Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Appellate Division

In the Case of: Community Northview Care Center, Petitioner, - v. - Centers for Medicare & Medicaid Services	DATE: December 31, 2009 Civil Remedies CR1848 App. Div. Docket No. A-09-23 Decision No. 2295

REMAND OF ADMINISTRATIVE LAW JUDGE DECISION[1]

The Centers for Medicare & Medicaid Services (CMS) appeals a September 29, 2008 decision of Administrative Law Judge (ALJ) Keith W. Sickendick. Community Northview Care Center, CR1848 (2008) (ALJ Decision). The ALJ Decision reversed CMS's determination that Community Northview Care Center (Northview) was not in substantial compliance with two Medicare participation requirements during a survey that began January 3, 2006 and ended January 6, 2006 (January survey) and also reversed a denial of payment for new admissions (DPNA) that took effect on February 21, 2006. CMS had imposed the DPNA based on noncompliance found on the January survey and on two prior surveys that took place in November 2005. The DPNA went into

[1] This decision is by a majority of the three-member panel that heard the above-captioned appeal. A concurring opinion follows the majority opinion.

effect 90 days after the last day of the first November survey, and after a February 13, 2006 survey (February survey) for which Northview waived its hearing rights found continuing noncompliance. In an order dated September 20, 2005, the ALJ denied CMS's motion for summary disposition, which he construed as a motion to dismiss for lack of jurisdiction. The same order denied Northview's written motion for summary judgment based on CMS's alleged failure to make a prima facie case of noncompliance.[2] ALJ Decision at 8. After a hearing and post-hearing briefing, the ALJ concluded that CMS did not make the required prima facie showing that Northview violated 42 C.F.R. § 483.30(a)(Tag F353) or any other federal requirement and that Northview, therefore, was in substantial compliance during the January survey. ALJ Decision at 5-6. The ALJ further found that Northview's compliance on the January survey interrupted the continuous 90-day period of noncompliance required to trigger the mandatory DPNA. Id. at 6. The ALJ also rejected CMS's argument that because CMS had the discretion to impose a DPNA and a basis for doing so given the noncompliance found on the unappealed February survey, the ALJ could grant no relief (i.e., the DPNA must remain in effect) even if the ALJ concluded that Northview was in compliance on the January survey.

Summary of CMS's arguments on appeal

On appeal, CMS disputes ALJ Findings of Fact (FF) 12, 13, and 14 and conclusions of law (CL) 1 and 2 and 5-8. CLs 1 and 2 relate to the ALJ's denial of CMS's motion for summary disposition on jurisdictional grounds. In CL 1, the ALJ concluded that Northview did not waive its right to a hearing on the findings of noncompliance on the January survey, or the remedies imposed for those findings, by waiving its right to a hearing on the

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[2] At the close of CMS's case-in-chief at the hearing, Northview moved to dismiss on the same ground. After stating that he viewed the Administrative Procedure Act as precluding rulings from the bench, the ALJ then said, "So for that reason I'll deny your motion." Tr. at 512. The ALJ added that his ruling "casts no reflection on the merits of the government's case . . . at this point." Id. at 512-13. In his decision, the ALJ calls his transcribed statement that he denied Northview's oral motion "incorrect" and states that, in context, he really "deferred ruling . . . until the decision on the merits of the case." Id. at 17, n.13, citing Tr. at 512. The ALJ adds, "The parties [sic] understanding that the issue was preserved is reflected by their extensive arguments in post hearing briefing about whether CMS made a prima facie showing." Id.

findings of noncompliance on the February survey. In CL 2, the ALJ concluded that he had jurisdiction to decide the case. FFs 12-14 and CLs 5, 6, 7 and 8 relate to the ALJ's conclusions on the merits of the appeal. In FFs 12-14, respectively, the ALJ found that the evidence did not show that Northview failed to deliver a care planned care or to meet a resident's care planned need; that insufficient staffing at Northview posed an unreasonable threat that Northview would fail to meet a resident's care planned need; or that any resident was exposed to the risk of more than minimal harm due to insufficient staffing at Northview. ALJ Decision at 5. In CLs 5 and 6, respectively, the ALJ concluded that CMS did not make a prima facie showing that Northview violated 42 C.F.R. § 483.30(a)(Tag F353) or that Northview was not in substantial compliance with program participation requirements during the January survey. Id. at 5, 6. In CL 7, the ALJ concluded that Northview was in substantial compliance during the January survey, thus stopping the running of the continuous 90-day period of noncompliance necessary for a mandatory DPNA to take effect and not triggering the DPNA effective February 21, 2006.[3] In CL 8, the ALJ concluded that the January survey did not provide a basis for the imposition of an enforcement remedy. Id. at 6.

With respect to the ALJ's denial of its threshold motion, CMS asserts several errors. CMS asserts that the ALJ erred in concluding that Northview did not relinquish its right to appeal the January survey results when it waived its right to appeal the February survey results because, CMS asserts, the DPNA was "based as much on the findings . . . from the February survey as on the findings from the November 2005 and January 2006 surveys." Request for Review (RR) at 18. CMS also asserts that contrary to the ALJ's conclusion, the mandatory DPNA regulation, 42 C.F.R. § 488.417(b)(1), does not require an uninterrupted 90-day period of noncompliance, but, rather, only a finding that

[3] CL 7 also relates to the ALJ's jurisdictional ruling to the extent that the ALJ found, as part of CL 7, that the 90-day period of noncompliance was interrupted, a finding that factored into his ruling that he had jurisdiction. However, as a threshold matter, CL 7 involves the ALJ's merits conclusion that Northview was in substantial compliance on the January 6, 2006 survey. Absent an affirmance of this conclusion, there is no basis for finding that the 90-day period was interrupted. As explained later in our decision, we find errors of law in the ALJ's merits decision and remand for further proceedings and a new decision. Accordingly, in this decision, we treat CL 7 as part of our merits discussion and vacate that CL.

the facility "is not in substantial compliance three months after the last day of the survey initially identifying the noncompliance." RR at 14. CMS's last argument with respect to the denial of its dispositive motion is that the ALJ erred in asserting jurisdiction because he could not grant relief even if he were to conclude that Northview was in substantial compliance on the January survey since CMS had the discretion to impose a DPNA based on the findings of noncompliance on the February survey, which Northview did not appeal. RR at 7-13. As part of this argument, CMS asserts that the ALJ erred in viewing a mandatory DPNA and a discretionary DPNA as two distinct remedies and concluding that the DPNA imposed as a mandatory DPNA could not survive as a discretionary DPNA because CMS did not actually give notice that it was imposing a discretionary DPNA. CMS argues that since CMS had an undisputed basis for imposing a DPNA, the ALJ was authorized, at most, to remand to CMS for a determination of whether to impose this remedy on a discretionary basis. RR at 10, n.4.

With respect to the merits, CMS argues on appeal that the ALJ's FFs are not supported by substantial evidence in the record as a whole and that the ALJ erred in his conclusions that CMS had not made a prima facie case of noncompliance and that the January survey did not provide a basis for the imposition of an enforcement remedy. RR at 20-39. As part of this argument, CMS asserts that the ALJ improperly rejected surveyor notes of interviews with staff, residents and family members and improperly excluded significant and probative evidence based on the theory that it was not explicitly described in the statement of deficiencies (SOD) and failed to consider evidence that conflicts with his findings. RR. at 21-38.

Summary of the Board's decision

We reject CMS's arguments that the ALJ erred in asserting jurisdiction. We conclude that Northview did not waive its right to a hearing on the DPNA when it waived its right to a hearing on the February 13, 2006 survey results. CMS cites no persuasive authority for its position that even though Northview timely appealed the January survey (which along with the preceding November surveys that precipitated imposition of the mandatory DPNA), Northview somehow forfeited that appeal by not also appealing the last survey finding noncompliance before the DPNA took effect. We do not resolve CMS's argument that 42 C.F.R. § 488.417(b)(1) does not require a 90-day uninterrupted period of noncompliance for imposition of a DPNA as a mandatory remedy, since it may be moot, but provide guidance on the issue if the ALJ needs to reach it on remand. We reject under the

facts of this case CMS's argument that because it had a basis for imposing a DPNA as a discretionary remedy for the unappealed findings of noncompliance on the February survey, the ALJ was required to treat the mandatory DPNA as a discretionary DPNA and, therefore, had no authority to grant the relief sought by Northview. We provide guidance to the ALJ on the appropriate course to address the DPNA if he again finds substantial compliance on the January 2006 survey.

We vacate the ALJ's decision on the merits and remand for further proceedings consistent with the Board's decision. We find that the ALJ erred by categorically excluding all surveyor notes of interviews with Community staff, residents and family members as "unreliable and lacking in probative value" based on his unsupported assumption of "possible investigator bias" when determining that CMS had not made its prima facie case. We also find that the ALJ erred by excluding evidence not cited on the statement of deficiencies (SOD) when making that determination, without considering whether the facility had received adequate notice of the evidence and CMS's reliance thereon. The evidence excluded by the ALJ was relevant and potentially material to CMS's prima facie case. We further conclude that the ALJ erred in failing to consider certain evidence in the record that conflicts with his findings. We also conclude that the ALJ erred by concluding that in making a prima facie case of noncompliance with 42 C.F.R. § 483.30(a)(1), CMS was limited to evidence showing failure to deliver or meet care needs specifically identified in the residents' individual care plans.

The Applicable Law

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.

A long-term care facility found not to be in substantial compliance is subject to various enforcement remedies, including a DPNA. 42 C.F.R. §§ 488.402(c), 488.406, 488.408. CMS has the option to impose a DPNA whenever a facility is not in substantial compliance. 42 C.F.R. § 488.417(a). By statute,

CMS must impose a DPNA "[i]f a facility has not complied with any of the requirements . . . within 3 months after the date the facility is found to be out of compliance with such requirements . . . ." Section 1819(h)(2)(D) of the Social Security Act (Act).[4] The implementing regulation provides for a mandatory DPNA if a "facility is not in substantial compliance . . . 3 months after the last day of the survey identifying the noncompliance." 42 C.F.R. § 488.417(b)(1).

Case Background[5]

Northview participates in the Medicare program as a skilled nursing facility (SNF) and in the State of Indiana Medicaid program as a nursing facility (NF). ALJ Decision at 1. On November 21, 2005, the Indiana State Department of Health (ISDH) conducted a survey at Northview and found that it was not in substantial compliance with federal requirements for participating in the Medicare and Medicaid programs.[6] ALJ Decision at 4 (FF1). On November 28, 2005, IDPH notified Northview that it could avoid the imposition of remedies if it

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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, and the U.S.C.A. Popular Name Table for Acts of Congress.

