Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Appellate Division

In the Case of:	DATE: June 30, 2009
NHC Healthcare Athens,	
Petitioner,	Civil Remedies CR1870 App. Div. Docket No. A-09-70
	Decision No. 2258
- v. -	
Centers for Medicare & Medicaid Services.	

FINAL DECISION ON REVIEW OF ADMINISTRATIVE LAW JUDGE DECISION

NHC Healthcare Athens (NHC, Petitioner), a skilled nursing facility in Athens, Tennessee that participates in the Medicare and Medicaid programs, appeals the December 3, 2008 decision of Administrative Law Judge (ALJ) José A. Anglada. The ALJ concluded that NHC failed to comply substantially with three federal requirements for skilled nursing facilities and their care of residents, and imposed a civil money penalty (CMP) of $800 per day for the period June 5, 2007 through October 11, 2007. NHC Healthcare Athens, DAB CR1870 (2008) (ALJ Decision). NHC appeals the ALJ's determinations that NHC failed to substantially comply with one federal requirement based on findings with respect to six residents who sustained falls, and with two other requirements in treating injuries of one of those residents. NHC does not appeal the ALJ's determinations that it was not in substantial compliance with regard to four other residents as to the first requirement, but does dispute the

severity level assigned to its noncompliance with all three requirements on the ground that the residents suffered no actual harm.

For the reasons discussed below, we sustain the ALJ Decision in full.

Applicable law

Federal law and regulations provide for surveys to evaluate the compliance of nursing facilities with the requirements for participation in the Medicare and Medicaid programs and to impose remedies on facilities that do not to comply substantially with those requirements. Sections 1819 and 1919 of the Social Security Act (42 U.S.C. §§ 1395i–3; 1396r); 42 C.F.R. Parts 483, 488, and 498.[1]

"Substantial compliance" is defined as "a level of compliance with the requirements of participation such that any identified deficiencies pose no greater risk to resident health and safety than the potential for causing minimal harm." 42 C.F.R. § 488.301. "Noncompliance" means "any deficiency that causes a facility to not be in substantial compliance." Id. Thus, noncompliance may exist even if no deficiency resulted in actual harm, so long as a potential for more than minimal harm is present.

CMS may impose a CMP for the days on which the facility is not in substantial compliance. 42 C.F.R. §§ 488.404, 488.406, 488.408. Where the noncompliance poses less than immediate jeopardy but has the potential for more than minimal harm, CMS may impose a CMP between $50 and $3,000 per day. 42 C.F.R. §§ 488.408(d), 488.438(a)(1)(ii). A facility must prove that it is in substantial compliance by the preponderance of the evidence. Batavia Nursing and Convalescent Center, DAB No. 1904 (2004), aff'd, Batavia Nursing & Convalescent Ctr. v. Thompson, 129 F. App'x 181 (6th Cir. 2005). Once CMS has presented prima

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

facie evidence as to any material disputed facts, the burden of proof shifts to the facility to show that it is more likely than not that the facility was in substantial compliance. Id.

Standard of review

Our standard of review on a disputed finding of fact is whether the ALJ decision is supported by substantial evidence on the record as a whole. Our standard of review on a disputed conclusion of law is whether the ALJ decision is erroneous. Guidelines -- Appellate Review of Decisions of Administrative Law Judges Affecting a Provider's Participation in the Medicare and Medicaid Programs, www.hhs.gov/dab/guidelines/prov.html. Substantial evidence is "more than a mere scintilla. It means such relevant evidence as a reasonable mind might accept as adequate to support a conclusion." Richardson v. Perales, 402 U.S. 389, 401 (1971), quoting Consolidated Edison Co. v. NLRB, 305 U.S. 197, 229 (1938). Under the substantial evidence standard, the reviewer must examine the record as a whole and take into account whatever in the record fairly detracts from the weight of the decision below. Universal Camera Corp. v. NLRB, 340 U.S. 474, 488 (1951).

