Department of Health and Human Services
DEPARTMENTAL APPEALS BOARD
Appellate Division

Cedar Lake Nursing Home
Docket No. A-11-29
Decision No. 2390
June 22, 2011

FINAL DECISION ON REVIEW OF ADMINISTRATIVE LAW JUDGE DECISION

Cedar Lake Nursing Home (Petitioner or Cedar Lake) appeals the September 27, 2010 decision of Administrative Law Judge (ALJ) Carolyn Cozad Hughes in *Cedar Lake Nursing Home*, DAB CR2252 (ALJ Decision). At issue before the ALJ was a determination by the Centers for Medicare & Medicaid Services (CMS) that Cedar Lake was not in substantial compliance with 42 C.F.R. § 483.25(k) as determined by a survey of the facility from April 13-16, 2009. The ALJ upheld CMS's determinations that Cedar Lake failed to comply substantially with section 483.25(k) because facility staff did not provide two of its residents with proper respiratory care and that its noncompliance posed immediate jeopardy to resident health and safety. In addition, the ALJ upheld CMS's imposition of a $9,500 per-instance civil money penalty (CMP).

For the reasons 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. Compliance with these requirements is verified by nursing home surveys conducted by state health agencies. 42 C.F.R. Part 488, subpart E. Survey findings are reported in a document called a Statement of Deficiencies (SOD). A "deficiency" is "any failure to meet a participation requirement." 42 C.F.R. § 488.301.

CMS may impose enforcement remedies on a SNF if it determines, on the basis of survey findings, that the facility is not in "substantial compliance" with one or more participation requirements. 42 C.F.R. § 488.402(b). A facility is not in substantial compliance when it has a deficiency that creates the potential for more than minimal harm to one or more residents. 42 C.F.R. § 488.301 (defining "substantial compliance" to mean the "level of compliance with the requirements of participation such that any identified deficiencies pose no greater risk to

resident health or safety than the potential for causing minimal harm"). Under the regulations, the term "noncompliance" means "any deficiency that causes a facility to not be in substantial compliance." *Id.*

The enforcement remedies that CMS may impose for a SNF's noncompliance include a per-instance CMP in the range of $1,000 to $10,000. 42 C.F.R. § 488.438(a)(2). 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), 488.438(f). The most serious noncompliance is that which puts one or more residents in "immediate jeopardy." *See* 42 C.F.R. §§ 488.404 (setting out the levels of scope and severity that CMS considers when selecting remedies), 488.438(a) (authorizing the highest CMPs for immediate jeopardy); State Operations Manual (SOM), CMS Pub. 100-07, § 7400.5.1.[1] Immediate jeopardy is defined as a situation in which the facility's noncompliance with one or more program requirements "has caused or is likely to cause serious injury, harm, impairment, or death to a resident." 42 C.F.R. § 488.301. For noncompliance determined to pose immediate jeopardy to facility residents, CMS may impose a per-instance CMP in an amount ranging from $1,000 to $10,000. 42 C.F.R. § 488.438(a)(2).

A SNF may request an ALJ hearing to contest a finding of noncompliance that has resulted in the imposition of a CMP or other enforcement remedy. 42 C.F.R. §§ 488.408(g)(1), 498.3(b)(13). In an ALJ proceeding, 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*, DAB No. 2069, at 7 (2007); *Batavia Nursing and Convalescent Center*, DAB No 1904 (2004), *aff'd, Batavia Nursing & Convalescent Ctr. v. Thompson*, 129 F. App'x 181 (6th Cir. 2005). "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." *Evergreene Nursing Care Center* at 7.

Section 483.25(k) provides that facilities "must ensure" that residents receive "proper treatment and care" for "special services." One of these "special services" is "[r]espiratory care." Section 483.25(k)(6). All of the special services delineated in section 483.25(k) are subject to the general quality of care requirement in the introductory statement in section 483.25 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

---

[1] The SOM is available on CMS's website at http://www.cms.hhs.gov/Manuals/IOM/ list.asp.

psychosocial well-being, in accordance with the comprehensive assessment and plan of care." Surveyors use a system of "tag numbers" to identify deficiencies under particular regulatory requirements in preparing the SOD. Section 483.25(k) deficiencies are cited under Tag F328. CMS Ex. 2, at 1.

The Board has held that a facility's failure to follow its own policies (as well as its failure to comply with physician orders or to provide services in accordance with a plan of care based on a resident's comprehensive assessment) can constitute a deficiency under section 483.25. *Woodland Village Nursing Center*, DAB No. 2053, at 9 (2006), *aff'd, Woodland Village Nursing Ctr. v. U.S. Dep't of Health & Human Servs.*, 239 F. App'x 80 (5th Cir. 2007), *citing Lakeridge Villa Health Care Center*, DAB No. 1988, at 22 (2005), *aff'd, v. Lakeridge Villa Health Care Ctr. v. Leavitt,* 202 F. App'x 903 (6th Cir. 2006).

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, http://www.hhs.gov/dab/guidelines/divisions/appellate/prov.html (Guidelines). Substantial evidence is "more than a mere scintilla. It means such relevant evidence as a reasonable mind might accept as adequate to support a conclusion." *Richardson v. Perales*, 402 U.S. 389, 401 (1971), quoting *Consolidated Edison Co. v. NLRB*, 305 U.S. 197, 229 (1938). Under the substantial evidence standard, the reviewer must examine the record as a whole and take into account whatever in the record fairly detracts from the weight of the evidence relied on in the decision below. *Universal Camera Corp. v. NLRB*, 340 U.S. 474, 488 (1951).

Case Background

Cedar Lake is a long-term care facility located in Malakoff, Texas, that participates in the Medicare program. From April 13-16, 2009, the Texas Department of Aging and Disability Services (State agency) conducted a survey of Cedar Lake and determined that the facility was not in substantial compliance with 42 C.F.R. § 483.25(k) (tag F328 – special needs) because it failed to provide proper respiratory care to two of its residents – R16 and R18. The citation regarding R16 was at the immediate jeopardy level, while the citation involving R18 was designated as non-immediate jeopardy. CMS Exhibit (Ex.) 2; P. Ex. 19, at 3. Based upon the survey results, CMS subsequently imposed a $9,500 per-instance CMP. CMS Ex. 1.

