Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

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

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-11-420

Decision No. CR2617

Date: September 19, 2012

DECISION

Petitioner, Hanover Hill Health Care Center (Petitioner or facility), is a long-term care facility located in Manchester, New Hampshire, that participates in the Medicare program. Following a survey completed on February 11, 2011, the New Hampshire Department of Health and Human Services (state agency) determined that the facility was not in substantial compliance with Medicare participation requirements, and that the facility's noncompliance posed immediate jeopardy to the health and safety of at least one of its residents, a demented man who died while eating peanut butter and crackers. Based on the state agency's findings, the Centers for Medicare and Medicaid Services (CMS) imposed a per-instance civil money penalty (CMP) of $7,500. Petitioner now appeals the noncompliance determination and enforcement remedy.

For the reasons set forth below, I find that Petitioner was not in substantial compliance with Medicare participation requirements and that the penalty imposed is reasonable.

I. Background

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

The Secretary contracts with state survey agencies to conduct periodic surveys to determine whether skilled nursing facilities are in substantial compliance. Act § 1864(a); 42 C.F.R. § 488.20. The regulations require that each facility be surveyed once every twelve months, and more often, if necessary, to ensure that identified deficiencies are corrected. Act § 1819(g)(2)(A); 42 C.F.R. §§ 488.20(a); 488.308.

Here, the state agency surveyed the facility between February 9 and 11, 2011 and cited deficiencies related to the care provided to one if its residents, referred to as "Resident 17" (R17). Among other deficiencies, the state agency cited two at the immediate jeopardy level, concluding that the facility did not address sufficiently R17's demonstrated swallowing difficulties:

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

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

[1] The state agency cited the facility for five related deficiencies that did not cause actual harm, with the potential for more than minimal harm: 42 C.F.R. §§ 483.13(c)(1)(ii)-(iii), (c)(2)-(4) (failing to report the results of an allegation of neglect within five days); 483.13(c) (failing to report its investigation results within five days); 483.20(d)(3) (failing to update R17's comprehensive care plan); 483.75 (failing to administer the facility in a manner that enabled it to provide residents with their highest practicable well-being); and 483.75(i) (medical director's failing to ensure adequate care and services be provided to R17, who had a history of choking). CMS did not impose a remedy for these deficiencies, however, expressly limiting the penalty to those deficiencies cited at the immediate jeopardy level.

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

Petitioner timely requested a hearing. CMS filed a pre-hearing brief and 13 proposed exhibits (CMS Exs. 1-13). Petitioner filed a pre-hearing brief and 28 proposed exhibits (P. Exs. 1-28). On December 5, 2011, I held a pre-hearing conference, during which I admitted CMS Exs. 1-13 and P. Exs. 1-28. Following the pre-hearing conference, CMS moved for summary judgment, which Petitioner opposed. With its motion for summary judgment, CMS submitted one additional document, the facility's application to participate in the Medicare program, which it marked as CMS Ex. 14. In the absence of any objection, I admit CMS Ex. 14.

I denied CMS's motion for summary judgment and, on January 23, 2012, convened a video hearing from the offices of the Departmental Appeals Board in Washington, D.C. Counsel for the parties and the witness convened in Manchester, New Hampshire. Ms. Jill Steinberg appeared on behalf of CMS, and Mr. Joseph L. Bianculli appeared on behalf of Petitioner.

The parties have each submitted a post-hearing brief (Post-Hr'g Br.) and a post-hearing reply brief (Post-Hr'g Reply Br.).

II. Issues

This case presents the following issues:

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

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

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

The facility apparently does not operate a nurse aide training program. CMS Ex. 14 at 1. Even if it did, CMS's scope and severity finding would not affect approval of such a program. By statute and regulation, if, as here, CMS imposes a penalty of $5,000 or more, the state agency cannot approve the program, so the facility would lose its approval without regard to the immediate jeopardy finding. Act § 1819(f)(2)(B); 42 C.F.R. § 483.151(b)(2)(iv).

