Department of Health and Human Services
DEPARTMENTAL APPEALS BOARD
Appellate Division

River City Care Center
Docket No. A-15-5
Decision No. 2627
March 24, 2015

FINAL DECISION ON REVIEW OF ADMINISTRATIVE LAW JUDGE DECISION

River City Care Center (River City) requests review of the August 12, 2014 decision by an Administrative Law Judge (ALJ) sustaining the imposition of civil money penalties (CMPs) by the Centers for Medicare & Medicaid Services (CMS). *River City Care Center*, DAB CR3327 (2014) (ALJ Decision). The CMPs at issue were based on deficiency findings from a May 2013 survey, all of which relate to the course of treatment of a single resident. River City challenges the ALJ's findings that its treatment of the resident from April 23-27, 2013 was inadequate, violated multiple regulatory requirements, and demonstrated an immediate jeopardy situation.

For reasons explained below, we affirm the ALJ Decision and uphold the CMPs as imposed.

Legal Authorities

To participate in Medicare, a skilled nursing facility (SNF) must comply with the requirements for long term care facilities set forth in 42 C.F.R. Part 483, subpart B. 42 C.F.R. § 483.1. State agencies under contract with CMS perform surveys to assess compliance with the requirements. 42 C.F.R. §§ 488.300, 488.305. Deficiencies – failures to meet participation requirements – are reported by the state agency on a Statement of Deficiencies (SOD) form. 42 C.F.R. § 488.301; State Operations Manual, Appendix P at http://cms.gov/manuals/Downloads/som107ap_p_ltcf.pdf. The SOD identifies each deficiency under the applicable requirement, citing both the regulation at issue and the corresponding "tag" number used by surveyors for organizational purposes.

CMS may impose enforcement remedies (including termination of the provider's Medicare agreement and CMPs) when it determines on the basis of survey findings that a facility has a deficiency or deficiencies constituting "noncompliance" with one or more participation requirements. 42 C.F.R. § 488.402. Under the regulations, the term

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

CMS may impose remedies on facilities with deficiencies, including per-day CMPs for the number of days that the facility is not in substantial compliance. 42 C.F.R. §§ 488.402, 488.406, 488.408, 488.430(a). CMS may impose a per-day CMP ranging from $50-$3,000 per day for each day of noncompliance determined to pose less than immediate jeopardy to facility residents, and of $3,050 - $10,000 per day for each day of noncompliance determined to pose immediate jeopardy. 42 C.F.R. §§ 488.408(d)(1)(iii), (e)(1)(iii), 488.438. Those remedies continue until "[t]he facility has achieved substantial compliance, as determined by CMS or the State based upon a revisit or after an examination of credible written evidence that it can verify without an on-site visit . . . ." 42 C.F.R. § 488.454(a)(1).

CMS determines the amount of a CMP based on the "seriousness" (scope and severity) of the facility's noncompliance. 42 C.F.R. § 488.404(a). The most severe deficiencies are those that place residents in "immediate jeopardy." 42 C.F.R. § 488.404(b). Immediate jeopardy is defined as "a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident." 42 C.F.R. § 488.301.

Case Background[1]

River City, a SNF in Texas, was subject to a series of surveys each of which found River City not in substantial compliance. CMS Exs. 1-4. In the survey ending May 6, 2013, triggered in part by a complaint to the state agency, surveyors determined that the care of one resident demonstrated that conditions presented immediate jeopardy to resident health or safety.[2] CMS Ex. 1, at 1. Immediate jeopardy was cited for four regulatory requirements set out at 42 C.F.R. § 483.10(b)(11) (consultation with physician and notification of representative/family of significant change in resident condition); 483.13(c)(development and implementation of policies to prohibit neglect); 483.20(k)(3)(i)(facility services meeting professional standards of quality); and 483.25 (quality of care). *Id*. at 3, 49, 74, 100. The underlying facts all arise from the facility's treatment of the resident from April 23 through April 27, 2013.

[1] This section summarizes the procedural history and provides an overview of the facts found by the ALJ or documented in the record which are not disputed before us. Nothing in this section is intended to replace or modify the ALJ's findings. In our analysis, we address the factual issues which River City challenges on appeal to us.

[2] The resident is identified in the SOD and ALJ Decision as Resident # 2, but since no other resident's care is at issue before us, we simply refer to her as "the resident."

The resident was a 57-year-old woman with diagnoses including dementia and psychiatric disorders, anemia, arthritis, and gastrointestinal reflux who was positive for human immunodeficiency virus (HIV). CMS Ex. 9, at 115. On April 23, 2013, at 3:45 AM, she complained of shortness of breath and manifested congestion. ALJ Decision at 2 (record citations omitted). The nursing staff determined that her oxygen saturation level had dropped to 84% and began administering supplemental oxygen. *Id*. The resident had not previously shown a need for supplemental oxygen and did not have a physician's order to receive it. *Id*.

