Department of Health and Human Services
DEPARTMENTAL APPEALS BOARD
Appellate Division

Columbus Nursing and Rehabilitation Center
Docket No. A-11-22
Decision No. 2398
June 30, 2011

REMAND OF
ADMINISTRATIVE LAW JUDGE DECISION

The Centers for Medicare & Medicaid Services (CMS) requests review of the September 13, 2010 decision of Administrative Law Judge (ALJ) Keith W. Sickendick. *Columbus Nursing and Rehabilitation Center*, DAB No. CR2241 (2010) (ALJ Decision). The ALJ concluded that Columbus Nursing and Rehabilitation Center (Columbus) was not in substantial compliance with program participation requirements from June 4, 2007 through August 2, 2007, due to violations of 42 C.F.R. §§ 483.25 (Quality of care), 483.25(c) (Pressure sores), and 483.25(i)(1) (Nutrition). The ALJ also concluded that Columbus did not violate either 42 C.F.R. § 483.13(c) (Staff treatment of residents) or § 483.10(b)(11) (Notification of change). The ALJ concluded that CMS's determination that the violation of 42 C.F.R. § 483.25 posed immediate jeopardy was clearly erroneous and that the remedies imposed by CMS were not reasonable. He found that reasonable enforcement remedies included a $3,050 per-day civil money penalty (CMP) from June 4 through June 13, 2007, a $200 per-day CMP from June 14 through August 2, 2007, imposition of a denial of payment for new admissions (DPNA) from July 20 through August 2, 2007, and withdrawal of authority to conduct a nurse aide training and competency evaluation program (NATCEP) for two years.

CMS requested review of the ALJ Decision, contending that it contains both factual and legal errors. CMS asks us to sustain CMS's imposition of an $8,800 per-day CMP for four violations at the immediate jeopardy level, and to reverse the ALJ's conclusion that Columbus came into substantial compliance with the participation requirements on August 3, 2007. CMS Request for Review (RR) at 3. Columbus did not challenge any of the ALJ's findings or conclusions, but responded to CMS's request.

For reasons explained more fully below, we affirm the uncontested conclusions from the ALJ Decision (see p. 4). We remand the contested conclusions for the ALJ to clearly detail his findings of fact in support of his conclusions of law, with sufficient analysis so we can determine whether he applied the proper legal standard, what findings he made that are material to his legal conclusions, how he evaluated conflicting and competing

evidence contained in the record, and why he drew or declined to draw particular inferences.

Applicable Law

The Social Security Act (Act) and federal regulations provide for state agencies to conduct surveys of each Medicare skilled nursing facility (SNF) and Medicaid nursing facility (NF) to evaluate compliance with the Medicare and Medicaid participation requirements. Sections 1819 and 1919 of the Act; 42 C.F.R. Parts 483, 488, and 498.[1] The participation requirements are set forth at 42 C.F.R. Part 483, subpart B. A facility's failure to meet a participation requirement is called a "deficiency." 42 C.F.R. § 488.301. "Substantial compliance" means a level of compliance such that "any identified deficiencies pose no greater risk to resident health or safety than the potential for causing minimal harm." *Id.* "Noncompliance" is defined as "any deficiency that causes a facility to not be in substantial compliance." *Id.*

Surveyor findings are reported in a statement of deficiencies (SOD), which identifies each deficiency under its regulatory requirement. Each deficiency is assigned a level of severity (whether it has created a "potential for harm," resulted in "actual harm," or placed residents in "immediate jeopardy") and a scope of the problem within the facility (whether it is "isolated," constitutes a "pattern," or is "widespread"). 42 C.F.R. § 488.404; *State Operations Manual* (SOM), CMS Pub. 100- 07, App. P - Survey Protocol for Long Term Care Facilities, sec. V (available at http://www.cms.gov/ Manuals/IOM/list.asp).

A long-term care facility that is not in substantial compliance is subject to enforcement remedies, including CMPs. 42 C.F.R. §§ 488.402(c), 488.406, 488.408. CMS may impose either a per-instance or per-day CMP when a facility is not in substantial compliance. 42 C.F.R. § 488.408. A per-day CMP may accrue from the date the facility was first out of compliance until the date it achieved substantial compliance. 42 C.F.R. § 488.440(a)(1), (b). For noncompliance determined to pose less than immediate jeopardy to facility residents, CMS may impose a per-day CMP in an amount ranging from $50-$3,000 per day. 42 C.F.R. § 488.408(d)(1)(iii). For noncompliance determined to pose immediate jeopardy to facility residents, CMS may impose a per-day CMP in an amount ranging from $3,050-$10,000 per day. 42 C.F.R. § 488.408(e)(1)(iii). The regulations set out several factors that CMS considers to determine the CMP amount. 42 C.F.R. §§ 488.438(f), 488.404.

[1] The current version of the Social Security Act can be found at http://www.socialsecurity.gov/ OP_Home/ssact/ssact.htm.

Relevant Background

Columbus, located in Columbus, Wisconsin, is authorized to participate in Medicare as a SNF and in the Medicaid program as a NF. The Wisconsin Department of Health and Family Services (WDHFS) conducted surveys at the facility ending on June 27, 2007, July 5, 2007, August 14, 2007 and September 14, 2007. ALJ Decision at 2.

