitted a prehearing brief (P. Pre-hrg. Br.) and eight proposed exhibits (P. Exs. 1-8). On September 18, 2013, I convened a prehearing conference by telephone, and I admitted CMS Exs. 1-19 and P. Exs. 1-8 into the record. During the prehearing conference, the parties declined the opportunity to cross-examine each other's witnesses, whose affidavits of direct testimony are part of the written record. The parties agreed that I would base my decision on a final exchange of written briefs and the documentary evidence of record. At my direction, each party submitted a final closing brief (CMS Closing Br. and P. Closing Br.).

II. Issues Presented

1. Whether Petitioner was in substantial compliance with Medicare participation requirements between November 22, 2012, and January 16, 2013;

2. If Petitioner was not in substantial compliance, whether CMS's determination was clearly erroneous that the deficiencies posed immediate jeopardy to the health and safety of residents in Petitioner's facility; and

3. Whether the enforcement remedies imposed, a $6,650 per day CMP for nine days of immediate jeopardy, from November 22, 2012 through November 30, 2012, and $1,000 per day CMP for 47 days of substantial noncompliance that was not immediate jeopardy, from December 1, 2012 through January 16, 2013, are reasonable.

III. Statutory and Regulatory Framework

The Social Security Act (Act) establishes the requirements that a long-term care facility must meet to participate in the Medicare program and authorizes the Secretary of Health and Human Services (Secretary) to promulgate regulations implementing those statutory requirements. Act § 1819.[1] Medicare participation requirements for long-term care facilities are found at 42 C.F.R. Part 483. The Secretary contracts with state survey agencies to conduct periodic onsite surveys to assess compliance with those requirements. Act §§ 1819(g), 1864(a); 42 C.F.R. Part 488, subpart E. A "deficiency" is a "failure to meet a participation requirement specified in the Act or [42 C.F.R. Part 483]." 42 C.F.R. § 488.301. A long-term care facility must remain in substantial compliance with program requirements to participate in Medicare. *See* 42 C.F.R. § 483.1(b). "Substantial compliance" means "a level of compliance with the requirements of participation such that any identified deficiencies pose no greater risk to resident health or safety than the potential for minimal harm." 42 C.F.R. § 488.301. The regulatory term "noncompliance" is defined as "any deficiency that causes a facility not to be in substantial compliance." *Id.*

State surveyors consider the "seriousness" of the facility's noncompliance and may consider other factors specified in the regulations. 42 C.F.R. § 488.404(a), (c). "Seriousness" is a function of two factors: (1) "severity" – that is, whether the noncompliance has created a "potential" for "more than minimal" harm to residents, resulted in "actual harm," or placed residents in "immediate jeopardy"; and (2) "scope" – whether the noncompliance is "isolated," constitutes a "pattern," or is "widespread." 42 C.F.R. § 488.404(b); State Operations Manual, CMS Pub. 100-07, Appendix P - *Survey Protocol for Long Term Care Facilities*, Part I, Chapter IV ("Deficiency Categorization"). "Immediate jeopardy" exists when "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.

Based on a survey's findings, CMS may impose various remedies on a facility that is found not to comply substantially with the participation requirements, including a per-day CMP for the number of days that the facility is not in substantial compliance. 42 C.F.R. § 488.408(d), (e). For deficiencies that do not constitute immediate jeopardy, CMS may impose per-day CMPs in amounts ranging from $50 to $3,000 per day. 42 C.F.R. § 488.438(a)(l)(ii). For deficiencies that constitute immediate jeopardy and any repeated deficiencies for which a lower level penalty amount was previously imposed, CMS may impose per-day CMPs of $3,050 to $10,000. 42 C.F.R. § 488.438(a)(l)(i), (d)(2).

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[1] The Act, as amended, is available at http://www.ssa.gov/OP_Home/ssact/ssact.htm. On this website, each section of the Act contains a reference to the corresponding chapter and code in the United States Code.

If CMS imposes one or more enforcement remedies against a facility based on a noncompliance determination, the facility may request a hearing before an administrative law judge (ALJ) to challenge the noncompliance finding and enforcement remedies. Act §§ 1128A(c)(2), 1866(h); 42 C.F.R. §§ 488.408(g), 498.3(b)(13). In its appeal, the facility may also contend that the amount of the CMP imposed for the noncompliance is unreasonable. *See Lutheran Home at Trinity Oaks*, DAB No. 2111, at 21 (2007).

