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Department of Health and Human Services (H.H.S.)
Departmental Appeals Board

Civil Remedies Division
IN THE CASE OF:

GLENBURNLEY
NURSING CENTER, PETITIONER

v.

CENTERS FOR MEDICARE & MEDICAID SERVICES

Docket No. C-99-053
Decision No. CR1217

September 27, 2004

DECISION

I decide that the conduct of Petitioner, **Glenburney** Nursing Center, with respect to its two residents requiring routine tracheostomy care, did not place either resident in immediate jeopardy, nor did such care constitute substantial noncompliance with federal participation requirements for Medicare and Medicaid for the period beginning April 3, through August 26, 1998. Thus, I overturn CMS's imposition of a \$3050 per day civil money penalty for this period. I also find that Petitioner has shown by a preponderance of the evidence that it was in substantial compliance with all but one of the Medicare program requirements or deficiencies alleged by the Centers for Medicare & Medicaid Services (CMS, formerly known as the Health Care Financing Administration or HCFA). Thus, I find that a civil money penalty for the period of August 27, 1998 through November 5, 1998 is reasonable and appropriate, but not at \$1000 per day as set by CMS.^[FN1] My reason for this is that CMS made its determination as to the \$1000 per day civil money penalty (CMP) based on the recommended findings in the Statement of Deficiencies (SOD) at the scope and severity level of D or above. As I discuss more fully below, CMS did not discuss in its posthearing brief or reply at least eight such deficiencies or F Tags; it only discussed five F Tags: F324, F157, F225, F272, and F314. Therefore, I conclude that CMS conceded that Petitioner's testimony, evidence, and argument, demonstrates that Petitioner was in substantial compliance with respect to those eight deficiencies. As a result, I considered whether the amount of the CMP imposed is reasonable in light of the fact that I sustain CMS with respect to only one deficiency and applying the factors listed in [42 C.F.R. § 488.438\(f\)](#). In so doing, I considered whether the evidence presented on the record concerning the relevant regulatory factors 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 other factors involved (financial condition, facility history, and culpability). I conclude that a CMP of \$50 per day for the period in question is reasonable and appropriate given the regulatory factors and circumstances here. Finally, I find that CMS was authorized to impose other remedies against Petitioner, including denial of payment for new Medicare admissions for the period of August 26, 1998 through November 5, 1998.^[FN2]

I. Background

Petitioner is a nursing facility. On August 20, 1998, surveyors from the State survey agency concluded a complaint and annual survey of Petitioner; Petitioner was surveyed for compliance with federal participation requirements. The State survey agency found that Petitioner was not complying substantially with some 15 participation requirements and that, at least as to two requirements, the level of Petitioner's noncompliance was so egregious as to constitute immediate jeopardy for residents of Petitioner's facility. CMS Ex. 33. A revisit survey on August 26, 1998 determined that Petitioner had removed the immediate jeopardy. On August 28, 1998, CMS issued its notice of imposition of remedies indicating its concurrence with the State survey agency's findings. CMS imposed a CMP of \$3050 a day for the period of April 3, through August 26, 1998, the period it determined the residents were in immediate jeopardy; a \$1000-per-day CMP for the period of August 27, 1998 through November 5, 1998, when the facility was determined to be in substantial compliance; a denial of payment for new admissions effective August 26, 1998; and directed in-service training. Petitioner was also required to submit a Plan of Correction (POC) for the deficiencies.^[FN3]

Petitioner requested a hearing to contest the findings of immediate jeopardy and substandard quality of care and the remedies imposed by CMS.

IV. Issues, findings of fact and conclusion of law

1. Petitioner's care to two residents requiring routine tracheostomy care was not deficient under the pertinent Medicare participation requirements for the period of April 8, 1998 through August 26, 1998.

CMS alleges that Petitioner failed to comply substantially with the requirements of [42 C.F.R. § 483.25](#) (Tag F309) and [42 C.F.R. § 483.25\(k\)](#) (Tag F328). CMS Ex. 33, at 14. This regulation provides in relevant part that-

Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

[42 C.F.R. § 483.25](#), Quality of Care.

That regulation further provides, that-

(k) *Special needs*. The facility must ensure that residents receive proper treatment and care for the following special services:

(1) Injections;

- (2) Parenteral and enteral fluids;
- (3) Colostomy, ureterostomy, or ileostomy care;
- (4) Tracheostomy care;
- (5) Tracheal Suctioning;
- (6) Respiratory care;
- (7) Foot care; and
- (8) Prostheses.