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

III. Discussion

A. *Petitioner was not in substantial compliance with Medicare participation requirements, because the facility did not implement its policy prohibiting resident neglect and did not provide R17 with the assessment, care, and services he needed after he showed signs of swallowing difficulties.*[2]

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

Section 483.13(c) "addresses a deficiency related to lack of an effective policy as opposed to one directed at the occurrence of neglect itself." *Emerald Oaks*, DAB No. 1800 at 12 (2001). However, the drafters of the regulation characterized as "inherent in [section] 483.13(c)" the requirement that "each resident should be free from neglect as well as other forms of mistreatment," 59 Fed. Reg. 56,130 (Nov. 10, 1994). The drafters also deliberately rejected the suggestion that the regulations require evidence of a negative outcome to support the finding of neglect.

> We do not accept this comment because neglect may be determined even if no apparent negative outcome has occurred. The *potential* for negative outcome must be considered.

59 Fed. Reg. at 56,130 (emphasis added).

The regulation requires that the facility "implement" its anti-neglect policies. 42 C.F.R. § 483.13(c). Implementing a policy requires more than drafting and maintaining

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

documents. Staff must carry out and follow the policy. The Board has recognized that examples of neglect can demonstrate that the facility has not implemented its policies. *Barn Hill Care Ctr.*, DAB No. 1848 at 9-12 (2002); *Emerald Oaks*, DAB No. 1800 at 18; 59 Fed. Reg. 56,130; *see also The Cottage Extended Care Ctr.*, DAB No. 2145 at 4 n.4 (2008); *Liberty Commons Nursing & Rehab. Ctr.-Johnston*, DAB No. 2031 at 7-17 (2006), *aff'd, Liberty Nursing & Rehab. Ctr.-Johnston v. Leavitt*, 241 F. App'x 76 (4th Cir. 2007).

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

The Facility's Policies and Procedures. Here, consistent with the regulations, the facility's "Abuse Prohibition" policy states that the facility "will make every effort to prevent patient/resident . . . neglect . . . by employing the seven components of prevention: screening, training, prevention, identification, investigation, protection and reporting/response." CMS Ex. 5 at 19. As part of the "prevention" component, the policy says that the facility will, among other requirements, "identify, correct, and intervene in situations in which . . . neglect . . . is more likely to occur"; will "assure that the staff assigned have knowledge of the individual residents' care needs"; and will "[a]ssess, care plan for[,] and monitor residents with needs and behaviors which may lead to . . . neglect . . . ." CMS Ex. 5 at 19-20.

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

The facility's "Aspiration Precautions" policy mandates that the facility promptly identify "signs or symptoms of aspiration, changes in swallowing function, and sign[s] and symptoms of aspiration pneumonia." CMS Ex. 5 at 1. Staff must "[e]ncourage resident[s] to eat in [a] supervised setting [and] [p]rovide supervision in [the resident's] preferred eating environment if [the] resident does not choose to attend supervised dining areas." CMS Ex. 5 at 1. Staff must also report changes in signs or symptoms of dysphagia (difficulty swallowing) to the resident's physician. CMS Ex. 5 at 1.

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

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

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

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

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

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

August 9, 2010 Incident. Nursing staff reported the August 9 choking episode to the facility's speech and language pathologist, Heather Marttila, who assessed R17's swallowing functions and "observed [R17] consuming a regular texture with thin liquids." CMS Ex. 6 at 47. Speech Pathologist Marttila reported that R17 was "tolerating [food] without overt signs [or] symptoms of aspiration [or] choking," and "[n]o coughing, throat clearing or change in subsequent vocal quality." CMS Ex. 6 at 47. She concluded that the "[c]hoking episode appears to be an isolated event" but recommended that nursing staff monitor him over the "next few shifts." CMS Ex. 6 at 47.

Nursing staff notified Enieda Islamovic, the on-call physician's assistant (covering for R17's primary care physician, Dr. Howard Suls), who issued no new orders. CMS Ex. 6 at 47. Staff also notified R17's daughter of the incident, and "reviewed and updated" R17's plan of care. CMS Ex. 6 at 41.

