

Department of Health and Human Services
DEPARTMENTAL APPEALS BOARD
Appellate Division

Putnam Center
Docket No. A-17-53
Decision No. 2850
February 14, 2018

**FINAL DECISION ON REVIEW OF
ADMINISTRATIVE LAW JUDGE DECISION**

Putnam Center (Putnam), a skilled nursing facility (SNF) in West Virginia,¹ and the Centers for Medicare & Medicaid Services (CMS) each filed requests for review of an administrative law judge (ALJ) decision partially upholding CMS's imposition of civil money penalties (CMPs) based on CMS's finding that Putnam was not in substantial compliance with requirements for long-term care facilities participating in the Medicare program. *Putnam Center*, DAB CR4769 (2017) (ALJ Decision). After conducting a de novo review of the record, the ALJ upheld CMS's determination that Putnam was not in substantial compliance with Medicare participation requirements from July 25, 2014, through December 16, 2014, and that its noncompliance under 42 C.F.R. § 483.25 involving Resident 87 (R87)² posed immediate jeopardy to residents during part of that period – July 25, 2014, through October 15, 2014.³ The ALJ, however, reversed CMS's finding of noncompliance and determination of immediate jeopardy for the period February 17, 2014, through July 24, 2014. The ALJ found reasonable the amounts of the CMPs imposed by CMS – \$5,100 per day for the immediate jeopardy-level CMP (July 25 through October 15, 2014) and \$250 per day for the continuing noncompliance at less than the immediate jeopardy level (October 16 through December 16, 2014).

¹ We use the term “SNF” since that is the term the ALJ used. *See* ALJ Decision at 2. Putnam indicates it is also a Medicaid “nursing facility” and that R87 “was a Medicaid beneficiary.” P. Request for Review (RR) at 10. A long-term care facility can participate in both programs, and the regulations for long-term care facilities cover both Medicare SNFs and Medicaid nursing facilities (NFs). 42 C.F.R. §§ 483.1; 483.5.

² “R87” is the identifier used on the survey Statement of Deficiencies (SOD) to protect the privacy of the resident in question. The ALJ Decision uses this identifier for the same reason, as does our decision.

³ The section 483.25 noncompliance at issue in this appeal is the noncompliance cited on the SOD for the October 21, 2014 survey under “F-tag” 309, which at the time of that survey was the identifier used by surveyors for the overall “Quality of care” regulation. *See* CMS Ex. 1, at 20-28. While CMS found continuing noncompliance with section 483.25 from October 16 through December 16, 2014, the continuing noncompliance involved subsection (a)(3) of section 483.25 (“F-tag 312”), which addressed a requirement (assistance with activities of daily living for dependent residents) not at issue in this appeal. *See* CMS Ex. 31, at 2; CMS Ex. 1 at 28-33. The continuing noncompliance also involved other regulatory requirements not at issue in this appeal. *See* CMS Ex. 31, at 2; CMS Ex. 1.

In its request for review, Putnam seeks reversal of the ALJ's finding of noncompliance for the period July 25, 2014, through October 15, 2014. However, Putnam does not dispute the ALJ's conclusions that a) Putnam had not shown to be clearly erroneous CMS's determination that the noncompliance during that period constituted immediate jeopardy or b) the ALJ's conclusion that Putnam's noncompliance continued at less than the immediate jeopardy level during the period October 16, 2014, through December 16, 2014. Nor does Putnam dispute the ALJ's finding that the CMP amounts imposed for Putnam's noncompliance – at both levels – were reasonable.

In its request for review, CMS seeks reversal of the ALJ's determination that Putnam was in substantial compliance from February 17, 2014, through July 24, 2014, and reinstatement of its finding of noncompliance and determination of immediate jeopardy for that period. Putnam responded to CMS's request for review; that response opposes extending the ALJ's finding of noncompliance to the pre-July 25, 2014, period. In its response, Putnam also questions a CMS argument regarding immediate jeopardy. Since Putnam's request for review did not challenge the ALJ's decision to uphold CMS's immediate jeopardy determination for the period July 25 through October 15, 2014, we conclude based on Board Guidelines that the question raised in Putnam's response to CMS's request for review, which we discuss later, applies only to CMS's immediate jeopardy determination for the period February 17 through July 25, 2014.⁴

For the reasons discussed below, we affirm the ALJ's conclusion that Putnam was noncompliant with section 483.25 at the immediate jeopardy level during the period July 25 through October 15, 2014, but reverse his conclusion that Putnam was in substantial compliance with section 483.25 from February 17 through July 24, 2014. We further conclude that Putnam has not shown CMS's immediate jeopardy determination for the February 17 through July 24, 2014, period (the only period for which Putnam addresses the immediate jeopardy determination) to be clearly erroneous. Since Putnam does not dispute the ALJ's determinations regarding its continuing noncompliance at less than the immediate jeopardy level for the period October 16 through December 16, 2014, or the ALJ's determination that the amounts of the CMPs imposed for its noncompliance were reasonable, we uphold those determinations without further discussion.

⁴ See *Guidelines -- Appellate Review of Decisions of Administrative Law Judges Affecting a Provider's Participation in the Medicare and Medicaid Programs, Starting the Review Process* ¶ (d) *Contents of request for review and Completion of the Review Process* ¶ (a) (providing respectively that a party's "request for review must specify each finding of fact and conclusion of law with which [it] disagree[s]" and that "[t]he Board will not consider issues not raised in the request for review" The *Guidelines* are available at <https://www.hhs.gov/about/agencies/dab/different-appeals-at-dab/appeals-to-board/guidelines/participation/index.html>.

Legal Background

To participate in the Medicare program, a long-term care facility, including a SNF, must be in “substantial compliance” with the requirements in 42 C.F.R. Part 483. 42 C.F.R. §§ 488.400, 483.1.⁵ These requirements include, as relevant here, the quality of care requirement at 42 C.F.R. § 483.25, which provides as follows:

Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

Under agreements with the Secretary of Health and Human Services, state survey agencies conduct onsite surveys of facilities to verify compliance with the Medicare participation requirements. *Id.* §§ 488.10(a), 488.11; *see also* Social Security Act (Act) §§ 1819(g)(1)(A), 1864(a).⁶ A state survey agency reports any “deficiencies” it finds in an SOD, which identifies each deficiency under its regulatory requirement and the corresponding “tag” number. At the time of the survey of Putnam, the survey “tag” number for a deficiency cited under section 483.25 was F309. CMS Exhibit (Ex.) 1. A “deficiency” is any failure to comply with a Medicare participation requirement, and “substantial compliance” means “a level of compliance with the requirements of participation 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 (also defining “noncompliance” as “any deficiency that causes a facility to not be in substantial compliance”).

CMS may impose one or more remedies on noncompliant facilities, including per-day CMPs. 42 C.F.R. §§ 488.402(b), (c), 488.406, 488.408(d)(1)(iii), (iv), (e)(1)(iii), (iv); 488.430(a). When CMS imposes a per-day CMP for noncompliance at a level less than immediate jeopardy, it chooses an amount within the \$50-\$3,000 “[l]ower range” for per-day CMPs. 42 C.F.R. §§ 488.438(a)(1)(ii), 488.408(d)(1)(iii). When CMS imposes a per-day CMP for noncompliance that it has determined poses immediate jeopardy, CMS must impose a CMP within the “[u]pper range” of \$3,050-\$10,000 per day. 42 C.F.R. §§ 488.438(a)(1)(i), 488.408(e)(1)(iii).

⁵ In October 2016, the requirements for long-term care facilities in subpart B of Part 483 were revised and redesignated effective November 28, 2016. 81 Fed. Reg. 68,688, 68,848 (Oct. 4, 2016). We cite to the prior provisions, which apply to this case.

⁶ The current version of the Act can be found at https://www.ssa.gov/OP_Home/ssact/ssact-toc.htm. Each section of the Act on that website contains a reference to the corresponding United States Code chapter and section. Also, cross-reference tables for the Act and the United States Code can be found at http://uscode.house.gov/table3/1935_531.htm and https://www.ssa.gov/OP_Home/comp2/G-APP-H.html.

Immediate jeopardy exists when a facility’s noncompliance “has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident.” 42 C.F.R. § 488.301. An ALJ must affirm an immediate jeopardy determination, which is a determination about the level of noncompliance, unless the petitioner shows that it is clearly erroneous. 42 C.F.R. § 498.60(c)(2).

Case Background⁷

The West Virginia state survey agency completed a survey at Putnam on October 21, 2014. State surveyors found, among other things, that an oral surgeon had determined in February 2014 that R87’s badly diseased teeth needed to be extracted. CMS Ex. 1, at 25-26. Based on the survey, CMS determined that Putnam did not follow up on the oral surgeon’s determination until the surveyors identified the issue during the October 2014 survey. R87 was a 62-year old male resident of Putnam at the time of the survey, and was first admitted to Putnam on April 11, 2013. ALJ Decision at 5, citing Petitioner Exhibit (P. Ex.) 1, at 1. R87’s admitting diagnoses included, among others, generalized muscle weakness, dysphagia, type II diabetes, unspecified protein-calorie malnutrition, atrial fibrillation, cirrhosis of the liver, weight loss, congestive heart failure, and hypertension. *Id.*, citing P. Ex. 1, at 2, 4. Petitioner’s teeth were in poor condition. *Id.*, citing P. Ex. 3, at 2. Prior to admission, R87 had surgery to remove cervical osteophytes, after which he developed shortness of breath, dyspnea and aspiration pneumonia, requiring intubation. *Id.*, citing P. Ex. 3, at 1. In March 2013, R87 underwent a tracheostomy and was transferred to a specialty hospital for pulmonary and medical management. *Id.* A history and physical report completed at the specialty hospital indicated he had lost 100 pounds in eight months and was “partially edentulous with poor dentition of remaining teeth.” *Id.*, citing p. Ex. 3, at 1, 2.

Putnam’s admissions assessment of R87 included, among other things, information that R87 “had a feeding tube, no mouth pain” – but in the prior five days had experienced pain and was on a pain medication schedule – “and all his teeth were in ‘poor’ condition.” *Id.*, citing P. Ex. 1, at 10, 11. Putnam’s minimum data set (MDS) assessment for R87 recited diagnoses of anemia, atrial fibrillation, coronary artery disease, heart failure, hypertension, cirrhosis, malnutrition and respiratory failure, but not pneumonia, and stated that R87 was on a pain medication regimen. *Id.* at 6, citing CMS Ex. 62, at 9-11. The MDS also stated the resident did not have cavities, broken natural teeth, inflamed/bleeding gums, loose teeth, abnormal mouth tissue or mouth pain. *Id.*, citing CMS Ex. 62, at 13. Dr. Christopher Skaggs was R87’s attending physician as well as Putnam’s Medical Director. *Id.*, citing P. Ex. 1, at 1, and P. Ex. 14, at 1.

⁷ The factual information in this section is drawn from the ALJ Decision (largely from Section IV – Findings of Fact) and the record and is presented to provide a context for the discussion of the issues raised on appeal. Unless otherwise noted, the facts stated here are undisputed.

A pain evaluation completed April 11, 2013, indicated that R87 reported severe back pain and left foot pain and was taking morphine and dilaudid. *Id.*, citing P. Ex. 1 at 15-16. A “Physician Determination of Capacity” completed by Dr. Skaggs, on April 14, 2013, found that R87 had “sufficient mental or physical capacity to appreciate the nature and implication of health care decisions.” *Id.*, citing P. Ex. 1, at 5.

