Department of Health and Human Services
DEPARTMENTAL APPEALS BOARD
Appellate Division

Longwood Healthcare Center
Docket No. A-11-48
Decision No. 2394
June 30, 2011

FINAL DECISION ON REVIEW OF ADMINISTRATIVE LAW JUDGE DECISION

Longwood Healthcare Center (Longwood, Petitioner), a Florida skilled nursing facility (SNF), appeals the December 20, 2010 decision of Administrative Law Judge (ALJ) Steven T. Kessel, *Longwood Health Care Center*, DAB CR2295 (2010) (ALJ Decision). The ALJ upheld the imposition of a $100 per-day civil money penalty (CMP) for the period February 15 through March 10, 2010. The Centers for Medicare & Medicaid Services (CMS) imposed the CMP based on findings by the Florida Agency for Health Care Administration (State agency) that Longwood was noncompliant with the Medicare participation requirement that services provided by the facility meet professional standards of quality (42 C.F.R. § 483.20(k)(3)(i)).

For the reasons explained below, we sustain the ALJ's decision to uphold the CMP imposed by CMS.

Legal Background

Long-term care facilities participating in the Medicare and Medicaid programs are subject to the survey and enforcement procedures set out in 42 C.F.R. Part 488, subpart E, to determine if they are in substantial compliance with applicable program requirements which appear at 42 C.F.R. Part 483, subpart B. "Substantial compliance" means a level of compliance such that "any identified deficiencies pose no greater risk to resident health or safety than the potential for causing minimal harm." 42 C.F.R. § 488.301. "Noncompliance," in turn, is defined as "any deficiency that causes a facility to not be in substantial compliance." *Id.*

Survey findings are reported in a Statement of Deficiencies (SOD). The SOD identifies each "deficiency" under its regulatory requirement. The regulatory requirement at issue here is at 42 C.F.R. § 483.20(k)(3)(i). Section 483.20 is titled "Resident Assessment," and subsection (k) is titled "Comprehensive care plans." Section 483.20(k)(3) provides in relevant part: "The services provided or arranged by the facility must – (i) Meet professional standards of quality[.]"

A long-term care facility found not to be in substantial compliance is subject to various enforcement remedies, including CMPs. 42 C.F.R. §§ 488.402(c), 488.406, 488.408, 488.430. A per-day CMP may accrue from the date the facility was first out of compliance until the date it achieved substantial compliance. 42 C.F.R. § 488.440(a)(1), (b). For noncompliance determined to pose less than immediate jeopardy to facility residents, CMS may impose a per-day CMP in an amount ranging from $50-$3,000 per day. 42 C.F.R. § 488.408(d)(1)(iii).

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 (Guidelines)*, http://www.hhs.gov/dab/guidelines/prov.html.

Substantial evidence is "more than a mere scintilla. It means such relevant evidence as a reasonable mind might accept as adequate to support a conclusion." *Richardson v. Perales*, 402 U.S. 389, 401 (1971), quoting *Consolidated Edison Co. v. NLRB*, 305 U.S. 197, 229 (1938). Under the substantial evidence standard, the reviewer must examine the record as a whole and take into account whatever in the record fairly detracts from the weight of the evidence relied on in the decision below. *Universal Camera Corp. v. NLRB*, 340 U.S. 474, 488 (1951).

Factual Background[1]

On February 15, 2010, the State agency conducted a revisit survey of Longwood's facility to verify correction of deficiencies found on a prior survey. CMS Ex. 1; CMS Ex. 8, at 7-10. The SOD cited a deficiency under section 483.20(k)(3)(i) on the ground that "the facility failed to ensure that 1 of 6 sampled residents were monitored upon return to the facility after a medical procedure." CMS Ex. 1, at 1. This deficiency was cited at scope and severity level "D," meaning that it caused no actual harm but had the potential for more than minimal harm. *Id.*; CMS Pub. 100-07 (State Operations Manual), § 7400.5.1 (available on CMS's website at http:// www.cms.hhs.gov/Manuals/IOM/list.asp).