[5] The information in this section is drawn from the ALJ Decision, the record before the ALJ, and the record of the ALJ proceedings and is presented to help the reader understand the context of the issues raised on appeal. Nothing in this section of our decision is intended to replace or supplement the ALJ's FFs or CLs, although our decision ultimately vacates FFs 12-14 and CLs 5, 6, at 8.

[6] Northview was out of compliance with nine requirements, including the requirement at 42 C.F.R. § 483.25(m)(1)(Tag F332) that was also found unmet on the subsequent January 1, 2006 survey. CMS Ex. 4, at 6. Prior to the hearing, CMS decided not to rely on the finding of noncompliance with this regulation but continued to use the evidence underlying this noncompliance, which involved late medication passes, to the extent that evidence related to the finding of noncompliance with section 483.30(Tag F353)(insufficient staff).

achieved compliance by December 21, 2005. CMS Ex. 2, at 1. Northview was found noncompliant on each of four surveys after the November 21, 2005 survey: November 28, 2005 and January 6, February 13, and March 3, 2006.[7] Id.; ALJ Decision at 11 and n.10. On January 18, 2006, ISDH notified Northview that based on the facility's continuing noncompliance on the January surveys and "as authorized by (CMS) . . ." it was imposing remedies that included a "Mandatory Denial of Payment for New Admissions effective February 21, 2006" and directed in-service training effective February 17, 2006.[8] ALJ Decision at 4 (FF8); CMS Ex. 1, at 1-2. The ISDH notice letter advised Northview of its right to appeal "the findings that resulted in the imposition of these remedies . . . ." Id.

Of the five surveys finding noncompliance, Northview requested a hearing only on the January 6, 2006 survey. ALJ Decision at 5 (FFs 9, 10). See also ALJ Decision at 10, n.9 (ALJ notes the parties' stipulation that only the January 2006 survey findings are at issue). Northview filed that hearing request on March 22, 2006. ALJ Decision at 5. On May 17, 2006, CMS notified Northview of its determination that Northview had returned to substantial compliance on April 26, 2006 based on a survey conducted by ISDH on that date and, therefore, that the DPNA that went into effect on February 21, 2006 was discontinued April 26, 2006. ALJ Decision at 10, n. 8; CMS Ex. 3. CMS's notice letter also reminded Northview of its option to waive a hearing on the February 13, 2006 survey and to thereby receive a 35% reduction in the amount of the CMP imposed for that noncompliance under the waiver regulation at 42 C.F.R. § 488.436. CMS Ex. 3. On May 31, 2006, Northview submitted a written waiver of its right to a hearing on the February 13, 2006 survey and paid the reduced CMP. ALJ Decision at 5 (FF10); ALJ Decision at 12.[9]

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[7] The November 28, 2005 survey was a life safety code survey. CMS Ex. 2, at 1; ALJ Decision at 11, n.10. The February 13, 2006 survey was a complaint survey that found immediate jeopardy level noncompliance under 42 C.F.R. §§ 483.13(b)(1)(i)(abuse) and 483.13(c)(staff treatment). CMS Ex. 2, at 1; ALJ Decision at 11. The March survey was a revisit and complaint survey that found D-level noncompliance with two requirements. CMS Ex. 2, at 2; ALJ Decision at 11.

[8] Neither party has raised an issue regarding the directed in-service training remedy.

[9] The ALJ's FF 9 says that Northview also waived its right

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On June 22, 2006, CMS filed a Motion for Summary Affirmance and supporting brief, which the ALJ construed as a motion to dismiss for lack of jurisdiction, based on the theory that Northview had waived its right to a hearing on the noncompliance found on the January survey by waiving its right to a hearing on the findings of noncompliance on the February survey. ALJ Decision at 8. On July 14, 2006, Northview filed a motion for summary judgment, and on July 28, 2006, Northview filed a brief in support of its motion for summary judgment. On September 20, 2006, the ALJ issued an order denying all motions. Id.

Discussion

A. The ALJ did not err in concluding that Northview had a right to a hearing on the January 2006 survey findings.

The ALJ rejected CMS's contention that Northview should be held to have waived its right to a hearing on the findings of noncompliance arising from the January survey. ALJ Decision at 5, 8 (CL1), 13. That contention was based on CMS's theory that, by explicitly waiving its hearing rights relating to findings of noncompliance arising from the later February survey (in exchange for a 35 percent reduction in the amount of the civil money penalty imposed based on the February noncompliance findings), Northview in effect also waived hearing rights as to findings of noncompliance from any other survey which formed any part of the basis for imposition of the mandatory DPNA. RR at 17-18.

CMS does not dispute that Northview timely requested a hearing on the findings of noncompliance on the January survey. CMS contends, however, that the mandatory DPNA was not imposed based on the January survey alone but was based "as much" on the February survey. RR at 18. CMS then concludes that, because after its waiver Northview "cannot challenge the DPNA imposed as a result of the" deficiency findings from the February 2006 survey," it follows that Northview cannot challenge the DPNA that resulted from deficiency findings from the January 2006 surveys. Id.[10]

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to a hearing on the March 3, 2006 survey. However, Northview did not waive its right under section 488.436; rather, it simply did not appeal that survey.

[10] Northview does not dispute that its waiver of its right to a hearing on the February survey resulted in all of the
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The ALJ did not, nor do we, disagree with CMS's position that the "mandatory DPNA was triggered by a three month period of noncompliance," which included findings of noncompliance arising from the January and February surveys (as well as those arising from the November and March surveys which Northview did not appeal). ALJ Decision at 8. Furthermore, CMS correctly states that the right to appeal granted in the regulations is a right to appeal findings of noncompliance that result in the imposition of remedies identified in the regulations. RR at 17, citing 42 C.F.R. §§ 488.408(g)(1), 498.3(b)(13), 498.3(b)(12), and 498.5.

We do not, however, accept CMS's suggestion that the right to appeal findings of noncompliance from one survey that resulted in imposition of a mandatory DPNA (or any other remedy) is defeated by the choice not to appeal or to waive appeal of findings of noncompliance from another survey which also resulted in the continued imposition of a mandatory DPNA (with or without other remedies). CMS argues that the waiver of appeal rights from the February 2006 survey somehow "means that the DPNA cannot be challenged." RR at 18. CMS's premise (i.e. that the DPNA was imposed as a result of findings from multiple surveys) is correct, but its conclusion does not follow logically. In fact, the terms of the applicable regulations, as well as the content of CMS's notice letters to Northview, make clear that the theory CMS advances here is unsupported.

A fundamental problem with CMS's position is that the regulations do not provide appeal rights from particular remedies, but from specified initial determinations. Among the appealable initial determinations for nursing facilities is any "finding of noncompliance that results in the imposition of remedy specified in § 488.406," which includes DPNAs. 42 C.F.R. § 498.3(b)(13)(emphasis added). Similarly, the regulations provide that a nursing facility "may appeal a certification of noncompliance leading to an enforcement remedy." 42 C.F.R. § 488.408(g)(1). A facility may not, on the other hand, appeal the choice of a particular remedy to be imposed based on a finding of noncompliance. 42 C.F.R. §§ 488.408(g)(2), 498.3(d)(11). Therefore, the issue is not whether the DPNA can be challenged but whether the findings of noncompliance from the January 2006 survey resulted in the imposition of, or led to, an enforcement remedy (here, a DPNA). When the question is thus properly posed, CMS's own assertions make clear that the answer

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findings of noncompliance from that survey becoming final.

is that the January 2006 survey findings did lead to the enforcement remedy.

Nothing in the notice of appeal rights sent to Northview hints that CMS viewed the enforcement remedy as tied only to a single survey's results. Thus, CMS's April 11, 2006 letter informed Northview that, "[b]ased on the deficiencies cited during this survey, the Division is giving notice of imposition of," inter alia, a "Mandatory Denial of Payment for New Admissions effective February 21, 2006." CMS Ex. 2. In context, it is clear that "this survey" refers to the February 2006 survey.[11] The letter also notified Northview of its right to appeal if it disagreed "with the findings that resulted in the imposition of these remedies . . . ." Id. at 2. In the same letter, CMS noted that, "[o]n January 18, 2006, the State survey agency gave you your appeal rights for noncompliance found during the November 21, 2005, November 28, 2005 and January 6, 2006 surveys **that resulted in the imposition of the denial of payment for new admissions** and the directed in-service training." Id. (emphasis added). It is thus plain that CMS viewed the noncompliance findings from each of these surveys as appealable initial

[11] The majority recognizes the concern of the concurring opinion but does not agree with the suggestion that imposition of a remedy occurs only at the point when a facility is provided the first notice that a remedy is being imposed. We find the longstanding rule to be that all findings of noncompliance which lead to a remedy being imposed constitute appealable initial determinations. We see no meaningful distinction between the first findings of noncompliance which result in a remedy being imposed and later findings of noncompliance which also lead to the imposition of that same remedy. The same understanding that imposition of remedy is not a single event bounded by an initial notice but rather an action which may be based on findings of noncompliance from one or more surveys also underlies our agreement with CMS that once all remedies are rescinded a facility loses the right to appeal any noncompliance findings which led to those remedies. See, e.g., Fountain Lake Health & Rehabilitation, Inc., DAB No. 1985 (2005); Schowalter Villa, DAB No. 1688 (1999). Were a remedy "imposed" once and for all only by a first notice of imposition, subsequent rescission would not be effective to undo imposition and these cases would be called into doubt. We do not find it necessary to address the concurring opinion in any more depth here, however, because the argument made there was not put forward by any party in this case.

determinations because they each resulted in the imposition of or led to the DPNA.

On appeal, CMS focuses on the claim that the waiver of appeal rights from the February 2006 survey means that "the facility cannot challenge the DPNA imposed as a result of those findings." RR at 18. CMS cites in support language from the preamble to the waiver regulation stating that the decision to accept the 35 percent CMP reductions means that the facility may not "deny the existence of deficiencies for any purpose . . . ." 59 Fed. Reg. 56,116, at 56,201 (1994). The comment to which this statement responded stated that the facility should not be permitted to deny the existence of the deficiency on which the CMP had been imposed after having waived its appeal rights. Id. The decision here does not permit Northview to deny the existence of the February 2006 noncompliance findings for any purpose. Nothing in the regulation or preamble suggests that waiver of appeal rights from one survey deprives the facility of its ability to challenge different noncompliance findings from a different survey merely because one of the remedies imposed based on the results of both surveys is a mandatory DPNA which went into effect after continued noncompliance allegedly persisted for more than 90 days.

