

XXXXXXXXXXXXXXXXXXXX

APPELLANT

v.

THE DEPARTMENT OF

HEALTH AND MENTAL HYGIENE

* BEFORE ALAN B. JACOBSON,

* AN ADMINISTRATIVE LAW JUDGE

* OF THE MARYLAND OFFICE

* OF ADMINISTRATIVE HEARINGS

* CASE NO.: DHMH-LCP-44-00000000

* * * * *

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STATEMENT OF THE CASE

The Appellant appealed on October 19, 2001 from a determination by the Department of Health and Mental Hygiene (“DHMH,” “the Department”) that it had failed to recognize the authority of an Advance Directive, established in compliance with Md. Code Ann., Health Gen. (herein, “HG”) § 5-602 (2000), and was therefore subject to a finding of a "deficiency" and subject to a civil money penalty, assessed at \$10,000.00. HG §§ 19-1401 through 19-1404.

A hearing was held on February 8, 2002 at the Office of Administrative Hearings (“OAH”), 11101 Gilroy Road, Hunt Valley, Maryland before Alan B. Jacobson, Administrative Law Judge (“ALJ”). HG § 19-343 (2000 & Supp. 2001) and Code of Maryland Regulations (“COMAR”) 10.01.03. Joseph L. Bianculli, Esq.¹ and Stephen J. Sfekas, Esq., represented the

¹ Licensed member of the Virginia Bar, appearing by authority of an order of the Circuit Court for Baltimore

Appellant. Wendy Kronmiller and John Nugent, Assistant Attorneys General, represented the Department.

Procedure in this case is governed by the contested case provisions of the Administrative Procedure Act, Procedures for Hearings before the Secretary of Health and Mental Hygiene, and the Rules of Procedure of the Office of Administrative Hearings. Md. Code Ann., State Gov't §§ 10-201 through 10-226 (1999 & Supp. 2001), COMAR 10.01.03, COMAR 28.02.01².

ISSUE

The issues presented on appeal are:

- 1) Whether the Appellant's provision of care and sustenance to the Resident violated the authority of an Advance Directive; and, if so,
- 2) Whether the Appellant nursing home committed an actual harm to the Resident; and, if so,
- 3) Whether the imposition of a civil money penalty of \$10,000.00 was proper.

SUMMARY OF THE EVIDENCE

Exhibits

The Department submitted the following documents, which were admitted into evidence:

Agency Ex. #1 – Curriculum Vitae of William M. Vaughan, R.N., B.S.N.

Agency Ex. #2 - Advance Directive, Resident #1, dated March 19, 1997 (same as App. Ex. #6).

Agency Ex. #3 - DHMH Notice to XXXXXX, Administrator, dated October 5, 2001.

Agency Ex. #4 – Medical Records including Doctor's Progress Notes, Physician Certifications,

Nurses Notes, Interim Orders, Physician Orders and Interim Plan of Care, and

County, *pro hac vice*. 0

² The current regulations are published at 27:26 Md. Reg. 2360 (Dec. 29, 2000, effective Jan. 8, 2001) (proposed 27:18 Md. Reg. 1678-1684 (Sept. 8, 2000)) (to be codified at Code of Maryland Regulations ("COMAR") 28.02.01).

Physician Order Forms (same as App. Exs. 7 – 13).

Agency Ex. #5 – Curriculum Vitae of Jack Schwartz, J.D.

Agency Ex. #6 – 85 Opinion of the Attorney General ____ (2000), slip op. issued, November 16, 2000.

Agency Ex. #7 – Timeline.

Agency Ex. #8 – Letter from Renee Webster to XXXXXX Hospital, dated November 27, 2001 with attached deficiencies and plan of correction.

Agency Ex. #9 – Social Progress Notes, dated June 17, 1999 through April 13, 2001.

Agency Ex. #10 – Letter to Resident #1's son from XXXXXX, Administrator, and XXXXXX, Director of Nursing, dated May 10, 2001.

The Appellant submitted the following documents, which were admitted into evidence:

App. Ex. # 1 - Statement of Deficiencies, dated August 21, 2001.

App. Ex. #2 – DHMH Notice to XXXXXX, Administrator, dated October 5, 2001.

App. Ex. #3 – Excerpts from Md. Code Ann. (Health Care Decisions Act).

App. Ex. #4 - Admission face sheet, Resident #1, dated April 13, 2001.

App. Ex. #5 – Nursing assessments, Resident #1, dated March through April 2001.

App. Ex. #6 – Advance Directive, Resident #1, dated March 19, 1997.

App. Ex. #7 – Excerpts from physician progress notes, Resident #1, dated March through April 2001.

App. Ex. #8 – Physician certifications, Resident #1, dated August 1999 through July 2000.

App. Ex. #9 – Excerpts from nursing notes, Resident #1, dated April 2001.

App. Ex. #10 – Excerpts from physicians' orders, Resident #1, dated January through May 2001.

