Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Appellate Division

In the Case of:	DATE: June 2, 2008
Sheridan Health Care Center,	
Petitioner,	Civil Remedies CR1641
	App. Div. Docket No. A-08-18
- v. -	
	Decision No. 2178
Centers for Medicare & Medicaid Services.	

FINAL DECISION ON REVIEW OF ADMINISTRATIVE LAW JUDGE DECISION

The Centers for Medicare & Medicaid Services (CMS) requested review of the decision of Administrative Law Judge (ALJ) Richard J. Smith in Sheridan Health Care Center, DAB CR1641 (2007) (ALJ Decision). Sheridan Health Care Center (Sheridan) is a skilled nursing facility located in Zion, Illinois. The ALJ Decision reversed the determination by CMS to impose on Sheridan a civil money penalty (CMP) of $3,050 per day from February 3, 2004 through February 10, 2004 and a CMP of $200 per day from February 11, 2004 through February 26, 2004. The CMS determination was based on survey findings made by the Illinois Department of Public Health (State agency). The ALJ concluded that Sheridan was in substantial compliance with the Medicare and Medicaid program participation requirements throughout the period at issue and that CMS was not authorized to impose remedies on Sheridan.

For the reasons detailed below, we reverse the ALJ Decision. First, we address CMS's argument that the ALJ erred in concluding that Sheridan was "in substantial compliance with program participation requirements at all relevant times" (ALJ Decision at 1) because he failed to consider the fact that Sheridan had stipulated to some of the noncompliance findings, as well as some

of the findings regarding individual residents used to support other noncompliance findings. We conclude that the ALJ's overall conclusion that Sheridan was in substantial compliance with the program participation regulations and his enumerated findings of fact and conclusions of law (FFCLs) are irreconcilable with Sheridan's own admissions and, consequently, erroneous as a matter of law.

We then address CMS's assertion that the ALJ erred in reversing the February 2004 survey finding of noncompliance with the general quality of care requirement at 42 C.F.R. § 483.25, which Sheridan challenged at the hearing.[1] We conclude that the ALJ applied the wrong legal standard, disregarded material undisputed facts, and made findings of fact that are not supported by substantial evidence on the record or that are irrelevant under the applicable requirements. Since we conclude that Sheridan was not in substantial compliance with the quality of care requirement of section 483.25, we then address CMS's determination that Sheridan's noncompliance posed immediate jeopardy to residents from February 3, 2004 through February 10, 2004. We conclude that Sheridan did not prove that the immediate jeopardy determination was clearly erroneous. We also uphold CMS's determination of the duration of the immediate jeopardy period. Finally, we conclude that the amount of the immediate jeopardy CMP was reasonable as a matter of law.

Sheridan's failure to comply substantially with the general requirement of section 483.25 was the only deficiency CMS cited at the immediate jeopardy level. In addition, Sheridan did not contest the CMP of $200 per day for the period from February 11, 2004 through February 26, 2004 relating to the other noncompliance findings. Therefore, we do not separately address FFCLs 2 and 3 of the ALJ Decision, in which the ALJ reversed the noncompliance findings involving the nutrition and hydration requirements at 42 C.F.R. § 483.25(i)(1) and 483.25(j). We summarily vacate those FFCLs and affirm the $200 per day CMP for the February 11, 2004 through February 26, 2004 period.

Accordingly, we vacate all of the ALJ's FFCLs and substitute FFCLs of our own that uphold CMS's determination.

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[1] All citations to the Code of Federal Regulations in this decision refer to the October 1, 2003 revision of the regulations unless indicated otherwise.

Standard of Review

Our standard of review on a disputed conclusion of law is whether the ALJ decision is erroneous. Our standard of review on a disputed finding of fact is whether the ALJ Decision is supported by substantial evidence on the record as a whole. Guidelines for Appellate Review of Decisions of Administrative Law Judges Affecting a Provider's Participation in the Medicare and Medicaid Programs, http://www.hhs.gov/dab/guidelines/prov.html; see also Batavia Nursing & Convalescent Inn, DAB No. 1911, at 7 (2004), aff'd, Batavia Nursing & Convalescent Ctr. v. Thompson, 143 Fed.Appx. 664 (6th Cir. 2005).

Discussion

I. The ALJ erred in concluding generally that Sheridan was in substantial compliance with the program participation requirements during the relevant time period and that CMS had no basis to impose CMPs.

In its request for review, CMS alleges that the FFCLs and the general conclusion in the ALJ Decision that Sheridan was in substantial compliance with the federal regulations governing participation in the Medicare and Medicaid programs and that CMS was not authorized to impose remedies against Sheridan are erroneous because they "effectively reversed" the noncompliance findings that Sheridan did not challenge at the ALJ hearing. CMS Br. at 56. CMS submits that the ALJ erred in denying CMS's September 19, 2007 motion to reopen the ALJ Decision to address this issue.

We agree. The noncompliance findings cited in CMS's April 23, 2004 determination were based on two surveys conducted by the State agency. The first survey was completed on January 29, 2004 (January survey), and the second survey was completed on February 26, 2004 (February survey). By letters dated April 29, 2004 and May 3, 2004, Sheridan appealed all of the deficiencies referenced in, and penalties imposed under, the CMS determination. Prior to the ALJ hearing, Sheridan and CMS entered into a stipulation, dated January 4, 2005, stating that Sheridan would challenge only the alleged findings of the February survey involving a facility resident who was identified for purposes of that survey as Resident 2 (R2). Sheridan stated that it would not challenge the deficiency findings of the January survey, nor the findings of the February survey involving three other residents (R1, R3 and R4).

The findings to which Sheridan admitted may be summarized as follows:

- January Survey Tag F309, Scope and Severity Level D: Sheridan did not contest that it was not in substantial compliance with the quality of care requirement at 42 C.F.R. § 483.25, 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, as evidenced by:

    - Failure to supervise a cognitively impaired resident who received self-inflicted injuries to his scrotum.

    - Failure to assess the potential for self-injury related to the resident's almost constant sexual behaviors.

    - Failure to care plan for those behaviors to prevent injury.

- January Survey Tag F494, Scope and Severity Level E: Sheridan did not contest that it was not in substantial compliance with 42 C.F.R. § 483.75(e)(2)-(3) because it failed to ensure that individuals working in the facility as nurse aides on a full-time basis had completed or were enrolled in a nurse aide training and competency evaluation program.

- February Survey Tag F325, Scope and Severity Level G: Sheridan did not contest the following findings relevant to Sheridan's compliance with 42 C.F.R. § 483.25(i)(1) (based on a resident's comprehensive assessment, the facility must ensure that a resident maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible):

    - Failure to identify, notify the physician and initiate an intervention when R3 had a significant weight loss in December 2003.

    - Failure to immediately notify the physician of R3's significant weight loss in February 2004 and failure

to initiate a care plan and interventions in a timely manner.

- Failure to develop an interim nutrition care plan for a new resident (R4) with an admit body mass index (BMI) of 13.5 and failure to provide dietary supplements and double portions per physician's order.

- Failure to initiate an intervention and have R1 re-assessed by a Registered Dietitian when his BMI fell below 19.

- Failure to have a care plan in place to address R1's low food intake, low BMI and risk for unintended weight loss.

- February Survey Tag F327, Scope and Severity Level G: Sheridan did not contest the following findings relevant to Sheridan's compliance with 42 C.F.R. § 483.25(j) (that the facility must provide each resident with sufficient fluid intake to maintain proper hydration and health):

  - Failure to have a plan in place to assure that R1, who was at risk for dehydration, received the amount of fluid needed to maintain hydration and to prevent dehydration.

- February Survey Tag F366, Scope and Severity Level D: Sheridan did not contest that it was not in substantial compliance with the dietary services requirement at 42 C.F.R. § 483.35(d)(4), that each resident receives and the facility provides substitutes offered of similar nutritive value to residents who refuse food served, as evidenced by:

  - Failure to offer a substitute to R1 who was at risk for unintended weight loss.

CMS Exs. 1, 7; Petitioner (P.) Ex. 19.

Although the ALJ Decision acknowledges the parties' January 4, 2005 stipulation, neither the overall conclusion nor the FFCLs limit the scope of the decision to the findings cited in the February survey statement of deficiencies (SOD) involving R2. ALJ Decision at 2. Rather, as noted above, the ALJ concluded that Sheridan "was in substantial compliance with program

participation requirements at all relevant times, and . . . [CMS] is not authorized to impose remedies against Petitioner." ALJ Decision at 1. In addition, the FFCLs read:

> 1. Petitioner was in substantial compliance with the participation requirement at 42 C.F.R. § 483.25 (Tag F309).
>
> 2. Petitioner was in substantial compliance with the participation requirement at 42 C.F.R. § 483.25(i)(1) (Tag F325).
>
> 3. Petitioner was in substantial compliance with the participation requirement at 42 C.F.R. § 483.25(j) (Tag F327).
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> 4. There is no basis for CMS to impose the CMPs it assessed.

CMS is authorized to impose remedies if a skilled nursing facility is not in "substantial compliance" with one or more participation requirements. 42 C.F.R. §§ 488.404, 488.406, 488.408, and 488.440. A facility is not in substantial compliance if it has one or more deficiencies that create the potential for more than minimal harm. 42 C.F.R. § 488.301. "Noncompliance" means "any deficiency that causes a facility to not be in substantial compliance." Id. CMS may impose a CMP for "either the number of days [the] facility is not in substantial compliance" (a per day CMP), or "for each instance that [the] facility is not in substantial compliance" (a per instance CMP). 42 C.F.R. § 488.430(a). If a per day CMP is imposed for noncompliance at the immediate jeopardy level, the CMP must be in the range of $3,050 to $10,000. 42 C.F.R. § 488.438(a)(i). If the noncompliance is less serious, the per day CMP must be set within the lower range of $50 to $3,000. 42 C.F.R. § 488.438(a)(ii). Under 42 C.F.R. § 488.454(a), a per day CMP continues to accrue until "[t]he facility has achieved substantial compliance, as determined by CMS or the State based upon a revisit or after an examination of credible written evidence that it can verify without an on-site visit."

Recognizing the survey findings that Sheridan did not contest, we conclude that the FFCLs in the ALJ Decision and the ALJ's overall conclusion that Sheridan was in substantial compliance with program requirements "at all relevant times" are clearly erroneous. Sheridan admittedly was not in substantial compliance, albeit at less than the immediate jeopardy level of scope and severity, with several requirements. Most notably,

Sheridan did not contest the finding, based on the January 2004 survey, that it was not in substantial compliance with the quality of care requirements at section 483.25 in that it failed to supervise, assess, and sufficiently care plan to prevent self injury by a cognitively impaired resident. Thus, even if we were to uphold the ALJ's determination that Sheridan was not deficient in providing care and services to R2 as found in the February 2004 survey (which, for the reasons discussed below, we do not), we could not reasonably conclude that Sheridan was in substantial compliance with all of the participation requirements at all relevant times. Accordingly, we find that the ALJ also erred in deciding that "CMS was not authorized to impose remedies against Petitioner." ALJ Decision at 1.

Sheridan argues that the ALJ did not err because the survey findings relating to residents other than R2 were not appealed or before the ALJ, as stipulated by the parties. P. Resp. Br. at 81. Sheridan also contends that the matter is now moot because Sheridan has already paid $4,800 in CMPs to CMS for the period from February 3, 2004 through February 26, 2004. Id. at 82. Sheridan says that the $4,800, which CMS calculated after the ALJ Decision was issued, in part represents a reduction of the penalty for the period beginning February 3, 2004 through February 10, 2004 from $3,050 per day (the immediate jeopardy level penalty that CMS had imposed based on the first finding of noncompliance involving R2) to $200 per day (the penalty amount for the non-immediate jeopardy level deficiencies that Sheridan did not contest). Id.