Factual Background

The following facts from the ALJ Decision are not in dispute.[2]

The Tennessee Department of Health concluded a complaint investigation and recertification survey of NHC's facility on September 28, 2007 and determined that NHC had nine deficiencies, each comprising failure to comply substantially with a federal requirement for Medicare participation specified in 42 C.F.R. Part 483. CMS adopted the surveyor's determinations and, on October 5, 2007, imposed a CMP of $800 per day effective May 30, 2007. CMS also notified NHC that a Denial of Payment for New Admissions would be effective December 28, 2007 and that its provider agreement would be terminated effective March 28, 2008. Those two remedies did not go into effect, however, because CMS determined that NHC had attained

[2] The information presented in the background section and in our analysis is from the ALJ Decision and the record and is undisputed except where noted. This information should not be treated as new findings.

substantial compliance with the participation requirements on October 12, 2007.

NHC timely requested an ALJ hearing to challenge three of the nine deficiencies, each designated by a "tag" number used in CMS's State Operations Manual (SOM) to identify the specific regulatory requirement at issue: 42 C.F.R. §§ 483.10(b)(11) (Tag F157), 483.25 (Tag F309), and 483.25(h) (Tag F323).[3] NHC subsequently waived its right to a hearing and requested that its appeal be decided on the parties' written submissions. Based on the parties' briefs and unopposed exhibits, the ALJ sustained the three deficiencies that NHC appealed, although he reversed CMS's findings with respect to one of the eight residents cited as examples under Tag F323. The ALJ also rejected NHC's challenges to the level of noncompliance assigned to the cited deficiencies. The ALJ upheld as reasonable the amount of the $800 per-day CMP for the deficiencies he sustained and those that NHC did not challenge, but determined that the period of NHC's noncompliance began on June 5, 2007, instead of May 30, 2007, as CMS had found.[4]

Analysis

1. **We sustain each of the ALJ's conclusions on noncompliance.**

A. 42 C.F.R. § 483.10(b)(11) (Tag F157)

The regulation, entitled "Notification of changes," requires, as relevant here, that a facility–

> must immediately . . . consult with the resident's physician . . . when there is . . .
>
> * * * *
>
> (B) A significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration

[3] The ALJ correctly concluded that CMS's findings of noncompliance with six other requirements were final and binding, and NHC does not appeal that conclusion. ALJ Decision at 35, citing 42 C.F.R. § 498.20(b).

[4] CMS does not challenge the ALJ's change in the duration of the CMP, so we do not discuss it below.

> in health, mental, or psychosocial status in either life-threatening conditions or clinical complications;
> (C) A need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment) . . .

Section 483.10(b)(11)(i).

The survey findings concerned a 91-year-old female resident (Resident 9) with severely impaired cognitive skills who was injured in a fall on May 30, 2007. X-rays taken on May 31 disclosed no fracture, but over the next four days the resident complained of pain in her pelvic area and left hip and was treated with pain medication. During the afternoon of June 5, Resident 9 was observed to have elevated temperature, heart rate and respiration. The physician ordered a urine sample. At 10:20 PM, the resident cried out when staff moved her left leg while attempting to apply a catheter to obtain the urine specimen. In addition, at that point, the resident's left hip joint area was noted as swollen and warm to the touch. NHC contacted the resident's physician the next morning at 7:45 a.m. He ordered the resident sent to a hospital emergency room, where x-rays disclosed a fracture of the left femur that had not been seen on the x-rays taken on May 31, the day after her fall. ALJ Decision at 6-9, 13. The resident required corrective surgery. A comparative review of the earlier x-ray still did not reveal a fracture on the earlier image. CMS Ex. 29, at 57.

The ALJ concluded that NHC should have notified Resident 9's physician immediately of her condition on the evening of June 5, instead of waiting until the next morning. The ALJ concluded specifically that the resident's acute pain "even with the slightest move" of her left leg, in conjunction with the swelling and warmth in her left hip joint, constituted a "significant change" in the resident's status under the regulation requiring that NHC "immediately" consult with her physician. Id. at 9, 12, 14.

NHC did not dispute before the ALJ, or on appeal, that it did not notify Resident 9's physician "immediately" upon observing the symptoms of pain and injury to the left hip area. ALJ Decision at 9. NHC contends instead that it was not required to do so under the circumstances because the resident's condition was not significantly changed from her baseline and no X-ray could be taken or read until the next morning in any case.