As a result of the June 27, 2007 survey, CMS notified Columbus that the facility violated 42 C.F.R. §§ 483.13(c), 483.25, 483.25(c), and 483.25(i)(1) and that the violations posed immediate jeopardy from June 4, 2007 through June 13, 2007. CMS also notified Columbus that numerous deficiencies continued on and after June 13, 2007 that did not rise to the level of immediate jeopardy. CMS imposed a CMP of $8,800 per day from June 4, 2007 through June 13, 2007, a $200 per-day CMP beginning June 14, 2007 until the facility returned to substantial compliance, and a discretionary DPNA beginning July 20, 2007. ALJ Decision at 2; CMS Ex. 1. After a revisit survey completed on September 14, 2007, CMS advised Columbus that the facility returned to substantial compliance on September 4, 2007, the total CMP due was $104,600, and the DPNA ended on September 4, 2007. ALJ Decision at 2; CMS Ex. 3.

As indicated above, the ALJ concluded that Columbus violated only three participation requirements, two at the immediate jeopardy level. He also reduced the amount of the immediate jeopardy CMP and concluded that the facility had returned to substantial compliance on August 3, 2007. Each heading in the ALJ Decision represents a numbered conclusion of law (CL).[2] On appeal, CMS challenges the ALJ's CLs 1, 2, 4, 9, 10, 12, and 13. The issues on appeal arise primarily from the set of facts related to two facility residents (R2 and R3), whom we describe briefly below. Specifically, CMS asks us to reverse the following CLs in connection with R3: Columbus did not violate section 483.13(c) (CL1); CMS's determination that the violation of section 483.13(c) posed immediate jeopardy was clearly erroneous (CL2); and CMS's determination that the facility's violation of section 483.25 posed immediate jeopardy was clearly erroneous (CL4).

CMS also asks us to reverse the ALJ's conclusion that, prior to August 10, 2007, R2 did not have a significant change in condition and the facility did not need to significantly alter her care and therefore did not violate section 483.10(b)(11) (CL10).

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[2] We note that the ALJ indicated that "his conclusions of law are set forth in bold followed by a statement of the pertinent facts and [his] analysis." ALJ Decision at 8. The ALJ did not make specific, numbered findings of fact, even though both parties submitted proposed findings of fact.

Finally, CMS asks us to reverse the ALJ's conclusions that Columbus returned to substantial compliance effective August 3, 2007 (CL9), the remedies imposed by CMS are not reasonable (CL12), and a reasonable remedy is a $3,050 per-day CMP from June 14 through August 2, 2007 (CL13).

Columbus does not contest the ALJ's conclusions that Columbus violated section 483.25 (CL3), violated section 483.25(c) (CL5) at an immediate jeopardy level (CL6), and violated section 483.25(i)(l) (CL7) at an immediate jeopardy level (CL8). CMS does not contest the ALJ's finding that Columbus did not violate section 483.25 (CL11) in connection with R22. Accordingly, we summarily affirm those uncontested conclusions.

Standard of Review

When the Board reviews an ALJ decision it may either issue a decision or remand the case. 42 C.F.R. § 498.88(a). 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 (Guidelines)*, http://www.hhs.gov/dab/divisions/appellate/guidelines/index.html. 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. *Id*.

Substantial evidence is "more than a mere scintilla. It means such relevant evidence as a reasonable mind might accept as adequate to support a conclusion." *Richardson v. Perales*, 402 U.S. 389, 401 (1971), quoting *Consolidated Edison Co. v. NLRB*, 305 U.S. 197, 229 (1938). Under the substantial evidence standard, the reviewer must examine the record as a whole and take into account whatever in the record fairly detracts from the weight of the evidence relied on in the decision below. *Universal Camera Corp. v. NLRB*, 340 U.S. 474, 488 (1951). The Board defers to an administrative law judge's findings on credibility of witness testimony unless there are compelling reasons not to do so. *See Woodland Oaks Healthcare Facility*, DAB No. 2355, at 7 (2010).

Analysis

The reason we remand this case to the ALJ is not because we adopt either party's position. Rather, we remand this case because we cannot discern from the ALJ Decision what factual findings the ALJ made on certain material, disputed issues and because he did not provide a rationale for each legal conclusion based on which we can determine whether he properly applied the relevant legal standard.

In general, the ALJ Decision merely recites evidence from the residents' medical records, according to the type of record and the date, rather than its relevance to a disputed factual

issue. The ALJ then discusses some but not all of the relevant testimony. While the ALJ said he gave more weight to the contemporaneous resident records than to conflicting testimony, the difficulty is that some of the evidence from the residents' records the ALJ describes could be viewed as supporting a result different from the result he reached, and he does not explain why he discounted that evidence.

Our review of the record indicates that it contains some evidence supporting findings that arguably justify the ALJ's conclusions that CMS challenges, but also contains conflicting evidence. With respect to some material factual issues, however, the ALJ did not clearly make any finding of fact, did not cite to the evidence supporting his finding, or did not explain why he discounted the countervailing evidence, much of which he mentioned. The ALJ indicated that he discussed only the evidence he found credible and gave the "greatest weight." ALJ Decision at 8. We cannot tell, however, whether he gave no weight or only some weight to other evidence supporting his conclusions. For example, the ALJ indicated that he found R3's physician, who testified on behalf of Columbus, to be "credible," but found the physician's testimony not to be "weighty and persuasive" on one issue – whether R3's moaning and crying out were due to dementia rather than pain. *Id.* at 24. The physician's testimony on other issues arguably supports the ALJ's conclusions regarding R3 and the services provided to her, but we simply do not know whether the ALJ credited it for these purposes and, if so, how he weighed that testimony against any other evidence that might undercut his conclusions. Similarly, direct written testimony by other witnesses arguably supports the ALJ's conclusions that CMS challenges, but he did not explicitly mention either that testimony or the countervailing evidence submitted by CMS.

