Department of Health and Human Services
DEPARTMENTAL APPEALS BOARD
Appellate Division

Embassy Health Care Center
Docket No. A-10-65
Decision No. 2327
August 5, 2010

FINAL DECISION ON REVIEW OF ADMINISTRATIVE LAW JUDGE DECISION

Embassy Health Care Center (Embassy), a long-term care facility that participates in Medicare and Medicaid, requests review of the April 7, 2010 decision of Administrative Law Judge (ALJ) Richard J. Smith. *Embassy Health Care Center*, DAB CR2107 (2010) (ALJ Decision). The ALJ upheld the determination by the Centers for Medicare & Medicaid Services (CMS) to impose a civil money penalty (CMP) of $350 per day from November 7, 2008, through December 11, 2008 (totaling $12,250) against Embassy based on findings made during a survey that ended November 7, 2008. The ALJ determined that Embassy failed to comply substantially with the quality of care requirement at 42 C.F.R. § 483.25. The ALJ further determined that Embassy had not contested 17 of the 19 deficiencies cited in the survey and that those 17 noncompliance findings were final and binding. Finally, the ALJ determined that the CMP amount was reasonable.

For the reasons explained below, we sustain the ALJ Decision.

Legal Background

The Social Security Act (Act) and federal regulations provide for state agencies to conduct surveys of Medicare skilled nursing facilities (SNF) and Medicaid nursing facilities (NF) to evaluate their compliance with the Medicare and Medicaid participation requirements. Sections 1819 and 1919 of the Act; 42 C.F.R. Parts 483, 488, and 498. [1] The participation requirements are set forth at 42 C.F.R. Part 483, subpart B. A facility's failure to meet a participation requirement is called a "deficiency." 42 C.F.R. § 488.301. "Substantial compliance" means a level of compliance such that "any identified

[1] The current version of the Social Security Act can be found at http://www.socialsecurity.gov/OP_Home/ssact/ssact.htm. Each section of the Act on that website contains a reference to the corresponding United States Code chapter and section. Also, a cross-reference table for the Act and the United States Code can be found at 42 U.S.C.A. Ch. 7, Disp Table.

deficiencies pose no greater risk to resident health or safety than the potential for causing minimal harm." *Id.* "Noncompliance" is defined as "any deficiency that causes a facility to not be in substantial compliance." *Id.*

Surveyor findings are reported in a statement of deficiencies (SOD), which identifies each deficiency under its regulatory requirement and a corresponding "tag" number used by surveyors for organizational purposes. Each deficiency is assigned a level of severity (whether it has created a "potential for harm," resulted in "actual harm," or placed residents in "immediate jeopardy") and a scope of the problem within the facility (whether it is "isolated," constitutes a "pattern," or is "widespread"). 42 C.F.R. § 488.404; State Operations Manual (SOM), CMS Pub. 100- 07, App. P - Survey Protocol for Long-Term Care Facilities (available at http://www.cms.hhs.gov/Manuals/IOM/list.asp), sec. V. A deficiency's scope and severity is designated in the SOD by a letter (A-L). *Id.* at § 7400(E).

A long-term care facility determined to be not in substantial compliance is subject to enforcement remedies, which include CMPs. 42 C.F.R. §§ 488.402(c), 488.406, 488.408. CMS may impose either a per-instance or per-day CMP when a facility is not in substantial compliance. 42 C.F.R. § 488.408(d)(3)(i). A per-day CMP may accrue from the date the facility was first out of compliance until the date it achieved substantial compliance. 42 C.F.R. § 488.440(a)(1), (b). For noncompliance determined to pose less than immediate jeopardy to facility residents, CMS may impose a per-day CMP in an amount ranging from $50-$3,000 per day. 42 C.F.R. § 488.408(d)(1)(iii). The regulations set out several factors that CMS considers to determine the CMP amount. 42 C.F.R. §§ 488.438(f), 488.404.