The requirement at section 483.10(b)(11)(i) that the facility "immediately" consult with the resident's physician "modifies each of the four types of circumstances described" following that requirement, including: "when there is a 'significant change in the resident's . . . status' (483.10(b)(11)(i)(B)); and . . . when there is '[a] need to alter treatment significantly' (483.10(b)(11)(i)(C))." The Laurels at Forest Glenn, DAB No. 2182, at 11 (2009). NHC argues that, on the evening of June 5, Resident 9 had no "life threatening conditions" or "clinical complications" requiring physician notification. RR at 6. NHC cites an affidavit from the resident's physician stating that the resident's "pain behavior" from May 30 through the night of June 5 was neither out of the ordinary nor unexpected "given the blunt trauma experienced on May 30" and that she "would not have expected to be notified of the Resident's pain behaviors." P. Ex. 5, ¶ 11. The physician also stated that, even if she had been notified of the resident's condition on the night of June 5, she would not have ordered further x-rays "given the previous x-ray findings and the Resident's customary complaints of pain." Id. ¶ 13. She further stated that she would not have ordered any intervention that night, including any additional pain medication, for the "temporary exacerbation" of pain when the leg was moved, "as the Resident was already receiving sufficient pain medication and was achieving adequate pain control." Id. NHC points to the physician's statement that the resident was not transported to the hospital for x-ray immediately after her May 30 fall because the physician knew that no radiologist was present to review the x-rays overnight. Id. ¶ 9. NHC argues that on the evening of June 5 its staff therefore believed that no radiologist would be available.

The ALJ adequately addressed these arguments. The ALJ found the physician's assertion that she would not have ordered further x-rays on June 5 if the facility had contacted her "unavailing" in light of the fact that, after NHC contacted the physician on the morning of June 6, she did order the resident to the hospital. ALJ Decision at 12. As the ALJ noted, x-rays at the hospital on June 6 disclosed a fracture requiring corrective surgery on her left femur, the same leg that staff had attempted to move, prompting her cry of pain. Id. at 13-14. The ALJ correctly concluded that the physician's assertion that she would not have ordered any intervention on the evening of June 5 did not excuse NHC's failure to notify her, since the clear requirement of the regulation that the facility contact (and consult with) the

physician is not contingent on how the physician might respond, but on the existence of facts requiring notification. Id. at 12-13.

Furthermore, the resident's cry of pain when staff moved her leg on the evening of June 5 was not the only indication that something was wrong. At that time staff also observed that her left hip joint was swollen and warm, and earlier that day they noted that the resident had elevated temperature, heart rate and respiration; the physician's statement does not discuss these symptoms and is limited to Resident 9's "pain behaviors." ALJ Decision at 8; P. Ex. 5. The ALJ found that the resident's symptoms were "not similar to" or consistent with her history of chronic pain due to arthritis. ALJ Decision at 12. Instead, he found, they were "a clear departure from the resident's clinical picture and level of discomfort previously reported" that "trigger[ed] an inference of acute rather than chronic pain," denoting a significant change in the resident's medical status. Id. at 12-13.

Under the substantial evidence standard we employ in reviewing ALJ decisions, we will defer to the inferences drawn by the ALJ where reasonable on the record. Park Manor Nursing Home, DAB No. 2005, at 12 (2005), aff'd, Park Manor v. U.S. Dep't of Health & Human Servs., 495 F.3d 433 (7th Cir. 2007), cert. denied, 128 S.Ct. 903 (2008); Barry D. Garfinkel, M.D., DAB No. 1572, at 5-6 (1996), aff'd, Garfinkel v. Shalala, No. 3-96-604 (D. Minn. June 25, 1997). The resident's symptoms and the subsequent disclosure of a fracture requiring surgery support the reasonableness of the ALJ's inference. NHC on appeal provides no reason to conclude that the ALJ's inference was unreasonable or that his determination that the resident had a significant change of status was erroneous or not supported by substantial evidence.