IV. Findings of Fact and Conclusions of Law

1. *Petitioner was not in substantial compliance with 42 C.F.R. § 483.10(b)(11) (Tag F-157) because Petitioner did not immediately consult with Resident 1's physician when Resident 1 experienced a life threatening condition.*

a. *Petitioner's staff knew, or should have known, that Resident 1 was at risk for aspiration, which could cause a significant deterioration in his physical health.*

On June 24, 2011, when Resident 1 was admitted to the facility, Petitioner was aware that he suffered from dysphagia, a swallowing disorder. CMS Ex. 8, at 1. Due to his dysphagia, Resident 1's comprehensive plan of care dated July 14, 2012, required a pureed diet and Petitioner's staff to monitor Resident 1 for changes in his ability to eat. CMS Ex. 8, at 10. Also, Resident 1's quarterly MDS dated October 1, 2012, noted his swallowing disorder and his need for nutrition by tube feeding. CMS Ex. 8, at 5. In the spring of 2012, Resident 1 also underwent a speech therapy and swallowing evaluation to assess his difficulty swallowing which resulted in his pocketing of food and producing mucus during meals. CMS Ex. 8, at 24. The speech therapist alerted nursing and physician assistants to the possibility of aspiration. CMS Ex. 8, at 26. The speech therapist directed Petitioner's staff to check Resident 1's lung sounds and to report wet cough, watering eyes, and gurgled vocal quality as these are signs and symptoms of aspiration. CMS Ex. 8, at 26-27.

CMS submitted as an exhibit a document it asserts was located at Petitioner's facility entitled Facility Spring 2011 Health Bulletin: Signs of Aspiration & Aspiration Pneumonia, which is a document from the "Division of Developmental Disabilities" and contains the facility's stamped address. CMS Ex. 13; CMS Pre-hrg. Br. at 7. According to the bulletin, aspiration is a common problem among people who have dysphagia or difficulty swallowing and occurs when food or fluids that should go into the stomach instead go into the lungs. CMS Ex. 13. The bulletin states that coughing before or after swallowing, much drooling (especially during meals) and nose running or sneezing are signs of aspiration. CMS Ex. 13. The bulletin also indicates that food and materials going into the lungs can cause aspiration pneumonia, which can quickly worsen if it is not properly diagnosed and treated, and that frequent coughing and the expulsion of foul-

smelling phlegm are signs or symptoms of aspiration pneumonia. CMS Ex. 13. The bulletin states that "[a]lthough, symptoms of aspiration pneumonia take several days to appear, do not neglect them" and aspiration pneumonia should be treated as a life threatening emergency. CMS Ex. 13. Petitioner's staff, therefore, was aware that Resident 1 was at risk for aspiration, and he needed to be carefully monitored for signs of aspirating, which could pose a life threatening risk to his physical health.

b. Petitioner did not take reasonable steps to immediately consult with Resident 1's physician when he experienced a significant change in his condition.

Facility staff must immediately consult with a resident's physician and notify the resident's legal representative, or an interested family member, when the resident experiences a significant change such as a deterioration in health in either life-threatening conditions or clinical complications. 42 C.F.R. § 483.10(b)(11).

Here, there were no such immediate notifications. For several hours on November 22, 2012, Resident 1 experienced, and staff observed, phlegm dripping from his mouth and he received no intervention other than staff wiping his mouth and "cleaning him up." CMS Ex. 5, at 2-3, 8. This started during the morning of November 22, 2012 and worsened around lunchtime. P. Exs. 2, 3; CMS Exs. 5, at 8; 18, at 4. As CNA C monitored Resident 1 throughout the morning she observed that the phlegm coming from his mouth had become "really thick" and "progressively worse." P. Ex. 2; CMS Exs. 5, at 8; 18, at 4. However, although Petitioner's staff was on notice that Resident 1 was at risk for aspiration, Petitioner's staff did not immediately consult with Resident 1's physician. CMS Ex. 5, at 2-3, 7-8. Eventually, CNA C recognized that Resident 1's phlegm had significantly increased, a lot of phlegm was coming out of both sides of his mouth, and she then reported this to her charge nurse, LVN A. P. Ex. 2, at 1.

According to Resident 1's therapy progress report in the spring of 2012, the speech therapist educated Petitioner's staff on recognizing the signs of aspiration and specifically informed the charge nurse to check Resident 1's lung sounds and report back to the physician assistant. CMS Ex. 8, at 26-27. Despite this history, when LVN A received a report from CNA C that Resident 1 was discharging phlegm from this mouth after lunch, she still did not immediately assess Resident 1 and consult with Resident 1's physician. CMS Ex. 5, at 2, 8. LVN A expressed to the surveyor that "if [she] could have been able to do things different; she would have taken vitals and listen[ed] to his lungs," and if she had thought he needed to be supervised, she would not have left him alone in his room. CMS Ex. 5, at 3. However, LVN A admitted that she only checked on Resident 1 as she passed by his door while taking care of other residents, rather than immediately assessing Resident 1 and consulting with his physician. Thus, Petitioner failed take reasonable steps to immediately assess Resident 1 and consult with his physician despite a significant change in Resident 1's physical condition on November 22, 2012. *See* P. Ex.

