Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Appellate Division

In the Case of:	
Carrington Place of Muscatine,	DATE: June 25, 2010
Petitioner,	Civil Remedies No. CR2019 App. Div. Docket No. A-10-29
- v. -	Decision No. 2321
Centers for Medicare & Medicaid Services.	

FINAL DECISION ON REVIEW OF ADMINISTRATIVE LAW JUDGE DECISION

Carrington Place of Muscatine (Carrington), an Iowa skilled nursing facility (SNF), appeals the October 21, 2009 decision of Administrative Law Judge Steven T. Kessel, Carrington Place of Muscatine, DAB CR2019 (2009) (ALJ Decision). The ALJ sustained a determination by the Centers for Medicare & Medicaid Services (CMS) that Carrington was not in substantial compliance with certain Medicare participation requirements from August 1, 2008 through November 13, 2008. The ALJ also sustained the remedies imposed by CMS for that alleged noncompliance. For the reasons discussed below, we affirm the ALJ Decision.

LEGAL BACKGROUND

In order to participate in Medicare, a SNF must comply with the participation requirements in 42 C.F.R. §§ 483.1-483.75. CMS may impose enforcement remedies if it determines, on the basis of survey findings, that a SNF is not in "substantial

compliance" with one or more participation requirements. 42 C.F.R. § 488.402. "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. Under the regulations, the term "noncompliance" means "any deficiency that causes a facility to not be in substantial compliance." Id.

The remedies that CMS may impose for a SNF's noncompliance include civil money penalties (CMPs) and a denial of payment for all new Medicare admissions (DPNA). 42 C.F.R. §§ 488.417, 488.430. When CMS elects to impose a CMP, it sets the CMP amount based on, among other factors, the "seriousness" of the SNF's noncompliance. 42 C.F.R. § 488.404(b). "Seriousness" is largely a function of the deficiency's "scope" (whether it is "isolated," constitutes a "pattern," or is "widespread") and "severity" (whether it has created a "potential for harm," resulted in "actual harm," or placed residents in "immediate jeopardy"). Id.; State Operations Manual (SOM), CMS Pub. 100-07, App. P - *Survey Protocol for Long-Term Care Facilities* (available at http://www.cms.hhs.gov/Manuals/IOM/list.asp), sec. V.

CASE BACKGROUND

The issues in this case arise from three surveys of Carrington during 2008.

On July 3, 2008, the Iowa Department of Inspections & Appeals (state agency) completed a recertification survey of Carrington (July survey). See CMS Ex. 1, at 1. As a result of the July survey, the state agency made 10 separate findings of noncompliance, including a finding that Carrington was noncompliant with 42 C.F.R. § 483.25(i)(1), which requires a SNF to "ensure" that each resident "[m]aintains acceptable parameters of nutritional status, such as body weight and protein levels[.]" CMS Ex. 7.

On August 28, 2008, the state agency performed a revisit survey of Carrington (the August survey). CMS Ex. 2, at 1. As a result of the August survey, the state agency made three additional findings of noncompliance, including a finding that Carrington was noncompliant with 42 C.F.R. § 483.35(i)(2), which requires a SNF to "[s]tore, prepare, distribute, and serve food under sanitary conditions." CMS Ex. 8.

On October 9, 2009, the state agency completed a complaint survey of Carrington (October survey). CMS Ex. 3, at 1. As a

result of the October survey, the state agency made two more findings of noncompliance, including a finding that Carrington was noncompliant with 42 C.F.R. § 483.25(i)(1), the requirement to maintain "acceptable parameters of nutritional status" for each resident. Id. at 9.

In sum, the state agency made 15 separate findings of noncompliance as a result of the July, August, and October surveys. Based on those survey findings, CMS imposed the following remedies on Carrington: (1) a $50 per-day CMP fro August 28 through October 8, 2008; (2) a $250 per-day CMP fro October 9 through November 13, 2008; and (3) a DPNA from August 1 through November 13, 2008.

Carrington timely requested a hearing to challenge the imposition of those remedies. The ALJ then conducted a hearing which included the submission of written direct testimony, followed by in-person cross-examination of witnesses and the submission of post-hearing briefs. Carrington presented evidence and argument challenging all 15 findings of noncompliance from the three surveys.

THE ALJ DECISION

The ALJ sustained the remedies imposed by CMS. ALJ Decision at 14-16. However, the ALJ limited his discussion to three of the 15 disputed survey findings (one finding from each of the three surveys). ALJ Decision at 3-14. Based on these conclusions, the ALJ sustained the remedies imposed by CMS. Id. at 14-16.

STANDARD OF REVIEW

Our standard of review on a disputed conclusion of law is whether the ALJ decision is erroneous. 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. *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.

DISCUSSION

On appeal, Carrington objects to the ALJ's conclusions that it was noncompliant with sections 483.25(i)(1) and section 483.35(i)(2). Carrington also criticizes the conduct of the hearing on various grounds and contends that the ALJ erred in failing to adjudicate its challenges to 12 of the 15 survey

findings.[1] Based on the following analysis, we affirm the ALJ's conclusions concerning the alleged noncompliance and find that Carrington's collateral arguments regarding the conduct of the hearing and other issues are without merit.[2]

1. *The ALJ's conclusion that Carrington was not in substantial compliance with section 483.25(i)(1) in its care of Resident 3 is supported by substantial evidence and not legally erroneous.*

We first address the ALJ's conclusion that Carrington was noncompliant with section 483.25(i)(1) in its care of Resident 3. This regulation states:

> Based on a resident's comprehensive assessment, the facility must ensure that a resident . . . [m]aintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible[.]

According to interpretive guidelines in CMS's State Operations Manual (SOM), section 483.25(i)(1) obligates the SNF to "provide[] nutritional care and services to each resident, consistent with the resident's comprehensive assessment" and to "[r]ecognize[], evaluate[], and address[] the needs of every resident, including but not limited to, the resident at risk or already experiencing impaired nutrition." SOM, App. PP - *Guidance to Surveyors for Long Term Care Facilities* (tag F325).

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[1] Carrington also contends that the ALJ erroneously denied its summary judgment motion. RR at 26. We decline to review the ALJ's July 22, 2009 summary judgment ruling because it concerns factual disputes about which a full evidentiary hearing was conducted. Haberman v. Hartford Ins. Group, 443 F.3d 1257, 1264 (10th Cir. 2006) ("[D]enial of summary judgment based on factual disputes is not properly reviewable on an appeal from a final judgment entered after trial."); E.E.O.C. v. Southwestern Bell Telephone, L.P., 550 F.3d 704, 708 (8th Cir. 2008) (same).

