Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Appellate Division

In the Case of: Golden Living Center - Frankfort, Petitioner, - v. - Centers for Medicare & Medicaid Services.	DATE: December 31, 2009 Civil Remedies CR1981 App. Div. Docket No. A-09-130 Decision No. 2296

FINAL DECISION ON REVIEW OF
ADMINISTRATIVE LAW JUDGE DECISION

Golden Living Center - Frankfort (Golden) appealed the June 29, 2009 decision of Administrative Law Judge (ALJ) Carolyn Cozad Hughes upholding the determination of the Centers for Medicare & Medicaid Services (CMS) imposing remedies on Golden based on finding the facility not in substantial compliance. Golden Living Center - Frankfort, DAB CR1981 (2009) (ALJ Decision). Specifically, the ALJ concluded that Golden's deficiencies posed an immediate jeopardy to resident health and safety from December 15, 2007 through January 28, 2008 and upheld a civil money penalty (CMP) of $3,750 per day for that period. Further, the ALJ concluded that noncompliance continued at a lower level from January 29, 2008 through March 2, 2008 and upheld a CMP of $100 per day for that period.

Golden disputes the ALJ's assessment of the evidence generally and her conclusions based on the competing testimony of medical experts in particular. For the reasons explained below, we find

no merit to Golden's arguments and we therefore uphold the ALJ Decision.

Background

Golden is a skilled nursing facility (SNF) providing long-term care to Medicare beneficiaries in Frankfort, Kentucky pursuant to the requirements of the Social Security Act (Act)[1] and its implementing regulations. Act § 1819; 42 C.F.R. Part 483. SNFs participating in the Medicare program are subject to survey and enforcement procedures set out in 42 C.F.R. Part 488, subpart E, to determine if they are in substantial compliance with applicable program requirements which appear at 42 C.F.R. Part 483, subpart B.

"Substantial compliance" means a level of compliance such that "any identified deficiencies pose no greater risk to resident health or safety than the potential for causing minimal harm." 42 C.F.R. § 488.301. "Noncompliance," in turn, is defined as "any deficiency that causes a facility to not be in substantial compliance." 42 C.F.R. § 488.301.

Surveys conducted at Golden that ended January 4 and 30, 2008 resulted in findings of noncompliance with five Medicare participation requirements at a level that posed an immediate jeopardy to resident health and safety. "Immediate jeopardy" is defined as a "situation in which the provider'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.

The five requirements at issue are: 42 C.F.R. § 483.25 (quality of care generally); 42 C.F.R. § 483.25(j) (hydration); 42 C.F.R. § 483.75(j)(laboratory services); 42 C.F.R. § 483.75(o)(quality assessment and assurance); and 42 C.F.R. § 483.20(k)(3) (comprehensive care plans). The factual underpinnings of all the noncompliance findings arise from the care which the facility provided to one resident (R1) during the month of December 2007.

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[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.

CMS determined that Golden removed the immediate jeopardy effective January 29, 2008 and returned to substantial compliance on March 3, 2008. The regulations provide that CMPs may be imposed in the range of $3,050-10,000 for each day of immediate jeopardy and of $50-3,000 for each day of noncompliance that does not constitute immediate jeopardy. As a result of the noncompliance findings, CMS imposed the CMPs set out above.

Standard of review

We review a disputed finding of fact to determine whether the finding is supported by substantial evidence on the record as a whole, and a disputed conclusion of law to determine whether it is erroneous. Departmental Appeals Board, *Guidelines -- Appellate Review of Decisions of Administrative Law Judges Affecting a Provider's Participation in the Medicare and Medicaid Programs* (DAB *Guidelines*), http://www.hhs.gov/dab/guidelines/prov.html; Golden Age Nursing & Rehabilitation Center, DAB No. 2026 (2006).

Analysis

Golden's arguments on appeal fall into two main categories: attacks on the ALJ's use of certain testimonial evidence and disagreements with the ALJ's evaluation of R1's care while at the facility.[2] We deal with the propriety of the ALJ's handling of written direct testimony and of medical expert testimony first, since Golden's position on these matters is inextricably entwined with its discussion of R1's care. We then address

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[2] We note that the ALJ stated that she declined to rule on every deficiency, discussing only those "that were persuasively established" and sufficed to support the remedies. ALJ Decision at 4, n.3. She further stated that no "inference should be drawn as to the merits" of the unaddressed noncompliance findings. Id. Golden suggests in a footnote that it "presumes" that these CMS noncompliance findings (including an immediate jeopardy finding under section 483.75(o)(1) and a lesser finding under section 483.25(m)(2)) have been abandoned and asks the Board to order that "these abandoned citations should be removed from the administrative record for all purposes." RR at 12, n.6. Golden points to no authority for such an order by the Board. Since we conclude that the noncompliance which the ALJ discussed was supported by substantial evidence in the record and was indeed sufficient to support the remedies imposed, we do not revisit her decision as to which deficiencies to discuss.

Golden's specific arguments as to R1, noting in several areas the pervasive mischaracterization of the ALJ Decision in Golden's briefing.

1. The ALJ did not err in her treatment of witness testimony.

A. Written direct testimony

The ALJ's pre-hearing order stated that the parties "must exchange as a proposed exhibit the complete written direct testimony of any proposed witness," and that "[g]enerally, [the ALJ] will accept the witness' written direct testimony as a statement in lieu of in-person testimony." ALJ Order, April 4, 2008, at 3. The ALJ further required that a "party must produce at the hearing for cross-examination any witness whose written direct testimony that party offers as evidence." Id. at 4. Golden does not assert that it took exception to any aspect of the ALJ's order or that it made any request below to require particular witnesses to present their direct testimony in person. Golden did request the opportunity to cross-examine two CMS witnesses in person, and the ALJ ordered that CMS produce them. ALJ Order, October 10, 2008, at 2. Again, the record does not reflect any objection to this ALJ order by Golden to indicate that it actually sought to have any of the witnesses provide their direct testimony in person as well (despite the fact that the October 20, 2008 order expressly provides ten days for parties to file any objections). Despite failing to raise any objection below to CMS's presentation of direct testimony in the form of sworn written statements in accordance with the ALJ's orders, Golden argues on appeal that it was error for the ALJ to consider the written direct testimony of CMS's expert witness, Dr. Jeffrey Fink. RR at 9.