NHC also argues, as it did below, that its position is supported by Park Manor Nursing Home, DAB No. 1926 (2004), where the Board determined that a resident's symptoms did not constitute a significant change requiring physician notification under section 483.10(b)(11). There as here, NHC asserts, the symptoms alleged to indicate a significant change were simply consistent with the resident's overall condition and CMS failed to show that the physician would have ordered any additional intervention if contacted sooner. NHC's Request for Review of ALJ Decision (RR) at 8-9. The present case is distinguishable because here the record supports the ALJ's determination that

Resident 9's symptoms were *not* consistent with the chronic condition that had produced previous complaints of pain. The ALJ also articulated valid reasons to discount the physician's statement that she would not have ordered x-rays on the evening of June 5. The specific facts in Park Manor were quite different from the present case. There, the resident in question was "likely in the final stages of an overall physical and mental decline" and in fact died less than four days after the beginning of symptoms CMS alleged indicated a significant change (at which time the physician had been notified), and the resident's care plan specified that he was "to receive comfort measures only." Park Manor at 3-4, 9-10. Also, the resident in Park Manor did not appear to be suffering any pain or discomfort, and his legal guardian had clearly communicated that she would refuse any treatment meant merely to prolong the resident's life. Id. at 10. By contrast, there is no suggestion that Resident 9 was experiencing a terminal decline or that her family wished no active treatment to be performed. In fact, her family twice requested that she be x-rayed. First, on May 30, after her fall, her son wanted her to be x-rayed that evening instead of the following day. Later, because her continuing symptoms, the resident's family requested on June 1 that the May 31 x-rays be retaken or rechecked, a request that the facility did not convey to the physician until June 6. ALJ Decision at 7, 9; CMS Ex. 29, at 7. Park Manor thus does not support a conclusion that Resident 9 did not experience a significant change of status requiring that NHC immediately contact her physician.

NHC also argues that the resident did not display a "clinical complication" as defined in the SOM. RR at 6. The SOM provision NHC cites is not an exhaustive or exclusive list of reportable clinical complications but simply offers several examples, stating that clinical complications are "*such things as* development of a stage II pressure sore, onset or recurrent period of delirium, recurrent urinary tract infection, or onset of depression." SOM App. PP, at Tag 157 (emphasis added); see also 56 Fed. Reg. 48,826, 48,833 (Sept. 26, 1991). Also, NHC has not shown why the symptoms of a fractured femur that the resident displayed were not of sufficient gravity to be considered clinical complications under this standard.

As to NHC's argument that the resident had no "life threatening conditions" on the evening of June 5 (RR at 6), the ALJ correctly pointed out that the regulation does not limit the term "significant change in . . . status" to mean only a "life

threatening condition," nor does it equate "significant change" with "medical emergency." ALJ Decision at 10. CMS emphasized this point in the preamble to the final rule publishing the regulation, where it stated that "in all cases, whether or not there is a medical emergency, the facility must notify the resident; [and] his or her physician . . . ." 56 Fed. Reg. at 48,832-33; ALJ Decision at 10-11.

For these reasons we sustain the ALJ's determination that NHC was not in substantial compliance with the requirements of section 483.10(b)(11) in its treatment of Resident 9.

B. 42 C.F.R. § 483.25 (Tag F309)

This regulation, entitled "Quality of care," requires 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.

Based on the same facts discussed under Tag F157, the ALJ concluded that NHC failed to provide the necessary care to reduce or relieve Resident 9's pain and to assess and manage her symptoms in violation of this regulation. The ALJ accepted that NHC routinely provided the resident with medication to treat the chronic pain of her arthritis and provided additional medication after her fall, as NHC asserted. The deficiency in NHC's treatment of this resident, according to the ALJ, lay in its failure to apprehend that by June 5 the nature and magnitude of the resident's complaints of pain and her other symptoms provided "staff with clear signals that her pain was no longer chronic, thus constituting a significant change" in her condition to which it should have responded appropriately with sufficient measures to determine the source of and relieve the pain and symptoms. ALJ Decision at 15. The ALJ also found that NHC failed to respond to her needs adequately by not immediately contacting her physician to report the inability to follow through with the physician-ordered urinalysis, and that the failure to do so further compromised the resident by causing continued pain and delaying the needed urine specimen. Id. Furthermore, as we noted, NHC failed to notify the physician of multiple new symptoms, including the acute pain and the local warmth and swelling, with the result that her needs for

treatment in relation to those symptoms were not assessed or addressed timely.

NHC asserts that the resident's cries and moans were not "'clear signals' of an acute problem" but "typical 'pain behaviors' which occurred despite the administration of what the treating physician deemed to be appropriate levels of pain medication." RR at 11. NHC argues that the ALJ "failed to understand and appreciate fully" the physician's statement indicating that the resident "typically engaged in such behaviors even before the May 30 fall." Id.[5] NHC also relies on the physician's statement as indicating that the resident experienced "no significant additional pain or harm between 10:20 p.m. on June 5 and the next morning when she was notified of the Resident's condition." Id.