App. Ex. #11 - Excerpts from interim care plans, Resident #1, date January through April 2001.

App. Ex. #12 – Physician orders, Resident #1, date March through May 2001.

App. Ex. #13 – Enteral protocol, Resident #1, dated April through May 2001.

App. Ex. #14 – XXXXXX policy and procedure re: advance directives, dated June
1996.

App. Ex. #15 - XXXXXX policy and procedure re: ethical issues dated June 1996.

App. Ex. #16 - XXXXXX policy and procedure re: patient care advisory
committee, dated June 1996.

App. Ex. #17 – Patient Care Advisory Referrals summary and referral re: Resident #1, dated
May 1, 2001.

App. Ex. #18 – Social service notes, Resident #1, dated February 1998 through March 2001.

Testimony

The following individuals testified on behalf of the Department:

William N. Vaughan, R.N., Chief Nurse, Health Facility Surveyor, Office of Health Care
Quality, DHMH.

Jack Schwartz, Esq., Director of Health Policy Development, Maryland Attorney General's
Office, accepted as an expert in the fields of bioethics and health policy.

Carol Benner, Director, Office of Health Care Quality, DHMH.

The following individuals testified on behalf of the Appellant:

XXXXXX, Director of Social Services, XXXXXXXXX

XXXXXX, Administrator, XXXXXXXXXX

XXXXXX, Director of Nursing, XXXXXXXXXX.

XXXXXX, Vice President of Clinical Services, XXXXXXX

STIPULATIONS OF FACT

The parties jointly stipulated to the following facts:

1. On March 19, 1997, an individual identified for purposes of this proceeding as “Mrs. R.” or “Resident #1” signed an Advance Directive.
2. As required by Maryland Law, two witnesses signed the Advance Directive. There is no contention that Mrs. R’s Advance Directive is fraudulent, that she was not competent at the time she signed it, or that it was not properly executed.
3. In February 1998 Mrs. R was admitted to XXXXXXXXXX, a nursing facility located in Baltimore County, which is operated by XXXXXXX. At the time of her admission, Mrs. R was 80 years old and suffered from a variety of serious medical ailments, including dementia.
4. Between 1998 and 2001, Mrs. R’s medical and mental condition declined, and she was hospitalized on several occasions for treatment of her various conditions, including episodic dehydration. As early as August 1998, Mrs. R was certified to be unable to comprehend information and to make decisions.
5. On August 25, 1999 and September 20, 1999, physicians certified that Mrs. R was in an end stage condition due to her condition of dementia.
6. Mrs. R was again certified as being in an end stage condition on July 17, 2000. On the certifications, tube feeding was noted to be medically ineffective.
7. On April 5, 2001, Mrs. R was admitted to XXXXXXX Hospital with a diagnosis of dehydration. During that hospitalization, a physician at the Hospital surgically inserted a device known as a “gastronomy tube,” “PEG-tube,” or “G-tube” into her stomach, and the Hospital initiated artificial administration of nutrition and hydration via the G-tube.
8. On Friday, April 13, 2001 Mrs. R was discharged from the Hospital back to XXXXXXX with the G-tube in place.
9. Between Friday, April 13, 2001 and Friday, April 20, 2001, XXXXXXX administered only water and medications to Mrs. R via her G-tube. XXXXXXX also attempted to feed Mrs. R orally during that time, but she was unable to take food by mouth.
10. After she was notified that the hospital had inserted a feeding tube into Mrs. R’s stomach, Mrs. R’s attending physician, XXXXXXX., on Monday, April 16, contacted XXXXXXX, M.D., a member of the XXXXXXX [Patient Care Advisory Committee] PCAC, seeking guidance regarding her obligations. Dr. XXXXXXX advised not to administer artificial nutrition, but medicine and water flushes, in accordance with the Advance Directive.

11. Dr. XXXXXXX, Mrs. R's attending physician, is not an employee of XXXXXXX however, she has privileges to practice at XXXXXXX.

12. On April 14, 2001 Mrs. R's attending physician wrote in her progress notes: "Patient was treated for dehydration. PEG tube is placed...G tube is placed against her living will...G tube flushes till the decision made regarding nutrition. Discussion with nursing home staff."

13. On April 16, 2001 Mrs. R's attending physician wrote: "Pt had PEG placed for nutritional purposes against the wishes of the patient. I personally do not recommend a tube placement. I want to respect patient wishes and I discussed with Dr. XXXXXXX. Present issues are notified to ethics committee of XXXXXXX. Continue G tube flushes no nutrition. Left message for family."

14. On April 19, 2001 Mrs. R's attending physician wrote: "Tried for family. Discussed with son and daughter-in-law. Looks like they have contacted the attorney and made the decision if patient is not fed they will sue us and also they refused to give the name of attorney."

15. Sometime between April 13 and 23, 2001, Mrs. R's attending physician contacted risk management at XXXXXXX Hospital in Baltimore, where she is on staff, and inquired about her responsibilities under the circumstances.