Golden recognizes that the Board has previously upheld the discretion of the ALJ to receive direct testimony in written form, "so long as the right to effective cross examination is protected and no prejudice is alleged and shown." Laurels at Forest Glenn, DAB No. 2182, at 9 (2008), citing Vandalia Park, DAB No. 1940, at 28-29 (2004), aff'd, Vandalia Park v. Leavitt, No. 04-4283, 2005 WL 3334522 (6th Cir. Dec. 8, 2005); Pacific Regency Arvin, DAB No. 1823, at 7-8 (2002).

Despite this longstanding precedent, Golden argues that the Board should revisit its position on the permissibility of written direct testimony based on this year's Supreme Court decision in Melendez-Diaz v. Massachusetts, ___ U.S. ___, 129 S.Ct. 2527 (2009). Golden acknowledges that Melendez-Diaz is "not directly on point," but still suggests that it somehow

means that a party to an administrative hearing has a right not only to have the opposing party produce all witnesses for cross-examination but also to insist that all direct testimony by the opposing party's witnesses must be provided in person. RR at 11.

Golden is certainly correct that such a conclusion does not follow "directly" from Melendez-Diaz. At issue in that case was the presentation by the prosecution in a criminal case of sworn certificates by laboratory analysts identifying drugs which the defendant was accused of distributing. 129 S.Ct. at 2531. The defendant objected that the admission of the certificates violated his right to confront the witnesses against him. Id. The Court rejected various arguments advanced for the proposition that the defendant had no right to confront the analysts, concluding that they were indeed witnesses presenting testimonial evidence adverse to the defendant regardless of whether they actually witnessed the crime or were merely proffering the results of forensic tests. Id. at 2533-39. The Court held too that the ability to independently subpoena the analysts did not eliminate the Confrontation Clause problem because the analysts might be unavailable or unwilling to appear at trial and the risk of a "no-show" should be on the prosecution since these witnesses are part of the prosecution's case. Id. at 2540. Obviously, Melendez-Diaz arises in the context of criminal law, a context with a much higher due process standard than administrative law, and addresses a specific constitutional right applicable only in that context.

Even were Melendez-Diaz applicable to these proceedings (which it is not), the case does not prohibit the use of written direct testimony as part of a hearing but rather precludes the use of an affidavit in place of testimony with no opportunity to cross-examine the affiant. The Board's prior decisions make clear that testimony proffered in written form before an ALJ may not be relied on if the proponent fails to produce the witness for cross-examination upon request of the opposing party. Furthermore, here Golden does not deny, and the record shows, that Dr. Fink was in fact produced by CMS and subjected to cross-examination by Golden. (Indeed, Golden asserts that Dr. Fink "significantly qualified" his direct testimony during cross-examination. RR at 9.)

Golden nevertheless contends that the "Melendez-Diaz problem is particularly acute," where CMS witnesses do appear for cross-examination but the ALJ "nevertheless uses" the written direct testimony in her decision. RR at 10. This contention is unexplained and without merit. The appearance of a witness in

person for cross-examination resolves any so-called "Melendez-Diaz problem" by allowing the ALJ to evaluate the weight and credence to be given that individual's assertions and hence ensures that Golden received ample due process. Nothing in Melendez–Diaz or any other authority identified by Golden supports the proposition that when a witness does appear for cross-examination, the judge should then disregard sworn direct testimony merely because it was presented in written form.

Golden further argues that written direct testimony should be disregarded because attorneys typically draft the language rather than the witnesses themselves. RR at 10. The involvement of an attorney in drafting is, as Golden admits, not per se improper. As the Board has previously noted, "witnesses must attest to their statements. Even if a statement is drafted by counsel after consulting with the witness, it is fair to assume the witness reads the statement before attesting and can correct any material drafting errors." Jennifer Matthew Nursing & Rehab. Center, DAB No. 2192, at 46, n.21 (2008). If a witness has signed on to testimony that does not accurately reflect the witness's personal knowledge and opinions, that testimony is likely to be less believable or to be undermined on cross-examination. The evaluation of the credibility and weight to be given to testimony in light of cross-examination is an area properly within the purview of the ALJ. Golden has not shown any reason for us to disturb the ALJ's assessment of either in this case.

B. Medical expert testimony

Golden also lodges a general objection to the ALJ's review of competing expert testimony. Golden states that "an ALJ has no authority to interpret, edit, extrapolate from, disagree with, or disregard *all* of the expert medical testimony in a record, which is what she did here." RR at 2 (emphasis in original). This assertion, while difficult to parse, appears in context to be based mostly on Golden's position that the testimony of Dr. Fink should have been read by the ALJ as consistent with that presented by Golden from R1's nurse practitioner and attending physician to show that the number, complexity and interactions of R1's ailments made her fluid levels "difficult or impossible" to manage. See RR at 3-5.

As we discuss in the next section, the ALJ actually did recognize the complexity of the resident's medical condition but concluded that Golden not only did not manage a difficult balancing act but fell short of providing even basic care according to its own assessments of R1's needs. As we note

there, the ALJ did not disregard or even disagree with consistent expert medical testimony or substitute her own judgment for uncontested medical evidence, as Golden suggests.