As we discussed above, the ALJ's reasonable inference of acute rather than chronic pain was consistent with other symptoms such as her fever and the swelling and warmth around the resident's left hip on June 5. Those symptoms and the order for a urinalysis indicated a need for additional data to inform a decision about the cause and possible treatment for the resident's changing condition. NHC fails to explain on appeal how the standing order to provide the resident with pain medications PRN could suffice to satisfy the resident's need for evaluation and care of a possible infection. NHC does not

[5] The ALJ could reasonably question the conclusory statements by the physician that the resident's post-fall pain was well managed and consistent with her chronic pain behaviors in light of the contemporaneous documentation recorded by nurses who were actually caring for the resident. As he discussed, nurses notes for the period May 30 through June 4, 2007 depict the resident "as 'yelling in pain;' complaining of 'severe pain in left hip;' . . . stating 'hurts real bad;' and 'yelling constantly, for med for pain.'" ALJ Decision at 15, citing CMS Ex. 29, at 10. NHC by contrast cites no contemporaneous records showing that the resident voiced comparable complaints of pain prior to her fall on May 30. We need not evaluate the adequacy of the facility's treatment of the resident's post-fall pain, however, because as noted CMS has not challenged the ALJ's determination to treat noncompliance as beginning on June 5.

document that it successfully obtained a urine sample on June 5 for testing.[6]

The ALJ also discounted the physician's statement because the physician did not address any of the symptoms other than a brief "exacerbation" of pain when the resident's leg was moved. The ALJ further pointed out that the physician's opinion that she would not have taken action if she had been notified of the resident's condition on the night of June 5 was inconsistent with the actual course of action on which she embarked the following morning. Id. at 13-14. The physician in fact ordered the resident taken to the hospital emergency room. The ALJ could reasonably conclude, too, that the revelation at the hospital that the resident had a fractured femur, combined with the symptoms observed during the previous evening, call into question the physician's assertion that the resident experienced no significant additional pain between 10:20 p.m. on June 5 and the next morning. Furthermore, the physician did not observe the resident during that time.

For these reasons we sustain the ALJ's determination that NHC was not in substantial compliance with the requirements of section 483.25 in its treatment of Resident 9.

C. 42 C.F.R. § 483.25(h) (Tag F323)

The "Quality of Care" regulation specifically requires a facility to ensure that each "resident receives adequate supervision and assistance devices to prevent accidents." 42 C.F.R. § 483.25(h)(2). The ALJ found that NHC failed to provide properly functioning safety devices to five residents (Residents 1, 9, 11, 13, and 23) and failed to provide adequate supervision during transfers to two other residents (Residents 15 and 26).[7] ALJ Decision at 16-32 passim. On appeal, NHC concedes that it was not in substantial compliance with the regulation as to

[6] There is an indication in the record suggesting that a nurse recorded a urine sample on June 5, but NHC does not dispute the ALJ's finding that staff were unable to obtain the urinalysis on that date. CMS Ex. 29, at 9; ALJ Decision at 12.

[7] CMS had alleged inadequate supervision as to a third resident (Resident 8), but the ALJ concluded that NHC successfully rebutted CMS's case. ALJ Decision at 26-28. CMS did not appeal that conclusion.

Residents 9, 11, 13 and 23, seeking to challenge only the level of noncompliance assigned (which we discuss in a later section). NHC thus challenges the noncompliance findings as to only Residents 1, 15, and 26. NHC's concessions of noncompliance as to multiple residents are sufficient to uphold the ALJ's conclusion that NHC was not in substantial compliance with the regulatory requirements. See, e.g., Jewish Home of Eastern Pennsylvania, DAB No. 2254 (2009). Nevertheless, as we discuss briefly below, ALJ did not err in concluding that NHC's care of Residents 1, 15, and 26 evidenced noncompliance with section 483.25(h)(2).