The resident continued to receive the supplemental oxygen but again complained of shortness of breath at 11 AM on April 23, 2013. *Id*. Nursing notes show that the resident's physician was contacted at that time and ordered a stat chest x-ray which was performed at about 1:30 PM and showed congestive heart failure (CHF) and mild pulmonary edema. *Id*. at 2-3; CMS Ex. 9, at 123-24. Later that day, at 4:18 PM, the resident was taken off of oxygen for a room air tolerance trial for 30 minutes but her oxygen saturation level dropped from 95% to 76%. ALJ Decision at 3; CMS Ex. 9, at 124. The staff then restored the oxygen and increased the rate of flow from two liters to four liters per minute. *Id*. After that, the resident was lethargic, ate none of her dinner, and increasingly required use of her accessory muscles to breathe. *Id*. A respiratory therapist began seeing the resident at 8 PM and recorded diminished breath sounds. ALJ Decision at 3; CMS Ex. 9, at 130.

On April 24 at 9AM, the nursing notes record a new order for Lasix to address the new CHF diagnosis. The nursing notes also indicate that the resident's sister called sometime after 11 AM that day to "inquire about resident." CMS Ex. 9, at 125. On April 24, the resident was referred for a hospice care consult. ALJ Decision at 5, 8-9; CMS Ex. 9, at 52, 125.

Notes of the nursing staff over the course of April 23-24 show that the resident continued to be bedridden (having previously been mobile), became lethargic, was not eating, was using accessory muscles and developed coarse rales in her breathing. ALJ Decision at 3; CMS Ex. 9, at 126-29. She began receiving multiple daily treatments from respiratory therapists on April 23. *Id.* at 130. Some of the respiratory therapists' notes describe the patient as "stable" or as having "no significant signs of distress"; other respiratory therapists' notes, however, describe the same kind of findings as in the nursing notes (lethargy, accessory muscle use, coarse rales, and diminished breath sounds) and report changing the patient from a nasal cannula to a mask and increased the rate of oxygen. CMS Ex. 9, at 130-31.

The hospice evaluated and accepted the resident on April 25. P. Ex. 6. It is not disputed that the resident began receiving drugs prescribed by the hospice physician, including morphine; that she continued to be lethargic and to need increasing levels of oxygen; that she developed swallowing problems; and that by April 26 she was not eating, drinking or

producing urine. ALJ Decision at 3, 6; CMS Ex. 9, at 126-27, 132-33. On April 27, the resident's sister had her transferred from the facility to a hospital, a move which the facility's records indicate was undertaken against medical advice (AMA). P. Exs. 2, at 7-8, and 7, at 1.

Based on the survey findings, CMS imposed remedies including a CMP of $4,050 per day for 14 days (April 23-May 6, 2013) for immediate jeopardy-level noncompliance and thereafter a CMP of $250 per day for 49 days for a period ending June 24, 2013 during which CMS found that the immediate jeopardy had been abated but noncompliance continued at a lower level. CMS Ex. 4.

River City challenged the deficiency findings leading to these remedies. Request for Hearing (July 19, 2013). The ALJ conducted a hearing on April 7, 2014 and May 20, 2014 (the latter date to take testimony of a surveyor who was unable to appear on the original date). The proceedings before the ALJ focused solely on the immediate jeopardy deficiencies and River City's appeal to the Board was similarly narrowed. Request for Review (RR) at 1.

Standard of review

We review a disputed finding of fact to determine whether the finding is supported by substantial evidence in the record as a whole, and a disputed conclusion of law to determine whether it is erroneous. *See Departmental Appeals Board, Guidelines-- Appellate Review of Decisions of Administrative Law Judges Affecting a Provider's Participation in the Medicare and Medicaid Programs* (Board Guidelines) at http://www.hhs.gov/dab/divisions/appellate/guidelines/prov.html; *Golden Living Ctr. – Frankfort v. Sec'y of Health & Human Servs.*, 656 F.3d 421, 426-27 (6th Cir. 2011) (holding that this is "the correct standard of review"). Substantial evidence 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 Board does not re-weigh the evidence or overturn an ALJ's "choice between two fairly conflicting views" of the evidence; instead, the Board determines whether the contested finding could have been made by a reasonable fact-finder "tak[ing] into account whatever in the record fairly detracts from the weight of the evidence" that the ALJ relied upon. *Universal Camera Corp. v. NLRB*, 340 U.S. 474, 488 (1951); *see also Allentown Mack Sales & Service, Inc. v. NLRB*, 522 U.S. 359, 377 (1998); *Golden Living Ctr. – Frankfort*, DAB No. 2296, at 9-10 (2009), *aff'd, Golden Living Ctr. – Frankfort v. Sec'y of Health & Human Servs*.

Analysis

1. Substantial evidence supports the ALJ's conclusion that River City failed to immediately consult the resident's physician after a significant change in condition.

(a) *Background and contentions*

Section 483.10(b)(11) provides in pertinent part:

> *Notification of changes*. (i) 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--
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> * * *
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> (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); [or]
> (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); . . . .