To the extent, however, that Golden's objection is intended to challenge the ALJ's general authority to determine the weight and significance of conflicting evidence, including expert testimony, we note here that this authority is part of the essential function of the ALJ as a factfinder. Golden relies for its contrary position largely on court cases involving ALJ hearings on disability claims. RR at 15, n.8, and cases cited therein. These cases apply the "treating physician rule" contained in Social Security disability regulations at 20 C.F.R. § 404.1527(d)(2). Under that provision, an ALJ is required, in evaluating whether a claimant is disabled, to give more weight to the opinion of physicians treating the individual than to those who do not have a treating relationship. The treating physician's opinion will be given "controlling weight" if it is found to be "well-supported by medically acceptable clinical and laboratory diagnostic techniques and . . . not inconsistent with the other substantial evidence . . . ." 20 C.F.R. § 404.1527(d)(2). When the opinion is not given controlling weight, the ALJ must state "good reasons." Id. The treating physician rule has no applicability to nursing home enforcement cases.[3] Even if it had applied, the regulation permits ALJs to consider whether a treating physician's opinion is supported or contradicted by other medical evidence, including laboratory results, and whether it is consistent with the weight of other substantial evidence.

Golden also overstates the constraints on ALJs in considering conflicting medical testimony and clinical evidence. For example, Golden quotes from a Third Circuit decision arising under the Black Lung Benefits Act to the effect that an "ALJ may not 'exercise absolute discretion to credit and discredit the expert's medical evidence'" and that by "'independently reviewing and interpreting [such medical evidence] the ALJ impermissibly substitute[s] his own judgment for that of a physician; an ALJ is not free to set his own expertise against that of a physician who presents competent evidence.'" RR at 15, n.8, quoting Kertesz v. Crescent Hills Coal Co., 788 F.2d

[3] The inapplicability of the treating physician rule in these cases does not imply that ALJs do not, or should not, consider such factors as a medical source's personal examination of or long-term experience with a patient in evaluating the weight to give testimony about that patient's medical condition.

158, 163 (3rd Cir. 1968). (Golden's quote omits without note citations in Kertsez to other cases.)[4] Golden omits the further conclusions of the Kertesz court that the --

> ALJ is not bound to accept the opinion or theory of any medical expert, but may weigh the medical evidence and draw his own inferences. Moreover, the ALJ should reject as insufficiently reasoned any medical opinion that reaches a conclusion contrary to objective clinical evidence without explanation.

788 F.2d at 163 (internal citations omitted).

We conclude that it was appropriate for the ALJ here to consider the testimony of CMS's medical expert, along with the testimony of the attending physician and nurse practitioner who treated R1 at Golden, and to evaluate and interpret the testimony (both on direct and cross-examination) along with the clinical records, including hospital records, nurses notes, and laboratory values.

2. The ALJ's findings are supported by substantial evidence in the record as a whole.

The ALJ found that Golden assessed R1 on her admission to the facility on December 7, 2007 as at risk for dehydration but capable of feeding herself and, according to Golden's own expert witness, probably in "pretty good balance" for fluids at that point. ALJ Decision at 4, citing CMS Exs. 9, at 36; 10, at 23-29; and 17, at 4 (Fink Decl.); and Tr. at 151 (Dr. Michael Yao, Medical Director of Golden's parent company). By December 25, R1 was back in the hospital with pneumonia, severe dehydration, and "dangerously high potassium levels." ALJ Decision at 4.

The ALJ concluded that the facility's inadequate treatment of R1 during her intervening 18-day stay contributed to her steep decline because its staff failed to "provide her with sufficient

[4] Golden's bracketed substitution erroneously gives the impression that the Court was criticizing the ALJ for independently reviewing medical expert testimony. The actual language of the decision is that the ALJ should not independently interpret "laboratory results" in the face of a contrary interpretation by the only physician who testified but rather, if the "ALJ believes additional medical testimony is needed to explain the clinical evidence, an effort to obtain such information should be made, rather than discrediting medical opinions because of its absence." 788 F.2d at 163.

fluid intake to maintain proper hydration and health," failed to "timely obtain necessary laboratory tests," failed to provide professional quality services in accordance with her individualized care plan, and failed to "provide her the care and services she needed to attain or maintain her highest practicable physical well-being."[5] ALJ Decision at 4 (footnote omitted). The ALJ then explained specifically how Golden's handling of R1's care violated each of the regulatory requirements at issue.

Golden admits that a nurse practitioner's order for a laboratory test was not carried out for several days and does not dispute the accuracy of the records showing that R1's fluid intake was far below the amount the staff dietician determined that she needed. Golden argues that the ALJ Decision should nevertheless be reversed on the grounds that the ALJ disregarded relevant medical evidence and overemphasized the information about the resident's fluid intake and the effect of a single delayed laboratory test in order to conclude erroneously that the facility was responsible for endangering R1's health. RR at 2-4, 33.

Our role is not to reweigh the evidence ourselves or to substitute our own evaluation, but rather to determine whether the findings reached by the ALJ are supported by substantial evidence viewed in the context of the entire record. Odd Fellow and Rebekah Health Care Facility, DAB No. 1839, at 4 (2002), citing Lake Cook Terrace Center, DAB No. 1785 (2001); Beverly Health and Rehabilitation - Spring Hill, DAB No. 1696, at 40 (1999), aff'd, Beverly Health & Rehab. Servs. v. Thompson, 223 F.Supp.2d 73 (D.D.C. 2002). Substantial evidence is "more than a mere scintilla. It means such relevant evidence as a reasonable mind might accept as adequate to support a

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[5] Golden states that "the crux of Petitioner's appeal is, and has been, disagreement with CMS's ultimate conclusion that any acts and omissions by Petitioner's staff caused or exacerbated the Resident's many complex ailments." RR at 2. This statement reflects a misunderstanding of the basis for determining noncompliance and immediate jeopardy. A deficiency need not cause or exacerbate an illness to constitute noncompliance under the regulations, but rather need only present a potential for more than minimal harm. 42 C.F.R. § 488.301. Furthermore, immediate jeopardy may be present in the absence of actual harm so long as the noncompliance is "likely to cause serious injury, harm, impairment, or death to a resident." Id.

conclusion." Richardson v. Perales, 402 U.S. 389, 401 (1971), quoting Consolidated Edison Co. v. NLRB, 305 U.S. 197, 229 (1938). Moreover, "as an appellate body, we do not disturb an ALJ's assessment about the relative credibility of testimony by witnesses who appear in person at the hearing absent a compelling reason to do so." Koester Pavilion, DAB No. 1750, at 15 (2000).