i. Resident 1

NHC does not dispute that Resident 1 was 91 years old, had severely impaired cognitive skills, suffered from osteoporosis, dementia and depression, and was totally dependent on staff for all mobility. ALJ Decision at 18, citing CMS Ex. 27, at 5, 10, 26, 28. The resident had a history of falls in which she was found on the floor by her bed. Id., citing CMS Ex. 27, at 33, 35. NHC's plan for this resident's care called for the use of padded side rails on both sides of her bed, floor mats beside the bed, a bed alarm, and two-person assists for any transfers. CMS Ex. 27, at 5, 10. It is not disputed that on July 7, 2007 the resident fell from her bed while the side rail was down, the bed alarm was turned off, and no floor mats were in place. ALJ Decision at 19; RR at 13. It is also undisputed that a CNA (certified nurse aide) who was providing bedtime care prior to the fall lowered the side rail, turned off the bed alarm and then stepped away from the bed to get a brief from the closet. Id. Resident 1 ended up on the floor and suffered a shoulder fracture. CMS Ex. 27, at 15, 32.

NHC argues that the CNA's failure to use the safety devices called for by the resident's plan of care was "justifiable." RR at 14. According to NHC, the alarm would serve "no useful function when the CNA was standing close by the Resident" and might disturb the resident. Id. Further, NHC contends, "[t]o the extent the side rails were an impediment to the Resident's necessary care, there was reason to lower them for a brief interval." Id. NHC insists that the CNA was close by because the closet was "two steps" from the bed. Id. at 13.

The ALJ rejected these contentions because he found they lacked factual support. ALJ Decision at 21. In particular, the ALJ found that NHC did not establish that the side rails were in

fact an impediment to the provision of care. In addition, he found that NHC did not explain why the CNA could not have followed the plan of care by raising the side rail and rearming the alarm while she retrieved the brief. Id. The ALJ noted that NHC did not dispute that one of its own nurses described the CNA's failure to do so as showing "poor judgment." Id. at 19, citing CMS Ex. 27, at 24; 21. The ALJ also noted that the CNA involved was inexperienced with this resident and had been left alone in the room after she and another CNA used a one-person assist to put the resident to bed (also contrary to the plan of care). Id. He concluded that the resident presented a foreseeable risk of falling from her bed and that NHC had not shown any reasonable justification for the CNA to disregard the interventions which the facility itself planned to minimize that risk. Id.

We agree with the ALJ that our decision in Burton Health Care Center, DAB No. 2051 (2006), does not require a different conclusion. On the contrary, the Board there reiterated that "while a facility is permitted the flexibility to choose the methods it uses to prevent accidents, the chosen methods must be adequate under the circumstances," and that "what are adequate supervision and assistance devices for a particular resident depends on the resident's ability to protect himself from harm." Id. at 9, citing Woodstock Care Center, DAB No. 1726 (2000), aff'd sub nom., Woodstock Care Ctr. v. Thompson, 363 F.3d 583 (6th Cir. 2003). In Burton, as here, the Board upheld an ALJ's conclusion that a facility failed to present any justifiable reason for failing "to implement the interventions that it had determined were necessary to minimize" a resident's fall risk, such as use of a waist restraint. DAB No. 2051, at 9. NHC relies on the Board's conclusion in Burton that the regulation was not violated in another incident in which the specific circumstances showed that a momentary "turning away" by a CNA supervising the resident's toileting did not deprive the resident of adequate supervision. RR at 14-15, citing Burton at 12-13. The ALJ adequately distinguished that incident in Burton from the facts before him in this case.

We conclude that substantial evidence supports the ALJ's finding of noncompliance in regard to Resident 1.

ii. Resident 15

NHC concedes that the facility assessed Resident 15 as requiring the assistance of two persons with all transfers and that a

single CNA tried to transfer the resident from wheelchair to bed on August 24, 2007. RR at 17; ALJ Decision at 28-29; see also CMS Ex. 32, at 10-12 (Post Fall Nursing Assessment). The resident began to slide down and had to be lowered to the floor. Id. The ALJ rejected NHC's attempt to avoid responsibility for the failure to provide required care in accordance with its own care plans to address a known fall risk by denying that the "facility" knew that its staff was not complying with the care plan. ALJ Decision at 29-30. We similarly reject that argument as reiterated by NHC on appeal.