We conclude that the ALJ did not err in providing Northview with a hearing to challenge the findings of noncompliance from the January 2006 survey.

B. CMS's claim that imposition of a DPNA is mandatory even if a facility has returned to substantial compliance in less than 90 days may be moot and might create a conflict with the statute.

CMS also argues on appeal that the ALJ's conclusion that the findings of noncompliance from the January 2006 survey were not supported on the evidence of record can have no legal effect because uncontested findings of noncompliance (from the surveys which were not appealed) demonstrate that Northview was not in substantial compliance on two dates at least 90 days apart. RR at 14. In other words, CMS now argues that the DPNA was mandated regardless of whether Northview came into substantial compliance during the three-month period, because Northview was concededly again out of substantial compliance in February 2006.

We do not conclusively resolve this question because CMS failed to raise this argument before the ALJ (and in fact took a directly conflicting position below) and because, depending on the ALJ's conclusions on remand, it may be moot. Nonetheless,

we note that CMS's theory on appeal appears contrary to the statutory language defining when CMS is required to impose a DPNA and inconsistent with CMS's notice to Northview here as well as with the overall role of mandatory DPNAs in the statutory and regulatory enforcement scheme. We therefore provide guidance below to the ALJ if this issue indeed needs to be addressed on remand.

Before the ALJ in the present case, CMS explained that a mandatory DPNA is imposed "because a facility is continuously out of substantial compliance with one or more regulation[s] for three months or more." CMS Brief in Support of Summary Affirmance at 13-14 (emphasis added).[12] Similarly, in its April 11, 2006 notice of imposition of remedies, CMS states that the mandatory DPNA was "imposed effective February 21, 2006 due to your facility's failure to achieve compliance within the required three months." CMS Ex. 2, at 2 (emphasis added).

This notice is consistent with the statute. Section 1819(h)(2)(D) requires that, if a facility has not achieved substantial compliance "within the 3 months after the date the facility is found to be out of compliance . . . , the Secretary shall impose" a DPNA. (Emphasis added.)

A review of the legislative history that lead to the statutory requirement further supports an interpretation that a DPNA is required when noncompliance continues for three months rather than when two findings of noncompliance are made 90 days or more apart. As the Board has discussed in prior decisions, before the Omnibus Budget Reconciliation Act of 1987, Public Law No. 100-203, provided a wider choice of remedies, the Secretary was authorized by section 1866(b)(2)(A) of the Act to terminate a provider agreement after determining that "the provider fails to comply substantially" with the agreement or the applicable law

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[12] The ALJ relied in part on this assertion in reaching his decision, stating that -

> CMS recognized in its brief on its motion, that if there had there [sic] been no deficiency findings on the January survey, the three month period triggered by the November survey would have been stopped as of the date of the January survey and the mandatory DPNA under 42 C.F.R. § 488.417(b)(1) would not have gone into effect on February 21, 2006.

ALJ Decision at 13, citing CMS Motion at 14.

and regulations. CMS essentially could only choose between terminating a facility or allowing it to continue operating despite deficiencies. The congressional purpose in providing for remedies short of termination was to encourage CMS to apply pressure to motivate facilities to solve problems quickly and also to protect residents without disrupting placements unnecessarily. See, e.g., H.R. Rep. No. 391, 100th Cong., 1st Sess. 942 (1987); see discussion of purpose at 59 Fed. Reg. 56,116-17, 56,177-78; see also CarePlex of Silver Spring, DAB No. 1683 (1999), Golden State Manor and Rehabilitation Center, DAB No. 1597 (1996).

While Congress thus sought to increase the options in CMS's repertoire short of terminating a provider, Congress also was concerned that payment not continue to be made indefinitely to a facility that does not respond by coming into substantial compliance. To that end, Congress added provisions which force CMS to act where a facility has persisted in noncompliance. We have already discussed the requirement to impose a DPNA after three months of noncompliance. In addition, under Sections 1819(h)(2)(C), CMS may not continue to make payments with respect to a facility that is not in substantial compliance for more than six months, i.e., termination becomes mandatory if substantial compliance is not achieved within six months.

CMS nevertheless contends that the regulation on mandatory DPNAs supports the theory that a DPNA is still required even if a facility is found to have returned to substantial compliance within three months. The regulations provides in relevant part as follows:

> Required denial of payment. CMS does or the State must deny payment for all new admissions when -
> (1) The facility is not in substantial compliance . . . 3 months after the last day of the survey identifying the noncompliance . . . .

42 C.F.R. § 488.417(b)(1). Contrary to CMS's argument, the plain language of this regulation does not indicate that any two findings of noncompliance separated by three months or more will trigger a mandatory DPNA. The regulation is ambiguous, at best, and is best read consistently with the statute as referring to the situation where three months have passed since an initial survey identifying noncompliance without the facility achieving substantial compliance. The following discussion of this provision in the preamble to the final rule reinforces that CMS intended the mandatory DPNA to be triggered not by multiple instances of noncompliance during the three months but by the

persistence of noncompliance for a three-month period or longer.

> Comment: One commenter suggested changing proposed wording requiring imposition of a DPNA "if a deficiency remains uncorrected after 90 calendar days (as opposed to within) of the last day of survey identifying the deficiency. As worded in the proposed rule, the mandatory sanction would have been imposed if a deficiency had existed at any time during the 90 days.
> Response: We agree with the intent of the comment, and although we are no longer referring to 90 days but to 3 months as the Act does, we are making this revision.

59 Fed. Reg. 56,116-01, 56,192-93 (emphasis added); see also id. at 56,212 (referring to "the mandatory denial of payment which the State or the Secretary is required to impose after the third month of noncompliance" (emphasis added).

CMS also argues in the alternative that even if there is sufficient ambiguity in the language of section 488.417(b)(1) to render the ALJ's interpretation possible, the Board should defer to CMS's interpretation so long as it is a permissible construction of the statute it implements. RR at 16-17. The Board has indeed deferred to authoritative agency interpretations of regulations (so long as the party adversely impacted by the interpretation either had notice of it or did not actually rely on a reasonable interpretation of its own.) Here, however, we cannot regard CMS's interpretation of 42 C.F.R. § 488.417(b)(1) in this appeal as CMS's authoritative interpretation of the regulation when CMS itself has not offered a consistent interpretation even for purposes of this litigation. Further, CMS has not persuaded us that the newly proposed interpretation would be permissible given the provisions of the statute discussed above.[13]

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[13] CMS relies on an ALJ decision in Castle Pines Health & Rehabilitation Center, DAB CR1321 (2005), which stated "all that the regulation requires is two events of noncompliance separated by a period of at least three months." CMS Post-hearing Brief at 2, n.1, quoting DAB CR1321, at 4. CMS also relies on an ALJ finding in Chicago Ridge Nursing Center, DAB CR1498 at 11-12 (2006). However, the Board affirmed Chicago Ridge on other grounds and, finding the ALJ's analysis for that finding "obscure," vacated it as unnecessary to the ALJ's or the Board's decision. Chicago Ridge Nursing Center, DAB No. 2151, at 17, n.13 (2008). Decisions of ALJs do not bind the Board, and, in particular, the ALJ's statement in Castle Pines (which did not

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CMS further suggests that holding that a mandatory DPNA is triggered only when three months have passed since an initial noncompliance finding without the facility returning to substantial compliance would amount to placing a burden on CMS to affirmatively prove the existence of noncompliance on each intervening day. RR at 16. This argument is mistaken. It is well-established that, once a facility has been found not to be in substantial compliance, a presumption attaches that the noncompliance continues unless and until the facility is found to have achieved substantial compliance. Thus, in Cary Health and Rehabilitation Center, DAB No. 1771 (2001), the Board explained that -

> the "triggering event" for a mandate to impose a DPNA is not a new determination of noncompliance on or after the 90th day, but the failure by the facility to demonstrate achievement of substantial compliance on or before the requisite date. See Act, § 1819(h)(2)(D); 42 C.F.R. § 417(b)(1). In other words, [CMS] did not have to take some new action or await another survey to "trigger" a basis for imposing the DPNA, but rather Cary had to act to avert it, by affirmatively showing that it had achieved compliance.

DAB No. 1771, at 21 (footnote omitted); see also Regency Gardens, DAB No. 1858 (2002) (regulatory scheme does not require CMS to "provide affirmative evidence of continuing noncompliance"). Our decision here in no way alters this longstanding rule. Where a facility has made a credible allegation of compliance and a revisit to verify that allegation has been conducted which finds substantial compliance has been achieved (whether the surveyors made that determination or the determination was made on de novo review by the ALJ), however, the facility has overcome the presumption of continuing noncompliance.

If the ALJ concludes on remand that this issue is not moot, he should take this analysis into account and may also receive further briefing from the parties.

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come to the Board on appeal) is undermined by the Board's action in Chicago Ridge.

C. The ALJ should determine on remand whether CMS in fact elects to impose a discretionary DPNA, if he again concludes that Northview was in substantial compliance in January 2006.

CMS argues on appeal that given its undisputed authority to impose a DPNA whenever a facility is not in substantial compliance and Northview's undisputed noncompliance on the February 13 and March 3, 2006 surveys, CMS had a basis for imposing the DPNA that took effect February 21, 2006 regardless of whether Northview prevailed on its appeal of the January survey. That being the case, CMS argues, the ALJ erred by asserting jurisdiction over Northview's appeal from the January survey because he could not overturn the DPNA even if Northview prevailed on that appeal. CMS argues, in effect, that the ALJ should have treated the DPNA as a discretionary DPNA even though it was originally imposed as a mandatory DPNA, since CMS had the authority to impose the DPNA as a matter of discretion. Alternatively, CMS argues, the ALJ should have remanded to CMS for a determination whether to exercise its discretion to impose a DPNA for the noncompliance on the February survey.