[42 C.F.R. § 483.25\(k\)](#).

Tag F309

The Statement of Deficiencies (SOD) stated that Petitioner did not meet the requirement of [42 C.F.R. § 483.25](#), as evidenced, in part, by the following stated findings:

Based on record review and interview, it was determined that the facility failed to maintain one resident's highest practicable physical well-being. The facility was not providing treatment and services for tracheostomy care, per the facility's policy and procedure, and were not assessing that the resident's need for additional care, other than the routine care being provided, placed Resident #17 in immediate jeopardy from 4/08/98 to 4/22/98 (when the resident expired).

* * * *

1. Resident #17: Record Review and Interview indicated that thorough assessment and intervention was not provided prior to the resident's death on 04/22/98 . . . The Emergency Room Death Summary . . . also stated that the patient's metal cannula that was in the resident's tracheostomy site was noted to be plugged with hard mucus. The resident had a relatively new tracheostomy at the time of nursing home admission on 04/08/98. The resident had voiced numerous complaints of being short of breath and requested suctioning from the date of admission until the resident expired. There was no indication that the resident was fully assessed or that the resident's physician was consulted during this time.

The comprehensive care plan contained approaches to assess the resident's respiratory status. There was no documented evidence that the facility implemented the care plan to monitor lung sounds and observe for cyanosis during the resident's stay or at the time that CPR was initiated.

CMS Ex. 33, at 14.

Resident 17

My review here is a *de novo* review of the evidence. I must determine whether Petitioner was not in substantial compliance with the program requirement cited. In this instance, the program requirement cited by CMS for Tag F309 is the quality of care requirement that each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care ([42 C.F.R. § 483.25](#)). Thus, at the very least, my examination must start with the facility's assessment of Resident 17 and her plan of care - namely, what care and services did her physician and

the facility determine were necessary to attain or maintain the highest practicable physical well-being for this resident specifically with regard to the treatment and services for her tracheostomy care.

Resident 17 entered the facility on April 8, 1998, on the orders of Dr. Tillman, her attending physician, a pulmonary specialist, after she was discharged from the hospital. Normally, he would have discharged a patient like her home, but he advised that she go to the Petitioner's facility since there was no one to look after her at home. CMS Ex. 27, at 16; Tr. 408 - 409.

Among other things, this 71-year old patient suffered from chronic obstructive pulmonary disease and asthma. She was alert and verbally responsive; she was well able to make her needs known. CMS Ex. 27, at 27, 43 - 50. She had had a tracheostomy in hospital on February 23, 1998, as a result of respiratory failure, to help her breathing. *Id.* at 16. The hospital discharge notes of her physician, the pulmonary specialist, noted that she had been on a ventilator at the hospital and, after a "very prolonged effort," she was weaned from the ventilator. *Id.* Her doctor further noted that she had a "speaking Trach . . . but clearly has fairly end stage lung disease." The physician's orders on admission for her tracheostomy care were for "Trach. care dly [daily] & PRN [as needed]" and "suction PRN." *Id.* at 21. He testified that at the time he determined that Resident 17 could be discharged from hospital, she was no longer in need of acute suctioning or routine, deep endotracheal suctioning. Tr. 408. He also knew at the time he discharged her from the hospital and transferred her to Petitioner's facility, that this facility did not perform deep endotracheal suctioning. Tr. 409, 415. He was well aware that if an episode occurred that required deep suctioning (which he expressly testified was not necessary for this patient on a routine basis), the facility would transfer the resident to the hospital and he was agreeable to that for his patient. *Id.* He pointed out that the hospital was "literally across the road" from the facility, and would take about three minutes to get there. Tr. 415. Dr. Tillman testified that this patient required just superficial suctioning and routine tracheostomy care:

This patient, and I think you made a general question, but let me also be specific about this patient.

This patient was able to cough, eat, talk. And so she can get secretions up. The mechanics of a trach makes it necessary to suction shallow the trach. But she's able to get it to the tracheal level and sometimes out of the trach.

Tr. 416.