Pursuant to arrangements made the previous week, the resident in question, Resident 20, was transferred from Longwood to a local kidney stone center on February 11, 2010, at 2:00 p.m., to undergo invasive procedures consisting of cystoscopy and stent removal. ALJ Decision at 2, citing CMS Exs. 1, at 2 and 4, at 1. The resident returned to Longwood around 6:00 p.m. on the same day. ALJ Decision at 2; CMS Ex. 1, at 2; P.

[1] The information in this section is drawn from the undisputed facts in the ALJ Decision and in the record before the ALJ.

Ex. 1, at 1; RR at 2.[2] The SOD states that "review of the nurses notes on 2/15/10 revealed the last documentation was on 2/11/10 at 11 a.m. for leave of absence to Dr.'s office for removal of stent. . . . There was no notes identifying that the resident had returned to the facility or [been] reassessed upon return." CMS Ex. 1, at 2; *see also* CMS Ex. 4, at 1-2.

The Florida Hospital Patient Discharge Summary for the resident dated February 11 includes "Follow-up and Care Instructions" stating in part: "Expect some burning or stinging on urination; expect some pink in urine . . . ." Petitioner Exhibit (P. Ex.) 2, at 2 (cited in ALJ Decision at 2). In addition, the document contains "Miscellaneous Discharge Instructions" that include instructions to "[c]all your physician for" any of the following symptoms: "Excessive drainage or bleeding;" "Increase in temperature (101 or higher), and/or increase in pain or foul drainage odor;" "Any difficulty with breathing;" and "Pain not relieved by prescribed medication." *Id.* at 3. The SOD states that the LPN unit manager "confirmed" in an interview with the surveyor "that discharge instructions were not in the clinical record." CMS Ex. 1, at 3; *see also* CMS Ex. 14 (2nd Declaration of Mindy Seltzer, RD) at 1 (surveyor's declaration stating that she "was informed by Longwood's staff (including the unit manager and licensed practical nurse Jessica Alford) that it did not have any patient discharge instructions from the kidney stone center in her facility file.").

The ALJ Decision

The ALJ found that "[e]ffectively, the discharge instructions directed Petitioner's staff to assess Resident # 20's condition and to monitor the resident for signs and symptoms that might indicate post-operative complications." ALJ Decision at 3. The ALJ further found that "Petitioner's records are devoid of any documentation that the staff complied with the discharge instructions" and that the "nurse who was responsible for the care given to Resident # 20 upon her return to the facility admitted that an assessment should have been done upon the resident's return but that one was not performed." *Id*. The ALJ concluded that "this absence of documentation, coupled with the admission of Petitioner's nurse, is prima facie proof of a failure by Petitioner's staff to assess the resident's condition and to carry out the other directives in the discharge instructions." *Id*. The ALJ noted that Longwood "contends that the staff monitored the resident and that the absence of any documentation showing that the resident was experiencing pain, side effects, or complications, proves that the staff did a good job providing the resident with care." *Id*. The ALJ rejected that contention, stating: "[S]imply 'monitoring' the resident – even if Petitioner's staff did that – is not enough to meet Petitioner's obligations to provide care of professionally acceptable quality. . . . Monitoring without assessment is not enough to discharge a facility's duty to its residents." *Id*. at 4.

[2] We cite to page numbers for Longwood's request for review and reply brief although no page numbers actually appear on those documents.

The ALJ found that, in any event, the exhibits on which Longwood relied either did not show that Longwood actually monitored Resident 20 or were not credible proof that she was monitored. *Id*. Finally, the ALJ concluded that the $100 per-day CMP was reasonable, stating that Longwood had not challenged the reasonableness of the CMP amount and also that there is "affirmative proof that the remedy is reasonable." *Id*.