2, at 1; CMS Ex. 18, at 5. When interviewed about the incident, the facility's administrator acknowledged Petitioner's failure and stated that "there [was] no excuse for [LVN A] to have not followed through and assess [Resident 1] when there was a change of condition." CMS Ex. 5, at 10.

Petitioner does not deny that Resident 1's physician was not immediately consulted regarding a significant change in his condition. However, Petitioner attempts to shift the blame for its noncompliance to LVN A and argues that she alone ignored Resident 1's significant change in condition. P. Pre-hrg. Br. at 7. However, as the Board has previously explained, for the purpose of evaluating a facility's compliance with the Medicare participation requirements, the facility acts through its staff and cannot dissociate itself from the consequences of its employees' actions. *Beverly Health Care Lumberton,* DAB Ruling No. 2008-5 (Denial of Petition for Reopening Decision No. 2156) at 6-7 (2008); *Emerald Oaks,* DAB No. 1800, at 7, n.3 (2001).

Petitioner argues that its failure to comply with 42 C.F.R. § 483.10(b)(11) was beyond Petitioner's control or knowledge. P. Br. at 6-8. Petitioner relies on *Koester Pavilion*, DAB 1750 (2000), and argues that a facility is not required to perform the impossible or guarantee against unforeseeable occurrences, but it is only required to do everything in the facility's power to prevent accidents from occurring. However, under the circumstances present in this case, I find that Petitioner's failures involved occurrences that were foreseeable and within Petitioner's control. It was possible for LVN A, or another employee of the facility who noticed Resident 1's worsening condition, to immediately consult with Resident 1's physician. Other actions were certainly possible, as LVN A told the state surveyors "if she could have done things different[ly], she would have taken [Resident 1's] vitals and listen[ed] to his lungs." CMS Ex. 5, at 3. These actions were not impossible or beyond Petitioner's control but were actually recommended interventions for Resident 1's aspiration risk.

2. *Petitioner was not in substantial compliance with 42 C.F.R. § 483.13(c) (Tags F-224 and 226) because the facility did not develop and implement policies and procedures that prohibit neglect of residents.*

A facility must develop and implement policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. 42 C.F.R. § 483.13(c). Petitioner has a policy entitled "Abuse Prevention Policy" that was effective January 2005 and revised in June 2009. CMS Ex. 10. This policy defines abuse to be "deprivation by an individual, including a caretaker of goods and services that are necessary to attain or maintain physical, mental and psychosocial well-being, presuming that the instance of abuse causes physical harm . . . ." and defines neglect as "failure to provide goods and services necessary to avoid harm, mental anguish or mental illness." CMS Ex. 4, at 16; CMS Ex. 10. The Abuse Prevention Policy specifically

states that the facility will prohibit abuse and neglect for all patients through the implementation of seven components: screening of potential employees, training of employees, prevention of occurrences, identification of possible incidents or allegations which need investigation, investigation of incidents and allegations, protection of patients during investigation, and reporting of incidents, investigations and facility response to the results of their investigations. CMS Ex. 10, at 1. Petitioner's policy also defined "prevention" and states "[f]or any concerns or questions, place notes in the Administrators box or contact the administrator personally. Supervisors will immediately correct and intervene in identified situations such as neglect, abuse, or misappropriation of patient's property." CMS Ex. 10, at 3.

Despite the awareness of multiple staff members that something was wrong with Resident 1 during the morning and early afternoon, and despite Resident 1's documented risk for aspiration, Petitioner admittedly failed to assess Resident 1 and immediately consult with his physician when he experienced a significant change in his condition. P. Exs. 2; 3; CMS Exs. 5, at 2-3, 8; 18, at 4. Petitioner's termination of LVN A supports CMS's findings because Petitioner cited her for not assessing Resident 1's change in condition and for substandard performance of her duties. P. Ex. 4.

Petitioner does not deny that a failure occurred. P. Br. at 3, 5, 7-8. However, Petitioner suggests that a "single nurse" did not implement Petitioner's policies and procedures as she was trained and licensed to do. P. Br. at 10. This "single nurse" however, was a supervisory employee of Petitioner, and she provided care to Resident 1 within the normal scope of her employment at the facility. The care any facility renders to its residents depends on the performance of the facility's individual staff members. Staff members assess the resident's condition, plan the resident's care, and implement care planning decisions. Thus, a facility is responsible for all of its staff's actions because it is those actions which comprise the care that residents receive. *Emerald Oaks*, DAB No. 1800, at 7, n.3; *Barn Hill Care Ctr.*, DAB No. 1848, at 10-12 (2002).