The facility's response to the August 9 choking incident presents no apparent problems. Staff identified signs of "changes in swallowing function," and, in accordance with the facility's aspiration precaution policy, timely notified the appropriate personnel (the speech and language pathologist). *See* CMS Ex. 5 at 1. Speech Pathologist Marttila assessed R17's swallowing function, concluding that the incident was likely "isolated," although she recommended supervision for the "next few shifts."[3] CMS Ex. 6 at 41, 47. Staff also notified the physician's assistant, as required by the facility's written policy. *See* CMS Ex. 5 at 1. Both the speech pathologist and the physician's assistant directed staff to monitor R17 for "a few shifts," *i.e.*, "for 72 hours." CMS Ex. 6 at 42, 47.

Thereafter, however, facility staff did not respond appropriately to growing evidence that R17's swallowing difficulties went beyond an isolated choking incident.

August 12, 2010 Incident. As noted above, on August 12, R17 coughed up the remnants of apple slices. Petitioner denies that the resident choked on or had any difficulty swallowing the food but argues that he experienced a benign coughing episode, which did not merit further attention. P. Post-Hr'g Br. at 13. I note first that Petitioner offers no testimony from anyone who witnessed the episode and that the contemporaneous nursing

[3] CMS questions the adequacy of Speech Pathologist Marttila's assessment, suggesting that it was a "screen" and did not meet the assessment standards described in the medical literature. CMS Post-Hr'g Br. at 5 n.4. I do not find that the speech pathologist's initial assessment contributed in any significant way, if at all, to the facility's substantial noncompliance. Even assuming that the assessment falls short of ideal (which I do not find), those purported short comings pale when compared to the staff's responses (or the absence of responses) when R17 again had problems swallowing.

note, entered by Melissa O'Donnell, seems to describe a swallowing problem that escalated into a choking incident. Moreover, coughing while eating, including before swallowing, is a sign of dysphagia. *See* CMS Ex. 9 at 2 (Jeanie Kayser-Jones and Kathryn Pengilly, *Dysphagia Among Nursing Home Residents*, 20 Geriatric Nursing 77, 78 (No. 2 1999)); CMS Ex. 10 at 5-7 (American College of Chest Physicians, Cough and Aspiration of Food and Liquids Due to Oral-Pharyngeal Dysphagia: *ACCP Evidence-Based Clinical Practice Guidelines* (2006)) (in which Speech Pathologist Marttila lists coughing as a symptom of aspiration or choking).

Obviously, Nurse O'Donnell, who witnessed the incident, thought that R17 was again having difficulty swallowing his food, because she wrote that she left a message with Physician Assistant Islamovic "regarding recent med[ication] change of oxycontin and *any relation to swallowing issues*." CMS Ex. 6 at 48 (emphasis added). In response, Physician Assistant Islamovic reduced R17's oxycontin dosage, although she did no assessment. *See* CMS Ex. 6 at 49. Inexplicably, no one mentioned the incident to Speech Pathologist Marttila.

The facility's registered dietician, Amy Goulas, who was in the facility at the time, also considered this a choking incident. She ordered kitchen staff to stop providing apple slices to R17, and wrote that staff supervised R17 at meals due to "*recent choking episodes on apples*." (emphasis added) CMS Ex. 6 at 38, 48. As Speech Pathologist Marttila acknowledges, apple slices "can be a difficult food for some people to chew and swallow." P. Ex. 25, at 1. From this, I can reasonably infer that facility staff suspected that R17 was again having difficulty swallowing certain foods, particularly since the facility suggests no other credible reason for discontinuing the apple slices.

Notwithstanding her contemporaneous notes and her actions, Dietician Goulas now claims that R17 was not choking. She says "I should have been clearer in my note, and written that the resident had started coughing while eating apple slices, and that in an exercise of caution that I had recommended replacement of that snack on his meal tray ticket." P. Ex. 19 at 3 (Goulas Decl.). I think it far more likely that Dietician Goulas wrote "choking episodes" because she thought that R17 had choked on his food. *See Jennifer Matthew Nursing & Rehab. Ctr.*, DAB No. 2192 at 52 (2008) (finding that the ALJ may reasonably give more weight to contemporaneous notes than to witness testimony). Moreover, other nurses also described the August 12 incident as a choking incident. *See* P. Ex. 20 at 2 (in which Licensed Practical Nurse (LPN) Judy Ballentine says that she was aware of two choking episodes: August 9 and "a few days later, when he began coughing on apple slices"); P. Ex. 18 at 4 (Unit Manager Shauna Bumford, R.N., conceding that the oxycontin "might have been . . . slowing his swallow reflex."). In any event, whether Dietician Goulas and the others accurately characterized the incident, its occurrence should have alerted them that the August 9 choking episode might not have been isolated after all and that R17's situation needed further investigation in order to ensure the resident's safety. That staff failed in this regard

violated federal regulations as well as the facility's own policies requiring staff to "identify, correct, and intervene," as well as "assess, care plan for, and monitor" residents with needs and behaviors that might lead to neglect. CMS Ex. 5 at 19-20.[4]