Analysis

As discussed in detail below, the ALJ did not err in concluding that the services provided by Longwood to Resident 20 following her return from the kidney stone center failed to meet professional standards of quality. The core issue here is whether Longwood provided services to meet the need identified in the discharge instructions to evaluate and monitor the resident's condition for post-surgical complications following her return to the facility. Longwood acknowledges that such services were required, citing to the SOD. RR at 7. Longwood also submitted an affidavit stating in relevant part that the "service required for Resident 20" as the result of the cystoscopy and stent removal "was that she be monitored for pain and any evidence of bleeding as a result of the removal of her stent" and that this "directive came from both the Discharge Report" from the kidney stone clinic and in a telephonic report from a nurse at the kidney stone center following the surgery. P. Ex. 4 (Statement of Tommy Hulsey), at 2 ¶6. However, the monitoring Longwood claims to have provided was merely the everyday care required by the care plan already in place for Resident 20. Even if this care was in fact provided, we agree with the ALJ that it fell short of meeting professional standards of quality for post-surgical monitoring.

Longwood also argues that the ALJ erred in finding that, in addition to monitoring Resident 20, Longwood's staff was required at the time of her return from the kidney stone center to "assess the resident to determine whether there might be any problems that the staff would have to plan for and address." ALJ Decision at 3. The ALJ found that "monitoring," as Longwood used it, failed to "encompass anticipating problems, planning for them in advance, and perhaps, preventing them before they eventuate." *Id*. at 4. We agree with Longwood that the ALJ overstated the facility's responsibility to anticipate and pre-plan for all possible problems. However, we also conclude this error is harmless because Longwood's failure to provide the type of monitoring it admits was required is sufficient to support the ALJ's conclusion that Longwood did not comply substantially with the requirement to provide services that met professional standards of quality.

Longwood also takes exception to the ALJ's conclusion that the $100 per-day CMP was reasonable in amount on the ground that any deficiency posed only a potential for minimal harm. We need not address this argument because Longwood did not raise it before the ALJ. In any event, for the reasons explained below, a CMP of at least $100 per day is reasonable.

1. The monitoring Longwood allegedly provided for Resident 20 following her return from the kidney stone center did not meet professional standards of quality.

Longwood asserts that it monitored Resident 20 in accordance with the discharge instructions following her return from the kidney stone center because "Resident 20's comprehensive plan of care already had interventions in place (from staff's evaluation of issues that occurred prior to her procedure) to monitor the Resident that would have alerted [staff] to the potential complications from surgery the Clinic identified." RR at 9; *see also id.* at 2, 8. Specifically, Longwood argues that its staff would have known to monitor the resident for "any unrelieved pain" because the resident "had a standing order that staff was to monitor her for pain each shift and record any evidence of pain they saw on an Unstable Pain Flow Sheet," and "also had a standing order for pain medication if and when she experienced pain." *Id*. at 2. Longwood argues further that its staff would have known to monitor the resident for "excessive bleeding" because they were "required to do two things that would involve observing her perineal area, the only place where bleeding from a stent removal from her urinary tract might have been manifested." *Id*. In particular, Longwood says, staff "were required to toilet the Resident each shift," at which time they would check her incontinence brief, and also "applied A and D ointment to her perineal area each shift, which required removal of her brief and examination of that area of her body." *Id*. at 3.[3]

We agree with the ALJ that, even if Longwood had established that it followed Resident 20's care plan, the care provided would not meet professional standards of quality for services to a resident who had just undergone a cystoscopy and stent removal. We note first that "unrelieved pain" and "excessive bleeding" were not the only signs and symptoms of complications listed in the discharge instructions, which also listed increase in pain, temperature above 101 degrees, excessive drainage, foul drainage odor, and difficulty breathing. Longwood cited to no evidence that facility staff responsible for Resident 20's care were alerted to watch for or report these signs and symptoms or that they would necessarily become aware of them timely in the course of her ordinary care. Thus, we conclude that Longwood did not adequately monitor Resident 20's condition based on the undisputed fact that Longwood did not monitor the resident for all of the signs and symptoms of complications in the discharge instructions.