The surveyor and CMS, however, determined that this patient needed deep tracheostomy suctioning and that the facility was not providing such care on-site. Tr. 18 - 19, 76 - 77, 81, 120; CMS Br. xiv-xiv; CMS Reply. I see no reference in Dr. Tillman's orders, nor do I find anything in the comprehensive care plan for Resident 17, that suggests that deep, endotracheal suctioning is necessary, care planned for Resident 17 or even considered to be needed. But Surveyor Hanna said she came to this conclusion by looking at each case individually:

Someone who has had a trach for many years, and it has healed, and they have maintained at home are fine without it. It probably would not be indicated unless there were other factors going on. But this patient or resident had a bad history. She had been in ICUs. They had had difficulty getting her off the ventilator . . .

Q. Did you talk to Dr. Tillman, her doctor, about what his thoughts were regarding her needs?

A. No. I talked to the emergency room physician.

Perhaps if the surveyor had spoken with Dr. Tillman, she might have understood why deep suctioning was not considered necessary for this patient.

The facility had a procedure in place as to how deep suctioning should be performed should the facility determine at some point that they could provide such a service (CMS Ex. 32, at 48 - 49;) , but, the facility's policy at the time was not to perform deep suctioning on-site. Rather, the facility had determined that considering its close proximity to the hospital, it was better practice and policy to have a respiratory therapist come from the hospital or to transport a resident in need of such care to the hospital for the suctioning. Tr. 265, 293 - 294; P. Br. at 17 - 20 and P. Reply at 8 - 9, 15. Moreover, the facility believed that while Mississippi licensing regulations allowed an RN to perform such services, since many registered nurses were “uncomfortable” doing such suctioning, it would not be good practice to require a reluctant RN to perform such a service. Tr. 279; P. Br. at 3 - 4, 16. It would seem to be much better practice, considering the closeness of this facility to the hospital, to transport a resident in need of such services to a hospital more routinely providing such services (deep, endotracheal suctioning) than have such a service be performed by a nurse who only occasionally and, perhaps reluctantly, has performed such care.

Based on my review of Resident 17's medical records and the testimony of the witnesses presented, I do not find the statements in the SOD with regard to this resident to be credible. For example, the statement in the SOD that “thorough assessment and intervention was not provided prior to the Resident 17's death,” (CMS Ex. 33, at 15) simply is not supported by the evidence in the record. Medicare program requirements provide that a comprehensive assessment of a resident be performed within 14 calendar days after admission to the facility. [42 C.F.R. § 483.20\(b\)\(2\)\(i\)](#). Petitioner did so. CMS Ex. 27, at 25 - 34. Shortly after Resident 17's admission on April 8, 1998, the facility performed the admission assessment on April 14 using the Minimum Data Set (MDS). Based on the results of the MDS and consistent with Resident 17's own physician's orders, a care plan was developed. CMS Ex. 27, at 35 - 40. The care plan requirements for Resident 17's trach care were identical to the physician's orders. *Compare* CMS Ex. 27, at 37 *with* CMS Ex. 27, at 21. The plan also directed staff to observe the resident's lung sounds and observe the resident for cyanosis, steps that Resident 17's doctor did not specifically order, but which the facility determined should be done because of Resident 17's diagnosis of COPD and asthma and her impaired gas exchange.^[FN9] CMS. Ex. 27, at 37.

The SOD further stated that the comprehensive care plan contained approaches to assess the resident's respiratory status and “[t]here was no documented evidence that the facility implemented the care plan to monitor lung sounds and observe for cyanosis during the resident's stay or at the time that CPR was initiated.” *Id.* at 16. I disagree. There is a preponderance of evidence in the record which shows that the Petitioner implemented the care plan. The facility's “Treatment Record” indicates that Resident 17 was provided with tracheostomy care on the 7 a.m. to 3 p.m. shift by the Licensed Practical Nurse (LPN) on a daily basis with the exception of three days. CMS Ex. 27, at 41. This is shown by the initials placed on the treatment record. On the three days that the LPN on the 7 a.m. to 3 p.m. shift did not provide daily “trach care,” the treatment record clearly shows that Resident 17 was provided with suctioning on those

