Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

In the Case of:	)	
	)	
Christian Health Care of Springfield East,	)	Date: September 23, 2009
	)	
Petitioner,	)	
	)	
- v. -	)	Docket No. C-08-450
	)	Decision No. CR2008
Centers for Medicare & Medicaid Services.	)	
	)	

DECISION

Christian Health Care Center of Springfield East, (Petitioner or facility), was in substantial compliance with Medicare and Medicaid participation requirements based on the survey of Petitioner's facility completed on March 5, 2008. Therefore, there is no basis for the Centers for Medicare & Medicaid Services (CMS) to impose remedies against Petitioner.

I. Background

Petitioner, located in Springfield, Missouri, is authorized to participate in Medicare as a skilled nursing facility (SNF) and the Medicaid program as a nursing facility (NF). On March 5, 2008, the Missouri Department of Health and Senior Services for the State of Missouri (the state agency) completed a survey of Petitioner's facility, the results of which are reported in a Statement of Deficiencies (SOD) bearing that date. The state agency determined that Petitioner was not in substantial compliance with Medicare and Medicaid participation requirements at the immediate jeopardy level and recommended that CMS impose remedies. CMS notified Petitioner by letter dated March 7, 2008, that it concurred with the state agency findings and recommendations, and that it intended to impose the following remedies: a per instance CMP of $10,000; a CMP of $100 per day if the facility was not in substantial compliance at revisit; a prohibition against approval of nurse aide training and competency evaluation programs (NATCEP); a denial of

payments for new admissions effective March 9, 2008; and termination from the program effective March 28, 2008, if the immediate jeopardy condition was not removed prior to the date of revisit. Another survey was conducted by the state agency on March 21, 2008, which found that the immediate jeopardy condition at the facility had been removed and Petitioner was advised that the facility's provider agreement would not be terminated. The state agency conducted a revisit survey of Petitioner's facility on April 15, 2008, and determined that Petitioner was back in compliance with participation requirements.

By letter dated May 6, 2008, Petitioner timely requested a hearing and denied all allegations of non-compliance. The case was assigned to me for hearing and decision on May 15, 2008.

I conducted an in-person hearing in Kansas City, Missouri on February 17-18, 2009. CMS offered exhibits (CMS Exs.) 1 through 3, which were admitted. Petitioner offered exhibits (P. Exs.) 1 through 36, which I admitted into evidence.

CMS elicited testimony from Jennifer Wallace, Registered Nurse (R.N.) (state surveyor). Petitioner elicited testimony from Ovais Zubair, M.D. (facility medical director); Larry Carey, M.D., Charles Watt, M.D., Paula Pyck, Licensed Practical Nurse (L.P.N.) (facility nurse); and Lynne Sharp, R.N. (facility director of nurses).

Both parties submitted a post-hearing brief (CMS Br. and P. Br., respectively), and response brief (CMS Reply and P. Reply, respectively) and each party received a copy of the hearing transcript (Tr.).

Based on the applicable law and regulations, the documentary evidence, and the testimony taken at the hearing, the preponderance of the evidence shows that Petitioner was in substantial compliance with applicable federal participation requirements governing nursing homes and, therefore, no enforcement remedy may be imposed.

A. Applicable Law

Petitioner is a long-term care facility participating in the federal Medicare program as a SNF and in the state Medicaid program as a NF. The statutory and regulatory requirements for participation by a long-term care facility are found at sections 1819 and 1919 of the Social Security Act (Act) and at 42 C.F.R. Part 483. Sections 1819 and 1919 of the Act vest the Secretary with authority to impose CMPs against a long-term care facility for failure to comply substantially with federal participation requirements. Facilities that participate in Medicare may be surveyed on behalf of CMS by state survey agencies in order to determine whether the facilities are complying with federal participation requirements. 42 C.F.R. §§ 488.10-488.28, 488.300-488.335. Pursuant to 42 C.F.R. Part 488, CMS may impose a per instance CMP (PICMP) or per day CMP

against a long-term care facility when a state survey agency concludes that the facility is not complying substantially with federal participation requirements. 42 C.F.R. §§ 488.406; 488.408; 488.430. The regulations in 42 C.F.R. Part 488 also give CMS a number of other remedies that can be imposed if a facility is not in compliance with Medicare requirements. *Id.*