Cedar Lake timely requested a hearing before an ALJ. On June 29, 2010, the ALJ held a hearing, via video teleconference, from the offices of the Departmental Appeals Board in Washington, D.C. The parties convened in Dallas, Texas. The ALJ admitted into evidence CMS's Exhibits 1-22 and Petitioner's Exhibits 1-6, 8-10, and 14-25. Transcript (Tr.) at 5. CMS called the following witnesses: Surveyors Delores Williamson, R.N. and Teresa Horton, R.N., as well as Daniel J. McElroy, R.N. Cedar Lake called Paul Sanner, M.D., Licensed Vocational Nurse (LVN) Candace Seiber, Jo Sparks, R.N., C. Lynn Morgan, R.N., and Jeff Wilson, C.N.A. as witnesses. As per the ALJ's Scheduling Order, the direct testimony of these witnesses was submitted in written form prior to the hearing. Although counsel for Cedar Lake cross-examined Surveyors Williamson and Horton, Tr. at 9, 49, 80-81, CMS elected to cross-examine only Nurse Morgan. *Id.* at 82, 106. The parties also submitted post-hearing briefs.

ALJ Decision

The ALJ sustained CMS's determination that Cedar Lake was not in substantial compliance with section 483.25(k), because facility staff did not provide R16 and R18 with proper respiratory treatment and care. ALJ Decision at 7. The ALJ specifically found that Cedar Lake failed to ensure that R16 consistently received supplemental oxygen as ordered by her physician. *Id.* Regarding R18, the ALJ found that Cedar Lake did not follow physician orders and did not seek to clarify orders that were incomplete or ambiguous. *Id.* at 9-11.

An ALJ may review CMS's scope and severity findings (which include a finding of immediate jeopardy) only if a successful challenge would affect the range of the CMP, or if CMS has made a finding of substandard quality of care that results in the loss of approval of a facility's nurse aide training program. 42 C.F.R. § 498.3(b)(14); 42 C.F.R. § 498.3(d)(10); *see Evergreen Commons*, DAB No. 2175 (2008); *Aase Haugen Homes*, DAB No. 2013 (2006). Because, as the ALJ noted, the remedy imposed here is a per-instance CMP, for which the regulations provide only one range ($1,000 to $10,000), the level of noncompliance in this case does not affect the range of the CMP. ALJ Decision at 3, *citing* section 488.438(a)(2). The ALJ also found that CMS's scope and severity finding in this case did not affect approval of the facility's nurse aide training program because Cedar Lake does not have any such program in place. ALJ Decision at 3*, citing* CMS Ex. 21, at 2. In any event, where, as here, the facility has been assessed a CMP of $5,000 or more, the State agency is precluded by law from approving its nurse aide training program. *See* Act § 1819(f)(2)(B); 42 C.F.R. § 483.151(b)(2)(iv). The ALJ concluded that she had no authority to review CMS's determination that the scope and severity of the noncompliance regarding

one of the residents was the immediate jeopardy level. ALJ Decision at 3. Finally, the ALJ found that the amount of the $9,500 per-instance CMP was reasonable. *Id.* at 12-13.

Analysis

Cedar Lake noted in its brief that it argued before the ALJ the noncompliance "citation has no factual or regulatory basis." Petitioner's Request for Review (RR) at 3. On appeal, Cedar Lake reiterates many of the same arguments that it raised before the ALJ – *i.e.*, that it substantially complied with section 483.25(k) and that it followed the physicians' orders regarding respiratory care to be provided to R16 and R18. RR at 4, 6, 8-9.[2] Cedar Lake also contends on appeal that the amount of the CMP is not reasonable primarily because "these residents did not suffer any harm and were not placed in immediate jeopardy." *Id.* at 14-15. We address below why Cedar Lake's arguments are without merit.[3]

A. The ALJ's conclusion that Cedar Lake was not in substantial compliance with 42 C.F.R. § 483.25(k) is supported by substantial evidence in the record and is free from legal error.[4]

1. Cedar Lake did not provide proper respiratory care to R16.

R16 was an 81-year-old woman suffering from congestive heart failure, peripheral vascular disease, seizure disorder, depression, and chronic obstructive pulmonary disease (COPD). CMS Ex. 5, at 6. Her physician ordered supplemental oxygen to be delivered by means of a nasal cannula at a rate of two liters per minute (L/M). ALJ Decision at 3-4, *citing* CMS Ex. 5, at 8, 13; CMS Ex. 8, at 5; CMS Ex. 9; P. Ex. 10. The ALJ found (and Cedar Lake concedes) that R16's physician had not ordered any parameters for maintaining oxygen saturation levels at the time of the of the incident here. ALJ Decision at 4, *citing* P. Cl. Br. at 4 (*citing* P. Ex. 10).

Surveyor Delores Williamson, R.N., testified that during the State agency's survey at 10:52 a.m. on April 15, she observed R16 "sitting in her wheelchair, lethargic,

---

[2] Cedar Lake does not contest the ALJ's conclusion that she lacked authority to review CMS's determination of immediate jeopardy. RR at 3.

[3] We have fully considered all arguments raised on appeal and reviewed the full record, regardless of whether we have specifically addressed particular assertions or documents in this decision.

[4] The information in this section is drawn from the ALJ Decision and the record before the ALJ and is intended to provide a context for a discussion of the issues raised on appeal. Nothing in this section is intended to replace, modify, or supplement the ALJ's findings of fact or conclusions of law.

without movement, with her eyes closed and with [only] one prong of her nasal oxygen tubing in her nose." CMS Ex. 21, at 3; Tr. at 22. Surveyor Williams also noted that R16's color was "dusky[.]" CMS Ex. 13, at 1; Tr. at 26, 30. R16 told Surveyor Williams that "she was having trouble breathing, did not feel well and was tired." CMS Ex. 21, at 3; Tr. at 26. It is not contested that fatigue, lethargy, and difficulty breathing can be symptoms of oxygen deprivation. CMS Ex. 17; CMS Ex. 21, at 3; Oral Argument Tr. (OA Tr.) at 21-22. R16 had a portable oxygen tank (E-tank) on the back of her wheelchair. *See* CMS Ex. 2, at 4-5; CMS Ex. 18, at 4-5; CMS Ex. 20, at 13; Tr. at 18.

