Department of Health and Human Services
DEPARTMENTAL APPEALS BOARD
Appellate Division

Autumn Ridge Rehabilitation Centre
Docket No. A-12-44
Decision No. 2467
June 29, 2012

FINAL DECISION ON REVIEW OF ADMINISTRATIVE LAW JUDGE DECISION

Autumn Ridge Rehabilitation Centre ("Autumn Ridge" or "facility"), a California skilled nursing facility (SNF), appeals a decision by Administrative Law Judge (ALJ) Steven T. Kessel, *Autumn Ridge Rehabilitation Centre*, DAB CR2467 (2011) (ALJ Decision). The ALJ upheld a determination by the Centers for Medicare & Medicare Services (CMS) that Autumn Ridge was not in substantial compliance with a Medicare requirement in 42 C.F.R. § 483.25(k) from November 4, 2010 through January 6, 2011. The ALJ also upheld CMS's determination that the noncompliance put one or more of Autumn Ridge's residents in "immediate jeopardy" from November 4 through December 13, 2010. Finally, the ALJ upheld CMS's imposition of civil money penalties (and other non-monetary remedies) on Autumn Ridge.

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

Legal Background

To participate in Medicare, a SNF must at all times be in "substantial compliance" with the requirements in 42 C.F.R. Part 483. 42 C.F.R. § 483.1. State health agencies conduct on-site surveys to verify compliance with those requirements. The term "substantial compliance" in Medicare's nursing home regulations is defined to mean "a level of noncompliance . . . 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. The same regulations define the term "noncompliance" to mean "any deficiency that causes a facility not to be in substantial compliance." *Id.*

Based on a survey's findings, CMS may impose enforcement "remedies" – including per-day civil money penalties (CMPs) – for any days on which the SNF is not in substantial compliance with one or more Medicare participation requirements. 42 C.F.R. §§ 488.402(b) and (c), 488.406. In choosing a remedy, CMS considers the "seriousness" of the SNF's noncompliance and may consider other factors specified in the regulations. *Id.* § 488.404(a), (c). "Seriousness" is a function of two factors: (1) "severity" – that is,

whether the noncompliance has created a "potential" for "more than minimal" harm, resulted in "actual harm," or placed residents in "immediate jeopardy" (the latter circumstance being the highest degree of severity); and (2) "scope" – whether the noncompliance is "isolated," constitutes a "pattern," or is "widespread." *Id.* § 488.404(b); State Operations Manual (SOM), CMS Pub. 100-07, Appendix P – *Survey Protocol for Long Term Care Facilities – Part 1*, sec. IV ("Deficiency Categorization").[1]

When CMS imposes a per-day CMP for noncompliance at the immediate jeopardy-level of severity, it must set the CMP amount within the "upper range" of $3,050 to $10,000 per day. 42 C.F.R. §§ 488.408(d)(3)(ii), 488.438(a)(1)(i). A per-day CMP for noncompliance below the immediate jeopardy level must be set within the "lower range" of $50 to $3,000 per day. *Id.* §§ 488.408(d)(1)(iii), 488.438(a)(1)(ii).

A SNF may challenge a finding of noncompliance that has resulted in the imposition of an enforcement remedy by requesting a hearing before an ALJ. *See* 42 C.F.R. §§ 488.408(g)(1), 498.3(b)(13), 498.5(b). When appealing a finding of noncompliance, a SNF may contend that the amount of the CMP imposed for the noncompliance is unreasonable. *See Lutheran Home at Trinity Oaks*, DAB No. 2111, at 21 (2007); *Capitol Hill Community Rehabilitation and Specialty Care Center*, DAB No. 1629, at 5 (1997).