[2] Based on his findings of noncompliance, the ALJ held that the CMPs imposed by CMS were reasonable in amount and duration. ALJ Decision at 14-15. The ALJ also held that CMS was legally authorized to impose a DPNA under the circumstances. Id. at 15-16. Carrington does not challenge those holdings.

CMS's guidelines further state that "[i]mpaired nutritional status is not an expected part of normal aging" and "may be associated with an increased risk of mortality and other negative outcomes such as . . . unplanned weight loss." SOM App. PP (tag F325). Weight, the guidelines state, "can be a useful indicator of nutritional status, when evaluated within the context of the individual's personal history and overall condition," and "[s]ignificant unintended changes in weight (loss or gain) or insidious weight loss may indicate a nutritional problem." Id. The guidelines specify the following "suggested parameters for evaluating [the] significance of unplanned and undesired weight loss" based on a resident's "usual body weight":

Interval	Significant Loss	Severe Loss
1 month	5.0%	Greater than 5%
3 months	7.5%	Greater than 7.5%
6 months	10.0%	Greater than 10%

In prior decisions applying section 483.25(i)(1), the Board has held that "the facility is responsible for taking all reasonable steps to ensure that the resident receives nutrition adequate to his or her needs," and that unplanned weight loss "'may raise an inference of inadequate nutrition and support a prima facie case of a deficiency.'" The Windsor House, DAB No. 1942, at 17, 18 (2004) (quoting Carehouse Convalescent Hospital, DAB No. 1799, at 22 (2001)); see also Desert Lane Care Center, DAB No. 2287, at 5 (2009). "If CMS relies on weight loss as evidence of a deficiency, the facility may present rebuttal evidence that the resident did receive adequate nutrition or that the weight loss is due to non-nutritive factors, such as a clinical condition." The Windsor House at 18; see also Desert Lane Care Center at 5. The Board's prior decisions, as well as regulatory preamble commentary, also "make clear that the clinical condition exception is a narrow one and applies only when the facility can demonstrate that it cannot provide nutrition adequate for the resident's overall needs, so the weight loss is unavoidable." The Windsor House at 18 (footnote omitted); 54 Fed. Reg. 5316, 5335 (Feb. 2, 1989). "[T]he mere presence of a significant clinical condition, without additional evidence, does not prove that maintaining acceptable nutritional status is not possible." The Windsor House at 18 (internal quotation marks omitted).

The ALJ made the following factual findings, all of which relate to the period from January through early July 2008. See ALJ Decision at 4-5. Upon admission to Carrington on January 16 following a two-day hospitalization, Resident 3 weighed 132 pounds and had no history of weight loss. On April 13, she

weighed 126 pounds. On April 15, the facility's dietician notified Resident 3's physician, Matthew Sojka, M.D., that her appetite was poor and that she had lost 5.7 pounds during the past 30 days, a weight loss that the dietician described as "significant." The dietician also reported that Resident 3's weight had previously been very stable (at 132-133 pounds). At the dietician's request, Dr. Sojka issued an order for a dietary supplement (Resource 2.0). Resident 3 received the supplement each day from April 16 through April 30. However, Carrington stopped providing the supplement after April 30. During May and June 2008, Resident 3 steadily lost weight. She weighed 124 pounds on May 2, 123 pounds on May 8, 120.5 pounds on May 16, 120 pounds on May 23, and 117 pounds on June 5 and June 16. During this period, Carrington's nursing staff did not communicate with the dietician or Resident 3's physician about the continuing weight loss. On June 24, the dietician reviewed Resident 3's status and reordered the supplement after determining that Resident 3 had not been receiving it. On July 1, a surveyor observed Resident 3 leave lunch after eating only a few bites of that meal. The staff did not encourage her to eat more. On July 2, Resident 3 was observed eating only a few small bites of her breakfast before leaving the dining area.

The ALJ found that these facts, "if unrebutted" by Carrington, were sufficient to prove its noncompliance with section 483.25(i)(1). ALJ Decision at 5. The ALJ further found that after April 2008, Carrington "failed to undertake necessary measures on behalf of Resident # 3 even though the staff was on notice of and, in fact, documented a decline in the resident's weight accompanied by a loss of appetite that Petitioner's dietician determined to be substantial." Id. In particular, said the ALJ, the nursing staff "failed to provide the resident with the dietary supplement that had been prescribed by the resident's physician and they failed to communicate with the two professionals most knowledgeable in the causes and treatment of weight loss - the treating physician and Petitioner's dietician - even as the resident continued to lose weight." Id. at 6. In addition, said the ALJ, the nursing staff "failed assertively to assist the resident with eating and to encourage the resident to eat." Id. at 5.

While not disputing any of the ALJ's findings of fact, Carrington argues that Resident 3 did not lose a "significant amount" of weight during the first six months of 2008, despite the state agency's finding that she had lost 11 percent of her body weight during that period. RR at 7-9. Carrington asserts that the state agency's weight loss calculation, which was apparently based on Resident 3's January 16 admission weight of

132 pounds, was erroneous because it overlooked the fact that Resident 3 had received a substantial amount of intravenous fluids in the hospital between January 14 and January 16, an infusion that allegedly elevated her weight by as much as seven pounds. RR at 7-8. In addition, Carrington asserts that shortly after Resident 3 was admitted to its facility, she received Lasix to decrease her body fluid levels. RR at 8. For these reasons, says Carrington, some of Resident 3's weight loss between January and June 2008 was "planned and desirable." Id.

The ALJ found the contention that Resident 3 did not lose significant weight to be "speculative," ALJ Decision at 6, and we agree it is unsubstantiated. The contention rests largely on Carrington's claim that Resident 3's usual body weight was her hospital admission weight of 122 pounds. RR at 8-9. However, the fact that Resident 3 weighed 122 pounds upon her admission to the hospital (on January 14) does not establish that 122 pounds was her usual body weight. The record indicates that Resident 3 was hospitalized because of vomiting, diarrhea, and dehydration. P. Ex. 4, at 1; CMS Ex. 18, at 45. Thus, the ALJ could reasonably conclude that Resident 3 came to the hospital below her usual weight and that the fluids she received brought her closer to her usual weight range. Carrington's argument is also undercut by the fact that Resident 3, with her usual diet, maintained her January 16 admission weight of 132 pounds through at least mid-March 2008.[3]
Carrington's records confirm that Resident 3 received Lasix (Furosemide) for one week beginning on February 6. P. Ex. 4, at 69. However, Carrington cites no evidence that Lasix contributed to the weight loss at issue in this case, and no evidence that the weight loss was "planned" or viewed as desirable by the nursing staff, dietician, or physician.