It would be inappropriate for us to make new findings or to substitute our judgment for that of the ALJ regarding the probative value of the evidence. As the Board stated in *Hillman Rehabilitation Center*, "an ALJ decision cannot be adequately reviewed unless it contains 'not only an expression of the evidence s/he considered which supports the result, but also some indication of the evidence which was rejected . . . [in order to determine] if significant probative evidence was not credited or simply ignored.'" *Hillman Rehabilitation Center*, DAB No. 1611, *aff'd, Hillman Rehabilitation Ctr. v. U.S. Department of Health and Human Svcs.*, No. 98-3789 (D.N.J. May 13, 1999), at 51, n.39, *citing Cotter v. Harris*, 642 F.2d 700, 705 (3rd Cir. 1981).

We also remand because some of the ALJ's legal conclusions – in particular, his conclusion regarding the level of noncompliance with section 483.25 in connection with R3 – are stated without any meaningful analysis and do not appear to follow logically from his discussion of the evidence and the applicable legal standard. Rather than trying to discern a possible rationale for the ALJ's challenged conclusions, we are exercising our authority to remand this case for the ALJ to provide a more complete, reviewable

rationale that is based on findings of material fact and that addresses the parties' arguments.

Our discussion below is designed to inform the ALJ about what we perceive to be the shortcomings of his decision and why, not to do our own evaluation of the evidence or to direct his findings of fact or conclusions of law.[3] We first discuss the issues with respect to R3's pain and whether the facility's noncompliance related to that pain was at the immediate jeopardy level. We discuss this issue first because it is also relevant to our consideration of the arguments about whether the facility was complying with the requirement to implement an anti-neglect policy, which we discuss next. We then discuss the issue regarding R2, involving the requirement for physician consultation when there is a significant change in a resident's physical, mental or psychosocial status. Finally, we discuss the issues related to the reasonableness of the amount of the CMP, including issues about the facility's financial condition.

I. The ALJ should address on remand what findings he made that are material to his conclusion that CMS's determination regarding the level of the facility's noncompliance with the quality of care requirement at 42 C.F.R. § 483.25 was clearly erroneous (CL4).

Each resident must receive and the facility must provide necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the resident's comprehensive assessment and plan of care. 42 C.F.R. § 483.25. This standard for the quality of care imposes an "overarching duty" on facilities to provide each resident "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." *Windsor Health Care Center*, DAB No. 1902, at 16 (2003).

R3 was admitted to Columbus in January 2007 and her diagnoses included dementia and Alzheimer's disease, depression, hypertension, generalized anxiety disorder, psychological pain disorder, myofascial pain, and osteoarthritis. ALJ Decision at 9. She was sent for psychiatric consultations in January and May 2007 and received psychotropic medications, including anti-anxiety medications. *Id.* at 10. These medications were reduced in April and May 2007 due to a concern she was oversedated, and, when her medication was reduced, there was an increase in her agitation, anxiety,

[3] The information in this decision is drawn from the ALJ Decision and the record before the ALJ, and is presented solely to provide a context for the discussion of the issues raised on appeal and should not be construed as a complete recitation of record. Nothing in this section is intended to replace, modify, or supplement any ALJ findings of fact or conclusions of law.

and moaning at times. *Id.* at 22. She had prescriptions for Tylenol for pain and later for Vicodin. *Id*. at 14, 16. In early June 2007, R3 was sent twice for hip X-rays after she complained of leg pain and the staff had noted repeated incidents of R3 moaning and crying out. *Id*. at 18. The X-rays did not reveal any fractures. *Id*. By early June, the staff had requested and obtained a new order for Vicodin, a half-tablet by mouth every six hours and "as needed" for pain. *Id.* at 17, 18. Her care plan required nursing staff to assess her pain each shift and as needed. *Id.* at 14. During the June 2007 survey, the surveyor observed R3 moaning and calling out loudly without assessments by a nurse to determine whether to administer her "as needed" pain medication. *Id*. at 19-20.

The ALJ determined based on these facts and others that Columbus was not in substantial compliance with section 483.25. The ALJ found "no evidence" that prior to the survey in June 2007, Columbus "developed a care plan for addressing [R3's behavior of moaning and crying out] or for systematically assessing and tracking the behavior to attempt to distinguish between behaviors due to pain and those due to dementia or some other cause." ALJ Decision at 16. He further found, based on Surveyor Tina Lubick's testimony, that there were "instances" when the facility's licensed staff did not assess R3 for pain, as required by her plan of care. *Id.* at 23. He concluded that the facility's attempt to rebut CMS's *prima facia* case on the theory that the resident was not suffering pain but instead her behavior was attributable to her dementia "must fail as the evidence does not support such a finding." *Id*. at 24. He then addressed the level of noncompliance, as follows:

> However, the violation does not support a determination of immediate jeopardy and the determination is clearly erroneous as it relates to this deficiency. Immediate jeopardy is present if a provider's noncompliance caused or is likely to cause a resident serious injury, harm, or impairment, or death. The evidence supports a conclusion that the resident, more likely than not, suffered pain that was not promptly relieved. I have no difficulty concluding that pain amounts to actual harm. However, given the resident's history of pain and the treatment she did receive for pain, it was not "likely" that she would suffer serious injury, harm, impairment, or death due to [Columbus'] failure to assess, monitor, and treat her pain given the facts of this case.