The ALJ acknowledged that discussions occurred between River City's staff and the resident's physician at various times during the relevant period, but found that these discussions did not constitute the required immediate consultation after significant changes in the resident's condition. ALJ Decision at 4. The ALJ emphasized that, even had there been frequent consultation with the physician after he was first notified at 11 AM on April 23, 2013 (which the ALJ found there was not), nothing in the record could excuse the failure to consult the physician for more than seven hours after the staff initiated continuous supplemental oxygen at 3:45 AM. *Id*. at 7. The ALJ further concluded that the resident deteriorated after April 23 in ways that should have demanded immediate consultations, including needing to use accessory muscles to breathe and increasing oxygen flow, becoming lethargic, and losing appetite and urine output. *Id*. at 6. Also, he found that, while the physician ordered the chest x-ray on April 23 to be performed stat (i.e., immediately or urgently), the results were not immediately reported to the physician. *Id*. at 3. While the ALJ noted various physician orders for treatment changes on April 25 and 26, he did not consider those orders sufficient to show that the staff was communicating with the doctor about the resident's ongoing deterioration. *Id*. at 6-7.

River City argues on appeal that the resident had pre-existing respiratory problems (including the pulmonary edema identified on the chest xray) for which she had a standing physician order for nebulizer treatments, so her need for respiratory treatment on April 23, 2013 did not demonstrate any significant change in condition. RR at 3-4.

Further, River City contends that it was "prudent" for the nurses to begin oxygen administration (which River City acknowledges is not the same as the nebulizer treatment previously ordered), to continue it, and to monitor the resident. *Id*. at 4-5. River City further argues that the generation of telephone orders is "evidence that a communication/consultation occurred." *Id*. at 5. River City argues that, although CHF was a new diagnosis, the physician learned of the x-ray results and issued new medication orders by the next day, and those were "carried out as instructed." *Id*.

River City points to a telephone order with a handwritten note added by the physician for administration of supplemental oxygen to be increased as needed as evidence that the use of oxygen was in compliance with orders of the resident's physician. *Id*. at 7; P. Ex. 3, at 5. River City, however, does not dispute that the physician's handwritten note was added later and that the version of the order in the facility's records did not include this note.

River City also describes the resident's condition in the succeeding days as "stable" and "much the same," although acknowledging that she developed difficulty swallowing on April 25 for which the physician immediately ordered a swallowing study. RR at 9-10, 12. As far as the resident's growing lethargy, River City views this "restful state" as either a desirable or unavoidable consequence of medications prescribed by the hospice physician. *Id*. at 11.

In sum, River City paints the nursing staff as in "frequent communication with the physician" about a resident who was terminal but stable and appropriately placed into hospice until her sister removed her to the hospital against medical advice. *Id*. at 14.

(b) *Substantial evidence supports the ALJ's finding that the resident underwent a significant change in condition at 3:45 AM on April 23, 2013.*

River City's portrayal of the resident's last days in its facility misrepresents core facts established by the record on which the ALJ's conclusions rest. At the heart of these facts is the reality that the record shows no prior history of abnormal oxygen saturation levels and no prior need for supplemental oxygen at the time this resident complained of breathing difficulty at 3:45 AM on April 23, 2013. The resident did have a preexisting diagnosis of pulmonary edema and an order for nebulizer medication as needed, so the ALJ may have overstated the situation in saying that the resident "did not suffer from significant respiratory deficiencies" before that date. ALJ Decision at 2. Nevertheless, River City has not identified any prior occasion on which the resident's oxygen saturation was compromised; nor has River City identified any prior occasion on which the prescribed nebulizer medication was tried but failed to effectively relieve the resident's shortness of breath. Moreover, River City provided no evidence of any preexisting order from the physician prescribing oxygen administration as an appropriate treatment under such circumstances.

River City offers testimony to suggest that these new developments and the new diagnosis of CHF might have been anticipated given her HIV status. P. Ex. 22, at 3-7 (Parker Affidavit). However, even were we to accept that testimony as persuasive (which we do not for reasons discussed later), we would not find that the resident therefore had no significant change in condition on April 23, 2013. On the contrary, the development of persistent low oxygen saturation was at a minimum a new clinical complication of her existing conditions and its significance is evidenced by the very reaction of the nurses in immediately commencing a new treatment for which no standing order was in place.

CMS does not disagree that the nursing staff properly responded to the resident's new condition by instituting oxygen at once without waiting to obtain a physician's order, in light of the drop in the resident's oxygen saturation levels. CMS argues, and we agree, that, the facility was then obligated to immediately consult with the resident's physician about the change and to obtain an order to support continued administration of oxygen.

(c) *River City's own records amply support the ALJ's conclusion that her physician was not consulted immediately about the change in her condition.*

River City attempts to obfuscate the question of when the physician was consulted about the new need for supplemental oxygen by emphasizing that the resident had an order for treatment as needed for shortness of breath. River City acknowledges, however, that an "inhaler," i.e., nebulizer, treatment is not the same as supplemental oxygen. RR at 4, n.3. River City also provides no evidence that shortness of breath is the same as low oxygen saturation. Yet even the most generous view of River City's evidence demonstrates no effort to consult the resident's physician for more than seven hours.

The Board has long made clear that "immediate" consultation means exactly that. The meaning of these terms was explained in a prior decision as follows:

> 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 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).
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> 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,
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> > 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.

Magnolia Estates Skilled Care, DAB No. 2228, at 8-9 (2009) (quoting DAB No. 2182 at 13) .