Surveyor Williamson testified that she examined the E-tank's gauge, observed that it was empty and summoned a nurse. CMS Ex. 21, at 3; Tr. at 18-19, 20. LVN Seiber came into the room at 10:56 a.m. CMS Ex. 21, at 3. LVN Seiber assessed R16 and found that her oxygen saturation level was 85% and her pulse was 103. P. Ex. 4, at 1; P. Ex. 2, at 2, 5; CMS Ex. 21, at 3; CMS Ex. 13, at 1; Tr. at 29. The ALJ found that the applicable standard of care required that "[i]n general, residents with oxygen saturation readings below 90% with pulse oximeter should have oxygen applied." ALJ Decision at 4, *citing* CMS Ex. 15, at 7. Surveyor Williams testified that "[f]or most patients[,] a pulse of 70 to 80 beats per minute would be considered normal." CMS Ex. 21, at 3; *see also* Tr. at 31. A pulse of 103 is consistent with oxygen deprivation – the heart speeds up to pump more oxygenated blood throughout the body. CMS Ex. 21, at 3. R16 subsequently asked to be put to bed, which required her to be disconnected from her E-tank and connected to an oxygen concentrator, which is a pump-like device that concentrates room oxygen and delivers it to the patient through a tube to a nasal cannula, or face mask. CMS Ex. 18, at 3; CMS Ex. 20, at 11-12; CMS Ex. 21, at 3-4; Tr. at 25-26. As the ALJ pointed out, "the tube must be attached to both the oxygen concentrator and the cannula/face mask, or the patient will not get the oxygen." ALJ Decision at 5, *citing* CMS Ex. 21, at 4.

LVN Seiber removed R16 from the E-tank and turned on the oxygen concentrator. P. Ex. 4, at 1; P. Ex. 2, at 2, 5. LVN Seiber also rubbed R16's back, instructed her to take deep breaths, and, after a few minutes, re-checked her oxygen saturation level, which had risen to 91%, according to the surveyor.[5] P. Ex. 4, at 1; P. Ex. 2, at 2, 5; CMS Ex. 13, at 1; Tr. at 30-31, 41. LVN Seiber then left the room to get assistance to help R16 get into her bed. P. Ex 2, at 2. Surveyor Williamson remained in R16's room after LVN Seiber left and observed that R16 continued to be tired and lethargic. CMS Ex. 2, at 5. At 11:21 a.m., when R16 again stated that she wanted to go to bed, Surveyor Williamson got another nurse, LVN Terry

---

[5] Surveyor Williamson testified that R16's oxygen saturation level could have initially improved as a result of LVN Seiber's rubbing R16's back and encouraging her to breath deeply. Tr. at 41.

McCan, who determined that R16's oxygen saturation level was 86% and her pulse was 104. CMS Ex. 2, at 5-6; CMS Ex. 13, at 2; CMS Ex. 21, at 4. LVN McCan examined the concentrator and told Surveyor Williamson that the tubing had not been connected to the concentrator. CMS Ex. 13, at 2; CMS Ex. 21, at 4; CMS Ex. 2, at 6; Tr. at 43. After LVN McCan connected the tubing to the concentrator, R16 "began coughing [up] thick, yellow sputum." P. Ex. 4, at 1. LVN McCan then increased the flow of oxygen to from 2 L/M to 3 L/M. *Id.* Surveyor Williamson testified that within seven minutes of being connected to the oxygen concentrator, R16's condition improved significantly – she became alert and able to carry on a conversation, and her color changed from dusky to pink. CMS Ex. 21, at 4; Tr. at 26-27, 43-44, 48.

Based on her observations that R16's E-tank was empty and that R16's appearance and condition significantly improved after she received supplemental oxygen, as well as LVN McCan's statement that R16 was not connected to the oxygen concentrator, Surveyor Williamson testified that R16 had suffered respiratory distress due to oxygen deprivation. CMS Ex. 21, at 4-5; CMS Ex. 2, at 2, 6; Tr. at 22, 26.

The ALJ found that "contemporaneous statements from the facility nurses, medical director, and R16's physician confirm that, on April 15, R16 was without the supplemental oxygen her physician had ordered and that she exhibited symptoms of respiratory distress." ALJ Decision at 7. For example, the ALJ found that the nurses' notes, dated April 15 and 16, are consistent with Surveyor Williamson's testimony with respect to all material facts as indicated below. *Id.* at 5.

- In a note dated April 15, LVN Seiber wrote that at "approx[imately] 10:45" she was notified by Surveyor Williamson that R16's "<u>O^2 tank was out or turned off.</u>" P. Ex. 4, at 1 (emphasis added). LVN Seiber went to R16's room and found R16 sitting in her wheelchair, saying that she wanted to go to bed. *Id.* LVN Seiber noted that R16 was wheezing, and her oxygen saturation level was 85%. *Id.* LVN Seiber took the resident off the wheelchair tank and "put on [the] concentrator" with nasal cannula. *Id.* She rubbed the resident's back and told her to breathe in through her nose and out through her mouth. *Id.* LVN Seiber also wrote that approximately three to five minutes later, R16's oxygen saturation level had risen to 95%. *Id.*

- In a nursing note dated April 16, LVN Seiber wrote that she was sitting at the nurses' station when the surveyor approached to say that R16's oxygen tank "<u>looks like its off.</u>" P. Ex. 2, at 2, 5 (emphasis added). According to the note, LVN Seiber and Surveyor Williamson "walked down to [R16's]

room." *Id.* LVN Seiber wrote – "I checked on [the] tank[,] and tank was out not off[.]" *Id.* LVN further wrote that she found R16 "wheezing" and, at the surveyor's request, checked R16's oxygen saturation level, which was 85%. *Id.* LVN Seiber noted that she put the oxygen concentrator's nasal cannula in place, and turned on the concentrator. *Id.* She then rechecked R16's oxygen saturation level, which, according to the note, read 95%. *Id.* The noted further states that LVN Seiber told R16 to breathe in through her nose and out through her mouth. *Id.*

