Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Appellate Division

In the Case of:	
Magnolia Estates Skilled Care,	DATE: February 13, 2009
Petitioner,	Civil Remedies CR1804 App. Div. Docket No. A-08-126
- v.-	Decision No. 2228
Centers for Medicare & Medicaid Services.	

FINAL DECISION ON REVIEW OF ADMINISTRATIVE LAW JUDGE DECISION

Magnolia Estates Skilled Care (Magnolia), a North Carolina skilled nursing facility (SNF), appeals the June 13, 2008 decision of Administrative Law Judge (ALJ) Keith W. Sickendick, Magnolia Estates Skilled Care, DAB CR1804 (2008) (ALJ Decision). At issue before the ALJ was a determination by the Centers for Medicare & Medicaid Services (CMS) that Magnolia was not in substantial compliance with various Medicare participation requirements, including 42 C.F.R. § 483.10(b)(11)(i), which obligates a SNF to (among other things) consult immediately with a resident's physician about an accident involving the resident or about significant changes in the resident's medical condition and treatment.

Based on evidence about Magnolia's care of a resident who fractured her right leg in late July 2005, the ALJ concluded that Magnolia was not in substantial compliance with section 483.10(b)(11)(i) and other Medicare participation requirements from July 25 through November 12, 2005. The ALJ also upheld CMS's determination that Magnolia's noncompliance was at the level of immediate jeopardy from July 25 through October 19,

2005. In addition, the ALJ concluded that the civil money penalties (CMPs) imposed by CMS for Magnolia's noncompliance – a $3,050 per day CMP for the period from July 25 through October 19, 2005, and a $50 per day CMP for the period from October 20 through November 12, 2005 – were reasonable in amount.

For the reasons discussed below, we affirm the ALJ Decision in its entirety.

Legal Background

The participation requirements for skilled nursing and other long-term care facilities that participate in Medicare and Medicaid are set forth at 42 C.F.R. Part 483, subpart B. State agencies under contract with CMS perform surveys to verify that facilities are complying with these requirements. A state survey agency reports any "deficiencies," or failures to comply with participation requirements, on a standard form called a "Statement of Deficiencies." The Statement of Deficiencies identifies each deficiency with a unique survey "tag" number that corresponds to the participation requirement allegedly violated.

CMS may impose enforcement remedies, including CMPs, when it finds that a SNF is not in "substantial compliance" with one or more participation requirements. See 42 C.F.R. §§ 488.400 et seq. "Substantial compliance" means a level of compliance such that "any identified deficiencies pose no greater risk to resident health or safety than the potential for causing minimal harm." Id. § 488.301. CMS's regulations (and we) use the term "noncompliance" to refer to "any deficiency that causes a facility to not be in substantial compliance." Id. § 488.301.

CMS determines the amount of a CMP based in part on the "seriousness" - or scope and severity – of a SNF's noncompliance. See 42 C.F.R. § 488.404. The most serious deficiency is one that creates "immediate jeopardy," which 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." Id. § 488.301.

Case Background

On October 20, 2005, the North Carolina Department of Health and Human Services (state survey agency) completed a survey of Magnolia. CMS Ex. 3, at 1. The state survey agency found multiple deficiencies, the most serious of which concerned the care provided to Resident 1 during July 2005. Id. at 1, 29, 60.

Under deficiency tag F157, the state survey agency found that as of July 25, 2005, Magnolia's care of Resident 1 was not in substantial compliance with 42 C.F.R. § 483.10(b)(11)(i) because a facility nurse had allegedly failed to: (1) consult immediately with Resident 1's physician about the need to use a pressure dressing to stem bleeding from Resident 1's right knee; (2) consult immediately with Resident 1's physician about bone "protruding through the skin" of Resident 1's right knee; and (3) immediately notify Resident 1's mother about Resident 1's seizures and related knee injuries. CMS Ex. 3, at 2. Based on its review of the care provided to Resident 1 during July 2005, the state survey agency also cited Magnolia for noncompliance with the general quality of care requirement in 42 C.F.R. § 483.25 (under tag F309) and with the general administration requirement in section 483.75 (under tag F490). Id. at 29, 60. The state survey agency also determined that Magnolia's noncompliance with sections 483.10(b)(11)(i), 483.25, and 483.75 was at the level of "immediate jeopardy" from July 25 through October 19, 2005, and that Magnolia's noncompliance with one or more participation requirements continued at a lower level of severity after October 19, 2005. Id. at 1-2, 29-30, 60. Later, a revisit survey found that Magnolia had come back into substantial compliance with all participation requirements on November 13, 2005. P. Ex. 4.

CMS concurred with the October 2005 survey findings. CMS Ex. 4. Based on those findings, CMS imposed a $3,050 per day CMP on Magnolia for the period from July 25 through October 19, 2005, and a $50 per day CMP for the period from October 20 through November 12, 2005. Id. at 2. The total amount of the CMPs imposed was $266,550.

Magnolia requested and received an evidentiary hearing before the ALJ to contest the findings of noncompliance. At the hearing, the ALJ received testimony from (among others): Maxine Deese, R.N., a state surveyor who participated in the October 2005 survey; Dr. William Obremskey, a board certified orthopedic trauma surgeon who provided expert testimony; and two facility nurses – Kim McCorkle, LPN and Lisa Hodges, LPN. (Nurses McCorkle and Hodges were involved in Resident 1's care on July 25, 2005.)

The ALJ's Findings of Fact and Conclusions of Law

In his decision, the ALJ confined his findings of fact and conclusions of law to the deficiency citations concerning Resident 1 (that is, the citations under tags F157, F309, and

F490).

The ALJ found the following facts:

Resident 1, a 45 year old woman, had Huntington's Chorea, a disorder which causes progressive cerebral degeneration. ALJ Decision at 3, ¶¶ 1-2. The disorder manifests itself in cognitive impairment and involuntary movement of the extremities. Id. ¶ 2. Resident 1's cognitive impairment had progressed to the point that she could no longer communicate in any meaningful way. Id. Her bed had padded side rails to help prevent injury from her uncontrolled or involuntary movements. Id. ¶ 6.

At approximately 5:30 p.m. on July 24, 2005, Resident 1 had a seizure that involved "jerking movements" of her extremities. ALJ Decision at 3, ¶ 7. The nurse on duty reported that Resident 1 suffered no physical injury during that seizure. Id.

At 12:45 a.m. on July 25, the nursing staff witnessed another seizure. ALJ Decision at 3, ¶ 8(a). Shortly after, a nurse phoned the office of Lloyd Nickerson, M.D., Resident 1's attending physician (and Magnolia's medical director), to relay information about Resident 1's condition. Id. ¶ 8(b). The on-call physician, Dr. Kirtley, ordered the nursing staff to continue monitoring Resident 1 and to consult a neurologist. Id. at 4, ¶ 8(c)-(d).

At 9:40 a.m on July 25, Nurse Hodges spoke with Caroline Adams, a geriatric nurse practitioner (NP) who worked for Dr. Nickerson. ALJ Decision at 4, ¶ 8(e). NP Adams cancelled the neurology consultation and ordered the administration of Dilantin. Id. ¶ 8(f).

At 2:35 p.m. on July 25, Nurse Hodges wrote in her nursing notes that she had contacted Resident 1's family about her recent seizures and "new orders." ALJ Decision at 4, ¶ 4(g). Nurse Hodges also wrote that she had seen a small bruise on Resident 1's right knee, an injury that Nurse Hodges attributed to Resident 1's seizure activity. Id.

At 10:10 p.m. on July 25, Nurse McCorkle wrote in her nursing notes that she was called to Resident 1's room and found that her right knee was swollen and bruised with a reddened area that was bleeding. ALJ Decision at 5, ¶ 8(h).