Petitioner also claims that CMS is unfairly holding the facility to a strict liability standard. P. Pre-hrg. Br. at 10. However, Petitioner misconstrues the relevant requirements. Requiring Petitioner to abide by the standard set forth in the Medicare participation regulations is not akin to applying a strict liability standard. *Tri County Extended Care Ctr.,* DAB No. 2060, at 5 (2007) (explaining that an ALJ holding a facility to the standards enunciated in the relevant Medicare participation requirements and its own policies and care plans is not tantamount to applying "strict liability").

The breakdown in the implementation of Petitioner's anti-neglect policies was not limited to one staff member on one occasion. Contrary to Petitioner's allegation that LVN A "hid" the failures, the evidence suggests that other staff also knew of Resident 1's significant change in condition around lunch time. P. Pre-hrg. Br. at 11; P. Ex. 2, at 1-2. CNA C stated that "right before lunch was served, Resident 1 had a lot of phlegm coming

out of both sides of his mouth, at which time [CNA B] asked [N.O,] to bring Resident 1 from the lunch room to me and he did." P. Ex. 2, at 1-2. Moreover, even though CNA C stated that LVN A did not react with urgency upon receiving her report of significant change in resident health, CNA C did not follow up on the report or attempt to alert other staff members about LVN A's non-responsiveness. *See* P. Ex. 2, at 2. Petitioner's staff had the opportunity to ensure that Resident 1 received appropriate care by implementing Petitioner's policies and procedures but, instead, neglected Resident 1 by failing to assess Resident 1's worsening condition and failing to immediately consult with his physician. Thus, within a several hour window of time, multiple staff members violated Petitioner's anti-neglect procedures, demonstrating an underlying breakdown in the facility's implementation of its abuse prevention policy.

3. *Petitioner was not in substantial compliance with 42 C.F.R. § 483.25 (Tag F-309) because Petitioner failed to provide Resident 1 the necessary care and services to attain or maintain his highest physical well-being in accordance with his comprehensive assessment and plan of care.*

The Board has held that 42 C.F.R. § 483.25 requires facilities to furnish the care and services set forth in a resident's care plan, to implement physicians' orders, to monitor and document residents' conditions, and to follow its own policies. *Life Care Center of Bardstown*, DAB No. 2479, at 22 (2012). The regulation "imposes on facilities an affirmative duty designed to achieve favorable outcomes to the highest practicable degree." *Id.* citing *Windsor Health Care Ctr.,* DAB No. 1902, at 16-17 (2003), *aff'd Windsor Health Care Ctr. v. Thompson,* No. 04-3018 (6th Cir. 2005). As previously discussed under the subsection 483.13(c) noncompliance, I find Petitioner did not follow its abuse prevention policy when attending to Resident 1 on November 22, 2012, which also supports a deficiency under 42 C.F.R. § 483.25.

Further, the facility did not provide the requisite care when it did not follow Resident 1's care plan and speech and swallowing evaluations, which were approved by Resident 1's doctor. CMS Ex. 8, at 10, 25, 32. When admitted to the facility, Resident 1 had a swallowing disorder and his plan of care required nectar-thickened liquids and monitoring for changes in his ability to eat and swallow. CMS Ex. 8, at 1, 5, 10. The care plan's approach required nursing staff to notify a doctor when Resident 1's ability changed. CMS Ex. 8, at 10. Approximately seven months before his death, Resident 1 underwent a speech therapy swallowing evaluation, and the speech therapist assessed Resident 1 as an aspiration risk with oral motor function to be moderately to severely impaired. CMS Ex. 8, at 24-26. The speech therapist also noted that she spoke to the charge nurse regarding checking Resident 1's lungs and to report a wet cough and watering eyes. CMS Ex. 8, at 27. When discharging him from speech therapy on May 19, 2012, the speech therapist noted that she educated staff on strategies to use to decrease Resident 1's risk of aspiration. CMS Ex. 8, at 31.

Despite Resident 1's treatment approaches, on November 22, 2012, Resident 1 began to cough up phlegm while getting ready for breakfast, and CNA C did not report this until several hours later, when the amount and thickness of the phlegm began to increase. P. Ex. 1. Then, LVN A did not assess Resident 1 when she received the report from CNA C, and did not immediately monitor Resident 1's lung sounds, despite the fact he was susceptible to aspirating. CMS Ex. 5, at 2-3; CMS Ex. 8, at 34. The facility's administrator acknowledged that Petitioner failed to provide necessary services to Resident 1 and stated that "there [was] no excuse for [LVN A] to have not followed through and assess [Resident 1] . . . ." CMS Ex. 5, at 10.