Case Background

At issue in this case is how Autumn Ridge cared for residents with tracheostomies. A tracheostomy, sometimes called a "stoma," is a surgically created opening through the front of the neck and into the trachea (windpipe) that helps a patient breathe. CMS Ex. 96, ¶¶ 11-13. A tube, or cannula, is often inserted through the tracheostomy in order to help maintain an airway and facilitate the removal of secretions from the respiratory tract, but, in this case, the residents' tracheostomies did not have cannulas. *Id.*, ¶¶ 11, 15, 18. A common complication of a tracheostomy is a buildup of mucus, or "mucus plug," that blocks the surgically created airway, inhibiting respiration. *Id.*, ¶¶ 21-22; P. Ex. 1, ¶ 3. Suctioning removes mucus from the airway that the patient cannot clear by coughing. *Id.*

Section 483.25(k) provides that facilities "must ensure" that residents receive "proper treatment and care" for "special services." 42 C.F.R. § 483.25(k). Those "special services" include "tracheostomy care" (e.g., keeping the skin around a tracheostomy clean and dry, monitoring the resident for signs of an obstructed airway, and assessing the

[1] Appendix P of the State Operations Manual is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/ downloads/som107ap_p_ltcf.pdf.

resident's need for suctioning) and "tracheal suctioning." *Id.* § 483.25(k)(4), (k)(5); SOM, CMS Pub. 100-07, Appendix PP (F328 guidelines).[2] The requirements in section 483.25(k) are part of a SNF's overall obligation under section 483.25 to provide each resident with "the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the [resident's] comprehensive assessment and plan of care."

On December 13 and 14, 2010, the Indiana Department of Health (DOH) surveyed Autumn Ridge in response to a complaint filed by the representative of Resident B, a 73 year-old male. CMS Ex. 78, at 1-2; CMS Ex. 96, ¶¶ 7-8. Resident B had a tracheostomy and various other medical problems, including end-stage chronic obstructive pulmonary disease (COPD), chronic bronchitis, and a history of pharyngeal cancer (a disease that led to the removal of his larynx). CMS Ex. 96, ¶ 10. His representative alleged that the nursing staff would not, or were not permitted to, suction his tracheostomy, even though he had a physician's order for the procedure.[3] CMS Ex. 78, at 1-2. The representative also alleged that Resident B had been sent to the hospital multiple times as a result of Autumn Ridge's failure to provide tracheal suctioning. In addition to investigating the complaint about Resident B's care, DOH investigated whether two other residents with tracheostomies – Resident C and Resident D – had received necessary care for their tracheostomies. CMS Ex. 96, ¶¶ 8-9 (and exhibits cited therein). (C and D were residents of Autumn Ridge during DOH's survey; Resident B was transferred to another SNF prior to the survey.)

Based on its complaint survey, DOH determined that Autumn Ridge was not in substantial compliance with section 483.25(k) in caring for Residents B, C, and D.[4] CMS Ex. 3, at 3-17. DOH also determined that this alleged noncompliance was at the "immediate jeopardy" level of severity from November 4 through December 13, 2010, and that Autumn Ridge remained out of substantial compliance at a lower level of

[2] Appendix PP of the State Operations Manual is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/ downloads//som107ap_pp_guidelines_ltcf.pdf.

[3] The record contains evidence of two other surveys of Autumn Ridge, one in September 2010 and the other in November 2010. CMS Exs. 1-2. Both surveys found noncompliance with Medicare requirements. *Id.* The noncompliance findings from the September and November surveys are not at issue in this case, however.

[4] DOH also found during the December 2010 complaint survey that Autumn Ridge was noncompliant, below the immediate jeopardy level, with sections 483.25(d) and 483.20(k)(1). CMS Ex. 3, at 1. The ALJ held that these non-immediate jeopardy-level deficiency findings, as well as noncompliance findings from the September and November 2010 surveys, were "administratively final" because Autumn Ridge had not submitted evidence or argument about them. ALJ Decision at 3. Autumn Ridge takes no exception to that holding.

severity on December 14, 2010. *Id.* at 5-6, 16-17. During a subsequent "revisit" survey, DOH determined that Autumn Ridge had come back into substantial compliance with section 483.25(k) and all other Medicare requirements by January 7, 2010. *See* CMS Ex. 9, at 1.