- A nursing note dated April 15 by LVN McCan states that, at 10:50 a.m., she was called into the resident's room and assisted the nurse aide in putting the resident back to bed. LVN McCan wrote that she noticed R16's nasal cannula was "connected to empty e-tank[.]" P. Ex. 4, at 1 (emphasis added). The note further indicates that R16's oxygen saturation level was at 87%. *Id.* LVN McCan then put R16 on the concentrator, which was set at 2 L/M. R16 began coughing up thick, yellow sputum; so LVN McCan increased the oxygen flow rate to 3 L/M and encouraged the resident to breathe in through her nose and out through her mouth. *Id.* After these steps, R16's oxygen saturation level increased to 96%. According to the note, R16 had complained that she had not slept well the night before because of her roommate's TV. *Id.*

- In another nursing note dated April 15, LVN McCan wrote that, at 11:20 a.m., R16's oxygen saturation level was at 94%, with oxygen administered at 2 L/M via nasal cannula on concentrator. P. Ex. 4, at 1. LVN McCan noted that R16's physician, Dr. Sanner, had been notified, who ordered that the oxygen be administered at 2-3 L/M via nasal cannula "to maintain O^2 sat ↑ 88%" – *i.e.*, above 88%. *Id.* LVN McCan's note further stated that Dr. Sanner directed staff to monitor R16's oxygen saturation level hourly for 24 hours. *Id.* LVN McCan also noted that R16 no longer was coughing or showing congestion. *Id.*

- In a typed statement dated April 16, 2009, R16's attending physician, Dr. Sanner, wrote that, at approximately 11:20 a.m. on April 15, he "was notified of the incident" involving R16. P. Ex. 3, at 2. Dr. Sanner wrote that staff reported that a state surveyor noticed that R16's oxygen tank was off. Dr. Sanner also states that facility "staff determined that she had been without oxygen supplementation for approximately 30-45 minutes; her O^2 sat was 85%; she complained that she was tired; she was wheezing and had a cough with thick yellow sputum. Staff put her back on oxygen per nasal cannula at 2 L/M then increased the rate to 3 L/M, and her O^2 sat level rose to 96%." *Id.* (emphasis added).

We agree with the ALJ that "overwhelming evidence" supports her finding that R16 had been deprived of oxygen because her E-tank was empty and the concentrator had not been connected. ALJ Decision at 7. The contemporaneous notes by more than one facility staff member are consistent with these ALJ findings. Dr. Sanner's initial assessment of the situation is particularly significant because it was based on information from the facility staff. Thus, the assessment that R16 had been without oxygen for 30-45 minutes originated with the facility staff, not with Surveyor Williamson.

Nonetheless, Cedar Lake argues that its staff followed the physician's orders to provide R16 continuous supplemental oxygen at 2 L/M and that R16 "was never without oxygen at any time on April 15." RR at 8 (emphasis in original). Cedar Lake contends that "Ms. Seiber determined that the tank was, in fact, not off, and that it was not empty." RR at 4, *citing* P. Ex. 1. Cedar Lake argues that the tank was "near empty" and that "there was still a small amount of oxygen in the tank." *Id.* In support of this claim, Cedar Lake points to LVN Seiber's testimony stating: "I checked the tank. The tank was not off. I personally observed the gauge on the tank, and it was not empty. The gauge was close to the red zone, which is where the gauge goes just before the tank empties, but the gauge was not yet on empty." P. Ex. 21, at 1; *see also* P. Ex. 1 (LVN Seiber's statement that "I observed the gauge on the tank, and it was not yet empty.")

However, as the ALJ found, LVN Seiber's testimony was inconsistent with her contemporaneous nursing notes on April 15 and 16. Specifically, the ALJ stated:

> I find not credible, although of marginal relevance, LVN Seiber's subsequent inconsistent claims that, when she entered R16's room on the morning of April 15, the resident's E-tank was not off, and the gauge was not on empty.

ALJ Decision at 6, *citing* P. Ex. 21, at 1.

In general, the Board defers to an ALJ's findings on credibility of witness testimony unless there are compelling reasons not to do so. *Woodland*, DAB No. 2355, at 7; *Koester Pavilion*, DAB No. 1750, at 15, 21 (2000). The Board has also previously held that an ALJ may reasonably give more weight to contemporaneous documentation of a resident's condition than to after-the-fact testimony. *See Woodland*, DAB No. 2355, at 8; *Jennifer Matthew Nursing & Rehabilitation Center,* DAB No. 2192, at 10-11 (2008) (finding nothing improper about according more weight to "eyewitness contemporaneous statements" in appropriate circumstances).

Here, the ALJ correctly found that LVN Seiber's written testimony was inconsistent with her contemporaneous nursing note stating the "tank was out not off." P. Ex. 2, at 2, 5. Moreover, LVN Sieiber's testimony is not consistent with the contemporaneous nursing notes of LVN McCan (who did not testify at the hearing) that the E-tank was empty (P. Ex. 4, at 1) and her statement to Surveyor Williamson that the tube was not connected to the oxygen concentrator (CMS Ex. 21, at 4), nor is it consistent with the initial assessment by Dr. Sanner that facility staff had determined that R16 had been deprived of oxygen for 30-45 minutes (P. Ex. 3, at 2). LVN Seiber's testimony is also inconsistent with the physical symptoms displayed by R16 such as "dusky" color, fatigue, lethargy, and difficulty breathing (CMS Ex. 13, at 1; CMS Ex. 21, at 3; Tr. at 26, 30). Her testimony is also inconsistent with the uncontested facts that, when R16 received supplemental oxygen on that date as ordered, she was able to open her eyes, sit up straight, and have a conversation with Surveyor Williamson. CMS Ex. 2, at 6; CMS Ex. 21, at 4; Tr. at 43-44, 48. In addition, R16 stopped yawning, and Surveyor Williamson could no longer hear the crackling, rattling noises by R16 on inspiration and expiration. *Id.* Furthermore, R16's color changed from "dusky" to "pink," and she was no longer lethargic. *Id.*

Cedar Lake has not provided a compelling reason why we should not defer to the ALJ's credibility determination about LVN Seiber's testimony. Counsel for Cedar Lake conceded during oral argument that Dr. Sanner does not deny that R16 was actually without oxygen for some period of time. OA Tr. at 25-26. LVN Seiber's testimony thus stands alone in the face of her own contrary contemporaneous notes, other facility records, the attending physician's statement and counsel's concession. For these reasons, the ALJ's conclusion that Cedar Lake failed to provide proper respiratory care to R16 is supported by substantial evidence in the record and is free from legal error.