The ALJ instead concluded that treating the DPNA as discretionary would exceed his authority. ALJ Decision at 9. The ALJ rejected CMS's request that he "treat the mandatory DPNA as though it was a discretionary DPNA," on the grounds that to do so would amount to choosing a different remedy than CMS imposed in contravention of the limitations on his authority in the regulations. Id., citing 42 C.F.R. § 488.408(g)(2)("A facility may not appeal the choice of remedy . . . ."); see also 42 C.F.R. § 498(d)(11)("The choice of alternative sanctions or remedy to be imposed" is not an appealable initial determination).[14]

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[14] We note that Northview argued that CMS failed to preserve the issue of its authority to impose a discretionary DPNA regardless of whether a DPNA is mandatory because CMS raised the issue only in a footnote in its post-hearing brief. Northview Br. at 5-6. Northview cites a Seventh Circuit decision in a bankruptcy case in which the court found that one issue, among many raised, was effectively waived because the appellant made only "a passing reference in a footnote." U.S. v. White, 879 F.2d 1509, 1513 (7th Cir. 1989), cert. denied, 494 U.S. 1027 (1990). White did not involve an alleged failure by the appellant to properly preserve in the district court an issue argued on appeal to the Seventh Circuit. Rather, White involved the appellant's failure during its appeal to the Seventh Circuit

(Continued. . .)

As discussed below, the Board has concluded that this matter must be remanded to the ALJ for further proceedings and a new decision on the merits. If the ALJ again finds that Northview returned to substantial compliance as of the January 2006 survey, the next question is what the effect of that decision would be on the applicable remedies. CMS characterizes the ALJ's conclusion as based on misconceiving mandatory and discretionary DPNAs as "somehow two different remedies," although the ALJ does not discuss the issue in those terms. RR at 10. CMS emphasizes that "nowhere in the regulation at § 488.406 is a distinction made between mandatory or discretionary DPNAs." RR at 11. The cited provision merely lists remedies available to CMS in addition to termination, including DPNAs and CMPs. On the other hand, the regulation directly addressing DPNAs is divided into sections on "optional denial of payment" at section 488.417(a) and "required denial of payment" at section 488.417(b). We conclude from our review of the regulations that denying payment for all new admissions is one of the remedies available for noncompliance. The only difference is in what choice CMS has in selecting that remedy, i.e., CMS may impose a DPNA whenever a facility is "not in substantial compliance" but must impose a DPNA when it is not in substantial compliance after three months.

That CMS has authority to impose a DPNA whenever a facility is out of compliance is, as CMS asserts, beyond dispute. Act § 1819(h)(2)(B)(i); 42 C.F.R. §488.417(a); Northern Montana Care Center, DAB No. 1930 (2004). RR at 7. The ALJ recognized that authority, and Northview does not dispute it on appeal. ALJ Decision at 6-7; Response at 1-8. It does not follow, however that, because the unappealed noncompliance on the February survey which remained uncorrected at the time the DPNA took effect would authorize CMS to impose a DPNA, the ALJ was required to uphold the DPNA as a discretionary DPNA regardless of whether he upheld it as a mandatory DPNA.

(Continued. . .)
to adequately develop the issues in its initial appeal brief. Whatever this comment may say about practice before that court, it says nothing about whether an issue raised in a footnote of a brief before an ALJ is preserved sufficiently for a party to later press the issue on appeal to the Board. The Board has never held that the placement of discussion of an issue in the body or footnotes of a brief has any substantive legal effect, and Northview has given us no basis to make such a holding in this case.

The ALJ went further, however, than declining to automatically assume that a discretionary DPNA would have been imposed if a mandatory DPNA had not been required. He viewed himself as lacking authority to consider whether a discretionary DPNA remained in effect on the grounds that he would be imposing a discretionary DPNA in place of the remedy selected by CMS. ALJ Decision at 9. As we have concluded, a DPNA is a single remedy, no matter how it is imposed. The ALJ thus would not have improperly substituted his judgment on choice of remedy for that of CMS by treating the mandatory DPNA that took effect on February 21, 2006 as a discretionary DPNA. The choice of remedy remains with CMS.

We also disagree with the ALJ that a change in the DPNA's imposition from required to optional impinges on Northview's rights to notice and due process. The ALJ stated that there was "no notice that CMS had imposed a discretionary DPNA based upon any of the findings and conclusions of any of the surveys in the survey cycle." ALJ Decision at 5 (FF 11). Although CMS's basis for imposing the DPNA as a discretionary remedy rests on the findings of noncompliance on the February survey, not on the findings of noncompliance from the January survey, Northview was on notice at the time that it waived appeal rights from the February survey that the remedies imposed based on the noncompliance findings from that survey included imposition of the DPNA. Therefore, Northview had all the information needed for it to decide whether to challenge those findings and chose not to. Northview had the right to appeal a survey finding of noncompliance leading to imposition of a remedy (here, a DPNA), but not CMS's selection of a particular remedy to address the noncompliance. See 42 C.F.R. §§ 488.408(g), 498.3(b)(12) and (13), 498.5(b); see also 59 Fed. Reg. 56,116, 56,121, 56,159.

That CMS may turn out to have the option not to impose the DPNA does not affect Northview's due process rights.[15]

[15] We note, however, that CMS may not retrospectively alter the starting date of the DPNA even though it could have imposed remedies beginning as early as the first day of noncompliance found in the February 2006 survey. Expanding the DPNA period would amount to a revised determination. Under 42 C.F.R. §§ 498.30 and 498.32, CMS may reopen and revise an initial determination only within one year of the initial notice and must state the basis or reason for its action in the revised determination notice.

The Board has previously addressed a situation in which a mandatory remedy turned out not to be required while CMS sought to have the same remedy remain in effect based on its discretionary authority in Beverly Health and Rehabilitation - Spring Hill, DAB No. 1696 (1999), aff'd, Beverly Health and Rehabilitation Services v. Thompson, 223 F.Supp.2d 73 (D.D.C. 2002). Beverly, like Northview, involved a remedy, in that case termination, that CMS either can impose or must impose depending on the circumstances. Compare 42 U.S.C. § 1395cc(b)(2) and 42 C.F.R. §§ 488.406(a), 456(b)(1)(i)(CMS may impose the remedy of termination whenever a long term care facility is not in substantial compliance with a requirement for participating in the Medicare program) with 42 C.F.R. § 488.410(a)(4)(CMS must impose the remedy of termination if a facility has not removed immediate jeopardy level noncompliance within 23 days after the last day of the survey first identifying the immediate jeopardy). In Beverly, CMS was required to impose termination because it found noncompliance findings at the immediate jeopardy level were not abated after 23 days. The ALJ overturned the immediate jeopardy determination but upheld findings of noncompliance. DAB No. 1696, at 3. He rejected Beverly's argument that because the termination was mandatory given the immediate jeopardy determination, the termination could not endure once the ALJ reversed that determination. Id. at 20-21. The ALJ found that he had no authority to rescind Beverly's termination since CMS had discretion to impose that remedy based on the findings of noncompliance that he upheld despite his reversal of CMS's determination that certain of the findings constituted immediate jeopardy. Id. In upholding the ALJ Decision, the Board rejected Beverly's argument that the ALJ and the Board must measure CMS's action by what CMS "actually did, not what it might have done, could have done or had the discretion to do," and, thus, could not uphold the termination absent immediate jeopardy since CMS imposed the remedy because of the jeopardy. Id. at 14. The Board held that "[t]he ALJ correctly found that he was without authority to rescind a termination for which [CMS] had shown an adequate legal basis." Id. at 20. The Board noted that the preamble to the regulations contemplated that CMS might continue to terminate a facility even after the immediate jeopardy findings which made termination mandatory were overturned, stating that, "even if a facility were able to successfully contest a conclusion that immediate jeopardy exists, the agency could still proceed with the termination action since the agency's authority to bring such an action is not limited to immediate jeopardy cases, but may span all noncompliant facility behavior." Id. at 22, citing 59 Fed. Reg. at 56,178. The same is true of a DPNA which CMS was

originally required to impose, but which it still had authority to impose even without the situation that made it mandatory.

The regulations thus reserve the discretion to choose an appropriate remedy to CMS whenever a facility is found not to be in substantial compliance. While the ALJ thus may not on his own overturn CMS's decision to impose a DPNA, it does not follow that he is precluded from determining whether CMS would choose to impose the DPNA based on the February 2006 noncompliance findings in light of the changed situation if substantial compliance was achieved in January 2006. The Board did not hold in Beverly that CMS must continue to impose a remedy when it is no longer mandatory, only that doing so is within its authority.

On appeal, CMS argues, in the alternative, that the ALJ should remand to give CMS a chance to exercise its discretion in determining whether to continue to impose the DPNA based on the February survey. In Beverly, the Board held that the ALJ could have remanded to ascertain "whether the position of the agency on the appropriate remedy has been altered as a result of the facts developed during the appeal process," while retaining jurisdiction. DAB No. 1696, at 25 (citations omitted). For various reasons, however, the Board also held that the ALJ was not required to remand in that case since "the ALJ could reasonably assume that [CMS] continued to believe that the remedy imposed was appropriate to address the deficiencies found in the survey and sustained by the ALJ, despite the reversal of those survey deficiencies that underlay the immediate jeopardy finding." Id. at 26-27. In the present case, we decline to presume that CMS will continue to believe that the DPNA is appropriate based solely on the February 2006 noncompliance findings even if no longer required. Therefore, the ALJ should obtain the input of CMS, either through a submission from an appropriate decision-maker or through a remand while retaining jurisdiction, as to whether CMS still chooses to impose the DPNA, if the ALJ again finds substantial compliance in January 2006.

D. The ALJ's determination that CMS did not make a prima facie case of noncompliance with 42 C.F.R. § 483.30(a) contains errors of law requiring us to vacate and remand the decision for further proceedings.

1. The ALJ's construction that 42 C.F.R. § 483.30(a) requires CMS to show failure (or threatened failure) to meet needs specifically identified in individual care plans is too narrow.

The ALJ found that CMS had not made a prima facie case of noncompliance with 42 C.F.R. § 483.30(a)(Tag F353) and concluded, therefore, that Northview was in substantial compliance with Medicare participation requirements on January 6, 2006, and that CMS had no basis for imposing remedies.[16] The ALJ made the following specific FFs:

12. The evidence does not show any failure by Petitioner to deliver a care planned care or to meet a resident's care planned need.
13. The evidence does not show that insufficient staffing at Petitioner's facility posed an unreasonable threat that Petitioner would fail to meet a resident's care planned need.