16. On Friday morning, April 20, 2001, Mrs. R's attending physician contacted the charge nurse on Mrs. R's unit at XXXXXXX by telephone and ordered her to begin feeding Mrs. R via the G-tube.

17. During this time, XXXXXXX administrators also sought guidance from various state officials, including the Maryland Medicaid Agency, the Ombudsman and the Attorney General's Office, regarding their obligations to Mrs. R.

18. Mrs. R. was transferred to Good Samaritan Hospital on May 2, 2001 for medical reasons.

19. On May 10, 2001 XXXXXXX advised Mrs. R's family that she would not be readmitted to XXXXXXX due to XXXXXXX disagreement with her family's decision to feed her via her G-tube. XXXXXXX advised the family that it had made arrangements for Mrs. R's admission to a different nearby nursing facility, XXXXXXX.

20. Mrs. R subsequently was discharged from XXXXXXX Hospital to the other XXXXXXX facility, where she died shortly thereafter. She was tube fed at XXXXXXX and XXXXXXX

FINDINGS OF FACT

Having considered all the evidence, I find the following facts by a preponderance of the evidence:

1. On March 19, 1997, an individual identified for purposes of this proceeding as “Mrs. R.”, or “the Resident”, or "Resident # 1", signed a legally valid Advance Directive. Stips. 1 and 2.
2. The Advance Directive made clear that, in the event Mrs. R were in an end-stage condition for which treatment would be medically ineffective, that it was her wish that she be permitted to die naturally with only the natural administration of food and water, and the provision of medication or the performance of any medical procedure necessary to provide comfort or alleviate pain. She further directed that no nutrition or sustenance be administered to her artificially, such as by the insertion of a feeding tube, and that any such artificial administration be terminated immediately. She further directed that no fluids be administered to her other than to administer drugs or narcotics or hydration artificially for the sole purpose of assuring her comfort and to alleviate pain. Agency Ex. 2, App. Ex. 6.
3. Prior to August 1998 Mrs. R was diagnosed with Dementia, a progressive disease. In August 1998 Mrs. R was certified to be unable to comprehend information and to make decisions. Stip. 4.
4. On August 25, 1999 and September 20, 1999, physicians certified that Mrs. R was in an end stage condition due to her condition of Dementia. Stip. 5.
5. On April 5, 2001, Mrs. R was admitted to XXXXXX Hospital with a diagnosis of dehydration. During that hospitalization, a physician at the Hospital surgically inserted a device known as a "gastrostomy tube," "PEG-tube," or "G-tube" into her stomach, and the Hospital initiated artificial administration of nutrition and hydration via the G-tube. Stip. 7.
6. On Friday, April 13, 2001, Mrs. R was discharged from the Hospital back to the Appellant nursing home with the G-tube in place. Stip. 8.
7. Between Friday, April 13, 2001 and Friday, April 20, 2001, the Appellant administered

only water and medications to Mrs. R via her G-tube. The Appellant also attempted to feed Mrs. R orally during that time, but she was unable to take food by mouth. Stip. 9.

8. Mrs. R's attending physician is not an employee of the Appellant but has privileges to practice at the Appellant nursing home. Stip. 11.

9. Mrs. R's attending physician was well aware that the G-tube was in violation of Mrs. R's Advance Directive. Stip. 13.

10. On Friday morning, April 20, 2001, Mrs. R's attending physician contacted the charge nurse on Mrs. R's unit at the Appellant nursing home by telephone and ordered her to begin feeding Mrs. R via the G-tube.

11. Mrs. R was tube fed by the Appellant nursing home in direct contravention of the Advance Directive from April 20, 2001 to May 2, 2001, when she was transferred to XXXXXX Hospital for medical reasons.

12. The Appellant nursing home arranged with the family of Mrs. R that Mrs. R would not return to the Appellant nursing home when she was discharged from XXXXXX Hospital. Instead, Mrs. R was transferred to another nursing facility under the same corporate management, XXXXXX. Stip. 19.

13. Mrs. R subsequently was discharged from XXXXXX Hospital to the other XXXXXX facility, where she died shortly thereafter. She was tube fed at XXXXXX and XXXXXX Center in direct contravention of the Advance Directive.

DISCUSSION

Maryland statutes provide for the review of the operations of a nursing home, such as the Appellant. The same statutes also provide for the finding in appropriate cases of a deficiency or

deficiencies in such operations and the assessment of appropriate civil money penalties against such nursing home at HG, title 19, subtitle 14 (2000 and Supp. 2001), in pertinent part as follows:

Subtitle 14. Nursing Homes.

§ 19-1401. Definitions.

(a) *In general.* -- In this subtitle, the following words have the meanings indicated.

(b) *Actual harm deficiency.* -- “Actual harm deficiency” means a condition existing in a nursing home or an action or inaction by the nursing home staff that has caused physical or emotional injury or impairment to a resident.

...