2. Cedar Lake did not provide proper respiratory care to R18.

R18 was a 72-year old man with COPD, and his physician ordered that R18 receive continuous oxygen via nasal cannula at a rate of 5 L/M to maintain oxygen saturation levels from 88% to 93%. CMS Ex. 12, at 22; CMS Ex. 22, at 3. Because elderly patients with COPD often have difficulty fully exhaling carbon dioxide, it is common for physicians to order lower oxygen saturation levels. CMS Ex. 22, at 3; CMS Ex. 19. In addition, R18's physician ordered a bi-level positive airway pressure machine (BiPAP) for R18 to use at bedtime. CMS Ex. 12, at 30; CMS Ex. 16, at 1; CMS Ex. 22 at 3; Tr. at 54, 58. The BiPAP machine provides a vehicle through which oxygen is delivered and is frequently used to treat sleep apnea and other breathing disorders. *Id.* The BiPAP machine helps someone breathe while asleep – *i.e.*, if a person stops breathing when asleep, the BiPAP machine will force air in. OA Tr. at 82-84. The BiPAP machine and the

oxygen delivery system operate independently. One line administering oxygen from the tank is connected to the patient's mask, while a separate line from the BiPAP machine is also connected to the mask. The settings on the BiPAP machine do not control the oxygen flow rate to the patient. *See* RR at 9-10, *citing* CMS Exs. 19 and 22; OA Tr. 82-84.

Surveyor Theresa Horton testified that, during the April 2009 survey, she saw R18's wife push his wheelchair to the nurses' station, and R18 then advised the staff that his oxygen tank was empty and needed to be refilled. Tr. at 51-52. Surveyor Horton interviewed R18, who told her that the nurses "put too much oxygen through his BiPAP machine," which scared him. Tr. at 54, 58, 59. Surveyor Horton checked R18's treatment records and observed that his oxygen saturation levels were as high as 98% at night. Tr. at 58. Surveyor Horton also observed that at 1:00 a.m. on March 15, 2009, nurses recorded that they administered oxygen to him at the physician-ordered rate of 5 L/M but R18's oxygen saturation increased to 98%. P. Ex. 17, at 2; CMS Ex. 12, at 47; Tr. at 63. After R18 complained that his oxygen level was too high, the nursing staff decreased the rate to 3 L/M, and his oxygen saturation level dropped to 92%. *Id.* Cedar Lake does not contest the ALJ's conclusion that "[n]o evidence suggests that the nurse contacted the physician before she decreased the amount of oxygen or anytime thereafter." ALJ Decision at 10. Nor does Cedar Lake contest the ALJ's finding that facility records show that R18's nightly oxygen saturation levels were often too high. *Id.* at 10-11.

Cedar Lake argues that its staff did not violate physician orders regarding the oxygen saturation levels for R18 on March 15 and 16 because no physician order setting parameters for this resident's oxygen saturation level was issued until March 18. RR at 12. The ALJ correctly found that Cedar Lake's argument is without merit:

> Under Petitioner's theory, staff would have been providing supplemental oxygen without any physician order, which is a serious deficiency. Presumably, however, an earlier order was in place that called for supplemental oxygen. That order should have included acceptable parameters for the resident's [oxygen saturation] levels. If no parameters were in place, the facility should have obtained them from R18's

> attending physician, who was, after all, the facility's medical director. Otherwise, assuming that facility staff were following the physician's order, they were administering oxygen without regard to the resident's [oxygen saturation] levels, putting him at risk for serious harm.

ALJ Decision at 10. Cedar Lake does not challenge the ALJ's reasoning stated above, nor does it explain why facility staff would administer oxygen without contacting the physician to ascertain what saturation levels would be appropriate. Thus, we find that the ALJ reasonably concluded that either Cedar Lake had a physician order establishing the oxygen saturation parameters for R18 prior to March 18 or facility staff should not have administered oxygen without contacting R18's physician to clarify what the parameters needed to be.

Cedar Lake cites oxygen saturation levels established by R18's physician as of March 18. RR at 12, *citing* P. Exs. 15 and 19. However, as to those parameters, the ALJ found that the oxygen saturation levels "regularly exceeded the ordered parameters." *Id.* Specifically, the ALJ found that the facility records show on April 1, R18's saturation levels ranged from 94% to 96% at night (P. Ex. 17, at 3, 4); on April 7, they were up to 97% at night (*id.* at 13, 14); on April 10, the levels were 98% at night (*id.* at 21); and on April 13, they were at 94% at night (*id.* at 64). On appeal, Cedar Lake does not dispute these ALJ findings. *See* RR at 12.

Despite R18's experiencing oxygen saturation levels exceeding the parameters ordered, the facility did not consult R18's physician about the high levels. The facility does not contest these findings. Instead, the facility argues that the high levels were not the result of staff's failure to follow physician orders but were related to R18's underlying medical conditions. RR at 13. However, the issue is not what caused the high oxygen saturation levels but whether facility staff followed the physician's orders to maintain the levels within established parameters, which the evidence shows it did not do on at least four occasions, and yet the facility staff did not attempt to notify R18's physician about those situations. Tr. at 58-60, 63.

Finally, the ALJ found that R18's physician did not provide instructions as to the BiPAP's settings. ALJ Decision at 11; *see also* Tr. at 55. The ALJ accepted the unrebutted testimony from Surveyor Horton that –

> the standards of practice dictate that the facility obtain a physician's order for the BiPAP settings. If the physician does not include them in his orders, staff should let him/her know that they need the

> information. If, by following the physician's orders, staff are unable to maintain the desired O^2 levels, they must also notify him so he can adjust his orders.

Id., citing Tr. at 55-57. Cedar Lake argued before the ALJ that only a physician or respiratory therapist determines the BiPAP settings, so the physician did not need to include them in his orders. The ALJ rejected this argument stating:

> No one disputes that the physician determines what the settings should be, but CMS correctly maintains that the physician must include that information in his orders. Moreover, Petitioner's claim is inconsistent with R18's care plan, which says that *nurses* will maintain "BiPAP setting per orders." In order to maintain those settings, nurses obviously needed to know what they are supposed to be.