Concurring with DOH's determinations, CMS imposed on Autumn Ridge a $3,550 per-day CMP for the period November 4 through December 13, 2010 (the immediate jeopardy period), and a $100 per-day CMP for the period December 14, 2010 through January 6, 2011.[5] CMS Ex. 10, at 1.

Autumn Ridge then requested an ALJ hearing to contest those remedies and the underlying determination that it was not in substantial compliance with section 483.25(k). In support of that noncompliance determination, CMS submitted documentary evidence (including nursing and hospital records) and the written direct testimony of DeAnn Mankell, R.N., the DOH surveyor who performed the complaint survey. *See* CMS Ex. 96. In response, Autumn Ridge submitted the written direct testimony of James P. McCann, M.D. (and two other exhibits). P. Exs. 1-3. Dr. McCann served dual roles: in addition to being Autumn Ridge's "Medical Director" (a physician designated by the facility to perform certain functions specified in section 483.75(i)), Dr. McCann was the attending physician of the three residents whose care is at issue here. P. Ex. 1, ¶ 2. During September 2011, the ALJ held a hearing during which Surveyor Mankell and Dr. McCann were cross-examined.

The ALJ Decision

The ALJ upheld CMS's noncompliance determination and associated remedies. In general, he found that Autumn Ridge had failed to provide Residents B, C, and D with "necessary care to address problems related to their tracheostomies." ALJ Decision at 3. More specifically, he found that "[Autumn Ridge]'s staff failed to suction the residents' tracheostomies to prevent them from becoming occluded or to remove mucus." *Id.* at 3-4. The ALJ also found that the nursing staff did not assess the residents' need for tracheal suctioning and did not formulate plans of care for their tracheostomies. *Id.* at 5-7.

[5] Based on the September and November 2010 surveys of Autumn Ridge (*see infra* note 3), CMS imposed "directed in-service training" and also notified Autumn Ridge that a "mandatory" denial of payment for new admissions (DPNA) would take effect on December 23, 2010 in the event that Autumn Ridge remained out of substantial compliance on that date. CMS Ex. 6, at 1-2. In the letter notifying Autumn Ridge of the CMPs imposed as a result of December complaint survey, CMS advised Autumn Ridge that the in-service training remedy remained in place and that the mandatory DPNA would take effect as scheduled on December 23, 2010 and remain in effect "until [the] facility has been determined to be in substantial compliance or [its] provider agreement is terminated." CMS Ex. 8, at 2. Autumn Ridge did not challenge the imposition of these non-CMP remedies before the ALJ, and it does not challenge those remedies on appeal either. *See* Request for Review; ALJ Decision at 10-11.

The ALJ focused largely on the evidence concerning Resident B, about whom he made the following findings of fact:

> Resident B lived at [Autumn Ridge] for a two-month period, from September 25, 2010 until November 25, 2010, when he was transferred to a hospital and then, to another nursing facility. During these two months, the resident was hospitalized four times [on October 7, October 31, November 7, and November 25] for problems related to breathing and/or obstruction of his tracheostomy site. This resident obviously had severe problems associated with his tracheostomy, and these problems were clearly well known to [Autumn Ridge]'s staff. But, the staff never prepared a care plan to address the resident's tracheostomy or to define measures that the staff would take to make sure that the resident's airway remained patent. Thus, the resident's care plan directed [Autumn Ridge]'s staff to observe the resident's tracheostomy stoma site for possible congestion and to observe the resident for symptoms of infection. But, it recited neither prophylactic treatments nor interventions in the event that problems developed, except to say that that the resident should receive medications and oxygen as ordered.
>
> On more than one occasion, physicians outside of Autumn Ridge ordered that the resident receive suctioning to keep his air passage clear. On each of these occasions, [Autumn Ridge]'s medical director [Dr. McCann] ordered that the suctioning order be discontinued. The consequence was that Resident B almost never received suctioning, despite orders from outside physicians that he receive it, and [Autumn Ridge] never evaluated or addressed the implications of this failure to provide care to the resident.