4. *Petitioner has not demonstrated that CMS's determination of "immediate jeopardy" was clearly erroneous.*

Immediate jeopardy exists when "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. CMS asserts that Petitioner's noncompliance constituted a pattern of "immediate jeopardy" (level "K") for nine days from November 22, 2012 through November 30, 2012. I must uphold an immediate jeopardy determination unless it is "clearly erroneous." 42 C.F.R. § 498.60(c). The "clearly erroneous" standard imposes on facilities a heavy burden to show no immediate jeopardy, and the Board has sustained determinations of immediate jeopardy where CMS presented evidence "from which '[o]ne could reasonably conclude' that immediate jeopardy exists." *See Barbourville Nursing Home*, DAB No. 1962, at 11 (2005) (citing *Florence Park Care Ctr.*, DAB No. 1931, at 27-28 (2004)).

I have found Petitioner neglected its duty to immediately consult with a physician regarding significant changes in Resident 1's condition. Due to Petitioner's inaction, medical treatment for Resident 1 was delayed, and Petitioner's failures placed him at risk for developing aspiration pneumonia, which "can worsen quickly if not properly identified and treated" and "can result in death." CMS Ex. 13.

Here, Petitioner in fact died with a diagnosis including aspiration pneumonia within two days of the events of November 22, 2012. There were also several other residents at the facility who received tube feedings and speech therapy and were similarly at risk of not receiving timely treatment due to the inaction of Petitioner's staff. CMS Ex. 18, at 6. As the surveyor noted, "the failures could affect 22 residents who received speech therapy and placed them at risk for not having the signs and symptoms of aspiration recognized and treated in a timely manner." CMS Ex. 18, at 6.

Petitioner argues that the case involves one resident and one nursing staff member's actions "for approximately one hour" and that there is no evidence in the record regarding any basis for determining there to be immediate jeopardy to residents after Resident 1

was discharged from the facility on November 22, 2012. P. Pre-hrg. Br. at 11-12. However, LVN A, the "rouge" employee, continued to be employed at the facility until November 30, 2012, Petitioner has not come forward with any evidence to show she was not treating patients during this time, and Petitioner has not contested that other residents were similarly situated to Resident 1. Although Petitioner argues this was an isolated incident and one nurse was at fault, the charge nurse (LVN A) as well as CNA B and CNA C were aware of Resident 1's condition, yet no staff member intervened.

Petitioner has not offered any evidence to dispute CMS's finding that the facility failed to meet the regulatory requirements with regard to the care of Resident 1 from November 22, 2012 to November 30, 2012, but instead it complains of irregularities in the survey process such as the state surveyors reopening the survey two weeks after exiting the facility on November 30, 2012 and declaring immediate jeopardy at that time. P. Pre-hrg. Br. at 3-5. However, Petitioner's complaints about the survey process are not relevant to my determination because inadequacies or irregularities in the survey process do not invalidate adequately documented deficiencies or relieve a facility of its obligations to meet all requirements for participation in Medicare. *See* 42 C.F.R. § 488.318(b).

5. *The CMPs CMS imposed are reasonable.*

a. The amount of the CMP is reasonable.

CMS must consider several factors when determining the amount of a CMP, which I consider de novo when evaluating the reasonableness of the CMP, which are: (1) the facility's prior history of noncompliance, including repeated deficiencies; (2) the facility's financial condition, *i.e.*, its ability to pay the CMP; (3) the severity and scope of the noncompliance; (4) the relationship of one deficiency to other deficiencies resulting in noncompliance; and (5) the facility's degree of culpability, which includes neglect, indifference, or disregard for resident care, comfort or safety. 42 C.F.R. §§ 488.438(f), 488.404(b),(c). Unless a facility contends that a particular regulatory factor does not support the CMP amount that CMS imposed, I must sustain it. *Coquina Ctr.*, DAB No. 1860, at 32 (2002).

The deficiencies here are very serious. After Petitioner's staff became aware that Resident 1 had suffered a significant change in condition, it did not immediately consult with his physician, which delayed necessary treatment. CMS Exs. 5, at 2-3; 17, 19; P. Exs. 2, 3. Resident 1 died two days later after being diagnosed with aspiration pneumonia. CMS Ex. 9, at 8. Petitioner's noncompliance with several regulations caused serious harm to Resident 1. Accordingly, a significant CMP is justified.

Also, Petitioner was highly culpable for its overall noncompliance. Petitioner's staff members either did not recognize their duty to consult with Resident 1's physician regarding significant changes in his condition or demonstrated an indifference to

Resident 1's signs of aspiration. Petitioner characterizes the series of events on November 22, 2012, as an isolated incident that LVN A hid from the facility. P. Pre-hrg. Br. at 11-12. However, as previously discussed, Petitioner is responsible for the acts of its employees and cannot escape its significant culpability by blaming its employee.