14. The evidence does not show that any resident was exposed to the risk of more than minimal harm due to insufficient staffing at Petitioner's facility.

ALJ Decision at 5. He then made the following conclusions of law:

5. CMS did not make a prima facie showing that Petitioner violated 42 C.F.R. § 483.30(a)(Tag F353).

6. CMS did not make a prima facie showing that Petitioner was not in substantial compliance with program participation requirements on January 6, 2006.

7. Petitioner was in substantial compliance during the survey conducted January 3 through 6, 2006, which stopped the running of the three month period that

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[16] CMS also cited noncompliance with 42 C.F.R. § 483.25(m)(1) (Tag F332)(medication errors) but notified the ALJ during the hearing process that while it would rely upon findings and allegations under this citation to make its prima facie case of noncompliance with 42 C.F.R. § 483.30(a), it would not continue to assert noncompliance with section 483.25(m)(1) itself. In CL 4, the ALJ concluded that CMS had not made a prima facie case of noncompliance with section 483.25(m)(1) based on CMS's decision not to proceed on that violation but did not make any findings about the alleged substance of that noncompliance, as cited on the SOD or shown in other evidence of record. ALJ Decision at 5, 14. CMS does not appeal CL 4 but continues to rely on the findings under section 483.25(m)(1) for its case of noncompliance with section 483.30(a).

began November 21, 2005, and the mandatory DPNA was not triggered effective February 21, 2006.

8. The survey that ended on January 6, 2006, did not provide a basis for the imposition of an enforcement remedy.

Id. at 5-6.

As indicated in the findings and conclusions above, the ALJ articulated the standard for making a prima facie case of noncompliance with 42 C.F.R. § 483.30(a) in terms of CMS having to provide evidence of failure to meet residents' "care planned" needs. The ALJ repeated this focus on needs identified in residents' care plans in his discussion of what CMS must show in order to make a prima facie showing of noncompliance with 42 C.F.R. § 483.30(a)(1). The ALJ stated that CMS must show that "(1) resident needs as identified in their care plans are not met or may not be met; (2) the inability or failure to meet needs of the residents was due to insufficient staffing; and (3) the failure to meet resident care planned needs posed the risk for more than minimal harm." ALJ Decision at 16. CMS had argued that it was not necessary to cite a quality of care deficiency in order to allege insufficient staffing and cited as evidence of noncompliance with the staffing requirement alleged failures to meet needs not necessarily identified in residents' care plans, such as not responding promptly to call lights, administering medications late, using too many incontinence pads and not showering residents as scheduled. CMS also presented evidence of unmet staffing schedules. CMS argued that the ALJ could infer noncompliance with section 483.30(a) from evidence of the alleged failures of care and the numbers of staff on duty. The ALJ rejected CMS's reading of the staffing requirement.

> My understanding is that CMS advocates that I should compare the assessed needs of residents with the number of staff on duty and infer or determine that staff was insufficient to meet the needs of the residents without evidence of a specific failure of Petitioner to meet a care planned need of a resident and without evidence of the specific care planned needs of the residents. CMS cites to no authority for this approach or case where such approach has been accepted by the Board. I conclude based upon my review of the facts as summarized hereafter, that CMS has failed to show any failure by Petitioner to deliver a care planned care or to meet a resident's care planned need.

ALJ Decision at 18.

We conclude that the ALJ's finding that section 483.30(a) requires evidence of failure to deliver a specific care planned need before an ALJ can determine that staff was insufficient to meet the needs of residents is too narrow. The staffing regulation provides:

> The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.
>
> (a) Sufficient staff. (1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:
>
> (i) Except when waived under paragraph (c) of this section, licensed nurses; and
> (ii) Other nursing personnel.
>
> (2) Except when waived under paragraph (c) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty.

42 C.F.R. § 483.30(a). The ALJ's reading of this regulation focused on the language "as determined by resident assessments and individual plans of care" and "in accordance with resident care plans." However, the staffing regulation incorporates the general quality of care language from section 483.25, that a facility "must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident . . . ." While the "necessary care and services" includes care and services identified in resident care plans, not all "care and services" that are "necessary" to meet this requirement would necessarily be specifically identified in care plans. Examples include care and services of the type that CMS alleged were not provided here, e.g., failure to respond to call lights promptly or failure to complete medication passes in timely fashion. Thus, we read the language "as determined by resident assessments or individual plans of care," or "in accordance with resident care plans" as referring to the requirement that resident care be consistent with each resident's individualized needs in addition

to basic care needs, not as limiting the scope of the care and services encompassed by the staffing requirement to care and services specifically identified in individual care plans or assessments. Reading the language as the ALJ did would mean, for example, that while failure to provide a specially care-planned meal due to short staffing would demonstrate a deficiency, failure to provide basic nutrition to multiple residents due to short staffing would be irrelevant. We conclude that while noncompliance with section 483.30(a) can be established based on evidence of failure to meet specific care planned needs, it can also be established based on evidence of failure to meet care needs, or to provide necessary services, that are not specifically identified in individual care plans.

Our interpretation is consistent with CMS's Guidance to Surveyors - Long Term Care Facilities in the State Operations Manual (SOM), including the passage the ALJ cited in his decision.

> [T]he determining factor in sufficiency of staff (including both numbers of staff and their qualifications) will be the ability of the facility to provide needed care for residents. A deficiency concerning staffing should ordinarily provide examples of care deficits caused by insufficient quantity and quality of staff. If, however, inadequate staff (either the number or category) presents a clear threat to residents reaching their highest practicable level of well-being, cite this as a deficiency. Provide specific documentation of the threat.

SOM, App. PP-135.8, Tag F353 (07-99); ALJ Decision at 15. These instructions do not limit "needed care" to care specifically identified in individual care plans; rather, they speak more broadly of "care deficits caused by insufficient quantity and quality of staff." Indeed, these instructions do not even require citation to specific care deficits, whether based on care plans or not, but permit CMS to "cite a deficiency" if "inadequate staff (either the number or category) presents a clear threat to residents reaching their highest practicable level of well-being . . . ." If CMS cites a deficiency for the latter reason, it must "provide specific documentation of the threat," but the important point is that the instructions cited by the ALJ himself support a broader reading of the regulation than that applied by the ALJ.

In addition, the probes listed in the SOM to guide surveyors in assessing compliance with the regulation include such inquiries as "Do work loads for direct care staff appear reasonable?"; "Do

residents, family and ombudsmen report insufficient staff to meet resident needs?"; "Are staff responsive to residents' needs for assistance, and call bells answered promptly?"; and "Are identified care problems associated with a specific unit or tour of duty?" SOM, App. PP-135.8-137 (07-99 and 06-95) (partial list); see also current version of SOM at App. PP at 446.[17] Such probes indicate that assessing compliance with the staffing regulation is broader than simply looking at whether staffing is sufficient to meet needs specifically identified in individual care plans. Only one probe mentions the plan of care: "How does the facility assure that each resident receives nursing care in accordance with his/her plan of care on weekends, nights, and holidays?" App. PP-137.

The Board decisions on which the ALJ relies did not address whether failures of care that might be found to evidence noncompliance were limited to care needs identified in individual resident assessments or care plans. However, our conclusion here that they are not so limited is consistent with the Board's analysis in those decisions. As the ALJ noted, our decision in Carehouse Convalescent Center, DAB No. 1799 (2001), held that "the essence of a deficiency under Tag F353" involved "the link or nexus between a facility's failure to deliver appropriate care and the number of staff the facility provided to deliver care to its residents." ALJ Decision at 15 (citing Carehouse at 39-40). Carehouse did not indicate that "appropriate care" was limited to care identified in a care plan. Neither, as the ALJ recognized, did that decision address "whether the number of staff on duty might give rise to an inference of poor quality of care," which the ALJ characterizes as "the principal theory advanced by CMS in this case." ALJ Decision at 15.

In Westgate Healthcare Center, DAB No. 1821 (2002), the Board did state that "compliance with the federal staffing requirement at 42 C.F.R. § 483.30(a)(1) is determined by whether the numbers of staff are sufficient to meet residents' needs, as determined by resident care plans . . . ." Westgate at 2. However, as discussed above, the language "as determined by resident care plans" simply mirrors the language of the regulation, which we have found does not mean that findings of noncompliance with that requirement can only be upheld based on evidence of failure to render care or services specifically identified in individual

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[17] These probes pertain to section 483.30(a) and (b)(Tags F353 and F354). Subsection (b) pertains to use of a registered nurse.

care plans. The staff must comply with the individual plans but must also provide all services required to meet the standard of "highest practicable physical, mental, and psychosocial well-being of each resident . . . ." 42 C.F.R. § 483.25. The Board certainly did not hold in Westgate that the only unmet resident needs that can be the basis for a staffing deficiency are those identified in individual care plans. That the Board neither held nor intended this limitation is indicated by its statement that "the ALJ's conclusion is consistent with the federal regulation since he analyzed the residents' needs, citing the residents' care plans and other relevant evidence in support of his findings." Id. at 12 (emphasis added). The "other relevant evidence" included evidence of falls and resident-to-resident confrontations in the dementia ward that the ALJ found, and the Board affirmed, resulted from inadequate staffing of that unit during the night shift. Id. at 22.

2. The ALJ erred by discrediting all surveyor recordings and recollections of interviews with residents, family members and staff based on his unsupported assumption of "possible investigator bias" and the absence of what he considered indicia of reliability in the interview process.

CMS presented evidence - the SOD, surveyor interview notes and testimony - of numerous complaints about care deficits from facility staff, residents and family members.[18] The ALJ decision discusses ten such complaints received by the surveyors during interviews, including three from family members, two from residents, and five from staff.[19] The complaints from family members concerned inadequate staffing to meet resident needs in timely fashion. The complaints from residents included allegations of having to wait too long for staff to respond to call lights or otherwise untimely care. ALJ Decision at 23.

The complaints from facility staff included complaints from three nurse aides about having too many residents and not being able to get their work done and a nurse reporting that staff

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[18] CMS presented other evidence, including evidence based on the surveyors' own observations of care during the survey (which the ALJ should consider on remand), but we do not discuss that evidence here.