At 10:15 p.m. on July 25, Nurse McCorkle wrote in her nursing notes that she called Dr. Nickerson and made him aware of Resident 1's right knee and that he had ordered an x-ray and

instructed the nursing staff to keep that knee propped-up. ALJ Decision at 5, ¶ 8(i). Nurse McCorkle also wrote that Dr. Nickerson wanted the results of the x-ray called in to his office and that he informed her that it was acceptable to have the x-ray done the following morning (on July 26). Id.

At 10:30 p.m. on July 25, Nurse McCorkle wrote in her nursing notes:

> [P]ressure dsg [dressing] to R knee small amt of bleeding noted Tip of bone through skin. Will continue to monitor.

CMS Ex. 5, at 4; ALJ Decision at 5 ¶ 8(k).

At around 12:40 p.m. on July 26, Resident 1's right knee was x-rayed pursuant to Dr. Nickerson's July 25 telephone order. ALJ Decision at 5, ¶ 9(b). At 2:00 p.m., Magnolia received an x-ray report that showed a comminuted fracture of Resident 1's distal femur just above the knee.[1] Id. NP Adams was notified of the x-ray results and ordered Magnolia to consult with an orthopedist for a "splint (immobilizer)." Id. ¶ 9(c). An appointment was then made for Resident 1 to see an orthopedist on July 27. Id. ¶ 9(c)-(d).

At 8:00 a.m. on July 27, a nurse reported that Resident 1's right knee was bleeding through the dressing. ALJ Decision at 5, ¶ 10(b). When the dressing was removed, staff observed a purple bruise and exposed bone. Id. A protective dressing was applied, and Resident 1 was given pain medication. Id.

At 9:45 a.m. on July 27, Resident 1 was transported to her appointment with the orthopedist, William Mason, M.D. ALJ Decision at 5, ¶ 10(c). At 12:00 p.m. on July 27, Dr. Mason's office informed Magnolia that Resident 1 was being transferred to the hospital for "debridement and open reduction surgery" to repair the fractured right femur. Id. at 6, ¶ 10(d). Dr. Mason's notes and July 27, 2005 operative report show that a piece of fractured bone had perforated the medial skin and that Resident 1 was reacting to pain from the fracture site. Id. ¶ 11.

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[1] The femur is the bone extending from the pelvis to the knee. The distal part of the femur, along with the patella and tibia, forms the knee joint. Dorland's Illustrated Medical Dictionary (28th ed.), at 615 (definition of "femur").

On July 28, 2005, Resident 1 returned to Magnolia with a splint/immobilizer and ace wrap on the right knee with an order for antibiotic therapy and other treatment. ALJ Decision at 6 n.3. Due to the progression of her Huntington's disease, Resident 1 was unable to keep her fractured leg straight. Id. In August 2005, Dr. Mason ordered that Resident 1's right leg be amputated above the knee because the femur was still protruding through the skin and because he determined that a cast would be ineffective in healing the fracture. Id.

Based on these (and other) findings of fact, the ALJ made the following conclusions of law. First, he concluded that Magnolia was not in substantial compliance with section 483.10(b)(11)(i) as of July 25, 2005. ALJ Decision at 6. In support of that conclusion, the ALJ found that Magnolia had failed to:

- consult immediately with Resident 1's physician about: (1) "bleeding at the right knee of such volume that a pressure dressing was required"; and (2) the fact that the nursing staff "could feel the tip of Resident 1's broken right femur pressing against the skin or protruding through the skin" above the right knee; and

- notify Resident 1's legal representative or an interested family member immediately about Resident 1's seizures, the treatment ordered for the seizures, and the clinical signs of a bone fracture.

Id. at 14-15. In concluding that Magnolia had failed to comply with the physician consultation requirement, the ALJ expressly found not credible Nurse McCorkle's testimony that she spoke with Resident 1's physician on July 25 about the bleeding and protruding bone at Resident 1's right knee.

Second, the ALJ concluded that Magnolia's care of Resident 1 in late July 2005 violated the participation requirements in sections 483.25 (quality of care) and 483.75 (administration). ALJ Decision 6, 18-19.

Third, the ALJ concluded that CMS's determination that Magnolia's noncompliance with sections 483.10(b)(11)(i), 483.25, and 483.75 had created an immediate jeopardy situation as of July 25, 2005 was not clearly erroneous. ALJ Decision at 6, 19-21.

Fourth, the ALJ concluded that Magnolia failed to prove that it abated the immediate jeopardy before October 20, 2005 or that it

returned to substantial compliance before November 13, 2005. ALJ Decision at 6, 21.

Finally, the ALJ concluded that the CMPs imposed by CMS for the noncompliance were reasonable in amount. ALJ Decision at 6, 22-23.

Standard of Review

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

"Substantial evidence" is "such relevant evidence as a reasonable mind might accept as adequate to support a conclusion." Richardson v. Perales, 402 U.S. 389, 401 (1971), quoting Consolidated Edison Co. v. NLRB, 305 U.S. 197, 229 (1938). Under the substantial evidence standard,

> the reviewer must examine the record as a whole and take into account whatever in the record fairly detracts from the weight of the decision below. The reviewer does not, however, reweigh the evidence or substitute his or her judgment for that of the initial decision-maker. Thus, the reviewer must not displace a "choice between two fairly conflicting views," even though a different choice could justifiably have been made if the matter had been before the reviewer de novo. The reviewer must, however, set aside the initial conclusions when he or she cannot conscientiously find that the evidence supporting that decision is substantial, when viewed in the light that the record in its entirety furnishes, including the body of evidence opposed to the [initial decision-maker's] view.

Golden Age Nursing & Rehabilitation Center at 8 (citations and internal quotations omitted).

Discussion

In its request for review, Magnolia states that it disagrees with all of the ALJ's conclusions of law. Request for Review (RR) at

2 (¶ 6). In addition, Magnolia disagrees with the ALJ's factual finding that its nursing staff did not immediately consult with Resident 1's physician about the need for a pressure dressing to stem bleeding from Resident 1's right knee or about the "possible protrusion" of bone from the skin above that knee. Id. at 2 (¶ 7), 3-6.

We conclude that Magnolia's contentions in this appeal are without merit.[2]

1. *The ALJ's conclusion that Magnolia was not in substantial compliance with 42 C.F.R. § 483.10(b)(11)(i) as of July 25, 2005 is supported by substantial evidence and is not based on an error of law.*

Section 483.10(b)(11)(i) states in relevant part:

> A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is –
>
> > (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;
> >
> > (B) A significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);
> >
> > (C) A need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment) . . . .

(emphasis added). The ALJ held, and we agree, that the word "immediately" in section 483.10(b)(11)(i) means "as soon as the change [or other regulatory predicate] is detected, without any intervening interval of time." ALJ Decision at 13. The ALJ's

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[2] CMS contends that the ALJ erred in excluding the testimony of Claudia Testa, M.D. Response Br. at 3 n.2. We do not consider this objection because CMS did not file a timely request for review of the ALJ Decision.

definition is consistent with the term's ordinary meaning. The dictionary defines the term "immediately" as meaning "at once" or "without delay." Webster's New World Dictionary (2nd College ed.) at 702. In turn, the term's ordinary meaning is consistent with the drafter's intent. As we discussed in The Laurels at Forest Glenn, DAB No. 2182, at 13 (2008), section 483.10(b)(11)(i), as originally drafted, gave the facility up to 24 hours to consult with the physician or notify the legal representative or interested family member of accidents or other significant changes in condition or treatment. After commenters objected that the 24-hour period was too long, CMS amended the proposed regulation to require "immediate" consultation and notification. DAB No. 2182, at 13; see also 56 Fed. Reg. 48,867, 48,833 (Sept. 26, 1991).