Case History

On November 7, 2008, the Illinois Department of Public Health (state agency) completed an on-site survey of Embassy. The state agency found that Embassy was not in substantial compliance with 19 Medicare and Medicaid participation requirements. CMS Ex. 1. The state agency concluded that the two most serious deficiencies posed isolated, actual harm to a resident that was not immediate jeopardy (level G). *Id.* Those deficiencies involved, respectively, the quality of care requirement at section 483.25 of the regulations, and the accidents and supervision requirement at section 483.25(h). *Id.* The remaining 17 deficiencies, the state agency determined, posed the potential for more than minimal harm that is not immediate jeopardy. *Id.*

In a notice to Embassy dated December 8, 2008, CMS stated that it was imposing a CMP on Embassy of $350 per day beginning November 7, 2008 and continuing until the facility achieved substantial compliance, based on the survey findings. CMS Ex. 3. CMS also stated that it was imposing a discretionary denial of payment for new admissions (DPNA) effective December 28, 2008. *Id.*

On January 16, 2009, Embassy requested an ALJ hearing. Embassy's hearing request listed the 19 noncompliance findings from the November 7, 2008 survey, but stated that the facility was challenging only the G-level deficiency finding that involved the quality of care requirement at 42 C.F.R. § 483.25. Notice of Appeal at 2-3; *see also* Embassy Report of Readiness to Present Evidence in Preparation for Adjudication at 2 (Adverse Findings Embassy Contests); Hearing Tr. (Tr.) at 19-20.

By notice dated February 4, 2009, CMS advised Embassy of the "final status of remedies imposed." CMS Ex. 2. First, CMS stated that it had deleted the G-level deficiency finding involving the accidents and supervision requirement at 42 C.F.R. § 483.25(h) based on documentation submitted by Embassy. Next, CMS stated that the state agency conducted a revisit of Embassy on January 13, 2009 and found with respect to the remaining deficiencies that the facility returned to substantial compliance effective December 12, 2008. CMS then advised Embassy that on the basis of the facility's "failure to comply with the Federal requirements," the final CMP amount was $350 per day, which accrued for a 35-day period, November 7, 2008 through December 11, 2008, for a total of $12,250. CMS also stated that it was rescinding the DPNA.

Following the submission of the parties' briefs and an in-person hearing held on August 7-8, 2009, the ALJ issued a decision on April 7, 2010 upholding CMS's action. The ALJ determined as a threshold matter that Embassy did not contest survey findings that it failed to comply substantially with 17 participation requirements. Consequently, the ALJ determined, the uncontested deficiencies were final and binding. With respect to the survey findings contested by Embassy, the ALJ determined that the facility failed to comply substantially with the quality of care requirement at 42 C.F.R. 483.25. Finally, the ALJ determined that the CMP amount was reasonable.

<u>Factual Background</u>

The contested noncompliance finding involved Embassy's care of one resident, identified as Resident 27 (R27), during an eight-day period beginning October 23, 2008 and ending October 31, 2008. The following facts relating to R27 are undisputed.

R27, a 52-year old male, was admitted to Embassy on September 25, 2008 with diagnoses that included asthma, chronic obstructive pulmonary disease (COPD), and a recent episode of pneumonia. CMS Exs. 1, 9, 10; Tr. at 32, 44, 75. On September 26, 2008, R27's physician, Dr. Jurak, ordered, among other things, a Combivent inhaler for R27 to "inhale 2 puff(s) by mouth every 4-6 hours as needed for shortness of breath." CMS Ex. 12, at 9. Embassy's plan of care for R27, dated September 28, 2008, stated that R27's physical needs were due to "<u>altered respiratory function</u> **secondary to:** [COPD and] asthma." CMS Ex. 9 (emphasis in original). The care plan directed staff to "observe and report signs of congestion, lethargy, labored breathing, wheezing, etc;" provide oxygen as ordered by R27's physician; "ausculate the lung fields for diminished

and abnormal breath sounds;" "ausculate breath sounds noting the presence of rhonchi/rales;" "assess for signs and symptoms of dyspnea and/or cyanosis;" and "check oxygen saturation as ordered and [as needed]." *Id.* The stated goal of the plan was for R27 to "be free from signs of respiratory distress (such as dyspnea and cyanosis) through the next review . . . 12-28-08." *Id.*

Embassy's nursing notes dated October 23, 2008, at 11:00 a.m., state that R27 complained of "weakness all over [his] body" and stated that he was "not feeling well." P. Ex. 3, at 4; CMS Ex. 8, at 5. The notes state that R27's "lungs [were] congested on expiratory" and that his oxygen saturation level measured "66% on [room] air." *Id.* The notes further show that oxygen was administered to R27 by mask, and that his oxygen saturation level increased to 98%. *Id.* Embassy paged Dr. Jurak, who gave new orders for R27, including albuterol nebulizer treatments and prednisone. *Id.*; P. Ex. 4, at 2; CMS Ex. 12, at 6. Dr. Jurak also ordered Embassy to "titrate [R27's] O2 to keep sats [above] 90%." *Id.* Embassy nursing notes show that the following three additional oxygen saturation levels for R27 were taken on October 23: 1:30 p.m., 90% on room air; 2:13 p.m., 92% on room air; and 10:00 p.m., 92%. P. Ex. 3, at 5; CMS Ex. 8, at 8.