Finally, Petitioner claims that Dietician Goulas and Physician's Assistant Islamovic simply exercised their "professional judgment" by not asking that R17 be re-assessed. P. Post-Hr'g Br. at 14. But the facility had an independent obligation to assess R17's swallowing difficulties, without regard to any obligations from the dietician or physician's assistant. So, even if I accepted that these medical professionals explicitly determined that no further action was needed (which I do not), I would still have to consider whether the facility met its obligation.[5]

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

---

[4] Speech Pathologist Marttila also testified that "elaborate swallowing studies" are not done after the "occasional occurrence" of swallowing problems. P. Ex. 25 at 2. This may be so, but here the evidence of swallowing problems – at least five documented incidents in three weeks – far exceeded an "occasional occurrence." Moreover, the problem was not that the facility failed to conduct an "elaborate swallowing study." The problem is that facility staff did not take these incidents seriously and, after August 9, no one assessed, in any meaningful way, R17's ability to swallow, and, aside from removing apple slices from his diet, no one considered how to protect him from harm caused by his difficulties swallowing.

[5] At a minimum, I would expect to see the type of documentation provided by Speech Pathologist Marttila on August 9, when she noted that, based on her clinical observations of R17, the choking incident that day "appears to be an isolated event." CMS Ex. 6 at 47. But I see no contemporaneous evidence suggesting that Dietician Goulas, Physician's Assistant Islamovic, or anyone else associated with R17's care even considered whether further assessment of R17's swallowing function was needed. I find wholly unpersuasive Petitioner's attempt to justify its inaction by now characterizing it as an undocumented exercise of professional judgment. *See* CMS Ex. 6 at 38, 47, 48; *Western Care Mgmt. Corp.*, DAB No. 1921 at 48 (2004) (holding that a fact-finder may "assume, absent contrary evidence, that a resident's medical records accurately reflect the care and services provided (or not provided)."

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

Even more compelling, the nurses' notes that document his difficulties taking oral medication describe swallowing difficulties, not behavioral issues.[7] He did not refuse to take his medication on August 14, for example. According to the note written by Kimberly Jacobson, R.N., he took his pills "with much difficulty," but refused to take the pills with applesauce or anything else "*to aid with swallowing.*" CMS Ex. 6 at 50 (emphasis added). From this, I can draw only one inference: that he was having trouble swallowing his pills.

On August 15, Nurse Jacobson again reported that R17 "took a significant time to swallow each individual pill with difficulty." She directed him to "focus on swallowing" but noted that he was "forgetful" and, again, would not allow the pills to be crushed or taken with applesauce "to assist with swallowing." CMS Ex. 6 at 50.

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

Malnutrition Risk Assessment. The facility periodically assessed R17's nutrition status, concluding each time that he was at high risk for malnutrition. *See, e.g*. CMS Ex. 6 at 65, 66. On August 24, Nurse O'Donnell completed a new assessment, again finding that he was at high risk for malnutrition. This assessment reflected two notable changes,

---

[6] Organic brain syndrome describes decreased mental function caused by a medical disease that is not a psychiatric disorder.

[7] For this reason I find unconvincing, at best, and deeply disturbing, at worst, Director of Nursing (DON) Heather Foster's claim that not one of her staff members ever reported that R17 had a physical problem swallowing medication. P. Ex. 24 at 3 (Foster Decl.).

however: 1) R17's mental status deteriorated from "alert-oriented x 3" (i.e. oriented to person, place and time) to "lethargic-disoriented x 2" and 2) R17 had an additional risk factor "difficulty swallowing/frequent choking." CMS Ex. 6 at 43.