In addition, regarding the requirement in section 483.10(b)(11)(i) to "consult" with a physician, we agree with the ALJ that "it is clear from the language of the regulation and its history" that consultation involves "more than merely informing or notifying the physician." ALJ Decision at 12-13. Consultation, said the ALJ,

> requires a dialogue with and a responsive directive from the resident's physician as to what actions are needed; it is not enough to merely notify the physician of the resident's change in condition. Nor is it enough to leave just a message for the physician. Also, the facility must provide the physician with all the information necessary to properly assess any changes to the resident's condition and what course of action is necessary. Failure to provide even one aspect of the change in a resident's condition can significantly impact whether the physician has been properly consulted.

ALJ Decision at 13.

At issue here is Magnolia's obligation under section 483.10(b)(11)(i) to consult immediately with the resident's physician and to notify the resident's legal representative or interested family member. As the regulation's text indicates, Magnolia must perform these tasks when there has been an "accident" involving the resident that has the potential to require physician intervention, when there is a "significant change" in a resident's status, or when there is a "need to alter treatment significantly."

a. Physician consultation

The ALJ concluded that section 483.10(b)(11)(i) required its nursing staff to consult immediately with Resident 1's physician, Dr. Nickerson, on July 25 about: (1) "bleeding to the right knee of such volume that a pressure dressing was required"; and (2) the fact that "the nursing staff could feel the tip of Resident 1's broken right femur pressing against the skin or protruding through the skin." ALJ Decision at 14. Magnolia does not dispute that the regulation obligated it to consult immediately with Dr. Nickerson about those matters on July 25. Magnolia's disagreement is with the ALJ's finding that it did not, in fact, do so.

We find substantial evidence in the record to support the ALJ's finding that Magnolia did not consult immediately with Dr. Nickerson on July 25 about the application of a pressure dressing or about the "protruding bone" above Resident 1's right knee. The treatment notes written by Nurse McCorkle on July 25 are the most significant evidence of this failure. Her 10:10 p.m. note indicates that she observed swelling, bruising, and bleeding on Resident 1's right knee. CMS Ex. 5, at 3. Her next note, at 10:15 p.m., states that she called Dr. Nickerson and that he was "made aware" but does not specify what she told him. Id. at 4. The next note, for 10:30 p.m., states: "pressure dsg to R knee small amt of bleeding noted Tip of bone through skin. Will continue to monitor." Id. at 5. No other calls to Dr. Nickerson were documented in Nurse McCorkle's notes for July 25.

On their face, these notes indicate that Nurse McCorkle did not apply a pressure dressing or find the "[t]ip of bone through skin" above Resident 1's right knee until after her 10:15 p.m. call to Dr. Nickerson. Because the nursing notes do not mention any phone calls to Dr. Nickerson after 10:15 p.m., and because Magnolia's nurses customarily documented their contacts with physicians and their offices, see, e.g., CMS Ex. 5, at 1-10, the ALJ reasonably inferred from the sequence of notes that Nurse McCorkle did not consult with Dr. Nickerson that evening about the need for a pressure dressing or the protruding bone. That inference is supported by evidence of the state survey agency's October 18, 2005 interview of Dr. Nickerson, during which he stated that the nursing staff did not inform him on July 25 about the protruding bone and that had he been told, he would have ordered Resident 1's immediate hospitalization.[3] CMS Ex. 3, at 8.

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[3] Dr. Nickerson did not testify at the hearing.

As the ALJ recounted, Nurse McCorkle testified that she spoke with Dr. Nickerson twice on July 25 – at 10:15 p.m. and at about 10:30 p.m. Tr. at 271-80, 289-95. Nurse McCorkle also testified that when she first examined Resident 1 at 10:10 p.m., she noticed swelling and a bruise on her right knee, blood on her incontinence pad, and blood that had trickled down from the area of her bruise and was in the process of drying (but no active bleeding). Tr. at 273, 302-04. When she ran her hand over the bruised skin, she felt a small piece of bone that was "trying to come through or protruding through the skin." Tr. at 274-75, 290.

Nurse McCorkle testified that during her first phone call to Dr. Nickerson (at 10:15 a.m.), she told him about the swelling, blood, and the fact that something might be "poking or protruding through the skin." Tr. at 276, 290. Dr. Nickerson then ordered an x-ray of the knee and indicated that it was acceptable to schedule it for the next morning.[4] Tr. at 276.

Nurse McCorkle testified that a few minutes after her 10:15 p.m. call to Dr. Nickerson, she was called back to Resident 1's room. Tr. at 277. This time, she saw "more blood on the pad," a small amount of bleeding, but "still nothing active." Tr. at 277, 291. She cleaned the knee and applied a pressure dressing "because I wasn't sure if it was going to start seeping or bleeding out when we left out of the room again." Tr. at 279. As for the protruding bone, she "couldn't really tell if the skin was actually open or what the little protrusion was"; she saw no "cut" or "open wound." Tr. at 277, 281-82. According to Nurse McCorkle, Resident 1 did not "grimace or draw up" when she (McCorkle) touched Resident 1's knee, and Resident 1 "was still moving her leg as if nothing was bothering her." Tr. at 278-79.

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[4] Nurse McCorkle also testified that after the 10:15 p.m. call to Dr. Nickerson, she phoned Magnolia's nursing director, Debra Clayton, R.N. Tr. at 280-81. Nurse McCorkle testified that during this call, she informed Nurse Clayton about the condition of Resident 1's right knee and about Dr. Nickerson's order for an x-ray of the knee. Id. However, it is unclear what precisely she told Nurse Clayton, if anything, about bone protrusion at the knee because neither nurse documented the phone call. See Tr. at 300. For her part, Nurse Clayton told surveyors in an October 18, 2005 interview that she did not become aware of bone protrusion until she read Nurse McCorkle's nursing notes, and that she could not recall when she read those notes. CMS Ex. 3, at 12; see also Tr. at 109.

At the time, she (McCorkle) did not suspect that Resident 1's right leg was broken, only "dislocated." Tr. at 306.

Nurse McCorkle testified that she called Dr. Nickerson for the second time (at around 10:30 p.m.) because of the bleeding and because she "wasn't sure" about the condition of the knee and thought that Dr. Nickerson might send Resident 1 to the hospital. Tr. at 279, 291-92, 314. During her second phone call, Dr. Nickerson gave no additional treatment orders other than an instruction to keep Resident 1's right leg "propped up." Tr. at 280. Nurse McCorkle testified that she forgot to document her second call to Dr. Nickerson because of her preoccupation with tasks associated with an upcoming shift change (her shift ended at 11:00 p.m. on July 25). Tr. at 282, 307, 309-10. She did not think that the situation was an "emergency" because Resident 1's vital signs were within normal limits, the amount of bleeding was small, and Resident 1 did not appear to be in any pain. Tr. at 285-86, 312.

When asked what she meant when she wrote "[t]ip of bone through skin" in her 10:30 p.m note, Nurse McCorkle testified:

> Well, I was a little unsure what it was, since if you ran your hand over the skin, you could feel it - something. And I was going on the assumption that it was through skin because the blood was coming from somewhere. It wasn't a great, large amount, but it had to [be] seeping from somewhere.

Tr. at 281. Later, she clarified that when she wrote "bone through skin," she meant that she could feel bone protrusion under the skin, not that she had felt something outside the skin. Tr. at 311.