Embassy nursing notes for the period October 24, 2008, through October 27, 2008, document one oxygen saturation level taken for R27, 90% on room air, dated October 24. P. Ex. 3, at 7; CMS Ex. 8, at 7.

On the morning of October 28, 2008, Surveyor Joella Daniels entered R27's room. Surveyor Daniels testified at the ALJ hearing that R27 "appeared to be in distress [and] was having difficulty breathing." Tr. at 24. Surveyor Daniels further testified that R27 also had trouble talking and that she "could hear from across the bed his respirations were wet and gurgling, and [that] when he would try and talk, he was coughing . . . nonproductively." *Id.* Surveyor Daniels testified that she immediately called a nurse to check R27. *Id.*

Embassy's October 28, 2008 nursing notes show that a nurse was summoned to R27's room because he was complaining of shortness of breath. P. Ex. 3, at 5; CMS Ex. 8, at 8. The notes state that R27 was given his Combivent inhaler, that his oxygen saturation was 71%, that his lung sounds had "inspiratory/expiratory wheezing," and that he had a nonproductive cough. *Id.* Embassy staff administered oxygen to R27, and, according to the nursing notes, R27's oxygen saturation level rose to 96-98%. *Id.* A subsequent nursing note, recorded at 12:30 p.m. on October 28, states that at R27's request, the oxygen was removed, and R27's oxygen saturation level dropped to 87%. P. Ex. 3, at 6; CMS Ex. 8, at 9. The October 28, 2008 nursing notes and R27's physician's orders show that the facility paged Dr. Jurak, who gave new orders to encourage R27 to wear his oxygen and to permit R27 to keep his Combivent inhaler at his bedside for use every six hours, two puffs. *Id.*; P. Ex. 4, at 1; CMS Ex. 12, at 2. Nursing notes from October 28

include one additional oxygen saturation measurement, “O2@ 22L 97%,” recorded at 1:00 p.m. P. Ex. 3, at 6; CMS Ex. 8, at 9.

Embassy’s nursing notes for R27 include one entry for October 29, 2008, which shows R27’s oxygen saturation level at 94%. CMS Ex. 8, at 7 The nursing notes include a single entry for October 30, which shows an oxygen saturation level for R27 of 93% on room air. *Id.*

On the morning of October 31, 2008, Surveyor Daniels again entered R27’s room and, according to her testimony, R27 was again experiencing shortness of breath and stated that he did not feel good. Tr. at 27. Surveyor Daniels testified that she again summoned a nurse to R27’s room. *Id.* Embassy nursing notes dated October 31, 2008, 9:50 a.m., document that R27 was “noted to have slight dyspnea,” had an oxygen saturation level of 79%-85%, and that his lung sounds were diminished bilaterally. P. Ex. 3, at 6; CMS Ex. 8, at 9. After R27 used his inhaler and was administered oxygen, the notes show, R27’s oxygen saturation rose to 90-95%. *Id.* The notes further provide that R27’s lung sounds continued to be diminished, that R27 “denie[d] any acute dyspnea,” and that R27 was a “chronic smoker” who refused to wear his nasal canula at times. *Id.* A chest x-ray dated October 31, 2008 showed that R27 had developed right upper lobe infiltrate, an abnormal accumulation of tissue in the cells. CMS Ex. 1, at 22.

Based on these facts and the record developed before him, the ALJ sustained CMS’s determination that Embassy failed to comply substantially with the quality of care requirement at section 483.25. The ALJ also determined that the CMP imposed by CMS was reasonable in amount. Embassy timely appealed the ALJ Decision.

Standard of Review

The Board’s standard of review on a disputed conclusion of law is whether the ALJ decision is erroneous. The Board’s standard of review on a disputed finding of fact is whether the ALJ decision is supported by substantial evidence in 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/divisions/appellate/guidelines/prov.html; *Batavia Nursing and Convalescent Inn*, DAB No. 1911, at 7 (2004), *aff'd*, *Batavia Nursing & Convalescent Ctr. v. Thompson*, 143 F. App'x 664 (6th Cir. 2005).

Analysis

A. The ALJ’s determination that Embassy failed to comply substantially with section 483.25 is supported by substantial evidence and free of error.