The ALJ did not find persuasive here the decision of another ALJ who declined to hold a different facility responsible for an isolated staff error in using a lift to transfer a resident. ALJ Decision at 29, discussing JFK Hartwick at Edison Estates, DAB CR840 (2001). NHC relies on Hartwick again on appeal, but we too do not find persuasive NHC's suggestion that CMS must show inadequate training or supervision of a staff person before CMS may cite a failure to provide a resident with care in accordance with its care plan. The regulation at issue does not speak to staff training or supervision; indeed, it does not specify how the facility may elect to carry out the care responsibilities which it undertakes toward its residents. Having undertaken to provide care of the nature and quality required by the regulation by using a CNA, the facility does not shed its regulatory responsibility to "ensure" that each resident "receives" the requisite level of supervision and assistance devices needed "to prevent accidents." 42 C.F.R. § 483.25(h)(2). We agree with the ALJ that NHC's "lack of knowledge as to whether the facility knew that its staff was not complying with its policies does not shield it from responsibility." ALJ Decision at 30, citing Beverly Health Care Lumberton, DAB No. 2156 (2008), *pet. to reopen denied*, Ruling No. 2008-5, at 6-7 (facility cannot "disown the acts and omissions of its own staff . . . [having] elected to rely on them to carry out its commitments").

We conclude that substantial evidence supports the ALJ's finding of noncompliance in regard to Resident 15.

iii. Resident 26

NHC concedes that this resident with multiple diagnoses required a two-person assist for all transfers and the use of a mechanical lift. RR at 18; ALJ Decision at 31; see also CMS Ex. 34, at 24, 26, 30. NHC argues, however, that two persons were

assisting with the transfer during which the resident fell from the lift, although NHC admits that one of the CNAs "briefly turned to get a washcloth." RR at 18. The ALJ concluded that the resident was not receiving the assistance of two CNAs throughout the transfer, and that the resident's care plan does not contemplate such assistance for only "part of the transfer process." ALJ Decision at 32. He noted that the fall occurred after one CNA let go of the resident's legs. Id. NHC did not contest the ALJ's finding that its administrator told the surveyors that the resident "did not have 2 person assist at time of fall" and that the CNA used "poor judgment" by "walking away." Id. at 31, quoting CMS Ex. 34, at 42.

We conclude that substantial evidence supports the ALJ's finding of noncompliance in regard to Resident 26.

2. **NHC has no legal basis to challenge the seriousness of the deficiencies.**

NHC argues that the deficiencies the ALJ sustained should be considered less serious than CMS determined. CMS cited the deficiencies under Tags F157 and F309 at a scope and severity level of "G," meaning actual harm that is not immediate jeopardy, and the deficiency under Tag F323 at level "H," meaning a pattern of actual harm that is not immediate jeopardy. CMS Ex. 6, at 1, 7, 14; SOM § 7400E (scope and severity grid, shown without alphabetic designations at 59 Fed. Reg. 56,116, 56,183 (Nov. 10, 1994)). NHC argues that no deficiencies caused actual harm to the residents involved and none therefore should be assessed above level 'D'," meaning no actual harm with potential for more than minimal harm that is not immediate jeopardy. RR at 9, 12, 19-21; P. Reply at 5.

As the ALJ correctly concluded, under the circumstances here CMS's determinations as to the scope and severity of the deficiencies are not subject to challenge before the ALJ or the Board. The appeal regulations permit a challenge to CMS's determination of the level of noncompliance only where it would affect "(i) [t]he range of civil money penalty amounts that CMS could collect" or "(ii) [a] finding of substandard quality of care that results in the loss of approval for a SNF or NF of its nurse aide training program."[8] 42 C.F.R. § 498.3(b)(14); see

[8] The Act prohibits approval of a nurse aide training program "offered by or in a skilled nursing facility which,

(Continued. . .)

also § 498.3(d)(10)(ii) (facility may not appeal CMS's determination as to the facility's level of noncompliance except as provided in subsection (b)). Neither of those two conditions exists here. The $800 per-day CMP imposed is already in the lower of the two ranges available for per-day CMPs, $50 to $3,000 per day, versus $3,050 to $10,000 per day for deficiencies that pose immediate jeopardy. 42 C.F.R. § 488.438(a)(1). The Board has held that the effect of the first condition is therefore to preclude review of the level of noncompliance absent a finding of immediate jeopardy. CarePlex of Silver Spring, DAB No. 1683, at 15-17 (1999).