ALJ Decision at 25.

CMS challenges the ALJ's conclusion that the finding of immediate jeopardy is clearly erroneous. RR at 12. CMS asserts that the ALJ did not analyze the question of whether the immediate jeopardy determination was clearly erroneous using the correct analytic framework. *Id*. at 14.

"Immediate jeopardy" means a "situation in which the facility's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident." 42 C.F.R. § 488.301. A determination that immediate jeopardy is present is a determination about the level of noncompliance, and "CMS's determination as to the level of noncompliance of an SNF or NF must be upheld unless it is clearly erroneous." 42 C.F.R. § 498.60(c)(2). In a case where an ALJ upheld a determination of noncompliance based on the facts asserted by CMS, the Board held that CMS's determination that those facts give rise to immediate jeopardy "is presumed to be correct, and the facility has a heavy burden to demonstrate clear error in that determination." *Brian Center Health and Rehabilitation/Goldsboro*, DAB No. 2336, at 6 (2010). Once CMS establishes noncompliance, it does not need to make a *prima facia* case as to the level of noncompliance. *Liberty Commons Nursing & Rehab Center - Johnston*, DAB No. 2031, at 18 (2006), *aff'd*, *Liberty Commons Nursing and Rehab Center - Johnston v. Leavitt*, 241 F. App'x 76 (4th Cir. 2007). The clearly erroneous standard was adopted because evaluating the seriousness of a deficiency cannot be reduced to a mathematical judgment, and therefore the surveyors are granted "flexibility and deference, in applying their expertise in working with these less than perfectly precise concepts." *Innsbruck HealthCare Center*, DAB No. 1948, at 6 (2004), *quoting* 59 Fed. Reg. 56,116, 56,179 (Nov. 10, 1994). For this reason, the Board has said that "it is material in evaluating the immediate jeopardy determination to consider the factual underpinnings on which the surveyors relied to apply their expertise." *Id.*

Here, the ALJ did not discuss how he applied the "clearly erroneous" standard, the concomitant burden of proof, or how Columbus met this burden. The ALJ simply said that he based his conclusion on "the resident's history of pain and the treatment she did receive for pain." ALJ Decision at 25. He did not specify what part of the resident's history he found relevant, however, nor address the parties' competing views of that history. Nor did he adequately explain why the history on which he based his conclusion of noncompliance would not also support CMS's immediate jeopardy determination under a clearly erroneous standard.

There are two additional flaws in the ALJ's legal analysis. First, although the ALJ concluded that R3 suffered pain amounting to actual harm, he did not address whether

that actual harm was serious. CMS argues that the ALJ erred because R3 suffered "severe" pain, relying on the testimony of Daniel Berlowitz, MD, who testified:

> I think the pain is serious, is serious harm . . . and what is so concerning is how despite many behaviors that were highly suggestive of pain, it seemed based on the surveyor's notes that it was often ignored.

Tr. at 354.[4]

The ALJ mentioned Dr. Berlowitz's testimony and also mentioned testimony by Surveyor Lubick that the noncompliance caused R3 serious harm. ALJ Decision at 21-22. The ALJ did not, however, discuss this testimony in connection with his conclusion about immediate jeopardy, so we do not know whether he found these opinions to be outweighed by the evidence presented by Columbus or simply did not consider them. Nor did the ALJ discuss how he reconciled arguably conflicting evidence in the record relevant to R3's level of pain.

Moreover, the ALJ did not specifically address how long R3 endured pain, saying only that it was not "promptly relieved." ALJ Decision at 25. The ALJ listed some evidence from the record which arguably undercuts the surveyor's view that the facility was simply ignoring for long periods of time signs indicating a high level of pain that should have been addressed with "as needed" Vicodin. ALJ Decision at 10-11; 14-21. On the other hand, the ALJ also listed some evidence that arguably supports the surveyor's view. *Id.* We simply do not know how the ALJ evaluated the conflicting evidence regarding the level and duration of pain R3 suffered or what was the nature of the actual harm he found.[5]

Second, the issue with respect to immediate jeopardy is not just whether it was likely that a particular resident would suffer serious injury, harm, impairment, or death, but whether the noncompliance found was likely to cause serious injury, harm, impairment, or death

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[4] Columbus argues that CMS did not timely raise the issue of whether R3's pain was severe. Columbus Response Br. at 14. Whether CMS may clarify or amend its determination of noncompliance depends on whether CMS provides timely and adequate notice of its reliance on the clarification or amendment. *See Livingston Care Center*, DAB No. 1871 (2003), *aff'd*, 388 F.3d 168 (6th Cir. 2004) (facility received adequate notice through CMS's summary judgment motion that CMS was relying on a surveyor's observation not included in SOD); *Spring Meadows Health Care Center*, DAB No. 1966, at 14-15 (2005) (ALJ erred in relying on a factual basis for which the facility did not have adequate notice, but error was not prejudicial). On remand, the ALJ should address the parties' arguments about whether CMS gave timely and adequate notice that it was alleging R3's pain was severe.

[5] CMS argues R3's pain led to other serious consequences, contributing to her pressure sores and weight loss. RR at 13-14. Columbus says CMS did not timely raise these issues. Columbus Response Br. at 14-15. On remand the ALJ should address the parties' arguments about whether CMS timely raised these issues.

to **any** resident. RR at 14, *citing Daughters of Miriam Center*, DAB No. 2067, at 9 (2007). The ALJ framed his conclusion only in terms of R3, however, without reaching any broader conclusion about the likelihood of serious injury, harm, impairment, or death to a resident from the noncompliance he found.