(d) *Deficiency.* -- “Deficiency” means a condition existing in a nursing home or an action or inaction by the nursing home staff that results in potential for more than minimal harm, actual harm, or serious and immediate threat to one or more residents.

(e) *Nursing home.* -- “Nursing home” means a facility (other than a facility offering domiciliary or personal care as defined in Subtitle 3 of this title) which offers nonacute inpatient care to patients suffering from a disease, chronic illness, condition, disability of advanced age, or terminal disease requiring maximal nursing care without continuous hospital services and who require medical services and nursing services rendered by or under the supervision of a licensed nurse together with convalescent, restorative, or rehabilitative services.

....

§ 19-1402. Imposition of penalties generally.

(a) *Sanctions.* -- If a deficiency exists, the Secretary may impose sanctions that include:

(1) A directed plan of correction with corrective measures necessary to protect residents; [and]

...

(4) Imposing a civil money penalty.

(b) *Standard.* -- A civil money penalty may be imposed when a deficiency exists or an ongoing pattern of deficiencies exists in a nursing home.

(c) *Factors.* -- In determining whether a civil money penalty is to be imposed, the Secretary shall consider, pursuant to guidelines set forth in regulations promulgated by the Secretary, the following factors:

(1) The number, nature, and seriousness of the deficiencies;

(2) The extent to which the deficiency or deficiencies are part of an ongoing pattern during the preceding 24 months;

(3) The degree of risk to the health, life, or safety of the residents of the nursing home caused by the deficiency or deficiencies;

(4) The efforts made by, and the ability of, the nursing home to correct the deficiency or deficiencies; and

(5) A nursing home's history of compliance.

(d) *Notice.* -- Upon determination by the Department that a deficiency or deficiencies exist, the Department shall notify the nursing home that:

(1) Unless corrective action taken pursuant to this section is substantially completed, a civil money penalty will be imposed; or

(2) An order imposing a civil money penalty will be issued, pursuant to § 19-1403 which shall include a list of all deficiencies and notice that a civil money penalty may be imposed until the time that the cited deficiencies have been rectified. . . .

§ 19-1403. Order proposing penalty.

(a) *Contents.* -- If a civil money penalty is proposed, the Secretary shall issue an order which shall state the basis on which the order is made, the deficiency or deficiencies on which the order is based, the amount of civil money penalties to be imposed, and the manner in which the amount of civil money penalties imposed was calculated.

. . . .

§ 19-1404. Amount of penalty.

. . .

(b) *Actual harm deficiencies.* -- A civil money penalty imposed under this subtitle for actual harm deficiencies:

May not exceed \$10,000 per instance; or

May not exceed \$1,000 per day for an ongoing pattern of deficiencies until the nursing home is in compliance.

. . .

(d) *Factors.* -- In setting the amount of a civil money penalty under this section, the Secretary shall consider, pursuant to guidelines set forth in regulations promulgated by the Secretary, the following factors:

(1) The number, nature, and seriousness of the deficiencies;

(2) The degree of risk to the health, life, or safety of the residents of the nursing home caused by the deficiency or deficiencies;

(3) The efforts made by the nursing home to correct the deficiency or deficiencies;

(4) Current federal guidelines for money penalties;

(5) Whether the amount of the proposed civil money penalty will jeopardize the financial ability of the nursing home to continue operating as a nursing home; and

(6) Such other factors as justice may require.

....

§ 19-1406. Administrative appeal.

...

(c) *Hearing.* -- (1) A hearing on the appeal shall be held in accordance with the Administrative procedure Act, under Title 10, Subtitle 2 of the State Government Article.

(2) The Secretary shall have the burden of proof with respect to the imposition of civil money penalties under § 19-1404 of this subtitle.

(3) A decision shall be rendered by the Office of Administrative Hearings within 10 working days of the hearing.

Provisions are made for the protection of the rights of residents of nursing homes in Maryland pursuant to COMAR Title 10, Subtitle 07, Chapter 09, **‘Residents’ Bill of Rights: Comprehensive Care Facilities and Extended Care Facilities.’** In particular, COMAR 10.07.09.08 provides, in pertinent part, as follows:

.08 Resident’s Rights and Services.

A. A nursing facility shall provide care for residents in a manner and in an environment that maintains or enhances each resident’s dignity and respect, and in full recognition of the resident’s individuality.

B. A nursing facility may not interfere with a resident’s exercise of rights guaranteed under the Constitution or laws of the United States and Maryland.

C. A resident has the right to:

...

(3) A dignified existence, self-determination, and communication with and access to individuals and services inside and outside the nursing facility;

(4) Be free of interference, coercion . . . from the nursing facility when exercising the resident’s rights;

...

(9) Participate in planning care and treatment, or changes in care or treatment;

...

(11) Consent to or refuse treatment, including the right to accept or reject artificially administered sustenance in accordance with State law; . . .

Further, COMAR, at 10.07.09.09, requires that a nursing facility implement the residents’ rights, as follows:

.09 Implementation of Residents’ Bill of Rights.