ALJ Decision at 4 (citations omitted); *see also* CMS Ex. 3, at 6-11 (describing Resident B's hospitalizations). According to the ALJ, Dr. McCann gave only "unarticulated policy reasons" for discontinuing other physicians' orders to suction Resident B's tracheostomy. ALJ Decision at 5.

The ALJ found that Resident C, like Resident B, had a tracheostomy but "no plan of care that addressed how to assure that the resident's airway remain[ed] open and free of mucus." ALJ Decision at 5. Furthermore, the ALJ found that although a hospital physician had issued an order for "routine tracheal care and suctioning," Autumn Ridge did not comply with that order, and Dr. McCann "countermanded" it without explanation. *Id.* In addition, said the ALJ, "[Autumn Ridge]'s staff performed no assessment of C showing that she did not need suctioning." *Id.*

As for Resident D, the ALJ found that she "had an order in her records for suctioning" but "no care plan addressing her tracheostomy or the means by which [Autumn Ridge]'s staff would attempt to keep her airway open." ALJ Decision at 5. In addition, the ALJ found that Resident D's "record is devoid of any evidence showing either that she ever received suctioning or that the staff assessed her and determined that suctioning was not needed." *Id.*

The ALJ summed up his findings:

> The picture presented of all three residents is of individuals with medical conditions that demanded that [Autumn Ridge] and its staff either provide specified medical care (tracheal suctioning) or to explain, in the course of assessing these residents and planning for their care, why such care was not necessary. [Autumn Ridge] and its staff did neither. The inescapable conclusion is that these residents' needs were simply ignored by [Autumn Ridge] and its staff. Moreover, in revoking explicit physicians' orders that residents receive tracheal suctioning, [Autumn Ridge]'s medical director, Dr. McCann, went beyond ignoring these residents' needs, he actively countermanded treatment that had been ordered for the residents without offering a coherent explanation for doing so.

ALJ Decision at 6.

Based on these and other findings, the ALJ concluded that Autumn Ridge was not in substantial compliance with section 483.25(k). ALJ Decision at 2, 3. The ALJ also concluded that CMS's determination that the noncompliance had placed one or more residents in "immediate jeopardy" was not clearly erroneous. *Id.* at 8. Finally, the ALJ held that the amounts of the per-day CMPs imposed by CMS for Autumn Ridge's noncompliance were reasonable. *Id.* at 11-13.

Autumn Ridge then filed its request for review, contending, *inter alia*, that: (1) "CMS failed to meet its burden of proving the alleged deficiencies"; (2) any noncompliance that may have existed was below the immediate jeopardy level of severity; and (3) the CMPs were excessive given the nature of any noncompliance and compared with penalties imposed in other cases. Request for Review (RR) at 2, 9, 13-19.

Standard of Review

The Board's standard of review concerning a disputed finding of fact is whether the finding is supported by substantial evidence on the record as a whole. *Guidelines – Appellate Review of Decisions of Administrative Law Judges Affecting a Provider's Participation in the Medicare and Medicaid Programs,* http://www.hhs.gov/dab/divisions/appellate/guidelines/index.html. The Board's standard of review concerning a disputed conclusion of law is whether the conclusion is erroneous. *Id.*

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 and Service, Inc. v. NLRB*, 522 U.S. 359, 377 (1998); *Golden Living Center – Frankfort*, DAB No. 2296, at 9-10 (2009).