days, sometimes on all three shifts. CMS. Ex. 27, at 41; Tr. 333, 335 (Testimony showing that Treatment Administration Record has a section to indicate in addition to “trach care daily and PRN,” a separate section for when suction is performed at the Resident's request or “Suction PRN”). Moreover, on the three days (April 10, 11, and 19, 1998) where an initial is not on the Treatment Record for “trach care daily,” the Resident's medical records contain other evidence such as written Nurse's Notes for those days documenting that treatment was given to the Resident. CMS. Ex. 27, at 45, 46, 48; P. Ex. 1, at 2, 5, 8; P. Ex. 37. In addition, the Nurse's Notes provide the resident's vital signs and the nurse's observations of the patient, such as that she was “alert and verbally responsive,” “some shortness of breath noted,” “no acute distress observed,” “alert, verbally responsive with clear coherent speech,” and “resp. [respirations] even and unlabored. No SOB [shortness of breath] noted.” CMS Ex. 27, at 44 - 46; P. Ex. 37; and CMS. Ex. 27, at 47. It is obvious from these notes that the nursing staff was making the necessary observations and monitoring Resident 17 as required by the care plan. Mr. Prater, the L.P.N. predominately responsible for the care of Resident 17 during the 7 am to 3 pm shift, stated in his testimony that he looked at Resident 17 and listened to her lung sounds bilaterally on a daily basis. Tr. 326. He indicated that this would not be written down specifically in the Nurse's Notes every day. He stated:

It's part of routine nursing care and judgment as well. So it's a daily thing that you do when you're making your rounds.

Id.

The SOD states that the Resident “voiced numerous complaints of being short of breath and requested suctioning from the date of admission until the resident expired.” CMS Ex. 33, at 16. If all the reader considered were the SOD and this particular language, one would believe that Petitioner took no action and that Resident 17's complaints were ignored. Nothing could be at greater variance with the facts. The statements of her numerous complaints were taken directly from the Nurse's Notes, which dutifully recorded when the Resident made complaints about her ability to breathe and which, at the same time, although not indicated in the SOD, dutifully recorded how Petitioner's staff responded to her complaints and provided the necessary care, consistent with her assessment, her care plan, and her doctor's orders. See, CMS. Ex. 27 and P. Ex. 1 and P. Ex. 37.

I am troubled by the SOD findings; the statements in the SOD appear inconsistent with the evidence patent in the records. In some significant cases, CMS seems to have adopted these findings without delving into the evidence and determining if the evidence supported the findings. For example, the SOD states “the resident had a relatively new tracheostomy at the time of admission.” The Resident had her tracheostomy on February 23, 1998 and there is simply no reason or evidence that would justify its characterization as “new.” In fact, Dr. Tillman indicated that normally he would have sent such a patient home, but he did not do so with Resident 17 because she had no one at home to assist in her care.^[FN10] Obviously, if he thought the “trach” were new, he would not have considered it appropriate to discharge her to her home. Tr. 408 - 409.

The SOD statements would lead one to believe that Resident 17 had complained about being short of breath and requested suctioning, and that Petitioner did nothing in response, but that clearly is not the case. The inferences which are drawn in the SOD are simply not supported by evidence from the

treatment record, the Nurse's Notes, the care plan, and the physician's notes. For example, the Nurse's Notes from April 13, 1998 state:

Continues to be anxious throughout these hrs. Voicing fear of machines not working correctly, not being able to breathe and needing to be suctioned. No acute SOB [shortness of breath] noted.

Suctioned small amt yellow drainage from canula. SOB noted only when assisted with ambulation to bathroom. Reassured several times that all equipment is functioning well and encouraged to relax.

Moral support given as needed. Will continue to observe.

CMS Ex. 27, at 46. The Nurse's Notes contain at least five to six other pages of such notes where the nursing staff record the resident's complaints and details how the nursing staff responded to them. In reviewing these notes and the treatment record, I find that Petitioner provided Resident 17 with the necessary care and services consistent with her doctor's orders and her care plan; I have not been shown what more they could have done or what they should have done differently.