[19] On page 20 of his decision, the ALJ states that the SOD listed two complaints from family members and three from residents, but the ALJ's discussion addresses complaints by three family members and two residents.

frequently called in that they could not work. ALJ Decision at 24. Two of the CNAs (Chapin and Price), according to the surveyor notes, stated that the nurses "do not do anything." Id. at 25 (citing CMS Ex. 21, at 5, 6). CNA Chapin, the notes indicate, specifically complained that meal trays sometimes sat for 20 minutes before residents were fed, that she had found four to six wet incontinence pads on wet sheets at times, that she was not able to get her work done, and she did not have time to provide oral care. Id. (citing CMS Ex. 21, at 5). CNA Price stated that she was not able to get her work done and that while she did not know why the night shift padded the bed so much (with multiple incontinence pads), she speculated that it was because residents were not checked every two hours. CNA Price also told the surveyors, according to their notes, that there was not enough time to feed residents so she fed as fast as possible and that there was known weight loss. Id. at 26 (citing CMS Ex. 23, at 8, 16). Another CNA (Goins) complained to surveyors that the facility was always short-staffed and that no showers were given the weekend before the survey. Id. at 25.

The ALJ discredited all of these complaints, among others, for various reasons, two of which we conclude constitute legal error that taints the ALJ's analysis of the evidence and requires us to vacate his findings and conclusions and remand for further proceedings and a new decision consistent with our decision. The first is the ALJ's conclusion that the recordings and recollections of all of the surveyors with regard to all of the interviews with residents, family members and staff were unreliable because of "possible investigator bias." The second is his finding that the interview notes lacked internal indicia of reliability.

On the "possible investigator bias" issue, the ALJ stated:

> The surveyor notes were made by the surveyor during the course of her duties as an investigator and there is no assurance that the contents of the notes were not affected by her perceptions as an investigator, i.e., what is recorded is the investigator's perception of responses to questions the investigator asked to which I am not privy and in a context that is not captured in the investigators notes. My concern about possible investigator bias applies to all the surveyors' recordings and recollections of complaints by staff and residents in this case.

Id. at 21 (emphasis added). The ALJ made this statement while discussing one surveyor's interview with one individual. However, it is clear from the sweeping language in the

underscored sentence that the ALJ's concern about "investigator bias" influenced his view of every recording and every recollection of complaints by every surveyor and extended to all of the surveyor notes on all interviews with residents, family members and facility staff and to surveyor testimony addressing recollections of such encounters.

The Board defers to an ALJ's determinations on credibility and the weight of the evidence, and generally does not disturb those determinations absent a compelling reason. Gateway Nursing Center, DAB No. 2283, at 7 (2009); Lakeridge Villa Health Care Center, DAB No. 1988, at 19-20 n.14 (2005); Koester Pavilion, DAB No. 1750, at 21 (2000). The Board has also recognized that, while admissible in administrative hearings, hearsay presents inherent reliability concerns since the declarant is not subject to the usual safeguard of cross-examination, and has further recognized that the ALJ must weigh those concerns against other reasons to accord credence to hearsay evidence. The Board explained the ALJ's role as follows:

> The question then is not whether various levels of hearsay may be admitted into evidence in this administrative hearing (they may be, subject to relevance and fundamental fairness), but what weight the ALJ should accord hearsay so admitted. That weight is determined by the degree of reliability, based on relevant indicia of reliability and whether the hearsay is corroborated by other evidence in the record as a whole.

Omni Manor Nursing Home, DAB No. 1920, at 17 (2004), quoted in Gateway Nursing Center at 6-7.

In this case, however, we find compelling reasons to reject the ALJ's determination to discredit all surveyor recordings and recollections for "possible investigator bias." The ALJ cites, and we find, no authority for a general principle of "investigator bias" or for the specific proposition that all records made by surveyors or all surveyors' reports of interviews are inherently biased in some systematic way.

Furthermore, the ALJ did not set out a factual foundation for his assumption that all surveyors are subject to some sort of investigator bias. The ALJ did find that testimony by surveyor Wolfgang about a statement allegedly made to her by Northview's DON "reflected a tendency to overstatement or exaggeration that reflects poorly upon her credibility . . ." because it differed

from what she wrote in her notes about the statement.[20] ALJ Decision at 24. The ALJ then stated that this overstatement or exaggeration "add[ed] to my concern that investigator bias affected surveyor recording and recollection of statements of residents and staff." Id. The ALJ also found that surveyor Smith's statement on direct that she saw three or more incontinence pads on beds was an "overstatement or exaggeration" because on cross-examination that she admitted not seeing more than three pads on one bed. Id. at 30. While the ALJ commented that this discrepancy reflected "badly upon her credibility," he did not connect it to any general investigator bias. Id. The ALJ made no comparable individual finding with regard to surveyor McNamee. While we accept the ALJ's determination that the two individual surveyors exaggerated or overstated these particular findings, we do not find in that determination support for the ALJ's sweeping conclusion discounting all surveyor recordings and recollections of interviews as not credible or lacking probative value because of "possible investigator bias." We do not hold here that an ALJ who finds and cites evidence of bias on the part of a particular surveyor or surveyors in a particular survey cannot factor that evidence into his or her credibility determinations. The ALJ's assumption of "possible investigator bias" here, however, was based not on evidence of bias in fact on the part of individual surveyors but, rather, on a presumption that bias is inherent in the surveyor role or necessarily evidenced by credibility issues regarding particular testimony.

The ALJ's characterization of the surveyors as investigators misperceives the nature and function of the survey process as well as the role of surveyors in that process. The survey process is a congressionally mandated method of assessing compliance with federal requirements for long-term care facilities. Act, §§ 1819(g)(1)(A) and 1919(g)(1)(A). The process is designed to protect vulnerable residents of nursing facilities by applying federally mandated standards of care to those facilities, employing survey procedures developed by CMS. The surveyors are trained professionals in medical or related fields and receive special training to fulfill those duties. 42 C.F.R. § 488.314. Interviewing residents, family members and

[20] In her notes, surveyor Wolfgang wrote that the DON said CNAs "usually" have no more than 10 residents to care for." ALJ Decision at 23. In her testimony, surveyor Wolfgang said the DON told her that CNAs "never" had to care for more than ten residents at a time during the day shift. Id. (citing Tr. at 186-87).

staff is an important part of the survey process. The ALJ's reasoning, taken literally, might lead to discarding all information gathered through such interviews without proper consideration of such factors as reliability, consistency, corroboration, and personal credibility. The Board has upheld ALJ evaluations (favorable or unfavorable) of individual surveyor credibility in the face of allegations of bias where the ALJ properly considered such factors. See, e.g., Canal Medical Laboratory, DAB No. 2041 (2006); Meadow Wood Nursing Home, DAB No. 1841 (2002); Carehouse Convalescent Hospital, DAB No. 1799 (2001). However, the Board has also pointed out that allegations of surveyor bias are largely irrelevant where noncompliance is demonstrated by objective evidence independent of surveyor reports or testimony. See, e.g., Canal Medical Laboratory at 5-6; Jewish Home of Eastern Pennsylvania, DAB No. 2254, at 13 (2009). Neither Community Northview nor the ALJ identifies any case in which the Board has upheld a blanket rejection of all surveyor notes, reports and testimony. We decline to uphold such an approach here.

In addition to discrediting all surveyor recordings and recollections based on an unsupported assumption of "possible investigator bias," the ALJ found the surveyor notes of interviews with family, staff and residents unreliable and lacking in probative value because they did not reflect the actual questions asked or the answers given or indicate that the interviewee saw what the surveyor recorded or agreed that it was an accurate summary and because CMS did not introduce any written statement indicating that the interviewee understood that he or she was obliged to respond truthfully. ALJ Decision at 21, 22, 23, 24, 25. The ALJ so found even though he noted that the surveyors used quotation marks in at least some of the interview notes. ALJ Decision at 21.

The ALJ erred in dismissing the interview notes out of hand for these reasons. He cited no authority requiring surveyors to incorporate such information in the interview process or requiring CMS to introduce evidence of the interviewee's understanding of the need to be truthful. The SOM requires surveyors to interview residents, family and staff, including when looking into a possible violation of section 483.30(a). See, e.g., SOM App. P at Tasks 2, 3, 4, 5.C (Informal and Formal Interviews), 6 (Investigative Protocol - Nursing Services, Sufficient Staffing) (08-05); SOM App. PP-135.7 (07-99 and 06-95); see also current version of SOM at App. P, Tasks 2-6; and App. PP at 446. The Principles of Documentation, which provide guidance to surveyors on how to effectively record their findings, do not instruct surveyors to write down verbatim

questions they pose or answers given during interviews. SOM, Chap. 9, Ex. 7A at 21-22. Neither do they require surveyors to admonish individuals to tell the truth, obtain sworn statements or have the person interviewed verify the surveyors' notes for accuracy. Id.

In Indiana Department of Public Welfare, DAB No. 958 (1988), the Board found no reason to discount employee interviews with CMS (then HCFA) auditors merely because they were summarized by the auditors in their work papers and not officially recorded and sworn, in part because it was an accepted practice to hold such interviews and make such summaries. Although Indiana Department of Public Welfare did not involve CMS's long-term care facility survey process, we see no reason why the same principle would not apply, at least where the guidelines for that survey process do not require recordings beyond surveyor notes or sworn statements. While an ALJ may consider whether sworn, signed or verbatim statements have greater indicia of reliability, it does not follow that surveyor records of interviews without such indicia should be entirely disregarded on that basis.
We find especially troubling the ALJ's rejection of surveyor notes recording interviews with facility staff members even though he acknowledged that admissions by Northview's staff to the surveyors were not hearsay to the extent the staff were acting within the scope of their employment. The ALJ stated that he was not treating the statements as hearsay. ALJ Decision at 25, n. 17. Nonetheless, the ALJ wholly discredited those statements based on his conclusion "that the recording of the surveyors' perception of their statements is not reliable or does not amount to a statement that any resident was denied a care planned care." Id. We have already concluded that the ALJ erred with respect to both his presumption of possible investigator bias and his reading that making a prima facie case of noncompliance with section 483.30(a) requires evidence of a failure to provide care specifically identified in individual care plans. Accordingly, the ALJ should not have dismissed the employee statements out of hand but should have weighed them together with other evidence of record, making determinations about credibility as necessary.