Moreover, Carrington's focus on the magnitude of the weight loss, as determined by the surveyors, overlooks the basis for the ALJ's conclusion that it was not in substantial compliance. The ALJ found that Carrington's dietician had determined in mid-

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[3] In mid-April 2008, when Resident 3 was 126 pounds, the dietician reported that Resident 3 had lost 5.7 pounds during the previous month, which suggests that Resident 3 weighed approximately 133 pounds as late as mid-March 2008, slightly more than she weighed when she was discharged from the hospital on January 16. CMS Ex. 18, at 57; see also id. at 3 (surveyor notes indicating that Resident 3's weight on March 3 was 133.5 pounds).

April 2008 that Resident 3 had poor appetite and had lost what the dietician considered to be a substantial amount of weight (5.7 pounds) during the previous 30 days. In response, the dietician recommended - and Dr. Sojka ordered - a dietary supplement. What the nursing staff did - or failed to do - *afterward* appears to be the basis for the ALJ's finding of noncompliance. As the ALJ found, and the evidence shows, Carrington provided the dietary supplement to Resident 3 during the last two weeks of April 2008 but stopped doing so in May, even though Dr. Sojka never rescinded his order for that item.[4] CMS Ex. 18, at 59, 71. Meanwhile, Resident 3 continued to lose weight. From April 15 (when she weighed 126 pounds) to June 5 (when she weighed 117 pounds), a period of about seven weeks, Resident 3 lost nine pounds, or seven percent of her weight. Id. at 3, 46. Despite this gradual but unmistakable weight loss, and despite the concern expressed by the dietician (in mid-April), there is, as the ALJ found, no indication in the resident's medical records that Carrington contacted the dietician or Resident 3's physician during that seven-week period. Nor is there evidence that the nursing staff assessed Resident 3 during that period to determine the reasons for her continued weight loss and whether it was a cause for concern. Not until June 24, three weeks after Resident 3's weight reached its lowest point (117 pounds), did the dietician reassess Resident 3, at which point the dietician reordered the supplement and recommended other measures.[5] See CMS Ex. 18, at 43.

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[4] Carrington contends that it failed to provide the supplement during May and June because of a third-party "pharmacy error." RR at 11. However, Carrington failed to explain why this purported error was not detected by its staff, which was responsible for providing the supplement to Resident 3. Indeed, Director of Nursing Donna Stewart acknowledged in her testimony that the staff checks the medication sheets monthly for the pharmacy to ensure that the pharmacy has the supplies available for its residents for the following month, but that "somehow [the fact that the supplement was not added to the medication sheet for Resident 3] was overlooked on our behalf." P. Ex. 20 at 9. Carrington has not shown how the purported error relieved it of its obligation to "ensure" that Resident 3 received the necessary care and services to maintain acceptable parameters of nutritional status.

[5] The results of the June 24 assessment were entered on a form designed to yield a numerical malnutrition risk score. CMS Ex. 18, at 42. On this form the dietician indicated that

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Carrington maintains that Resident 3 was always above or near her "ideal body weight," which was 110 pounds plus-or-minus 10 pounds, according to an April 2008 handwritten notation to her January 2008 plan of care. RR at 9; CMS Ex. 18, at 38. However, Carrington does not point to any evidence to support the conclusion that ideal body weight was an appropriate marker of Resident 3's nutritional status, or was regarded as such by the dietician or physician, between April and June 2008. Moreover, we could find no evidence that, prior to the July survey (which began on June 23), the dietician determined an appropriate weight range for Resident 3 based on her clinical condition and history, prognosis, and other relevant factors. We emphasize that section 483.25(i)(1) does not require CMS to prove that a resident's weight (or other parameter of nutritional status) exceeded, equaled, or fell below particular thresholds. Cf. The Windsor House at 19 n.18 ("neither the regulation nor the SOM require[s] indicia of malnutrition before a deficiency may be cited for failure to maintain adequate parameters of nutritional status"). Instead, the regulation obligates a SNF to "ensure" that a resident maintains "acceptable parameters of nutritional status," which means that a SNF must take reasonable and timely measures to minimize the risk that nutritional impairment will become manifest. Thus, a SNF may be noncompliant with section 483.25(i)(1) if, for example, it fails to identify and assess the nutritional needs of a resident found to be at risk for malnutrition, or if it fails to implement prescribed interventions to minimize that risk. This is true even if the resident does not become malnourished during the period under review. Here, Carrington identified Resident 3 as being at risk for nutritional impairment both in January 2008, shortly after her admission to the facility, and again in April 2008, when the dietician expressed concern about a recent weight loss. CMS Ex. 18, at 25, 40-41; see also id. at 38 (plan of care indicating that Resident 3 was "at Risk for Altered Nutritional Status"). The facility's noncompliance in this case was not its failure to prevent Resident 3's weight from dipping below a particular

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Resident 3's usual body weight was between 120 and 130 pounds. Id. Although it is unclear what information or factors the dietician relied upon to determine that weight range, the assessment indicates that Resident 3's "meal intake" was "poor" and that she was (based on her score) at "high risk" for malnutrition. Id.

threshold, but its failure to take reasonable and timely steps to help ensure that she maintained acceptable parameters of nutritional status.

Carrington argues that it "took substantial measures" to address Resident 3's weight loss and monitor her nutritional status, such as performing periodic laboratory tests, weighing her weekly, discussing her nutritional status at weekly weight meetings, performing quarterly nutritional assessments, and trying (albeit unsuccessfully) to place her in "assisted dining." RR at 10-11. However, this argument overlooks the fact that the nursing staff failed to implement the physician's order for a dietary supplement after April 2008 or to timely consult with the dietician and physician about the post-April weight loss.