In a written statement that she gave to surveyors on October 18, 2005, Nurse McCorkle claimed that she told Dr. Nickerson during the first telephone call on July 25 (at 10:15 p.m.) that she had noticed swelling and a "protruding area to knee" but that no skin had been broken. CMS Ex. 32, at 311. However, she stated that when she returned to Resident 1's room after the first phone call, she noticed "active bleeding" and a "small size piece of bone protruding through skin" without reiterating or qualifying her earlier comment that Resident 1's skin had not been broken. Id. at 311-312 (emphasis added). She further stated that she called Dr. Nickerson a second time to make him aware of the protruding bone and that a pressure dressing had been applied to stem the bleeding. Id. at 312. As discussed, Nurse McCorkle did not document her second call to Dr. Nickerson (at 10:30 p.m.) in

her nursing notes, and those notes do not indicate what, if anything, she told Dr. Nickerson about the "protruding" bone.

The ALJ did not find that a piece of fractured bone had actually protruded outside the skin of Resident 1's right knee on July 25. Rather, he found that "[t]he bruising to the right knee, the bleeding at the right knee, and the protruding bone, whether just pressing under the skin or actually protruding through the skin, were obvious signs that Resident 1 had experienced a displaced fracture of her right femur." ALJ Decision at 14 (emphasis added).

While not disputing the ALJ's finding that Resident 1 displayed "obvious signs" of a bone fracture on July 25, Magnolia contends that the "preponderance of evidence" proves that its nursing staff did consult with Dr. Nickerson on July 25 about the protruding bone and need for a pressure dressing. RR at 3. To support this contention, Magnolia relies on the testimony of Nurse McCorkle. Id. at 3-4.

We reject this contention, noting first that it fails to acknowledge or account for the Board's standard of review. As an appellate body, the Board does not decide whether a "preponderance of evidence" supports a particular conclusion. Preponderance of evidence is the standard of proof applied by the ALJ to determine whether a SNF has met its burden of rebutting CMS's prima facie case of noncompliance. See Evergreene Nursing Care Center, DAB No. 2069, at 7 (2007).[5] The Board's role in reviewing the ALJ's findings of fact is, rather, to determine whether the ALJ's findings of fact are supported by "substantial evidence" in the record as a whole. Under that standard of review, the Board does not – as Magnolia seems to be asking us to do – reweigh the evidence to determine whether it met its burden of proof below. Golden Age Nursing & Rehabilitation Center at 8.

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[5] Under the well-established framework for allocating the parties' evidentiary burdens on the issue of whether a SNF was in substantial compliance, "CMS has the burden of coming forward with evidence related to disputed findings that is sufficient (together with any undisputed findings and relevant legal authority) to establish a prima facie case of noncompliance with a regulatory requirement." Evergreene Nursing Care Center at 4. "If CMS makes this prima facie showing, then the SNF must carry its ultimate burden of persuasion by showing, by a preponderance of the evidence, on the record as a whole, that it was in substantial compliance during the relevant period." Id.

As its appeal brief shows, the linchpin of Magnolia's case is the testimony of Nurse McCorkle. Magnolia urges us to accept that testimony as credible. However, it is "ALJ's role as the finder of fact . . . to evaluate the credibility of witnesses, to decide what testimony to believe and what weight to assign." The Laurels at Forest Glenn at 27. The ALJ, who had the opportunity to assess the witnesses' demeanor, found it "not credible that LPN McCorkle contacted Dr. Nickerson a second time or that she ever made clear to him the obvious signs of an open fracture of Resident 1's right femur." ALJ Decision at 16. We do not disturb this credibility finding unless it is clearly erroneous.[6] Bradford County Manor, DAB No. 2181, at 4 (2008); Woodland Village Nursing Center, DAB No. 2172, at 7 (2008).

We find no clear error in the ALJ's credibility finding. The ALJ did not believe Nurse McCorkle's testimony for two reasons. First, he found, and we agree, that the testimony was inconsistent with Nurse McCorkle's own treatment notes. ALJ Decision at 16. Second, the ALJ pointed to what he believed to be an inconsistency in her testimony. Id. Nurse McCorkle testified that she called Dr. Nickerson a second time on July 25 because she thought he might change his order and send Resident 1 to the hospital. Tr. at 315-16. She also admitted that a bone protruding through skin constituted an emergency situation requiring immediate treatment to stabilize the limb and minimize the risk of infection. Tr. at 288. In addition, Nurse McCorkle testified that in an emergency she could have sent Resident 1 to the hospital without an order from Dr. Nickerson but did not think hospitalization was warranted. Tr. at 315-16. The ALJ reasoned that if he had accepted her testimony that hospitalization was not warranted on July 25, then it was "not likely" that she called Dr. Nickerson at 10:30 p.m. believing that he would change his mind and order Resident 1 to be hospitalized. ALJ Decision at 16. Magnolia does not dispute this reasoning, and we do not find it illogical or unsubstantiated. Furthermore, we think it was reasonable for the ALJ to give more weight to the nursing notes written on July 25 than to Nurse McCorkle's after-the-fact (post-July 25) recollections given a nurse's professional obligation to document – and Magnolia's evident practice of documenting – contacts with

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[6] The ALJ's assessment of witness credibility is especially critical in this case given the conflicting documentary evidence about what Nurse McCorkle told Dr. Nickerson on July 25.

residents' physicians.[7]

Magnolia points to an "Incident/Accident Report" that was prepared on July 26, after the facility received the x-ray report at 2:00 p.m. RR at 4 (citing P. Ex. 28). The report, which was signed by Debra Clayton, R.N. (Magnolia's nursing director) on July 26 and later by NP Caroline Adams and Dr. Nickerson, states that "according to nurse on duty M.D. was made aware of swelling + potential sm. protrusion of sm. bone." P. Ex. 28, at 1; see also CMS Ex. 32, at 6; Tr. at 210-11. The record also contains a document entitled "Investigation of Unwitnessed Resident Incident." P. Ex. 28, at 3. That document, which was signed by Nurse Clayton on July 26, 2005, outlines the findings of her investigation about what occurred the previous day. According to this document, Nurse McCorkle reported to Nurse Clayton that the physician had been "made aware" of a "possible sm. splinter bone showing." Id.

The ALJ assigned no weight to the documents just described. ALJ Decision at 17. He gave specific reasons for not doing so, one of them being that the incident report did not specify when Nurse McCorkle allegedly told the doctor about the protruding bone, and another being that Nurse Clayton's investigative report was not signed by Dr. Nickerson or NP Adams or otherwise acknowledged by them to be accurate. Id. Magnolia does not contend that these

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[7] In Sheridan Health Care Center, we found:

> [P]rofessional standards of quality nursing care require nursing notes to include nurses' clinical observations of patients and to document the care and services furnished to patients. Professional standards of quality also require that notes be timely entered, preferably at the end of the nurse's shift if at all possible, and generally within a 24-hour period. The purpose of timely and accurate notes is to communicate significant patient care issues not only to all nurses and aides caring for a patient, but also to the professionals (e.g. physicians, dietitians, social workers, and psychologists) who rely on these records to make informed decisions about patient care. When entries are not timely or simply do not exist, it makes it very difficult to determine a baseline for the resident and to determine if the resident needs additional care.

DAB No. 2178, at 33 (citations and internal quotations omitted).

reasons were unfounded or illegitimate, and they do not seem on their face to be so. For these reasons, we decline to find that the ALJ erred in not giving that evidence the weight Magnolia now argues he should have.

Magnolia contends that Nurse McCorkle "did not waiver in her testimony under cross-examination," and that she gave "consistent" statements or reports about what occurred in her nursing notes, in the July 26 incident report, in her October 2005 written statement, and at the hearing. RR at 3, 4. We disagree that her statements and reports were consistent. While her post-July 25 statements might be consistent with one another, those statements are not consistent with the best evidence of what occurred (or did not occur) on July 25 – namely, Nurse McCorkle's July 25 nursing notes, which show no contact with Dr. Nickerson about the protruding bone and application of a pressure dressing. Her nursing notes are the best evidence because they were written contemporaneously with the incident as part of her duty, under professional standards, to timely and accurately document care (see infra footnote 7).