The regulations specify that a CMP that is imposed against a facility on a per day basis will fall into one of two broad ranges of penalties. 42 C.F.R. §§ 488.408, 488.438. The upper range of CMP, of from $3050 per day to $10,000 per day, is reserved for deficiencies that constitute immediate jeopardy to a facility's residents, and, in some circumstances, for repeated deficiencies. 42 C.F.R. §§ 488.438(a)(1)(i), (d)(2). The lower range of CMP, from $50 per day to $3000 per day, is reserved for deficiencies that do not constitute immediate jeopardy, but either cause actual harm to residents, or cause no actual harm, but have the potential for causing more than minimal harm. 42 C.F.R. § 488.438(a)(1)(ii). There is only a single range of $1000 to $10,000 for a PICMP that applies whether or not immediate jeopardy is present. 42 C.F.R. §§ 488.408(d)(1)(iv), 488.438(a)(2).

The Act and regulations make a hearing before an ALJ available to a long-term care facility against which CMS has determined to impose a CMP. Act, section 1128A(c)(2); 42 C.F.R. §§ 488.408(g), 498.3(b)(13). The hearing before an ALJ is a *de novo* proceeding. *Anesthesiologists Affiliated, et. al*, DAB CR65 (1990), *aff'd*, 941 F.2d 678 (8th Cir. 1991); *Emerald Oaks*, DAB No. 1800, at 11 (2001); *Beechwood Sanitarium*, DAB No. 1906 (2004); *Cal Turner Extended Care Pavilion*, DAB No. 2030 (2006); *The Residence at Salem Woods*, DAB No. 2052 (2006). A facility has a right to appeal a "certification of noncompliance leading to an enforcement remedy." 42 C.F.R. § 488.408(g)(1); *see also,* 42 C.F.R. §§ 488.330(e), 498.3. However, the choice of remedies by CMS or the factors CMS considered when choosing remedies are not subject to review. 42 C.F.R. § 488.408(g)(2). A facility may only challenge the scope and severity level of noncompliance found by CMS if a successful challenge would affect the amount of the CMP that could be collected by CMS or impact upon the facility's nurse aide training program. 42 C.F.R. §§ 498.3(b)(14), (d)(10)(i). CMS's determination as to the level of noncompliance "must be upheld unless it is clearly erroneous." 42 C.F.R. § 498.60(c)(2). This includes CMS's finding of immediate jeopardy. *Woodstock Care Center*, DAB No. 1726, at 9, 39 (2000), *aff'd, Woodstock Care Center v. U.S. Dept. of Health and Human Services*, 363 F.3d 583 (6th Cir. 2003). The Departmental Appeals Board (the Board) has long held that the net effect of the regulations is that a provider has no right to challenge the scope and severity level assigned to a noncompliance finding, except in the situation where that finding was the basis for an immediate jeopardy determination. *See, e.g., Ridge Terrace*, DAB No. 1834 (2002); *Koester Pavilion*, DAB No. 1750 (2000). Review of a CMP by an ALJ is governed by 42 C.F.R. § 488.438(e).