ALJ Decision at 11 (citation omitted).

On appeal, Cedar Lake reiterates its argument that it did not fail to follow the physician's orders regarding the BiPAP settings because only a physician or respiratory therapist, not nurses, can adjust the settings on the BiPAP machine and that when R18 was admitted to the facility, his machine had the settings already established. RR at 10. Thus, Cedar Lake asserts the nursing staff had no order to follow. *Id.* This argument is without merit.

We assume for the sake of argument that Cedar Lake is correct in stating that nurses cannot change the settings on the BiPAP machine. *See* Tr. at 104 (Nurse Morgan testified that "the BiPAP machine settings were adjusted by a respiratory therapist and the physician, not by staff facility."). However, the nurses can still observe whether the settings are in the range that the physician ordered. If the initial settings became changed in some way, then the nurses could notify the physician so that the respiratory therapist could adjust them. Tr. at 56. As the ALJ observed, even though the nursing staff would not adjust the settings on the BiPAP machine, they needed to know what the settings should be so that they could be maintained. ALJ Decision at 11. If the physician order does not state what the settings are to be, then the nursing staff, by definition, could not "maintain" them. Cedar Lake does not dispute that the facility's nursing staff failed to contact the physician to ascertain what the correct settings should be, thereby putting R18 at risk if the settings were altered. Thus, we find that the ALJ reasonably concluded there was no physician order establishing the BiPAP settings at any time and that facility staff did not contact R18's physician to clarify what the settings needed to be as required by the standards of practice. *Id.*

For these reasons, the ALJ's conclusion that Cedar Lake failed to provide proper respiratory care to R18 is supported by substantial evidence in the record and is free from legal error.

B. The ALJ's conclusion that the amount of the per-instance CMP is reasonable is not erroneous.

When a per-instance CMP is imposed based on a finding of noncompliance, the CMP must be in the range of $1,000 to $10,000. Section 488.438(a)(2). In determining the amount of a CMP, CMS and the ALJ must use the factors listed at section 488.438(f), which are: (1) the facility's history of noncompliance; (2) the facility's financial condition; (3) factors specified in 42 C.F.R. § 488.404; and (4) the facility's degree of culpability, which includes neglect, indifference, or disregard for resident care, comfort or safety. Section 488.438(f) also states: "The absence of culpability is not a mitigating circumstance in reducing the amount of the penalty." *Id.* Section 488.404 includes as factors the seriousness of and relationship among the deficiencies and the facility's history of noncompliance in general and specifically as to the cited deficiencies.

The Board has held that in assessing whether CMP amounts are within a reasonable range, the ALJ should not look into CMS's internal decision-making process but rather should make a de novo determination by applying the regulatory criteria based on the record developed before the ALJ. *See, e.g.*, *Kingsville Nursing and Rehabilitation Center*, DAB No. 2234, at 15, and cases cited therein. The Board has also held that in considering the reasonableness of the amount of the CMP imposed, the ALJ's evaluation should focus on "whether the evidence presented in the record concerning the relevant regulatory factors supports a finding that the amount of the CMP is at a level reasonably related to an effort to produce corrective action by a provider with the kind of deficiencies found and in light of the other factors involved (financial condition, facility history, and culpability)." *Wisteria Care Center*, DAB No. 1892, at 11 (2003), *quoting CarePlex of Silver Spring*, DAB No. 1683, at 8 (1999). Finally, the Board has held that "whether the CMP amount is reasonable is a legal conclusion to be drawn from the application of regulatory criteria to the facts of the case." *Cedar Lake Nursing Home*, DAB No. 2288, at 14 (2009); *aff'd, Cedar Lake Nursing Home v. U.S. Dep't of Health & Human Servs.*, 619 F.3d 453 (5th Cir. 2010), *reh'g denied*, No. 10-60112 (5th Cir. 2010).

The ALJ determined that the $9,500 per-instance CMP imposed by CMS was reasonable in amount. The ALJ Decision addresses the regulatory factors as follows. First, CMS imposed just one $9,500 per-instance CMP. Although the amount is at upper end of the penalty range ($1,000-$10,000), the ALJ concluded that the CMP is modest under the circumstances. ALJ Decision at 13. Second, the

ALJ rejected as "disingenuous" Cedar Lake's assertion that it "does not have a history of uncorrected F328 violations." ALJ Decision at 13. The ALJ observed that "just two months prior to this survey (February 2009), it failed to provide proper respiratory care to one of its residents and was therefore not in substantial compliance with 42 C.F.R. § 483.25(k)." *Id., citing Cedar Lake Nursing Home*, DAB CR2137 (2010).[6] As the ALJ observed, the imposition of a $6,000 per-instance CMP based on noncompliance with the same requirements in February 2009 obviously "proved insufficient to produce ongoing corrective action" in light of the repeat noncompliance found in April 2009. ALJ Decision at 13. The ALJ also considered that based on a March 2008 survey, Cedar Lake was not in substantial compliance with 42 C.F.R. § 483.25(h) (accident prevention), and CMS imposed a $5,000 per-instance CMP. *Id., citing Cedar Lake*, DAB No. 2288. The ALJ concluded that the $5,000 CMP was "insufficient." *Id.* The ALJ also concluded that the facility is culpable because "[i]t did not follow physician orders and did not clarify ambiguous or incomplete orders, which caused its residents significant distress and put them at risk of even more serious harm." *Id.* Finally, Cedar Lake did not contend before the ALJ (or on appeal) that its financial condition affects its ability to pay the CMP.

On appeal, Cedar Lake asserts that the amount of the CMP is excessive under the facts of this case for three primary reasons. We disagree for the reasons that we address below.

1. The ALJ did not err in considering the seriousness of the noncompliance when evaluating the reasonableness of the CMP amount.