Magnolia also contends that Dr. Nickerson's interview statement that the nursing staff did not inform him about the protruding bone is unreliable and deserves no weight because Dr. Nickerson did not have Resident 1's medical records in front of him during the interview. RR at 4. This contention is purely speculative because there is no evidence about what medical records, if any, Dr. Nickerson had in front of him during the interview and no evidence about what records, if any, he reviewed in preparing for the interview.[8] See CMS Ex. 3, at 8; Tr. at 219-20.

Magnolia also asserts that Dr. Nickerson's "inability to recall" that Nurse McCorkle had told him about the protruding bone on July 25 "can be explained due to different meanings of 'protruding bone' to different people[.]" RR at 4. This assertion also lacks foundation. Magnolia does not specify what those "different meanings" of "protruding bone" are, nor does it point to any evidence that Dr. Nickerson's understanding of that term was different from Nurse McCorkle's understanding.

Finally, Magnolia suggests that we overturn the ALJ's finding that it failed to consult immediately with Dr. Nickerson about bone protrusion because the "evidence demonstrates that there was

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[8] We note that Magnolia could have subpoenaed Dr. Nickerson to question him about his recollection but did not do so.

no open wound actually observed until approximately 8:00 a.m. on July 27, 2005."[9] RR at 6 (emphasis added). By "open wound," we assume that Magnolia means a skin break or perforation caused by a piece or the tip of a fractured bone. We reject Magnolia's suggestion because regardless of whether a piece of Resident 1's fractured femur actually perforated or protruded outside the skin on July 25, Nurse McCorkle was obligated to consult immediately with Dr. Nickerson if she had reason to think that it had done so or if there was bone protrusion under the skin suggesting a possible fracture. See The Laurels and Forest Glenn at 13 (quoting regulatory preamble which states that injuries having the "potential" for needing physician intervention must be reported to the physician). Furthermore, at the hearing Nurse McCorkle tacitly conceded that she had reason to suspect that bone had protruded outside the skin, testifying that, on July 25, she "was going on the assumption that [the bone tip or protrusion] was through skin because the blood was coming from somewhere."[10] Tr. at 281.

In sum, we have carefully reviewed Nurse McCorkle's testimony in light of the entire record and based on that review we cannot say that the ALJ's credibility determination was clearly erroneous. For that and other reasons discussed in this section, we find

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[9] In support of this argument, Magnolia asserts that the company that x-rayed Resident 1 on July 26 expressed no concern about an open fracture, and the x-rays themselves did not show or suggest that bone had exited the skin. RR at 9. However, as CMS points out, Dr. Obremskey testified that determining whether a fracture is open or closed is a clinical, not a radiographic, decision. Tr. at 174. Dr. Obremskey testified that it might not be possible to determine from looking at an x-ray whether bone has protruded outside the skin. Tr. at 174-75.

[10] Magnolia contends that any failure to tell Dr. Nickerson about the application of a pressure dressing to Resident 1's knee did not violate section 483.10(b)(11)(i) because (1) the bleeding was "minimal," (2) a surveyor testified that it was common for nurses to note the application a pressure dressing in a resident's chart, and (3) a pressure dressing is the usual treatment to stop bleeding, even on a superficial wound. RR at 5. However, even if the continued bleeding did not, in itself, warrant physician consultation (and we make no such finding), we think the record as a whole indicates that it was necessary for Magnolia to consult with Dr. Nickerson about the bleeding because, as Nurse McCorkle indicated, the protruding bone was a possible or likely cause of the bleeding. Tr. at 281.

that substantial evidence supports the ALJ's conclusion that Magnolia was not in substantial compliance with 42 C.F.R. § 483.10(b)(11)(i) on July 25, 2005.

b. Family notification

The ALJ concluded that Magnolia did not meet its regulatory obligation to notify Resident 1's legal representative or an interested family member because it failed to notify Resident 1's mother "immediately" about: (1) her daughter's seizure activity; (2) the July 25 orders of Dr. Kirtley (the on-call physician) and NP Adams; and (3) "signs of a displaced and open fracture." Id. at 14-15. The ALJ found that Magnolia notified Resident 1's mother at 2:35 p.m. on July 25 but should have made that notification during the morning of that day because a significant change in Resident 1's condition was apparent by that time. Id. at 14-15 & n.13.

Although Magnolia asserts that it "properly . . . notified the family" of Resident's seizures and injuries, RR Br. at 6 (emphasis added), its appeal brief does not specify any reasons for disagreement with the ALJ's finding that notification did not occur "immediately" after a "significant change" in Resident 1's condition or treatment.[11] As noted, section 483.10(b)(11)(i) expressly requires that notification of a significant change occur "immediately." For these reasons, we summarily affirm the ALJ's conclusion that Magnolia was not in substantial compliance with section 483.10(b)(11)(i)'s family notification requirement as of July 25, 2005. We also note and agree with the ALJ about the importance of family notification in this case because Resident 1 was unable to communicate or participate in decision-making about her care. See ALJ Decision at 15 n.12.

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[11] The ALJ's analysis of the family notification issue implies that "signs of a displaced and open fracture" were apparent by the mid-afternoon of July 25 and that Resident 1's mother should have been notified about them at that time. However, the available evidence indicates that these signs did not become apparent until the evening of July 25. Nevertheless, this fact would not lead us to conclude that Magnolia was in substantial compliance with the family notification requirement because Magnolia's failure to notify Resident 1's mother immediately about other matters – namely, the seizures and resulting treatment orders – is a sufficient basis to uphold this element of the deficiency citation under tag F157.

2. *The ALJ's conclusion that Magnolia was not in substantial compliance with 42 C.F.R. § 483.25 as of July 25, 2005 is supported by substantial evidence and is not based on an error of law.*

Title 42 C.F.R. § 483.25 states that "[e]ach resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being" of the resident, consistent with the resident's comprehensive assessment and care plan. Such care and services, the Board has found in prior cases, include consulting a resident's physician about the resident's condition in prescribed circumstances. See The Laurels at Forest Glenn at 6, 20 (citing cases and affirming a finding by the ALJ that a SNF violated section 483.25 because its nursing staff failed to consult an attending physician when, according to the facility's own protocol, such consultation was necessary).

The ALJ concluded that the facts that proved a violation of section 483.10(b)(11)(i) also proved a violation of section 483.25. ALJ Decision at 18. "The bottom-line on this deficiency," said the ALJ, "is that Resident 1 was not seen by any physician, let alone the orthopedist, until the early afternoon of July 27, 2005, some 38 hours after the bone [in Resident 1's right leg] was first noted to be protruding." Id. The ALJ also observed: "The fact that [Magnolia] did not determine it was necessary to obtain emergency treatment more promptly is no defense and is, in fact, indefensible." Id. In short, the ALJ concluded that Magnolia was not in substantial compliance with section 483.25 as of July 25, 2005 because it failed to recognize an emergency and take appropriate steps – including consultation with a physician – to ensure that Resident 1 received prompt treatment of the bone fracture in her right leg.

There is substantial evidence in the record to support that conclusion. As discussed, substantial evidence supports the ALJ's finding that on the evening of July 25, 2005, the on-duty nurse, Nurse McCorkle, failed to inform Resident 1's physician about protruding bone and the application of a pressure dressing to Resident 1's right knee, information which, the ALJ found, should have led the nursing staff to conclude or strongly suspect that Resident 1 had fractured a bone in her right leg and that a piece of the fractured bone had become exposed or exited the skin above her knee. Dr. Obremskey testified that this condition – an open fracture – presented a medical emergency that required prompt immobilization or stabilization of the affected limb, administration of antibiotics, and debridement of the bone and

wound in order to prevent infection and further damage to the limb. Tr. at 147-48, 157.