The quality of care requirement at 42 C.F.R. § 483.25 states that –

> Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

The Board has held that the language of section 483.25 requires long-term care facilities to furnish the care and services set forth in a resident's care plan; to monitor and document the resident's condition; and to implement physician orders. *See, e.g.*, *Sheridan Health Care Center*, DAB No. 2178 (2008); *Spring Meadows Health Care Center*, DAB No. 1966, 16-20 (2005); *Omni Manor Nursing Home*, DAB No. 1920 (2004), *aff'd*, *Omni Manor Nursing Home v. Thompson*, 151 F. App'x 427 (6th Cir. 2005). The quality of care provision also "implicitly imposes on facilities a duty to provide care and services that, at a minimum, meet accepted professional standards of quality since the regulations elsewhere require that the services provided or arranged by the facility must meet such standards." *Sheridan* at 15, quoting *Spring Meadows* at 17.

Applying the quality of care standard to the record evidence, the ALJ determined that Embassy did not provide R27 with the care and services that he needed to attain or maintain his highest practicable physical well-being, as required under section 483.25. ALJ Decision at 7-18. Specifically, the ALJ found that R27's compromised respiratory condition, plan of care, and physician's order to maintain R27's oxygen saturation level above 90% required Embassy to measure R27's oxygen saturation level with a pulse oximeter several times each day. *Id*. at 11-16. To support this finding, the ALJ cited Surveyor Daniels' and Director of Nursing (DON) Jodie Foster's testimony that a resident's oxygen saturation level can be measured only by a pulse oximeter. ALJ Decision at 14, citing Tr. at 28, 104. The ALJ also relied on Surveyor Daniel's testimony that only through regular and frequent pulse oximetry readings could Embassy ensure that R27's oxygen levels not fall "dangerously low into the 60s and 70s" and "determine whether R27's oxygen intake should be increased or decreased." ALJ Decision at 13-14. Since Embassy staff took R27's pulse oximetry reading only three times over the period October 24-27, 2008, and October 29-30, 2008, the ALJ determined, the facility failed to meet the quality of care requirement. *Id*. at 15. Further, the ALJ concluded, "the fact that R27 had three episodes of respiratory distress in an eight-day period," (on October 23, 28, and 31, 2008), was indicative of the facility's failure to provide the necessary care. *Id*. at 12.

On appeal to the Board, Embassy argues that the ALJ's determination is not supported by substantial evidence and that CMS, in fact, did not establish a prima facie case of noncompliance because CMS did not proffer any "medical testimony" to establish "what the duty of care is when monitoring oxygen saturation levels." P. Br. at 10. According to Embassy, the surveyor's hearing testimony that Embassy staff should have taken pulse

oximetry readings for R27 at every shift, which the ALJ "improperly accepted," represented only an unsubstantiated, "subjective opinion." *Id*. at 10-11.

Embassy's arguments have no merit. At the outset, we note, substantial evidence in the record supports the ALJ's finding that R27's "respiratory system was compromised" and required careful monitoring. ALJ Decision at 11; CMS Exs. 9, 10, 12. Embassy's assessment of R27 shows that R27 required, as a "special treatment and procedure," "monitoring [his] acute medical condition." CMS Ex. 10, at 7. Further, Embassy's own plan of care for R27 directed staff to monitor R27's respiratory system and **to check his oxygen saturation level as ordered and as needed**, with the stated goal that R27 "**be free from signs of respiratory distress (such as dyspnea and cyanosis) through the next review . . . .**" CMS Ex. 9 (emphasis added). Moreover, Embassy's records plainly show that on September 23, 2008, Dr. Jurak ordered R27's oxygen saturation level to be maintained above 90%. P. Ex. 4, at 2.

Consistent with the assessment, plan of care, and Dr. Jurak's order, Surveyor Daniels testified that oxygen saturation "for a normal person breathing at room air" is "90 or above;" that oxygen levels below 90% cause a person to experience lack of oxygenation to the organs, brain and tissues; and that a 70% oxygen saturation level indicates a person is "very compromised." Tr. at 25. Surveyor Daniels also testified that an order to titrate oxygen to maintain normal saturation levels requires frequent monitoring by use of a pulse oximeter, which "records the oxygen saturation level with a specific number percent." Tr. at 28. Based on her experience, Surveyor Daniels further testified, titrating oxygen levels for a "compromised resident" who has had "recent episodes of . . . respiratory distress" requires a facility to check oxygen saturation levels with a pulse oximeter at every 8-hour nursing shift and to document those levels. Tr. at 28, 68-69. In addition, as summarized above, Surveyor Daniels testified that, based on record review and personal observation, R27 experienced three episodes of respiratory distress over an eight-day period – on October 23, 28 and 31, 2008. Tr. at 24-27, 34. The ALJ found the surveyor's testimony as to both the applicable standard of nursing care and R27's respiratory condition to be credible. ALJ Decision at 13.