A nursing facility shall:

A. Ensure that:

- (1) The rights of residents as set forth in the Residents' Bill of Rights are protected . . .
- (2) Employees of the nursing facility are trained to:
 - (a) Respect and enforce the Residents' Bill of Rights and the nursing facility's policies and procedures that implement the Residents' Bill of Rights, and
 - (b) Protect the rights of residents;
- (3) The nursing facility's policies and procedures implement all rights of the residents as set forth in [citations omitted] . . . [and]
- (d) the regulations of this chapter; and
- (4) The nursing facility's policies comply with the requirements of federal and State law concerning advance directives. . . .**
... [and]

K. Educate staff, residents, representatives, and interested family members on advance directives; [Emphasis added.]

The present case involves the execution and implementation, or alleged failure to implement, a document referred to as an Advance Directive. By the Advance Directive, a resident at the Appellant nursing home sought under certain specified circumstances to limit efforts to provide her with life sustaining medical procedures. The authority and nature of Advance Directives generally in Maryland has been thoroughly analyzed by the Court of Appeals. *Wright v. Johns Hopkins Health*, 353 Md. 568 (1999). Thus, the Court has noted:

In May 1993, the General Assembly . . . enacted the Health Care Decisions Act (the Act), . . . §§ 5-601 through 5-618 of [HG]. The Act overlies an individual's existing common law right to refuse life sustaining medical procedures. . . . *Wright v. Johns Hopkins Health*, 353 Md. 568 (1999). *See Mack v. Mack*, 329 Md. 188, 211, 618 A.2d 744, 755-56 (1993) ("Although the United States Supreme Court's decision in *Cruzan*³ made no holding on the subject, all of the justices, save Justice Scalia, either flatly stated or strongly implied that a liberty interest under the Fourteenth Amendment gives rise to a constitutionally protected right to refuse life saving hydration and nutrition.") (citation omitted). (Cited in *Wright*, 353 Md. at 572.)

Continuing, the Court stated:

The Act establishes the framework by which health care decisions may be made. An individual, called the declarant, may make an advance directive. This may be done orally or in writing. § 5-601(b). The declarant may also appoint an

³ *Cruzan v. Director, Missouri Dept. of Health*, 497 U.S. 261, 110 S.Ct. 2841 (1990).

agent for health care. § 5-601(c). . . .

Under the Act “[a]ny competent individual may at any time, make a written advance directive regarding the provision of health care to that individual, or the withholding or withdrawal of health care from that individual.” § 5-602(a). The writing must be signed by or at the express direction of the declarant, dated, and subscribed by two witnesses. § 5-602(c)(1). . . .

Once an attending physician is notified of a written advance directive the physician must “make the fact of the advance directive, including the date the advance directive was made and the name of the attending physician, a part of the declarant’s medical records.” § 5-602(f)(2)(ii).

An advance directive becomes effective either when conditions specified by the declarant are determined to have been satisfied in the manner specified by the declarant or “when the declarant’s attending physician and a second physician certify in writing that the patient is incapable of making an informed decision” regarding the treatment. §§ 5-602(e)(1), 5-606(a)(1).

Wright, 353 Md. at 574-575.

On March 19, 1997, Mrs. R signed an Advance Directive. The Advance Directive made clear that, in the event Mrs. R were in an end-stage condition for which treatment would be medically ineffective, that it was her wish that she be permitted to die naturally with only the natural administration of food and water, and the provision of medication or the performance of any medical procedure necessary to provide comfort or alleviate pain. She further directed that no nutrition or sustenance be administered to her artificially, such as by the insertion of a feeding tube, and that any such artificial administration be terminated immediately. She further directed that no fluids be administered to her other than to administer drugs or narcotics or hydration artificially for the sole purpose of assuring her comfort and to alleviate pain. Agency Ex. 2, App. Ex. 6.

The Advance Directive also had provisions respecting the designation by Mrs. R of a health care agent, *i.e.*, her son. Although the document in many ways uses language authorizing

the agent to take any action as he deems necessary or appropriate, the agent is limited by the following language, at paragraph A.2.:

2. My agent is to make health care decisions for me based on the health care instructions I give in this document and on my wishes as otherwise known to my agent. If my wishes are unknown or unclear, my agent is to make health care decisions for me in accordance with my best interest, to be determined by my agent after considering the benefits, burdens and risks that might result from a given treatment or course of treatment, or from the withholding or withdrawal of a treatment or course of treatment.

Department Ex. 2.

The investigator in this matter, William M. Vaughan, R.N., Chief Nurse, Health Facility Surveyor, Office of Health Care Quality, DHMH, testified and described his investigation and findings. He stated that he learned of the Appellant's potential conflict with the Advance Directive of Mrs. R as a result of inquiries that the Appellant had made concerning the policy of tube feeding. The Resident died in another facility before his investigation began. He stated that he made two on-site visits to the facility to interview various staff members and review files. Mr. Vaughan found that the staff was virtually unanimous in the opinion that the Resident, who had been in an end stage condition for several months by April 2001, did not wish her life to be artificially prolonged through the administration of tube feeding, and that her wishes in that regard were clear in the Advance Directive. However, the staff implied that they were acting defensively on the advice of the risk management authorities of the Appellant.