In sum, the ALJ Decision does not make clear findings on disputed issues of fact material to whether the actual harm to R3 was serious harm, does not provide any rationale for disregarding testimony by CMS's witnesses regarding the level of harm to R3, reaches a conclusion about the likelihood of serious harm that lacks sufficient explanation with respect to R3 and without considering other residents, and does not provide a sufficient rationale for that conclusion, consistent with the clearly erroneous standard.

II. The ALJ should address on remand what findings he made that are material to his conclusion that Columbus did not fail to implement its anti-neglect policy as required by 42 C.F.R. § 483.13(c) (CLs 1 and 2).

Facilities are required to develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. 42 C.F.R. § 483.13(c). The ALJ determined that CMS's argument that Columbus did not develop a sufficient policy to prohibit neglect was without merit. ALJ Decision at 11. The ALJ noted that Columbus had objected to CMS arguing for the first time in its post-hearing brief that Columbus did not implement its anti-neglect policy and that this objection was "well taken." ALJ Decision at 11. He nonetheless went on to address the issue without explaining why he was doing so.[6] In doing so, the ALJ noted that R3's clinical record "shows that there was an extensive effort to deliver goods and services to [R3]." *Id*. at 13. The ALJ stated that, although he concluded Columbus was not in substantial compliance with some program participation requirements related to its care of R3, he did "not conclude that the deficiencies reflect a systemic problem with [Columbus] implementing its policy prohibiting the neglect or abuse of residents." *Id*.

CMS does not claim on appeal that the ALJ erred in finding the facility's anti-neglect policy to be adequate. Instead, CMS challenges the ALJ's conclusion regarding implementation of the anti-neglect policy, arguing that the ALJ incorrectly applied Board decisions and that "a facility that fails to provide goods and services to a resident necessary to avoid physical harm or mental anguish has failed to implement its neglect policies." RR at 9-12.

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[6] Before the Board, Columbus again asserts that this issue was not timely raised by CMS. Columbus Response Br. at 4. On remand the ALJ should address the parties' arguments about whether CMS timely raised this issue.

Section 483.13(c) by its plain terms does not address neglect or abuse per se, but requires a facility to have and implement policies and procedures to prohibit abuse and neglect. In *Emerald Shores Health & Rehabilitation Center*, the Board upheld an ALJ's conclusion reversing a finding of noncompliance under section 483.13(c), noting that CMS must establish "some relationship between the failure to provide [the specified] services and a failure to implement polic[ies] or procedures to prevent neglect" in order to support a noncompliance finding under section 483.13(c). DAB No. 2072, at 22-23 (2007), *reversed sub nom. on other grounds*, *Emerald Shores Health Care Associates., LLC* v. *U.S. Dep't of Health & Human Servs.*, 545 F.3d 1292 (11th Cir. 2008), *accord Britthaven of Havelock*, DAB No. 2078 (2007).

In cases in which a facility had developed the requisite policies and procedures and there was no direct evidence that the facility had failed to implement them, the Board has discussed whether an ALJ could reasonably infer (or decline to infer) from the evidence in the record that a facility failed to implement the policies and procedures, as required. Those cases establish that 1) an isolated instance of neglect is not sufficient, *per se*, to support the inference; 2) the inference is reasonable if the circumstances as a whole demonstrate a systemic problem in implementing the policies and procedures; and 3) an ALJ may reasonably infer from multiple or sufficient examples of neglect, even with respect to one resident, that the facility did not implement its anti-neglect policy. *See Carehouse Convalescent Hospital*, DAB No. 1799, at 34 (2001), *Columbus Nursing & Rehabilitation Center*, DAB No. 2247, at 27 (2009)(*Columbus I*); *Liberty Commons*, at 14, and cases cited therein.

The ALJ Decision here discussed and distinguished *Columbus I*, which involved the same general anti-neglect and anti-abuse policy and procedures at issue here. ALJ Decision at 12. In *Columbus I*, where there was only an allegation of abuse, the Board said it "has never required that multiple incidents of abuse have occurred in order for CMS to cite noncompliance with this requirement." *Columbus I*, at 27. The Board concluded that the ALJ reasonably inferred that Columbus had failed to implement the policy based on facts showing that multiple facility staff had failed to take specific steps called for by the policy in response to an allegation of abuse and that one staff member was unaware of the policy's provisions. In other similar Board cases, such as *Liberty Commons* and *Lake Mary Health Care*, DAB No. 2081 (2007), the Board found such an inference reasonable where multiple staff members failed to take specified steps pursuant to the policy at issue. In contrast, CMS alleges here only that there were multiple instances of neglect by multiple staff members, not that Columbus failed to take specific steps required by its policy.

In such cases, the Board recently said, the focus "is not simply on the number or nature of the instances of neglect (i.e., failure to provide necessary care or services) but on whether

the facts found by the ALJ surrounding such instance(s) demonstrate an underlying breakdown in the facility's implementation of the provisions of an anti-neglect policy." *Oceanside Nursing and Rehabilitation Center,* DAB No. 2382, at 11 (2011). Clearly, the Board was not using the term "systemic" in earlier decisions to mean that the failure has to be "systemwide."