Sheridan's arguments are unavailing. CMS's April 23, 2004 determination imposing the CMPs was appealed by Sheridan, which subsequently stipulated that it would contest only those findings involving R2. Consequently, the evidentiary hearing scheduled by the ALJ involved only issues related to R2. That Sheridan paid a $200 per day CMP for the entire period based on its stipulations does not, however, correct for the ALJ's error in failing to account for Sheridan's admissions in his overall conclusion and FFCLs, which are erroneous.

II. The ALJ erred in concluding that Sheridan was in substantial compliance with the general quality of care requirement at 42 C.F.R. § 483.25 with respect to the care and services provided to R2.

CMS argues that the ALJ's determination that Sheridan was in substantial compliance with section 483.25 of the regulations with respect to the care and services furnished to R2 is not

supported by substantial evidence in the record and is contrary to law.

To address CMS's argument, we begin by setting out the relevant undisputed facts relating to R2. We then summarize the ALJ Decision regarding this matter. Next, we provide background on the quality of care regulation. Then, applying the relevant legal standards to the facts in the record, we discuss the bases of our conclusion that the ALJ erred in finding Sheridan to have been in substantial compliance with section 483.25 in the care it provided to R2. Specifically, we find that Sheridan did not provide R2 with the following care and services consistent with R2's assessment and plan of care, its own policies, and professional standards of care: A) Sheridan was required to notify R2's physician of R2's weight loss in January 2004 but did not do so; B) Sheridan failed to adequately monitor and document R2's food intake; C) Sheridan failed to timely and adequately document R2's condition and the care and services that were provided to him; and D) Sheridan's plans of care for R2 did not adequately address his needs. In our analysis, we describe the instances wherein the ALJ misapplied the legal standards of the regulation, misconstruing the relevance of facility policy, the specific requirements of R2's care plans and professional standards of quality care. We also discuss how, in some instances, the ALJ did not take into account all undisputed material facts, and in other instances, made factual findings either not supported by substantial evidence on the record or irrelevant under the applicable regulatory standards.

A. Summary of Undisputed Facts

We provide here a summary of the undisputed facts relevant to our conclusions, drawn from the ALJ Decision and documents in the record on which both parties rely. We leave for our analysis below the discussion of those relevant factual issues that are still in dispute on appeal.

• R2 was a 52-year old male with a diagnosis of schizophrenia and blindness who had resided at Sheridan since August 31, 1998. CMS Ex. 55; CMS Ex. 65, at 8.

• R2 died on February 3, 2004. CMS Ex. 124. According to R2's medical certificate of death, the immediate cause of R2's death was respiratory arrest, and the conditions that gave rise to that

cause were cachexia[2] and dehydration. CMS Exs. 124. According to R2's attending physician, the cause of R2's death was respiratory failure secondary to cachexia and malnutrition. CMS Ex. 50, at 27; see also ALJ Decision at 5; CMS Ex. 73, at 7, 32.[3]

• An August 28, 1999 nutrition therapy note on R2 made by the Registered Dietitian states: "Appetite is generally good although he states he has to 'fast' at times and that is when he does not eat." P. Ex. 12, at 1; CMS Ex. 67, at 3.

• A February 5, 2000 nutrition therapy note by the Registered Dietitian states: "Resident will state he is 'fasting' on occasion – refuses to be on meal monitoring, refused to discuss appetite. No new nutritional labs. Continue plan of care as outlined by CDM. Monitor wt closely for further wt loss." CMS Ex. 67, at 3. The Registered Dietitian noted that R2's weight in January 2000 was 140 pounds. Id.

• Beginning in October 2000, R2 refused to take any medication to treat his schizophrenia. P. Ex. 10, at 6.

• The last time that R2 was seen by a registered dietitian and provided with recommendations of a registered dietitian was in December 2002. CMS Ex. 67, at 4; Tr. at 52.

• Sheridan's August 15, 2003 nutritional assessment on R2 by Sheridan's Dietary Manager assessed R2's overall risk relating to nutrition to be "high" based on R2's: weight changes; oral/nutritional intake of 26-75% of planned meals; BMI below 19; uncontrolled diseases/conditions of blindness and residual type schizophrenia; and required supervision while eating due to physical and mental functioning. CMS Ex. 67, at 1.

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[2] "Cachexia" is physical wasting or "accelerated loss of skeletal muscle tissue . . . brought on by an inflammatory response in the body that causes the body to use skeletal muscle and other muscle and organs in the body to provide energy." Tr. at 41.

[3] Sheridan acknowledges the death certificate's listings of the causes of R2's death, but notes that Sheridan's Medical Director, Dr. Monahan, testified that R2 most likely died of sepsis related to an intra-abdominal catastrophe. P. Resp. Br. at 17, n.6, citing CMS Ex. 124, Tr. at 314, 337, 344-45. Sheridan does not, however, argue that the ALJ's finding that R2 died of respiratory failure secondary to chachexia and malnutrition is not supported by substantial evidence on the record. ALJ Decision at 5.

• R2 was last seen by his psychiatrist, Dr. Baker, in October 2003. At that time Dr. Baker wrote in R2's chart: “Alert high & continues to do well. Denies any problems.” CMS Ex. 63, at 2.

• According to R2's assessment dated December 2, 2003, R2's cognitive skills for daily decision-making were “moderately impaired; his decisions were poor and he required cues and supervision.” CMS Ex. 64, at 2.

• A December 2, 2003 addition to the plan of care for R2 identified the following “Problems/Needs/Strengths:”

A) Below I[deal] B[ody] W[eight] R-Has never been heavy always been worried about wt.
B) BMI<19
C) Refuses to eat at times
D) Refuses to eat sweets or fruits

CMS Ex. 58, at 7.

• R2's December 2, 2003 plan of care set forth the following interventions and services to be provided to R2 to meet the goals that he “eat at least 75% of meals” and “increase BMI to help with prevention of health problems” by March 2, 2004:

Approaches	IDT
a) D. M. provide quarterly nutritional note	D[ietary] M[anager]
b) R. D. provide yearly and/or PRN recommendations	R[egistered] D[ietician]
c) Monitor and encourage oral intake	Nurs
d) Provide tray set-up	Diet/Nurs
e) Monitor monthly wts	Nurs/Diet
f) Weigh as ordered	Nurs
g) Inform M.D. of abnormal lab results–any problems	Nurs
h) Encourage H2O-Provide extra fluids mealtimes-Groups-1 to 1's	All Staff
i) Provide diet Regular-High protein-Double portions whole milk Q meal	Dietary
j) Provide substitutes food dislikes as requested	Nurs/Diet
k) Inform nurse if doesn’t eat	Aide

CMS Ex. 58, at 7; Tr. at 52.

• R2's treating physician, Dr. Suescun, last saw R2 on December 12, 2003. CMS Ex. 63, at 1. Dr. Suescun noted at that time that R2 had no new complaints and was "cooperative to talk . . . ." Id.

• R2's ideal body weight was 172 pounds, with a range of 155-189 pounds. At the beginning of January 2004, R2 weighed 128 pounds. CMS Exs. 67 and 69, at 2; Tr. at 45.

• A nursing note dated January 24, 2004, states in part that at 1:30, R2 "[a]sked staff to help him find his coffee maker wanting to use it," and that the nurse refused the request, explaining "it would be unsafe." CMS Ex. 60, at 8. The next nursing note, made at 6:45 on the same day, states that R2 told a nurse that "he's not feeling good and needs to see a doctor." Id. When asked why, R2 "said he's afraid of something but didn't know what." Id. R2 allowed the nurse to take his vital signs; the nurse noted R2 "to be cold and clammy but not in resp. distress." Id. R2 then asked the nurse for "a dollar [for] a pop/soda . . . and was refused." After the nurse told R2 to stay on the floor and not to go outside so that he could be monitored, R2 replied, "I'm independent and I can do what I want . . . I'm feeling better anyway." Id. The last part of the entry reads: "Will endorse to next shift nurse." Id.

• On the evening of February 2, 2004, R2 requested Tylenol from a nurse but refused it when it was brought to him in applesauce. CMS Ex. 50, at 10; Tr. at 29-30.

• There are no contemporaneous nursing notes on R2 from January 25, 2004 until February 3, 2004, the date of R2's transfer and death. CMS Ex. 60; see also ALJ Decision at 7, citing CMS Ex. 7, at 3.

• There are no entries about R2 in Sheridan's 24-hour nursing log from January 19, 2004 through February 2, 2004. CMS Ex. 50, at 2; Tr. at 61-62.

• There are several "late entry" notes that were written by Sheridan staff on February 4, 2004, the day after R2 died, to document events that occurred on January 27 and 30, 2004. CMS Ex. 60, at 9-11; CMS Ex. 7, at 3.

• When he was weighed on January 27 or 28, 2004, R2's weight was 115 pounds. CMS Ex. 7, at 6; Tr. at 40. R2 had lost 13 pounds since the beginning of the month, a loss of more than 10% of his

body weight in less than 30 days. A revised plan of care for R2 dated January 28, 2004, identified the "recent weight loss of 13 pounds" as a problem and noted that R2 "frequently refuse[s] meals - states he is 'fasting' due to religious beliefs - displays delusional behavior about religion." CMS Ex. 58, at 3; see also CMS Ex. 50, at 7; CMS Ex. 69, at 2.

• The January 28, 2004 addition to the plan of care for R2 listed the following interventions to address the targeted goal that "[r]esident will show no further weight loss:"

1) provide diet as ordered
2) encourage resident to eat at least 75% of meals
3) provide 1:1 intervention and counseling
4) notify MD of further wt loss
5) monitor weight weekly

CMS Ex. 58, at 3.

• Sheridan used meal monitoring logs designed to show what percentage of the food and fluids provided at each meal a resident had consumed. CMS Ex. 70. The logs that Sheridan provided for R2 cover the periods August 2003 through November 2003, and January 2004 through February 3, 2004. Id. Sheridan was unable to locate and provide the log for December 2003. Tr. at 48.

• R2's physician, Dr. Suescun, was first notified of R2's January 2004, 13-pound weight loss on February 3, 2004, the day R2 was transferred to the hospital and died. ALJ Decision at 8, citing CMS Ex. 7, at 11. Dr. Suescun stated in an interview with one of the State agency surveyors that he told the facility that they should have notified him of R2's condition. CMS Ex. 50 at 27-28; Tr. at 65-66.

B. Summary of the ALJ's determination that Sheridan was in substantial compliance with 42 C.F.R. § 483.25 with respect to the care and services provided to R2

The ALJ found that Sheridan provided the requisite care and services to R2 under section 483.25 of the regulations "within [the] context" of R2's regular resistance to, and refusal of, care and assistance, his history of weight fluctuations and his history of fasting "on a rather consistent basis in the exercise of his religious beliefs." ALJ Decision at 9, 27. The ALJ rejected CMS's arguments that there were significant changes in R2's weight, behavior and appearance in January 2004 and that

Sheridan was required to notify R2's physician of these changes. With respect to R2's weight, the ALJ found that it "fluctuated broadly" and "trended downward" over the course of R2's residence at Sheridan. Id. at 12, 27. R2's physician, the ALJ inferred, was aware of these fluctuations since he initialed the entries on the sheet recording R2's weights. Id. at 27. The ALJ further found that Sheridan was not deficient in documenting R2's condition, assessing and developing care plans for R2, and implementing those care plans. Id. at 20-24. In addition, the ALJ concluded that Sheridan sufficiently documented and monitored R2's food intake "given the difficulties that R2's resistance and eating habits presented." Id. at 23. The ALJ concluded that "the overall picture of the care that [Sheridan] gave to R2 is that of an attentive, not an indifferent, facility." Id. at 29.