The second condition permitting review of scope and severity is also absent here. NHC does not dispute the ALJ's finding that NHC presented no evidence that it has a nurse aide training program or is seeking approval for one, and that NHC thus does not face loss of approval "of its nurse aide training program" as the regulation requires.[9] ALJ Decision at 33; 42 C.F.R. § 498.3(b)(14) (emphasis added).

NHC argues, however, that regulations permitting the ALJ to consider the seriousness of deficiencies as a factor when reviewing the reasonableness of the amount of a CMP furnish a legal basis for NHC to dispute the scope and severity assigned

(Continued. . .)

within the previous 2 years" has been assessed a CMP of at least $5,000 or been found to have provided substandard quality of care, which is defined to include a deficiency under section 483.25, that represents a pattern of actual harm that is not immediate jeopardy, as the ALJ determined for the deficiency under Tag F323, addressed below. Act §§ 1819(f)(2)(B)(iii) (Medicare) and 1919(f)(2)(B)(iii) (Medicaid); 42 C.F.R. § 488.301; ALJ Decision at 32-34.

[9] CMS cites language from the preamble to the rulemaking adopting section 498.3(b)(14)(ii) as demonstrating that review is not available for a facility that is neither operating a nurse aide training program nor seeking approval to operate one. See generally 64 Fed. Reg. 39,934 (July 23, 1999). CMS Br. at 7. The preamble is not free from ambiguity since it refers several times to a facility's loss of the ability to operate a nurse aide training program. The regulatory wording is, however, consistent with CMS's position here.

by CMS. P. Reply at 2, citing 42 C.F.R. §§ 488.404, 488.438(e), (f). On their face, these regulations simply permit the ALJ to take into account in weighing the reasonableness of a CMP amount the scope and severity level assigned to the deficiency or deficiencies on which the CMP is based. Nothing in the wording of these regulations suggests that they were intended to circumvent the very explicit restriction of ALJ review of the level of noncompliance to the two conditions explained above. We therefore do not read these regulations to authorize review CMS's determination of the scope and severity of a deficiency in assessing the reasonableness of the CMP amount.

For that reason, our review does not address NHC's arguments about the absence of actual harm. Here, it would likely have made no difference to the outcome even had we reviewed scope and severity because much of NHC's argument is based on the erroneous premise that CMS is precluded from presenting proof of actual harm unless the harm is spelled out in the statement of deficiencies (SOD). See, e.g., RR at 15. The Board has long made clear that the SOD does not rigidly frame "the scope of evidence to be admitted concerning any allegation relating to a cited deficiency," so long as the facility has notice and an opportunity to respond to any allegation raised. Kingsville Nursing and Rehabilitation Center, DAB No. 2234, at 12-13 (2009), quoting Pacific Regency Arvin, DAB No. 1823, at 9-10 (2002), and other cases cited therein. NHC had ample notice from CMS's submissions below of the allegations, such as those relating to Residents 13 (bruise on hip) and 23 (pain), as to which the ALJ found actual harm. ALJ Decision at 24-25. In any event, there can be little doubt that the pain and other symptoms experienced by Resident 9, who was the subject of all three deficiency determinations, constituted actual harm as CMS determined.

3. **We uphold the ALJ's conclusion on the reasonableness of the amount of the CMP.**

NHC argues that the amount of the $800 per-day CMP was not reasonable, but relies only on the same arguments on the merits of the noncompliance findings which we have rejected above. RR at 21-22. The per-day amount of $800 is well within the range ($50 - $3,000) of per-day CMPs authorized for deficiencies that have the potential for more than minimal harm.

The three noncompliance findings addressed by the ALJ were at level "G" or "H", both of which evidence actual harm either in

an isolated situation or in a pattern. In addition, NHC did not challenge six other noncompliance findings before the ALJ. The nature of NHC's noncompliance collectively supports CMS's determination of the amount of the CMP despite the ALJ's removal of one instance from the basis for one of the noncompliance findings.

As NHC offered no evidence or argument as to any other regulatory factor, we affirm the ALJ's conclusion that the amount of the CMP is reasonable.

Conclusion

For the reasons explained above, we affirm the ALJ's findings of fact and conclusions of law and uphold the ALJ Decision in full.

_____/s/_____
Judith A. Ballard

_____/s/_____
Stephen M. Godek

_____/s/_____
Leslie A. Sussan
Presiding Board Member