Magnolia's failure to consult with Dr. Nickerson immediately about the signs of an open fracture, and about an appropriate response to that development, resulted in substantial delay in the provision of necessary care and treatment. For example, no attempt was made by the nursing staff to stabilize the fractured leg. Dr. Obremskey testified that stabilization was necessary to minimize pain and prevent further damage to the leg or enlargement of the skin wound. Tr. at 157. He also testified that the nursing staff could have stabilized or immobilized the leg on an emergency basis using common or ordinary materials, such as blankets and tape. Tr. at 153-57. Both Dr. Obremskey and Surveyor Deese indicated that stabilization was an important measure because Resident 1 lacked control over the movement of her extremities. Tr. at 123, 157. They also indicated that the right leg should have been immobilized on the night of July 25 but certainly no later than the afternoon of July 26, when Magnolia received x-ray confirmation of the fracture. Tr. at 123, 152-57. There is no evidence that Resident 1's fractured leg was immobilized prior to her leaving the facility at 9:45 a.m. on July 27. See CMS Ex. 5, at 3-5; Tr. at 295.

Magnolia contends that the ALJ improperly faulted it for not sending Resident 1 to the hospital on its own initiative on July 25. RR at 7. Magnolia contends that there was no medical emergency on July 25, and thus no need to send Resident 1 to the hospital that day, because:

- the nursing staff observed only a small amount of bleeding on Resident 1's right leg;
- the nursing staff did not see any "open wound, cut or laceration" on Resident 1's right leg;
- the amount of swelling above Resident 1's right knee appeared to be the same throughout the evening shift on July 25;
- Resident 1's vital signs were "within normal limits";
- Nursing staff did not see any bleeding when pressing on Resident 1's right leg in the area of the apparent injury;
- Resident 1 did not show any signs of pain or

appear to be in any distress; and

- Resident 1 exhibited "normal" leg movements and did not appear to have limitation on her range of motion.

RR at 7-8. Magnolia asserts that given the observations of its nursing staff on July 25, it had "no reason to question the attending physician's order for an x-ray the next morning [July 26] and no reason to send Resident No. 1 to the emergency room on the night of July 25, 2005." Id. at 8.

We find this argument unpersuasive because, contrary to Magnolia's contention, the ALJ did not fault Magnolia for not sending Resident 1 to the hospital on the night of July 25. Instead, he faulted Magnolia for failing to recognize signs of a medical emergency[12] and to consult with a physician immediately about them. As discussed more fully in the next section, that failure contributed to a delay in Resident 1 receiving necessary medical treatment, some of which (antibiotics and stabilization) could have been provided at Magnolia or in a physician's office. Failure to notify a physician about a clinical condition that required immediate physician consultation and intervention in order to mitigate a risk of infection and more serious physical injury is clearly a failure to provide "necessary care and services" to ensure that a resident attains or maintains her highest practicable well-being. We thus uphold the ALJ's conclusion that Magnolia was not in substantial compliance with section 483.25.

3. *The ALJ's conclusion that Magnolia was not in substantial compliance with 42 C.F.R. § 483.75 as of July 25, 2005 is supported by substantial evidence and is not based on an error of law.*

Title 42 C.F.R. § 483.75, entitled "Administration," states in

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[12] Two of Magnolia's nurses testified that they did not recognize these signs. Nurse McCorkle testified that she did not suspect a bone fracture, only a "dislocation." Tr. at 306. In addition, Nurse Hodges, who changed Resident 1's dressing on the morning of July 27, testified that exposed bone would not always constitute a medical emergency, an opinion at odds with the testimony of CMS's medical expert, Dr. Obremskey. Tr. at 147, 339. Given Dr. Obremskey's qualifications and experience as an orthopedic trauma specialist, the ALJ reasonably gave more weight to his opinion than to the opinion of Nurse Hodges.

its prefatory paragraph that a facility "must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident." The ALJ concluded that Magnolia "was not administered" in the manner required by section 483.75 because it did not have policies, procedures, and other "systems" that were "effective" to prevent the violations of sections 483.10(b)(11)(i) and 483.25. ALJ Decision at 19. The ALJ noted that the citation of noncompliance with section 483.75, as formulated by the state survey agency, was "derivative of" the violations of sections 483.10(b)(11)(i) and 483.25, and that the Board has "approved derivative deficiencies cited under 42 C.F.R. § 483.75, in prior cases." Id. (citing Cross Creek Health Care Center, DAB No. 1665 (1998) and Eastwood Convalescent Center, DAB No. 2088 (2007).

Asserting that the ALJ's conclusion with respect to the requirement in section 483.75 was based solely on Nurse McCorkle's failure to notify the physician about Resident 1's bleeding and protruding bone, Magnolia contends that this single error does not by itself constitute a failure or lack of effective administration. RR at 10. Magnolia contends that it had "an appropriate system" in place to ensure that residents received necessary care – a system that included written resident care policies, "standing" treatment orders that are implemented for residents with certain conditions, and the use of "incident reports" that are reviewed by the director of nursing. Id. at 10-11. Magnolia also points to evidence which, it says, reveals that its nursing staff implemented or followed certain pre-established procedures and practices, including "repeated monitoring and assessment" of Resident 1, "repeated communications" between the nursing staff and Resident 1's attending physician and nurse practitioner, use of "24-hour report sheets" to ensure that information is relayed from shift to shift, and implementation of orders by the physician and nurse practitioner. Id.

We find this argument unpersuasive because at least one of the processes identified by Magnolia – investigation of significant incidents by the nursing director – was not effective in ensuring Resident 1's well-being. The record shows that Magnolia had procedures or policies that called for the nursing staff to report an accident and other significant events in writing to the nursing director. The nursing director would then review the report and investigate the incident to ensure that proper care had been or was being provided. See CMS Ex. 3, at 12-13; P. Ex. 28, at 3; Tr. at 283.

The evidence suggests that this process was not implemented or administered with the diligence or rigor that Resident 1's condition demanded. Nurse McCorkle testified that she phoned Nurse Clayton on July 25 to inform her about Resident 1's condition (Tr. at 280), but there is no documentation of any such call. Nurse Clayton told surveyors that she did not remember whether Nurse McCorkle phoned her about Resident 1 on July 25 but also stated that she did not learn about the bone protrusion until she read Nurse McCorkle's nursing notes. CMS Ex. 3, at 12. She also could not remember when she read the notes. Id.

Assuming that Nurse Clayton read the July 25 nursing notes, she should have questioned whether Nurse McCorkle had notified Dr. Nickerson about bone protrusion because those notes do not indicate that she consulted with Dr. Nickerson about that problem. Similarly, no records indicate that Nurse Clayton sought to confirm the adequacy of Nurse McCorkle's consultation with Dr. Nickerson at 10:15 p.m. on July 25, and Nurse Clayton told surveyors that she never personally examined Resident 1's knee to verify that Resident 1 was receiving appropriate treatment.[13] CMS Ex. 3, at 12. Under the circumstances, we cannot accept that Magnolia was administered in a way that enabled Resident 1 to achieve her highest practicable well-being. We thus uphold the ALJ's conclusion that Magnolia was not in substantial compliance with section 483.75.

4. *The ALJ did not err in concluding that CMS's immediate jeopardy determination was not clearly erroneous.*

As noted, "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" (emphasis added). Title 42 C.F.R. § 498.60(c) provides that CMS's determination about the level of noncompliance must be upheld unless it is clearly erroneous. The Board has held that section 498.60(c) places a heavy burden on a SNF to overturn CMS's finding regarding the level of noncompliance. Edgemont Healthcare, DAB No. 2202, at 20 (2008) (citing cases).