In this case, the first communication with the physician after the resident began continuous oxygen at 3:45 AM was, as noted above, 11 AM. The record of that communication is in the form of a telephone order for the stat chest x-ray due to shortness of breath and congestion. P. Ex. 3, at 5. Neither that order nor the nursing notes contain any documentation of what information was provided to the physician or what discussion occurred about the resident's condition. Even if we accept River City's contention that telephone orders indicate communication, and even if we assume that the content of this order implies some awareness of respiratory problems, we see no reason that the ALJ was obliged to infer that the information communicated included the new facts that the resident had low oxygen saturation and required continuous oxygen supplementation.

We note that the ALJ appears to have mistakenly understood River City to have asserted that the physician provided a telephone order for oxygen PRN on April 23 but noted that no written record of such an order arrived at the facility until May 6, 2013. ALJ Decision at 5, citing P. Ex. 3, at 5. In fact, it is undisputed that, at the time of the survey, no written record or physician's order at all appeared in the facility's documents authorizing the nurses to provide continuous oxygen supplementation to the resident. River City contends that a handwritten note for oxygen added to the physician's copy of an **April 24, 2013** telephone order for a medication change after the CHF diagnosis was made

reflected the physician's intention to permit oxygen administration as needed.[3] P. Ex. 3, at 5. The physician's copy was provided to the surveyors on the last day of the survey. H'g Tr. at 120. Apparently, the ALJ conflated this order with the record of the telephone order of April 23, 2013 for the stat chest x-ray, copied on the same page of the same exhibit. In fact, however, the earliest that any physician order for oxygen is even alleged to have been written was actually **more than 24 hours** after the nursing staff began administering continuous oxygen on its own initiative.

As the ALJ noted, River City claims that the handwritten addition shows that the physician actually included a PRN instruction for oxygen in a telephone order responding to the results of the chest x-ray but that the nurse who took the order merely forget to include the instruction to administer oxygen. *See* RR at 7. This explanation is unpersuasive. The handwritten addition appears only on the physician's copy of the telephone order form. If the physician received a copy of the record of his telephone order and found it incomplete, it is hard to see why he would add the missing element by hand to his own carbon copy but not either send the corrected order to the facility or make an urgent call to ensure the facility made the correction on its copy.[4] Yet no one testified for the facility that a corrected copy was received or a telephone correction called in. The Board has generally been unwilling to accept that treatments that are not documented have nevertheless been performed, and similarly here, we are not willing to assume that an order that was not documented at the facility was nevertheless communicated to and complied with by the nursing staff, absent credible evidence of such communication. *See, e.g.*, *Evergreene Nursing Care Ctr.*, DAB No. 2069, at 25 (2007), citing *Western Care Mgmt. Corp. d/b/a Rehab Specialties Inn*, DAB No. 1921, at 48 (2004).

Also, River City asserts that the licensed vocational nurse (LVN) averred that she "personally spoke" to the physician "in the presence of the administrator and ADON [assistant director of nursing] to obtain these orders[.]" RR at 5 citing P. Ex. 11 (declarations of facility administrator, LVN and ADON). Yet, the LVN states only that the telephone order she received on April 24, 2013 was for the CHF medications and hospice consult "due to [patient] change in condition," and that the call was witnessed by the administrator and ADON. P. Ex. 11, at 2. Only the ADON mentions any authorization for oxygen administration, stating that she "intended to go back and rewrite the order to show the oxygen order" but did not complete it due to "other issues on the

[3] In the state informal dispute resolution process, River City explicitly acknowledged that not until April 24, 2013 did the physician "clarified that the facility was allowed to use oxygen[.]" P. Ex. 19, at 4; *see also* RR at 7 and P. Ex. 20, at 4 (expert witness nurse says physician authorized oxygen by telephone order "[l]ater in the day on April 24").

[4] Even the physician who testified as an expert for River City and who opined that it was common practice for physicians to fill in missing information from a telephone order after receiving a copy stated that in that case the physician "corrects it when he signs it for return to the nursing home." P. Ex. 22, at 5.

floor that needed immediate attention." *Id*. at 3. River City does not explain why the LVN who took the order does not report authorization for oxygen (but does recognize that a change in condition had occurred, which River City now denies), or why the ADON did not later record the oxygen order anywhere even if she was distracted from doing so at once.

In light of this record, we agree with the ALJ that even if the physician gave a verbal order for oxygen (and we have seen no reliable evidence of it), the failure to document it in the nursing notes or elsewhere in the resident's record meant that the nursing staff could not have known about or acted on its instructions. ALJ Decision at 5-6. Indeed, the surveyor was told by at least one nursing staff member that there was no physician's order for oxygen. CMS Ex. 1, at 7; CMS Ex. 22, at 6-7. River City argues that the failure to transcribe the order for oxygen anywhere in the resident's records was insignificant because the nurses must have heard it since they did increase the resident's oxygen rate when her saturation level dropped. RR at 7, n.5. Since the same nursing staff began administering oxygen without an order and continued to do so for more than 24 hours, we see no reason to infer that the staff must have heard of the (supposed) unrecorded order merely because they continued to administer oxygen thereafter as the resident's condition worsened.

We conclude that River City failed to immediately consult a physician when the resident underwent a significant change in condition which the staff treated as precipitating a need for continuous supplemental oxygen, and this failure violated the regulatory requirement at 42 C.F.R. § 483.10(b)(11).