C. The quality of care requirements of 42 C.F.R. § 483.25

The opening provision of 42 C.F.R. § 483.25, which implements sections 1819(b)(2) (Medicare) and 1919(b)(2) (Medicaid) of the Social Security Act,[4] states:

> 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.

Following the lead-in language, the subsections of the regulation set forth specific requirements relating to particular types of care, services and resident needs.

Based on the legislative history and the implementing regulations and their history, the Board has previously stated that the quality of care requirement is "based on the premise that the facility has (or can contract for) the expertise to first assess what each resident's needs are (in order to attain or maintain the resident's highest practicable functional level) and then to plan for and provide care and services to meet the goal." Spring Meadows Health Care Ctr., DAB No. 1966, at 16 (2005). The Board

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[4] The current version of the Social Security Act can be found at www.ssa.gov/OP_Home/ssact/comp-ssa.htm. Each section of the Act on that website contains a reference to the corresponding United States Code chapter and section. Also, a cross reference table for the Act and the United States Code can be found at 42 U.S.C.A. Ch. 7, Disp Table.

explained that the wording of the provision "reflect[s] an approach that emphasizes resident care outcomes, rather than procedural and structural requirements." Id. The regulation thus "imposes on facilities an affirmative duty designed to achieve favorable outcomes to the highest practicable degree." Windsor Health Care Center, DAB No. 1902, at 16-17 (2003), citing Woodstock Care Center, DAB No. 1726, at 3-4 (2000), *aff'd*, Woodstock Care Ctr. v. Thompson, 363 F.3d 583 (6th Cir. 2003); 42 C.F.R. §§ 488.26(c)(2)(resident outcome as determinant of compliance), 488.110 (survey process emphasizes resident outcomes). As the Board has previously observed, the requirement is designed "to focus on evaluating actual facility performance in meeting the purposes of the program and to move away from simply imposing checklists of capacities and services that must be available." Koester Pavilion, DAB No. 1750, at 25-26 (2000), citing Woodstock, DAB No. 1726, at 28-29.

While the regulation emphasizes resident outcome as a measure of compliance, CMS acknowledged in the 1989 preamble to the final rule "that a facility cannot ensure that the treatment and services will result in a positive outcome since outcomes can depend on many factors, including a resident's cooperation (i.e., the right to refuse treatment), and disease processes." 54 Fed. Reg. 5316, 5332 (1989). Nevertheless, the preamble states, "we believe that it is reasonable to require the facility to ensure that 'treatment and services' are provided, since the basic purpose for residents being in the facility is for 'treatment and services' and that is why the Medicare or Medicaid program makes payment on the residents' behalf." Id. Moreover, CMS explained, "it is reasonable to require the facility to ensure that the resident does not deteriorate within the confines of a resident's right to refuse treatment and within the confines of recognized pathology and the normal aging process." Id. Hence, the regulation "permit[s] the facility to direct surveyor attention to any evidence . . . to show that a negative resident care outcome was unavoidable." Id. In sum, while the regulatory standard does not impose strict liability or "make facilities unconditional guarantors of favorable outcomes," it does "impose an affirmative duty to provide services . . . designed to achieve those outcomes to the highest practicable degree." Woodstock, DAB No. 1726, at 25. The facility must take "reasonable steps" and "practicable measures to achieve that regulatory end." Clermont Nursing & Convalescent Ctr., DAB No. 1923, at 21 (2004), *aff'd* Clermont Nursing & Convalescent Ctr. v. Leavitt, 142 Fed. App. 900 (6th Cir. 2005), citing Josephine Sunset Home, DAB No. 1908, at 14 (2004); Windsor at 5 (2003).

The plain language of section 483.25 also requires that the services provided to a resident must "be in accordance with" the resident's "comprehensive assessment and plan of care." See, e.g., Coquina Center, DAB No. 1860 (2002) (upholding deficiency findings where a facility failed to follow steps in a plan of care that were directed at preventing accidents); Act §§ 1919(b)(2)-(3). The comprehensive care plan "describes the medical, nursing, and psychosocial needs of the resident" and "includes measurable objectives and timetables to meet a resident's . . . needs that are identified in the comprehensive assessment." Act §§ 1919(b)(2)(A), 1919(b)(2)(B); 42 C.F.R. § 483.20(k). A resident's comprehensive care plan must also specify the services to be furnished under section 483.25 and "any services that would otherwise be required under § 483.25 but are not provided due to the resident's exercise of rights . . . , including the right to refuse treatment under § 483.10(b)(4)." 42 C.F.R. § 483.20(k)(1).

The Board also has held that the quality of care regulation implicitly imposes on facilities a duty to provide care and services that, at a minimum, meet accepted professional standards of quality "since the regulations elsewhere require that the services provided or arranged by the facility must meet such standards." Spring Meadows at 17, citing 42 C.F.R. § 483.75; see also Omni Manor Nursing Home, DAB No. 1920 (2004) (holding that an accepted standard of clinical practice need not be specified in a regulation before it may be considered by an ALJ in assessing whether the skilled nursing facility was compliant).

In addition to evaluating a facility's compliance with the quality of care provision based on a resident's plan of care and evidence establishing general standards of professional quality, the Board has considered whether a facility has provided care and services consistent with the facility's own policies. The Board has held that CMS may reasonably rely on a facility policy as evidence of the provider's own judgment as to what must be done to attain or maintain its residents' highest practicable physical, mental, and psychosocial well-being, as required by section 483.25. For example, the Board has determined that a facility's "failure to follow its policy and the recommendations of its dietitian could support a prima facie showing of a violation of the regulation since one could reasonably infer that the policy and recommendations reflect[ed] the [facility]'s determinations of what care and services were necessary to permit the resident to attain or maintain the highest practicable physical, mental, and psychosocial well-being. . . ." Woodland Village Nursing Center, DAB No. 2053 (2006), citing Spring Meadows.

D. Findings and conclusions related to 42 C.F.R. § 483.25

1. CMS properly relied on the introductory language of 42 C.F.R. § 483.25 to support deficiency findings.

Sheridan argued in its briefs to the ALJ that CMS should not be able to rely on the introductory language of section 483.25 to support a deficiency finding (P. Post-hearing Br. at 61-62). Sheridan based its argument on the principle of statutory construction, expressio unius est exclusio alterius (the expression of one thing is the exclusion of another). Sheridan contended that, since the subsections of the regulation set forth the services that a facility must provide under the quality of care provision, CMS should not be permitted to use the "general introductory paragraph" of the regulation to require any other services. Id.

The Board has, however, previously determined that a facility may be found deficient under section 483.25 based on the lead-in language alone. That language sets out the overarching requirement and congressional mandate of the quality of care provision. As reflected in CMS's State Operations Manual (SOM), CMS "has long treated the lead-in language as a requirement that could be cited even if the more specific requirements in the subsections were met, thus recognizing that limiting application of the section to those narrow instances would not meet congressional intent regarding facility quality of care." Spring Meadows at 19. Accordingly, the SOM directs surveyors to use tag number F309 – the number separately assigned to the lead-in language of the regulation – in instances of deficiencies not specifically covered by the subsections of the regulation. SOM, App. PP (Guidance to Surveyors for Long-Term Care Facilities).

Further, the overarching requirement of the quality of care regulation "encompasses (and prefaces) [the] other, more specific quality requirements," set forth in the subsections of the regulation. Lake Park Nursing and Rehabilitation Center, DAB No. 2035, at 6, n.1 (2006). Thus, "citing a deficiency under the general lead-in language of this section [is] particularly appropriate where [a facility's] failure to meet the needs of the resident in question cut across more than one specialized need category." Lakeridge Villa Health Care Center, DAB No. 1988, at 22-23 (2005), aff'd, 202 Fed. Appx. 903 (6th Cir. 2006).

2. The ALJ erred in concluding that Sheridan was not required to notify R2's physician of R2's weight loss in January 2004.[5]

CMS argues, among other things, that the ALJ erred in failing to find that R2 experienced a significant weight loss in January 2004 and that Sheridan should have notified R2's physician of this change. CMS contends that the ALJ based his conclusion that R2's January 2004 weight loss was consistent with R2's history of broad weight fluctuations on an incorrect factual premise regarding R2's weight in October and November 2003. CMS also contends that Sheridan had a duty to notify the physician even if the changes in R2's condition were attributable to his fasting behavior, and even if that behavior constituted a legitimate, protected religious practice, as the ALJ concluded.

As a preliminary matter, we find that the ALJ's conclusion that R2 had a history of broad weight fluctuations of which his attending physician was aware is, in part, based on a factual error. To support his conclusion about R2's history, the ALJ set forth R2's weights between August 1998 and February 2004, as recorded on R2's monthly weight and vital chart and reflected in nutritional progress notes. ALJ Decision at 13-16, 27, citing CMS Exs. 67, 69; P. Exs. 12, 13. According to the ALJ Decision, the broadest short term fluctuation in R2's weight before 2004 occurred in the last quarter of 2003. According to the ALJ, R2 lost 15 pounds between the beginning of October 2003 (when he weighed 128 pounds) and the beginning of November 2003 (when he weighed 113 pounds); R2 then gained 14 pounds the subsequent month, weighing 127 pounds at the beginning of December 2003. Id. The ALJ Decision suggests that, since R2 had recently experienced a weight loss comparable to that which he experienced in January 2004, the January 2004 weight loss was not a "significant change." Moreover, the ALJ infers that, since R2's physician had known about the earlier weight fluctuation and had not made new orders to respond to it, Sheridan arguably would not

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[5] The following discussion addresses whether Sheridan was required by section 483.25 to notify R2's physician of R2's condition earlier than February 3, 2004. It does not address whether Sheridan also failed to meet the requirement at 42 C.F.R. § 483.10(b)(11) that a facility must consult with the resident's physician if there is "a significant change in the resident's physical, mental, or psychosocial status" or "a need to alter treatment significantly." Arguably, the record would support such a finding. In view of our conclusions below, however, we do not need to reach this issue.

have had reason to notify the attending physician of R2's January 2004 weight loss any earlier than February 3, 2004.

The ALJ's finding concerning R2's weight fluctuation between October 2003-December 2003, however, is not supported by substantial evidence on the record as a whole, which shows that the November 2003 entry on R2's monthly weight and vital chart of 113 pounds was an error. According to Surveyor Brennan's hearing testimony, Sheridan's care plan coordinator stated that after the inaccurate November 2003 weight was recorded and a new care plan was initiated to address R2's weight loss, Sheridan staff re-weighed R2 and found that he had not, in fact, lost weight. Tr. at 51. Sheridan's Dietary Manager also told the Surveyor that she believed the November entry of 113 pounds was inaccurate. CMS Ex. 50, at 24. The ALJ Decision does not address this uncontradicted testimony, nor did the ALJ make any general finding that Surveyor Brennan was not a credible witness.

Further, as the ALJ Decision notes, next to the November 2003 weight and vital sheet entry of "ll3 lbs" is a hand-written note that states "re-weigh-127," and another part of R2's chart showing his monthly weights contains a hand-written note next to the November 2003 entry of 113 pounds which reads: "triggered a c[are]/p[lan] re-weighed on new scale at 127#." ALJ Decision at 15, n.7, citing CMS Exs. 68, 69; see also Tr. at 57. Inexplicably, however, the ALJ states that, "[n]othing in the records indicates that R2's recorded weight of 113 pounds was incorrect." ALJ Decision at 15, n.7. This statement clearly disregards both the contemporaneous records and the statements to the surveyor which show that the "113" was corrected to "127" after R2 was reweighed. In addition, we note that, had the November 2003 entry of 113 pounds been correct, R2's minimum data set (MDS) assessment form dated December 2, 2003 would have shown that R2 had a weight gain of more than 5% in the past 30 days. Yet, it did not. CMS Ex. 64, at 5.