In reviewing the arguments, exhibits and testimony, we must not consider only the evidence relied on by the ALJ but also "take into account whatever in the record fairly detracts from the weight of the decision below." Life Care Center of Bardstown, DAB No. 2233, at 9 (2009); Britthaven, Inc. d/b/a Britthaven of Smithfield, DAB No. 2018, at 2 (2006), citing Universal Camera Corp. v. NLRB, 340 U.S. 474, 488 (1951). In so doing, we must consider "whether conflicting evidence in the record has been addressed by the ALJ and whether the inferences drawn by the ALJ are reasonable." Britthaven at 2, citing 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). Applying these principles, we turn next to Golden's challenge to the ALJ's factual findings underpinning her conclusions that the facility was not in substantial compliance with each of the cited regulatory requirements.

Golden's disagreement with the ALJ's approach to the merits is largely founded on a straw-man argument. Golden mischaracterizes the ALJ Decision as arising from three false premises: (1) that R1 was "in 'stable' condition and with only 'modest' impairments" when she arrived at the facility (RR at 1); (2) that R1 ended up at the emergency room in a "very clearly dehydrated" condition on December 25, 2007 as a result of Golden's inadequate care of her rather than as the unavoidable result of her extremely complex illnesses (RR at 2-3); and (3) that Golden was responsible for shortcomings attributable to the resident's attending physician and primary caregiver (Nurse Practitioner Susan Payton)(RR at 3). A close reading of the ALJ Decision makes evident that ALJ never adopted the premises that Golden attributes to her. Furthermore, a review of the record as a whole demonstrates that the ALJ reasonably found that Golden's portrayal of its staff's actions (as doing everything possible for R1 but stymied by the complexity of her illnesses) was unsupported, not because the resident's condition was uncomplicated but because her

vulnerability made the inadequacies of Golden's treatment of her even more troubling.[6]

Contrary to Golden's arguments, the ALJ clearly understood that 66-year-old R1 first arrived at the facility from a week-long acute hospitalization with both chronic and acute health issues. ALJ Decision at 4. The ALJ specifically noted R1's medical history, including "coronary artery disease, congestive heart failure [CHF], massive cerebrovasular accident (stroke), seizure disorder and chronic kidney disease" and that R1 "suffered from hypotension and gout." Id. The observation that she was, despite her multiple co-morbidities, sufficiently stable to be transferred to the nursing facility was made by CMS's medical expert, Dr. Fink, and apparently by the hospital physicians who approved the transfer. Neither the ALJ nor the expert's testimony treated the fact that her condition had stabilized to that degree as implying that she was in good health. The ALJ noted that R1 had a history of fluid imbalances and was at high risk for further fluid problems, with which Golden appears to be in agreement, and that the facility itself assessed her as at high risk of dehydration. ALJ Decision at 4. She also noted that the testimony before her suggested that fluid overload was hazardous to R1, as well as dehydration, but pointed out that neither the facility's care plans and records nor her attending physician's assessment at the time showed any awareness of this problem (despite Golden's emphasis on it on appeal). ALJ Decision at 5.[7]

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[6] We discuss our reasons for these conclusions below but we do not attempt to respond to every miscasting of the ALJ's rationale or every mischaracterization of the evidence because many of the statements in Golden's briefs are either patently unsupported or lack any citation to the record. Whether or not we explicitly discuss every argument herein, we have considered all of the briefing and evidence in reaching our decision.

[7] Golden repeatedly argues that the ALJ "critiqued" or "belittled" the medical treatment and opinions of Dr. Quarles and Nurse Practitioner Payton. See, e.g., RR at 3, n.1. The ALJ does point out disturbing shortcomings in the clinical documentation for Dr. Quarles and Nurse Practitioner Payton. See, e.g., ALJ Decision at 5, 7-9. The record adequately supports these observations. Even Dr. Yao commented on the absence in Dr. Quarles's written report of his examination of R1 of any mention of R1's "difficulties in dealing with fluid that I would expect to have seen." ALJ Decision at 5, n.5., quoting Tr. at 161; compare P. Ex. 5 (Quarles report). The ALJ finds

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It is not disputed that Nurse Practitioner Payton examined R1 on December 12 and ordered a chest X-ray and laboratory tests. It is further undisputed that, by December 13, R1 had developed pneumonia and, the next day, Nurse Practitioner Payton directed Golden's staff to "push fluids" and administer antibiotics. ALJ Decision at 7; RR at 21, and record citations therein. It is also undisputed that the facility's protocol in the case of a "push fluids" order was that its staff would monitor intake and (to the extent feasible) output, and record daily totals. Id.; CMS Ex. 12. The ALJ observed that the resident's recorded intake did not increase after the "push fluids" order but remained far below the resident's assessed needs. ALJ Decision at 7. Golden does not identify any evidence that the daily intake amounts were totaled prior to the survey, any documentation that the intake records were ever reviewed by staff or clinicians, or any indication that its staff sought to care plan or take action in regard to R1's continued low intake.