The Board has addressed the allocation of the burden of persuasion and the burden of production or going forward with the evidence in past cases, in the absence of specific statutory or regulatory provisions. Application of the Board's analysis and approach is not disputed in this case and is appropriate. When a penalty is proposed and appealed, CMS must make a prima facie case that the facility has failed to comply substantially with federal participation requirements. "*Prima facie*" means generally that the evidence is "(s)ufficient to establish a fact or raise a presumption unless disproved or rebutted. *Black's Law Dictionary* 1228 (8th ed. 2004). In *Hillman Rehabilitation Center*, DAB No. 1611, at 8 (1997), *aff'd*, *Hillman Rehabilitation Center v. HHS*, No. 98-3789 (GEB) (D.N.J. May 13, 1999), the Board described the elements of the CMS *prima facie* case in general terms as follows:

> HCFA [now known as CMS] must identify the legal criteria to which it seeks to hold a provider. Moreover, to the extent that a provider challenges HCFA's findings, HCFA must come forward with evidence of the basis for its determination, including the factual findings on which HCFA is relying and, if HCFA has determined that a condition of participation was not met, HCFA's evaluation that the deficiencies found meet the regulatory standard for a condition-level deficiency.

Hillman, DAB No. 1611, at 8. Thus, CMS has the initial burden of coming forward with sufficient evidence to show that its decision to terminate is legally sufficient under the statute and regulations. To make a *prima facie* case that its decision was legally sufficient, CMS must: (1) identify the statute, regulation or other legal criteria to which it seeks to hold the provider; (2) come forward with evidence upon which it relies for its factual conclusions that are disputed by the Petitioner; and (3) show how the deficiencies it found amount to noncompliance that warrants an enforcement remedy.

In *Evergreene Nursing Care Center*, DAB No. 2069 (2007), the Board explained as follows:

> CMS has the burden of coming forward with evidence related to disputed findings that is sufficient (together with any undisputed findings and relevant legal authority) to establish a *prima facie* case of noncompliance with a regulatory requirement. If CMS makes this *prima facie* showing, then the SNF must carry its ultimate burden of persuasion by showing, by a preponderance of the evidence, on the record as a whole, that it was in substantial compliance during the relevant period. *See Hillman Rehabilitation Center*, DAB No. 1611 (1997), *aff'd*, *Hillman Rehabilitation Ctr. v. HHS*, No. 98-3789 (GEB) (D.N.J. May 13, 1999); *Batavia Nursing*

> *and Convalescent Inn*, DAB No. 1911 (2004), *aff'd, Batavia Nursing and Convalesent Center v. Thompson*, No. 04-3687 (6th Cir. 2005); *Guardian Health Care Center*, DAB No. 1943 (2004); *Fairfax Nursing Home, Inc.*, DAB No. 1794 (2001), *aff'd, Fairfax Nursing Home v. Dep't of Health & Human Srvcs.*, 300 F.3d 835 (7th Cir. 2002), *cert. denied*, 537 U.S. 1111, 123 S. Ct. 901 (2003).

CMS makes a *prima facie* showing of noncompliance if the evidence CMS relies on is sufficient to support a decision in its favor absent an effective rebuttal. *Hillman Rehabilitation Center*, DAB No. 1663, at 8 (1998), *aff'd, Hillman Rehabilitation Ctr. v. HHS*, No. 98-3789 (GEB) (D. N.J. May 13, 1999). A facility can overcome CMS's *prima facie* case either by rebutting the evidence upon which that case rests, or by proving facts that affirmatively show substantial compliance. *Tri-County Extended Care Center*, DAB No. 1936 (2004). "An effective rebuttal of CMS's prima facie case would mean that at the close of the evidence the provider had shown that the facts on which its case depended (that is, for which it had the burden of proof) were supported by a preponderance of the evidence." *Id.* at 4 (*quoting Western Care Management Corp.*, DAB No. 1921 (2004)).

II. Issues, findings of fact and conclusions of law

B. Issues

The issues in this case are:

> Whether there is a basis for the imposition of enforcement remedies; and, if so,
>
> Whether the remedies imposed are reasonable.