Moreover, there is inadequate evidence that some of the other measures mentioned by Carrington were actually implemented. For example, we see no evidence of periodic laboratory tests to monitor Resident 3's nutritional status during the critical months of May and June 2008. A test for pre-albumin, a marker for nutritional status, was performed in mid-April 2008. See P. Ex. 4, at 92; P. Ex. 28, at 4; CMS Ex. 18, at 4, 41. The results were in the normal range (see P. Ex. 28, at 4), but the test was not repeated during the May and June weight loss period. Carrington's dietician and Director of Nursing (DON) Donna Stewart testified that Resident 3's situation was "routinely" discussed in "weekly weight meetings" that they attended. See P. Ex. 20, at 8; P. Ex. 28, at 4. They did not confirm, however, that one or more of those meetings occurred during the critical post-April 2008 weight loss period (May 1 to June 24), and there is no documentary evidence of any such meetings in Resident 3's medical records. Assuming that one or more weight meetings occurred between May 1 and June 23, it is unclear from the testimony what was then discussed. Neither the dietician nor DON Stewart testified that they evaluated Resident 3's post-April weight loss - or discussed whether additional measures were appropriate to stem that weight loss - during a weight meeting. Had a weight meeting occurred in which those topics were discussed, it is likely that Carrington would have discovered earlier than June 24 that Resident 3 was no longer receiving the supplement that had been ordered for her in April 2008.[6]

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[6] The ALJ noted that DON Stewart did not rebut an assertion by the dietician to the surveyor that she (the dietician) had received no communication from the nursing staff

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Carrington also contends that Resident 3's weight loss "was due to non-nutritive factors." RR at 6-7. It points to evidence that Resident 3: (1) had a history of gastric problems, bile duct bypass surgery, and depression - all of which affected her appetite and eating habits; (2) was diagnosed with pneumonia in late March 2008 and placed on Levaquin, a medication that can affect appetite; (3) started taking Verpamil, a medication that helps the body rid itself of excess fluid, during April 2008; and (4) underwent a change in her antidepressant medication during April 2008. Id. However, the ALJ found "no conclusive evidence . . . establishing precisely what caused the resident to lose weight." ALJ Decision at 6. Presumably, the ALJ meant merely that Carrington did not show that the resident's clinical condition made it impossible to maintain acceptable parameters of nutrition (which would not necessarily require conclusive proof of the precise cause of a weight loss). The ALJ could reasonably conclude that the evidence before him was insufficient to show that the post-April 2008 weight loss was attributable to the factors identified by Carrington in its appeal, or to show that the weight loss was not evidence of a decline in nutritional status. Neither Dr. Sojka nor the dietician offered an opinion about the causes of Resident 3's post-April 2008 weight loss. P. Ex. 28, at 2-6; P. Ex. 30, at 1-2. Moreover, assessments of Resident 3's nutritional status mention only depression as a possible factor. See CMS Ex. 18, at 25 (RAP Worksheet), 58 (note to physician recommending a medication shown to be effective for depression and loss of appetite), 84 (indicating that the dietician believed that Resident 3's lack of appetite was related to her depression).

Even if non-nutritive factors affected Resident 3's weight, that fact alone would not be dispositive. As we have stated, a SNF must do more than posit a cause for significant unplanned weight loss in order to demonstrate substantial compliance with section 483.25(i)(1); it must prove that the weight loss was unavoidable. The Windsor House at 17-19. To do so, a SNF must demonstrate that the weight loss occurred despite adequate and timely steps to ensure that the resident received adequate nutrition. Id. at 23. Such steps include assessing the

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prior to June 24 about the staff's failure to provide the dietary supplement or about the weight loss during May and June 2008. ALJ Decision at 8; see also CMS Ex. 7, at 29. We also note that the dietician did not deny that she had made the statement to the surveyor. P. Ex. 28.

resident for risks to her nutritional status, implementing appropriate interventions based on the assessment's findings, and monitoring the efficacy of those interventions. Id. at 23-34 (discussion of Residents 2, 5, 14, and 15). Here, Carrington did not meet its burden because it failed (after April 2008) to provide Resident 3 with a physician-prescribed item - a dietary supplement - whose purpose was to help maintain or improve her nutritional status, and because it failed to perform a timely assessment (in consultation with the dietician and physician) to determine why Resident 3 continued to lose weight.

Carrington suggests that Resident 3's weight loss should be regarded as unavoidable because even without the supplement, she did, in fact, consume "adequate nutrition" throughout the period in question. RR at 10-11. In support of this contention, Carrington points to three exhibits: (1) the initial nutritional assessment for Resident 3, dated January 22, in which the dietician estimated that Resident 3 needed 1500 to 1800 calories of nutrition per day (CMS Ex. 18, at 44-45); (2) a calorie chart for the no-added-salt menu provided to Resident 3 and other Carrington residents (P. Ex. 33 and P. Ex. 28, at 7); and (3) meal intake records which show the percentage of meals consumed by Resident 3 each day (P. Ex. 4, at 78; CMS Ex. 18, at 50-54). According to the calorie chart, says Carrington, Resident 3's meals were designed to deliver a minimum of 2049 to 2632 calories per day, with an average of 2297 calories per day. Id. Thus, even if Resident 3 consumed only 67 percent of her meals, she was receiving at least 1500 to 1800 calories per day, as called for in her January 22 nutrition assessment. Id. Carrington asserts that Resident 3's meal intake records, when cross-referenced with the calorie chart, establish that Resident 3 consumed 1500 to 1800 calories per day. Id. Carrington also asserts that Resident 3 ate snacks in her room, and thus her calorie consumption was even greater than the amount revealed by the meal intake records. Id.

We find this argument unpersuasive in part because the ALJ could reasonably have given greater weight to the dietician's own assessment on June 24 that Resident 3 was generally consuming only 25 to 50 percent of her meals, and to the dietician's contemporaneous decision to restart the supplement on that date. See CMS Ex. 18, at 42; Tr. at 38. There is also evidence in the record that some of the reported meal intake percentages were inaccurate or unreliable. A surveyor testified that, based on her observation, the meal intake amounts were not being accurately recorded. Tr. at 62. In addition, the nursing records do not indicate that staff kept track of the nature, quantity, or calorie content of snacks consumed by Resident 3.

Carrington suggests that the weight loss was the result of Resident 3 exercising her right not to eat. RR at 11-12. According to Carrington, the surveyor "knew this resident only ate the amount she wanted to (which was her right under federal law), even though Resident #3 was presented with an abundance of food, and had multiple health care conditions that reasonably influenced her weight loss." RR at 12. The ALJ fully considered this contention, and, in our view, he gave sound reasons for rejecting it, which we do not reiterate here. See ALJ Decision at 8-9.

Finally, Carrington contends that the ALJ misapplied the relevant regulatory standard when he stated that the "underlying cause of [Resident 3's] weight loss" was "irrelevant." RR at 12 (quoting ALJ Decision at 6). We do not read the ALJ's statement to mean that the underlying cause of a resident's weight loss is irrelevant as a matter of law in determining whether a SNF is noncompliant with section 483.25(i)(1). An underlying clinical condition may, of course, be relevant to the compliance analysis if the condition made it impossible for the SNF to maintain acceptable parameters of nutritional status. See Carehouse Convalescent Hospital at 22 (indicating that the cause of the resident's weight loss was an issue in determining whether noncompliance had occurred). Under the factual circumstances of this case, however, the ALJ could reasonably determine that the causes of Resident 3's weight loss during May and June 2008, whatever they were, were immaterial because Carrington itself recognized (in both January and mid-April 2008) that Resident 3 was at risk for a decline in nutritional status, yet failed to provide her with the dietary supplement that had been ordered to mitigate that risk and failed to perform a timely follow-up assessment of Resident 3's nutritional status in response to her post-April 2008 weight loss.