It is not disputed that, on December 15, barely a week after her admission, R1 was taken to the emergency room. Golden acknowledges that its staff had failed to perform the laboratory tests ordered on December 12, although it argues that the delay was harmless, because when the tests were finally done on December 17, they were allegedly consistent with results of tests done in the hospital on December 15 and even with those from December 7. RR at 22. Golden insists that R1's elevated potassium levels were unimportant because "it is undisputed that high potassium is asymptomatic." RR at 23. Golden's assertion

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"troubling" the statement by Nurse Practitioner Payton that she did not find R1 dehydrated on admission and "nothing subsequent to that time indicates that the [r]esident's hydration status changed significantly or required any specific intervention." ALJ Decision at 8, quoting P. Ex. 38, at 6 (Payton Decl.). While Golden suggests that R1's multiple undisputed symptoms and laboratory results indicative of dehydration could be accounted for by R1's disease processes and drug interactions even in the absence of dehydration (RR at 16), nothing in the clinical records indicates that Nurse Practitioner Payton evaluated the symptoms and reached such a conclusion at the time. Despite these observations, the ALJ made very clear that her evaluation of the care provided by Golden was based on the failures of Golden's own staff to follow explicit orders that were given (e.g., to "push fluids" and to obtain laboratory test results) and to provide needed monitoring and care to R1, not on any faults of Dr. Quarles or Nurse Practitioner Payton.

that the high potassium levels found when laboratory test results were obtained at the hospital were insignificant is far from undisputed, however. CMS points to evidence that the hospital physicians immediately ordered medication to reduce those levels and ordered that her potassium chloride treatment be held for two days. P. Ex. 11 at 5, 8, & 11. Dr. Fink testified that R1's potassium level was "extremely high," which can lead to "extremely serious medical issues and possibly death." CMS Ex. 17, at 5. The ALJ's conclusion that the facility failed R1 by resuming potassium administration after two days with no evaluation of the risks and no monitoring of her potassium level (even though the diuretic medicine which likely triggered the use of potassium pills had itself been discontinued) is compelling and amply supported by substantial evidence on the record as a whole.[8] ALJ Decision at 13, and record citations therein.

The ALJ found that, during the period between December 15 and December 25, Golden's staff continued to record inadequate fluid intake and also recorded 13 episodes of diarrhea and significant weight loss (7.3 pounds over 11 days after her admission). ALJ Decision at 9, and record citations therein. R1 became groggy and unable to care for or feed herself. Yet, the ALJ found, the facility did nothing to act in response to these changes or to alter her care, as her condition deteriorated. Id.

The medical records and testimony certainly support Golden's claims that the resident had many medical problems and that treatments for some of these conditions might exacerbate other conditions. The conclusion that the ALJ reached from reviewing this evidence was not that R1's condition was actually simple and called only for increased fluids, but that R1's multiple problems required careful monitoring of fluids precisely because of the complexity of managing her constellation of ailments, including chronic CHF and worsening renal function. That

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[8] Golden itself admits that it is "conceivable that the Resident might have been developing a high potassium level on December 13 or 14 . . . and that Nurse Practitioner Payton might have ordered treatment for the condition on December 14 had she known about it at that time," as she might have if the tests had been done as ordered. RR at 32. Golden argues, however, that the "record certainly does not compel this conclusion" and suggests that "the evidence is actually to the contrary." Id. A conclusion need not be compelled in order to be supported by substantial evidence, and Golden does not cite any contrary evidence.

conclusion was directly supported by the testimony of Dr. Fink, as well as by Golden's own medical testimony and R1's clinical records.

Dr. Fink, a board-certified nephrologist with long experience in long-term care for the elderly, stated that R1's laboratory results at admission showed her with "only mild renal impairment related to chronic kidney disease." ALJ Decision at 4, and citations therein. He based this comment on her laboratory results before she was transferred to the facility on December 7, 2007. CMS Ex. 17, at 3-4 (Fink Decl.). He also noted that, while she did have a history of CHF, the hospital doctors concluded that she actually did not have an acute episode of CHF nor did she suffer from occult sepsis during her pre-facility hospital stay (although Golden repeatedly asserts that she did have both). Id. at 2-3, citing CMS Ex. 4, at 378-81. He opined that the resident's fluid status should have been manageable "[w]ith a moderate degree of vigilance from the nursing home staff and physician/nurse practitioners" upon her transfer, yet she ended up hospitalized (at the family's request) on December 15, 2007 with an "extremely high" potassium level and much more elevated laboratory results, which suggested that her "kidney function was worsening because of volume depletion and dehydration." Id. at 5, 6. The ALJ could reasonably credit Dr. Fink's testimony to conclude that the evidence of grossly inadequate intake, along with an absence of any documented efforts to address that problem, demonstrated that Golden's staff's failures contributed to her decline in kidney function.

Despite Golden's broad claims that Dr. Fink "significantly qualified" his direct testimony during cross-examination, a close review of Golden's citations to Dr. Fink's cross-examination in fact reveals nothing that undercuts his direct testimony. See, e.g., RR at 2, 16. For example, Golden says that Dr. Fink "seemed to opine" in his written direct that R1 "did not have serious kidney disease" but on cross-examination "agreed that [R1] did not have normal kidney function." RR at 16, citing Tr. at 21-22, 32. These two statements are not inconsistent on their face, as it is perfectly possible to have abnormal kidney function without having serious kidney disease. In fact, in his written direct, Dr. Fink testified that R1 "had acceptable renal function and only mild renal impairment related to chronic kidney disease" based on her hospital laboratory tests from December 7. CMS Ex. 17, at 3. On cross-examination, Dr. Fink testified about the potential harm from reinstating potassium pills after R1's return to Golden from her emergency room visit of December 15 given that R1 "we know has at least some impaired kidney function." Tr. at 32. Thus, in context,

Dr. Fink testified consistently that R1 had chronic kidney disease but was functioning within acceptable limits, "nowhere near end-stage renal disease," when she was admitted to Golden, and that, by the time she returned from the emergency room on December 15, she had some functional impairment which should have led to reevaluation of the potassium pills and careful monitoring of fluid balance. CMS Ex. 17, at 5.