A Putnam “Pain Screening and Evaluation Tool” dated October 8, 2013, documents that R87 complained of acute pain in his teeth over the last five days and requested a dental consultation. *Id.*, citing P. Ex. 1, at 27-28; CMS Ex. 13, Part H at 13-14. An interdisciplinary progress note completed the same day also documented R87’s request for a dental appointment because he was experiencing tooth pain. ALJ Decision at 6, citing CMS Ex. 13, Part C at 36, and P. Ex. 2, at 1. On October 9, 2013, a dentist, Dr. Bowles, examined R87 and concluded he needed to have his remaining teeth extracted by an oral surgeon; he noted that R87 was “just off antibiotics & not having pain” and “[m]aking arrangements for med clearance.”⁸ *Id.*, citing P. Ex. 2, at 2, and CMS Ex. 13, Part D at 61, 62. On October 16, 2013, Dr. Skaggs wrote an order for R87 that stated he “may have teeth extractions with local or minimal twilight [sic] sedation only.” *Id.*, citing P. Ex. 2, at 3, and CMS Ex. 13, Part D at 60.

On November 23, 2013, R87 was admitted to Thomas Memorial Hospital (Thomas Memorial) for treatment of pneumonia. *Id.*, citing CMS Ex. 13, Part H, at 56-58, and P. Ex. 5, at 4.⁹ A November 28, 2013 progress note written by a physician’s assistant at the hospital states, “Needs full dental extraction[;] will see if SW can determine if this could be done at Select, or if he will need to be assessed in NH.” *Id.* at 7; P. Ex. 4, at 2. The hospital discharged R87 on November 29, 2013, and he returned to Putnam. The discharge report stated that R87 “needs full dental extraction because he has multiple infected teeth.” ALJ Decision at 7, citing CMS Ex. 13, Part H at 58.¹⁰ On December 3, 2013, Dr. Bowles wrote in his treatment notes, “Nursing Home Request Referral for Mt. State – Mailed Pano [panographic x-ray] and referral to Mt. State.”¹¹ *Id.*, citing P. Ex. 2,

⁸ We read Dr. Bowles’ diagnosis a bit differently than the ALJ finding. Our reading is that all of the resident’s teeth except perhaps numbers one and 16 needed to be extracted. *See* CMS Ex. 13, Part D at 61. However, neither party has disputed the ALJ’s understanding of Dr. Bowles’ diagnosis. The distinction is not material to our decision, and R87 ultimately had a full dental extraction.

⁹ The citation to the CMS exhibit is correct, but the citation to Petitioner exhibit 5 is not. The documents relating to this hospitalization are in Petitioner exhibit 4, not Petitioner exhibit 5.

¹⁰ We note Putnam did not include the discharge report along with the other documents relating to this hospitalization in Petitioner exhibit 4.

¹¹ “Mt. State” is the abbreviation for Mountain State Oral & Maxillofacial Surgeons, the office of the oral surgeon who examined R87 in February 2014, and extracted his teeth in January 2015. Like the ALJ, we use the abbreviation “Mt. State” or the phrase “oral surgeon’s office” in our discussion.

at 2. Dr. Bowles' office also faxed a completed referral form with information required prior to R87's appointment; on this document, Dr. Bowles wrote, "Ext teeth marked with I.V. sedation," and, circled "IV" for "Type of Anesthesia Requested." *Id.*, citing P. Ex. 2, at 4, and CMS Ex. 13, Part D at 37.

On January 28, 2014, Mt. State faxed Putnam forms required to be filled out before R87's evaluation by the oral surgeon. *Id.*, citing P. Ex. 2, at 5-13, and CMS Ex. 13, Part D at 47-55. These included a health history form, a "Request for Medical Clearance," and forms seeking consent for anesthesia and extraction of teeth, and intravenous sedation/anesthesia. The Request for Medical Clearance contained these comments: "Patient needs to have multiple teeth extracted under IV anesthesia. Requesting recent H & P and medical clearance." *Id.*, citing P. Ex. 2, at 7, and CMS Ex. 13, Part D at 36, 49. R87 and Angela Hodges, a nurse and unit manager at Putnam, completed the forms together, and Ms. Hodges returned them to Mt. State. *Id.*, citing P. Ex. 16, at 3. The health history form stated that the "main problem" for the referral to Mt. State was "frequent infection, rotting of teeth." *Id.*, citing CMS Ex. 13, Part D at 52. On February 13, 2014, during a "routine follow up regarding recurrent infections," R87's pulmonologist, Dr. Grey, noted "no recent infection" and "no new symptoms" and "has an appt to see a dental surgeon." *Id.*, citing CMS Ex. 13, Part H at 59.

Dr. Krajekian, a Mt. State oral surgeon, examined R87 on February 17, 2014, four days after his original appointment had been cancelled due to weather conditions. *Id.*, at 8, citing P. Ex. 2, at 17-18; *see also id.* at 7, citing CMS Ex. 13, Part C at 30, and CMS Ex. 13, Part D at 35. The doctor's notes from the February 17 examination state that R87 has been referred by Dr. Bowles "for removal of remaining maxillary and mandibular teeth, decayed" and further state, "[w]e will try to obtain clearance from his physician, coordinate his care and see if he is a candidate for either mach or general anesthesia in a hospital setting." *Id.*, at 8, citing P. Ex. 2, at 18, and CMS Ex. 13, Part D at 46.

In a March 28, 2014, progress note from a "routine follow up" for R87's pneumonia, Dr. Grey examined R87 and reported he was "feeling about the same." Dr. Grey noted R87 "saw a dental surgeon about extraction and states they are working on it." *Id.*, citing P. Ex. 10, at 7. A Putnam social worker assessed R87 on April 29, 2014, and her report stated that R87 "needs teeth removed but due to current health status Dr. unwilling to do under anesthesia." *Id.*, citing P. Ex. 1, at 12. On June 4, 2014, Dr. Grey did another follow-up examination in which he reported that R87 "is feeling about the same" and described R87 as a "[p]atient with chronic aspiration pneumonia who has a stoma from trach still and peg [feeding tube] but still having problems" and who "is supposed to have dental extraction but they are waiting on his breathing." *Id.*, citing P. Ex. 10, at 9.

On June 8, 2014, R87 went to the emergency room at Thomas Memorial Hospital and was admitted on June 9, 2014, with a diagnosis of aspiration pneumonia and a noted comorbidity of sepsis. *Id.*, citing CMS Ex. 51, Part A at 1-2, 52, and P. Ex. 5, at 1, 2. In his consulting examination report, Dr. Modi reported that R87 had also been treated for pneumonia at the hospital in November and had a “‘history of recurrent aspiration . . . [and] very severe periodontal disease.’” Dr. Modi further noted, “‘There has been discussion about a full dental extraction; however, his underlying medical condition limits anesthetic options.’” *Id.*, citing P. Ex. 5, at 4. On June 19, 2014, R87 was discharged from Thomas Memorial and transferred to Select Specialty hospital. ALJ Decision at 8, citing P. Ex. 5, at 1, and P. Ex. 6, at 1. The discharge report discussed his pneumonia and a related “‘acute episode of respiratory failure . . . that required mechanical ventilation via tracheostomy tube for less than 96 hours.’” *Id.* at 8-9, citing P. Ex. 5, at 2-3, 5. The report stated “‘[b]ecause the patient has had multiple recurrent episodes of aspiration pneumonia and has severe periodontal disease, efforts were made to contact oral surgery for tooth extraction. Dr. Martin is now on staff at Thomas Memorial Hospital and is awaiting the appropriate radiographic machinery to be able to do this procedure in our surgical suite and has agreed to see the patient as an outpatient for dental extraction once the appropriate device is in place.’” *Id.*, at 9, citing P. Ex. 5, at 2-3, 5. This report went to Dr. Skaggs and other doctors. *Id.*

Select Specialty admitted R87 on June 19, 2014, and an examining physician noted “‘very, very poor dentition.’” *Id.*, citing P. Ex. 6, at 1-3. A July 4, 2014 infectious disease progress note referred to his history of aspiration pneumonia “‘with severe periodontal disease’” *Id.*, citing P. Ex. 6, at 9. Select Specialty discharged R87 on or around July 17, 2014. The discharge report stated, among other things, “‘During his stay at Thomas Memorial Hospital, it was deduced that the reason behind the patient’s multiple recurrent episodes of aspiration pneumonia was secondary to his severe periodontal disease[.]’” and referred to the planned extraction of his teeth at Thomas Memorial “‘in the very near future.’” *Id.* at 9-11, citing P. Ex. 6, at 4-6.

On July 23, 2014, Katie Craig, the Surgical Assistant/Hospital Scheduling Coordinator for Dr. Krajekian, sent a letter directly to R87 to inform him that their office had not received the medical clearance from his physician and asked “‘that R87 obtain the medical clearance ‘in order to move forward with scheduling’ the teeth extraction procedure.’” *Id.* at 11, citing CMS Ex. 59, at 3, P. Ex. 2, at 25, and Tr. at 275-76. Nurse Hodges at Putnam became aware of this letter and informed the oral surgeon’s office that R87 was hospitalized and not currently a resident, so they needed to get clearance from his physician at the hospital. *Id.*, citing Tr. at 177-81.

On the following day, R87 was readmitted to Putnam. *Id.*, citing P. Prehearing Br. at 16, and P. Ex. 1, at 13. A July 31, 2014, nutritional assessment stated that R87 had lost weight during his absence from Putnam and “‘appears malnourished, cachectic’” and that current recommendations of the dietician would relate to “‘maintenance vs any significant improvement based on overall poor prognosis.’” *Id.*, citing P. Ex. 1, at 13-14. The assessment also stated that R87 was “‘awaiting complete dental extraction.’” *Id.*, citing P. Ex. 1, at 13.

On September 20, 2014, a licensed practical nurse (LPN) did an oral assessment of R87 and “‘documented that R87 experienced pain in his mouth, jaw, or tongue; his teeth were decayed; and more than three teeth were missing.’” *Id.*, citing CMS Ex. 13, Part H at 8, and P. Ex. 1, at 71. The LPN noted that R87 “‘was awaiting dental procedure.’” *Id.*, citing CMS Ex. 13, Part H at 8.

On September 23, 2014, R87 experienced breathing problems and was transported to Thomas Memorial for a lung evaluation; an x-ray did not show pneumonia, but physicians ordered intravenous antibiotics. ALJ Decision at 11-12, citing P. Ex. 1, at 68, 71. On September 26, 2014, according to a progress note, Putnam’s social worker left a message with Thomas Memorial’s social work department “‘pertaining to [R87’s] teeth extraction. Currently awaiting a call back.’” ALJ Decision at 12, citing P. Ex. 1, at 63.

On September 27, 2014, R87 again underwent an evaluation at the Thomas Memorial emergency room, this time for a fever. *Id.*, citing P. Ex. 7, at 1, and P. Ex. 1, at 62. Admitting documents cited his history of pneumonia. *Id.*, citing P. Ex. 7, at 1, 2, 5. A consulting physician, Dr. Eggleston, examined R87 and noted that his lungs were “‘significantly diminished bilaterally’” and that he “‘has multiple decayed teeth’” *Id.*, citing P. Ex. 7, at 12. On September 29, 2014, another consulting physician, Dr. Modi, examined R87 and, in a report on which Dr. Skaggs was copied, noted R87’s history of hospitalization for “‘aspiration pneumonia and acute respiratory failure’” and found that R87 “‘has very poor dentition’” and that his “‘[t]eeth are in extremely poor condition with caries.’” *Id.*, citing P. Ex. 7, at 7, 9, 10, and CMS Ex. 13, Part H at 1, 3, 4.