The ALJ Decision here discusses neither the number nor the nature of any instances of neglect, nor does it discuss what circumstances surrounding any such instances the ALJ thought were relevant. The ALJ noted that R3 "was the only resident out of 15 sampled" during the survey for which the surveyors identified any neglect, but did not sufficiently analyze the allegations of neglect involving R3. ALJ Decision at 9. The ALJ did elsewhere in his decision state some of his noncompliance findings in terms such as the "inadequacy" of the services provided to R3, the delay in providing them, and the lack of "systematic" assessment (rather than as a failure to provide needed services), but did not specifically conclude that these failures were not "neglect." Instead, the ALJ merely summarized R3's clinical records to show the "extensive care and services provided." We cannot tell from the ALJ Decision what in the records the ALJ thought either undercut CMS's allegation that there were multiple instances of neglect, or was otherwise material in determining whether to infer from the circumstances as a whole that Columbus failed to implement its anti-neglect policy. Moreover, with respect to his finding of noncompliance with respect to R3's pressure sores, the ALJ did conclude that Columbus "failed to deliver necessary care and services to [R3] to prevent the development of new pressure sores," which suggests that he did find some instances of neglect with respect to her pressure sores. ALJ Decision at 36.

In sum, the ALJ's analysis of why he concludes that Columbus did not fail to implement its anti-neglect policy includes no explanation to reconcile this conclusion with his noncompliance findings related to R3. We cannot discern from the ALJ Decision whether the ALJ was relying on evidence that undercuts CMS's allegation that there were multiple instances of neglect or had different reasons for concluding that the circumstances as a whole do not demonstrate a systemic problem in implementing the anti-neglect policy. On remand, the ALJ should explain his conclusion in light of the noncompliance findings he made, specify what findings he made regarding the alleged instances of neglect, and identify more specifically the other circumstances he found relevant.

III. The ALJ should address on remand what findings he made that are material to his conclusion that Columbus did not violate section 483.10(b)(11) (CL10) with respect to R2.

Section 483.10(b)(11)(i)(B) of 42 C.F.R. requires a SNF to "immediately ... consult with the resident's physician ... when there is ... [a] significant change in the resident's physical, mental or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications)." [7] CMS's interpretation of the regulation, set forth in Appendix PP of SOM, states that "[c]linical complications are such things as development of a stage II pressure sore, onset or recurrent periods of delirium, recurrent urinary tract infection, or onset of depression." Section 483.10(b)(11)(i)(C) requires a facility to consult with the resident's physician when there is a "need to significantly alter treatment (i.e., a need to discontinue an existing form of treatment due to adverse consequences or to commence a new form of treatment)."

The requirement to "consult" means that the facility must engage in a dialogue with the physician and may not simply leave a message for the physician without following up if the physician does not timely return the call. *Magnolia Estates Skilled Care*, DAB No. 2228, at 9 (2009). The Board has previously stated that the physician consultation requirement "is not a mere formality;" it ensures a resident's right to timely receive the treating physician's input as to the care required under the circumstances. *Britthaven of Goldsboro*, DAB No. 1960, at 11 (2005).

R2 was diagnosed with multiple sclerosis and suffered from severe contractures. ALJ Decision at 50; CMS Ex. 63. R2 had a history of urosepsis and septic shock. *Id.* On August 9, 2007 at 12:30 pm, the nursing staff documented that R2 had a two by one centimeter hard, rough mass protruding from the vaginal opening one centimeter that was "grey in color, painful [with] slight touch," and a white discharge was noted. ALJ Decision at 50. At 1:35 pm, facility staff called R2's physician about the mass and left a message with the physician's nurse, but they did not follow up on that call. That evening R2 refused her evening meal, which was not uncommon for her, and she had no complaints of pain or discomfort. The next morning, R2 was assessed with a temperature and the on-call physician was notified at 9:45 am about the mass, elevated temperature and R2's refusal of food and fluids. The physician ordered R2 sent to the emergency room. At the emergency room, a vaginal examination was deferred due to R2's

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[7] The preamble to the final rule that promulgated section 483.10(b)(11) states: "We recognize that judgment must be used in determining whether a change in the resident's condition is significant enough to warrant notification, and accept the comment that only those injuries which have the potential for needing physician intervention must be reported to the physician." 56 Fed. Reg. 48,826, 48,833 (Sept. 26, 1991).

excruciating discomfort from trying to position her for examination. The emergency room physician determined that sedation to examine R2 was required; after sedation, the mass was extracted from R2's vagina. The physician ordered intravenous antibiotics due to a severe urinary tract infection (UTI) and to avoid any complications due to the mass. R2 was discharged from the hospital the following day and returned to the facility. *Id.* at 50-51.

After reciting information from R2's record, the ALJ then described competing testimony from Surveyor Ann Angell and the facility's witnesses. He concluded that the facility did not violate section 483.10(b)(11), stating:

> I am convinced based upon the policy guidance of the SOM that the facts do not amount to a violation of the regulation because there was no significant change in the condition of the resident or need to significantly alter care within the meaning of the regulations on August 9, 2007. When on August 10, 2007, [R2] manifested signs and symptoms consistent with a possible infection, staff immediately consulted with the on-call physician who ordered that the resident be sent to the emergency room for treatment.