Golden asserts that the ALJ "simply lists the amount of fluids the Resident ingested, and concludes that the Resident was severely dehydrated." RR at 4. The amount of fluid that Golden's staff recorded as R1's intake over the weeks that she was in the facility was dramatically below that called for by its own dietician (2170 mls per day). ALJ Decision at 6, quoting P. Ex. 20; CMS Ex. 9, at 38. Nurse Practitioner Payton indicated that she would defer to the dietician's estimate of R1's needs. Tr. at 136-37. Yet, for many days, R1's recorded intake was as low as 240 mls.[9] Although the ALJ did point out that such facially inadequate intake might suffice to show noncompliance with section 483.25(j), "particularly where, as here, no evidence suggests that the facility recognized or addressed the problem," she did not rely only on the intake records in finding Golden's treatment of R1's hydration needs to be sorely lacking. ALJ Decision at 6. The overarching problem that the ALJ identified with Golden's care of the resident was not simply a failure to provide enough fluids to her. On the contrary, the ALJ emphasized that, in the face of ample evidence

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[9] Golden claims that its "records are extraordinarily detailed and document literally every meal the Resident consumed during her stay, and her fluid intake and output (to the extent the latter could be measured) . . . ." RR at 26. The records to which Golden points contain daily notes on percentages of meals consumed which were used by a facility nurse to arrive at a chart showing the (very low) totals on which the ALJ relied. That nurse testified that the chart totals were not compiled until after the survey when the chart was used at the state informal dispute resolution process. P. Ex. 41, at 1. To the extent that Golden is emphasizing a claim that these totals represented complete documentation of her actual intake, the extreme inadequacy of the intake shown and the absence of evidence of any facility reaction to that inadequacy, are all the more disturbing. The detailed reports of output in the form of frequent episodes of diarrhea contained in the records cited by Golden also highlight that threat to R1's fragile fluid balance. P. Ex. 18. Yet, Golden points to no documentation of any responsive concern or action by Golden's staff.

alerting Golden to the urgency of close monitoring of and quick response to the resident's hydration status and in the face of the nurse practitioner's own orders to push fluids and to perform laboratory tests, the facility failed to track her intake with any consistency, failed to respond to and alert the clinicians to dropping intake, frequent diarrhea, and changes in mental status, and failed to carry out orders promptly. The ALJ explained that, while Golden made "much of R1's fragility and complicated health issues," in fact, "for this very reason, she required especially careful assessment and monitoring, and the facility had a heightened duty to provide her the care she needed." ALJ Decision at 15. Yet, "the problem here was not that the facility fell short of providing a complicated level of care; rather, the facility failed to provide even an ordinary level of care." Id. at 16.

Thus, whether the result was dehydration, as the test results suggest, or, as Golden now claims, repeated fluid overload, the inadequacies of the care provided to R1 by Golden are evident on any objective reading of the record in this case. Strikingly, even after her return to the facility from the hospital on December 15, R1 continued to take only minimal amounts of fluid and to suffer from diarrhea but still no record shows that any interventions were considered, planned, or undertaken. While Golden emphasizes, and the clinicians agree, that fluid overload could present a danger to R1 as well as dehydration, especially given her history of congestive heart failure, the ALJ reasonably concluded that this double risk meant that her intake and fluid status should be monitored especially closely. The facility did not deny that its own policy for residents who have a "push fluids" order is to record accurately the resident's intake and, to the extent possible, output, and to watch for signs of dehydration.

The ALJ found that R1 demonstrated many signs associated with dehydration during her brief stay at Golden, including changes in mental status, blood pressure, and skin turgor. ALJ Decision at 9, and record citations therein. Golden in fact acknowledges that R1 was "on a more or less continual downward slide" throughout her stay. RR at 35. While Golden contends that all of her deterioration might have been unavoidable given her longstanding illnesses, or might have been caused by conditions other than dehydration (Golden Reply Br. at 8; RR at 2-3), the ALJ could reasonably conclude that the evidence did not demonstrate that Golden's staff promptly reported or evaluated these signs to determine their cause. Given the overwhelming evidence that R1's intake was either far below her assessed needs or very inconsistently recorded, there can be no doubt

that substantial evidence on the record supports the ALJ's conclusion that the facility did not provide close monitoring of her intake even after she returned from the emergency room with alarming test results.

By December 25, R1 could not be aroused and the hospital physician found her "clearly very dehydrated," having taken nothing "by mouth for the past four days," and suffering from fever and chills.[10] CMS Ex. 6, at 1. Her potassium level that had reached 7.4 and she was admitted with diagnoses of sepsis, acute renal failure ("likely secondary to severe volume depletion"), hyperkalemia, and "multiple other medical problems." Id. at 3.

We conclude that the record as a whole, considering all of the testimony and evidence presented by Golden,[11] as well as all of

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[10] Golden suggests that the emergency room physician's opinion that R1 was severely dehydrated was merely a natural "first suspicion" for an elderly patient with "initial lab tests" indicating chemical imbalances, but argues that the ALJ should have undertaken a "much more sophisticated analysis." RR at 28. This emergency room physician, however, expressly noted that R1 was known to him "from her prior hospitalization" before she went to Golden and commented that she had "progressively gotten worse on a daily basis" since her December 15 visit. CMS Ex. 6, at 1.