We also note that Sheridan effectively admitted that R2 did not experience the dramatic weight loss and gain in the fourth quarter of 2003 that the ALJ says took place. The chart of R2's weights that Sheridan submitted in its post-hearing brief shows that R2's weight remained stable at 127-128 pounds between October 2003 and the beginning of January 2004, and that his weight at the beginning of November 2003 was 127 pounds. P. Post-hearing Br. at 14. Moreover, Sheridan does not directly contend on appeal that R2 lost 15 pounds in the month of October 2003 and regained roughly the same amount in the following month.

P. Resp. Br. at 23-25.[6] Rather, Sheridan has acknowledged that prior to January 2004, the greatest weight loss that R2 had experienced in a single month occurred between April and May 2002, when R2's weight dropped from 133 pounds to 125 pounds. P. Resp. Br. at 22-23; P. Ex. 13, at 1; CMS Ex. 69. Also, Sheridan's own Medical Director testified at the hearing that before January 2004 R2 had never experienced a loss of more than 10% of his body weight in a single month. Tr. at 355. In sum, the ALJ erred in disregarding the overwhelming evidence in the record and Sheridan's own admission that R2's weight at the beginning of November 2003 was 127 pounds. The ALJ also failed to recognize that there is no credible evidence that R2 had ever before January 2004 weighed as little as 115 pounds.

Furthermore, we conclude that even if substantial evidence supported the ALJ's finding that R2 had a history of broad weight fluctuations, including losses of more than 10% of his body weight in a single month, that history would not reduce the gravity of R2's precipitous January 2004 weight loss, nor would it diminish the importance of notifying R2's physician of R2's weight loss. As we explain below, such notice was required under R2's comprehensive assessment and plan of care, as well as accepted professional standards. Indeed, given that R2 was already severely underweight at the end of 2003, any further weight loss was cause for serious concern. As Surveyor Brennan testified, at the beginning of January 2004, R2 "was 74% [of] his ideal body weight, which was very significant. It indicated he had very few reserves. And that put him at risk for a lot of health concerns." Tr. at 45-47.

Turning then to the ALJ's analysis of whether, under 42 C.F.R. § 483.25, Sheridan was required to notify R2's attending physician of R2's weight loss in January 2004, we conclude that the ALJ did not apply the regulation's requirement that a skilled nursing facility must provide "necessary care and services . . . in accordance with the [resident's] comprehensive assessment and

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[6] Instead, Sheridan submits in its response brief that the ALJ "carefully noted the data relating to R2's November weight." Also, Sheridan notes, one of the documents cited by the ALJ as showing R2's weight in November 2003 to have been 113 pounds was prepared three months later. P. Resp. Br. at 25, citing CMS Ex. 68. "Presumably," Sheridan contends, "if [the data] was incorrect, it would not have been entered three months later." Id. Such a presumption is unreasonable, however, given that the document itself (as well as other evidence) indicates that the 113 was incorrect.

plan of care." Specifically, the ALJ overlooked the evidence in the record that R2's December 2, 2003 care plan, which was in effect in January 2004 and designed to address R2's low body weight and BMI, expressly provided that Sheridan's nurses were to "inform . . . M.D." of "any problems." CMS Ex. 58, at 7. The contemporaneous record shows that Sheridan's staff identified R2's precipitous weight loss in January 2004 as a "problem" involving R2's nutritional status. The January 28, 2004 care plan listed R2's "recent weight loss of 13 pounds" under the heading "STRENGTH/NEED/PROBLEM." CMS Ex. 58, at 3.

This is not surprising. The CMS minimum data set (MDS), the instrument developed pursuant to sections 1819(b)(3) and 1919(b)(3) of the Act and used for nursing home resident assessment and care screening, provides that a weight change of 5% or more in 30 days triggers the need to develop a care plan to address the resident's nutritional status. CMS Ex. 64, at 5. Further, under the objective standards included in Appendix PP of the SOM, a weight loss of 5% of a resident's body weight in one month is considered "significant," and a weight loss of more than 5% in a single month is considered "severe."[7] Yet, while Sheridan developed a revision to R2's plan on January 28, 2004 to address his weight loss, neither Sheridan nursing staff nor any other Sheridan employee notified Dr. Suescun of R2's January 2004 weight loss before February 3, when R2 was hospitalized and died.

Thus, with respect to the issue of physician notification, we conclude that the ALJ erred in failing to recognize and properly apply in this case the legal standard established under section 483.25 that a skilled nursing facility must provide necessary care and services in accordance with a resident's comprehensive assessment and plan of care.

Furthermore, even if R2's plan of care did not explicitly require Sheridan to notify R2's physician of the problem of R2's weight loss in January 2004, Sheridan had a duty to provide such notice under professional standards of quality nursing care. The record includes testimony and evidence addressing and explaining this professional standard, the relevance of which the ALJ overlooked. Both Surveyor Schubert, a licensed nurse, and Surveyor Brennan, a registered dietician and certified dietary manager, testified that professional standards of care required Sheridan to notify R2's physician of R2's marked weight loss in January. Tr. at 69-

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[7] The SOM, of which SNFs are aware, is available at http://www.cms.hhs.gov/manuals/downloads/som107ap_pp_guidelines ltcf.pdf.

70, 134, 197. For example, Surveyor Schubert testified that, as a nurse, he believed the standard of care requires physician notification of a 10% weight loss in a month of a patient already significantly underweight. Tr. at 197. Surveyor Brennan testified that Sheridan "should have notified the physician . . . of the significant and . . . severe weight loss. [R2's] primary care physician should have been given the opportunity to implement the medical intervention." Tr. at 134. The reason that a facility is required to immediately notify the physician of such a change in condition, she testified, is that, as the individual responsible for dictating the medical care of the patient, the physician must assess and evaluate the patient to determine what medical intervention is appropriate. Tr. at 69. In the case of R2's weight loss, Surveyor Brennan further testified, it was particularly important to notify the physician because R2 "was so under weight to begin with . . . ." Tr. at 69-70. Supporting Surveyor Brennan's testimony, the MDS, as noted above, provides that a "weight loss [of] 5% or more in [the] last 30 days or 10% or more in [the] last 180 days" triggers the requirement for a new assessment and care planning on nutritional status. CMS Ex. 64, at 2, 5. Consistent with the surveyors' testimony, the weight and vital statistics chart that Sheridan used to track R2's weight in fact has a column to indicate whether a resident's physician has been notified of a "weight change," indicating that Sheridan understood that a significant weight change should be communicated to the resident's treating doctor. CMS Ex. 69.

Finally, R2's physician himself told Surveyor Brennan that he should have been notified of R2's significant weight loss prior to February 3, 2004, when R2 was taken to the hospital emergency room and the doctor found R2 "cachectic" and "emaciated." CMS Ex. 50 at 27-28; Tr. at 65-66; CMS Ex. 73, at 6. Indeed, Dr. Suescun told the Surveyor that he was angry that Sheridan had not notified him earlier of R2's condition. Id. We note that in concluding that physician notification was not required under 42 C.F.R. § 483.25, the ALJ appeared to have relied in part on the testimony of Dr. James Monahan, Sheridan's Medical Director. The ALJ described Dr. Monahan's testimony to have been that the doctor "would not have wanted to [have] be[en] notified by staff that R2 had los[t] 10 percent of his body weight even if he was not scheduled to visit R2 for another three weeks." ALJ Decision at 26-27, citing Tr. at 353-355. The ALJ also noted that Dr. Monahan testified that it would have been sufficient for R2's attending physician, who saw R2 approximately every two months, to obtain the weight loss information from the patient's chart when the physician next made regular rounds. Id. The ALJ did not, however, expressly give more weight to Dr. Monahan's

testimony than he did to the evidence and testimony about Dr. Suescun's contrary opinion, nor did the ALJ find the representations of Dr. Suescun's alleged interview statements not to be credible. Rather, the ALJ stated that "[w]hile there are some variances in the statements of Dr. Suescun and Dr. Monahan, I do not believe that they are material, and do not believe that they reduce the value of the statements generally." ALJ Decision at 28.

We note, however, that the ALJ's description of Dr. Monahan's testimony is incomplete. Specifically, while Dr. Monahan initially stated that if he had been R2's attending physician he would not have expected to have been notified of R2's January 2004 weight loss, Dr. Monahan later modified that testimony. He ultimately stated that if he was *not* scheduled to see the patient on routine rounds "in the near future" or in "three and-a-half weeks," he *would* have wanted notification of R2's weight loss before his next routine visit. Tr. at 359.

In any event, the issue of whether professional standards of *nursing* care required Sheridan to have given earlier notice to Dr. Suescun of R2's weight condition is not a question of whether a particular physician would have wanted such notice. Dr. Monahan's testimony, however credible, simply does not contradict CMS's evidence that Sheridan failed to comply with professional standards of quality nursing care involving physician notification.

We also conclude that Sheridan was required under section 483.25 to inform Dr. Suescun of R2's January 2004 weight loss regardless whether R2's fasting behavior was a legitimate exercise of religious belief, as the ALJ determined, or "delusional behavior about religion," as Sheridan's staff appears to have concluded in developing R2's January 28, 2004 care plan (or if, alternatively, R2's refusals to eat many meals in January/February stemmed from an underlying physical illness). ALJ Decision at 16-17, 20; CMS Ex. 58, at 3. As a practical matter, the act of notifying R2's physician of R2's extreme weight loss in January 2004 would not have interfered with R2's religious practices or violated R2's right to refuse medical treatment or food. Rather, the notification would have provided the individual who had primary responsibility for R2's medical care an opportunity to assess R2 (as Dr. Suescun ultimately did on February 3) to "provide input and direction as to the care appropriate under the circumstances," and in R2's case, rule out whether R2's fasting behavior and marked weight loss in January 2004 were associated with or caused by an underlying psychological or physical problem. See Britthaven of Goldsboro, DAB No. 1960, at 11

(2005)(facility failed to comply with physician notification requirement where resident suffered an acute episode of respiratory distress and the physician was not contacted until as much as an hour later, after the resident's acute symptoms had subsided).

Moreover, R2's prior resistance at times to care and assistance does not excuse Sheridan from failing to fulfill its obligation to notify Dr. Suescun of the status of R2's weight in January. Indeed, R2's unusual request on January 24 to be seen by a doctor, and the fact that he allowed his vital signs to be taken at that time,[8] suggest that R2 may have been more receptive to his doctor's intervention at that time than he had been during routine physician visits. CMS Ex. 60, at 8; Tr. at 124-125, 461. There is no evidence that at the times R2 (who was only 52 years old when he died) refused physical examinations in the past, he had either complained of, or showed signs of, being physically ill.