With regard to Petitioner's financial condition and ability to pay the CMP, CMS states that the CMP total of $106,850 represents 3.58% of the estimated annual Medicaid gross revenue for Petitioner's facility. Petitioner presents only a non-specific affidavit from Petitioner's Chief Financial Officer as evidence of its financial condition. The affidavit states that "[c]omparing the revenue for the period of March through May 2013, I note that such revenue has declined 5.4%. Also . . . Medicaid revenue does not cover the costs of providing Medicaid services and a civil money penalty will further impede Petitioner's quality to provide nursing facility services consistent with state and federal standards." P. Ex. 8.

I assign little weight to this testimony because it is not probative of whether Petitioner lacks the ability to pay the CMP without going out of business or jeopardizing resident health and safety. *See Meadowwood Nursing Center*, DAB No. 2541, at 18 (2013). The Board has explained that non-specific information, such as information about a facility's "annual profits or losses, may not be an accurate reflection of a facility's financial health or ability to pay and must be considered in the light of such other indicators as the facility's financial reserves, assets, credit-worthiness, and 'other longterm indicia of its survivability.'" *Meadowwood Nursing Center*, DAB No. 2541, at 18; citing *Guardian Care Nursing & Rehab. Ctr.*, DAB No. 2260, at 8 (2009), citing *Kenton Healthcare, LLC*, DAB No. 2186 (2008) (explaining all indicia of a facility's financial situation, as well as financing options and not merely cash flow, should be considered for this factor) and *Windsor Health Care*, DAB No. 1902 (2003) (explaining that adequacy of assets, not profits, is the relevant inquiry). The information Petitioner provided is insufficient to establish that payment of the CMP would put Petitioner out of business or compromise resident health and safety, and there is no evidence to suggest that Petitioner is unable to pay the total CMP imposed. P. Ex. 8; P. Pre-hrg. Br. at 12.

CMS has also presented evidence of Petitioner's history of noncompliance. CMS Ex. 16.[2] CMS states that "this was the eighth noncompliance cycle and fourth enforcement action since October 2009" involving Petitioner. CMS Ex. 17, at 8. In October of 2009, Petitioner was cited for 42 C.F.R. § 483.25, (Tag F-309), a pattern of actual harm for failing to thoroughly assess and intervene on behalf of a resident with bruising and knee

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[2] CMS Ex. 16 consists of a "Provider Full Profile." The first six pages of the report appear to relate to another facility. However, the last four pages (CMS Ex. 16, at 7-10) clearly relate to Petitioner. I have not considered CMS Ex. 16, at 1-6, as this portion of the exhibit is not relevant to this case.

pain and failure to intervene on behalf of a resident who had a painful itching rash for two months. In March of 2011, Petitioner was cited for 42 C.F.R. § 483.25(h), (Tag F-323) for isolated actual harm when failing to provide adequate supervision to prevent accidents for one resident who exited the building without staff knowledge and rolled off the porch in his wheelchair. Further, in July of 2012, Petitioner was cited for 42 C.F.R. § 483.25(h), (Tag F-323), at a scope and severity determination of isolated immediate jeopardy, for failing to provide adequate supervision to prevent accidents for one resident who fell from bed and subsequently died. CMS Ex. 17, at 8. This similarity in citations as well as the scope and severity of the noncompliance in the several years prior to the instant case is significant and also supports a higher CMP.

In assessing the reasonableness of a CMP amount, I am required to look at the per-day amount, rather than the total amount of CMP accrual. *See Kenton Healthcare, LLC*, DAB No. 2186, at 28-33. I have found immediate jeopardy level noncompliance to be not clearly erroneous, and therefore the minimum CMP I am required to sustain is $3,050 per day for the period of immediate jeopardy. The $6,650 per day CMP that CMS imposed is in the middle range for immediate jeopardy level noncompliance. CMS also imposed a CMP of $1,000 per-day for the period of noncompliance which was not immediate jeopardy, which is also in the middle range deficiencies that do not constitute immediate jeopardy. In light of all of the factors discussed, I find that the moderate CMP of $6,650 per day for nine days from November 22, 2012 through November 30, 2012, and $1,000 per day for 47 days from December 1, 2012 through January 16, 2013 is reasonable in amount in light of the seriousness of Petitioner's noncompliance, culpability, and history of noncompliance.

b. The duration of the CMP is reasonable.

i. CMS's determination of the duration immediate jeopardy was not clearly erroneous.

A "determination by CMS that a [facility's] ongoing compliance remains at the level of immediate jeopardy during a given period constitutes a determination about the 'level of noncompliance' and, therefore, is subject to the clearly erroneous standard of review under section 498.60(c)(2)." *Brian Ctr. Health & Rehab./Goldsboro,* DAB No. 2336, at 7-8 (2010). In addition, Petitioner bears the burden of persuasion regarding the entire duration of immediate jeopardy noncompliance. In *Owensboro Place and Rehabilitation Ctr*, DAB No. 2397 (2011), the Board stated:

> The burden of persuasion is on the facility. The Board has made it clear that the facility bears the burden of showing that it returned to substantial compliance on a date earlier than that determined by CMS and has rejected the idea that CMS must establish a lack of substantial compliance during each day in which a remedy remains in effect . . . .