[11] On December 22, 2009, Golden filed a motion to supplement the record with a second declaration by Dr. Yao and an article from the Journal of American Medical Directors Association addressing dehydration in elderly people. (The submission was received by the Board on December 30.) The article was published in the October 2009 edition of the Journal, and the declaration was executed December 22, 2009. Golden fails to show why the documents were not submitted until months after the Journal article was available. In any case, we find that the proffer is not material under 42 C.F.R. § 498.86. Dr. Yao's declaration expressly notes that the points being derived from the article are largely ones that the declarant and Nurse Practitioner Payton already made. The focus of the declaration is that the article supports the conclusions that dehydration is more complex than simple volume depletion and that dehydration is especially difficult to define and manage in the elderly, especially those with many medical complications. As discussed in the text, we have considered these points and concluded that, if anything, they suggest that Golden had even

(Continued. . .)

the evidence cited and discussed by the ALJ, provides substantial evidence in support of her conclusions that Golden was not in substantial compliance with the four cited requirements in its care of R1.

3. The ALJ's conclusions as to the level and duration of noncompliance are free of legal error and supported by substantial evidence.

Golden asserts that "a principal basis for [its] entire case always has been that both the level of noncompliance, i.e., the 'immediate jeopardy' allegations that triggered an enhanced CMP, as well as the duration of the alleged noncompliance, are far out of proportion" to the basis. RR at 34. Golden mistakenly states that the ALJ ruled that it had waived any challenge to both the amount and duration of the CMP. The ALJ plainly stated at the hearing and in her decision, however, that she considered the issue of duration of the CMP necessarily before her and therefore included duration in her statement of the issues. She held only that Golden waived any challenge to the reasonableness of the CMP amounts.

Golden argues that the "rationale" for the ALJ's determination regarding the duration of the CMPs is unclear. Golden alleges that CMS's witnesses "critiqued only supposed errors and omissions" prior to December 15, the date that R1 was taken to the emergency room and then returned to the facility. RR at 34. Further, Golden asserts that CMS offered no evidence of any "specific act or omission *on or after* December 15." RR at 35 (emphasis in original).[12] Golden further argues that Board decisions have required that CMS "define the temporal boundaries

(Continued. . .)
more reason to have been diligent in monitoring R1's intake issues, her diarrhea, and her various signs of possible dehydration or other fluid imbalances.

[12] Golden also suggests that Dr. Fink's statement that the "clock was reset" after the hospital visit should be interpreted to mean that "any risk of harm to [R1] ended on December 15." RR at 35, citing Tr. at 46. This argument misrepresents Dr. Fink's testimony. In fact, Dr. Fink was asked only whether the hospital testing interrupted "the connection between the labs that were ordered on the 12th and [R1's] deteriorating condition," which he agreed that it did, while also opining that, had the ordered tests been done promptly, that "may have prevented the emergency room visit." Tr. at 45-46.

of the alleged noncompliance" when the deficiency "focuses on one or more specific incidents" and that ALJs "must evaluate whether any proposed CMP actually has" a remedial purpose. RR at 36, citing Guardian Health Care Center, DAB No. 1943 (2004) and Emerald Oaks, DAB No. 1800 (2001).

Golden's arguments are without merit. Golden does not identify what in the cited decisions it relies on for the stated legal propositions, and neither cited case in fact stands for those propositions. In Guardian, CMS sought summary judgment on a single noncompliance finding, which the state survey agency found was corrected by a certain date. The ALJ granted, and the Board upheld, summary judgment as to that finding. However, CMS argued that the remedies imposed should remain in place after the date on which that finding was corrected because, among other reasons, it contended that other noncompliance continued to exist. The Board concluded that summary judgment could not be granted as to the duration of the noncompliance under those circumstances and remanded for further record development on that issue. Nothing in Guardian distinguishes deficiencies based on specific acts from other kinds of deficiencies or imposes any special burden on CMS regarding "temporal boundaries."

In Emerald Oaks, the Board rejected the argument that the ALJ should review how CMS applied the regulatory factors specified at 42 C.F.R. § 488.438 to determine a reasonable CMP amount. The Board held that the ALJ there "conducted the correct inquiry" by evaluating de novo the regulatory factors and concluding that they "demanded a 'severe penalty,' and hence that the amount imposed was within the reasonable range of amounts appropriate to achieving the remedial purposes of such sanctions." DAB No. 1800, at 13. Nothing in that decision suggested that ALJs are mandated to evaluate whether particular CMPs actually serve remedial purposes apart from conducting their de novo review of the regulatory factors where the reasonableness of the amount is challenged.

Golden is also mistaken that CMS's witnesses and evidence demonstrated problems with R1's care only prior to December 15. This error is largely based on Golden's mistaken view that only the missed laboratory tests were the basis for finding noncompliance, a view which we addressed in the prior section. The record shows problems with R1's fluid intake, diarrhea, and weight loss and signs of increasing kidney dysfunction after December 15 with no evidence of any appropriate response by Golden's staff. ALJ Decision at 9; CMS Exs. 9, at 37, 73-74 and 17, at 7-8 (Fink Decl.). The inadequacy of R1's care went far

beyond Golden's failure to comply with the order to obtain laboratory results, or even its failure to implement the order to push fluids.

The regulations provide that, once a facility has been shown to be noncompliant, the remedies imposed "continue until . . . [t]he facility has achieved substantial compliance, as determined by CMS or the State based upon a revisit or after an examination of credible written evidence that it can verify without an on-site visit" or until the facility is terminated. 42 C.F.R. § 488.454(a). Consequently, the Board has long held that CMS is not obliged to "provide affirmative evidence of continuing noncompliance for each day that a remedy is in place." Coquina Center, DAB No. 1860, at 23 (2002); Regency Gardens Nursing Center, DAB No. 1858 (2002). This standard is not, as Golden contends (RR at 37), an irrebutable presumption, but, rather, recognizes that the statute and regulations place a burden on the facility to demonstrate not only that an event that exposed its noncompliance is over but that the facility has completed all measures necessary to correct the underlying noncompliance and prevent its recurrence.