On October 4, 2014, R87 was discharged from the hospital and returned to Putnam with a discharge report stating, “‘Overall his lung condition improved’” ALJ Decision at 12-13, citing P. Ex. 7, at 14-15.

An October 15, 2014, progress note, completed during the State survey, documents that Nurse Hodges contacted Mt. State to follow up on R87’s teeth extraction procedure and states that “‘Mountain State requested ‘current medical clearance for extraction,’” that “[Nurse Hodges] would obtain the clearance from Dr. Skaggs and that ‘[R87]’ is aware.” ALJ Decision at 13, citing P. Ex. 1, at 57; *see also* P. Ex. 1, at 53 (Nurse Hodges’

notation of speaking with Dr. Skaggs and receiving from him the pulmonologist referral directive). Also on October 15, 2014, Mt. State faxed a request for medical clearance to Putnam. ALJ Decision at 13, citing P. Ex. 2, at 20, and CMS Ex. 13, Part D at 58. The same day, Dr. Skaggs wrote on the request that he would refer R87 to his pulmonologist for the medical clearance and “[i]t appears that [Putnam] then faxed the form back to the oral surgeon’s office that same day.” *Id.*, citing P. Ex. 2, at 26.

An October 16, 2014, progress note written by the nurse practitioner states that the writer had discussed the risks of the surgery with R87 and that he was weighing them and would decide definitively whether to undergo the procedure if a surgeon was found and his pulmonologist gave medical clearance. *Id.*, citing P. Ex 1, at 54. A Social Services progress note written the same day indicates that the social worker discussed the tooth extraction issue with R87 “to ensure he felt the facility was adequately meeting his needs[]” and that R87 responded, in part, that “he felt the facility had done everything possible to assist him with his oral needs and voiced no complaints related to our attempts in assistance.” ALJ Decision at 14, citing P. Ex. 1, at 53.

On October 20, 2014, Dr. Grey, R87’s pulmonologist, provided written medical clearance, stating in relevant part:

[R87] is a 62 y/o male with recurrent Pneumonia who has horrible dental carries [sic] in need of total dental extraction. He has a Permanent trache which can be utilized for mechanical ventilation if needed. He has high risk from a pulmonary standpoint but would be able to have surgery if warranted. . . . [R87] needs total dental extraction which I believe is warranted.

Id., citing P. Ex. 2, at 28 (internal quotation marks omitted). Also on October 20, 2014, Nurse Hodges documented the medical clearance from Dr. Grey for “IV sedation for teeth extraction.” Nurse Hodges also stated in her note that the “Clearance states resident is high risk[]” and indicated that R87 was aware of the clearance and stated his understanding. ALJ Decision at 14-15, citing P. Ex. 1, at 52. Also on October 20, 2014, Dr. Skaggs wrote a letter which states the following:

To Whom It May Concern: I am caring for [R87] as his primary care physician at Putman [sic] [R87] has a long list of significant medical problems including chronic respiratory failure as well as severe dysphasia and protein calorie malnutrition requiring a peg tube. It is my professional medical opinion that he has not been medically stable to undergo complete dental extraction from February 2014 [through] June 2014.

Id. at 15, citing CMS Ex. 13, Part C at 25 (internal quotation marks omitted).

On November 6, 2014, Dr. Grey examined R87 and found, inter alia, “Pt with trach who needs total extraction of [his] teeth to hopefully prevent recurrence of ASP Pneumonia Extraction hopefully will help.” *Id.*, citing P. Ex. 2, at 29. The surgery was scheduled for January 15, 2015, R87 was informed and “stated he was aware of the risks” but “looking forward to getting it done . . . believes it will be worth it [and] thinks once teeth are out he will have no more pneumonia.” *Id.*, citing P. Ex. 1, at 44. Dr. Krajekian performed the full dental extraction procedure on R87 on January 15, 2015, as an outpatient procedure using general anesthesia. *Id.*, citing P. Ex. 1, at 33, and CMS Ex. 55, Part B at 23, 26-27, 29, 32, 42-43.

Standard of Review

The Board reviews a disputed finding of fact to determine whether the finding is supported by substantial evidence, and a disputed conclusion of law to determine whether it is erroneous. See *Guidelines, Completion of the Review Process* ¶ (c), available at <https://www.hhs.gov/about/agencies/dab/different-appeals-at-dab/appeals-to-board/guidelines/participation/index.html>.

Analysis

- A. The ALJ’s conclusion that Putnam was not in substantial compliance with 42 C.F.R. § 483.25 from July 25 through October 15, 2014, with regard to its care of R87 is supported by substantial evidence and free of legal error.

CMS found Putnam noncompliant with section 483.25, as relevant here, from February 17 through October 15, 2014.¹² The ALJ, however, concluded that Putnam’s “noncompliance did not begin until July 25, 2014, the day after R87 was readmitted to the facility following an extended hospitalization.” ALJ Decision at 17; *but see id.* at 16, Conclusion of Law 1 (containing no limitation as to the timing of the noncompliance).¹³ In this section of our decision, we explain why we affirm the ALJ’s conclusion that Putnam was not in substantial compliance with section 483.25 at the immediate jeopardy level, from July 25 through October 15, 2014. In the following section, we explain why we reverse the ALJ’s conclusion that Putnam was in substantial compliance with section 483.25 during the period February 17 through July 24, 2014.

¹² CMS found that the noncompliance with section 483.25 during this period was at the immediate jeopardy level. As we indicated in FN3, *supra*, CMS found continuing noncompliance with section 483.25 (and other regulatory requirements) from October 16 through December 16, 2014, at less than an immediate jeopardy level under a subsection of that regulation that is not at issue here and that did not involve the deficiencies in Putnam’s care of R87 addressed in the case before us.

¹³ For purposes of our decision, we have disregarded the discrepancy between the ALJ’s statement of his conclusion on page 16 of his decision and the statement of his conclusion on page 17 of his decision because the discrepancy is not material.

1. *Contrary to Putnam’s argument, the ALJ correctly interpreted and applied section 483.25 as requiring Putnam staff to follow up on the oral surgeon’s determination that R87 needed to have his teeth surgically removed.*

Section 483.25 addresses “quality of care,” providing that “[each] resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.” The ALJ concluded that Putnam was not in substantial compliance with 42 C.F.R. § 483.25 “because [its] staff failed to provide necessary care and services to R87 to address his severe periodontal disease.” ALJ Decision at 16 (Conclusion #1). The ALJ’s conclusion was based on his findings that medical professionals – the dentist and oral surgeon to whom Putnam referred R87 after his complaints of pain and doctors in two hospitals where R87 had been treated for aspiration pneumonia – had determined that R87 needed the oral surgery (ALJ Findings of Fact (FF) 11, 12, 15, 16, 17, 22, 27, 30) but that Putnam staff did not arrange for the surgery until the surveyors questioned why they had not done so (FF 42, *et seq.*). The ALJ’s findings, as evidenced by his citations, were based largely on Putnam’s own exhibits and records, and Putnam states in its request for review that it “agrees that most of the ALJ’s Findings of Fact are essentially accurate”¹⁴ P. RR at 1. Nonetheless, Putnam argues that its failure to follow up on the physicians’ assessment that R87 needed the surgery did not violate section 483.25 as a matter of law. *See id.* (“Instead [of disputing the essential accuracy of the ALJ’s findings of fact], the gist of this appeal is that the ALJ’s Conclusions of Law do not follow from his Findings of Fact, nor do they accurately reflect controlling Board precedent.”).

The core of Putnam’s argument is that while the teeth extraction surgery was necessary, Putnam’s failure to schedule the surgery prior to the survey did not violate section 483.25 because Dr. Skaggs, who was both R87’s attending physician and Putnam’s Medical Director, made a medical judgment that R87’s overall medical condition rendered him too ill for the surgery under general anesthesia and staff regarded that judgment as a physician order that it was required to follow. P. RR at 28-29. The conclusion that Putnam was not in substantial compliance with section 483.25, Putnam argues,

¹⁴ Putnam qualifies its concession that the ALJ’s findings of fact are “essentially accurate” by stating “(although Petitioner shows that some are incomplete, and that the ALJ did omit some important material evidence).” Putnam later devotes 20 pages to a “Summary of Evidence,” which, Putnam says, “summarizes what it believes is the material evidence, with references to the ALJ’s Findings of Fact” P. RR at 7-27. Much of what appears in the summary is Putnam’s interpretation or coloration of evidence in the record, not differences concerning the evidence itself or the ALJ’s factual findings based on it. Moreover, as will be clear from our discussion, none of the additional “facts” Putnam discusses are material. The material facts are contained in the ALJ’s findings.

misstated the actual wording of Section 483.25, which is that residents “must receive and the facility must provide the necessary care and services to attain or maintain the highest *practicable* physical, mental and psychosocial well-being” (emphasis added). That language plainly implies that a resident’s overall condition, preferences, etc., *are* pertinent to the analysis.

P. RR at 28 (emphasis in original). Putnam goes on to state,

Petitioner has argued throughout this case (and its witnesses testified) that no reasonable *nurse* – that is, no reasonable employee or agent of the Center – would disagree with *Dr. Skaggs’ medical judgment* that, in the context of the Resident’s *overall* condition – that is, his highest *practicable* status – his need for oral surgery was *not* his most pressing medical problem at any given point in time.

Id. (emphasis in original).

It is Putnam that misreads the regulation and its application here. Section 483.25, the Board has held, imposes an “affirmative duty designed to achieve favorable outcomes to the highest practicable degree.” *Pearsall Nursing & Rehab. Ctr. – North*, DAB No. 2692, at 6 (2016), citing *Windsor Health Care Ctr.*, DAB No. 1902, at 16-17 (2003), *aff’d*, *Windsor Health Ctr. v. Leavitt*, 127 F. App’x 843 (6th Cir. 2005). This means “that a facility must provide care and services so that a resident attains the highest level of well-being the resident is capable of attaining” *Ridge Terrace*, DAB No. 1834, at 7 (2002). The regulation does not state, and cannot reasonably be read as meaning, as Putnam seems to contend, that the mere fact that a resident has serious and pressing problems justifies ignoring an issue that is undermining the resident’s capacity to improve and to reach the “highest level of well-being the resident is capable of attaining.” Accepting Putnam’s reading would require reading into the regulation an exception for residents with serious and pressing problems that is neither stated in the regulation nor consistent with its aspirational goal. A proper reading of the regulation, and the Board’s holdings as to its meaning, is that where, as here, a SNF knows of a care or treatment that is needed to improve a resident’s level of well-being, the SNF must take action toward providing that care or treatment, regardless of whether the care ultimately is not provided based on the facility’s assessment that it cannot be provided in a manner consistent with the resident’s overall condition. While a resident’s condition may be relevant to the final judgment about whether or when to proceed with a treatment identified as necessary, it is not a justification for simply failing to pursue any medical clearances needed for the treatment.

Regardless of whether the tooth extraction surgery was R87's most pressing medical need, Putnam does not dispute that R87 needed the surgery to improve his health and well-being because 1) R87's severe periodontal disease caused him oral pain and 2) physicians at Thomas Memorial who treated R87 for recurrent aspiration pneumonia concluded in a discharge report that there was a connection between the periodontal disease and the pneumonia. ALJ Decision at 21, 24, 27; *see also id.* at 6, 8-11 (FF 10, 27, 30). Putnam attempts to downplay the pain R87 experienced due to his rotting teeth but concedes that staff scheduled a dental appointment with Dr. Bowles and, on Dr. Bowles' recommendation, with Dr. Krajekian, the oral surgeon, because of R87's complaints of tooth pain. P. RR at 10-11; *see also* ALJ Decision at 6 (FF 10, 11) (indicating that R87 had requested a dental appointment because of the pain).