C. Findings and Discussion

By a post-hearing motion dated June 24, 2009, Petitioner sought to exclude CMS's post-hearing references to, and prevent CMS from discussing, Resident 1's alleged abnormal emesis or possible bowel obstruction/impaction symptoms. The references to which Petitioner objected appeared in CMS's post-hearing briefing. At the in-person hearing on February 17, 2009, the parties stipulated that the allegations of non-compliance in this case would be based on facts involving Resident 1's abnormal vital signs, and not related to abnormal emesis or possible bowel obstruction/impaction. Therefore, I do not consider any allegations other than abnormal vital signs as a basis for non-compliance by Petitioner.

I make findings of fact and conclusions of law (Findings) to support my decision in this case. I set forth each finding below as a separately numbered heading. I discuss each Finding in detail.

Based on the applicable law and regulations, the documentary evidence, and the testimony taken at the hearing, the preponderance of the evidence shows that Petitioner was in substantial compliance with federal participation requirements governing nursing homes and, therefore, no enforcement remedy may be imposed.

1. Petitioner established by a preponderance of the evidence that it was in compliance with 42 C.F.R. § 483.25 (Tag F 309).

The regulations at 42 C.F.R. § 483.25 require a long-term care facility to provide to each of its residents the care and services that are necessary for the resident to attain or maintain the highest practicable level physical, mental, or psychosocial well-being in accordance with the comprehensive assessment and plan of care.

CMS's statement of deficiencies (SOD) from the March 5, 2008 survey alleges that Petitioner failed to notify Resident 1's physician of abnormal vital signs and foul smelling emesis; failed to provide follow up assessments of concerns identified by a direct care staff and failed to provide appropriate nursing interventions to address the change in condition of Resident 1, who later died. CMS Ex. 1, at 2-3.

However, as I have noted above, at the in-person hearing on February 17, 2009, CMS stipulated that it would proceed based on allegations of non-compliance regarding Petitioner's failure to notify the physician of abnormal vital signs *only*, and not based on allegations of abnormal emesis or possible bowel obstruction/impaction. Tr. 80. The following discussion will be limited to the question of vital signs and the facility's actions regarding them.

This immediate jeopardy deficiency allegation (F-309) from the March 5, 2008 survey stem from events that occurred during the late evening of February 16th, and early morning hours of February 17, 2008 involving Resident 1. I find, for purposes of this discussion, that the evidence presented by CMS in its case-in-chief is sufficient to establish a *prima facie* case of a violation of 42 C.F.R.
§ 483.25, but that Petitioner proved by a clear preponderance of the evidence that it was in substantial compliance with applicable regulations.

Resident 1 was an 86-year-old woman who was admitted to Petitioner's facility on September 1, 2006, with diagnosis of breast cancer, chronic back pain, obesity, depression, and acid reflux. P. Ex. 26. Resident 1 had a "do not resuscitate" directive in effect. P. Ex. 12, at 1-2; Tr. 86.