Interviews with facility staff are a usual and important part of the survey process. Accordingly, an ALJ should not discredit statements made by staff to surveyors in the ordinary course of a survey without giving an adequate explanation for that decision. We note in this regard that where a facility disputes the veracity or reliability of a surveyor's recording of an interview with a staff member, the facility has the option of providing testimony rebutting that recording through sworn

declarations or testimony at a hearing. See Lutheran Home at Trinity Oaks, DAB No. 2111, at 15-16 (2007)(ALJ did not err in crediting a surveyor report of statement made by facility nurse in light of circumstances that included facility's failure to produce nurse as a witness); Indiana Department of Public Welfare, DAB No. 958, at 7 (rejecting challenges to the veracity of statements made to auditors, as reported by the auditors, where the State could have submitted, but did not submit, written sworn statements from the personnel in an effort to prove that the challenged statements were false).

For all of these reasons, we find that the ALJ erred in discrediting the surveyor recordings of statements during interviews with staff, family and residents because they lacked the kind of information he described as necessary to make them reliable and probative.

3. The ALJ erred in excluding evidence not cited in the SOD without considering whether the facility had received adequate notice of the evidence, and CMS's reliance thereon, during the prehearing process.

CMS argues on appeal to the Board that the ALJ erred in excluding a surveyor's testimony about her observations of Resident D not receiving adequate assistance with eating his lunch because Resident D was not one of the examples cited on the SOD for this deficiency. RR at 29, citing Tr. at 178-187. CMS also argues that the ALJ erred in ruling that another surveyor could not testify about her conversation with Resident E about call light response time because that conversation had not been described in the SOD. RR at 30, citing Tr. at 349-356.

We conclude that the ALJ erred in not allowing the surveyor to testify about her observations of Resident D, but did not err in excluding testimony by another surveyor with respect to her conversation with Resident E.[21] The Board has held that the SOD

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[21] The ALJ permitted CMS's attorney to make a proffer of evidence with respect to the testimony of both surveyors on these matters. Tr. at 184-85, 350-55. CMS counsel made the following proffer as to the surveyor's excluded testimony about her observation of Resident D: "What her observation is on, is that he [Resident D] was brought his tray. It was uncovered by staff, but no one attempted to assist him or feed him for 20 minutes." Id. at 185. With respect to the excluded testimony about another surveyor's interview with Resident E, CMS proffered that the surveyor would have testified that the

(Continued. . .)

is a notice document that "is not designed to lay out every single detail in support of a finding that a violation has been committed." Pacific Regency Arvin, DAB No. 1823, at 7 (2002); see also Northern Montana Care Center, DAB No. 1930 (2004). As the Board stated in Northern Montana, the SOD does not "rigidly frame the scope of the evidence to be admitted concerning any allegation relating to a cited deficiency, nor does it require formal amendment to allow additional supporting documents." DAB No. 1930, at 26. While fairness requires that the SOD give notice of CMS's bases for imposition of remedies, the SOD may be amended or notice of additional evidence may be provided through prehearing record development without amending the SOD. Alden Town Manor Rehabilitation and Health Care Center, DAB No. 2054, at 18 (2006), citing Pacific Regency Arvin, DAB No. 1823, at 9-10 (2002). In Livingston Care Center, DAB No. 1871, at 20 (2003), aff'd, Livingston Care Ctr. v. U.S. Dep't of Health & Human Servs., 388 F.3d 168 (6th Cir. 2004), for example, the Board upheld the ALJ's reliance on evidence of a surveyor observation that was recorded in the surveyor notes and discussed in CMS's summary judgment brief but did not appear on the SOD.

Here, CMS had discussed the surveyor's observations of Resident D in its Prehearing Brief. CMS Prehearing Br. at 15. In addition, CMS Exhibit 21, which CMS served on Northview more than six months before the hearing, contained surveyor notes regarding these observations. See CMS Ex. 21 at 1. Furthermore, the SOD had given Northview general notice that survey findings regarding insufficient staff to feed residents were one of the bases for CMS's findings of noncompliance with section 483.30(a). See CMS Ex. 4, at 7. This general notice, together with the evidence submitted during the prehearing process and discussed in CMS's prehearing brief, provided sufficient notice, and the ALJ should have permitted the surveyor to testify about her observations. The ALJ's ruling not allowing the testimony was error that could well have prejudiced CMS's ability to make its case. In this regard, we note that CMS cited evidence of record indicating that the facility had assessed Resident D as requiring assistance with

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(Continued. . .)
resident was cognitively able to determine the amount of time staff took to respond to a call light and that the resident said she had waited more than an hour on at least one occasion and often waited more than 15 minutes. Tr. at 353-54.

eating.[22] CMS Ex. 8, at 2. The cited evidence tends to undercut the ALJ's general finding that CMS cited no failures to meet specific care-planned needs. We have concluded in this decision that it is possible to make a prima facie case of noncompliance with section 483.30(a) without citing such failures. Nonetheless, the ALJ's legal analysis of what the regulation required provided the context in which he determined whether CMS had made its prima facie case. Had the ALJ had the benefit of surveyor testimony about an incident that was directly tied to a resident's specific assessed need for assistance with feeding, this might have altered the ALJ's determination that CMS had not made a prima facie case. We, therefore, cannot consider this error harmless.

CMS alleged for similar reasons that the ALJ erred in excluding surveyor testimony about a conversation with Resident E regarding call light response time. CMS asserts that the facility had identified Resident E as interviewable and that notes of the surveyor's interview with the resident were included in a CMS exhibit provided to Northview during the prehearing process. RR at 30, citing CMS Ex. 8 and CMS Ex. 23, at 12. However, CMS does not allege before us that it notified Northview via its prehearing brief (or any other prehearing submission discussing the merits of its case) that it would rely on these notes, and our review of CMS's prehearing brief reveals no mention of the conversation with Resident E. (On the issue of alleged staff slowness in responding to call lights, CMS's prehearing brief addresses only surveyor observations of an alleged slow response and an interview with the husband of Resident OO on this issue.) See CMS Prehearing Br. at 16. Thus, while the ALJ erred in excluding the proffered testimony

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[22] Neither the care plan nor the resident assessment instrument (RAI) for Resident D is in the record. See 42 C.F.R. § 483.20 (requiring comprehensive assessments for each resident using the RAI with the information to be used to develop, review and revise the resident's comprehensive plan of care). However, the document CMS cites is a list of residents requiring feeding assistance that, based on a handwritten notation, appears to have been provided to the surveyors by Northview's DON. Resident D is on the list, and the word "yes" appears next to his identifier under the column heading "FEEDING ASSISTANCE." This indicates that the facility did assess Resident D as needing assistance with feeding even though his formal assessment and care plan are not in the record. (The list also designates which residents are capable of being interviewed, but Resident D is not designated as one of those residents.)

regarding Resident E simply because the conversation with Resident E was not mentioned on the SOD, we find this error harmless under the facts of this case. Under these circumstances, the ALJ could reasonably have concluded that Northview did not have sufficient notice of the new allegations and an opportunity to develop its defense to them.[23] See Kingsville Nursing and Rehabilitation Center, DAB No. 2234, at 13 (2009).

4. The ALJ erred in failing to consider certain evidence of record that conflicts with his findings.

The Board has held that while an ALJ does not have to address every fact in the record, the ALJ must address evidence that conflicts with the evidence supporting his or her findings of fact. Estes Nursing Facility Civic Center, DAB No. 2000, at 5-6 (2005), citing Hillman Rehabilitation Center, DAB No. 1611, at 51 (1997), aff'd, Hillman Rehabilitation Ctr. v. U.S. Dep't of Health & Human Servs., No. 98-3789 (GEB)(D.N.J. May 13, 1999). In Hillman, the Board stated, "an ALJ decision cannot be adequately reviewed unless it contains 'not only an expression of the evidence s/he considered which supports the result, but also some indication of the evidence which was rejected . . . [in order to determine] if significant probative evidence was not credited or simply ignored.'" DAB No. 1611, at 51, n.39, citing Cotter v. Harris, 642 F.2d 700, 705 (3rd Cir. 1981). CMS alleges here that the ALJ ignored a shower schedule admitted to the record that CMS says corroborated information received from CNA Goins during an interview that no showers were given the weekend before the survey and showed that 35 residents who were scheduled to receive showers that weekend did not receive them. RR at 37, citing CMS Ex. 27. CMS further alleges that the ALJ erred in concluding that CMS had not alleged or shown that any resident suffered harm or risk of harm by not receiving a shower that weekend, noting that the ALJ overlooked testimony by two surveyors to the effect that not receiving scheduled showers harms resident dignity and quality of life. Id., citing Tr. at 376, 476.

We do not agree with CMS that the record indicates the ALJ overlooked testimony by two surveyors on the issue of risk of harm connected with the alleged failure to give showers as scheduled due to staff shortages. The transcript citations CMS

[23] We do not hold here that a surveyor note alone can never be sufficient to provide notice of CMS's reliance on particular evidence.

makes are to testimony by two surveyors (Smith and McNamee) as to how insufficient staffing can pose a risk of harm to resident dignity. However, only the testimony of surveyor Smith addressed the relationship between the alleged insufficient staffing and the alleged failure to give showers.[24] Nonetheless, we agree that the ALJ should have considered the testimony of surveyor Smith on this issue since affronts to resident dignity can constitute harm. Cf. Lineville Nursing Facility, DAB No. 1868 (2003)(holding that facility's failure to develop effective scheduled toileting program increased the risk of persistent or increasing incontinence and attendant consequences - including undermining a resident's sense of dignity - which, if they occurred, would cause more than minimal harm).

We also find error in the ALJ's failure to address the shower schedule, notwithstanding his findings that the surveyor notes "do indicate that CNA Goins told the surveyors that no showers were given the weekend before the survey . . . ." ALJ Decision at 26. The shower schedule had the potential to corroborate the surveyor notes and establish that care was not given as scheduled. The ALJ concluded that even "[a]ssuming showers were actually scheduled for that weekend, CNA Goins did not indicate that showers were not provided before or after the weekend to accommodate scheduling, but the notes clearly do not show she told the surveyors that any resident was denied a shower." Id. This conclusion seems to assume that a failure to give the showers on the weekend, as scheduled, cannot be a violation of section 483.40(a) if the showers were given at some other time. The ALJ might have reached a different conclusion if he had considered the testimony of surveyor Smith discussed above.