(d) *The x-ray results on April 24, 2013 demonstrated an additional significant change in condition for which no immediate consultation occurred*.

In addition to the new complication of low oxygen saturation on April 23, the facility clearly became aware of another significant clinical complication when the report of the x-ray disclosed a new diagnosis of CHF. Once the facility received the x-ray report, the information in it required immediate consultation with the physician.

Plainly, the physician considered the information urgent, since he requested the x-ray be performed stat. Equally plainly, the information was significant for the resident's care, since once the physician did receive it, he promptly altered the resident's treatment to add medications for CHF. It is even evident that the facility staff understood that the information needed to be shared with the physician at once in order to consult about how the physician wanted to address it, since a call was quickly placed to the physician's office. Despite all this, when the physician could not be reached, the staff simply gave up trying to reach him and left a note for the next shift, which did not act on it.

The nursing notes record that the x-ray results were received at 1:35 PM on April 23, 2013 and the physician's office was called but the answering service said that he would not be available until 2:10 PM. CMS Ex. 9, at 124. The nurse recorded that the next shift would be notified to follow up. *Id*. During the next shift, at 4:18 PM, the resident was taken off of oxygen for a room-air tolerance test. *Id*. Her oxygen saturation fell to a new low of 76%. *Id*. *After* oxygen was re-applied, her saturation level recovered to 95%, but she became lethargic and remained in bed through the whole shift,[5] was unable to eat any dinner, and began making heavy use of her accessory muscles to breathe. *Id.* at 124-25. Yet, the first evidence of any consultation with the physician about the CHF finding, or these further deteriorations in the resident's condition, is a telephone order at 9 AM on April 24, 2013 for new medications to address the CHF and for a hospice consult. *Id*. at 232.

River City denies that the CHF diagnosis constituted a significant change in condition basing this contention on the after-the-fact opinion of River City's expert witness physician that the x-ray results may have represented a late stage of AIDS instead of CHF. P. Ex. 22, at 3. The expert acknowledges, however, that the report itself identified CHF, which was a new diagnosis. River City provides no basis to conclude that disputing such a report would be within the competence of the nursing staff. The expert's suggested alternative reading of the x-ray is therefore irrelevant to the facility's obligation to immediately consult the physician. The treating physician evidently did not share this opinion in any case, since, as noted, he proceeded to order medications for CHF.

We conclude that the report of CHF shown on a stat chest x-ray ordered by the resident's physician constituted information to the facility about a clinical complication new to the resident and requiring consideration of new treatments. River City itself argues that one of the "most critical factors to analyze" in considering whether a deficiency should have been cited under this regulation is whether the situation required a change in treatment, especially a new treatment not previously used by the resident. RR at 2-3. River City contends that no change was required during the period at issue because PRN orders were in place for shortness of breath. *Id*. at 3. As we discussed above, those orders covered only nebulizer treatment which proved insufficient to restore her oxygen saturation and which River City does not dispute is not the same as oxygen administration. The need

[5] River City argues that the ALJ erred in treating lethargy as a further change in condition on the ground that the hospice physician ordered morphine and other medications known to induce a "restful state," so lethargy was an intended outcome. RR at 11-12. Whatever the merits of this argument, it is undisputed that the resident did not come into the care of hospice until April 25, 2013. *See* CMS Ex. 9, at 65 (election form – with single terminal diagnosis of CHF). Nursing notes record her lethargy and poor food intake beginning on the afternoon of April 23, 2013, after previously being mobile and eating well. CMS Ex. 9, at 122-27. Therefore, the later addition of medications by hospice does not explain these changes.

for new treatments is, if anything, even clearer in the case of the x-ray results which showed a new diagnosis and resulted in the addition of several new medications. We conclude that the facility's failure to consult the physician immediately about the x-ray report delayed needed treatment and violated 42 C.F.R. § 483.10(b)(11).

(e) *River City was required to, but did not, immediately notify the resident's interested family member about the significant change in her condition on April 23, 2013.*

In addition to informing the resident and consulting with the physician when a resident undergoes a significant change in condition, the regulation requires a facility to "if known, notify the resident's legal representative or an interested family member" of such a change. 42 C.F.R. § 483.10(b)(11). The ALJ found that the resident's sister who was known to the facility as her primary caregiver should have been, but was not, informed of the resident's change of condition even as she required more and more oxygen and was referred for a hospice consult. ALJ Decision at 8-9. River City has offered three arguments which we address in turn: (1) that the sister was adequately informed; (2) that the sister did not need to be notified because her power of attorney did not become effective as long as the resident had not been declared incompetent; and, on appeal to the Board, (3) that the regulation should not be read to require notifying an interested family member when the resident was her own legal representative.

On the first point, the question is not whether the sister eventually obtained information about the resident's decline but whether the facility acted to notify her of significant changes. As to the changes which we have discussed in detail above, the answer is that the facility took no action to contact the sister. The record indicates that the sister called the facility herself, apparently after having been contacted by hospice to which the facility had referred the resident for consultation. Nursing notes indicate that call took place sometime between 11 AM and 2:45 PM on April 24, 2013, and state that the "change in condition has been explained to the sister." P. Ex. 2, at 4. This conversation was at least 31 hours after the resident was placed on continuous oxygen, more than 20 hours after the x-ray results were received with the CHF diagnosis, and at least two hours after the physician added medications for CHF and ordered the hospice consult. P. Ex. 2, at 1-4 (given times of these events in nursing notes). These time frames do not demonstrate immediate notification.