While CMS and Petitioner emphasize different aspects of the facts of the controversy in their briefs, the essence of what occurred on February 16-17, 2008 is as follows. On February 16, 2008 at around 2:00 P.M., Resident 1 complained of nausea and vomiting. P. Ex. 26, at 32; CMS Ex. 1, at 6. L.P.N. Umbenhower, who worked the 7:00 A.M. to 11:00 P.M. shift, contacted the on-call physician, in order to report Resident 1's condition. P. Ex. 14, at 1. The on-call physician ordered facility staff to administer Compazine suppositories[1], 25 mg., every eight hours as needed *Id.* P. Ex. 26, at 32. L.P.N. Umbenhower administered a Compazine suppository upon receiving the order. P. Ex. 26, at 32, 120. At approximately midnight on February 17, 2008, L.P.N. Pyck gave Resident 1 Percocet[2] medication as scheduled. P. Ex. 13, at 2-3. Shortly after ingesting the medication, Resident 1 vomited the pills and a small amount of emesis. Tr. 190. L.P.N. Pyck asked a nurse on duty to obtain a full set of vital signs from Resident 1. P. Ex. 13, at 2. The vital signs indicated a blood pressure of 162/108, a pulse rate of 122 beats per minute, and respirations of 40 per minute. P. Ex. 26, at 101; Tr. 135-136. Her body temperature was not recorded. *Id.* Resident 1 appeared anxious and her breathing became more rapid. Tr. 192; P. Ex. 13, at 2. L.P.N. Pyck spoke with Resident 1 and verbally coached her into slowing her breathing. *Id.* Shortly thereafter, Resident 1's pulse rate dropped to 86 and her respirations to 28. P. Ex. 26, at 101. L.P.N. Pyck administered a dose of Compazine suppository to Resident 1. P. Ex. 13, at 2-3. At about 5:00 A.M., Resident 1 awakened and requested her pain medication. *Id.* L.P.N. Pyck gave her another dose of Percocet medication, however, she vomited the pills and an amount of brown colored emesis shortly thereafter. CMS Ex. 3, at 257-258. L.P.N. Pyck administered another dose of Compazine suppository. *Id.* At about 6:00 A.M., Resident 1 was resting and appeared comfortable. CMS Ex. 3, at 258. At around 6:30 A.M. Resident 1 asked to get out of her bed and into her wheelchair. Tr. 203-205. L.P.N. Pyke went to locate nursing assistants to help transfer Resident 1 to her wheelchair. *Id.* At approximately 7:00 A.M., a C.N.A. reported to L.P.N.'s Pyck and Umbenhower that Resident 1 was not breathing. P. Ex. 14, at 2. L.P.N's Pyck and Umbenhower were unable to locate a pulse from Resident 1, and it was determined that she had died. *Id.*

CMS's chief complaint regarding these events is that Petitioner failed to notify the physician when Resident 1 experienced markedly elevated vital signs, which according to CMS indicated a significant change in condition. CMS Br. 11-13. CMS avers that Petitioner's failure to notify the physician when required amounts in these particular circumstances to a failure to provide the necessary care and services to attain or maintain the highest practicable physical, mental, psychosocial well-being pursuant to 42 C.F.R. § 483.25. *Id.*

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[1] A prescription medicine used to treat severe nausea, vomiting, and anxiety, that is inserted into the rectum.

[2] A prescription narcotic pain killer.

Nurses' notes show that during the early morning hours of February 17, 2008, at about 12:00 midnight Resident 1 on at least one occasion experienced unusually-high blood pressure, pulse rate, and respiration. Resident 1's vital sign flow sheet on February 17, 2008 indicate a blood pressure of 162/108, a pulse rate of 122 beats per minute, and respirations of 40 per minute. P. Ex. 26, at 101; Tr. 135-136. During the same 11:00 P.M. – 7:00 A.M. shift, Resident 1's pulse rate and respirations were later recorded as 86 and 28 respectively. P. Ex. 26, at 1. During an interview conducted on the day of the survey, a facility L.P.N. described abnormal vital signs as: Blood pressure – less than 70/40 and greater than 160/90; Pulse rate – less than 60 and greater than 88; Respiration – greater than 24 breaths per minute. CMS Ex. 1, at 16-17. CMS points out that Resident 1's vital signs on February 17, varied greatly from previous readings and were significantly higher than average normal. For example, for the months of October and November 2007, Resident 1's respirations were never recorded above 22 respirations per minute. P. Ex. 26, at 99-100. However, on February 17, Resident 1's respirations measured at 40, and later in the shift at 28. P. Ex. 26, at 101. Resident 1's pulse rate had not been recorded above 88 throughout October and November, but on February 17, it had leaped to 122 beats per minute, later dropping to 86 beats per minute. P. Ex. 26, at 99-101. Similarly, her blood pressure on February 17, climbed to a high of 162/108. P. Ex. 26, at 101. If I interpret this evidence generously in favor of CMS's position, I find that by it CMS established a *prima facie* case of non-compliance. But, as will be seen, Petitioner proved by a preponderance of the evidence that it was in compliance with applicable regulations.