We conclude that the ALJ reasonably relied on Surveyor Daniels' testimony. The record shows that Surveyor Daniels is a registered nurse with over 20 years of experience as a state agency surveyor, and that she has received ongoing training and skill updates throughout her career, including training in respiratory care. Tr. 22-23; CMS Ex. 4 (Joella A. Daniels C.V.). Moreover, the surveyor's findings in this matter were based not only on her knowledge, professional experience, review of facility records and interviews, but also on her observations during two of the episodes when R27 manifested signs of respiratory distress, including dyspnea. Tr. at 24-28. As the ALJ noted, on both October 28 and October 31, 2008, "it was Surveyor Daniels who found R27 to be in a state of distress, experiencing shortness of breath and difficulty breathing," and in both instances, it was Surveyor Daniels who called for a nurse to assist R27. ALJ Decision at

12. Thus, Surveyor Daniels' testimony was not merely "subjective opinion," as Embassy alleges, but reliable evidence provided by an experienced and informed medical professional of the care R27 required and was provided. This evidence, either alone or in combination with other evidence of record, was more than sufficient to establish CMS's prima facie case.

Embassy contends that even if CMS did establish a prima facie case of noncompliance, Embassy "put forth more than enough evidence to rebut" CMS's case. P. Br. at 10. Specifically, Embassy argues that its DON, Jodi Foster, testified that "there are other ways to monitor oxygen saturation levels besides pulse oximetry" and that when there is no physician's order specifying how a facility should monitor the patient, it is "up to the nursing staff's judgment." *Id*. at 11. Since Dr. Jurak did not order Embassy "to perform pulse oximetry [for R27] on any kind of set schedule," Embassy contends, its nursing staff met the quality of care requirements by using "their own judgment to monitor R27's oxygen saturation levels through regular nursing observation . . . and by obtaining pulse oximeter readings from time to time." *Id*. at 5, 11. According to Embassy, the ALJ improperly rejected the DON's testimony without explanation. *Id*. at 11, citing *Reconsideration of Wesley Hal Livingston*, DAB No. 1406 (1993)(If there is evidence in the record which directly contradicts the evidence cited by the ALJ, the ALJ should not disregard that evidence without explaining why.)

These arguments mischaracterize the DON's testimony as well as the ALJ Decision. The hearing transcript shows that DON Foster did not testify that a resident's oxygen saturation levels could be measured by means other than pulse oximetry, as Embassy alleges. Rather, in response to the question of whether there are "other ways besides taking pulse ox saturations that the patient's condition or oxygenation can be observed," the DON testified: "Yes. [A] resident's **condition can be observed** . . . [t]here's **other ways to observe besides pulse oximetry**." Tr. at 77 (emphasis added). In response to the question of whether oxygen saturation levels can be obtained by observation, however, DON Foster testified: "**No . . . [that is done by] pulse oximetry**." Tr. at 104 (emphasis added).

Furthermore, the ALJ provided a detailed and persuasive explanation why he rejected the evidence that Embassy proffered to support its contention that staff sufficiently monitored R27's oxygen saturation levels. The ALJ acknowledged the DON's testimony that the question of whether it was necessary to take pulse oximetry readings on R27 was a matter of "nursing judgment . . . because there was no order for [the nurses] to take a daily pulse ox or a weekly pulse ox." ALJ Decision at 15, citing Tr. at 99. However, the ALJ found this testimony unpersuasive in light of Dr. Jurak's order and the uncontested evidence that oxygen saturation levels cannot be measured through observation. ALJ Decision at 15; P. Ex. 4, at 2; CMS Ex. 12, at 6; Tr. at 28, 104. The ALJ reasonably concluded that there "was only one way for petitioner's staff to ensure that R27's O2 saturation level was kept above 90% in accordance with Dr. Jurak's order, and that was

by taking the necessary pulse oximetry readings." ALJ Decision at 15. Determining a specific oxygenation percentage clearly requires a specific measurement. Embassy's DON and Surveyor Daniels agreed that pulse oximetry was the only way to obtain that measurement. Therefore, the ALJ logically determined, frequent pulse oximetry readings "were not unimportant or medically unnecessary" as the DON suggested, but central to the care that R27 required to attain or maintain his highest practicable physical well-being. *Id.*