For all these reasons, substantial evidence supports the ALJ's conclusion that Carrington was not in substantial compliance with its obligation to ensure that Resident 3 maintained acceptable parameters of nutritional status.

2. *The ALJ's conclusion that Carrington was not in substantial compliance with section 483.25(i)(1) in its care of Resident 1 is supported by substantial evidence and not legally erroneous.*

As a result of the October survey, the state agency cited Carrington for noncompliance with section 483.25(i)(1) in its care of Resident 1. CMS Ex. 9, at 5. Concerning this citation the ALJ found the following facts. On August 8, Resident 1 was

admitted to Carrington weighing 188 pounds. He "rapidly" lost weight during the ensuing month: he was 181 pounds on August 15, 180.5 pounds on August 22, 175 pounds on August 29, and 171 pounds on September 9. On August 26, the facility's dietician reviewed Resident 1's record and became concerned about his weight loss in the facility. The dietician talked with Resident 1's family about the problem and documented that the family intended to bring him his favorite foods from home in order to encourage him to eat. However, Resident 1's plan of care was not amended to reflect this intervention, and no instructions were provided to the nursing staff about it. In addition, Carrington did not notify Resident 1's physician about the weight loss until September 9 (when Resident 1 weighed 171 pounds). On that date, the dietician faxed the physician a note recommending a daily dietary supplement for Resident 1.

Based on these facts, the ALJ found:

> The evidence offered by CMS describes a *lack of comprehensive planning and consultation by Petitioner's staff* in the face of a sudden and very substantial weight loss by one of Petitioner's residents. Between August 8 and September 4, 2008 the only intervention that the staff developed was to encourage the resident's family to bring food from home in order to tempt the resident to eat. But, even *that intervention was not closely documented, planned, or monitored by Petitioner's staff*. During that first month of the resident's stay, there was *no consultation with the resident's physician about the substantial loss of weight* experienced by the resident, nor was there any comprehensive planning done by Petitioner's staff to address the problem.

ALJ Decision at 10 (italics added). Based on these factual findings, the ALJ concluded that the record concerning Resident 1 demonstrated a lack of substantial compliance with section 483.25(i)(1).

Preliminarily, we note that Carrington does not dispute any of the key facts found by the ALJ concerning Resident 1's care during August and September 2008. For example, Carrington does not dispute that Resident 1 lost 17 pounds during his first month in the facility (a nine percent drop from his admission weight of 188 pounds) or that his weight loss prompted concern by the dietician during late August. In addition, Carrington does not claim that Resident 1's weight loss during August and September 2008 was insignificant or claim that his weight on

September 9 - the day that the dietician contacted his physician to recommend a dietary supplement - was acceptable given his overall clinical status and prognosis.[7] Nor does Carrington dispute the ALJ's finding that it failed to consult the physician or engage in "comprehensive planning" to mitigate the risk of a decline in his nutritional status.

Instead, Carrington contends that a violation of section 483.25(i)(1) did not occur because there is "a substantial amount of undisputed evidence demonstrating that [the nursing staff] was providing Resident # 1 with sufficient nutrition," and because the weight loss was the result of "non-nutritive factors." RR at 13. As we explain below, this argument is unpersuasive.

Daily progress notes indicate that on August 21, about two weeks after being admitted to Carrington, Resident 1 began feeling ill. CMS Ex. 23, at 79, 177. His illness, a suspected abdominal infection, was accompanied by occasional nausea, diarrhea, weakness or fatigue, and loss of appetite. Id. at 79-97. A plan of care signed by a member of the nursing staff on August 25 noted that Resident 1 was at risk for weight loss and abdominal distress and instructed the nursing staff to (among other things) monitor his appetite and weight, encourage the consumption of his prescribed diet, and "offer snacks within [his] diet." Id. at 56.

Meal intake charts indicate that between August 21 and August 30, Resident 1 generally consumed less - and often substantially less - than 50 percent of his meals and skipped some altogether. CMS Ex. 23, at 175-77. He displayed signs of feeling better on

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[7] Carrington asserts that Resident 1's admission weight of 188 pounds was unrepresentative of his usual body weight (i.e., 182 pounds), and thus his post-admission weight loss was not as serious as the ALJ found. RR at 14. As documented in Resident 1's Comprehensive Nutritional Assessment, which the dietician completed on August 18, 2008, Resident 1's usual body weight was between 180 to 185 pounds. CMS Ex. 23, at 171; see also P. Ex. 28, at 1. However, Carrington has not alleged, much less established, that the post-admission weight loss was clinically insignificant. By August 29, Resident 1 weighed 175 pounds, and by September 9, 2008, he weighed 171 pounds, five percent less than the lower end of his usual body weight range. Under CMS's interpretive guidelines, an unplanned weight loss of five percent in a one-month period is considered "significant." SOM, App. PP (tag F325).

August 29 and 30, but his appetite (as evidenced by his meal consumption) only slowly improved. Id. at 93-95, 175-76. During the first week of September, Resident 1 was still generally consuming 50 percent or less of his meals. Id. at 176.

Not surprisingly (given his poor appetite), Resident 1 lost weight in late August and early September. Between August 22 and 29, he lost 5.5 pounds, which was on top of a seven pound weight loss between August 8 and August 21. Laboratory tests performed on September 5 were below the normal range for protein and albumin. CMS Ex. 23, at 150; P. Ex. 30, at 3. By September 9, Resident 1 weighed 171 pounds, 5.2 percent less than he weighed on August 22, when he started feeling ill.

Physician assistant Andrea Tidrick testified that Flagyl, an antibiotic drug that Resident 3 started taking on August 25 (and continued taking through September 5), is "notorious for causing lack of appetite and weight loss" and that it would not have been reasonable to start Resident 1 on tube feeding or "hyperalimintation"[8] during his illness because it would have been likely to cause further gastrointestinal upset. P. Ex. 30, at 3; CMS Ex. 23 at 86, 128. Tidrick further testified:

> It's expected almost. Expected to have a weight loss during acute gastroenteritis so the usual course would be to monitor them, encourage fluids and nutritional supplements if they will take them and expect that the appetite will improve and patient will gain weight once the infection has cleared.