First, Cedar Lake asserts that the CMP is excessive because the "treating physicians for the residents whose care is at issue here confirmed that these residents did not suffer any actual harm and were not placed in immediate jeopardy." RR at 15. Cedar Lake also contends that R16's symptoms, while consistent with someone suffering respiratory distress, were simply a manifestation of her underlying medical condition and her lack of sleep the previous night. *Id.* at 5, 8. Cedar Lake further contends that "Dr. Sanner is in the best position to know the condition of his patient, and it is his opinion that [R16] was not in respiratory distress at any time on April 15, 2009" and that R16 could go up to an hour without supplemental oxygen because she could maintain her "baseline" oxygen saturation rate of 85% on room air. *Id.* at 5-7; OA Tr. at 17, 25;

---

[6] The Board recently affirmed the ALJ Decision in DAB CR2137, including the reasonableness of the amount of the CMP. *See Cedar Lake Nursing Home*, DAB No. 2344 (2010).

P. Ex. 3, at 2; P. Ex. 24. However, the ALJ rejected Cedar Lake's assertions "as unsupported by any reliable evidence." ALJ Decision at 7. For the reasons addressed below, we agree with the ALJ.[7]

As an initial matter, it appears that Cedar Lake is attempting to collaterally challenge CMS's immediate jeopardy determination by arguing that the noncompliance was not serious enough to warrant a $9,500 CMP because R16 did not suffer any actual harm. However, Dr. Sanner's opinion that R16 was not in immediate jeopardy is not an issue in this case because the ALJ had no authority to review CMS's finding of immediate jeopardy under the circumstances of this case, which Cedar Lake does not contest.[8] *See* ALJ Decision at 3; RR at 3.

At oral argument, Cedar Lake contended that Dr. Sanner's testimony is unrebutted and must be accepted as a matter of law because CMS did not proffer an expert witness who was a physician and because CMS did not object to any portion of his direct testimony. OA Tr. at 11. Having rejected Dr. Sanner's factual premise (*i.e.*, that an 85% saturation rate was baseline for R16), the ALJ was not bound to accept his opinion based on the premise that being deprived of supplemental

---

[7] During oral argument Cedar Lake argued for the first time that the ALJ had no basis to determine Dr. Sanner's credibility and committed procedural error because she did not permit Dr. Sanner to testify in person after CMS decided not to cross-examine him. OA Tr. at 7, 8-9. This argument is without merit. Counsel for Cedar Lake stated during oral argument that had Dr. Sanner testified, he would have answered questions about the baseline condition of R16 based upon his experience as her treating physician for over 11 years. OA Tr. at 10-11, 17. However, Dr. Sanner had already testified about this issue in his affidavit and should have presented any additional information he had to support his assertions at that time. *See* P. Ex. 24; *see also* P. Ex. 3, at 2. Moreover, the record indicates that Cedar Lake neither made a proffer of what Dr. Sanner's additional testimony would be, nor sought to call him as a rebuttal witness. Indeed, when asked by the ALJ what additional factual information would be elicited from Dr. Sanner, counsel for Cedar Lake replied: "[T]here's none. We will stand on Dr. Sanner's affidavit [P. Ex. 24] and his prior statement [P. Ex. 3, at 2]." *Id.* at 107. Thus, we find no prejudicial error.

[8] The Board has held that "the regulations which permit an [ALJ] to consider the seriousness of a SNF's noncompliance in assessing the reasonableness of a CMP amount do not authorize the [ALJ] (or the Board) to entertain a dispute about the merits of a finding by CMS about the severity and scope of the noncompliance if that finding is non-appealable under 42 C.F.R. Part 498." *Oaks of Mid-City Nursing and Convalescent Center*, DAB No. 2375, at 26 n.12 (2011), *citing* NHC Healthcare Athens, DAB No. 2258, at 16-17 (2009).

oxygen would not present a potential for more than minimal harm to R16 (the standard necessary to establish noncompliance). ALJ Decision at 8.[9] Moreover, Dr. Sanner's conclusions on noncompliance or the level of noncompliance (including immediate jeopardy) are legal conclusions rather than a matter of medical expertise, and the ALJ was free to reject those conclusions. *See Dumas Nursing and Rehabilitation*, L.P., DAB No. 2347, at 19 (2010) ("an administrative law judge is not bound by a witness's legal conclusions"), *citing Guardian Health Care Center*, DAB No. 1943, at 11 (2004). Furthermore, Cedar Lake provided no authority requiring a fact-finder to accept expert testimony that is not intrinsically persuasive or that contradicts other evidence in the record, even in the absence of contrary expert testimony.

Cedar Lake next argues that, as a registered nurse, Surveyor Williamson is prohibited under Texas law from rendering a medical diagnosis or opining as to the cause of any medical diagnosis – *i.e.*, that R16 suffered respiratory distress due to oxygen deprivation. RR at 7-8; OA Tr. at 12, 14-15, 21-22. Cedar Lake contends that "[t]hese determinations can only be made by a licensed physician, and in this case the physician determined that there was no respiratory distress." RR at 7. Cedar Lake's argument and citation to various Texas malpractice cases are not relevant. *Id.* at 7-8 (citations omitted). Although a nurse may not be qualified to render an expert opinion regarding the legal issue of causation in a medical malpractice case in Texas, the issue of noncompliance in this case is governed by the federal regulation at section 483.25(k), not by Texas tort law. Indeed, counsel for Cedar Lake conceded during oral argument that "there is absolutely no question that the controlling law is 42 C.F.R. 483.25 subsection (k)." OA Tr. at 13; *see also Omni Manor Nursing Home*, DAB No. 1920, at 44 (2004), *aff'd, Omni Manor Nursing Home v. Thompson*, 151 Fed. App'x 427 (6th Cir. 2005) (Part 498 cases differ materially from state tort law concepts). Thus, the cited case law applicable in Texas medical malpractice cases does not control here.

In any event, Surveyor Williamson's testimony largely consisted of her <u>observations</u> regarding R16's medical condition and the facility staff's actions on

---

[9] The ALJ found no documentation in the record that R16's baseline oxygen saturation rate was 85%. ALJ Decision at 8. We agree that the record contains (and Cedar Lake identified) no evidence, such as facility records relating to R16, supporting the assertion that her baseline rate was around 85%. The ALJ could reasonably infer that, were this indeed her normal baseline, the resident's records, which were in Cedar Lake's control, would provide such evidence and therefore construe the absence of such documentation against Cedar Lake and decline to accept Dr. Sanner's uncorroborated assertion to the contrary. *See Edison Medical Laboratories*, DAB No. 1713, at 23 (1999), *aff'd, Edison Medical Lab v. Thompson*, 250 F.3d 735 (3rd Cir. 2001) (ALJ may give less weight to witness testimony that is uncorroborated or contradicted by other evidence in the record).