Putnam questions the "great weight" the ALJ accorded the Thomas Memorial discharge report, arguing that the report's assertion that R87's periodontal disease was a contributing factor to his recurrent aspiration pneumonia was contradicted by Dr. Skaggs' written testimony that lab reports indicated "no correlation between the Resident's poor dentition and the Resident's respiratory problems (his pneumonias were not caused by oral bacteria). . . ." P. RR at 36, 37; *see also id.* at 9 n.3 (discussing the lab reports); P. Ex. 14, at 3 (Dr. Skaggs' declaration statement that he "showed the surveyors a number of lab reports that showed that the Resident's recurrent bouts of pneumonia were not caused by periodontal bacteria"). The Board defers to an ALJ's weight and credibility determinations absent compelling reasons for rejecting them. *E.g., Miss. Care Ctr. of Greenville*, DAB No. 2450, at 6 n.4 (2012), *aff'd, Miss. Care Ctr. of Greenville v. U.S. Dep't of Health & Human Servs.*, 517 F. App'x 209 (5th Cir. 2013); *Woodland Oaks Healthcare Facility*, DAB No. 2355, at 7 (2010). We find no reason to question the weight the ALJ here accorded the discharge reports on the issue of the relationship between R87's periodontal disease and his recurrent bouts of pneumonia. Dr. Skaggs' testimony about the lab reports was vague; he did not identify when the reports were done or under what circumstances. Moreover, the mere fact that some reports might have shown no causal relationship between oral bacteria and the resident's aspiration pneumonia does not rule out the possibility that R87's periodontal disease was a contributing factor. Indeed, as the ALJ noted, Dr. Skaggs himself did not rule out the possibility that R87's severe periodontal disease was a contributing factor when he admitted on cross-examination that "there's an association between periodontal disease and increased mortality from pneumonia[]" and that R87's rotting teeth caused "oral bacteria [which] can cause aspiration pneumonia." ALJ Decision at 28, citing Tr. at 440-42 (internal quotation marks omitted); *see also* P. Ex. 14 at 3 (Dr. Skaggs' direct testimony acknowledging, "It is possible that oral bacteria might have contributed to

some of [R87's] respiratory problems . . ."). Finally, the ALJ did not rely on the discharge reports alone. He also relied on Dr. Cheifetz's expert testimony that extracting R87's decayed teeth was a "priority procedure," not an elective procedure, due to the health risks posed by the teeth, including, but not limited to, the risk of local or systemic infections as well as aspiration pneumonia. *See* ALJ Decision at 25-28; Tr. at 674-75; CMS Ex. 58, at 9-10.

Based on the foregoing and the record as a whole, we find substantial evidence that the oral surgery proposed by Dr. Krajekian in February 2014 was "necessary" in order "to achieve favorable outcomes" for R87 "to the highest practicable degree," and Putnam staff should have followed up on obtaining the medical clearance needed for the surgery. We recognize that a facility may need to assess how a resident's overall condition and specific diagnoses at any given time affect what action(s) the facility decides to take, or the timing of those actions, toward providing a care or service needed to achieve the resident's highest practicable level of well-being. However, the resident's overall condition and diagnoses at a particular time are not an excuse for not taking any action.

Thus, the ALJ correctly looked to the record to determine what steps, if any, Putnam staff took to schedule this necessary teeth extraction surgery. As the ALJ found, the record as a whole shows that Putnam took no steps toward scheduling the surgery until prodded to do so by the surveyors' findings. "Although Petitioner's staff was apparently aware that R87 was to have oral surgery, there is no evidence that Dr. Skaggs or anyone else took any action to follow up on R87's teeth extraction procedure after he returned to the facility [in July 2014, following his hospitalization]." ALJ Decision at 21. Putnam staff did not do so, the ALJ noted, even though the "hospital discharge reports from Thomas Memorial and Select Specialty show the expectation that R87 would eventually have the oral surgery . . . and that [Putnam's] staff would take appropriate action and make 'further arrangements' for the surgery to happen." *Id.*

On appeal, Putnam does not dispute the ALJ findings that staff took no action toward scheduling the surgery based on the discharge reports but attempts to downplay staff inaction by suggesting the ALJ improperly interpreted the discharge reports as orders binding the facility to schedule the surgery. P. RR at 30 n.21. The ALJ did not treat the reports as orders, but, rather, as assessments by the physicians who treated R87 at the hospital, assessments that Putnam, after readmitting R87, would logically be expected to consider and take seriously enough to at least do some follow-up evaluation. *See* ALJ Decision at 21 ("One would have expected that, after R87 returned to Petitioner's facility, Dr. Skaggs and Petitioner's staff would have reviewed the hospital discharge reports and, in accordance with the discharge instructions, evaluated R87's dental issues with the

objective of moving forward expeditiously with arranging his oral surgery.”). Contrary to what Putnam argues (P. RR at 30 n.21), we find nothing “illogical” or improper about the ALJ’s expectation that having resumed the responsibility of providing long-term care to R87 after his extended hospitalization for aspiration pneumonia, Putnam would have taken some action toward scheduling the surgery based on the hospital’s discharge summaries. At the very least, Putnam and Dr. Skaggs, as R87’s personal physician, should have assessed R87’s condition at that time and determined how that surgery might be provided, consistent with that condition and his other medical issues. Yet, as we discuss in the next section of our decision, Dr. Skaggs did not even do an assessment.

Putnam argues it was improper for the ALJ to find a violation of section 483.25 based on the delay in obtaining the oral surgery since the ALJ acknowledged that R87 did not question the delay and understood that the reason for the delay was that he was too sick to have the surgery. P. RR at 2, 32, 33; ALJ Decision at 28-29. The ALJ, however, did not find noncompliance based on the delay itself but, rather, on Putnam staff’s inaction which caused the long delay. Moreover, Putnam cites no authority for its suggestion that a SNF has no duty to provide necessary care and services to a resident under section 483.25 if the resident does not demand the care or services or object to their not being provided. We also note R87’s testimony on cross-examination that his statement in his direct testimony that he “knew” Putnam nurses were calling the oral surgeon and Thomas Hospital to try to arrange the surgery was based on what they were telling him, that he himself “was in doubt” as to whether they were actually doing it. Tr. at 27-28. He also clarified that the calls staff told him they were making occurred after he returned from his June 2014 hospitalization, not before. *Id.* at 29.

Contrary to Putnam’s suggestion, there is no resident rights issue here. The ALJ acknowledged R87’s right to make his own medical decisions (*see* ALJ Decision at 29) but also found “no indication from R87’s testimony that the Thomas Memorial physicians were of the opinion that he was too ill to tolerate having oral surgery or that R87 himself questioned the physicians as to whether he was physically able to undergo the procedure.” *Id.* The record also provides no evidence that R87 opposed the surgery; indeed, the record contains evidence that R87 signed a consent form at the time of his February 2014 appointment with Dr. Krajekian. P. Ex. 2, at 16, 19.

In light of Putnam’s essential acceptance of the ALJ’s material findings that R87’s surgery was a “necessary care and service” (regardless of whether it was his most pressing need) and that Putnam did not attempt to schedule the surgery prior to the survey, Putnam’s assertion that CMS “did not establish even a prima facie violation of any regulation[]” (P. RR at 27) is specious. Putnam concedes that “[m]ost surgery,

especially for very ill elderly patients, presumably is ‘necessary,’ and this [R87’s] surgery certainly was.” *Id.* at 29 (emphasis added); *see also* Petitioner’s Reply to CMS’s Response (P. Reply) at 5 (“Thus, as Petitioner and all its witnesses agree, no one disputes that extraction of [R87’s] teeth was ‘necessary’ – obviously, no one has such a procedure unless it is necessary – or that bad teeth and periodontal disease are associated with all sorts of potential bad outcomes, including the potential for pneumonia.”) Thus, Putnam effectively concedes that R87’s oral surgery was a “necessary care and service” within the meaning of section 483.25. Since Putnam also does not dispute that its staff did not take steps to schedule the surgery until the surveyors raised the issue, Putnam has essentially conceded that CMS established at least a prima facie case of noncompliance with section 483.25. *See, e.g., Evergreene Nursing Care Ctr., DAB No. 2069, at 7-8 (2008)* (holding that CMS’s burden to establish a prima facie case of noncompliance with a regulatory requirement is met if CMS comes forward with evidence related to disputed findings that together with any undisputed findings and relevant legal authority is sufficient to show noncompliance absent a showing by the SNF, by a preponderance of the evidence on the record as a whole, that it was in substantial compliance). Moreover, as we discuss in the next section, Putnam has not rebutted that prima facie case.

2. *Substantial evidence supports the ALJ’s rejection of Putnam’s argument that staff did not need to pursue the surgery because, according to Putnam, they were following a medical judgment or order by Dr. Skaggs that R87’s condition precluded the surgery.*

Putnam seeks to escape the evidence that its staff failed to act and, thus violated section 483.25, by arguing that the ALJ misframed the issue, that instead of focusing on its staff’s failure to pursue the surgery, the ALJ should have focused on “whether [Putnam’s] staff reasonably relied on [R87’s] physician’s orders” or “medical judgment[]” that “in his opinion the Resident was not strong enough to survive anesthesia.” P. RR at 2. By failing to focus on Dr. Skaggs’ orders or medical judgment, Putnam argues, the ALJ ignored Board decisions which Putnam avers “do not authorize CMS to impose liability against a nursing facility solely because its staff failed to ‘second-guess’ a physician’s apparently reasonable medical judgments” *Id.*; *see also id.* at 27 (asserting that the ALJ Decision “fail[s] to address consistent Board precedent that describes a nursing facility’s responsibility to follow clear physician orders”); *id.* at 31 (characterizing

Beverly Health & Rehab. – Spring Hill, DAB No. 1696 (1999) as holding that “regulatory liability *cannot* be premised simply on CMS’s disagreement with a physician’s medical judgment diagnosis or order (whether or not it turns out to be wrong).”¹⁵ We find no merit in this argument.

Putnam does not accurately characterize Board precedent. In *Beverly Health and Rehab.*, for example, while the Board upheld the ALJ’s finding that under the facts of that case facility staff had no regulatory obligation to challenge the physician’s treatment orders, the Board also made it clear that “[a] nursing facility does have an independent obligation to plan for and provide services to meet the medical needs of each resident to help each resident maintain the highest practicable physical well-being.” *Beverly Health & Rehab.*, DAB No. 1696, at 38. The case at hand involves Putnam’s independent obligation to plan for and meet the medical needs of R87. Moreover, Putnam’s case is easily distinguishable on its facts from the Board decisions Putnam cites. In those decisions, it was undisputed that staff were following actual medical judgments and treatment orders by treating physicians that were based on and consistent with the physician’s actual assessments and diagnoses. Here, by contrast, the ALJ found, and we agree, that “[t]he record contains no evidence that Dr. Skaggs addressed R87’s dental issues following his readmission or even acknowledged that R87 was still awaiting the teeth extraction procedure” ALJ Decision at 21.