River City's assertion that the power of attorney had not taken effect because the resident had not become incompetent may be factually accurate, but it is legally irrelevant. If the sister was not the resident's representative, she was still her interested family member. Indeed, the facility knew she was the resident's primary caregiver. In either capacity, she was entitled to be notified by the facility of the significant changes in the resident's condition, not merely to become aware of them belatedly through her own initiative. The

argument is disingenuous as well, because the facility points out repeatedly that the sister was the one who signed the consent for the resident's admission to hospice, which suggests that she was indeed treated as the resident's representative able to make decisions relating to the resident's care. RR at 9, citing P. Ex. 6, at 1-5.

On its third contention, River City's counsel explained at oral argument that the regulation only requires notifying the representative **or** an interested family member, not both. Oral Argument Tr. (OA Tr.) at 42. Further, River City reasoned that, since the resident was not incompetent and remained her own responsible party, she was therefore her own legal representative. *Id*. Presumably, River City believed the resident was adequately notified of her changing condition by virtue of undergoing the changes and treatments and that, therefore, she was notified as her own representative and no additional notice to her sister was required. We find this proposed reading of the regulation unsupportable in context.

Under the first clause of the regulatory section, a facility is obliged to inform the resident (whether or not legally represented and whether or not competent to serve as the responsible party) of significant changes to the resident's condition or care. It makes little sense, then, to instruct a facility to notify "if known" a representative or family member, if that meant notify the resident again if unrepresented. Obviously, the resident would always be known to the facility. The only plausible reading is that, **in addition to the resident**, the facility is to notify either a legal representative (where one exists) or a family member who has shown interest, so long as the facility knows of either. Here, the resident had no representative. In the absence of a legal representative, the family member who was actively interested in her care was her sister. River City does not dispute that the sister's involvement was well-known to the facility.

2. River City's other arguments do not undercut our conclusions.

(a) *River City has shown no basis to disturb the ALJ's weighing of the testimony provided by the parties' witnesses*.

River City complains that the ALJ gave undue weight to expert testimony by the surveyors and failed to give sufficient weight to the gerontological nurse and geriatric physician whose statements River City presented as expert opinions. RR at 21-23. In general, the Board defers to an ALJ's findings on weight and credibility of witness testimony (oral or written) unless there are "compelling" reasons not to do so. *See, e.g., Van Duyn Home & Hosp*., DAB No. 2368, at 10-11 (2011); *Koester Pavilion*, DAB No. 1750, at 16, 21 (2000). River City's arguments about the testimony of these witnesses do not provide any compelling reason for us to disturb the weight assigned by the ALJ.

First, River City notes that Surveyor Reeves was not a nurse, whereas Surveyor Lewis, who River City admits was a nurse for many years, was new as a surveyor. RR at 21. Surveyor Reeves expressly declined to offer any opinion on applicable nursing standards of practice because that was not her area of expertise. H'g Tr. at 51-52. Surveyor Lewis's length of service as a surveyor is of limited relevance to her testimony about nursing standards of practice in the situations involving the resident here, since that testimony was mostly based on her training and experience as a nurse.

Second, River City characterizes the surveyors' testimony as going beyond the scope of state nursing practice by attempting to attribute the resident's "shortness of breath to something other than her long-standing chronic medical conditions" and to "make the causal link between River City's actions" and the resident's "ultimate harm." RR at 21-22. River City does not cite to any testimony that supports these characterizations. The surveyors do not diagnose the cause of the resident's shortness of breath but rather Surveyor Lewis opines that River City's nurses should have obtained the guidance of a physician when the resident appeared to require supplemental oxygen, a new event, due to the new symptom of low oxygen saturation. H'g Tr. at 90-91, 119-21. The fact that the new symptom was ultimately attributed to a cause other than the pre-existing diagnoses occurred because the physician, once made aware of the problem, immediately ordered a chest x-ray and, based on the results, began treatment for the new diagnosis of CHF.

As for causation, the Board has repeatedly held that an immediate jeopardy determination does not require a finding that a deficiency resulted in actual harm to a particular resident but only that the facility's noncompliance either caused or was likely to cause serious harm to one or more residents. *See, e.g. Lakeport Skilled Nursing Ctr.*, DAB No. 2435, at 6 (2012) ("Where a facility's noncompliance is **likely** to cause serious harm to **a resident**, immediate jeopardy exists, regardless of whether any particular resident has already suffered serious harm or is likely to suffer serious harm.") (bolding in original). In this case, moreover, the ALJ made clear that he reserved to himself the determination of whether immediate jeopardy was established based on the factual record before him rather than the opinions of either party's witnesses. Tr. at 50-51.