Magnolia contends that, if any deficiencies occurred, they were not serious enough to cause or result in immediate jeopardy

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[13] In addition, as we have discussed, Nurse McCorkle did not document her alleged telephone conversation with Nurse McCorkle at 10:30 p.m. on July 25.

because Resident 1 was monitored "constantly," she was "assessed for pain and treated accordingly," and her physician was consulted "immediately and on numerous occasions" between July 25 and 27, 2005. RR at 12. "Although [Resident 1] suffered an injury," says Magnolia, "it was not because of anything Magnolia did or did not do." Id.

This argument does not persuade us that the immediate jeopardy finding is clearly erroneous. Even if the noncompliance did not cause or result in actual harm to Resident 1, that fact would not be dispositive. An immediate jeopardy finding does not require proof that a resident was harmed as a result of a SNF's noncompliance; CMS need only determine that the noncompliance was "likely to cause" serious harm. Sunbridge Care and Rehabilitation for Pembroke, DAB No. 2170, at 34 (2008).

The basis for CMS's finding of noncompliance in this case was Magnolia's failure to consult immediately with a physician about signs of an open fracture of Resident 1's right leg. Magnolia does not dispute that failure to notify a physician about signs of an open fracture had the potential for causing serious harm. Instead, Magnolia suggests that the nursing staff's "monitoring," pain assessment, and other measures render such harm unlikely.

This contention overlooks the evidence of serious harm that can result absent immediate and accurate consultation with the physician. Dr. Obremskey testified that an open fracture requires prompt administration of antibiotics and debridement of the bone and wound in order to prevent infection, which Magnolia does not deny would constitute serious harm. Tr. at 147-48. Dr. Obremskey also testified that "bacteria proliferate fairly quickly," that the medical literature supported a conclusion that antibiotics should be administered within three hours after occurrence of an open fracture, and that "some of the best predictors of preventing long-term infection have been the timing of administration of antibiotics." Tr. at 136. The record shows Resident 1 did not receive antibiotic treatment until her hospitalization sometime around 12:00 p.m. on July 27, 2005, approximately 38 hours after Nurse McCorkle first reported bone protruding through the skin of Resident 1's right leg. See P. Ex. 18 (noting a prescription for "Ancef," an antibiotic, under "New Medications"); CMS Ex. 5, at 1-6.

Dr. Obremskey testified that debridement – that is, removal of foreign substances and dead or injured tissue – should be performed within 24 hours. Tr. at 135, 159. Resident 1 did not undergo debridement until she was hospitalized for surgery on July 27, approximately 38 hours after Nurse McCorkle reported

seeing bone protrusion. P. Ex. 19.

In addition, Dr. Obremskey testified that Resident 1's right leg needed to be stabilized or immobilized. Tr. at 147, 157. Both Nurse Deese and Dr. Obremskey testified – and Magnolia does not dispute – that immediate stabilization was necessary because Resident 1's periodic seizures and inability to control the movement of her legs posed a significant risk that she would aggravate the bone fracture or increase the skin wound. Tr. at 125, 157. As indicated, there is no evidence that Magnolia stabilized Resident 1's right leg during the period at issue (July 25-27, 2005).

In light of the evidence discussed, and because Dr. Nickerson indicated that he would have sent Resident 1 to the hospital on July 25 had he been told of bone protrusion that day, it is apparent that the nursing staff's noncompliance either caused or contributed to a delay in procuring treatment (antibiotics, debridement, and stabilization) necessary to prevent serious harm (e.g., infection and other related complications). That delay appears to be substantial (approximately 38 hours) and in excess of the timeframes specified by Dr. Obremskey for wound debridement and administration of antibiotics. Magnolia has not proven that delay in administering that treatment, or in stabilizing Resident 1's fractured leg, was not likely to cause serious harm. Nor does it point to any evidence that it took satisfactory steps to mitigate potential harm from the delay.

In short, Magnolia has not shown that the ALJ erred in concluding that Magnolia did not meet its heavy burden of showing that CMS's determination was clearly erroneous, and we affirm the ALJ's conclusion.

5. *The ALJ's conclusion regarding the duration of the noncompliance is supported by substantial evidence and not legally erroneous.*

The Board has held:

> Once a facility is found out of compliance it remains out of compliance until CMS finds that it has achieved substantial compliance based upon a revisit or after an examination of credible written evidence that it can verify without an on-site visit . . . . The skilled nursing facility has the burden of proving that it achieved substantial compliance on a date earlier than that determined by CMS.

Sunbridge Care and Rehabilitation for Pembroke at 36 (citations and internal quotations omitted).

After concluding that Magnolia was out of compliance on July 25, 2005 at the immediate jeopardy level, the ALJ found that Magnolia had "presented no credible evidence" that it abated the immediate jeopardy prior to October 20, 2005 or that it returned to substantial compliance before November 13, 2005. ALJ Decision at 21. Magnolia does not expressly challenge that finding in its request for review. See RR at 13-14 (stating only that it "denies that it was out of compliance during the time frame for which the CMP was imposed"). Nor does Magnolia point to any "credible evidence" that it abated the immediate jeopardy prior to October 20, 2005 or took corrective action sufficient to bring it back into substantial compliance before November 13, 2005.

Magnolia merely suggests that its noncompliance was short-lived and did not persist beyond July 27, 2005 when Resident 1 was hospitalized for surgery on her right leg. More specifically, Magnolia asserts that the circumstances triggering the deficiency citations were "isolated," and that "no other resident was affected before, during or after the timeframe that the alleged deficiency occurred and therefore it should be viewed as a single occurrence[.]" RR at 13-14. However, CMS's failure to identify other instances of noncompliance is not proof that Magnolia had corrected the noncompliance that arose on July 25, 2005.[14] As the ALJ correctly stated, achieving substantial compliance

> means not only that the specific cited instances of substandard care are corrected and that no other instances occur, but also, that the facility has implemented a plan of correction designed to assure that no such incidents occur in the future. The burden is on the *facility* to prove that it has resumed complying with program requirements, not on CMS to prove that deficiencies continued to exist after they were discovered.

ALJ Decision at 21 (citing Asbury Center at Johnson City, DAB No. 1815, at 19-20 (2002)); see also Franklin Care Center, DAB No. 1900, at 12-13 (2003); Barn Hill Care Center, DAB No. 1848, at

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[14] If Magnolia is contending that CMS was obligated to prove that noncompliance existed on all days on which the CMPs accrued, we note that our decisions have consistently rejected that view. See Briarwood Nursing Center, DAB No. 2115, at 16 (2007).

12-15 (2002). Here, Magnolia has not demonstrated that it took affirmative steps (i.e., implementation of a plan of correction) either to abate the immediate jeopardy before October 20, 2005 or to resume substantial compliance with all participation requirements before November 13, 2005.

For these reasons, we affirm the ALJ's conclusion that immediate jeopardy existed at Magnolia from July 25 through October 19, 2005, and that Magnolia remained in a state of noncompliance from October 20 through November 12, 2005.

6. *The per-day CMP amounts were reasonable.*

As noted, when CMS finds that a facility is or was not in substantial compliance, it may impose a CMP on the facility. The regulations authorize two types of CMP. CMS may, as it did here, impose a per-day CMP for the "number of days" that a SNF was not in substantial compliance with one or more participation requirements. 42 C.F.R. § 488.430(a). A "per day" CMP must fall within one of two ranges – an upper range of $3,050 to $10,000, or a lower range of $50 to $3,000. Id. § 488.438(a). The upper range is reserved for deficiencies that constitute immediate jeopardy (or for some "repeated" deficiencies). Id. § 488.438(a)(1)(i), (d)(2). The lower range is for deficiencies that do not constitute immediate jeopardy but either caused "actual harm" or had the "potential for more than minimal harm." Id. § 488.438(a)(1)(ii).