Putnam’s insistence that Dr. Skaggs made a “specific medical judgment” (P. RR at 31) that R87 could not tolerate the oral surgery and that the ALJ “did not disagree that this was Dr. Skaggs’ actual judgment” (*id.* at 29) is not supported by the record. As the ALJ found, the record contains no contemporaneous evidence to support Dr. Skaggs’ claim on cross-examination that he assessed R87’s dental issues between the date of his initial limited approval of the surgery in October 2013, and the October 2014 survey. The ALJ found:

¹⁵ Putnam asserted in its request for review “that the way CMS and the ALJ have framed and decided this issue is so important that this is the rare appeal that demands oral argument in which the parameters and implications of this ALJ Decision can be addressed. In this regard, it is vital that the limits of nursing facilities’ regulatory liability for such physicians’ (apparently appropriate) medical judgments, orders and actions for their patients must be clearly established.” P. RR at 4. We concluded oral argument would not be helpful since the topic Putnam proposed mischaracterizes the issue before the Board. The legal issue in this case does not involve a SNF’s legal liability for a physician’s medical judgment or order. Rather, the legal question is whether Putnam’s staff violated section 483.25 by not taking all reasonable steps toward scheduling the oral surgery they knew R87 needed according to the clinical evaluations of an oral surgeon and other physicians who treated R87, evaluations that neither Dr. Skaggs nor Putnam has disputed. Moreover, as we will discuss, Putnam’s argument that staff were following Dr. Skaggs’ medical judgment or order assumes the actual existence of a medical judgment or order, an assumption that the ALJ found, and we agree, is not supported by substantial evidence in the record.

Dr. Skaggs claimed on cross-examination that he addressed R87's decayed teeth between October 17, 2013, and October 15, 2014; however, I find the record contains no contemporaneous evidence . . . to corroborate his assertion. [citation omitted] In fact, Dr. Skaggs concedes that, in his handwritten notes focused upon by CMS, he "did not specifically mention [R87's] teeth." [citation omitted] Rather, as the record plainly shows, it was not until the surveyors brought R87's serious dental issues to Dr. Skaggs' attention during the October 2014 survey, that he and the nursing staff were finally prompted to take any action to move forward with R87's oral surgery.

ALJ Decision at 22, citing Tr. at 448-50, 452. The ALJ found evidence of only two assessments by Putnam staff mentioning R87's teeth after he returned to the facility following his hospitalization. *Id.*, citing P. Ex. 1, at 13-14 (July 31, 2014, nutritional assessment by registered dietician), and CMS Ex. 13, Part H at 8 (September 20, 2014, oral assessment by an LPN). Dr. Skaggs did not do either assessment, and both assessments made only a vague reference to "awaiting" a dental extraction without indicating that the facility was taking any specific steps toward scheduling such surgery or that Dr. Skaggs had assessed R87 for the surgery and made a medical judgment about it.¹⁶ The ALJ also noted that on cross-examination, Dr. Skaggs "concede[d] that, in his handwritten notes focused upon by CMS, he 'did not specifically mention [R87's] teeth.'"¹⁷ *Id.* at 22, citing Tr. at 452. The ALJ concluded, "Although Petitioner's staff was apparently aware that R87 was to have oral surgery, there is no evidence that Dr. Skaggs or anyone else took any action to follow up on R87's teeth extraction procedure after he returned to the facility." *Id.* at 21.

¹⁶ Petitioner does not argue that the ALJ should have viewed either of these records as evidence that staff, in fact, were taking steps toward obtaining the surgery. Similarly, although Putnam cites March and June 2014 progress notes by Petitioner's pulmonologist noting that the resident had indicated, in one instance, that "they were working on it" and, in the other instance, that they were "waiting on his breathing," Putnam does not cite these as evidence that staff was taking action to schedule the surgery. *See* P. RR at 17, citing P. Ex. 10, at 7, 9. On the contrary, Putnam cites these documents as evidence to try to support Nurse Hodges' alleged understanding that Mt. State, not Putnam, was responsible for obtaining medical clearance for the surgery. *Id.* at 17-18.

¹⁷ Dr. Skaggs also testified that he did not recall receiving any request for medical clearance for oral surgery other than the one in October 2013. Tr. at 453. According to the SOD, he told the surveyor that he was not notified of the need for a medical clearance after R87's visit to the oral surgeon. CMS Ex. 1, at 26. Dr. Skaggs also testified on cross-examination, that he "d[id]n't recall speaking to any particular nurse about [making arrangements for the dental extraction]." Tr. at 457. Adam Skeens, who became Director of Nursing (DON) of Putnam in April 2014, testified that he was aware of only one medical clearance document provided to the oral surgeon's office, the October 2013 clearance for twilight sedation that Putnam included in the packet referring R87 to Mt. State for his February appointment with the oral surgeon. Tr. at 36, 51-53.

The ALJ found unpersuasive Putnam's attempts to minimize the importance of documentation and Putnam's argument that it "should not be faulted for this because ultimately, R87's condition actually improved." *Id.* at 22 (citations omitted). The ALJ noted that Putnam had not cited any authority "to support its premise that documentation is unnecessary where the resident has not suffered a poor outcome." *Id.* The ALJ also found Putnam's position inconsistent with the testimony of Dr. Cheifetz, who "testified emphatically that documentation plays a crucial role in the monitoring of a patient's condition" and also testified that "[the] standard of care" is to document in a patient's record "any discussion about [the] patient" *Id.* at 28, citing Tr. at 732-33. Indeed, Dr. Cheifetz testified that "[w]e [the medical community] live by documentation." *Id.*, citing Tr. at 735. The ALJ concluded that Dr. Cheifetz's testimony "further undermines the credibility of Dr. Skaggs, whose dismissive attitude regarding his lack of documentation on R87's dental issues and teeth extraction procedure was evident during his cross-examination." *Id.* Once again, we find no reason to disturb the ALJ's credibility determinations.

On appeal, Putnam does not dispute the ALJ's finding that the record contains no contemporaneous documentation to support Dr. Skaggs' testimony that he evaluated R87's readiness for oral surgery during the period October 17, 2013, through October 15, 2014. Nor does Putnam specifically challenge Dr. Cheifetz's testimony about the importance of documentation or the ALJ's reliance on that testimony. Putnam nonetheless questions the "logic" of the ALJ's conclusion "that the fact that Dr. Skaggs did not *document* that he had examined [R87's] teeth after his return from the hospital somehow undercuts either his decision making process, or the actual decision about the Resident's readiness for surgery that all agree he actually made." P. RR at 31 n.22, citing ALJ Decision at 22 (emphasis added by Putnam). Putnam does not explain who "all" includes, and that term clearly does not include the ALJ who found no evidence that the physician made such a judgment. If Putnam is referring to its staff, it cites no documentation that Dr. Skaggs informed staff members that he had made such a judgment and that they did not pursue the surgery for that reason.

Putnam suggests no such documentation was necessary because Dr. Skaggs' October 2013 order (approving surgery with twilight sedation only) automatically remained in effect. Putnam points to testimony by DON Skeens responding to questions about whether, in light of the changes in R87's condition (including several bouts of pneumonia) since Dr. Skaggs had written that order, there was a need for a more timely evaluation by Dr. Skaggs. P. RR at 18 n.12, citing Tr. at 51; *see generally* Tr. at 48-53. DON Skeens testified that he had conversations with Dr. Skaggs about that matter at some point after he began working at Putnam in April 2014, but could not confirm the dates of those conversations and admitted he did not document them. Tr. at 50-51. DON Skeens testified that he did not document his discussions with Dr. Skaggs because he "didn't feel any further documentation was required at the time based off of the fact that the medical clearance [the October 2013 order] was in place." Tr. at 51.

Putnam suggests that this testimony is “commonplace and common sense evidence” that the ALJ should have accepted as a substitute for documentation. P. RR at 18 n.12. We disagree. Undisputed evidence of record shows substantial fluctuation in R87’s condition between the date of Dr. Skaggs’ order and R87’s readmission to Putnam in July 2014. Undisputed evidence of record also shows repeated input from the other doctors who treated R87 during this period, input that included emphasizing R87’s need for the oral surgery because the doctors saw a connection between the resident’s serious periodontal disease and his recurrent bouts of pneumonia. There was also a new request for medical clearance requiring Dr. Skaggs’ attention. In light of this evidence, even if Dr. Skaggs did not ultimately change his opinion, it was clearly inappropriate for him not to reassess R87 (in consultation with the other physicians and the oral surgeon as appropriate), document that assessment and issue new instructions to staff. Similarly, if Putnam staff continued to rely on Dr. Skaggs’ October 2013 order notwithstanding the fluctuations in R87’s condition, the input of the other physicians and Dr. Krajekian’s outstanding request for a new medical clearance, it was clearly inappropriate for staff to do so without following up with Dr. Skaggs on the need for a new assessment and documenting that follow-up.

Dr. Cheifetz’s testimony and the ALJ’s findings about the importance of documentation are consistent with Board decisions regarding the critical importance of clinical documentation. *See, e.g., Autumn Ridge Rehab. Ctr.*, DAB No. 2467, at 20 (2012) (citing 42 C.F.R. § 483.75(1) – which provides that a SNF must maintain complete and accurate clinical records); *see also Embassy Health Care Ctr.*, DAB No. 2327, at 6 (2010) (holding that the duty to document a resident’s condition is part of the quality of care requirement in section 483.25). Absent any contemporaneous documentation to support Dr. Skaggs’ testimony that he assessed R87’s dental issues after his return to Putnam, we find no basis to disturb the ALJ’s rejection of that testimony. We also note that, during cross-examination, Dr. Skaggs receded from his claim that he had addressed R87’s tooth decay during that period to a position that R87 “was too ill to address it.” Tr. at 449.

Even assuming Dr. Skaggs had assessed R87 for the oral surgery after R87 returned to the facility and made the medical judgment Putnam alleges (an assumption not supported on the evidence), there is no documentation that he communicated any such judgment – either verbally or in writing – to staff during the period.¹⁸ We note, for example, that Dr. Skaggs’ October 2013 “medical judgment” appears on a physician’s order form but that there is no subsequent order form containing similar content in the record. Putnam’s

¹⁸ As we noted earlier, DON Skeens testified that he had conversations with Dr. Skaggs about this matter but couldn’t confirm exactly when the discussions occurred and did not document them. *See* Tr. at 50-51. However, since DON Skeens indicated these discussions occurred around the time he began working at Putnam in April 2014, they would have occurred, if at all, several months before R87’s return to the facility in July 2014.

argument relies heavily on characterizing Dr. Skaggs' "medical judgment" as a physician's "order" that staff was required to follow (*see, e.g.*, P. RR at 2-4) but does not explain why any subsequent medical judgment by Dr. Skaggs regarding R87's ability to undergo the surgery, or any limitations as to anesthesia, would not also need to take the form of an order or some other written document. Moreover, Dr. Skaggs admitted that he "did not" document his judgment. Tr. at 475. When asked how staff or other providers would have known of his conclusion that the risks of anesthesia outweighed the benefits of the surgery when he did not document it, Dr. Skaggs responded, in effect, that staff should have inferred his judgment in July 2014 from the limited medical clearance he wrote in October 2013. *Id.* The response that staff should have inferred that Dr. Skaggs reassessed R87 and reached the same conclusion he did in October 2013 is not an adequate response since a primary purpose of documentation in the nursing home context is to avoid leaving staff to guess what care or treatment they are required to give a resident.

In summary, we conclude that the record amply supports the ALJ's rejection of Putnam's argument that staff did not need to pursue the surgery because, according to Putnam, they were following a medical judgment or order by Dr. Skaggs that R87's condition precluded the surgery.

B. The ALJ erred in concluding that Putnam's noncompliance did not begin until July 25, 2014, following his readmission to Putnam after his hospitalization for pneumonia.