ALJ Decision at 52. CMS asserts, however, that the discovery of the mass on August 9, 2007 was a significant change in condition. RR at 19.[8]

The ALJ's analysis is incomplete because it does not specifically address whether the presence of the mass was a significant change in physical status and failed to discuss whether the evidence (such as staff notation of foul odor and yellow-white discharge) showed signs of infection earlier than August 10, 2007 that required immediate physician consultation. Instead, the ALJ points out that the facility immediately consulted with the physician on the morning on August 10, when R2 had a temperature of 100 degrees and complained she was not feeling well. The ALJ does address some evidence relevant to whether there was a significant change before then. *See, e.g.,* ALJ Decision at 50 and exhibits cited therein (not uncommon for R2 to refuse meals and fluids except for taking a little water; R2 did not complain of pain or discomfort in the evening on August 9 or the morning of August 10). The ALJ also does not explicitly evaluate whether, based on this evidence and the record as a whole, he concluded that the facility nurses reasonably exercised their judgment that there was no significant change in the resident's status on August 9, despite the presence of the mass and the signs noted at that time. The ALJ

[8] CMS also appeals the ALJ's conclusion that Columbus returned to substantial compliance with program participation requirements effective August 3, 2007 (CL9). RR at 15. CMS's argument is based on the alleged noncompliance with section 483.10(b)(11) with respect to R2. The ALJ should address this issue on remand *if* he changes his overall conclusion regarding this allegation.

does not explain what in the SOM convinced him there was no significant change or how he weighed the testimony he described. Nor does he analyze whether the mass itself was a clinical complication that required immediate physician intervention or discuss matters such as why he declined to infer from the fact that a facility nurse attempted to contact the physician on August 9 (as the surveyor had) that she thought there was a significant change.

We also are unable to ascertain the ALJ's reasons for rejecting CMS's position that, based on the fact that the physician ordered R2 to be immediately sent to the hospital on August 10, Columbus should have consulted with a physician on August 9. According to CMS, this fact distinguishes the situation here from that addressed in *Lake Cook Terrace Nursing* Center, DAB No. 1745, at 3-4 (2000), on which Columbus relies. *See* Columbus Response Br. at 22. The ALJ Decision does not discuss this issue, however.

In short, without some further explanation by the ALJ, we cannot evaluate whether substantial evidence supports the ALJ's finding that there was no significant change in R2's health status on August 9. While the ALJ is not required to discuss every piece of evidence in the record, the ALJ should provide sufficient analysis of that evidence and the inferences he drew from that evidence so that we can provide a meaningful review, without simply substituting our judgment for his.[9]

IV. The ALJ should address on remand what findings he made that are material to his conclusion on the reasonableness of the remedies imposed by CMS (CLs 12 and 13) and how he weighed the relevant factors.

In determining the reasonableness of the amount of a CMP, the ALJ is to consider the factors set out in 42 C.F.R. § 488.438(f), which are (1) the facility's history of noncompliance, (2) its financial condition, (3) factors specified in section 488.404, and (4) the facility's degree of culpability, defined as including neglect, indifference, or disregard for resident care, comfort or safety. Absence of culpability is not a mitigating factor. 42 C.F.R. § 488.438(f)(4). The factors specified in section 488.404, in turn, include the seriousness (scope and severity) of the deficiencies, their relationship to each other, and the facility's prior history of noncompliance in general and with respect to the particular deficiencies at issue.

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[9] In addition to concluding that there was no significant change in R2's condition, the ALJ also concluded that there was no need to significantly alter R2's treatment within the meaning of the regulations. ALJ Decision at 52. Columbus asserts that the SOD did not contend that the facility was required to consult with a physician about a need to significantly alter treatment in accordance with 483.10(b)(11)(i)(C). On remand, the ALJ should address the parties' arguments about whether CMS timely raised this issue.

The ALJ concluded that the remedies imposed by CMS are not reasonable and that reasonable remedies are a $3,050 per-day CMP from June 4 through June 13, 2007; a $200 per-day CMP from June 14 through August 2, 2007; a DPNA effective from July 20 through August 2, 2007, and a withdrawal of approval to conduct a NATCEP.

CMS asserts that the $8,800 per-day CMP is reasonable, even based on the ALJ's findings of two immediate jeopardy deficiencies rather than four. RR at 23. CMS also asserts that the ALJ's finding that the CMP would put Columbus out of business is not supported by substantial evidence and was contrary to law. RR at 24. CMS further contends that the ALJ erred by failing to give adequate consideration to the facility's history of noncompliance. RR at 34. We address each of these assertions below.

a. The seriousness and relationship of the deficiencies

In reducing the amount of the CMP, the ALJ noted that he had found that the facility's noncompliance with section 483.25 with respect to R3 was not at the immediate jeopardy level and that he had reversed another noncompliance finding altogether. ALJ Decision at 57. An ALJ is required to consider the seriousness and relationship of the deficiencies. Thus, an ALJ may conclude that a reduction in the number and seriousness of the deficiencies warrants a reduction in the CMP amount, especially where each of the deficiencies involves the same resident, whose problems are interrelated.

In *The Residence at Salem Woods*, DAB No. 2052, at 11 (2006), the Board stated that if the ALJ "overturns some of the deficiencies upon which [CMS's determination about the CMP amount] is based, the ALJ may legitimately consider whether the CMP amount, as originally imposed, is reasonable for the remaining deficiencies." *Cf. Western Care Management Corp., d/b/a Rehab Specialties Inn*, DAB No. 1921, at 20 (2004) (noting that if an ALJ elects not to make findings about certain disputed deficiency citations, the ALJ must also consider whether findings favorable to the facility regarding those unaddressed citations could materially affect a fact-finder's determination about whether the amount of the CMP imposed by CMS was reasonable). In *Salem Woods*, the Board also held, however, that the ALJ "may . . . find the CMP amount to be reasonable based on fewer deficiencies than those upon which CMS relied to impose the penalty." *Salem Woods*, at 11, *citing Madison Health Care*, DAB No. 1927, at 23 (2004).