Similarly, there is no legal basis to support the inference in the ALJ Decision that R2's history of weight fluctuations, of which his physician was aware and to which his physician did not respond with new orders for treatment, absolved Sheridan of its duty to notify Dr. Suescun of R2's weight loss in January 2004. Merely because in the past R2's physician may not have given new orders when R2's weight dropped does not mean that the physician did not need to assess R2 at the end of January 2004 to determine whether his unprecedented weight loss and all-time low weight of 115 pounds might be associated with an underlying physical or psychiatric problem. Nor does it necessarily mean that the physician would not have given new orders to address the weight loss. Such orders might have included an order for a psychiatric evaluation "to determine the competence of the patient," which Dr. Suescun in fact made when he saw R2 on February 3, 2004. CMS Ex. 73, at 7. Or, the physician might have included an order for an evaluation by the Registered Dietitian to determine ways to supplement R2's diet in addition to providing double portion

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[8] According to nursing notes, R2's vital signs were unremarkable, but he appeared "cold and clammy." CMW Ex. 60, at 8. Surveyor Schubert testified that these are abnormal symptoms which "can be consistent with hypovolemic shock or cardiogenic shock." Tr. at 235. Surveyor Schubert also testified that when a resident "displays a new symptom, such as cold and clammy skin . . . I would make the physician aware of that." Tr. at 194.

meals, such as with dietary supplements like those ordered for R4. Tr. at 197; CMS Ex. 7, at 24.

Finally, in reaching the conclusion that Sheridan was required to have provided notice to Dr. Suescun of R2's weight loss in January 2004, we recognize that providing such notice might not have ensured a positive outcome for R2 since, as the preamble to section 483.25 acknowledges, outcomes can depend on many factors, including a resident's cooperation and right to refuse treatment. 54 Fed. Reg. 5316, 5332 (1989). Nevertheless, Sheridan had an affirmative duty to take this reasonable, noninvasive step, which its own interdisciplinary team had deemed necessary, as part of the facility's obligation "to provide the necessary care and services to attain or maintain [R2's] highest practicable physical, mental, and psychosocial well-being." The fundamental reason R2 resided at Sheridan was to receive such "treatment and services." Woodstock, DAB No. 1726, at 25.

3. The ALJ erred in concluding that the nutritional assessments and recommendations provided to R2 were sufficient under 42 C.F.R. § 483.25.

CMS argues on appeal that R2's care plan required Sheridan to provide yearly and as-needed recommendations by a registered dietician to address R2's nutritional status. The last time a registered dietician assessed R2 was in December 2002. CMS Ex. 67 at 4; Tr. at 52. Thus, CMS submits, R2 was due for a nutritional assessment and recommendations by a registered dietician in December 2003. Because Sheridan was required to provide this service under R2's care plan, CMS argues, Sheridan's failure to do so constituted "[a]nother independent basis" to find that Sheridan was not in substantial compliance with 42 C.F.R. § 483.25. CMS Br. at 30.

We find merit in this argument and conclude that the ALJ did not apply the correct legal standard to determine whether the nutritional assessments and dietary recommendations Sheridan provided to R2 satisfied the requirements of section 483.25. As discussed above, the plain language of the regulation requires a facility to provide necessary care and services "in accordance with the [resident's] comprehensive assessment and plan of care." In this case, R2's December 2, 2003 plan of care explicitly required a registered dietitian to "provide yearly and/or PRN [as needed] recommendations." CMS Ex. 58, at 7. Since the last time R2 was fully assessed by a registered dietician was in December 2002, Sheridan was required under R2's care plan to provide for such an assessment no later than December 2003. Sheridan did not provide this service, even when R2 was weighed at the end of

January 2004, and found to have lost more than 10% of his body weight in less than 30 days.

Rather than directly addressing whether Sheridan provided services in accordance with the intervention in R2's care plan calling for annual and as-needed registered dietician recommendations, the ALJ found "that the Dietary Manager's August 2003 evaluation was a comprehensive assessment of R2's nutritional status." ALJ Decision at 24, citing CMS Ex. 67, at 1. Further, the ALJ concluded: "While the evidence indicates that R2 was not seen by a registered dietician after December 2002, it is clear that another qualified professional – [Sheridan's] Dietary Manager – was involved in evaluating R2's status," and that the Dietary Manager's "nutritional assessment and progress notes show that [Sheridan's] staff did evaluate R2's nutritional status and was not indifferent to his nutritional needs." ALJ Decision at 26.

By framing the issue as whether Sheridan's staff was "indifferent" to R2's nutritional needs, the ALJ Decision ultimately fails to address the relevant question posed by section 483.25, whether Sheridan in fact provided care and services that were "in accordance with" the intervention for registered dietician services in R2's comprehensive assessment and plan of care. Determining compliance with the quality of care requirement by merely evaluating whether facility staff is "indifferent" to a resident's needs undercuts that requirement. The comprehensive assessment and plan of care reflects the premise of the statute and regulations that to provide "quality" care to meet residents' needs, a facility must have qualified staff from various disciplines evaluate what those needs are and together plan the best way to meet those needs. The plan of care then serves as a roadmap for all of the resident's caregivers, including aides not qualified themselves to decide what a resident needs, as well as staff who may be unfamiliar with a resident, to provide consistent services and care tailored to the resident's actual needs. Tr. at 189-90. Consequently, no matter how caring or attentive staff may be, if the facility has not ensured that they are providing services in accordance with the comprehensive assessment and plan of care, the facility is not providing services that meet the federal standards for quality.

However, even if one read the ALJ Decision to mean that the Dietary Manager's assessments and progress notes were "in accordance with" the comprehensive assessment and plan of care, we find that such a conclusion is not supported by substantial evidence on the record as a whole. At the outset, we note that the interdisciplinary team that developed R2's December 2003 care

plan assigned different responsibilities to the Dietary Manager (provide quarterly nutritional notes) and the Registered Dietician (provide yearly and as needed recommendations), indicating that the services furnished by, and the responsibilities, training and capabilities of, the two types of professionals are not the same. Further, it was Sheridan's own practice that, in addition to the services furnished by the Dietary Manager, a registered dietician was to review each resident's charts at least annually and provide additional services more frequently when needed. Tr. at 422-23.

Surveyor Brennan, who is a licensed registered dietician as well as a certified dietary manager, testified that a comprehensive assessment by a registered dietician would involve: making observations of physical appearance for signs of dehydration and poor nutrition; fully evaluating what the resident was eating and drinking; conducting meal observations; and analyzing laboratory data and calorie requirements. Tr. at 36, 54, 70. If the registered dietician found a problem, Surveyor Brennan testified, he or she would initiate an assessment to identify the resident's risks for weight loss and recommend approaches to prevent weight loss. Id. The dietician would also address the resident's behaviors. Id. According to the Surveyor:

> A registered dietician would do a comprehensive assessment of the resident's nutritional status and would make recommendations for that resident's nutritional status, which may or may not be different from the dietary manager but most likely would.

Tr. at 70.

In addition to R2's care plan and the Surveyor's testimony, a note made by Sheridan's Dietary Manager herself to "[f]ollow any recommendations RD may make," shows that R2 should have received the ordered registered dietician services and that the services furnished by the Dietary Manager were not a sufficient substitute. CMS Ex. 67, at 2. Thus, applying the relevant legal standard to the evidence of record, we conclude that the comprehensive nutritional assessment and recommendations made by Sheridan's Dietary Manager may not be equated with, or deemed to satisfy, the ordered intervention for registered dietician services in R2's plan of care.

Sheridan argues that to find it noncompliant under section 483.25 merely because it missed by two months the requirement in R2's care plan calling for yearly visits by a registered dietician would be relying on a "hyper-technical[ity]" that "provides no

basis to conclude that the resident was not receiving necessary care or services at the highest practicable level." P. Resp. Br. at 39-40. Sheridan also submits that Surveyor Brennan admitted that a full nutritional assessment was done in August 2003, that no regulation specifies how often a nutritional assessment must be done, and that no regulation says that a facility's dietary manager is not a qualified professional to make such assessments. Id. at 39-40. Sheridan also quotes the Sixth Circuit Court of Appeals in Crestview Parke Care Ctr. v. Thompson, 373 F.3d 743, 754 (6th Cir. 2004) as noting "that the use of the word 'practicable' in § 483.25 indicates that a reasonableness standard inheres in the regulation and that a facility may show that there was a justifiable reason for noncompliance with the strictures of § 483.25." P. Resp. Br. at 41.

As the Board has previously stated, a facility's duty under section 483.25 to provide care and services in accordance with the comprehensive assessment and plan of care is based on the premise that the care plan reflects the interdisciplinary team's judgment of the services that a particular resident needs to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Coquina Center at 21, citing Cherrywood Nursing and Living Center, DAB No. 1845, at 8 (2002); Crestview Parke Care Center, DAB No. 1836 (2002); Asbury Center at Johnson City, DAB No. 1815 (2002). In this case, Sheridan's interdisciplinary team determined that R2 required a number of different interventions to respond to his "high risk" nutritional status, including yearly and as-needed recommendations by a registered dietician (as well as the separate intervention by the Dietary Manager to make quarterly notes). Thus, providing the planned services in a timely fashion was not a mere technicality, as Sheridan suggests, particularly in light of the facility's own practices and Sheridan's knowledge at the end of January 2004 that R2, who was already severely underweight at the beginning of the month, had lost an additional 10% of his body weight.

Furthermore, Sheridan neither established that its Dietary Manager was sufficiently qualified to make the recommendations called for in R2's care plan nor offered a justifiable reason to explain why it did not provide the registered dietician services called for under R2's care plan. Under 42 C.F.R. § 483.35, a "qualified dietitian" is "one who is qualified based upon either registration by the Commission on Dietetic Registration of the American Dietetic Association, or on the basis of education, training, or experience in identification of dietary needs, planning, and implementation of dietary programs." See also 56 Fed. Reg. 48,826 (1991)("In keeping with our emphasis on proper outcomes, we decided not to include specific qualifications for

dietetic service supervisor where that individual is other than a dietitian. . . . however, we have strengthened the requirement for consultation where the dietetic service supervisor is not a dietitian."). Sheridan knew that the question whether its dietary manager was qualified to provide the registered dietitian services called for in R2's plan of care was at issue, but provided no evidence to show that she was qualified under the applicable regulatory criteria.[9] We therefore conclude that the ALJ erred in determining that the Dietary Manager was "qualified" to make the nutritional assessment and recommendations. That determination was not based on the standard in the regulation or evidence in the record, but apparently based on the ALJ's own personal opinion.

Sheridan also argues that, "if one is to look to technicalities," the wording of the care plan does not strictly require an annual review by a registered dietitian because it says "provide yearly and/**or** PRN [as needed] recommendations." P. Resp. Br. at 40 n.17, citing CMS Ex. 58, at 7 (emphasis added by Sheridan). Sheridan also submits that since R2's care plan is dated December 2, 2003, the annual review by a registered dietitian would not have been due until December 2, 2004, ten months after R2's death. Id.

These arguments are unavailing. That the notation in R2's care plan meant that a registered dietitian should provide recommendations yearly, at a minimum, and more frequently, as needed, is supported by the testimony of Sheridan's own witness, Mr. Zeller, who said that it was facility practice that a registered dietitian was to review each resident's charts yearly, at a minimum, and provide additional services more frequently when called upon. Tr. at 422-23. Given R2's condition, it is arguable that the care plan required more frequent assessments of R2 than yearly. Further, the time for R2's annual assessment required by the care plan logically ran from the date of his last assessment, not from the date the care plan was drafted.

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[9] As noted above, by its own admission Sheridan also did not provide necessary registered dietitian services to another resident identified in the February survey, R1. Specifically, Sheridan did not contest that it failed to initiate an intervention and have the resident re-assessed by a registered dietitian when his BMI fell below 19 or that it failed to have a care plan in place to address R1's low food intake, low BMI and risk for unintended weight loss as required under the quality of care nutrition requirement at 42 C.F.R. § 483.25(i)(1). CMS Ex. 7, at 14-15.

Sheridan presented no evidence that the care planners for R2 intended the year to run from the care plan date.