1. *The ALJ's conclusion is inconsistent with his finding that Putnam staff did not follow up on the oral surgeon's February 17, 2014, request for medical clearance at any time before October 2014.*

The ALJ rejected CMS's determination that Putnam's noncompliance with section 483.25 began on February 17, 2014, the date Dr. Krajekian, the oral surgeon, examined R87, confirmed that all his teeth needed to be surgically removed and stated, "[W]e will try to obtain clearance from his physician." ALJ Decision at 8. The ALJ, instead, concluded that Putnam's noncompliance with section 483.25 began July 25, 2014, the day after his readmission to Putnam following his extended hospitalization at Thomas Memorial for aspiration pneumonia. *Id.* at 17. The ALJ based his conclusion on his finding that R87's medical condition made the oral surgery feasible after July 25 but not before that date.

Between February 17, 2014 and July 2014, R87's health was greatly compromised and he would not have been a suitable candidate for oral surgery during this time frame. The record reflects that during this period, R87's condition deteriorated and he was hospitalized for an extended time beginning in June 2014 with aspiration pneumonia, MRSA, and sepsis. . . . However, by July 25, 2014, R87's condition had improved and stabilized such that Petitioner's staff should have moved expeditiously forward with arranging for his teeth extraction procedure.

ALJ Decision at 17 (citations omitted). We reverse the ALJ's conclusion that Putnam was in substantial compliance from February 17 through July 24, 2014 because, as we have explained, the material issue under section 483.25 is what, if anything, Putnam staff did to follow up on Dr. Krajekian's determination that R87 needed surgery to remove his teeth and, in particular, whether Putnam staff tried to obtain the medical clearance needed for Dr. Krajekian to schedule that surgery. The ALJ correctly focused on this issue in finding noncompliance during the period on and after July 25, 2014, and he should have focused on the same issue for the prior period rather than trying to discern R87's ability to tolerate the surgery at any given time.¹⁹ We conclude, as explained below, that substantial evidence in the record as a whole shows that Putnam staff and Dr. Skaggs did not follow up on Dr. Krajekian's determination that R87 needed the surgery and, in particular, made no attempt to provide the necessary medical clearance at any time prior to being prodded by the surveyors to do so. The responsibility for monitoring R87's changing condition and obtaining medical input to determine whether or at what point he could undergo the required extractions lay with Putnam, which undertook to provide all necessary care to R87 and failed, based on the documented record it maintained, to establish that it met that responsibility. It was not the responsibility of the ALJ to attempt to determine retrospectively, on that inadequate record, what medical judgment would have been appropriately made at the time.

¹⁹ While we disagree with the ALJ's determining when Putnam's noncompliance began by reference to whether and when R87 could tolerate the necessary oral surgery, we do not agree with Putnam's repeated assertions that the ALJ's finding was based on "substituting his medical judgment for that of the Resident's physician . . ." P. RR at 3; *see id.* at 4, 5, 31. In the first place, the ALJ found "no contemporaneous evidence in the record to corroborate [Dr. Skaggs']" claim "that he addressed R87's decayed teeth between October 17, 2013 and October 15, 2014." ALJ Decision at 22. Moreover, the ALJ based his finding on record evidence that included the "credible and persuasive" expert opinion of Dr. Cheifetz "that R87's compromised health status would not have precluded him from undergoing the teeth extraction procedure." *Id.* at 23, citing CMS Ex. 58, at 14. Dr. Cheifetz, the ALJ noted, was "a Board-certified oral and maxillofacial surgeon with 35 years of experience[;] . . . Board-certified by the National Dental Board of Anesthesiology[;]" and "well-qualified to testify about R87's dental issues and the care he received from Petitioner." *Id.* at 22. The ALJ also found that Dr. Cheifetz's "testimony undermined the credibility of Dr. Skaggs." *Id.* at 23. Putnam, the ALJ further found, "did not rebut Dr. Cheifetz's expert opinions"; on the contrary, "Dr. Cheifetz's opinion regarding R87's status is supported by Dr. Skaggs' own testimony." *Id.* at 26. The ALJ cited, *inter alia*, Dr. Skaggs' testimony that R87's condition began to improve "'between the end of July [2014] and the survey in October"; Dr. Skaggs' "admi[ssion] that the tracheostomy procedure . . . made it safer for [R87] to undergo the oral surgery"; and, Dr. Skaggs' failure to deny on cross-examination "that R87 successfully underwent the tracheostomy under general anesthesia in June 2014." *Id.* (transcript citations omitted).

We begin by noting that the same facts cited by the ALJ in support of his conclusion that Putnam staff failed to act on and after July 25, 2014, the day after R87's readmission to the facility, evidence staff inaction from February 17, 2014, through July 24, 2014. The ALJ found that Dr. Krajekian's February 17, 2014 report stated that he had examined R87 on referral from Dr. Bowles "'for removal of his remaining maxillary and mandibular teeth, decayed' and that '[w]e will try to obtain clearance from his physician, coordinate his care and see if he is a candidate for either mach or general anesthesia in a hospital setting.'" ALJ Decision at 8 (FF22), citing P. Ex. 2, at 18, and CMS Ex. 13, Part D at 46; *see also* P. Ex. 2, at 18, and CMS Ex. 13, Part D at 46 (Dr. Krajekian's February 17, 2014 report stating that he "went through [with R87] the surgery, anesthesia, complications, risks, benefits and alternatives" of removing all remaining teeth). The ALJ found that Putnam, notwithstanding this report, made no effort to obtain an evaluation for medical clearance until "after the oral surgeon's office faxed another request for medical clearance to Petitioner's facility on October 15, 2014," a request that Dr. Skaggs then referred to R87's pulmonologist who provided the medical clearance. *Id.* at 31. The ALJ further found the staff failed to pursue a medical clearance even though, as Putnam does not dispute, Ms. Craig, Dr. Krajekian's surgical assistant and hospital scheduling coordinator, wrote R87 a letter on July 23, 2014 "informing him that the office had not received the requisite medical clearance from his physician as of that date." *Id.* at 30, citing CMS Ex. 59, at 3, and P. Ex. 2, at 25.

As the above indicates, the ALJ did not limit his finding of total staff inaction, which is the crux of the noncompliance, to the period beginning July 25, 2014. Moreover, the ALJ's discussion of other evidence of record and his rejection of Putnam's arguments regarding the inaction affirm that he regarded the inaction as occurring throughout the February 17 through October 15, 2014 period. Putnam argued before the ALJ, as it does here, that Nurse Hodges understood from Dr. Krajekian's report, and from her discussions with R87 and Putnam staff who accompanied R87 to his appointment, that Mt. State was going to obtain their own medical clearance for R87, not that Dr. Krajekian was waiting for Putnam to obtain the clearance from R87's attending physician. P. RR at 17, citing P. Ex. 16, at 3 (Nurse Hodges' direct testimony), and Tr. at 155-56, 161, 166 (Nurse Hodges' cross-examination testimony). Putnam claims this understanding is supported by Ms. Hodges' testimony "that she called Mountain State numerous times during that period to determine the status of the case." P. RR at 18, citing P. Ex. 2, at 21-21, and Tr. at 162. The ALJ rejected Putnam's argument, stating that he "g[a]ve little weight to" Nurse Hodges' testimony. ALJ Decision at 31. The ALJ noted that "Nurse Hodges documented her alleged phone contacts in her personal calendar for 2014, not in R87's clinical record." *Id.*, citing Tr. at 162, and P. Ex. 2, at 21-24. As previously noted, the Board does not disturb an ALJ's credibility determinations absent a compelling reason for doing so. We find no such reason here. In addition to the fact that Nurse Hodges' notes were not part of R87's clinical records, as one would expect them to be, Nurse Hodges admitted on cross-examination that the notes "don't talk about anything substantive" Tr. at 162.

In addition to giving “little weight” to Nurse Hodges’ testimony, the ALJ found,

Nothing in the record supports [Nurse Hodges’] claim that obtaining medical clearance for R87’s teeth extraction procedure was the responsibility of the oral surgeon’s office. It is clear that the medical clearance requested by the oral surgeon’s office was always to have been provided by R87’s physician. And, in fact, this is exactly what occurred – after the oral surgeon’s office faxed another request for medical clearance to [Putnam] on October 15, 2014

ALJ Decision at 31. Putnam has given us no reason to reject this finding which, contrary to Putnam’s suggestion, is consistent with the language in Dr. Krajekian’s report and supported by the record. The language in Dr. Krajekian’s report states: “We will try to obtain clearance from his physician, coordinate his care and see if he is a candidate for either mach or general anesthesia in a hospital setting.”²⁰ P. Ex. 2, at 18. The sequencing indicates that the oral surgeon needed medical clearance before he could proceed with arrangements for the surgery, including determining the appropriate anesthesia, and the language “clearance from his physician” plainly indicates that R87’s physician was responsible for providing the medical clearance. There is no language in Dr. Krajekian’s report to support an understanding that Dr. Krajekian would try to obtain medical clearance elsewhere or schedule surgery before receiving clearance from R87’s physician.

Dr. Cheifetz’s testimony about general procedures for obtaining medical clearance for surgery also undercuts Putnam’s argument. Dr. Cheifetz testified that once the surgeon requests medical clearance, “it becomes the nursing home’s and the attending physician’s responsibility to evaluate the patient physically, offer an opinion as to the status of the patient physically and mentally, and either [1] clear the patient . . . outright . . . [2] say[] the patient has some conditions that need to be addressed, and once the conditions are addressed and brought under control he can have surgery . . . [o]r [3] [the attending physician] can say this patient is not cleared for surgery at this time, but we will follow-up and reevaluate him [at subsequent intervals].” Tr. at 626. Dr. Cheifetz also testified to the following sequence of procedures for scheduling surgery once a request for

²⁰ Dr. Cheifetz, on whose testimony the ALJ relied, used the acronym “MACH” rather than “mac” and explained that the term means “monitored anesthesia care,” that is, “an anesthesiologist is present in the operating room, monitoring the patient.” See ALJ Decision at 24 n.6, citing Tr. at 704. Dr. Cheifetz also explained “that the lightest form of intravenous anesthesia is conscious sedation (the term “twilight sedation” [the term used by Dr. Skaggs] is no longer used), and next on the continuum are deep sedation and general sedation.” *Id.*, citing Tr. at 703-05, and CMS Ex. 58, at 4. General anesthesia, Dr. Cheifetz further explained, requires that the patient “must have the airway maintained, possibly with a ventilator” *Id.*, citing CMS Ex. 58, at 4. Doctors at Thomas Memorial used general anesthesia for R87’s tracheostomy. ALJ Decision at 24.

medical clearance has been made: “[t]he primary care physician, along with other specialists if he feels necessary, provide[s] the medical clearance[;] . . . the patient is given pre-admission testing[;] . . . and then the anesthesiologist will evaluate the patient, either at that time, at the pre-admission testing, or sometimes just prior to surgery.” Tr. at 706. Although the ALJ did not cite this particular testimony by Dr. Cheifetz, we can infer he credited it since the ALJ gave great weight to Dr. Cheifetz’s testimony as a whole. *See* n.18, 19, *supra*. Dr. Cheifetz’s testimony puts the responsibility for obtaining medical clearance squarely on Putnam.