The ALJ Decision contains no explanation from which we can determine to what extent he relied on the reduction in the number and seriousness of the deficiencies as a basis for reducing the CMP amount. As explained below, the ALJ should on remand discuss more specifically how he weighed the various factors, in light of his findings and conclusions.

b. The facility's financial condition

The ALJ also stated that he considered the facility's financial condition in reducing the CMP amount. He found that Columbus produced credible oral testimony from Martin Metten, executive vice president and chief financial officer (CFO) of the company which owns and operates the facility. ALJ Decision at 58. The ALJ found that the "unrebutted" evidence showed that the facility's financial condition was poor and that imposition of a large CMP would put Columbus out of business. *Id*. Among other things, the ALJ found credible the CFO's testimony that Columbus had a negative net worth.[10] *Id.* CMS presented evidence from the facility's 2006 cost report showing an owners' equity of $393,025, but the CFO testified (and CMS concedes on appeal) that Columbus had operating losses in the subsequent two years of approximately $830,000. CMS Ex. 5, at 2; RR at 32 n.15, *citing* Tr. at 878, 884.

Columbus bears the burden of proving its financial condition by the preponderance of the evidence. *Western Care Mgt. Corp.*, DAB No. 1921, at 91, *citing* 59 Fed. Reg. 56,116, 56,204 (Nov. 10, 1994). In *Windsor Health Care Center*, the Board described a facility's assets as a key factor in assessing financial condition, but recognized that there are other relevant factors. A facility's liabilities are one of the relevant factors, so an ALJ is not limited to considering what assets a facility has. Instead, as the Board indicated in *Kenton Healthcare, LLC,* DAB No. 2186, at 30 (2008), other factors such as a facility's financial reserves and its credit-worthiness are also relevant. The Board has, however, upheld an ALJ decision disregarding or discounting facility testimony on financial condition where there was no written documentation concerning the facility's finances showing an inability to pay the CMP. *Highland Pines Nursing Home, Ltd.*, DAB No. 2361, at 6-7 (2011); *Wisteria Care Center*, DAB No. 1892, at 13 (2003).

Here, the ALJ mentions that the CFO's testimony was unrebutted, which is significant since the ALJ gave CMS an opportunity to present a rebuttal after the hearing. *See* RR at 32 n.15. The ALJ Decision here, however, does not discuss specifically what part of Mr. Metten's testimony the ALJ thought showed that the facility would go out of business or what financial information the ALJ considered relevant. Moreover, the decision does not mention CMS's evidence, or even refer to the facility's burden of proof. To do a meaningful review, we need a more complete explanation from the ALJ about why he concluded that a CMP greater than the minimum amount would put Columbus out of business. On remand, he should specifically discuss the facility's burden of proof, and what evidence in addition to Mr. Metten's testimony he considered, if any.

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[10] As CMS notes, "owner's equity" is commonly referred to as "net worth" and is defined as "total assets minus total liabilities." Reply Br. at 18 n.10. Thus, if a company has a "negative net worth," presumably the owner has no equity in it.

CMS also argues on appeal that the ALJ erred as a matter of law in expanding his *de novo* review of the reasonableness of the CMP to consider data about the facility's financial condition for the two years after CMS imposed the CMP, up until the hearing date. RR at 29. Columbus responds that the ALJ's analysis based on information at the time of the hearing was legally correct. Columbus Br. at 34-35. Columbus also argues that CMS did not object to the CFO's testimony at the hearing and was given an opportunity to provide supplementary evidence after the hearing. *Id.* at 33. On remand, the ALJ should address whether CMS gave timely and adequate notice of the issue about the relevance of data for periods after CMS imposed the CMP and, if so, specifically address this issue, discussing any relevant legal authority.

c. The facility's history of noncompliance and other factors

In earlier decisions involving Columbus, the Board upheld a finding of noncompliance with section 483.25(c)(pressure sores) and a finding of noncompliance with section 483.13 for failure to implement an anti-abuse policy. *See* RR at 35. The ALJ Decision notes that "the facility's prior history of noncompliance in general and specifically with respect to the cited deficiencies" is a factor the ALJ must consider and says that he "considered evidence of [Columbus's] prior history of noncompliance." ALJ Decision at 58. Yet, his decision does not explain what that history was or why he found that the facility's financial condition justified a reduction to the minimum amount for immediate jeopardy despite the history of noncompliance and other factors. We note, for example, that the ALJ Decision does not clearly indicate whether he was aware of the repeated deficiency – at a level indicating substandard quality of care – with respect to section 483.25(c).

On remand, the ALJ should explain what he found regarding the prior history of noncompliance and the degree of culpability, how he took these factors into account, and why he found that factors that could support an increase above the minimum amount are outweighed by his findings on the facility's financial condition. Of course, if on remand the ALJ reconsiders any of his conclusions regarding substantial compliance or the level of noncompliance, he will need to consider his new conclusions in determining the reasonableness of the CMP amount.

Conclusion

For the reasons stated above, we affirm the uncontested conclusions from the ALJ Decision. With respect to the contested conclusions, the ALJ Decision cannot be adequately reviewed. Accordingly, we remand this case for the ALJ to issue a supplemental initial decision, consistent with our directions above.

/s/
Stephen M. Godek

/s/
Sheila Ann Hegy

/s/
Judith A. Ballard
Presiding Board Member