Third, River City suggested that the ALJ erred by accepting expert testimony from the surveyors because they "looked backwards" from an "end result" when they reviewed the resident's records at the hospital before reviewing the records of her stay at the facility. RR at 22. River City's counsel depicted the testimony as somehow atypical of nursing home enforcement cases because the surveyors were asked to testify not as to "whether the regulations were violated, but whether the facility complied with reasonably accepted standards of care." OA Tr. at 15-16. River City contends that by offering such

testimony the surveyors were precluded from such backward reasoning under the requirements for expert scientific testimony established by the Supreme Court in *Daubert v. Merrell Dow Pharm., Inc*., 509 U.S. 579 (1993). *Id*. at 16-18; RR at 22, citing *Daubert* and progeny. River City both misunderstands and misapplies *Daubert*.

Contrary to River City's comments (see also OA Tr. at 15-17, 49-50), it is not unusual in nursing home compliance cases for nurses to testify for either or both parties what nursing standards of practice call for in various situations presented in the care of residents. With respect to the *Daubert* argument, the Court was interpreting changes made to evidentiary standards in Rules 402 and 702 of the Federal Rules of Evidence and concluded that those changes departed from the preexisting requirement to show "general acceptance" before novel scientific evidence could be admissible. 509 U.S. at 585-87. The Court held that the Rules had defined admissibility more liberally to encompass as relevant any evidence tending to make a consequential fact more or less probable and to admit expert testimony by a qualified witness where it will "assist" a trier of fact. *Id.* at 587-88. Despite concluding that the Rules intended broader admission of expert evidence, the Court still recognized a "gatekeeping" role for the trial judge to ensure reliability of scientific knowledge as being derived from valid methods and reasoning within the relevant discipline and tied to a fact at issue as to which it may be helpful. *Id.* at 589-92, 597.

The Federal Rules of Evidence do not apply in these administrative hearings, although ALJs may look to them for guidance them where useful and appropriate, as in excluding unreliable evidence. *Realhab, Inc.*, DAB No. 2542, at 4 (2013), citing Civil Remedies Division Procedures and 42 C.F.R. § 498.61. Hence the interpretation of those rules is not directly applicable here, although it may be informative. Moreover, the gatekeeping function contemplated by *Daubert* is meant to protect lay factfinders from confusion, but the ALJ sits without a jury and needs no such protection in evaluating evidence.

Later cases have extended the *Daubert* "gatekeeping" approach beyond strictly scientific research evidence to include other kinds of technical expertise. *See, e.g., Kumho Tire Co., Ltd. v. Carmichael*, 526 U.S. 137 (1999) (trial court may use factors from *Daubert* where relevant in assessing reliability and relevance of methodology applied by any expert witness). However, River City misquotes the case on which it relies in its attempt to extend this approach to condemn the surveyor's methods as "backward reasoning." River City quotes the Texas Supreme Court as saying that "coming to a conclusion first and then doing research [or looking for records] to support it is the **antithesis of the scientific method**." RR at 22, *quoting E.I. DuPont deNemours & Co., Inc. v. Robinson*, 923 S.W.2d 549 (Tex. 1995) (bolding and bracketed material added in RR). The decision actually reads as follows:

> Scientists may form initial tentative hypotheses. However, "coming to a firm conclusion first and then doing research to support it is the antithesis of this [scientific] method." *Claar v. Burlington Northern R.R.*, 29 F.3d 499, 502–03 (9th Cir.1994).

923 S.W.2d at 559 (bracketed material in *DuPont* decision). Nothing in this statement correctly quoted, or in the decision from which it was excerpted, condemns entering into a study with a hypothesis or dictates the order in which records or data may be collected. The surveyor testimony to which River City refers merely indicates that the surveyors began their complaint investigation by visiting the hospital to which the resident had been moved. RR at 22, citing H'g Tr. at 91-93. No testimony indicates that the surveyors had formed any firm conclusion about the resident's care at River City before collecting and evaluating all of the data, including facility records and interviews with facility and hospice staff, as well as with the resident's sister. The order in which data are collected does not demonstrate that the reasoning process is outcome-driven rather than data-driven which is the point of avoiding backward reasoning.

Furthermore, by permitting the nurse-surveyor to testify as to the applicable nursing standards of practice but not as to the ultimate question of whether the care provided by the facility met the regulatory requirements, the ALJ essentially retained for himself the analytical work of applying the standards to the facts as he found them. Therefore, the role of the surveyors in collecting evidence and in providing information about professional practices was subject to the de novo evaluation of the ALJ. We find no error in that process.

Finally, River City insists that its physician expert witness is the "most qualified witness in this case" who offered "medical reasons" for his opinion that no significant change in condition occurred "in ways that nurses (even nurse surveyors) are not qualified to do," including why the resident's condition "progressed as it did." River City Reply Br. at 2-3. The issue for which expert testimony was relevant, however, was precisely the question of what the **nurses** were qualified and expected to do within the scope of their professional standards when confronted with the new symptoms and needs that the resident developed between April 23 and April 27, 2013, not what a physician (such as that expert witness), given all the records after-the-fact, might conclude about the medical reasons for the progression of the resident's condition.[6] On nursing practice issues, the ALJ could reasonably conclude that he should place more reliance in the testimony of an experienced professional nurse.

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[6] There is some irony in River City's reliance on the physician's testimony given its *Daubert* argument discussed above. Clearly, the physician did not view "the facts in this case from the same perspective as the nursing home" had at the time its nurses were caring for the resident, as River City suggested that the surveyors should have done. *Cf.* RR at 22; *see also* OA Tr. at 45.