Jack Schwartz, Esq., Director of the Division of Health Care Policy, Office of the Attorney General of Maryland, testified for the Department. Mr. Schwartz was accepted as an expert in bioethics and health care. In essence, Mr. Schwartz testified as to his view of the purpose of the Health Care Decisions Act. As he participated in the formulation of the

legislation and is quite experienced in the application of Advance Directives, his testimony was persuasive. Mr. Schwartz stated his view that the Advance Directive in this case is unambiguous as to the patient's wishes with regard to withholding life sustaining measures in the circumstances which actually occurred.

At one point, counsel for the Appellant asked Mr. Schwartz, in effect, is it part of the deficiency finding that the staff of the Appellant chose to ignore the terms of the Advance Directive? Mr. Schwartz answered with a factual description of what happened in this case. In other words, although Mr. Schwartz stated that he has no responsibility for interpreting the enforcement provisions of HG after a deficiency finding, he recited the facts that the Resident unambiguously directed that no artificial or ineffective measure be taken to prolong her life, but that she was fed with a "G-tube" nonetheless. It was Mr. Schwartz' opinion that if the nurse in charge of the resident's care opined, as was the case in this matter, that the physician's direction to begin feeding was in conflict with the Directive, that it was the duty of the nurse to bring the matter to the attention of the provider of care's Patient Care Advisory Committee (PCAC, or "ethics committee") or other authority. Test. Schwartz and XXXXXX. Further, Mr. Schwartz gave his opinion that, regardless of what other actions it were to take, the health care provider should not violate the resident's refusal of treatment unless told by a court to do so. In sum, Mr. Schwartz was of the opinion that the "default position," in the words of the Appellant's counsel, was that the sustenance and treatment should be withheld in accordance with the Directive until countermanded by a higher authority such as a court order.

The Department noted that the statute provides for an expedited court proceeding to test the validity of an Advance Directive. HG § 5-612. Such a proceeding may be brought *either* by a provider who believes that the Directive is inconsistent with generally accepted standards of

patient care, or by a [listed] family member. *Id.*

Finally, Mr. Schwartz stated his view that HG § 5-613, regarding transfers of patients in the instance where the health care provider declines to carry out the order of the health care agent or surrogate, does not apply to the present case. That section would appear to authorize a provider, challenged by the resident or the health care agent or surrogate with a dispute about the care provided pursuant to an Advance Directive, to offer the resident or the family an opportunity to transfer to another facility. It was Mr. Schwartz' view, and I agree, that there was no such declared dispute between the provider, the Appellant, and the health care agent, the resident's son. In any case, it is not likely that the legislature intended for the transfer suggested by statute to be to another arm of the same corporation, as happened in the present matter.

The Appellant never made a firm decision to overrule the attending physician's feeding order of April 20, 2001. As the events unfolded, the son expressed his demand that Mrs. R be fed and threatened to sue the attending physician and the facility if she were not; the facility agreed to permit the feeding. In fact, at the beginning of May 2001, after Ms. R. was discharged from a brief hospital stay, during which she was fed, the Appellant facility arranged for her transfer to a *sister facility*, also operated by XXXXXX. At the latter facility as well, the feeding continued in flagrant disregard of the Resident's declared intent in the Advance Directive, until she died.

The Director of the Office of Health Care Quality, Ms. Benner, testified that in her opinion the Appellant's disregard of the Advance Directive in this case was an "egregious" violation of law. Her view was that the violation was a particularly serious one because it arose from ignoring the pre-existing written wishes of a defenseless resident as to the conditions of the final stage of her life. Yet, she noted that although a serious civil money penalty was imposed,

\$10,000.00, that was less than the available fine of \$50,000.00 under the statute.

Counsel for the Appellant argued that the facility did not directly contravene the law and that the default position should be to keep the patient alive while the Patient Care Advisory Committee resolved an ambiguity. Therefore, he argued that a summary decision should be entered in favor of the Appellant. Counsel for the Department, Ms. Kronmiller, argued in answer to the Appellant's counsel that there was no substantial ambiguity, and that violating an Advance Directive did in fact constitute a harm justifying a finding of a deficiency under the law. She argued that tube feeding the Resident for 12 days against the Resident's wishes was a harm in fact because it amounted to a battery and a dismissal of the Resident's last wishes. I denied the oral Motion to Dismiss the deficiency (perhaps better characterized as a Motion for Directed Decision), made by the Appellant's counsel at the end of the Department's case, because on its face the Department's position established a *prima facie* case of a deficiency in the Appellant's ignoring the Advance Directive. COMAR 10.07.09.08 C(11), and 10.07.09.09.