Embassy further contends that "at the heart" of the determination "that oxygen saturation levels were not properly monitored is Embassy's purported failure to always maintain R27's oxygen saturation levels at or above 90%." Embassy Reply at 4. However, Embassy argues, section "483.25 does not [require] a nursing home [to] guarantee that oxygen saturation levels always and at all times be at or above 90%." *Id.* Embassy contends that "the fact that the oxygen saturation levels were not at or above 90% all the time is not a basis to conclude that saturation levels were not monitored." *Id.* "To the extent that [R27] suffered any respiratory discomfort in between nursing observations and pulse oximetry readings," Embassy writes, "he had the means necessary [an in-room inhaler] to quell any such discomfort." Embassy Br. at 12.

While the quality of care regulation does not require facilities "to guarantee positive outcomes," it does place on them "an affirmative duty to provide services designed to achieve those outcomes to the highest practicable degree." *Woodstock Care Center*, DAB No. 1726, at 25 (2002), *aff'd*, *Woodstock Care Ctr v. Thompson*, 363 F.3d 583 (6th Cir. 2003). The ALJ's determination that Embassy's monitoring of R27 was insufficient under this standard was not premised on the fact that R27's oxygen saturation level fell below 90% on several occasions, as Embassy's argument suggests. Rather, based on the record evidence, the ALJ determined that the services R27 required under his physician's order and plan of care included regular and frequent pulse oximetry readings because that was the only way to measure R27's oxygen saturation levels. The fact that R27's oxygen saturation levels dropped to dangerously low levels on three separate occasions, the ALJ therefore reasonably found, was an indicator of the facility's failure to meet its affirmative duty. ALJ Decision at 12. Moreover, the testimony and records establish that R27 did not merely experience "discomfort" when, at times, his oxygen saturation levels dropped below 90%. Rather, substantial evidence shows that on three separate occasions over an eight-day period, R27's oxygen saturation levels fell to perilously low levels in the 60s and 70s, posing the risk of more than minimal harm.

Embassy also contends that while its staff followed the nursing practice of "documentation by exception," wherein only significant changes in a resident's condition are recorded, "Embassy took special care to record R27's O2 levels almost on a daily basis several times a day." P. Br. at 5, citing Tr. at 78.

The record does not support these contentions. Embassy's nursing notes show that staff did not follow a practice of "documentation by exception." For example, while some entries indicate changes in R27's condition, there are numerous entries documenting R27's condition to be stable and unremarkable. *See, e.g.*, P. Ex. 3, at 4-5; CMS Ex. 8, at 5, 8 (10/22/08 "Resident resting in bed, skin warm to touch. Respirations unlabored, shows no signs of distress;" 10/26/08 "Lungs clear. [No] resp distress noted. [No] concerns voiced. Will continue to monitor."). Indeed, for October 26, there are three nursing note entries, each reflecting observations that R27 appeared to be stable. P. Ex. 3, at 5, 7; CMS Ex. 8, at 7-8. In contrast, there are no nursing note entries for October 25. While acknowledging the notes from the 26th, Embassy nevertheless attributes the absence of any recorded observations for the 25th to "no change in R27's condition." P. Br. at 6; Tr. at 83. In addition to evidencing inconsistency in Embassy's documentation practices, the nursing notes contain irregular entries, multiple notes that are not in chronological order. P Ex. 3; CMS Ex. 8. As the Board has previously stated, "accurate and timely nursing notes are integral to a facility's ability to provide coordinated and responsive care and services to each resident," which the quality of care standard requires. *Sheridan Health Care Center*, DAB No. 2178, at 34 (2008).

In addition, the record does not support Embassy's contention that it "took special care to record" R27's oxygen saturation levels "almost on a daily basis several times a day." During the periods October 24-27, and October 29-30, 2008 there are a total of only three recorded pulse oximetry readings – one on October 24, one on October 29, and one on October 30. P. Ex. 3, at 5, 7; CMS Ex. 8, at 7-8. Further, as the ALJ accurately observed, "[n]othing in the nurse's notes indicates that [Embassy's] staff had taken pulse oximetry readings" on October 23, 28 or 31, 2008 "prior to R27's episodes of compromised oxygen intake" on those days. ALJ Decision at 13. We note, as did the ALJ, that the DON testified that staff might have taken, but not recorded, additional pulse oximetry readings on R27. Tr. at 98-99. As the ALJ correctly stated, Embassy had the burden to produce documentation or other credible evidence to show that any additional readings were taken, but failed to carry this burden. ALJ Decision at 16; *see generally Evergreene Nursing Care Center*, DAB No. 2069 at 7-8 (2007) (discussing the "well-established framework for allocating the burden of proof on the issue of whether [a] SNF was out of substantial compliance").