This Resident, by all accounts, was not afraid to make her wishes known. She was anxious, particularly about her ability to breathe, and was not timid about asking to be suctioned. She was well able to make her needs known. CMS Ex. 27, at 43, 44, 45, 46 47. *See also* P. Ex. 37. The record shows that from the time she was admitted, she had continuous restlessness, anxiety, and nervousness because of her COPD and because of her tracheostomy. She often complained of shortness of breath and voiced concern that the machines were "doin nothing." P. Ex. 37; CMS. Ex. 27, at 44, 45, 46. On the morning of April 22, 1998, the Nurse's Notes indicate that at 10 am, Resident 17 was up on her bedside requesting "trach care" and suctioning. CMS. Ex. 27, at 47. She also complained of shortness of breath. She was suctioned and a small amount of mucus was removed; she asked to be hospitalized for I.V. therapy. *Id.* While the SOD findings are written in such a way as to lead a reader to conclude that little or nothing was done in response to this resident's complaint, that conclusion would be incorrect. The medical records indicate that, at this time, the nursing staff recorded Resident 17's vital signs and recorded that Resident 17's physician was called regarding her status and her request for hospitalization. *Id.* at 47. Resident 17 was informed that a message was left with the physician's receptionist as he was with a patient. It is recorded that Resident 17 understood. *Id.* The Nurse's Notes from 11:45 AM on that date reflect that the resident was served her lunch tray and responded to the CNA, "you all are feeding me too much." There is no indication that during this period of less than two hours, the resident was in any kind of distress. It was within three to five minutes after that the housekeeper summoned help to Resident 17's room and they found resident "in resp [respiratory] distress - Pulse very weak & irreg.- skin cool & dry - full CPR initiated . . . Ambulance also summoned for emergency transfer to NRMC . . . Ambulance here @@ 12N. . . ." *Id.* The housekeeper provided a written statement indicating what occurred:

I remember, I went to visit Miss J [name redacted], [Resident 17] was sitting on her bed eaten [sic] her dinner. I spoke to her to [sic]. She say she didn't feel very well. I went back to Miss J. When I look up again, I saw [Resident 17] about to fall over, I went and caught her and I laid her back on the bed. Then I went to call for help.

P. Ex. 4. At all times up until this event, the resident was talking and eating. Consequently, there is no indication that she was having any problems breathing; the housekeeper said the resident had been talking and when she looked up just a few minutes later, the resident was about to fall over. Petitioner called an expert medical witness, a cardiologist, who reviewed the events and the medical records leading up to the resident's death and determined that her death resulted from a sudden event, very

probably cardiac in nature and not related to her tracheostomy. Testimony of Dr. Malcolm Taylor, Tr. 454 - 455, 461. There was significant expert testimony that if this resident was having breathing difficulties due to a plugged tracheostomy tube, as CMS and the surveyor seem to suggest, then the patient would exhibit certain symptoms, such as difficulty talking and audible noises from the blockage to the trach, none of which were found to be present. Tr. at 390, 423, 454 - 455, 461. CMS never rebutted this evidence or presented any expert testimony that responded to Petitioner's expert testimony.

Rather, the Surveyor seized on the fact that Resident 17 arrived at the hospital shortly thereafter and died at 12:15 pm. *Id.* at 60 - 61. The Emergency Room Physician's Notes indicate that the admitting diagnosis for the patient was "cardio-respiratory arrest." *Id.* at 60; *see also* P. Ex. 2 at 1. The Emergency Room Physician's Report, by Dr. Benson Grigsby, M.D., stated, in relevant part, as follows:

CHIEF COMPLAINT: Cardiac arrest

HPI:

She [Resident #17] reportedly was having some trouble breathing at the nursing home facility where she is living. When EMS got there she had only faint pulses and subsequently went into ventricular fibrillation and PEA. . . The patient was pronounced dead at 1215 hours. . . The patient's metal cannula that was in her tracheostomy site on inspection was noted to be completely plugged with hard mucous. Dr. Barry Tillman has been informed of these findings.

IMPRESSION: Cardiorespiratory arrest, expired.

CMS. Ex. 27, at 15, 59.

CMS then adopted the surveyor's finding. **While the death of a resident is always difficult, it does not, in and of itself, indicate deficient care by the facility especially when we are dealing, like here, with a patient with end-stage lung disease as well as other serious medical issues.**^[FN11] **Therefore, it is important when performing an after-the-fact record review to make sure that all of the records are reviewed and all relevant caregivers are interviewed before making a determination as to whether a facility was not in substantial compliance with program requirements. The surveyor determined that the death of Resident 17 indicated that Petitioner was somehow deficient in its care of Resident 17 with regard to her tracheostomy. In so doing, however, she did not accurately reflect the contents of Resident 17's contemporaneous medical records, her comprehensive care plan, and her doctor's orders.**

Therefore, I conclude that Petitioner has shown, by more than a preponderance of the evidence, that it was in substantial compliance with the program requirements of the Medicare program with respect to Tag F309 for the period of April 3 through August 26, 1998 for Resident 17. Thus, I conclude there is no basis for CMS's finding of immediate jeopardy for this resident and I overturn CMS's findings.