P. Ex. 30, at 3 (emphasis added). When asked if there was "anything more that the facility should have been doing" to ensure that Resident 1 maintained an acceptable weight and other parameters of nutritional status, Tidrick (who provided care to Resident 1 under the direction of his physician, Dr. Weis) responded "no". Id.

Tidrick's opinion that there was nothing more that the nursing staff could reasonably have done to stem the weight loss is undercut by an apparent failure to meet the standard of care she described. According to Tidrick, the standard treatment for Resident 1's abdominal illness included offering nutritional

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[8] Hyperalimination is "ingestion or administration of a greater than optimal amount of nutrients." Dorland's Illustrated Medical Dictionary (28th ed.)

supplements. Not until September 4, however, did Carrington's dietary manager ask Resident 1 to try a nutritional supplement. CMS Ex. 23, at 44. The next day, September 5, the dietary manager reported that Resident 1 had tried a supplement and that she would ask the nursing staff to obtain a physician's order for it. Id. at 43. However, Resident 1 did not start receiving the supplement until September 9, 18 days (or so) after the onset of his illness and 11 days after the nursing staff started reporting signs of improvement in his condition. Id. at 128. No justification is offered by Carrington for the delay in offering and providing the supplement.

It is also important to note that Tidrick's opinion constitutes a *retrospective* assessment of Resident 1's nutritional status and needs during late August and early September 2008. However, an assessment of Resident 1's nutritional status and needs is precisely what the nursing staff, in consultation with the dietician and physician, should have performed (but failed to perform) in late August or early September 2008 in order to develop a coordinated response to his recent weight loss and the risk of additional weight loss. After Resident 1 became ill (on August 21 or 22), his weight dropped from 180.5 pounds (on August 22) to 175 pounds (on August 29). Despite this weight loss and the risk of additional decline (which should have been apparent given his poor appetite), there is no evidence of any consultation among the nursing staff, dietician, and physician between August 29 and September 9 concerning his nutritional status.[9] See CMS Ex. 23, at 93-110. Timely assessment - and coordinated planning based on an assessment - are elements of a SNF's obligation to ensure that a resident maintains acceptable parameters of nutritional status. See Tr. at 123-24; SOM, App. PP (tag F325) (indicating that a "systematic approach" to "optimize a resident's nutritional status" includes "identifying and assessing each resident's nutritional status and risk factors, evaluating/analyzing the assessment information, developing and consistently implementing pertinent approaches,

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[9] Tidrick recollected seeing Resident 1 on September 1. P. Ex. 30, at 3. However, treatment records show no visits by Tidrick until September 4, and those records do not describe any consultation by Tidrick concerning Resident 1's nutritional status, nor do they report any judgments by Tidrick as a result of the consultation, assuming one occurred. See CMS Ex. 23, at 43, 104-05. Moreover, Tidrick did not testify that it was appropriate for the nursing staff to wait until September 9 to contact the physician or consult the dietician for guidance about Resident 1's nutritional status. P. Ex. 30.

and monitoring the effectiveness of interventions and revising them as necessary").

For the reasons discussed above, substantial evidence supports the ALJ's conclusion that Carrington was not in substantial compliance with its obligation to ensure that Resident 1 maintained acceptable parameters of nutrition status.

3. *The ALJ's conclusion that Carrington was not in substantial compliance with section 483.35(i)(2) is supported by substantial evidence and not legally erroneous.*

Title 42 C.F.R. § 483.35(i)(2) requires a SNF to "store, prepare, distribute and serve food under sanitary conditions." CMS's interpretive guidelines state that the intent of this requirement is to ensure that the SNF:

- Obtains food for resident consumption from sources approved or considered satisfactory by Federal, State or local authorities; and

- Follows proper sanitation and food handling practices to prevent the outbreak of foodborne illness. . . .

SOM, App. PP (tag F371).

In discussing whether Carrington was compliant with section 483.35(i)(2), the ALJ relied upon observations by Surveyor Jeannine Gothard that were reported in the state agency's Statement of Deficiencies. ALJ Decision at 12-13. The ALJ held that these observations were sufficient to support findings that: (1) Carrington "failed to store food under sanitary conditions"; (2) "there was expired food in [Carrington's] refrigerator and . . . the refrigerator had a leaking condenser that was dripping water in the vicinity of stored food"; and (3) Carrington "was using unclean and food-contaminated dishes and . . . the staff failed to correct the problem after the surveyor observed it." Id. at 13.

Carrington contends that Surveyor Gothard's observations are insufficient to demonstrate that the facility was not in substantial compliance. We find that her observations about the cleanliness of Carrington's food dishes, coupled with undisputed evidence about a malfunctioning dishwasher, constitute substantial evidence of noncompliance with section 483.35(i)(2).

Surveyor Gothard testified that she found food particles on dishes that supposedly had been washed. Tr. at 108-09. Carrington asserts that her testimony and notes are inconsistent about what she found on the dishes. RR at 19. Carrington also points to evidence that its dietary manager had examined the same dishes but found them to be only discolored and not unclean. RR at 19 (citing P. Ex. 31, at 4-5, and P. Ex. 15, at 5).[10]

On the issue of whether the dishes inspected by Surveyor Gothard were clean, the ALJ expressly credited her in-person testimony. Unless there are compelling reasons not to, we defer to the findings of the ALJ on weight and credibility of testimony. Koester Pavilion, DAB No. 1750, at 15, 21 (2000). We see no compelling reasons not to defer here because the evidence cited by Carrington does not clearly rebut each of Surveyor Gothard's reported observations (in particular, the initial August 26 observation of eggs on five different plates, and the August 27 observation of dried pork or chicken). Thus, we accept the ALJ's credibility finding and hold that Surveyor Gothard's testimony and observations (as reported in the Statement of Deficiencies) constitute substantial evidence that the dishes in question were not clean.

The apparent source of those dirty dishes was a dishwasher that had a clogged soap dispenser and was not operating at a high enough temperature. CMS Ex. 8, at 4-5; Tr. at 113-16. Carrington does not dispute that its dishwasher was malfunctioning during the August survey. See P. Ex. 15, at 5. Failure to properly sanitize dishes and other equipment clearly poses a risk of more than minimal harm to residents. See SOM, App. PP (noting that a "potential cause of foodborne outbreaks is improper cleaning (washing and sanitizing) of contaminated equipment"). We thus conclude that substantial evidence supports the ALJ's conclusion that Carrington was noncompliant with section 483.35(i)(2) during the August survey.