We further find that, even if unrelieved pain and excessive bleeding had been the only two signs and symptoms for which monitoring was required by the discharge instructions, the routine once-per-shift inquiry about pain and toileting/ointment application called for by Resident 20's care plan would have been inadequate. These care plan interventions provided no assurance that staff would identify promptly these

[3] Resident 20's comprehensive care plan is not in the record. Longwood cites instead to pages from the resident's "Medication Record" (CMS Exhibit 4, at 8-9) and "Treatment Record" (CMS Exhibit 4, at 11).

two symptoms because staff who provided these services were not informed that she needed to be monitored for them. As we explain below, there was nothing in Resident 20's record to alert her caregivers that she had undergone this surgery, much less that she needed to be monitored for unrelieved pain and excessive bleeding in the days following the surgery. As we have noted, it is undisputed that the discharge instructions were not in Longwood's records for Resident 20.[4] Moreover, Longwood admits that "staff did not record a narrative nursing note upon her return, nor were any nursing notes recorded for her on any of the following four days." RR at 2. Longwood argues nevertheless that late nursing note entries and a nursing entry on the "Wing A Worksheet" "demonstrated that staff was aware the Resident had her procedure and there was a need to monitor her for hematuria."[5] RR at 16. Longwood's argument is without merit.

The late nursing notes to which Longwood refers consist of two February 15 entries in the nurse's notes for Resident 20, one identified in the notes as a "late entry for 2/11/10" and the other identified in the notes as a "late entry for 2/12/10." The late entry for February 11 states: "Res arrived at 6 pm [with] ambulance. . . . She's alert oriented x 3 and talkative. She is two person total assist [with] transfer from stretcher to bed. She denies pain and voiding well. Briefs saturated [with] amber color urine presently rests [with] eyes closed. Skin intact[.]" CMS Ex. 4, at 2. The late entry for February 12 states: "Resident alert to name, awake, period of intermittent sleeping noted. Voiding well. No [complaints of] pain. [Zero] distress [illegible]. No hematuria noted." *Id*. at 2-3.[6] Neither entry states that the resident had undergone a cystoscopy and stent removal, that monitoring for post-surgical complications was required, or what the signs and symptoms of such complications would be. Even if it were clear from the entries that the resident required monitoring for pain and hematuria following this surgery, the entries could not have communicated this information to facility staff until four days after Resident 20 returned from the kidney stone center, when the entries were actually made. While Longwood submitted an affidavit stating that it "is an accepted nursing practice to make late nursing notes provided that the author notes that they are being submitted as late entries" (Statement of Tommy Hulsey, P. Exhibit 4, at 4), it does not follow that the late nurse's notes at issue here served the purpose that Longwood claims they served, i.e., alerting its staff that following a cystoscopy and stent removal on February 11, the

[4] Notwithstanding this fact, Longwood acknowledges that it was required to follow these instructions. RR at 7.

[5] The omission from this statement of a reference to the need to monitor Resident 20 for pain as well as hematuria (blood in urine) could be viewed as an admission that Longwood's staff was not aware that there was a need to monitor her for pain.

[6] The ALJ Decision cites to CMS Exhibit 4, at 4 instead of the nurse's notes to which Longwood's argument refers, which are at CMS Exhibit 4, at 2-3. CMS Exhibit 4, at 4 contains "Nurse's Medication Notes" with a "late entry" at 3 p.m. on February 15 for February 11 at 5:30 p.m. stating: "nurse to nurse report recieved [sic] to monitor for hematuria and pain & urine [zero] other orders on report". Longwood does not rely on this entry to show that its staff was informed that the resident required monitoring following surgery. In any event, it is apparent that the note could not have served this purpose because the entry was made four days after the surgery.

resident needed to be monitored for signs and symptoms of complications from the surgery.

The Wing A Worksheet also could not have served this purpose. The worksheet, dated February 11, 2010, contains a list of residents in the facility, presumably those residing on Wing A, and a column for each of the three shifts that day. CMS Ex. 4, at 20. The column for the 7-3 shift across from Resident 20's name contains the notation "LOA [leave of absence] to Dr. Lemoinu's office for removal of stent. Stent removed." *Id*. The column for the 3-11 shift across from Resident 20's name contains the notation "Back from Kidney Stone Center denies pain voids well." *Id*. Nothing in the worksheet indicates that the observations "denies pain voids well" were made as part of monitoring the resident for complications following a cystoscopy and stent removal. In addition, the worksheet does not contain any observation regarding bleeding. Moreover, it is undisputed that the worksheet "is a document used to inform one shift what happened during another and was not part of Resident 20's clinical file[.]" CMS Br. at 3 n.5. The information on the worksheet was therefore communicated only to staff working the 11 p.m. (February 11) to 7 a.m. (February 12) shift, not to other staff responsible for the resident's care.