We also note Ms. Craig’s testimony that she told Nurse Hodges that Putnam staff needed to obtain clearance from R87’s physician, and that in these discussions, Nurse Hodges responded that she would get it. Tr. at 254, 261, 263-64, 275. Putnam does not dispute this particular testimony by Ms. Craig, and Nurse Hodges’ testimony, on which Putnam relies, was not consistent with regard to her communications with Ms. Craig. At one point, Nurse Hodges denied having “multiple conversations” with Ms. Craig in which the latter conveyed the need for medical clearance. Tr. at 186. However, at another point, Nurse Hodges admitted she had “several” conversations with Ms. Craig and “c[ould]n’t specifically say what Katie and I discussed about this resident” Tr. at 185. In other testimony cited by the ALJ, Ms. Craig stated that “on February 17, 2014, [the oral surgeon’s] office faxed a [document titled] Request for Medical Clearance to [Petitioner’s facility] to obtain medical clearance from . . . Dr. Skaggs” because Dr. Skaggs’ limited clearance, provided by Putnam prior to R87’s appointment with Dr. Krajekian, “was not sufficient.” ALJ Decision at 29, quoting CMS Ex. 59, at 2-3; *see also id.*, citing Tr. at 247, 261. Putnam does not dispute Ms. Craig’s testimony that the oral surgeon’s office sent the February 17, 2014 fax informing Putnam that it needed to obtain medical clearance from R87’s physician in order for Dr. Krajekian to schedule the surgery.²¹ Putnam merely says that “there is no evidence” that Dr. Krajekian or anyone else at Mt. State communicated directly with Dr. Skaggs about the need for medical clearance or that Mt. State “initiated any communication with anyone about the matter (for instance, another physician or anesthesiologist) while Ms. Craig was on maternity leave between March and late June, 2014.” P. RR at 17-18 (emphasis added). These assertions do not constitute a specific denial that Putnam received the February 17, 2014, fax or a specific denial of the communications Ms. Craig testified she had with Nurse Hodges.

²¹ We note in particular that Putnam does not purport to rely on Nurse Hodges’ testimony on redirect examination that she did not see that document – among others created in connection with R87’s February 2014 examination by Dr. Krajekian – until Mt. State faxed them to her during the survey on October 15, 2014, in response to her “request [for] all the records they had from every appointment that [R87] had had with Mountain State.” Tr. at 189-90. We also note that Nurse Hodges effectively conceded Mt. State had notified her of the need for a new medical clearance after R87’s appointment when she acknowledged in her written direct testimony that Putnam staff who accompanied R87 to his appointment reported to her the need for a new clearance and that she discussed this with a nurse at Mt. State who followed up with a note, although she could not identify whether or where the note was in the record. *See* P. Ex. 16, at 3.

Putnam asserts that the ALJ “ultimately found that he did not need to determine whether Mountain State ever actually asked the Center to obtain additional medical clearance for general anesthesia from Dr. Skaggs.” P. RR at 19. Putnam cites no support for this assertion in the ALJ Decision, and we find none. If Putnam is referring to the following statement by the ALJ, it does not support that assertion: “Inasmuch as I have determined that R87 was too ill through July 24, 2014, to have had the teeth extraction procedure, it is not necessary for me to consider whether there were multiple requests for medical clearance from the oral surgeon’s office between March and July 23, 2014 which Petitioner may have ignored during this time frame.” ALJ Decision at 30 (emphasis added). Given the reference to “multiple requests . . . between March and July 23, 2014 . . .,” it is clear the ALJ was not referring to or questioning Ms. Craig’s testimony that she faxed the request for medical clearance to Putnam on February 17, 2014, but, rather, to Ms. Craig’s further testimony that “because she did not receive any response from Petitioner [to the February fax], she re-faxed the Request for Medical Clearance form to Petitioner on March 3, 2016 [and] every two weeks [there]after . . . except during the period March 17, 2014, through the beginning of June 2014, when she was out of the office on leave.” ALJ Decision at 29 n.9. Whether the further communications occurred is immaterial since Putnam does not specifically dispute either that Ms. Craig faxed the request for medical clearance on February 17, 2014, or that Nurse Hodges,²² or some other Putnam staff member, either received that February fax or knew through some other means, such as Ms. Craig’s conversations with Nurse Hodges, that Dr. Krajekian needed the clearance in order to schedule the surgery. In particular, we note Nurse Hodges’ acknowledgment in her written direct testimony that Putnam staff who accompanied R87 to his appointment reported to her the need for a new clearance and that she discussed this with a nurse at Mt. State who followed up with a note. *See* P. Ex. 16, at 3; *see also* n.20, *supra*.

The ALJ also rejected Putnam’s suggestion, reprised here, that even assuming R87 was at times well enough for the surgery, the long delay in scheduling it could not have been avoided given the “logistics” of arranging for such surgery for a Medicaid beneficiary in the Charleston area. P. RR at 10-11, 36. The ALJ found –

The cause of the protracted delay in arranging for R87’s teeth extraction procedure . . . had nothing to do with logistics, but can be entirely attributed to [Putnam’s] staff, including Dr. Skaggs. At the time of the survey . . . R87 still had not had the teeth extraction procedure. Although eight months had passed since R87’s appointment with the oral surgeon, there

²² As the ALJ noted, Nurse Hodges testified that she “received only one faxed request for medical clearance from the oral surgeon’s office, and was unaware of other requests that may have been faxed to the facility.” ALJ Decision at 31, citing Tr. at 184. However, as previously noted, the ALJ “g[a]ve little weight” to this and other testimony by Nurse Hodges. *Id.*

was no evidence that anyone on [Putnam's] staff, including Dr. Skaggs, had taken any action to follow up on the oral surgery so that it could move forward and be scheduled. In fact, when questioned as to whether any plan existed in October 2014, Dr. Skaggs admitted that, at the time of the October survey, the facility had no plan in place to get medical clearance for R87 or to move forward with the procedure. Tr. 481. Had it not been for the surveyors intervening on behalf of R87, one wonders how many more months would have passed before [Putnam's] staff took any meaningful action with regard to moving forward with R87's teeth extraction procedure. See CMS Ex. 1, at 26-27.

ALJ Decision at 31.

Substantial evidence supports the ALJ's finding regarding the total lack of action by Putnam to pursue a medical clearance for oral surgery, which, the record amply shows, and Putnam does not dispute, R87 needed to remove a factor contributing to his immediate recurrent bouts of aspiration pneumonia and to achieve his "highest practicable physical, mental and psychosocial well-being." That same evidence, however, as well as the ALJ's finding on its face, applies to the entire period February 17 through October 15, 2014.²³ Accordingly, we reverse the ALJ's conclusion that Putnam's noncompliance with section 483.25 did not begin until July 25, 2014.

2. *Putnam's noncompliance continued from February 17 through December 16, 2014, notwithstanding R87's fluctuating condition and temporary hospitalization in June and July 2014.*

We acknowledge the ALJ's concern that R87 was not able to undergo the teeth extraction surgery during certain periods of time because of his medical condition or because, when he was hospitalized, he was not under Putnam's direct control. However, that concern did not provide a basis for the ALJ to conclude that Putnam was in substantial compliance with section 483.25. CMS's determination that Putnam was not in substantial compliance was based on the failure of Putnam staff to follow up on Dr. Krajekian's February 2014 request for a new medical clearance even though, as the ALJ

²³ As indicated earlier, Putnam's noncompliance continued after October 15, and through December 16, 2014, at a level less than immediate jeopardy, but we do not address that period of continuing noncompliance because Putnam does not dispute it.

found (and substantial evidence supports), Putnam staff knew of that request.²⁴ Dr. Krajekian's request for medical clearance, and his underlying evaluation of R87, put Putnam staff on notice from February 17, 2014 onward that oral surgery was "necessary care" for R87 yet staff did nothing to follow up on the request for the medical clearance needed to proceed with that surgery. The Board has consistently held that once CMS finds a facility out of compliance, the facility's noncompliance is presumed to continue until CMS finds the facility back in compliance. *E.g.*, *Crawford Healthcare & Rehab.*, DAB No. 2738, at 14 (2016), citing *Libertywood Nursing Ctr.*, DAB No. 2433, at 15 (2011), *aff'd*, *Libertywood Nursing Ctr. v. Sebelius*, 512 F. App'x 285 (4th Cir. 2013); *see also Owensboro Place & Rehab. Ctr.*, DAB No. 2397, at 12 (2011) ("The Board has made it clear that the facility bears the burden of showing that it returned to substantial compliance on a date earlier than that determined by CMS and has rejected the idea that CMS must establish a lack of substantial compliance during each day in which a remedy remains in effect."); 42 C.F.R. § 488.454(a) (stating that remedies CMS imposes for SNF noncompliance continue until CMS or the State finds the facility has achieved compliance). These and other Board decisions clearly place on the SNF the burden of showing removal of the conditions that caused it to be found noncompliant. Thus, Putnam's noncompliance is presumed to have existed throughout the period beginning February 17, 2014, and ending December 16, 2014, before CMS found the noncompliance corrected, regardless of R87's fluctuating medical condition and his hospitalization for much of June and July 2014.²⁵

Putnam did not show that it had removed the conditions that caused CMS to find it noncompliant and, thus, did not rebut the presumption of its continuing noncompliance. As discussed above, the ALJ found no credible evidence that staff made any attempt to follow up on Dr. Krajekian's request for medical clearance from Dr. Skaggs at any time prior to October 2014, and we have concluded that the ALJ's finding is supported by substantial evidence. The responsibility of Putnam's staff to do that follow-up did not

²⁴ There can be no genuine dispute that Dr. Krajekian's request was for a new medical clearance since, as Putnam admits, Dr. Skaggs' October 2013 order was in the packet Dr. Krajekian received prior to examining R87. P. RR at 14.

²⁵ With regard to R87's fluctuating medical condition, we note that Dr. Cheifetz, CMS's expert witness, "disagreed with Dr. Skaggs' opinion that R87 was too sick to undergo the teeth extraction procedure during the entire period that spanned February 17, 2014 through October 2014[]" and testified that "'there were windows of opportunity' during this time frame when R87 would have been able to have the procedure." ALJ Decision at 23, citing Tr. at 675, 706-07, and CMS Ex. 58, at 14. The ALJ found that Dr. Cheifetz's opinions were "credible and persuasive" and "undermined the credibility of Dr. Skaggs." *Id.* at 23.

end simply because R87 was temporarily absent from Putnam due to his hospitalization. Putnam staff needed to follow up on Dr. Krajekian's request before and after R87's hospitalization. We note in this respect that R87's hospitalization was preceded by nearly four months of total inaction by Putnam staff with regard to Dr. Krajekian's request for medical clearance, and that this total inaction continued for nearly another three months after R87's readmission to Putnam.

Moreover, contrary to Putnam's suggestion, R87's temporary hospitalization neither removed the conditions at Putnam that caused CMS's finding of noncompliance nor terminated Putnam's duty of care. While Putnam staff did not have control over R87's hospital care, they continued to have responsibility for his long term care once he was discharged from the hospital. Thus, Putnam staff continued to be responsible for following up on Dr. Krajekian's request for medical clearance during and after R87's hospitalization in order to assure that Dr. Skaggs knew of the request and would be sufficiently informed of R87's situation to be able to grant, deny or delay the clearance as expeditiously as possible after R87 returned to Putnam and as his condition improved.²⁶ Yet staff did not fulfill this responsibility; indeed there is no evidence that they even communicated the request for a new medical clearance to Dr. Skaggs. We note in this respect Dr. Skaggs' testimony that he "d[i]dn't remember any specific request" for medical clearance other than the one in October 2013. Tr. at 453; *see also* CMS Ex. 1, at 26 (surveyor report that Dr. Skaggs "stated he was not notified of the need for medical clearance in February 2014 after the . . . visit to the oral surgeon.").