I find this persuasive evidence that facility staff recognized R17's growing problem with swallowing. Under the facility's nutrition policy, the nurse or dietician should have conveyed this new information to the Nutrition-at-Risk Committee so that the committee could reconsider the resident's treatment in light of the changes. CMS Ex. 5 at 2 ¶¶ 1, 2. Because they failed to do so, they neither implemented the facility's written policy to prevent neglect nor provided R17 with the care and services he needed to maintain his highest practicable physical well-being.

Petitioner justifies its failure to follow its own policy by attacking the validity of the assessment. In remarkable testimony, the facility's administrator, Lori McIntire, and its DON, Heather Foster, R.N., claim that R17's "malnutrition risk assessment" inaccurately describes R17's "difficulty swallowing/frequent choking." P. Ex. 24 at 3 (Foster Decl.); CMS Ex. 6 at 43. According to DON Foster, "the software that generates this form automatically enters that language when the nurse completing the assessment enters *any* episode of choking. . . ." P. Ex. 24 at 3 (Foster Decl.). These claims are belied by the medical record, with its documented incidents of swallowing problems and choking. Moreover, a resident's assessment is supposed to be individualized and, it should go without saying, *must accurately reflect the resident's actual condition.* 42 C.F.R. § 483.20(b)(2)(ii). An inaccurate assessment compromises the integrity of the resident's care plan, because the care plan – which is supposed to describe the "services to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under [section] 483.25" – is based on the assessment. Basing a care plan on an inaccurate assessment obviously puts the facility out of substantial compliance with the quality of care regulation, 42 C.F.R. § 483.25, and would evidence a very serious deficiency. Conversely, disregarding the assessment would also put the facility out of substantial compliance and would evidence a very serious deficiency.

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

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

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

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

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

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

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

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

> Q [D]o you have a recollection that you, in fact, did make a professional judgment at some point that no intervention for that [the August 9 choking incident] was necessary?

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

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

Despite the instances of R17's swallowing difficulty after that incident, the facility took no further action but just relied on what was, by August 12, an outdated assessment. *See also* P. Ex. 18 at 4 (in which Unit Manager Bumford explains that she "personally did not consider another such assessment necessary [on August 12] since the speech pathologist had assessed [R17] only a few days earlier and found no swallowing problem."). It therefore failed to implement its policies that required staff to provide R17 with the services he needed to avoid physical harm, in violation of 42 C.F.R. § 483.13(c), and it failed to provide him the care and services he needed to maintain his highest practicable physical well-being in accordance with his assessment and care plan, in violation of 42 C.F.R.
§ 483.25.[8]

[8] Petitioner also complains that CMS did not offer expert testimony about R17's swallowing issues. P. Post-Hr'g Br. at 2-3; P. Post-Hr'g Reply Br. at 2-7. But CMS need

B. *The penalty imposed is reasonable.*

To determine whether a CMP is reasonable, I apply the factors listed in 42 C.F.R. § 488.438(f): 1) the facility's history of noncompliance; 2) the facility's financial condition; 3) factors specified in 42 C.F.R. § 488.404; and 4) the facility's degree of culpability, which includes neglect, indifference, or disregard for resident care, comfort or safety. The absence of culpability is not a mitigating factor. The factors in 42 C.F.R. § 488.404 include: 1) the scope and severity of the deficiency; 2) the relationship of the deficiency to other deficiencies resulting in noncompliance; and 3) the facility's prior history of noncompliance in general and specifically with reference to the cited deficiencies.

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

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

---

not establish that R17 had a swallowing disorder or that his inability to swallow ultimately caused his death. The facility's own documents unequivocally describe R17's swallowing problems, which put the facility on notice that he needed further assessment and, likely, additional care. Its failure to respond violated the facility's policies and the regulations.

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

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

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

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

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

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

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

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

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

The facility history alone justifies the relatively low penalty.

With respect to the remaining factors, multiple staff did not recognize or chose to ignore symptoms of a potentially serious condition – the inability to swallow – which put the resident in immediate jeopardy. Although they had many opportunities to intervene, they effectively ignored the multiple warning signs that occurred after August 9, taking no action to ensure the resident's safety. The facility is culpable for their inaction.

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

IV. Conclusion

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

/s/
Carolyn Cozad Hughes
Administrative Law Judge