Ms. XXXXXX, Social Worker for the Appellant, testified concerning communications with the Resident's family, in which they expressed their desire to keep the Resident alive notwithstanding the words of the Advance Directive. She testified that it was her belief that the insertion of the tube was in clear violation of the Resident's wishes. However, she did not feel that she had any authority in the matter. Test. XXXXXX.

Ms. XXXXXX, Administrator of the Appellant nursing home, testified that her response to receiving the Resident back from the hospital on April 13, 2001 with a feeding tube was to convene the "ethics committee," *i.e.*, the PCAC. She contacted the corporate headquarters representative from XXXXXX, XXXXXX, concerning the interpretation of the Advance Directive in this matter. Ms. XXXXXX testified that the family told her that the Resident had

changed her mind at some indefinite point in the recent past, perhaps during a Thanksgiving holiday family visit, and wanted to continue living. Ms. XXXXXX also testified that she knew that the tube feeding beginning April 20, 2001 was in direct conflict with the Advance Directive. She stated that her action in response to this violation of the Resident's declared wishes was to call the State for guidance. In fact, on May 10, 2001 Ms. XXXXXX sent a letter to the Resident's son concluding that the tube feeding was "in direct conflict" with the Advance Directive. Dept. Ex. 10; Test. Ms. XXXXXX. Nevertheless, Ms. XXXXXX testified that she did not take any direct action to withhold the artificial sustenance.

XXXXXX, Director of Nursing at the Appellant nursing home, testified concerning the attending physician's directives. On the Monday following the directive to begin the feeding, she stated that she began making telephone calls to the State and the Appellant's parent corporation as to what response she should make. Test. XXXXXX.

Early during the cross-examination of the Department's witnesses, counsel for the nursing home sought to deflect attention from these rather unorganized efforts at obtaining policy information after a serious change was made in the Resident's care. Counsel referred to the State's attempts to characterize the Appellant's efforts as "like a chicken with its head cut off," whereas it was his argument that the Appellant responded responsibly. I find that the Department has demonstrated beyond doubt that the Appellant had no apparent plan for the staff to follow in order to formulate a decision in this matter or react to a serious challenge by the attending physician to the judgment of the staff as to the correct action regarding the medical care for the Resident. In short, the staff's view that the Advance Directive was being violated was simply overridden through inaction.

Finally, XXXXXX, Vice President of Genesis for Clinical Affairs, XXXXXX, testified

concerning the activities of the PCAC, which held a full meeting for the first time at the facility on May 1, 2001. It was the consensus of the staff involved at this regional corporate level as well that the Advance Directive, applied literally, would prevent the feeding. Ms. XXXXXX testified that she urged the Appellant's staff at the local level to "establish a dialogue" with the family. She also testified, however, that the legal advisor to the PCAC felt that the health care agent, the son, "had broad powers." She wanted the family to have an opportunity to express the basis for their belief that the Resident had changed her mind. Counsel for the Appellant asked Ms. XXXXXX why it took 12 days to resolve this issue.⁴ Her response was that the family had not cooperated with communications with the committee. Also, the corporate staff members were concerned that the family had threatened to sue the facility if the sustenance were withheld. Test. XXXXXX.

After May 1, tube feeding was not stopped. On May 2, Ms. R was transferred to the hospital and then transferred to another XXXXXX facility, where she died. Moreover, Ms. XXXXXX testified, in answer to my question, that it was a local decision by the Appellant for the facility to continue feeding the Resident. However, she testified that the Medical Director of the facility could have sought to have the attending physician change her order for feeding. The Medical Director, however, never took a direct action to countermand the order, and Ms. XXXXXX testified that such would rarely if ever occur. Test. XXXXXX.

In rebuttal, Mr. Vaughan was recalled to testify for the Department. He testified that the Medical Directors of nursing homes often countermand attending physicians' orders. Test. Vaughan.

In order for me to uphold the decision of the Department to issue the deficiency findings

⁴ In fact, there was no resolution even after 12 days. The Resident was artificially fed until she died.

and the imposition of a civil penalty, I must find that there was a cognizable harm to the Resident, which is recognized as such by the Resident's Bill of Rights or other applicable Maryland statute, and that the harm was caused by actions or inaction by the Appellant. The burden of proof of these matters is on the Department. For the reasons which follow, I hold that the Department has met its burden.

Counsel for the Appellant repeatedly argued that the statutes are vague and that therefore the Department must be acting on behalf of some philosophical principle which allegedly does not bear close examination. Quite to the contrary, I hold that the Department has proved violations of specific provisions of law. In particular, the Statement of Deficiencies cited three specific sections of the State Health Care Regulations.

First, the Statement cites COMAR 10.07.02.07A(2). This provision requires the administrator to be responsible for the implementation and enforcement of all provisions of the Resident's Bill of Rights under COMAR 10.07.09. Accordingly, it was not only proper but also mandatory for the Department to investigate where there was an apparent conflict between the directions of a Resident in her Advance Directive and the actions of the Appellant.