The ALJ properly reviewed the question of when Golden achieved substantial compliance. She determined that numerous steps were required and undertaken to address the systemic problems that resulted in staff not responding to signs of dehydration, not following orders in obtaining tests, not ensuring the recommended fluid intake for at-risk residents, not tracking intake and output effectively, and not alerting a clinician of problems. ALJ Decision at 17. She found that the facility's own plan of correction did not claim that the necessary corrections, including in-service training and a review of all at-risk residents, would be completed before March 3. CMS accepted this date as the end of the period of noncompliance. We find no error in the ALJ's conclusion that, since Golden did not establish that an effective plan of correction was implemented any earlier, she would sustain CMS's determinations as to the duration of the immediate jeopardy and the remaining noncompliance and, and hence of the CMPs.

4. Golden failed to preserve any challenge to the reasonableness of the per-day amounts of the CMPs.

As discussed above, CMS determined that immediate jeopardy was not abated until January 29, 2008, and that noncompliance continued until March 4, 2008, which resulted in a total CMP of $172,150, an amount which Golden argues is unreasonable. RR at 33-37. The ALJ ruled that Golden had abandoned any challenge to

the reasonableness of the amount of the CMPs imposed. ALJ Decision at 3. Golden disputes this.

As the ALJ points out, the duration of the CMPs (that is, the number of days on which CMPs could properly be imposed) remained at issue and was considered in the ALJ Decision. ALJ Decision at 3, n.1. Furthermore, the ALJ also considered (and rejected) Golden's claim that CMS's immediate jeopardy determination was clearly erroneous. ALJ Decision at 15-16. Hence, the only issue which the ALJ found that Golden failed to preserve was whether the per-day amounts imposed were unreasonable.
The minimum per-day amount for a CMP in the case of immediate jeopardy is $3,050, while here CMS imposed $3,750. 42 C.F.R. § 488.438(a)(1); see also 42 C.F.R. § 488.438(e)(ALJ may not reduce CMP to zero or review CMS's choice to impose a CMP). The minimum per-day amount for a non-immediate jeopardy CMP is $50, while here CMS imposed $100 for the period after immediate jeopardy was abated. 42 C.F.R. § 488.438(a)(2). Thus, the total amount by which the ALJ could have reduced the CMPs based on a reasonableness challenge is $33,200 (($700 x 45 days = 31,500) + ($50 x 34 days = 1700)).

Golden's request for hearing stated that it challenged "the amount and duration of the CMP." Request for Hearing, March 27, 2008, at 7. The ALJ advised the parties that their pre-hearing briefs were required to "contain any argument that a party intends to make" or that argument might be excluded. Initial Pre-Hearing Order, April 4, 2008, at 4. The ALJ stated that CMS's pre-hearing brief argued that the amount of the CMPs was reasonable, but Golden's pre-hearing brief (although not filed until a month later) did not contain any argument as to the reasonableness of the amount. ALJ Decision at 3.

Golden now argues that it did brief the issue of reasonableness, in that "a principal basis for Petitioner's entire case always has been that both the level of noncompliance, i.e., the 'immediate jeopardy' allegations . . . as well as the duration of the alleged noncompliance, are far out of proportion to the only matter that even possibly could have supported any citation, i.e., the short delay in obtaining the lab test." RR at 34. This summary of its position actually supports the ALJ's conclusion that Golden did not offer argument on whether the amounts of the CMPs were reasonable apart from the questions of whether Golden was in substantial compliance, whether any noncompliance was at the level of immediate jeopardy, and how long any noncompliance lasted. The ALJ found only that any issue about the reasonableness of the per-day amounts was waived. Although Golden asserts that it briefed reasonableness

in "all of its pleadings," Golden actually cites only to its post-hearing brief. A review of the cited pages of that brief reveals only Golden's insistence that it did challenge the duration of the noncompliance, not an argument about the reasonableness of the amounts. Golden Post-hearing Brief, April 6, 2009, at 43-46. The only reference to the reasonableness of the CMP amounts even in the post-hearing brief (after the ALJ had already informed Golden that it had failed to preserve that issue in its pre-hearing brief) is the following paragraph:

> Finally, the Board has made clear that ALJs have the obligation to determine whether a CMP is "reasonable." Suffice it to say that a $170,000 CMP for a short delay in obtaining a single lab test is not reasonable.

Golden Post-hearing Brief at 46. Our discussion above makes amply clear that the CMPs at issue were not imposed merely for "a short delay in obtaining a single lab test." Furthermore, as we have explained, the bulk of the CMP amount simply reflects the duration of the immediate jeopardy and noncompliance multiplied by the minimum per-day amounts. Stating that the total CMP amount is "not reasonable" does not raise a clear dispute about the reasonableness of the per-day CMP amounts.

But, in any case, this minimal reference to the total amount is not adequate to respond to the ALJ's warning at the hearing that Golden's omission of this issue in its pre-hearing brief, in the face of the clear instructions of the initial pre-hearing order, amounted to a waiver that resulted in the ALJ excluding this issue from her further consideration.

We conclude that the ALJ acted within her authority in declining to reach the separate issue of the reasonableness of the per-day amounts of the CMPs when Golden failed to include any argument as to that issue in its briefing in accordance with her instructions.

Conclusion

For the reasons explained above, we uphold the ALJ Decision in its entirety.

/s/
Judith A. Ballard

/s/
Constance B. Tobias

/s/
Leslie A. Sussan
Presiding Board Member