DAB No. 2397, at 12 (citations omitted).

I find that CMS's determination that Petitioner was not in substantial compliance with participation requirements at the immediate jeopardy level beginning on November 22, 2012, the date Resident 1 was sent to the hospital, and ending November 30, 2012, the date Petitioner culminated the process of terminating LVN A, was not clearly erroneous.

Petitioner argues that the facility took certain actions to reduce the risk to its residents starting on November 23, 2012, when the DON identified LVN A's failure to chart an assessment for Resident 1 and when Petitioner began the process of retraining staff. P. Pre-hrg. Br. at 2-3; P. Closing Br. at 4. Petitioner explains the facility "immediately began the task of retraining all health care staff on identifying aspiration, treating residents at risk of aspiration, assessing changes in condition, notification of physician and family, and compliance with [Petitioner's] abuse and neglect policy." P. Closing Br. at 4. Petitioner contends that it implemented new quality assurance procedures and tools and that the state surveyor "observed these corrective measures and the modification of the quality assurance procedures, and based on those observations she was not inclined to declare [immediate jeopardy] upon her exit on December 3, 2012." P. Closing Br. at 4.

However, immediate jeopardy is abated "only when the facility has implemented necessary corrective measures so that there is no longer any likelihood of serious harm." *Life Care Ctr. of Bardstown*, DAB No. 2479, at 35 (2012), *citing Pinehurst Healthcare & Rehab. Ctr.*, DAB No. 2246, at 15 (2009). Also, in *Fairfax Nursing Home, Inc.*, DAB No. 1794, at 13-14 (2001), the Board stated that "a finding of immediate jeopardy is not contingent on a finding that each individual incident placed a resident at such a degree of potential or risk of serious harm that there was a likelihood of harm to that specific resident at that particular time . . . . Findings about incidents related to individual residents are not themselves the deficiencies that must be corrected – the deficiency is the underlying failure to meet a participation requirement evidenced by the incident." *Aff'd*, *Fairfax Nursing Home v. Dep't of Health & Human Servs.*, 300 F.3d 835 (7th Cir. 2002), *cert. denied*, 537 U.S. 1111 (2003).

Here, the facility did not fully address the underlying situation that resulted in immediate jeopardy until after November 30, 2012. Petitioner states that the facility "began the process of terminating [LVN A's] employment on November 25, 2012 . . . which culminated on November 30, 2012." P. Pre-hrg. Br. at 3; P. Exs. 1, 3, 4. Petitioner also contends it implemented significant modifications and provided extensive training to staff on November 30 and December 1, 2012. P. Pre-hrg. Br. at 4; CMS Ex. 4, at 17-25. Petitioner recognized that corrective actions and additional staff training were necessary to ensure the safety of its residents. Until the facility completed these tasks, the likelihood of serious harm to residents had not been eliminated.

Overall, Petitioner has not offered any specific evidence or argument that the period of noncompliance at the immediate jeopardy level was shorter than cited. Accordingly, Petitioner has not met its heavy burden of demonstrating that CMS's determination about the duration of the period of immediate jeopardy was clearly erroneous.

ii. Petitioner did not meet its burden of demonstrating by a preponderance of the evidence that it returned to substantial compliance prior to January 17, 2013.

I now must determine whether the facility demonstrated by a preponderance of the evidence that it returned to substantial compliance with Medicare participation requirements sometime after November 30, 2012 and before January 17, 2013, as CMS determined. I first note that, in both of its briefs, CMS appears to confuse the period of substantial noncompliance that was not immediate jeopardy and references a "$1,000 per day [CMP] from December 1, 2012, through January 16, 2012" and a "$1,000 per-day CMP from December 1, 2012 through December 17, 2012." CMS Pre-Hrg. Br. at 2; CMS Closing Br. at 2, 16. However, both the official notice letter and Petitioner's closing brief reference CMS's determination that Petitioner was found to not be in substantial compliance with Medicare requirements at a level that was not immediate jeopardy for 47 days beginning December 1, 2012 and continuing through January 16, 2013. CMS Ex. 2, at 1; P. Closing Br. at 4-5.

A facility must ultimately show by a preponderance of evidence that it returned to substantial compliance at a date earlier that CMS determined. *See Golden Living Ctr. – Foley*, DAB No. 2510, at 28-31 (2013). The burden is on the facility to show that it timely proposed an acceptable plan of correction and completed the implementation of that plan, and "[i]t is not enough that some steps have been taken, but rather the facility must prove that the goal has been accomplished." *Lake Mary Health Care*, DAB No. 2081, at 29 (2007).