In lieu of a per day CMP, CMS may impose a CMP "for *each instance* that [the] facility is not in substantial compliance." 42 C.F.R. § 488.430(a) (italics added). A per-instance CMP must be in the range of $1,000 to $10,000 per instance. Id. § 488.438(a)(2).

A SNF may challenge the reasonableness of the CMP amount in an ALJ proceeding. CarePlex of Silver Spring, DAB No. 1683, at 11 (1999). In deciding whether a CMP amount is reasonable, an ALJ may consider only those factors specified in the regulations. Id.; see also 42 C.F.R. § 488.438(e), (f). Those factors include the SNF's financial condition and history of noncompliance. 42 C.F.R. § 488.438(f). An ALJ may not review CMS's "exercise of discretion" to impose a CMP. Id. § 488.438(e)(2). In other words, an ALJ may not review CMS's decision that a CMP – as opposed to some other remedy, or no remedy at all – is an appropriate response to the noncompliance found. The ALJ may review only whether the CMP amount chosen by CMS is reasonable.

Magnolia contends that the CMPs here were unwarranted because it was in substantial compliance with all participation requirements

from July 25 through November 12, 2005. RR at 13. We have affirmed the ALJ's conclusion that Magnolia was not in substantial compliance during that period, as well as his conclusion that CMS's immediate jeopardy finding was not clearly erroneous. Thus, the ALJ had an adequate legal basis to affirm the imposition of CMPs within the ranges specified in the regulations.

Magnolia contends that the CMPs were "excessive" for the following reasons. RR at 13. First, it asserts that the noncompliance involving Resident 1 was an aberration or isolated incident and that prior to the October 2005 survey, it had never been cited for failing to obtain appropriate treatment for a resident or failing to notify the physician or a family member about a significant change in a resident's condition or treatment. Id. Magnolia asserts that because no resident other than Resident 1 was affected by the noncompliance, the noncompliance should be regarded as a "single occurrence," warranting at most a per-instance CMP instead of the per-day CMP imposed by CMS. Id. at 13-14. Second, Magnolia submits that it had no history (prior to the survey) of being cited for noncompliance of high scope and severity. Id. at 14. And third, Magnolia contends that the ALJ improperly rejected its claim that the penalties would have a "negative impact on [its] stability" and "hinder [its] ability to continue to provide quality care to its residents." Id.

These contentions provide no basis for reducing or vacating the CMPs. As a preliminary matter, we have no authority to impose a per-instance CMP in lieu of the per-day CMPs imposed by CMS. The choice to impose a particular type of remedy is one that is committed to CMS's discretion by the regulations and not subject to Board review. Kenton Healthcare, LLC, DAB No. 2186, at 28 (2008) (citing 42 C.F.R. § 488.438(e)(2) and other regulations).

When it decides to impose a CMP on a per-day basis, CMS must set the per-day penalty amount within the upper and lower ranges specified in 42 C.F.R. § 488.438(a)(1). The ALJ correctly noted that the per-day CMP amounts that CMS imposed on Magnolia – $3,050 per day for the period of immediate jeopardy July 25 through October 19, 2005, and $50 per day thereafter – were the minimum amounts that CMS was permitted to impose under section 488.438(a)(1). As such, they are reasonable as a matter of law, regardless of Magnolia's financial condition, history of noncompliance, or other factors. Sheridan Health Care Center, DAB No. 2178, at 44 (2008); Premier Living and Rehab Center, DAB No. 2146, at 22 (2008) Century Care of Crystal Coast, DAB No. 2076, at 26 (2007). Once we determine that a legal basis existed

for CMS to impose a CMP within one of the regulatory penalty ranges, we have no authority to reduce the CMP amount below the minimum amount specified by the applicable penalty range. 42 C.F.R. § 488.438(e)(1), (2); Final Rule, *Medicare and Medicaid Programs; Survey, Certification and Enforcement of Skilled Nursing Facilities and Nursing Facilities*, 59 Fed.Reg. 56,116, 56206 ("[W]hen the administrative law judge or State hearing officer (or higher administrative review authority) finds noncompliance supporting the imposition of the civil money penalty, he or she must remedy it with some amount of penalty consistent with the ranges of penalty amounts established in § 488.438."); Century Care of Crystal Coast at 26.

7. *The ALJ committed no error or abuse of discretion in not making findings of fact and conclusions of law regarding other deficiencies cited during the October 2005 survey.*

In addition to alleging noncompliance with the participation requirements discussed earlier, the Statement of Deficiencies cited Magnolia for noncompliance with 42 C.F.R. §§ 483.25(m), 483.65(a), and 483.75(o). CMS Ex. 3, at 54, 57, 66. The surveyors found that this other noncompliance was at a level less than immediate jeopardy. See id.

At the end of CMS's presentation at the evidentiary hearing, Magnolia asked the ALJ to rule in its favor regarding the deficiency citations alleging noncompliance with sections 483.65(a) and 483.75(o), noting that CMS had presented no evidence to support those citations other than the Statement of Deficiencies, which it called a "charging document." Tr. at 263. The ALJ denied the motion. Tr. at 264-65.

In his decision, the ALJ stated that in the interest of "judicial economy," he had decided not to rule on the merits of certain citations in the Statement of Deficiencies – including the ones alleging noncompliance with sections 483.65(a) and 483.75(o) – because he believed that his conclusions regarding Magnolia's alleged noncompliance with sections 483.10(b)(11)(i), 483.25, and 483.75 were sufficient to support the remedies imposed by CMS. ALJ Decision at 9 n.4.

Magnolia now contends that the ALJ erred in not "dismissing" the deficiency citations alleging noncompliance with sections 483.65(a) and 483.75(o), asserting again that CMS had presented "no evidence" supporting those citations. RR at 14. The ALJ committed no error, however. He was under no obligation to issue a ruling on the merits of those citations at the evidentiary

hearing.[15] Furthermore, he committed no error in not addressing those citations in his June 13, 2008 decision. The Board has held that an "'ALJ has discretion, as an exercise of judicial economy, in determining whether to address findings that are not material to the outcome of a case[.]'" Grace Healthcare of Benton, DAB No. 2189, at 5 (2008) (quoting Western Care Management Corp. d/b/a Rehab Specialties, DAB No. 1921, at 19 (2004)). There may be instances, as the Board has noted, in which the ALJ's failure to address all of the deficiency findings could affect the remedy imposed by CMS and be prejudicial to the facility, such as when CMS relies on the additional deficiency findings in setting the amount of a CMP above the minimum amounts specified by regulation, or in determining that the facility had not achieved substantial compliance before a certain date. Harmony Court, DAB No. 1968, at 3 n.3 (2005). In this case, the ALJ found that the additional deficiency citations were not material to the outcome and that finding, as Magnolia does not dispute, is legally correct.

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[15] At the hearing, Magnolia was mistaken when it implied that the Statement of Deficiencies lacked evidentiary value. We have said that "the [Statement of Deficiencies] is a contemporaneous record of the survey agency's observations and investigative findings, and . . . CMS may make a prima facie showing of noncompliance based on that document if the factual findings and allegations it contains are specific, undisputed, and not inherently unreliable." Guardian Health Care Center, DAB No. 1943, at 14 (2004).

Conclusion

For the reasons set out above, we affirm the June 13, 2008 decision of the ALJ.

/s/
Sheila Ann Hegy

/s/
Leslie A. Sussan

/s/
Stephen M. Godek
Presiding Board Member