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[10] In addition, Carrington asserts that the ALJ erroneously denied its request to submit surveyor notes that allegedly impeached Surveyor Gothard's testimony. RR at 19. We agree with the ALJ that Carrington could and should have included the surveyor notes in its pre-hearing exchange, and therefore he did not abuse his discretion in refusing to admit those notes. See Tr. at 109-110; Sept. 26, 2008 Acknowledgment and Pre-Hearing Order at 2 (requiring parties to submit "all proposed exhibits" as part of its pre-hearing exchange).

4. *The ALJ committed no prejudicial error in declining to rule on the merits of the other disputed findings of noncompliance from the July, August, and October surveys.*

As noted in the background section, the July, August, and October surveys resulted in 15 separate findings of noncompliance by the state agency, all of which were appealed by Carrington, but only three of which were addressed by the ALJ. The ALJ found it unnecessary to address the remaining 12 survey findings because the three he did address were, in his judgment, sufficient to support the remedies imposed. ALJ Decision at 3. Carrington contends that its due process rights have been violated because the ALJ's failure to adjudicate its appeal of the other survey findings has left "smudges on its record that will not go away" but that will "remain in a database to be used by CMS to determine the level of the facility's penalties in the future" or "used against the facility in civil litigation." Reply Br. at 12, 15. In support of this contention, Carrington relies on Grace Healthcare of Benton v. U.S. Dep't of Health & Human Servs., 589 F.3d 926 (8th Cir. 2009), *amended by* 603 F.3d 412 (8th Cir. 2010). Reply Br. at 15-16. Carrington argues that "it is clear that under Grace Healthcare, the ALJ must address [the] other F-Tags [survey findings], and if the ALJ fails to do so, then the unaddressed F-Tags must be expunged from the Petitioner's record and cannot be used against the Petitioner because it creates a material adverse impact." Id. at 16.

"The Board has held that an ALJ has discretion, as an exercise of judicial economy, not to address findings that are immaterial to the outcome of an appeal." Alexandria Place, DAB No. 2245, at 27 n.9 (2009) (citing decisions); see also Community Skilled Nursing Centre, DAB No. 1987, at 5 (2005) (holding that "ALJs are not required to make findings of fact and conclusions of law on deficiencies that are not necessary to support the CMP imposed"); Northern Montana Care Ctr. v. Leavitt, No. CV 04-97 GF SEH, 2006 WL 2700729 (D. Mont. Sept. 18, 2006) ("Without a recognized property interest in the continued participation in Medicare/Medicaid programs, NMCC cannot claim that the ALJ's decision not to rule on all of its deficiencies was a violation of due process."). The court in Grace Healthcare did not reject that holding or otherwise find that it was improper to uphold a remedy based on fewer than all survey findings of noncompliance appealed by the SNF. The court held only that the principle that an ALJ may decline to address findings that are immaterial to the outcome had been "misapplied" in that case. 603 F.3d at 422. Here, Carrington does not contend that rulings on the other 12 survey findings of noncompliance were necessary to support the remedies imposed or were otherwise material to the

outcome of the case. We thus conclude that the ALJ committed no prejudicial error in failing to adjudicate the validity of those 12 survey findings.

Moreover, Grace Healthcare did not endorse or approve the relief sought by Carrington, which is expungement of the deficiency findings not addressed by the ALJ. Although the Eighth Circuit initially ordered CMS to expunge all findings or determinations of immediate jeopardy-level noncompliance associated with the litigation, 589 F.3d at 935, the court on rehearing rescinded that order, 603 F.3d, at 422-43.

5. *The ALJ committed no prejudicial error in rejecting elements of the parties' Joint Stipulation.*

Carrington contends that the ALJ erroneously rejected the parties' Joint Stipulation. RR at 22-25. The ALJ Decision indicates that he read paragraph eight of the stipulation as mistakenly stating - or at minimum implying - that CMS lacks the authority to impose a DPNA unless the noncompliance has resulted in actual harm. ALJ Decision at 15, citing ALJ Ex. 1, ¶ 8; see also Tr. at 12-16, 73-77. In fact, the Medicare statute and regulations authorize CMS to impose a DPNA for any period in which the SNF is or was not in substantial compliance, regardless of the level of noncompliance, including whether there was actual harm. Social Security Act §§ 1819(h)(2)(A)(ii), 1819(h)(2)(B)(i); 42 C.F.R. § 488.417(a).[11] It is also clear that the ALJ did not reject any of the stipulation's factual assertions, including the assertion that CMS had selected the DPNA pursuant to a policy set out in its State Operations Manual and "solely as a consequence of" (1) CMS's finding, from the July survey, that Carrington's noncompliance with section 483.25(i)(1) had resulted in actual harm to Resident 3, and (2) one or more findings of actual harm from a previous (January 2008) survey. ALJ Ex. 1, ¶ 8.

Furthermore, we have affirmed the ALJ's findings of noncompliance (including the finding concerning Resident 3). Even if stipulation eight is read to mean that, absent a finding of actual harm, CMS's policy would be not to impose a discretionary DPNA, it would not make a difference here because CMS's finding that the noncompliance involving Resident 3

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[11] 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.

resulted in actual harm (CMS Ex. 7, at 25) was unappealable in these circumstances. See 42 C.F.R. § 498.3(b)(14).

For these reasons, we find no basis to modify or reverse the ALJ Decision based on the ALJ's comments about the parties' Joint Stipulation.

6. *We find no error in the ALJ's rulings regarding cross-examination.*

At the outset of the in-person phase of the evidentiary hearing, the ALJ set out certain "ground rules" for cross-examination. See Tr. at 21. One of the rules was that cross-examination "should generally be confined to the scope of direct." Id. Carrington contends that the ALJ's ground rules improperly constrained its cross-examination of CMS's witnesses. RR at 37-39. In support of this general complaint, Carrington points to several instances in which the ALJ allegedly applied these rules. RR at 37-38. In addition, Carrington maintains that the ALJ "was in a hurry" to conclude the hearing, and that "when [he] presumed counsel was taking too long when questioning witnesses, he would prompt counsel to go faster and/or skip certain questions and just address any issues in their post-hearing brief." RR at 39.