(b) *We need not resolve whether the resident should have been transferred to the hospital at an earlier point or should not have been transferred against medical advice.*

River City treats as a central issue in the case the question of whether the resident should have been sent to a hospital sooner or whether, instead, her sister inappropriately removed her from hospice care and insisted she be hospitalized. *See, e.g.*, RR at 2, 9-10, 12-14; OA Tr. at 4-5. River City emphasizes that neither of the physicians (her own and the hospice's) caring for the resident in her last days at the facility recommended that she be taken to the hospital. According to River City, the absence of any care plan or recommendation for hospitalization demonstrates that the resident was not in medical need of hospitalization. Instead, River City contends, appropriate end-of-life measures were in place in accordance with the resident's wishes when her sister removed her to the hospital against medical advice (AMA). RR at 14.

The surveyors clearly felt that an earlier transfer was called for. H'g Tr. at 94. Moreover, since we have concluded that the resident's physician was not timely consulted when the resident's condition deteriorated and that River City's records do not contain the purported physician's orders, we would not necessarily find dispositive the mere fact that no physician order for hospital transfer appears in the record.

In the final analysis, however, we need not resolve this issue. No one disputes that the resident was moved at the insistence of her sister and against the wishes of the facility, or that her discharge summary noted that the move was AMA. P. Ex. 7. But we see no legal significance for this case in those circumstances. Even assuming the AMA notation evidences that the physician did not see a need to transfer the resident at that point, the issues presented in the case ultimately go to the actions of the facility while the resident was under its care, not to when she should have left its care.

3. The amount of the CMP is reasonable even without addressing the other deficiency findings arising from the same events.

Given our conclusion that the facility failed to meet the requirements of section 483.10(b)(11) in multiple ways, we do not find it necessary to address in any detail the ALJ's conclusions that the same course of events evidenced noncompliance with the other cited regulations. The essence of the other deficiency findings is that (1) the nursing staff failed to ensure physician oversight as the resident deteriorated with the result that she did not get care calculated to assure that she would attain her highest practicable level of physical, mental, and psychosocial well-being; and (2) such neglect of her needs demonstrated that River City did not have or implement policies adequate to prevent neglect.

River City proffers arguments about the precise scope that should be given to the regulations being applied. RR at 14-19. River City contends that section 483.25 only requires that services to maintain such well-being be provided in accordance with the assessment and plan of care and that CMS has not identified a specific service named in the care plan that was omitted. *Id*. at 19. Further, River City argues that it did have an adequate anti-neglect policy and that allegations of "generalized neglect" cannot be sufficient to show a failure to implement it. *Id*. at 15-16.

We do not agree with the narrow characterizations of the regulatory requirements on which River City relies, but we would only find it necessary to fully discuss their application here if resolving the additional violations affected our conclusion about the reasonableness of the amount of the CMP imposed. We conclude for the reasons explained below that they do not.

River City suggests that the Board should address the challenges on scope and severity outlined in River City's post-hearing brief to the ALJ, which it sought to incorporate by reference here. RR at 20-21. The Board Guidelines, sent to River City with the ALJ Decision, explicitly state that a party's submission "may not incorporate by reference a brief or parts of a brief previously submitted to the ALJ." We therefore do not consider arguments contained in the brief before the ALJ but not set out on appeal.

River City also cites the declaration of its expert witness nurse. RR at 22-23, citing P. Ex. 20. That declaration contains a paragraph which opines that the total amount of all CMPs is excessive because the facility should not have been found out of compliance, at least at the immediate jeopardy level, and had no "culpability." P. Ex. 20, at 12. The nurse also opines that "CMS does not appear to have followed the proper criteria in formulating the proposed penalty." *Id*.

These contentions have no merit. We have already concluded that River City was indeed out of compliance at the immediate jeopardy level. The regulation that sets out the factors affecting the amount of a CMP expressly provides that the "absence of culpability is not a mitigating circumstance in reducing the amount of the penalty." 42 C.F.R. § 488.438(f)(4). Furthermore, the Board has repeatedly made clear that the ALJ (and the Board) consider de novo whether the amount of a CMP is reasonable in light of the regulatory factors and, thus, do not review whether or how CMS considered those factors in setting the proposed amount. *North Carolina State Veterans Nursing Home, Salisbury*, DAB No. 2256, at 24-25 (2009) (explaining that CMS need not detail its findings on the regulatory factors because the ALJ conducts a de novo review of findings of noncompliance which are disputed).

River City thus offered no persuasive reason for us to reduce the amount of the CMP. In any event, the only CMP at issue on appeal is the per-day $4,050 for immediate jeopardy. This CMP is at the lowest end of the range applicable to noncompliance at the immediate

jeopardy level, i.e., from $3,050 to $10,000 per day. We find that the amount of the CMP is amply supported based on the immediate jeopardy level noncompliance with section 483.10(b)(11) which we have upheld as well as the applicable regulatory factors.

Conclusion

We uphold the ALJ Decision.

/s/
Stephen M. Godek

/s/
Sheila Ann Hegy

/s/
Leslie A. Sussan
Presiding Board Member