April 15. Cedar Lake concedes that, as a nurse, Surveyor Williamson is clearly qualified to make and report those observations and does not dispute the accuracy of them. OA Tr. at 14. As previously discussed, Cedar Lake also does not challenge the ALJ's finding that Surveyor Williamson's testimony regarding all material facts was consistent in all material respects with notes from facility nurses on April 15 and 16, which indicate that R16 exhibited symptoms that are consistent with respiratory distress. Indeed, during oral argument, counsel for Cedar Lake agreed that the symptoms that surveyor Williamson observed R16 display on that date would be consistent with respiratory distress for "another resident." OA Tr. at 18, 21-22. The ALJ could reasonably draw inferences from those observations and the supporting records. *See Community Skilled Nursing Centre*, DAB No. 1987 (2005), *aff'd*, *Community Skilled Nursing Ctr. v. Leavitt*, No. 05-4193 (6th Cir. Feb. 23, 2006) (In making credibility evaluations of testimony, the ALJ may reasonably consider many factors, including "witness qualifications and experience, as well as self-interest.").

For these reasons, Cedar Lake has not provided a compelling reason why we should not defer to the ALJ's credibility determination about Dr. Sanner's testimony. Thus, we conclude that substantial evidence in the record supports the ALJ's finding that R16 exhibited symptoms of respiratory distress resulting from the facility's failure to provide supplemental oxygen as ordered on April 15, 2009.

However, even if R16 did not suffer any respiratory distress, the ALJ also found that the facility's failure to follow physician orders and not to seek clarification of ambiguous or complete orders also "put [the residents] at risk of even more serious harm." ALJ Decision at 13; *see also id.* at 10. Cedar Lake does not contest this finding on appeal. Thus, we find that the deficiencies are serious enough to support the amount of the CMP regardless of whether R16 suffered respiratory distress, and we find no error in the ALJ's conclusion regarding the seriousness of the noncompliance that warrants a reduction in the amount of the CMP, especially given her findings regarding the other regulatory factors discussed next.

2. The ALJ did not err in finding that Cedar Lake had a prior history of noncompliance when evaluating the reasonableness of the CMP amount.

Second, Cedar Lake argues that it "does not have a history of uncorrected F328 violations . . . [and] Judge Hughes' statement that Petitioner 'disingenuously claims' no history of uncorrected F328 violations is simply wrong." RR at 14. This argument is flawed because the relevant factor under section 488.438(f)(1) that the ALJ correctly considered is the facility's history of noncompliance, not a history of uncorrected violations. Moreover, Cedar Lake does not challenge the ALJ's finding based on the public record that the facility had a prior history of

noncompliance identified during surveys conducted in March 2008 and February 2009. Indeed, the noncompliance identified during the February 2009 survey involving the failure to provide proper respiratory care occurred only two months prior to the April 2009 survey at issue here.[10] ALJ Decision at 13. One of the purposes for CMS to impose a CMP is to motivate a facility to correct a deficiency quickly and to maintain substantial compliance with program requirements. 59 Fed. Reg. 56,116, at 56,206 and 56,175 (Nov. 10, 1994); *Life Care Center of Elizabethton*, DAB No.2367, at 17 (2011). Although Cedar Lake subsequently corrected the deficiencies at issue in the March 2008 and February 2009 surveys, the ALJ reasonably concluded that the $5,000 and $6,000 per-instance CMPs that CMS had previously imposed against the facility in those circumstances did not produce ongoing compliance with program requirements only two months later. The closeness in time to the two deficiencies adequately indicates that the amount of the initial two CMPs was insufficient to motivate the facility to maintain ongoing substantial compliance with program requirements. Thus, the ALJ did not err in considering the entire history of Cedar Lake's noncompliance, rather than only the history of uncorrected violations.

3. The ALJ did not err in finding that Cedar Lake was culpable when evaluating the reasonableness of the CMP amount.

Finally, Cedar Lake argues that "[t]here was no culpability on the part of Cedar Lake." RR at 14, *citing* P. Ex. 19, at 9 (Affidavit of C. Lynn Morgan, R.N.). However, neither the facility in its brief on appeal nor Nurse Morgan's testimony address the underlying factual basis for the ALJ's conclusion that the facility was culpable – *i.e.*, because "it did not follow physician orders and did not clarify ambiguous or incomplete orders" – which we have previously held is supported by substantial evidence in the record. Instead, Nurse Morgan testified that the facility implemented a plan of correction regarding a similar citation of noncompliance for failure to provide proper respiratory care following the survey conducted in February 2009 and in doing so, surveyors from the State agency "commented that Cedar Lake had gone above and beyond what was required with respect to staff training regarding respiratory care." P. Ex. 19, at 9; *see also* P. Ex. 22, at 6-7. Even if true, this testimony is simply not relevant to the culpability of Cedar Lake for the noncompliance determination from the subsequent unrelated April 2009

---

[10] Cedar Lake argues that the ALJ inappropriately relied upon the noncompliance finding from the March 2008 survey because there was no F328 citation at issue in that survey. RR at 15. The Board rejected this same argument by Cedar Lake in its appeal involving the April 2009 survey. There, the Board stated: "The fact that the 2008 survey found noncompliance with a different quality of care requirement (accident prevention) than the one at issue here (respiratory care) is immaterial. The relevant fact is that Cedar Lake, as the ALJ noted, does not have an unblemished compliance history." *Cedar Lake*, DAB No. 2344, at 13.

survey. For the reasons previously discussed, Nurse Morgan's testimony that Cedar Lake was not culpable is purely a legal conclusion rather than a matter of medical expertise, and the ALJ was free to arrive at her own legal evaluation. We also note that section 488.438(f)(4) specifically provides that "[t]he absence of culpability is not a mitigating circumstance in reducing the amount of the penalty."

For these reasons, we conclude that the ALJ did not err in determining that the $9,500 CMP was reasonable.

Conclusion

For the reasons stated above, we affirm the ALJ decision.

/s/
Sheila Ann Hegy

/s/
Leslie A. Sussan

/s/
Stephen M. Godek
Presiding Board Member