C. Putnam did not appeal the ALJ's decision to uphold the immediate jeopardy determination for the period July 25 through October 15, 2014, and we conclude that Putnam also has not shown CMS's determination of immediate jeopardy for the period February 17 through July 24, 2014 to be clearly erroneous.

Immediate jeopardy exists when a facility's noncompliance "has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident." 42 C.F.R. § 488.301. A determination that immediate jeopardy exists, or continues to exist, is a determination about the level of noncompliance and, thus, must be sustained by an ALJ or the Board unless the SNF shows that determination to be clearly erroneous. 42 C.F.R. § 498.60(c)(2); *Brian Ctr. Health & Rehab./Goldsboro*, DAB No. 2336, at 7-8 (2010). The ALJ here found "no question that [Putnam] placed R87's health in immediate

²⁶ We note Putnam does not assert that it did not expect R87 to return to Putnam. In addition, Dr. Skaggs conceded that "R87's condition began to improve 'between the end of July [2014] and the survey in October.'" ALJ Decision at 26, citing Tr. at 497.

jeopardy . . . [by] the complete lack of follow up and involvement by [Putnam's] staff with respect to R87's teeth extraction procedure." ALJ Decision at 32. He noted that R87 "experienced actual harm in the form of pain in his teeth in October 2013" and "pain in his mouth, jaw, or tongue in September 2014." *Id.* The ALJ also cited Dr. Cheifetz's testimony that "R87's decayed teeth put him at risk of suffering serious consequences, such as a localized mouth infection that could become extensive and systemic, or aspiration pneumonia caused by oral bacteria" as well as "Dr. Skaggs['] . . . adm[is]sion . . . that R87 was susceptible to such consequences by not having the teeth extraction procedure." *Id.* Finally, the ALJ found that R87 himself appeared to recognize the possible serious health risks he faced if his teeth were not removed, noting that "after his surgery was finally scheduled, [R87] expressed his hope that once his teeth were extracted, he would no longer have pneumonia." *Id.* at 33, citing P. Ex. 1, at 44.

Since the ALJ found Putnam's noncompliance did not begin until July 25, 2014, his decision to uphold CMS's immediate jeopardy determination for that noncompliance relates only to the period July 25 through October 15, 2014. In its request for review of the ALJ Decision, Putnam did not dispute the ALJ's determination that Putnam had not shown CMS's immediate jeopardy determination to be clearly erroneous. In its request for review, CMS argued not only that the ALJ's immediate jeopardy determination for the period July 25 through October 15, 2014, should be affirmed, but also that immediate jeopardy existed for the period February 17 through July 24, 2014. CMS Request for Departmental Appeals Board Review (CMS RR) at 3, 36-39.

In its response to CMS's request for review, Putnam did not take issue with the ALJ's decision to uphold CMS's immediate jeopardy determination or his stated reasons for doing so. Instead Putnam took issue only with an argument CMS made in explaining its position that the ALJ erred in not finding noncompliance at the immediate jeopardy level for the February 17 through July 24, 2014 period. CMS argues that "[a]s a matter of law, the fact that [R87] temporarily left the facility for a period of hospitalization from June 19, 201[4] through July 19, 201[4] did not automatically invalidate or abate the [immediate jeopardy] determination." CMS RR at 36; *see* Putnam Response at 27-29.²⁷ Putnam characterizes CMS's immediate jeopardy argument as "alleg[ing] only that the Center's staff failed to 'arrange for' oral surgery for one specific resident, [as opposed to

²⁷ Putnam did not specifically state that it was challenging CMS's argument about continuing immediate jeopardy only as it applied to the period of noncompliance prior to July 25, 2014, but one can infer this limitation from Putnam's statements in its brief and the fact that Putnam raised no challenge in its request for review to the ALJ's determination of immediate jeopardy.

systemic factors] under very unusual circumstances, which included long periods of time when the Resident had been discharged to other facilities and was not under Petitioner's (or Dr. Skaggs') control." Putnam Response at 28 (emphasis added). Putnam responds that "CMS's assertion that Section 483.25 can impose liability for supposed improper care of a single resident on a specific medical issue even after the Resident has been discharged from a facility is at best overbroad." *Id.* at 27 (emphasis added). Putnam further asserts, "CMS cannot reasonably assert that following discharge to another facility, a resident nevertheless remains the responsibility of the discharging facility for one purpose (continuing liability for acts or omissions specific to the resident during his stay) but not others (notably, ability to direct care)." *Id.* at 29 (emphasis added).

In the immediately prior section of this decision, we rejected Putnam's argument that R87's hospitalization somehow ended Putnam's responsibility to follow up on Dr. Krajekian's order, and we rely on the same reasoning in rejecting Putnam's argument here. We also note that Putnam's argument repeatedly and erroneously conflates R87's transfer to the hospital with a "discharge," ignoring the distinction between the two terms in the regulations governing long-term care facilities.²⁸ The applicable regulations define the terms "discharge" and "transfer" separately. 42 C.F.R. § 483.202. "Discharge," in relevant part, means movement from a SNF "to a noninstitutional setting when the discharging facility ceases to be legally responsible for the care of the resident." *Id.* "Transfer" is defined, in relevant part, as the "movement from [a SNF] . . . to another institutional setting when the legal responsibility for the care of the resident changes from the transferring facility to the receiving facility." *Id.*; see also *Chicago Ridge Nursing Ctr.*, DAB No. 2151, at 15 n.11 (2008) (noting the separate definitions in a decision involving a SNF resident's transfer to a hospital). Thus, R87's being sent to the hospital by Putnam was a transfer, not a discharge. Moreover, assuming R87 remained eligible for Medicaid and continued to require the services provided by Putnam, once R87 was discharged from the hospital, Putnam was required to readmit him to its facility "immediately upon the first availability of a bed in a semi-private room . . ." 42 C.F.R. § 483.12(b)(3). Indeed, Putnam did readmit R87. Accordingly, R87's hospitalization changed legal responsibility for R87's direct care from Putnam to the hospital temporarily but did not end Putnam's legal responsibility for his long-term care. See Tr. at 661 (Dr. Cheifetz's testimony that, although R87's primary care "transferred, if you will, to the attendings at the hospital" during R87's hospitalization, "Dr. Skaggs

²⁸ As indicated in note 1, *supra*, these regulations apply to both SNFs participating in the Medicare program and nursing facilities participating in the Medicaid program. 42 C.F.R. § 483.1.

maintains some responsibility for following up upon discharge for medical situations that existed prior to the hospitalization”). Putnam was responsible for following up on Dr. Krajekian’s request for medical clearance before R87 was admitted to Thomas Memorial and remained responsible for following up that request if the hospital did not provide the surgery during his temporary stay in that institution, as it did not.

We also note that R87’s hospitalization was preceded by nearly four months of total failure to follow up by Putnam staff with regard to Dr. Krajekian’s request for medical clearance for the oral surgery, and this total inaction continued for nearly another three months after R87’s readmission to Putnam. Putnam did not even attempt to show that it was clearly erroneous for CMS to determine that the lack of follow-up during these long periods of time when it was responsible for R87’s direct care put him in immediate jeopardy. Indeed, CMS’s determination was entirely reasonable given the expert testimony about how R87’s decaying teeth contributed to the recurrent pneumonia that caused his hospitalizations and, as the ALJ noted, Dr. Skaggs’ own “admi[ssion] on cross-examination that R87 was susceptible to such consequences by not having the teeth extraction procedure.” ALJ Decision at 32.

Putnam’s challenge to CMS’s argument that, once cited, the immediate jeopardy continued until, CMS determined, it had been abated, is also undercut by its own concession that the Board “has accepted this notion in some circumstances” Putnam Response at 27. Putnam’s concession is an understatement. The Board has consistently held that a facility’s “burden of demonstrating clear error in CMS’s immediate jeopardy determination ‘extends to overcoming CMS’s determination as to how long the noncompliance remained at the immediate jeopardy level.’” *E.g., Owensboro Place & Rehab. Ctr.* at 12, citing *Azalea Court*, DAB No. 2352, at 17 (2010), *aff’d*, *Azalea Court v. U.S. Dep’t of Health & Human Servs., Ctrs. for Medicare & Medicaid Servs.*, 482 F. App’x 460 (11th Cir. 2012), citing *Brian Center Health & Rehab./Goldsboro* at 7. Putnam cites no authority for its assertion that the Board has limited this holding to circumstances “typically where CMS offers evidence that some ‘systemic’ breakdown threatens harm to a resident or category of residents until it is corrected, or even in some cases where a very specific error or omission (inadequate monitoring, poor skin care, etc., manifested in a single incident) allows such an inference.” Putnam Response at 27. We note that the immediate jeopardy citations upheld by the Board in *Owensboro Place* and *Brian Center* each involved the care of a single resident, and those decisions contained no discussion of systemic factors.

Contrary to what Putnam suggests, harm or the likelihood of harm to a single resident can be the basis for an immediate jeopardy determination, and, as the ALJ found, the record shows both actual harm and a likelihood of harm to R87 due to the failure of Putnam staff to follow up on Dr. Krajekian's recommendation for oral surgery. ALJ Decision at 32-33. However, we also note that Putnam contradicted its own assertion that CMS's determination of noncompliance and immediate jeopardy did not involve systemic factors by referring to "CMS's suggestion that there was some sort of 'systemic' issue separate and apart from the condition of [R87] himself." Putnam Response at 28. Indeed, CMS discusses in its request for review "the systemic failures that resulted in multiple staff members neglecting to follow through on arranging a necessary tooth extraction procedure that was recommended by the Oral Surgeon." CMS RR at 38. In addition, the SOD shows that when citing the immediate jeopardy, the surveyors noted that the failure to obtain medical clearance for R87 "has the potential to affect [other] residents in need of medical clearance for dental procedures," and that the plan for abating the immediate jeopardy provided for such facility-wide corrective measures as staff education in the need to document and follow up when a resident needs surgical clearance. CMS Ex. 1, at 23. Surveyor Rebecca Lucas also testified that Putnam's DON told her the facility's Quality Assurance Committee had identified a problem with its procedures for following up with consulting clinics and physicians. Tr. at 348-54.

For the reasons stated, we affirm the ALJ's determination that Putnam did not show CMS's determination of immediate jeopardy for the noncompliance with section 483.25 during the period July 25 through October 15, 2014 to be clearly erroneous. We further hold that Putnam has not shown CMS's determination that immediate jeopardy also existed with respect to the noncompliance CMS found, and we have concluded existed, between February 17 and July 24, 2014 to be clearly erroneous. We conclude that our holding with respect to this earlier period is supported by the ALJ's own analysis of the immediate jeopardy for the later period, an analysis Putnam does not dispute on appeal.

Conclusion

For the reasons stated above, we affirm the ALJ's decision that Putnam was not in substantial compliance with section 483.25 at the immediate jeopardy level from July 25 through October 15, 2014; reverse the ALJ's conclusion that Putnam was in substantial compliance from February 17 through July 24, 2014, and conclude that Putnam was noncompliant during that period as well as during the period July 25 through October 15, 2014; and conclude that Putnam's noncompliance was at the immediate jeopardy level for the entire period February 17 through October 15, 2014. We also affirm without

discussion (since Putnam has not disputed these aspects of the ALJ's decision) the ALJ's conclusions that Putnam's noncompliance continued at less than the immediate jeopardy level for the period October 16 through December 16, 2014, and that the amounts of all CMPs imposed by CMS are reasonable.

/s/

Christopher S. Randolph

/s/

Leslie A. Sussan

/s/

Sheila Ann Hegy
Presiding Board Member