Finally, Sheridan has framed this case as one "in which the government, looking backward, contends that a resident should not have been allowed to exercise his religious beliefs . . . ." P. Resp. Br. at 1. Similarly, the ALJ Decision reflects the concern that CMS's arguments may rely on "the benefit of hindsight" and "after-the-fact review." ALJ Decision at 28. Some of CMS's arguments in this case may not fully take into account the difficulties posed in caring for R2, which the record shows were many. But the plan of care is the facility's own judgment of how to address the individual's assessed needs, and Medicare and Medicaid payments are based on the premise that the facility is providing care in response to those assessed needs. Thus, it is not "second-guessing" or relying on hindsight to say that Sheridan should have provided the services that the facility itself identified as necessary to attain or maintain the highest practicable well-being of R2. Moreover, Sheridan provided no evidence to show that implementing fully R2's plan of care would in any way have prevented R2 from exercising his religious beliefs.

Accordingly, we conclude that Sheridan was not in substantial compliance with section 483.25 in that Sheridan was required, but failed, to provide R2 with annual and as needed registered dietitian recommendations in accordance with R2's comprehensive assessment and plan of care.

4. The ALJ erred in concluding that Sheridan sufficiently monitored and documented R2's food intake.

CMS also argues that the ALJ erred in concluding that Sheridan provided the meal monitoring services called for in R2's care plan. CMS points out that "Sheridan admits [its monitoring] was almost wholly ineffective because R2 refused meal monitoring, and because its staff did not attempt to record what R2 ate of the food he took back to his room, in violation of Sheridan's own meal monitoring policy." CMS Br. at 34, citing CMS Ex. 50, at 31, Tr. at 48-49, 53, 163; CMS Ex. 119, at 3. Moreover, CMS argues, Sheridan failed to follow its own policy requiring staff to notify the nurse in charge when a resident ate less than 25% of any meal.

These arguments are well-founded. The ALJ determined that the quality of care standard was met and that Sheridan "monitored R2's food intake to the extent it could." ALJ Decision at 23.

The ALJ largely excused Sheridan from its meal monitoring responsibilities, "given the difficulties that R2's resistance and eating habits presented." Id. In reaching this conclusion, the ALJ disregarded uncontradicted evidence showing that, notwithstanding R2's resistance to monitoring, Sheridan could have taken a number of practicable steps to more effectively monitor R2's food and liquids intake, yet failed to do so. Furthermore, the ALJ erroneously discounted the significance and applicability of Sheridan's own meal monitoring policy.

To address R2's low body weight, low BMI, and history of refusing to eat at times, R2's December 2003 plan of care required Sheridan nursing staff to "monitor and encourage oral intake," and aides to "inform nurse if [R2] doesn't eat." CMS Ex. 58, at 7. In addition, R2's August 15, 2003 nutritional assessment stated that R2 required supervision while eating due to physical and mental functioning. CMS Ex. 67, at 1. These interventions were consistent with Sheridan's facility-wide, written meal monitoring policy, which stated that:

> It is the policy of Sheridan Health & Rehab Center that meal monitoring should be done with every meal. Documentation will include how much the Resident eats and drinks. If it is less than 25 percent of food and fluid intake, it shall be reported to the nurse in charge. All monitoring will be documented on the meal monitoring sheet. All aspects of the meal are to be monitored, including food items taken to the Resident's room.

CMS Ex. 119, at 3 (emphasis added).

In its appeal, Sheridan relied on R2's monthly meal monitoring logs (except the log for December 2003, which Sheridan was unable to locate) to demonstrate that, to the extent practicable, it satisfied its meal monitoring and documenting responsibilities. The ALJ accepted this argument, concluding that, while they might "not give an accurate picture of what R2 was eating," the logs established that Sheridan "documented R2's food intake." ALJ Decision at 23; CMS Ex. 70. The ALJ further noted that Sheridan "appear[ed] to concede that its staff did not follow its meal monitoring policy with respect to R2" but that it did "as best as it could under the circumstances. . . ." ALJ Decision at 23-24, citing P. Br. at 43.

The ALJ did not apply the appropriate regulatory standard in concluding that Sheridan satisfied the quality of care standards in monitoring R2's food and liquids consumption. First, we note

that the instructions on the meal monitoring logs, like R2's care plan and Sheridan's facility-policy, directed staff to "enter [on the forms] % *of intake*." CMS Ex. 70 (emphasis added). That is, the logs were designed to show the percentage of food and liquids at each meal that the resident actually consumed. The testimony and evidence show, however, that R2's forms were filled out based not on what staff observed or knew R2 to have consumed, but based on what was left on R2's meal trays when they were returned to the kitchen. Tr. at 47-49, 163-164. That this method of measuring or monitoring R2's food intake was fundamentally flawed is evident from survey findings that Sheridan did not dispute. Sheridan staff told the surveyors that R2 frequently took his bologna sandwiches, which were the main part of all of his regular lunches and dinners, back to his room, and that staff made no attempts to determine whether R2 in fact ate those sandwiches. CMS Ex. 7, at 5; CMS Ex. 50, at 4; Tr. at 252-253.

Further, the ALJ Decision disregards Surveyor Brennan's testimony that, as a dietitian looking at meal records, she would not consider food taken to a resident's room to have been eaten because the resident might be "throwing it out or stashing it." Tr. at 58. Indeed, one Sheridan staff member told the Surveyor that there were sandwiches piled up in R2's closet. CMS Ex. 50, at 4; Tr. at 58. Under 42 C.F.R. § 483.25, Sheridan was obligated to take reasonable steps to supervise and accurately document R2's food intake, including actions to determine whether R2 consumed the food that he brought back to his room. Taking into account R2's resistance to meal monitoring, those steps, Surveyor Schubert testified, could have included searching the resident's room, looking in drawers and trash cans, searching pockets, and making all staff aware of the need to work together to accurately monitor R2's oral intake. Tr. at 196-197. Sheridan, however, provided no evidence that it even considered taking such steps.[10] Moreover, Sheridan provided no evidence that it actually reviewed or analyzed the information on the logs to assess the sufficiency or insufficiency of R2's intake of food and liquids. In sum, even within the context of R2's resistance to meal monitoring, Sheridan did not take reasonable steps to sufficiently implement R2's plan of care and adequately monitor and document R2's food intake, as required under the regulation.

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[10] While the facility needed to respect R2's privacy, Sheridan did not demonstrate that staff could not have looked in R2's room to find evidence of what he ate when, for example, R2 left his room to go outside to smoke cigarettes.

Even assuming the logs were sufficiently accurate, in any event, the ALJ erred in failing to take into account the planned intervention in R2's December 2003 care plan requiring aides and staff to inform the nurse when R2 refused meals, as well as the facility-wide policy requiring aides to report to the nurse in charge if a resident consumed less than 25% of the food provided at a meal. Like the meal monitoring called for under both R2's care plan and the facility-wide policy, the reporting measure, had it been implemented, would have enabled Sheridan staff and the interdisciplinary team to track the effectiveness of the diet, services and treatment R2 was receiving and to respond timely to R2's eating and fasting behaviors that placed his physical health at risk. Sheridan, however, provided no evidence or testimony to show that aides implemented or were even aware of this policy. Indeed, despite the direction in R2's care plan for nursing staff to "encourage oral intake," one nursing assistant told the Surveyor that, at R2's request, she had written a note, which she showed to other staff, that said R2 could fast a couple of days a week as a religious practice and not to bother him. CMS Ex. 50, at 15.

Finally, we conclude that the ALJ erred in evaluating the significance and applicability of Sheridan's facility-wide meal monitoring policies. The ALJ stated that Sheridan "correctly note[d] that a facility's failure to follow its own policy is not, in and of itself, a deficiency." ALJ Decision at 23, citing Barbourville Nursing Home, DAB CR1135 (2004), aff'd, DAB No. 1962 (2005). The Board, however, has held that, absent contrary evidence, it "is reasonable to presume that [a] facility's policy reflects professional standards of quality." Spring Meadows at 18. In this case, the testimony of the state agency surveyors, described above, in fact confirmed that Sheridan's meal monitoring and documentation policies (including the policy that staff were to report to the charge nurse when a resident ate or drank less than 25% of the food and fluid at a meal, and that "food items taken to the resident's room" should be monitored) were wholly consistent with professional standards of quality. Moreover, the Board has previously held that if a facility adopts a policy it is reasonable to infer that it did so because the policy is necessary to attain or maintain resident well-being. Woodland Village at 9. Thus, Sheridan's failure to provide meal monitoring services in accordance with R2's plan of care, as well as its failure to follow its own meal monitoring policies, constituted a deficiency under section 483.25. See Lakeridge, at 22.

5. The ALJ erred in concluding that Sheridan sufficiently documented R2's status and the care and services provided to him.

CMS also argues that the ALJ Decision does not accurately address Sheridan's failure to "keep adequate nursing notes on R2," and to timely document important events and the status of R2's health. CMS Br. at 29, 39. CMS contends that the ALJ erred in concluding that "some of the entries concerning the incident of January 27, 2004, were late entries." CMS Br. at 29, citing ALJ Decision at 12l. In fact, CMS submits, all of the entries for that day were late. CMS Br. at 29; CMS Ex. 60 at 8-11. Sheridan, CMS further argues, had a duty to assemble and analyze the "warning signs" and available data on R2 so that nursing staff could judge or make "a considered decision whether or not a significant change in R2's condition had occurred." CMS Br. at 28-29, citing IHS of Kansas City at Alpine North, CR1353, at 17 (2005); Tr. at 48; see also CMS Post-hearing Br. at 3, 17-18.

As reflected in Surveyor Schubert's testimony, professional standards of quality nursing care require nursing notes to include nurses' clinical observations of patients and to document the care and services furnished to patients. Tr. at 193. Professional standards of quality also require that notes be timely entered, "preferably at the end of the nurse's shift if at all possible," and generally within a 24-hour period. Id. at 193. The purpose of timely and accurate notes is to communicate "significant patient care issues" not only to all nurses and aides caring for a patient, but also to the professionals (e.g. physicians, dietitians, social workers, and psychologists) who rely on these records to make informed decisions about patient care. Id. at 189, 193. When entries are not timely or simply do not exist, "it makes it very difficult to determine a baseline for the resident and to determine if the resident needs additional care." Id. at 290.

To evaluate whether Sheridan's nursing notes on R2 met the quality of care standards under 483.25 of the regulations, it was incumbent on the ALJ to recognize and apply these standards. While the ALJ appears to have concluded that the nursing notes did not meet these standards, he excused their shortcomings and untimeliness by viewing them as relevant only to his post-hoc analysis of the question whether R2 had undergone a "significant change in condition:" "Even granting that the incident of January 24, 2004 was not perfectly documented at the time, and even granting that some of the entries concerning the incident of January 27, 2004 were late entries," the ALJ wrote, "R2's behavior and appearance on those dates were not remarkable to

those staff who knew him well, and over a long time." ALJ Decision at 12.

The relevance of the documentation standards extends beyond the question whether or not a patient has undergone a "significant change" in condition, however. Indeed, as reflected in Surveyor Schubert's testimony, accurate and timely nursing notes are integral to a facility's ability to provide coordinated and responsive care and services to each resident, to "attain or maintain the [resident's] highest practicable physical, mental, and psychosocial well-being." 42 C.F.R. § 483.25.