CMS also argues that the ALJ erred by overlooking the fact that time cards and an "as worked" schedule admitted into evidence corroborated other evidence of insufficient staffing. RR at 31. However, this argument goes to the weight the ALJ afforded the evidence and conclusions he drew from it, not to any failure to admit or consider the evidence. The ALJ did "accept the information as presented" and concluded that it "shows that at times Petitioner operated with fewer staff than the DON preferred." ALJ Decision at 24. The ALJ nonetheless concluded that the "evidence does not show that any resident was denied care as a result and I draw no inference based on this evidence

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[24] CMS's citation to page 476 of the transcript is to testimony by surveyor McNamee that the alleged failure to give timely pericare or incontinent care could adversely affect resident dignity.

that the level of staffing posed an unreasonable risk that care planned care would not be delivered." Id. Thus, we do not find the legal error alleged by CMS. However, we do note that the ALJ's conclusion, as stated, rests on his analysis that section 483.40(a) requires a showing of failure to provide care specifically identified in a care plan, an analysis that we have found is legally erroneous because it is inconsistent with the regulations. Thus, on remand, the ALJ should reconsider, using the legal analysis set forth in our decision, whether the evidence of staff shortages he accepted as true supports finding a prima facie case of noncompliance with 42 C.F.R. § 483.30(a) and, if so, whether Northview has rebutted that case by a preponderance of the evidence.

CMS also asserts that the ALJ ignored surveyor notes and testimony that, in CMS's view, would have corroborated statements made by Resident PPP's daughter that her mother had pressure sores and urinary tract infections (UTIs) and that leaving her mother in wet incontinence briefs for long periods of time contributed to these conditions. RR at 38, citing CMS Ex. 15, at 4 (Resident Review Worksheet indicating that Resident PPP had a pressure sore on her coccyx), CMS Ex. 21, at 6 (surveyor notes of interview with Resident PPP's daughter). CMS notes that the ALJ dismissed the daughter's opinion on the ground that she was not qualified to make such a judgment but asserts that the ALJ ignored surveyor testimony consistent with this judgment, that is, that not having sufficient staff can result in incontinence care not being provided timely, which, in turn, can cause skin breakdown and UTIs. Id., citing Tr. 229, 476.

We agree that the ALJ did not discuss CMS Exhibit 15, at 4, which corroborated the daughter's statement that Resident PPP had a pressure sore. He also did not discuss the surveyor testimony cited by CMS about the potential for UTIs and skin breakdown when incontinence care is not provided in timely fashion. However, contrary to CMS's assertion, the ALJ did discuss CMS Exhibit 21, at 6, the surveyor notes reporting the daughter's statements making a connection between untimely incontinence care and her mother's UTIs and skin breakdown. ALJ Decision at 22. Thus, the ALJ did not ignore the daughter's statement; nor did he find that the mother did not have UTIs or skin breakdown or that untimely incontinence care could not contribute to these conditions under some circumstances. He concluded, instead, that the daughter's statement, and the notes reporting that statement, did not show that the mother was, in fact, wet during the alleged long periods of time that she did not receive timely incontinence care, and, thus, did not support

the daughter's assertion that the alleged untimely incontinence care contributed to the mother's UTIs or skin breakdown. We find no error in the ALJ's conclusion that the evidence cited by CMS fell short of establishing this connection and, thus, need not reach the issue of whether the ALJ properly concluded that the daughter was not qualified to draw the conclusion she articulated to the surveyors.

CMS also argues that the ALJ "dismissed the ISDH surveyors' finding that residents were not being provided prompt and thorough pericare." RR at 38. We find no basis for this assertion. CMS says the ALJ "ignored" what CMS terms the ADON's "admission" that Northview staff did not always perform pericare after a resident had an incontinence episode at night. RR at 39, citing Tr. at 735, 743, 769 and 773. However, this is not an accurate characterization of the ADON's testimony as a whole. Taking into consideration the ADON's testimony on cross-examination as well as direct examination, it is not clear that, as CMS asserts, she testified that some residents would not be checked at 2-3 hour intervals to determine if they required pericare. On direct examination, the ADON testified that staff doing bed checks at night "may leave a resident to rest until the next time." Tr. at 735. However, the ADON "clarified" on cross-examination that she meant if the resident was clean and dry and did not mean that staff would leave a resident observed to be wet until the next time. Tr. at 774. We recognize that this "clarification" falls short of saying that each resident would be checked to ascertain if he/she was clean and dry and would be cleaned and changed if observed to be soiled or wet. However, we conclude that the testimony is sufficiently ambiguous, that the ALJ could reasonably have concluded it did not undercut his findings on this issue; therefore, we find no error in his failure to address this testimony.

Likewise, we reject CMS's assertion that the ALJ "overlooked DON Smith's testimony that foul odors result from pericare not being provided promptly and thoroughly." RR at 39, citing Tr. at 636. This is not an accurate statement of the DON's testimony. The DON testified that foul odors, as well as urinary tract infections, were possible effects of inappropriate pericare, not that they necessarily resulted from same. Tr. at 636. The DON also responded "No" when asked whether she "recall[ed] noticing particularly high incidences of odors with residents during that time period?" Tr. at 637. Taken together, this testimony does not tend to undercut the ALJ's apparent conclusion that the evidence of urine odors did not necessarily indicate a failure to provide appropriate incontinence care.

Finally, we reject CMS's suggestion that the ALJ overlooked the survey findings or testimony regarding the use of multiple incontinence pads. The ALJ discussed this evidence at some length in his decision, including the surveyors' testimony regarding the standard of care with respect to using incontinence pads. See ALJ Decision at 29-32. While CMS may disagree with the conclusions the ALJ drew from the evidence regarding pericare and incontinence care, including the evidence related to the use of multiple incontinence pads, CMS points to no evidence that the ALJ clearly overlooked in reaching those conclusions and, thus, we find no legal error with respect to these issues.[25]

Above we concluded that the ALJ erred by construing section 483.30(a) too narrowly with regard to the showing necessary to make a prima facie case of noncompliance under that regulation. We also concluded that the ALJ erred by discrediting all surveyor recordings and recollections of interviews with residents, family members and staff based on his unsupported assumption of "possible investigator bias" and the absence of what he considered indicia of reliability in the interview process. We further concluded that the ALJ erred in excluding evidence not cited in the SOD without considering whether the facility had received adequate notice of the evidence, and CMS's reliance thereon, during the pre-hearing process. We also concluded that the ALJ erred in failing to consider certain evidence of record that did not support his findings. We find that these errors were sufficiently serious to taint the ALJ's determination that CMS did not make a prima facie case of noncompliance with 42 C.F.R. § 483.30(a).

Accordingly, we are vacating the ALJ's FFs 12-14, and CLs 5 through 8 and remanding for further proceedings and a new decision on the merits consistent with our decision. Under section 498.88, the Board could issue a decision rather than remand. However, in deference to the ALJ's role as trier of fact and given the rather extensive evidentiary record in this matter, we deem it more appropriate in this case to remand to the ALJ. On remand, we instruct the ALJ to correct the legal

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[25] Our rejection of CMS's assertions of error should not be construed as upholding the ALJ's evidentiary findings on the pericare or incontinence care issues. Since we find legal error and are remanding for reconsideration and a new decision on the merits by the ALJ, using correct legal standards, we do not consider whether these evidentiary findings are supported by substantial evidence.

errors discussed in our decision and to consider and weigh the evidence of record, and any additional evidence the ALJ may determine to take, using the correct legal standards set forth in our decision.

Conclusion

We uphold the ALJ's determination that he had jurisdiction to hear Northview's appeal and specifically affirm the ALJ's CLs 1 and 2. We provide guidance for the ALJ if, depending on his resolution on remand of the merits of the noncompliance at issue, he again reaches the question of whether a DPNA is mandatory only when noncompliance persists for three months. We reject the ALJ's conclusion that he lacked authority to consider whether a DPNA could apply based on CMS's discretion even if it were not compelled by law and provide guidance for that issue. We affirm without comment the ALJ's FFs 1 through 11 since CMS did not appeal those FFs. We vacate the ALJ's FFs 12 through 14 and CLs 5 though 8 for the reasons stated in this decision. As stated above, we remand for further proceedings and a new decision consistent with our decision.

/s/
Leslie A. Sussan

/s/
Constance B. Tobias

CONCURRENCE IN DECISION NO. 2295

I agree with and join in the majority's jurisdictional conclusions in Part A of the decision. I also agree with and join in the majority's conclusions in Parts B. and C. of the decision as well as its conclusions with respect to the ALJ's decision on the merits in Part D. of the decision and its disposition of this case, including the remand with instructions. I concur rather than sign the majority decision because I do not agree with one aspect of the majority's analysis in Part A. which I deem sufficiently problematic to warrant this concurring opinion. I agree with the majority's conclusion that the ALJ did not err in asserting jurisdiction and providing Northview with a hearing to challenge the findings of noncompliance from the January 2006 survey. I find no error by the ALJ on this issue because there is no dispute that Northview timely appealed the findings of noncompliance from the January 2006 survey, which findings, together with the findings on the November 2005 surveys, provided the basis for imposing the DPNA, as indicated in the ISDH notice letter dated January 18, 2006. In my view, this resolves the jurisdictional issue. As the majority indicates, CMS cites no persuasive authority for its position that by waiving its right to a hearing on the findings of noncompliance on the February survey, Northview somehow also waived its right to a hearing pursuant to its timely filed hearing request. I have considered the other arguments that CMS briefed as part of its jurisdictional argument, but that the majority addresses in Parts B. and C. of its decision as issues not impacting its conclusion that the ALJ had jurisdiction. I agree with the majority's treatment, analysis and disposition of these issues.

My disagreement with the majority analysis, and the reason for this concurring opinion, involves the majority's assertions in Part A. to the effect that the DPNA was imposed as a result of findings of noncompliance on surveys after the January 2006 survey as well as the findings of noncompliance on the November 2005 and January 2006 surveys. I do not agree that the DPNA was "imposed" based on the findings of noncompliance on any of the surveys after the January 2006 survey. As a result of the findings on those later surveys, the previously imposed DPNA merely continued on track to take effect and ultimately took effect as scheduled on February 21, 2006. I view the distinction between findings of noncompliance that result in a remedy being imposed and findings of noncompliance that result in a remedy's taking effect or continuing as an important distinction for determining whether appeal rights exist under Part 498 in any given case. While the majority's, and my,

conclusion in this case that the ALJ had jurisdiction does not depend on making that distinction, I find it necessary to assert the distinction here in order to preserve the issue for other cases where it may be material to the result. A more expansive explanation of my analysis of this issue is contained in my Partial Concurrence in and Dissent to Decision No. 2293.

/s/

Sheila Ann Hegy
Presiding Board Member