Thus, none of the documents discussed above timely alerted staff who might have been responsible for checking Resident 20 for pain or for toileting her and applying A and D ointment that she needed to be monitored for particular signs and symptoms resulting from a cystoscopy and stent removal beginning the evening of February 11. Moreover, Longwood does not dispute that a facility nurse who was interviewed by the surveyor told her that she could not find any record to show Resident 20 had returned to Longwood from the kidney stone center. *See* CMS Ex. 12 (surveyor's declaration) at 2, ¶9; CMS Ex. 1 (SOD) at 2.

Without knowing that Resident 20 needed to be monitored for pain resulting from a cystoscopy and stent removal, a nurse checking Resident 20 for pain in accordance with her care plan might not ask the resident whether she had pain in the relevant area. In addition, the intensity of pain might not be recorded, in which case a nurse might not be able to determine whether there had been an increase in pain since the last observation (which was a sign or symptom related to unrelieved pain).[7]

Furthermore, without knowing that Resident 20 needed to be monitored for excessive bleeding following a cystoscopy, staff toileting Resident 20 or applying A and D ointment to her perineal area in accordance with her plan of care might not have identified this symptom. Longwood asserts that the ALJ should have concluded based on "common sense and experience" that even "without specific written instruction in a

[7] The Unstable Pain Flow Sheet (CMS Exhibit 4, at 12) includes space to record the "Current Intensity" of pain for each time/date monitoring occurs, but Longwood does not dispute the ALJ's finding (at ALJ Decision at 4) that its staff did not fill out this sheet.

resident's record to monitor for hematuria, any nurse who removes [a] resident's diaper for any reason and sees blood would . . . recognize a problem that required the resident's physician to be notified." RR at 15. However, Longwood's witness Tommy Hulsey stated in his affidavit that "[i]t is an accepted nursing practice with a resident who wears a brief, for staff to examine the brief for evidence of bloody urine to determine if a resident has hematuria after a procedure such as the one done for Resident 20." P. Ex. 4, at 4 ¶ 11 (emphasis added). One can reasonably infer from this statement that a nurse (or other facility staff) removing a resident's wet or soiled diaper would likely throw it away without checking it for blood unless notified that the resident was to be monitored for bleeding in the perineal area. Moreover, Longwood did not explain why any blood in the urine would necessarily be apparent to someone applying A and D ointment to the resident's perineal area.

We therefore conclude that, even if Longwood provided the services required by its care plan, Longwood was not in compliance with the Medicare regulations because those services did not meet professional standards of quality for post-surgical monitoring.

In view of this conclusion, it is unnecessary to reach the issue of whether the ALJ erred in finding that Longwood's staff did not actually monitor Resident 20 for pain or bleeding in accordance with her care plan from February 11-15 in order to uphold his finding of noncompliance. Nevertheless, we conclude that substantial evidence supports the ALJ's finding that these services were not performed. The ALJ found specifically that, although there were initials for each date on the resident's "MAR" (medication record) under the column captioned "monitor for Pain Q Shift Using Unstable Pain Flow Sheet," the Unstable Pain Flow Sheet that Longwood maintained for Resident 20 "is completely blank and undated." ALJ Decision at 4. In addition, the ALJ found that the Resident Care Flow Record showing that the resident was toileted contained no reference to monitoring the resident for hematuria. The ALJ stated that "while Petitioner may not have been required by law to document what its staff did, it may not now contend persuasively that its staff did what it failed to document." ALJ Decision at 5. While Longwood vigorously challenged the ALJ's finding in its request for review, we defer to the ALJ's finding because it is supported by substantial evidence. *See Estes Nursing Facility Civic Center*, DAB No. 2000 (2005) ("We defer to this ALJ finding because the ALJ did weigh the evidence, and as an appellate body, we do not reweigh the evidence or substitute our judgment for the ALJ's even if a different choice could have justifiably been made in a de novo review. Community Skilled Nursing Center, DAB No. 1987 (2005), citing Universal Camera Corp. v. NLRB, 340 U.S. 474, 488 (1951).").