According to CMS, Resident 1's elevated vital signs on February 17, 2008 compared to her baseline or normal vital signs should have put facility staff on notice that Resident 1 suffered a significant change in physical condition requiring facility staff to notify the physician. CMS Br. 7-13. The physician was not notified at that time, and according to CMS this inaction presented a state of immediate jeopardy to Resident 1's health and safety in violation of 42 C.F.R. § 483.25. *Id.* Additionally, CMS maintains that Petitioner failed to meet general nursing standards requiring that documentation be kept of abnormal vital signs, and failed to follow its own nursing home policy regarding acute episodes which require facility staff to take and record vital signs every four hours for a minimum of 48 hours or until signs and symptoms such as nausea, vomiting, diarrhea, etc., no longer exist. CMS Ex. 3, at 275; CMS Br. 12-13.

Petitioner argues that it met professional standards of conduct with respect to its care of Resident 1, and that she did not experience significant change in condition which required physician notification. P. Br. 10-13.

I find that Petitioner established by a preponderance of the evidence that it was in compliance with 42 C.F.R. § 483.25. I do not conclude, as CMS urges, that Resident 1's abnormal vital sign readings on February 17, required physician notification.

The parties do not disagree on the essential facts of the case. The parties agree that Resident 1 had at least one set of abnormal vital sign readings on February 17, and Petitioner does not dispute that it failed to take and record Resident 1's vital signs on several occasions on February 16-17, 2008. As indicated above, the parties stipulated at hearing that the immediate jeopardy citation and imposed sanctions were based exclusively on vital signs observed for Resident 1 during the late night and early morning hours of February 16-17, 2008, and not based on allegations of abnormal emesis or possible bowel obstruction/impaction. Tr. 80. Although CMS complains that Petitioner failed to meet general nursing standards that require documentation be kept of abnormal vital signs, and failed to follow its own nursing home reporting requirements, the facility was not cited for violating these requirements.

CMS cites the Petitioner for failing to report a change in condition under 42 C.F.R. § 483.25 (F-309). This regulation requires a facility to provide care and services necessary to attain the highest practicable well-being. Implicit in this regulation, however, is a facility's obligation under 42 C.F.R. § 483.10(b)(11), which requires that a facility must inform a resident's physician when there is a *significant change* in the resident's physical, mental, or psychosocial status.

Thus the dispute between the parties seems to turn on how "significant change" should be defined and interpreted under the regulations.

The preamble to the final rule implementing this regulation defines "significant change" as:

> a deterioration in health, mental, or psychosocial status in either life-threatening conditions (for example, heart attack, stroke) or clinical complications (for example, development of a stage II pressure sore, onset or recurrent periods of delirium).

56 Fed. Reg. 48826, 48833 (Sept. 26, 1991).

In the context of resident assessments, the regulations further define "significant change" as:

> a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the care plan, or both.

42 C.F.R. § 483.20(b)(2)(ii).

Both CMS and Petitioner cite Board and ALJ decisions such as *Park Manor Nursing Home*, DAB No. 1926 (2004), *Britthaven of Guilford*, DAB No. CR1210 (2004), and *Lake Care Extended Care Center*, DAB CR494 (1997), in an effort to shed light on how the concept of "significant change" should be applied to the facts of this case. Each party maintains that these cases support its particular position, and believe that the cases should be interpreted in a manner that is most favorable to there respective sides. While instructive, a review of these cases indicates that the very specific facts of these cases largely determine their outcomes: they are "fact-bound," and are helpful insofar, but only so far, as they present factual situations similar to this one.