In this agency adjudication, the conduct of the hearing rests generally in the ALJ's discretion. See 42 C.F.R. § 498.60(b)(3) (stating that "the ALJ decides the order in which the evidence and the arguments of the parties are presented and the conduct of the hearing"); Richardson v. Perales, 402 U.S. 389, 400 (1971). The Board has indicated that it will vacate or modify an ALJ's decision based on an allegedly improper evidentiary ruling only if the appellant demonstrates that the ruling was prejudicial. See Royal Manor, DAB No. 1990, at 14-29 (2005) (rejecting objections to evidentiary and other rulings because the appellant failed to demonstrate prejudicial error); *Guidelines* (indicating that the possible bases for modifying or reversing a decision by the Administrative Law Judge include a "prejudicial error of procedure").

Here, we find no error at all. None of the ground rules established by the ALJ at the outset of Carrington's hearing are unreasonable. For example, requiring cross-examination to be within the scope of the direct examination is a limitation no more onerous than the rule governing cross-examination in federal courts. See Fed. R. Evid. 611(b) (providing that "[c]ross-examination should be limited to the subject matter of the direct examination and matters affecting the credibility of

the witness"). Moreover, Carrington has failed to explain with any specificity how the ALJ's conduct of the hearing impaired its ability to litigate specific issues material to the outcome of the proceeding. For example, Carrington does not allege that it was prevented from examining witnesses about testimony that the ALJ relied upon in reaching his conclusion about the validity of particular survey findings. We thus find no basis to disturb the ALJ Decision based on Carrington's complaints about the conduct of the hearing. See Beatrice State Developmental Center, DAB No. 2311, at 15-16 (2010) (rejecting claim that the ALJ violated the facility's right to due process by allegedly conducting the hearing with "amazing speed").

7. *It is unnecessary to address whether the ALJ improperly denied Carrington's post-hearing motion to supplement the record.*

After the hearing and submission of post-hearing briefs, Carrington moved to supplement the record with excerpts from a October 2009 deposition given by Surveyor Margaret Brotherton during a related state enforcement proceeding. See P.'s Motion for Leave to Suppl. Record (Oct. 8, 2009). Carrington's motion alleged that Surveyor Brotherton's deposition testimony was relevant to issues before the ALJ, provided a basis for questioning her veracity, and constituted an "admission against interest." Id. In denying the motion, the ALJ stated that he had not relied on Surveyor Brotherton's hearing testimony and that her hearing and deposition testimony did not appear to be inconsistent in any event. ALJ Decision at 2 n.2.

Carrington contends that the ALJ erroneously denied the motion but does not dispute the ALJ's assertion of non-reliance. Carrington also concedes that the excluded deposition testimony concerns a survey finding that the ALJ did not address - namely, tag F444, which alleged a violation of section 483.65(b)(3). RR at 20-22; Reply Br. at 11–12. Given that concession, we do not need to address whether the ALJ erroneously denied the motion.

8. *Carrington's other due process claims are without merit or are beyond the Board's authority to review.*

Carrington contends that certain elements of this administrative proceeding violated its constitutional right to due process. RR at 35. In support of that contention, Carrington cites CMS regulations that: (1) limit the ability of a SNF to appeal findings concerning the seriousness of its noncompliance; (2) require a SNF to prove, when a finding concerning the seriousness of its noncompliance is appealable, that the finding

is clearly erroneous; and (3) preclude review of CMS's choice of remedy. RR at 35-37, citing 42 C.F.R. §§ 488.408(g)(2), 498.3(b)(14), and 498.60(c)(2). Carrington also suggests that the Board improperly assigns to the SNF the ultimate burden of proof on the issue of whether it was in substantial compliance. RR at 36. According to Carrington, these circumstances create a scheme in which a SNF is unconstitutionally forced to bear the burden of proof in order to avoid CMPs and other remedies that constitute "quasi-criminal" sanctions. RR at 35-37; Reply Br. at 12-14.

To the extent that Carrington is challenging the constitutionality of CMS's duly promulgated regulations, we will not entertain that challenge. It is "well established that administrative forums, such as this Board and the Department's ALJs, do not have the authority to ignore unambiguous statutes or regulations on the basis that they are unconstitutional." Sentinel Medical Laboratories, Inc., DAB No. 1762, at 9 (2001), aff'd sub nom., Teitelbaum v. Health Care Financing Admin., No. 01-70236 (9th Cir. Mar. 15, 2002), reh'g denied, No. 01-70236 (9th Cir. May 22, 2002); see also 1866ICPayday.com, L.L.C., DAB No. 2289, at 14 (2009).

We further note that Carrington's constitutional due process argument is founded on the false premise that the CMPs and DPNA imposed in this case were quasi-criminal sanctions. To the contrary, those enforcement remedies were remedial in nature. CMS imposed these remedies not to punish Carrington but to motivate it to correct its deficiencies and maintain substantial compliance with Medicare participation requirements for the benefit and protection of its residents. See 42 C.F.R. § 488.402 (stating that the purpose of remedies specified in section 488.406 is "to ensure prompt compliance with program requirements"); Embassy Health Care Center, DAB No. 2299, at 11 (2010) ("the purpose of nursing home enforcement CMPs is to ensure compliance with program requirements, making them not punitive but remedial in nature").

Carrington also contends that placing the burden of persuasion on the SNF violates the Administrative Procedure Act (APA), a position that, it says, was accepted by the Eighth Circuit in Grace Healthcare. Reply Br. at 14. The Board has consistently held, based on analysis of the applicable statutory and regulatory provisions, that allocating the burden of persuasion to the SNF does not violate APA procedural requirements. See Batavia Nursing and Convalescent Center, DAB No. 1904, at 15 (2004), aff'd, Batavia Nursing & Convalescent Center v. Thompson, 129 F. App'x 181 (6th Cir. 2005). The court in Grace

Healthcare did not take a contrary position, as we noted in a recent decision. See Life Care Center of Tullahoma, DAB No. 2304, at 47-48 (2010). The Board has also held that the allocation of evidentiary burdens - requiring the SNF to demonstrate substantial compliance by a preponderance of evidence once CMS makes a prima facie showing of noncompliance - does not violate the SNF's constitutional right to due process. Fairfax Nursing Home, Inc., DAB No. 1794, at 8 (2001), aff'd, Fairfax Nursing Home v. U.S. Dep't of Health & Human Servs., 300 F.3d 835 (7th Cir. 2002), cert. denied, 537 U.S. 1111 (2003); Batavia at 15; Universal Healthcare/King, DAB No. 2215, at 26 (2008). Carrington's legal arguments do not persuade us that the Board's prior decisions on these issues were erroneous.

CONCLUSION

Based on the foregoing analysis, we affirm the ALJ Decision.

/s/
Judith A. Ballard

/s/
Sheila Ann Hegy

/s/
Stephen M. Godek
Presiding Board Member