Some of the potential repercussions of a facility's failure to keep accurate and timely nursing records of noteworthy events in a resident's physical, mental or psychosocial status are evident in the case of Sheridan's failure to make contemporaneous nursing notes and entries in its 24-hour nursing log about R2 between January 24, 2004 and February 3, 2004. On January 24, the last contemporaneous note in R2's chart documented that R2 said he did not feel good and needed to see a doctor, that he allowed the nurse to take his vital signs, and that he was "cold and clammy but not in resp[iratory] distress." CMS Ex. 60, at 8. It is undisputed that R2's statement that he did not feel good was highly unusual for him, and that it was equally unusual for R2 to allow his vital signs to be taken. Tr. at 59, 499. Thus, it would be reasonable to expect those caring for him to monitor and document his status closely in the following days. Tr. at 289-290. Further, by January 28, 2004, Sheridan had recorded R2's weight to be at an all-time low of 115 pounds. CMS Ex. 69. Remarkably, however, there are no contemporaneous nursing notes from the period between January 24 and February 3, which might have addressed whether R2's January 24 complaints or symptoms had abated, whether he had developed any new symptoms or behaviors that might impact his "high risk" nutritional status or general medical status, or whether the interventions called for under the revised care plan of January 28, 2004 had been implemented and were effective.

The absence of contemporaneous notes and entries in Sheridan's 24-hour nursing log between January 24 and February 3 was not because it was an unremarkable period for R2. Some of the late entries for this period show that R2 at times resisted care, told staff that he was "fine," and asked staff to "leave his room." CMS Ex. 60, at 10. Other entries show, however, that R2 was exhibiting signs of illness, continuing to lose weight, and did not feel good. Indeed, multiple late entry notes evidence that R2: "looked too thin;" was continuing to fast; "had gone outside to smoke without a coat even though it was very cold;" was "very

clammy," "not looking well" and "pale;" appeared to have a "change in L[evel] O[f] [C]onsciousness" and be "more delusional;" and was agitated and believed "someone was trying to kill him." CMS Ex. 60, at 9-11. Also, it is undisputed that on the evening of February 2, 2004, after refusing to eat or drink anything the entire day, R2 requested Tylenol from a nurse. CMS Ex. 50, at 10; CMS Ex. 70, at 1; Tr. at 107. Yet, R2 refused to take the Tylenol when it was brought to him in applesauce, in the nurse's "hopes of getting [R2] to eat something." CMS Ex. 50, at 10. This, too, was not documented in either the nursing notes or the 24-hour log.

Had the notes been made contemporaneously, staff responsible for R2's care would have been able to analyze collectively the information in them and might have viewed his fasting, behaviors and symptoms during this period in a different light. For example, had the staff on duty on January 27 timely documented their observations, it might have been more apparent to those attending to R2 that his medical condition was deteriorating and that he was exhibiting symptoms of possible dehydration, low blood pressure, hypovolemia (low fluid volume) or cardiogenic shock. Tr. at 191-192, 235, 243. In sum, had Sheridan staff made the notes in a timely fashion, staff might have seen the need to alert his physician earlier than February 3, when R2 was found "in bed weak [and] emaciated," and arrived at the hospital "emaciated," "cachectic," "dehydrated," and with an "intestinal bleed." CMS Ex. 60, at 8; CMS Ex. 73, at 6-7, 36.

Sheridan presented testimony by some of Sheridan's staff that, as late as 8:00 on the morning of February 3, 2004, R2 did not express complaints to them and did not appear to be in any "physical distress." Tr. at 493-495, 503. These witnesses' encounters with R2 were admittedly brief. Despite the observations of R2's condition on both January 24 and January 27, there is no indication of any further attempts after January 27 until February 3 to assess or to actively monitor R2's physical condition.

Accordingly, because Sheridan failed to timely and accurately document R2's condition and the care and services provided to him as required by professional standards of quality nursing care, we conclude that the ALJ erred in concluding that Sheridan was in compliance with section 483.25 of the regulations.

6. The ALJ erred in concluding that Sheridan's care planning for R2 was sufficient under 42 C.F.R. § 483.25.

The participation requirement that facilities conduct comprehensive resident assessments and develop comprehensive care plans reflects the "importance of unified and coordinated resident assessments to the provision of high quality care." 52 Fed. Reg. 38,582, 38,585 (1987). Accurate and complete assessments and care plans ensure that "the care received by the resident is appropriate and thus contributes to his or her health and safety." Id. Thus, a comprehensive care plan must "include measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs . . . . 42 C.F.R. § 483.20(k)(1). A care plan also "must describe . . . [t]he services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under section 483.25." 42 C.F.R. § 483.20(k)(1)(i). Further, the plan of care must be "prepared by an interdisciplinary team, that includes the attending physician, a registered nurse . . ., and other appropriate staff in disciplines as determined by the resident's needs." 42 C.F.R. § 483.20(k)(2)(ii); see also Tr. at 189; Britthaven of Havelock, DAB No. 2078, at 12-14 (2007). Without a properly developed and implemented care plan, it is not possible to ensure that the care provided to a resident by all of the staff and professionals in a facility (not all of whom may be familiar with the resident) is consistent, coordinated and meets the patient's specific needs. Tr. at 189-90.

In this case, the ALJ rejected CMS's contentions that Sheridan did not adequately care plan for R2. ALJ Decision at 21-22, 30-32; CMS Ex. 7, at 6; CMS Post-hearing Br. at 3, 14. Based on the December 2003 care plan documents and the January 28, 2004 care plan update, the ALJ concluded that Sheridan "established that its staff had in place care planning documents for R2. The documents show that Petitioner's staff had assessed R2's weight loss and fasting behavior and attempted to address these issues with appropriate interventions." ALJ Decision at 21-22. Further, the ALJ held, "R2's physician and other staff were involved in his care planning and assessments, which did take into account his fasting behavior." ALJ Decision at 29.

The ALJ's conclusion appears in part to be a response to what he saw as CMS's position that *no* care planning was responsive to R2's fasting behavior. We agree with the ALJ that the care plan did have some measures to address this behavior, most notably the double-portion diet. We conclude, nevertheless, that the ALJ did

not apply the correct legal standard to determine whether Sheridan's care plans for R2 were sufficient under section 483.25. The quality of care and comprehensive assessment and plan of care provisions require a facility not merely to have care plans "in place" that "attempt[] to address" the resident's needs with "appropriate interventions." ALJ Decision at 22. As we previously discussed, a comprehensive care plan functions as a roadmap for all of the resident's caregivers, including those unfamiliar with a resident or without professional training, to provide consistent care and services tailored to "attain or maintain the [resident's] highest practicable physical, mental and psychosocial well-being." 42 C.F.R. § 483.20(k). Accordingly, the care plan must include sufficient guidance to ensure that the services provided promote the plan's specified objectives. See Britthaven at 12-14 (failure to develop a plan for neurogenic bowel care created a risk of physical harm and contributed to the physical harm a resident suffered and to his death).

In this case, while the December 2003 care plan identified R2's low weight, low BMI, and "refus[als] to eat at times" as problems, it did not provide staff with meaningful guidance to respond effectively and consistently to R2's fasting behaviors, which Sheridan knew to have an injurious effect. CMS Ex. 58, at 7. For example, the care plan broadly called for staff to "encourage oral intake" and "encourage H2O," but it provided no direction or strategies to do so. Id. The care plan also did not identify the individuals who might be most effective in encouraging R2 to eat and drink more, or the approaches those individuals should take, even though the record shows that R2 had a better rapport with some members of the staff than others. CMS Ex. 50. Assistant Administrator Zeller, who was an ordained Lutheran pastor but not a nurse, testified that he frequently met with R2 and tried to use Bible stories as a way to encourage R2 to eat. Tr. at 375-376, 386-387. Mr. Zeller admitted that his attempts were not effective, and there was nothing in R2's care plan suggesting that R2's physician, psychiatrist, or the director of social services, believed this approach to be appropriate. Tr. at 384, 386-87. Nor is there anything in the plan to make staff aware of when, if at all, to inform the Assistant Adminstrator that R2 was fasting.

The record also shows that, as a consequence of the insufficiency of the care plans, staff at times appeared to be working at cross-purposes. For example, while some individuals, such as Mr. Zeller, attempted to discourage R2 from fasting, one CNA wrote a note (at R2's request) for R2 to show others which stated that R2

had "permission" to fast two to three days a week. CMS Ex. 50, at 15-16.

In addition, under the regulatory standards, a comprehensive care plan must be "[p]eriodically reviewed and revised by a team of qualified persons. . . ." 42 C.F.R. § 483.20(k)(2)(iii). As noted above, the care plan must describe the services to be furnished to attain and maintain the resident's highest practicable level of well-being. 42 C.F.R. § 483.20(k)(1)(i). Implicit in these requirements is the facility's obligation to develop care plan revisions that meaningfully respond to changes in a resident's particular needs. Thus, CMS's SOM provides that a facility must evaluate the results of the interventions in a resident's care plan and revise the interventions as necessary. SOM, App. PP (Guidance to Surveyors for Long-Term Care Facilities).

Sheridan provided no evidence, however, that its care plan revisions for R2 were based on any evaluation of the interventions already planned and why the goal was not being met. When R2 was weighed on January 27 or 28, 2004, and found to have lost more than 10% of his body weight in less than a month, Sheridan developed revisions to R2's care plan, as required by the MDS. CMS Ex. 58, at 3; CMS Ex. 64, at 5. According to Surveyor Schubert's testimony, under professional standards of quality, a plan of care for a resident in R2's condition at the end of January 2004 should have taken into account: the resident's eating habits; the times of day or week when the resident was more likely to eat; the possibility of increasing the resident's caloric consumption at those times; the possibility of supplementing the resident's meals with "finger foods" or "snacks,"[11] and whether the resident should be provided with food substitutes that he had favored in the past. Tr. at 197-98. In addition, we note that another resident, R4, had

[11] Sheridan argues that snacks such as ice cream, fruit and sandwiches were available to residents between meals, that vending machines were available to residents and that R2 could use the vending machines "with limited assistance." P. Resp. Br. at 13, citing Tr. at 430, 481. Sheridan, however, did not dispute the Surveyor's testimony that, according to Sheridan's Dietary Manager, R2 was not actively provided snacks between meals. Tr. at 49-50; CMS Ex. 50, at 23. Indeed, although R2 sought to make coffee in his room and asked for money to buy a soda on January 24, 2004, notes show that staff denied these requests. CMS Ex. 60, at 8. The notes do not indicate that any substitute was offered.

orders to provide a nutrient dense supplement in addition to a double portion diet. CMS Ex. 7, at 24. Yet, there is no evidence that Sheridan considered providing such supplements to R2. Furthermore, it should have been clear to Sheridan staff that the interventions in the December 2003 care plan, as implemented, had not prevented R2's nutritional status from deteriorating. Yet, Sheridan's January 28, 2004 care plan revisions for R2 reflected no such considerations or understanding. Rather, the only new interventions ordered in the revision dated January 28 were: "provide 1:1 intervention and counseling"; notify MD of <u>further</u> wt loss"; and "monitor weight weekly." CMS Ex. 58, at 3 (emphasis added).

Furthermore, like the December 2003 plan, the January 28, 2004 revision did not direct staff how to respond consistently to R2's fasting behavior, which staff contemporaneously attributed to "delusional behavior about religion." CMS Ex. 58, at 3. While individual "counseling" with social services staff was ordered, the care plan does not make clear how or when counselors were to address R2's fasting – whether it was to be viewed as a symptom of his mental illness, as the revised plan indicates, or a legitimate religious practice, as Sheridan argues on appeal. We also note that there is no evidence that social services staff provided any 1:1 intervention or counseling pursuant to the instruction.