Finally, Embassy points out that the ALJ determined that the facility obtained timely medical evaluations for R27 on October 23, 28 and 31 and obtained a physician order for R27 to keep his inhaler by his bed, contrary to the survey allegations. P. Br. at 11-12; ALJ Decision at 17-18. Embassy argues that the ALJ's determination that Embassy was not in substantial compliance with the quality of care standard is inconsistent with these findings, which demonstrate that R27 did receive adequate nursing care. *Id*.

We disagree. As summarized in the ALJ Decision, the survey SOD set out four separate allegations of Embassy's noncompliance with section 483.25: 1) failure to closely

monitor oxygen saturation and respiratory status on [R27] with compromised respiratory status; 2) failure to obtain timely medical evaluation after any of 3 separate episodes of respiratory distress; 3) failure to follow physician orders to maintain oxygen saturation levels greater that 90% and to encourage oxygen use; and 4) failure to obtain orders for resident access as needed to his bronchodilator inhaler. ALJ Decision at 7; CMS Ex. 1, at 18. The ALJ found that R27 did obtain timely evaluations by his physician (over the phone) after each "episode[] of respiratory distress." ALJ Decision at 17. The ALJ further determined that while Embassy's "staff should probably have acted on R27's request [to keep his inhaler bedside] sooner, it appears that once they received Dr. Jurak's order, they complied with it." *Id.* at 18. These findings, however, are independent of, and in no way detract from, the ALJ's determination regarding the facility's failure to properly monitor R27's oxygen saturation levels, as required under his plan of care and physician's order, or the seriousness of that failure. This determination, without more, is sufficient to support the finding of noncompliance.

Accordingly, we conclude that substantial evidence on the record supports the ALJ's determination that Embassy failed to provide R27 the necessary care and services to attain or maintain his highest practicable physical well-being, in accordance with his comprehensive assessment and plan of care, as required under section 483.25.

B. The ALJ's conclusion that the CMP of $350 per day from November 7, 2008, through December 11, 2008 is reasonable is supported by substantial evidence and free of error.

As noted, for noncompliance determined to pose less than immediate jeopardy to facility residents, CMS may impose a per-day CMP in an amount ranging from $50-$3,000 per day. 42 C.F.R. § 488.408(d)(1)(iii). To determine the amount of a CMP, CMS must take into account the factors listed at section 488.438(f). Those factors are: (1) the facility's history of noncompliance; (2) the facility's financial condition; (3) factors specified in section 488.404; and (4) the facility's degree of culpability, which includes neglect, indifference, or disregard for resident care, comfort or safety. 42 C.F.R. § 488.438(f). The factors set forth in section 488.404 include the seriousness of, and relationship among, the deficiencies, and the facility's history of noncompliance.
The Board has held that in assessing whether CMP amounts are within a reasonable range, the ALJ may not look into CMS's internal decision-making process but, rather, must make a de novo determination as to whether the amounts are reasonable, applying the regulatory criteria to the record developed before the ALJ. *See, e.g.*, *Kingsville Nursing and Rehabilitation Center*, DAB No. 2234, at 13 (2009) and cases cited therein.

Applying the regulatory factors to the record in this case, the ALJ upheld as reasonable in amount the $350 per-day CMP imposed from November 7, 2008, through December 11, 2008, which totaled $12,200. The ALJ determined that the presence of the 17 uncontested deficiencies posing at least the potential for more than minimal harm was

"significant enough to justify a CMP of $350 per day." ALJ Decision at 19. The ALJ further found that Embassy's noncompliance with the quality of care requirement gave "CMS a separate basis to impose a $350 per-day CMP" in light of the relevant factors. *Id*. at 19-20.

On appeal, Embassy argues that the CMP "is not reasonable under the circumstances." P. Br. at 12. First, Embassy argues, "CMS assessed the CMP on the basis of two G tags." *Id*. at 13. The 17 uncontested, "less severe tags," Embassy writes, "were plainly not the basis for the original assessment of the $350 per day CMP." *Id*. at 13-14. Since one of the G tags was deleted, Embassy argues, the ALJ should have reduced the CMP amount. Embassy also argues that the ALJ's determination to sustain the full amount of the CMP is inconsistent with the ALJ's simultaneous findings that R27 received timely medical evaluations on October 23, 28 and 31, 2008 and that Embassy did not fail to obtain orders regarding an in-room inhaler for R27, as CMS had alleged. P. Br. at 1.