2. Longwood was required to evaluate the resident's condition on return in order to begin monitoring for post-operative complications, but was not required to perform a comprehensive assessment.

The ALJ concluded that the services Longwood provided to Resident 20 following her return from the kidney stone center should have included not only monitoring but also an initial assessment. The ALJ made a distinction between monitoring the resident and providing an initial assessment which he explained as follows:

> [S]imply 'monitoring' the resident – even if Petitioner's staff did that – is not enough to meet Petitioner's obligations to provide care of professionally acceptable quality. As Petitioner uses that term, "monitoring" means observing the resident and recording either signs of problems or the resident's complaints. "Monitoring" in this sense does not encompass anticipating problems, planning for them in advance, and perhaps, preventing them before they eventuate. Monitoring without assessment is not enough to discharge a facility's duty to its residents.

ALJ Decision at 4.

Longwood argues that the ALJ erred in concluding that the type of initial assessment described in the quoted language was required. According to Longwood, the ALJ went beyond what CMS said was required as an assessment – a determination of whether Resident 20 "was experiencing 'pain or discomfort or other symptoms following surgery'" – which Longwood says was no different from CMS's description of the monitoring that Resident 20 required. RR at 7, quoting CMS Pre-Hearing Br. at 1. Longwood asserts that the only "assessment" required by regulation is the comprehensive assessment required by 42 C.F.R. § 483.20(b), which, Longwood implies, was not required to be performed when Resident 20 returned to the facility. RR at 8 (including n.4); Longwood Reply Br. at 2. Longwood also argues that it was improper for the ALJ to conclude that the assessment he described "was a professional standard" without citing to any "outside authority" of the type listed in the State Operations Manual (SOM), such as "an OBRA regulation, a regulation promulgated by [the State agency], [or] a published standard of any professional association or licensing board." RR at 8; *see also id*. at 6-7, citing P. Ex. 5 (SOM PP-157-158). According to Longwood, moreover, the ALJ erred in relying on the surveyor's declaration to conclude that such an assessment was required because the surveyor "is not a nurse and thus was not qualified to opine as to what professional services were required." RR at 8 n.4.

We agree that Longwood was not cited for failure to conduct a comprehensive assessment under section 483.20(b) and that CMS has not shown that a new comprehensive assessment was required during the time at issue. On the other hand, an initial evaluation of the resident's condition on return from surgery was necessary to

establish a baseline to monitor for the changes in condition which the discharge instructions identified as problematic. According to the surveyor, a facility nurse told her "that there should have been documentation in Resident 20's facility record of an assessment of her status upon return." CMS Ex. 12, at 2 ¶ 11. The surveyor herself states that she "expected to find in Resident 20's facility clinical record . . . . an assessment of her physical symptoms upon return." *Id*. at ¶8. The ALJ could reasonably rely on the surveyor's professional opinion based on her training and experience. *See, e.g.*, *Omni Manor,* DAB No. 1920 (2004) (holding that a surveyor dietician could testify concerning non-dietary issues based on training and experience related to surveying). As the Board has previously stated, moreover, the interpretive guidelines in the SOM "do not suggest that CMS must in every case verify the existence of an applicable clinical standard through published sources."[8] *Life Care Center of Tullahoma*, DAB No. 2304, at 33-34 (2010) (finding that the facility violated standards of nursing care based in part on the testimony of CMS's medical expert, a physician).

Thus, substantial evidence supports the ALJ's finding that professional standards of quality required some evaluation of the resident's physical condition on return from surgery. We also find supported the ALJ's finding that "[t]here is no documentation that the resident was assessed for pain, discomfort, bleeding, or discharge, following her return to the facility." ALJ Decision at 3. Longwood does not dispute the ALJ's finding that its nurse told the surveyor that no assessment was performed upon the resident's return to the facility. *See id*. In addition, we defer to the ALJ's finding that the late nurse's notes made on February 15 were not credible evidence of any assessment or monitoring on February 11. *See id.* at 5. Moreover, as indicated in the prior section, the observations "denies pain voids well" recorded on the Wing A Worksheet were not sufficient to evaluate the resident's condition post-surgery.