In sum, we conclude that the ALJ erred in failing to evaluate the sufficiency of Sheridan's care plans for R2 under the appropriate regulatory standards. Having assessed R2 to be at "high risk" for nutrition, and knowing that he was engaging in injurious fasting behaviors, Sheridan was required under 42 C.F.R. §§ 483.20(k) and 483.25 to develop a comprehensive plan of care and revisions to it that included reasonable measures to address R2's status and behavior, regardless whether R2's fasting was a product of mental illness or an expression of legitimate religious belief. The December 2003 plan of care for R2 and the January 28, 2004 revisions fell far short of these requirements.

III. CMS's determination that Sheridan's noncompliance with 42 C.F.R. § 483.25 posed immediate jeopardy was not clearly erroneous.

The ALJ did not review CMS's determination that Sheridan's noncompliance with section 483.25 posed immediate jeopardy to Sheridan residents since the ALJ concluded that Sheridan was in substantial compliance with the program participation requirements. Because we reverse the ALJ's determination and conclude that Sheridan was not in substantial compliance with the

quality of care requirements, we now address CMS's immediate jeopardy finding.

"Immediate jeopardy" is defined in section 488.301 of the regulations as a "situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident." 42 C.F.R. § 488.301. An immediate jeopardy finding by CMS may be set aside only if it is "clearly erroneous." 42 C.F.R. § 498.60(c)(2). Woodstock, DAB No. 1726, at 9. The Board has held that a facility has a "heavy burden" to show that there is no immediate jeopardy, and has sustained a determination of immediate jeopardy where CMS presented evidence from which "[o]ne could reasonably conclude" that immediate jeopardy exists. Barbourville, DAB No. 1962, at 11; Florence Park Care Ctr., DAB No. 1931, at 27-28 (2004), citing Koester.

CMS determined that Sheridan's noncompliance with section 483.25 posed immediate jeopardy to Sheridan residents from February 3, 2004 through February 10, 2004, and imposed a CMP of $3,050 per day for that period. According to the State agency and CMS, the immediate jeopardy ended after Sheridan demonstrated that it had taken a number of corrective actions, including: developing and initiating the use of a weight change/doctor notification form; initiating a plan for communicating concerns from the staff nurse to the nurse manager; generating a list of residents identified as being at risk for weight loss and/or dehydration (on February 12, 2004, the Consultant Dietitian reviewed 21 residents identified at nutritional risk, and on February 15, 2004, the Consultant Dietitian reviewed 35 such residents); in-servicing staff and nurses on refusal of treatment, weight loss and dehydration, meal monitoring, assessment and documentation; assessing and developing care plans for residents identified to be at risk for weight loss and dehydration; revising facility policies on physician notification and obtaining, documenting and reporting resident weights; revising facility policy on dehydration; and revising facility policy on weight calibration. CMS Ex. 7, at 11-13; CMS Post-hearing Br. at 45.

In response to CMS's determination that Sheridan's noncompliance with the requirements of section 483.25 created immediate jeopardy, Sheridan first argues that the noncompliance findings cited under sections 483.25(i)(1) and 483.25(j) (the nutrition and hydration requirements) were "premised on the same factors" as those involving section 483.25. Yet, Sheridan contends, CMS cited the nutrition and hydration deficiencies at a lower level of scope and severity. P. Resp. Br. at 80. Sheridan submits

that this "fundamental inconsistency . . . must be addressed." P. Resp. Br. at 79.

We conclude that it was not inconsistent for CMS to find that Sheridan's noncompliance with 42 C.F.R. § 483.25 posed immediate jeopardy to Sheridan residents and at the same time cite the facility's noncompliance with the nutrition and hydration requirements at a lower level of scope and severity. While some of the examples cited under the deficiencies were the same, Sheridan's noncompliance with section 483.25 involved a wide array of deficiencies cutting across and impacting multiple areas of need, as described in detail above. The deficiencies involving nutrition and hydration, taken in isolation, might not have created a situation that caused, or was likely to cause, serious injury, harm, impairment, or death to a resident. Nevertheless, CMS could logically conclude that Sheridan's noncompliance with the overarching quality of care requirement posed immediate jeopardy because Sheridan's failure to provide care and services according to assessed needs, the care plan, professional standards, and the facility's own policies taken together presented risks for all residents. Accordingly, we reject Sheridan's argument that the immediate jeopardy determination must be reversed on the ground that CMS's scope and severity determinations were fundamentally inconsistent.

We also reject Sheridan's contention that the circumstances involving R2 were so "unique" that the deficiencies cited in connection with R2's care did not pose immediate jeopardy to other residents. P. Resp. Br. at 80. As described above, Sheridan effectively admitted that it had failed to notify an attending physician of R3's significant weight loss, failed to develop a sufficient nutrition plan of care for R4, and failed to initiate an intervention and have R1 reassessed by a registered dietitian. CMS Exs. 1, 7. Moreover, one of the measures Sheridan undertook to correct its deficient practices was to generate a list of all residents who were at risk for weight loss and/or dehydration. CMS Ex. 7, at 12. On February 12 and 15, 2004, the Consultant Dietitian reviewed a total of 56 residents identified at nutritional risk. CMS Ex. 7, at 13. Accordingly, it was reasonable to conclude that Sheridan's deficient practices posed ongoing harm to these other residents as well.

In sum, we conclude that Sheridan did not show that CMS's immediate jeopardy determination was clearly erroneous. As noted above, the regulations make clear that we may set aside an immediate jeopardy finding by CMS only if it is "clearly erroneous." 42 C.F.R. § 498.60(c)(2). R2's medical status on February 3, 2004 – his "emaciated" and "cachectic condition"--

stemmed from R2's fasting behaviors and marked weight loss to which the facility did not sufficiently respond, or properly address, under the quality of care requirements. CMS Ex. 73, at 5-6. In light of Sheridan's own admissions of noncompliance regarding care and services furnished to other residents, its corrective actions, and the testimony in the record, it was reasonable for CMS to conclude that Sheridan's deficient practices together could have created situations in which others at high risk for malnutrition would, like R2, face significant danger of infection, impaired organ function, low blood pressure, decubitus ulcers, cognitive impairments, pneumonia, chacexia, and other acute illnesses. Tr. at 46-47, 71. Moreover, given that Sheridan also admitted that it had failed to prevent a cognitively impaired resident from receiving self-inflicted injuries, it was reasonable for CMS to conclude that Sheridan's deficient practices could have led to situations wherein other residents were at risk of self-injurious behaviors or actions. Thus, it was not clearly erroneous for CMS to determine that Sheridan's failures to meet the standards of quality care under section 483.25 created a likelihood of serious harm to others.

Accordingly, we conclude that CMS's determination that Sheridan's deficient practices under 42 C.F.R. § 483.25 posed immediate jeopardy was not clearly erroneous.

IV. The immediate jeopardy period continued from February 3, 2004 through February 10, 2004.

Sheridan also argues that the duration of the $3,050 per day CMP was not reasonable and should be reduced to one day. Specifically, Sheridan contends that the deficiency related only to R2, who left the facility on February 3, 2004, and that "[t]he circumstances relating to him were unique." P. Resp. Br. at 80. The SOD, Sheridan submits, did not allege that any other resident was in immediate jeopardy due to fasting or weight loss. Id. Thus, Sheridan submits, the duration of the immediate jeopardy could not have extended beyond February 3, 2004.

Sheridan also notes that the State agency had initially recommended a CMP of $3,500 for only one day, February 11, 2004. Id. at 78, citing P. Ex. 18 (Notice of March 5, 2004). After Sheridan requested informal dispute resolution, the State agency changed its recommendation, expanding the duration of the immediate jeopardy to the period beginning February 11, 2004 "continuing until" February 14, 2004. P. Ex. 19, at 1. CMS thereafter determined to impose the immediate jeopardy CMP for the eight-day period beginning February 3, 2004 through February 10, 2004.

The regulations governing the duration of a CMP are found in 42 C.F.R. §§ 488.440 and 488.454. Section 488.440(a)(1) provides that the per day CMP may begin to accrue "as early as the date that the facility was first out of compliance, as determined by CMS or the State." Under section 488.454(a), "alternative remedies," including per day CMPs, continue to accrue until "[t]he facility has achieved substantial compliance, as determined by CMS or the State based upon a revisit or after an examination of credible written evidence that it can verify without an on-site visit." Section 488.454(e) states that an alternative remedy may terminate on a date prior to a revisit survey if the facility "can supply documentation acceptable to CMS or the State survey agency that it was in substantial compliance" on that earlier date and was capable of remaining in substantial compliance. Section 488.440(b) provides that a per day CMP is "computed and collectible . . . for the number of days of noncompliance until the facility achieves substantial compliance."

The Board has previously held that a facility's noncompliance, or failure to meet a participation requirement, "is what constitutes the deficiency, not any particular event that was used as evidence of the deficiency." Regency Gardens Nursing Ctr., DAB No. 1858, at 21 (2002) citing 42 C.F.R. § 488.301. "There is no requirement," the Board has concluded, "that the duration of a remedy coincide with particular events that form the evidence of lack of substantial compliance." Id. Thus, "a facility's noncompliance is deemed to be corrected or removed only when the incidents of noncompliance have ceased and the facility has implemented appropriate measures to ensure that similar incidents will not recur." Florence Park at 30, citing Lake City Extended Care Center, DAB No. 1658, at 14 (1998). Similarly, immediate jeopardy is deemed to have been removed only when the facility has implemented necessary corrective measures. See Fairfax Nursing Home, Inc., DAB No. 1794 (2001) (finding that CMS's determination that the facility had taken inadequate steps to abate the immediate jeopardy was not clearly erroneous), aff'd, Fairfax Nursing Home v. Dep't of Health & Human Servs., 300 F.3d 835 (7th Cir. 2002), cert. denied, 537 U.S. 1111 (2003).

Applying the regulations and prior holdings to the facts presented, we conclude that CMS reasonably determined that the period of immediate jeopardy began on February 3, 2004. CMS is not bound by the State agency's recommendations, nor did Sheridan provide evidence that the immediate jeopardy period began at a later date. Further, R2's transfer out of Sheridan on February 3, 2004 did not alone end the immediate jeopardy. Rather, the immediate jeopardy period ended only after Sheridan had

implemented the appropriate and necessary corrective measures summarized above, which took place on February 11, 2004. CMS Ex. 7, at 11-13; CMS Ex. 9, at 1. While the SOD cited the facility's noncompliance with section 483.25 using the example of R2, the findings and immediate jeopardy determination relate to the facility's failure to provide care and services according to assessed need, the plan of care, professional standards, and the facility's own policies. These failures presented risks not exclusively tied to a particular resident or event.

Accordingly, we conclude that CMS's determination that the immediate jeopardy period began on February 3, 2004 and ended on February 11, 2004 was not clearly erroneous.

V. A CMP of $3,050 per day for the period of immediate jeopardy is reasonable.

The amount of $3,050 is the minimum CMP that may be imposed for immediate jeopardy. 42 C.F.R. § 488.438(a)(1)(i). Thus, unless an immediate jeopardy determination is found to be clearly erroneous, the $3,050 per-day CMP is reasonable in amount as a matter of law since it is the minimum per-day CMP prescribed in the case of immediate jeopardy.

Because the CMP imposed by CMS for the immediate jeopardy period was at the $3,050 per day minimum, we conclude that the CMP is reasonable as a matter of law.

Conclusion

For the reasons set out above, we reverse the ALJ Decision and vacate the FFCLs in it. We uphold CMS's determination to impose on Sheridan a CMP of $3,050 per day from February 3, 2004 through February 10, 2004 and a CMP of $200 per day from February 11, 2004 through February 26, 2004, based on our findings and conclusions set out above.

/s/
Leslie A. Sussan

/s/
Constance B. Tobias

/s/
Judith A. Ballard
Presiding Board Member