CMS urges that Resident 1's markedly elevated vital signs compared to her base line vitals as discussed above, coupled with her obvious physical distress indicated by her nausea and vomiting amounted to a "significant change" in physical condition, requiring physician notification. Thus, CMS maintains that facility staff's failure to notify the physician as required, is a failure to provide Resident 1 with the necessary care and services required under 42 C.F.R. § 483.25.

Petitioner points to the testimony of Drs. Zubair, Carey, and Watt, to support its argument that Resident 1 did not under go a "significant change" in condition, which required physician notification. For the reasons I shall set out next, I find the three physicians' testimony highly credible and ultimately persuasive.

Resident 1's treating physician Dr. Zubair testified that he believed that L.P.N. Pyck, the lead nurse treating Resident 1 at the time she experienced elevated vital signs, acted in accordance with appropriate nursing standards, and that the facility administered good care to Resident 1. Tr. 94-99. Indeed, Dr. Zubair testified that:

> I feel very strongly about this particular case because I personally have this feeling this nurse [L.P.N. Pyck] did everything she could possibly do. And in a way, you know, it was probably lucky that I was not on call because if I had been on call, I would still not have done anything different and the patient still would have had a bad outcome as she did have, and I would have felt miserable about it. But the fact of the matter is I would not have changed anything.

Tr. 98-99.

Both Dr. Zubair and director of nurses Lynn Sharp suspected that Resident 1's nausea and vomiting were due to a gastrointestinal flu virus that was widespread at the facility during late January and February 2008. Tr. 88-90, 134-135, Tr. 225; P. Ex. 12, at 2.

Dr. Carey, an associate medical director at the facility, Dr. Watt, medical director for multiple facilities, and Dr. Zubair, all testified that that they would expect elevations in an elderly resident's blood pressure, heart rate, and respirations due to the physical and emotional stress associated with bouts of vomiting or emesis. Tr. 89-92, 153-155, 221-223. Treating L.P.N. Pyck stated that Resident 1's elevated vital signs subsided within a short period of time, and that she was able to go back to sleep for about 4-5 hours without any signs of distress. Tr. 194-197, P. Ex. 13, at 2-3. All three physicians testified that they would not expect a nurse to contact them based on one set of elevated vital signs. Tr. 94-96, 154-155, 222-223. I find that each physician testified credibly: each possesses exceptional experience in the kind of care here at issue and in the context of long-term care facilities, and each claims a distinguished academic background. Tr. 81-84, 150-152, 213-216; P. Ex. 12, at 1; P. Ex. 9, at 1. Each doctor testified from the perspective of an expert familiar with the medical history of the Resident. Moreover, I note that the three physicians' testimony was consistent throughout, that is, all three agreed on virtually every significant point. Other than the testimony of surveyor R.N. Wallace, CMS simply did not offer comparable expert medical testimony that directly rebutted the cumulative weight of expert testimony from Drs. Zubair, Carey, and Watt. I cannot disagree with the doctors, and must accord their testimony great weight: I find and conclude that Resident 1's elevated vital signs on February 17, at around midnight did not amount to a "significant change" in the Resident's physical condition, and therefore, Petitioner was not required to notify the physician.

I am further persuaded by what the overall record shows about the facility's readiness and sense of obligation to deal with changes in Resident 1's condition. The evidence demonstrates that facility staff was attentive to Resident 1 and delivered the necessary care and services required. 42 C.F.R. § 483.25. Indeed, L.P.N. Umbenhower contacted the on-call physician when Resident 1 first complained of nausea and vomiting on February 16, 2008 at about 2:00 P.M. L.P.N. Umbenhower reported Resident 1's condition to the on-call physician. P. Ex. 26, at 32. The on-call physician ordered the facility staff to administer Compazine suppositories, every eight hours as needed. The record indicates that facility staff administered the Compazine and other medication to Resident 1 as required throughout the episode. P. Ex. 26, at 32, 120.