Embassy's arguments provide no basis for overturning the ALJ's determination. Embassy's contention that CMS assessed the $350 per-day CMP solely "on the basis of two G tags" is not supported by the record. CMS's December 8, 2008 initial notice to Embassy stated that the survey found "the most serous deficiencies at scope and severity level G." However, the notice advised Embassy that CMS was imposing a CMP of $350 "as a result of the survey findings." Since "the survey findings" included the 17 noncompliance findings Embassy chose not to contest, the uncontested deficiencies plainly were taken into account by CMS in its original penalty assessment. Furthermore, CMS's February 4, 2009 notice of the "final status of remedies imposed" advised Embassy that the CMP amount remained $350 per day, even after one of the G-level deficiencies (tag F323, involving the accidents and supervision requirement at 42 C.F.R. § 483.25(h)) had been deleted. In any event, as noted, the ALJ was responsible for making a de novo determination as to whether the penalty amount was reasonable, applying the relevant factors to the record developed before him without regard to how CMS weighed the uncontested and contested deficiencies or specific survey findings to derive the penalty amount.

We conclude that the ALJ properly applied the relevant criteria to the evidence before him to reach the determination that the CMP imposed was reasonable. As the ALJ accurately observed, a $350 per-day penalty is at the low end of the penalty range. We concur in the ALJ's determination that the severity, scope and number of the 17 uncontested deficiencies support the imposition of a $350 per-day penalty even without the finding of noncompliance with section 483.25. The undisputed findings include evidence of deficiencies that, among others, involve infection control identified as widespread in scope; a pattern of staff intimidation of residents; a pattern of failure to address resident grievances; staff denying a resident access to his minister; the use of unnecessary restraints; failure to accurately assess residents' nutritional needs; failure to follow food safety standards; and failure to track, monitor, and provide physician-ordered

immunizations. CMS Ex. 1. Embassy did not deny that all of these deficiencies, which represent merely examples of the 17 undisputed deficiencies, posed the potential for more than minimal harm to residents. The seriousness of Embassy's noncompliance with section 483.25 and the facility's culpability further support imposition of a $350 per-day CMP. As discussed at length above, Embassy's failure to monitor closely R27's respiratory status was extremely serious, and showed significant disregard for R27's safety.

We additionally find that substantial evidence supports the ALJ's finding that Embassy "has a significant history of substantial noncompliance." ALJ Decision at 18, citing CMS Ex. 13, at 3, 5. Specifically, a summary report submitted by CMS covering the survey cycles beginning December 10, 2004 through April 24, 2009 shows that Embassy had multiple citations under the quality of care standard, including two at the immediate jeopardy level and one at the G-level of scope and severity, in the last four years. CMS Ex. 15, at 3, 5. Embassy does not deny the accuracy of this report. In addition, while not explicitly addressed by the ALJ, the report also shows Embassy has a history of noncompliance with several of the other of the participation requirements cited in the November 2008 survey, including the comprehensive assessment requirement at section 483.20; the comprehensive care plan requirement at 483.20(k)(3)(i); and the accommodation of needs standard at section 483.15(e)(1). CMS Ex. 13, at 1-5.

Finally, the requirement to consider a facility's financial condition in determining the amount of a CMP is to ensure that the facility has "adequate assets to pay the CMP without having to go out of business or compromise resident health and safety." *Sanctuary at Whispering Meadows*, DAB No. 1925, at 19 (2004) and cases cited therein; 59 Fed. Reg. 56,204 (1994). In this case, substantial evidence supports the ALJ's finding that Embassy had sufficient funds to pay the penalty. ALJ Decision at 18. A summary financial profile of Embassy submitted by CMS shows that Embassy had net patient revenues of over $7 million and net income of $91,811 at the end of 2007. CMS Ex. 14. Embassy has not challenged the accuracy of this evidence, nor has it provided evidence or argument that its financial condition is such that it cannot pay the penalty.

Accordingly, we sustain the ALJ's determination that the CMP imposed was reasonable.

Conclusion

For the reasons discussed above, we affirm the ALJ Decision.

/s/

Judith A. Ballard

/s/

Stephen M. Godek

/s/

Sheila Ann Hegy
Presiding Board Member