CMS contends that the facility remained out of compliance until January 17, 2013, because the facility had not completed the required directed in-service training and Petitioner "was still inservicing staff and monitoring the effectiveness of the Plan of Removal." CMS Ex. 4, at 3, 27. Petitioner argues, however, "that there is no question that it was in substantial compliance with the regulations cited against it" at the time of the initial on-site survey on December 3, 2012. P. Closing Br. at 1-2. Petitioner contends that the DON immediately began to retrain staff on assessing changes in condition and the requirements for notification of physician and family to ensure compliance with Petitioner's policies and procedures. P. Closing Br. at 4; P. Ex. 3, at 2. Petitioner states that when the CMS surveyor returned to the facility on December 18, 2012, Petitioner presented her with a corrective action plan, which contained all of the retraining and quality assurance measures Petitioner accomplished on November 30, 2012 and December 1, 2012. P. Ex. 3, at 2. According to Petitioner, the surveyor accepted the

plan and asked the DON to prepare a quiz to test the efficacy of the retraining conducted. P. Ex. 3, at 2. The DON prepared the quiz, and the surveyor used it to ask Petitioner's staff some questions. P. Ex. 3, at 2. Petitioner argues that when the CMS surveyor left the facility on December 17, 2012, she had "accepted the corrections performed prior to December 3, 2012 as the acceptable corrective action plan and lifted the [immediate jeopardy] on December 18, 2012 based upon those corrective action measures taken prior to December 3, 2012 and the staff's ability to respond to questions regarding such measures taken." P. Closing Br. at 4; P. Ex. 3 at 2.

On January 7, 2013, however, Petitioner received the statement of deficiencies and learned that CMS was requiring it to complete a directed in-service training, by a third party acceptable to the state agency, prior to its certification of return to substantial compliance. P. Closing Br. at 5. Petitioner explained the directed in-service training took approximately nine days to schedule before staff conducted it on January 16, 2013. P. Closing Br. at 5; P. Ex. 3 at 2. Petitioner argued this directed in-service training was "redundant and even less informative, than the training that was conducted prior to December 3, 2012." P. Closing Br. at 4. Petitioner also argues that the directed in-service on January 16, 2013 "was not as comprehensive as that prior re-training and did not address any quality assurance tools and measures such as we implemented in that November 30 and December 1, 2012 re-training effort." P. Ex. 3, at 2-3. Petitioner presents documentation relating to the re-training on November 30, 2012 and December 1, 2012 (P. Ex. 5) and documentation relating to the directed in-service on January 16, 2013 (P. Ex. 6).

Despite Petitioner's argument that the directed in-service was redundant and less informative than its own retraining efforts, the documentation relating to directed in-service appears more extensive (67 pages) than the materials relating to the November 30-December 1, 2012 re-training effort (23 pages). I find further the information provided to staff does not appear to cover the same material. *See* P. Exs. 5, 6. It appears the directed in-service training provided detailed information on the violations of the facility, relevant regulatory requirements, and medical literature regarding pneumonia in older residents of long-term care facilities. P. Ex. 6, at 2-56. Petitioner's staff also received questionnaires regarding topics of "F157 Change of Condition" and "F309 Aspiration (Quality of Care)". P. Ex 6, at 2, 57-60. In contrast, the documentation from Petitioner's internal retraining focused on instructions for implementing the "Interact Early Warning Tool," a form to help identify and document significant changes in residents' conditions, and Petitioner's policies for medication administration. *See* P. Ex. 5, at 3-13.

In sum, although Petitioner presented evidence of its efforts to retrain its staff from November 30 to December 1, 2012, including providing a quiz about aspiration and aspiration pneumonia (P. Ex. 5, at 13-14), CMS did not accept this as credible written evidence that the facility had achieved substantial compliance and required the facility to

still perform the directed in-service training, facilitated by a third party. *See* CMS Ex. 4, at 25; CMS Ex. 17, at 2. The training evidence supports that the in-service training, completed on January 16, 2013, was more comprehensive and interactive than Petitioner's earlier staff trainings. *Compare* P. Ex. 5 and P. Ex. 6. Petitioner has not provided any other evidence, such as witness testimony, to persuade me otherwise. Considering Petitioner has concurrently claimed it was in substantial compliance with all of the substantive deficiencies I have upheld here, I find it reasonable that CMS required a third party trainer to provide the requisite care training and did not solely rely upon the facility's internal instruction as evidence that returned it to substantial compliance. I conclude, therefore, that Petitioner did not meet its burden showing that it had returned to substantial compliance on a date earlier than that which CMS determined.

/s/

Joseph Grow
Administrative Law Judge