The broad requirements of 42 C.F.R. § 483.25 implicitly include a requirement that a facility adhere to professionally recognized standards of care in providing care and treatment to its residents. There is no professionally-recognized objective standard of care for reporting of residents' vital signs. The implied requirement in 42 C.F.R. § 483.25 is that a facility should monitor a resident's vital signs as necessary, and if a resident suffers a "significant change" in condition, the resident's treating physician should be contacted. The regulations do not necessarily require a facility to contact a resident's treating physician if her vital signs stray from baseline or exceed a predetermined number. Thus, whether a "significant change" or deterioration in the

resident's condition occurred is largely a matter of professional nursing judgment. *See Park Manor Nursing Home*, DAB No. 1926 (2004).

Indeed, the preamble to the final rule implementing 42 C.F.R. § 483.10(b)(11) requiring physician notification when there is significant change in the residents physical, mental, or psychosocial status acknowledges this:

> We recognize that judgment must be used in determining whether a change in the resident's condition is significant enough to warrant notification, and accept the comment that only those injuries which have the potential for needing physician intervention must be reported to the physician.

56 Fed. Reg. 48826, 48833 (Sept. 26, 1991).

The full record of credible, informed, competent evidence shows, and I am accordingly satisfied and convinced, that the facility exercised reasonable professional judgment in accordance with recognized standards of care when providing treatment to Resident 1.

L.P.N. Pyck's observations of Resident 1's vomiting and nausea around midnight, February 17, 2009, were consistent with symptoms resulting from a "flu bug" which was prevalent at the facility at the time. Resident 1's initial elevated blood pressure, heart rate, and respirations would be expected responses to an episode of nausea and vomiting. L.P.N. Pyck observed these vital signs, and followed up with appropriate nursing interventions that resulted in decreased vital signs, and the Resident being able to sleep. L.P.N. Pyck appropriately responded to the Resident's symptoms throughout the evening and early morning hours based on the information known to her at the time. And it may deserve mention here that L.P.N. Pyck herself testified from the perspective of a highly-experienced, well-educated, intensely-practical career caregiver: in effect, she was Petitioner's fourth expert witness and I have credited her testimony accordingly.

The fact that Resident 1 died does not mean that Petitioner failed to deliver necessary care and services as CMS suggests. CMS Br. 13. Based on Resident 1's medical history, Dr. Watt testified that the Resident may have died as a result of one of several possible causes including cerebral aneurysm, pulmonary embolism, metastatic disease, abdominal aortic aneurysm, acute cerebral bleed, or a cardiac event brought on by the stress of gastroenteritis. Tr. 229-231. In addition, the fact that Resident 1 had a "do not resuscitate" order suggest to me that physician notification would not likely have resulted in a different outcome because any physician interventions would have been limited by the Resident's desire to be offered comfort measures only.

Therefore, I find that Petitioner established by a preponderance of the evidence that it was in compliance with 42 C.F.R. § 483.25.

Other Deficiency Allegations

In addition to the immediate jeopardy deficiency allegation regarding Resident 1, the SOD alleges additional non-immediate jeopardy allegations (F 282, F 309) for Residents' 4, 5, 6, 7, and 9. CMS Ex. 1. The parties focused their attention at the hearing almost exclusively on allegations of non-compliance regarding Resident 1. Thus, deficiency allegations concerning these non-immediate jeopardy tags are not addressed in this decision.

2. A per-instance CMP of $10,000 is unreasonable based on the fact that there are no violations and therefore no basis for the imposition of a CMP.

The remedy determinations made by CMS in this case are premised on the findings of noncompliance made during the survey period. I have found that Petitioner was in compliance with applicable participation requirements. Consequently, there is no basis for CMS to impose remedies against Petitioner.

III. Conclusion

For all of the reasons set out above, I find and conclude that Petitioner was in substantial compliance with participation requirements at issue in this case, and therefore, no enforcement remedy may be imposed by CMS.

/s/ Richard J. Smith
Administrative Law Judge