Secondly, the Statement cites COMAR 10.07.09.08C(11), which provides that the Resident has the right to consent to or refuse treatment, including the right to accept or reject artificially administered sustenance in accordance with State law. Counsel for the Appellant argued vociferously that the connection between the "licensure provisions," as he characterized the Resident's Bill of Rights, and the Health Care Decisions Act, enabling and authorizing Advance Directives, must be attenuated. He argued in his opening statement that the Department needed to "build a bridge" between the statutes in order to meet its burden. Yet the bridge is self-evident in the language of the regulation cited when it requires facilities, such as the

Appellant, to permit the Resident to “reject artificially administered sustenance in accordance with State law.” Clearly, the referenced State law is the Health Care Decisions Act.

I also reject counsel’s argument that the language of the Advance Directive is ambiguous. Although the instrument gives extensive powers to the health care agent, his powers are limited not only by the specific language of the Directive but by its very context and existence. If the Resident wished to leave matters to the son’s judgment in every instance she could have provided a much different document. Instead, she executed a document clear on its face that she did not wish to receive ineffective medical intervention or artificial sustenance in the end stage of her life. Yet those were precisely what she did receive through the actions or, in another sense, nonintervention of the Appellant.

Third, the Statement of Deficiencies cites COMAR 10.07.09.08C(3). That section provides that the Resident is entitled to a dignified existence, self-determination, and communication with and access to individuals and services within and outside the nursing home. Yet, as the Statement recites, the nursing home failed to recognize the Resident’s self-determination as communicated by her to individuals and services within and outside the nursing home, and expressed in the only way available to her in advance of her actually being in an end stage condition, namely her Advance Directive.

For much the same reasons, I find that the Department more than adequately justified its finding of an actual harm caused by the Appellant to the Resident by denying her wishes not to receive artificial sustenance, particularly where, as here, her own physicians had stated that tube feeding was likely ineffective. Test. Vaughan. Moreover, the Director of the Office of Health Care Quality was emphatically clear when she called this an egregious violation. Instead of acting on their own best judgment that the Directive required withholding artificial sustenance,

as eventually declared in writing even by their own administrator, the managing authorities at the Appellant nursing home temporized and delayed, refusing to assume their responsibility either to accede to the Resident's wishes or to challenge the Advance Directive in court, as provided by the statute. Instead, they evidently paid the greatest attention to the son's complaints and threats of a lawsuit, which would likely have little merit.⁵ It bears noting here that the statute provides protection from an action against a provider who withholds care in a good faith effort to effectuate an Advance Directive. HG § 5-609. Referral to an advisory body, such as the PCAC here, was simply not an effective measure standing alone, and as such amounted to ignoring the statutory directives in the Health Care Decisions Act.

When the Appellant's counsel asked, "Where is the harm from the delay?," counsel for the Department responded persuasively. Both Mr. Nugent and Ms. Kronmiller stated that the harm lies in a regulated nursing facility choosing not to follow the Resident's Bill of Rights for reasons extraneous to its mandate, and in the possible additional suffering endured by the Resident. Test. Schwartz and Vaughan. In other words, far from a law school exercise in hypotheticals, as argued by the Appellant's counsel, this case involves actions and inaction by the Appellant which denied to the Resident important rights guaranteed by statutes and regulations, and may have caused her actual physical suffering.

The imposition of a \$10,000.00 civil money penalty was thus fully justified by the importance of the deficiency and the failure of the Appellant to take effective action, which was available to prevent the harm.

CONCLUSIONS OF LAW

⁵ The facts in this case are the reverse of those in *Wright*, cited above. Here, the party challenging the directive would have a difficult burden in overcoming the written directive with vague impressions of the Resident's alleged wishes supposedly gathered by the family after the Resident had already been certified as incompetent.

Based upon the foregoing Findings of Fact and Discussion, I conclude, as a matter of law, that the Appellant nursing home ignored the Advance Directive executed by Ms. R, and in doing so caused her harm in fact, and violated and failed to implement the Patient's Bill of Rights. COMAR 10.07.09.08 and COMAR 10.07.09.09. I further conclude that the Department has established that the Appellant has committed a serious violation of the Resident's rights to decide the conditions of her final health care in life and that this was an actual harm to the Resident, and that the Appellant could have taken but failed to take effective action to correct the deficiency, thus warranting a substantial civil money penalty. HG §§ 19-1402, 19-1403, 19-1404. I further conclude that the assessment of a civil money penalty in the amount of \$10,000.00 was authorized under the circumstances of this case. HG § 19-1404.

ORDER

Upon consideration of the foregoing Findings of Fact and Conclusions of Law, I **ORDER** that: The Appellant pay a civil money penalty of \$10,000.00, and provide a plan of correction as directed by the Secretary.

February 25, 2002
Date

Alan B. Jacobson
Administrative Law Judge

ABJ/db
#39508