The ALJ, however, appeared to use the term "assessment" in a more expansive sense that would be more appropriate in the context of the conduct of a comprehensive assessment. Thus, the reference to "anticipating problems, planning for them in advance, and perhaps, preventing them before they eventuate" (ALJ Decision at 4) seems to go well beyond checking the resident's condition and needs post-surgery. The ALJ did not identify any source for this broad formulation in the regulations or the testimony of the surveyor or others. To the extent that the ALJ's language overstated the facility's obligations, however, the error was harmless because Longwood's failure to provide the type of monitoring it admits was required (which includes an initial evaluation) is sufficient to

[8] The SOM defines "professional standards of quality" as "accepted standards of clinical practice" that "may apply to care provided by a particular clinical discipline or in a specific clinical situation or setting." P. Ex. 5, at 1. The SOM states that such standards "may be published by a professional organization, licensing board, accreditation body or other regulatory agency" and "may also be found in clinical literature" and lists examples of published sources of standards. *Id.*

support the ALJ's conclusion that Longwood did not comply substantially with the requirement to provide services that met professional standards of quality.

3. The ALJ did not err in concluding that the $100 per-day CMP was reasonable in amount.

Longwood argues that, even assuming there was a deficiency under section 483.20(k)(3)(i), no CMP was warranted because the deficiency "presents only a minimal chance of harm." RR at 17. Longwood's argument appears to be that it was in "substantial compliance," as that term is defined in section 488.301, because any deficiency posed "no greater risk to resident health or safety than the potential for causing minimal harm." As noted above, CMS found instead that the deficiency caused no actual harm, but had the potential for more than minimal harm.

We need not consider Longwood's argument because Longwood did not raise it before the ALJ. *See Guidelines* (the "Board need not consider . . . issues which could have been presented to the ALJ but were not.").[9]

In any event, we are not persuaded that there was no potential for more than minimal harm in this case. Longwood asserts that "the only possible deficient practice that may have occurred was staff's failure to write contemporaneous nursing notes showing the Resident's condition upon her return to the facility, a documentation error" and that this error had "no impact on the care and services provided" to Resident 20. RR at 17. Longwood wrongly characterizes the deficiency as a mere documentation error, however. As discussed above, Longwood failed to provide services to meet Resident 20's need for evaluation and monitoring of her condition for post-surgical complications. As the ALJ observed, this noncompliance "left this resident open to the possibility that she would suffer needlessly." ALJ Decision at 6. Specifically, it is reasonable to infer from the directive in the discharge instructions to "[c]all your physician" if any of the listed signs and symptoms are observed that there was a potential for more than minimal harm if any of these signs and symptoms went unobserved and the resident did not receive medical attention for them.

We further conclude that the ALJ did not err in upholding CMS's imposition of a $100 per-day CMP. Section 488.438(a)(1) authorizes imposition of a CMP between $50 and $3,000 for non-immediate jeopardy level deficiencies. As the ALJ stated, "[v]ery little evidence is necessary to establish a penalty amount that is so low to be reasonable." ALJ Decision at 6. The ALJ found, and we agree, that Longwood's compliance history (its failure to comply substantially with four health and safety requirements and two life safety code requirements on a survey in January 2010) and the "relatively serious" nature

[9] The ALJ stated that "Petitioner has not offered evidence or argument to show that CMS's remedy determination is unreasonable" but proceeded to find that "there is also affirmative proof that the remedy is reasonable." ALJ Decision at 6.

of its noncompliance in February and March 2010 were sufficient to justify the amount of the CMP. *See id*.

Conclusion

For the foregoing reasons, we sustain the ALJ's decision to uphold a $100 per-day CMP for the period February 15 through March 10, 2010 based on Longwood's failure to comply substantially with the requirements of section 483.20(k)(3)(i).

_____/s/_____
Leslie A. Sussan

_____/s/_____
Constance B. Tobias

_____/s/_____
Stephen M. Godek
Presiding Board Member