Discussion

1. *Substantial evidence supports the ALJ's conclusion that Autumn Ridge was not in substantial compliance with 42 C.F.R. § 483.25(k).*

As the summary above indicates, the ALJ concluded that Autumn Ridge was noncompliant with section 483.25(k) because its staff failed to do one or more of the following for Residents B, C, and D: (1) assess the resident's need for tracheostomy-related nursing care, especially tracheal suctioning; (2) formulate a plan of care to meet the resident's assessed need for tracheal suctioning (and other tracheostomy-related care); and (3) provide tracheal suctioning to keep the resident's airway clear and minimize the risk of developing mucus plugs. As we discuss below, there is substantial evidence in the record for the ALJ's overall conclusion, most of it relating to Residents B and C, and most of it contained in Autumn Ridge's own nursing records and the records of the residents' hospitalizations.[6]

[6] Because the evidence relating to Resident B and Resident C is sufficient to support the ALJ's conclusions, we need not discuss the evidence relating to Resident D.

a. Resident B

The record shows that Resident B was admitted to Autumn Ridge on September 25, 2010 with a physician's order for tracheal suctioning to be performed "p.r.n." (as needed). CMS Ex. 84, at 54, 68, 88. Dr. McCann testified that because of their tracheostomies and "previous respiratory problems," Resident B (and Residents C and D as well) were "at risk" for developing "mucus plugs" that could lead to a "sudden decrease" in oxygen saturation (a measure of the amount of oxygen dissolved in the blood) unless they were coughed or suctioned out. P. Ex. 1, ¶ 3.

The undisputed evidence about Resident B's hospitalizations during October and November 2010 illustrates the risk described by Dr. McCann. On 12:00 a.m. on October 7, 2010, Resident B was noted to have "diminished lung sounds" and intermittent productive cough with clear sputum. CMS Ex. 84, at 103. Later that morning, at 9:00 a.m., the nursing staff reported that Resident B was short of breath and had an abnormally low oxygen saturation of 82 percent while on oxygen (normal oxygen saturation is 93 percent or higher). *Id.*; P. Ex. 1, ¶ 3. At 9:15 a.m., the nursing staff reported that Resident B was coughing thick sputum out of his tracheostomy. CMS Ex. 84, at 104. By 9:30 a.m., Resident B had been transported to the hospital emergency room, where he was treated for pneumonia, "acute" hypoxia (insufficient oxygen saturation), and a plugged tracheostomy (for which he received tracheal suctioning). *Id.* at 1-2, 5-6, 77, 79, 104. The ER physician noted that Resident B's tracheostomy "look[ed] good except for a lot of mucus present." *Id.* at 77 (emphasis added). Resident B returned to Autumn Ridge the same day. *Id.* at 104.

Paramedics transported Resident B to the hospital again on October 31, 2010 with shortness of breath and low oxygen saturation. CMS Ex. 84, at 3, 119. The paramedics found a mucus plug, which Resident B partly managed to expel on his own, and again he was suctioned in the hospital. *Id.* at 3, 4, 80. Resident B returned to Autumn Ridge the same day with a physician's order for tracheal suctioning (with saline) every four hours. *Id.* at 37, 60.

On November 7, 2010, Resident B was sent to the hospital after becoming "very SOB [short of breath] upon any exertion." CMS Ex. 84, at 8, 138. Noting that Resident B had not responded to tracheal oxygen, the hospital admitted him "for more aggressive treatment [of] his end stage [COPD]" and an "acute exacerbation" of his chronic bronchitis. *Id.* at 8-9. Although records do not indicate whether Resident B had a mucus plug or received tracheal suctioning on this occasion, the hospital's admission report states that Resident B had been previously hospitalized to remove a "mucous plug blocking in his airway causing hypoxia." *Id.* at 8. Another report, authored by Dr. McCann in his role as

Resident B's attending physician, states that Resident B "occasionally needed suctioning which the nursing home is not able to provide." *Id.* at 14. On November 10, 2010, the hospital sent Resident B back to Autumn Ridge with an instruction to "suction trachea prn." *Id.* at 32.

A fourth hospitalization occurred on November 25, 2010. On that day, Autumn Ridge's staff discovered a mucus plug and reported that Resident B was "having SOB [shortness of breath] and anxiety related to mucus plug." CMS Ex. 84, at 18, 128. He was sent to the hospital to have the plug removed, after which he was transferred to another SNF. *Id.* at 18, 19, 34, 128. The hospital's admission report states that Resident B "[a]pparently easily gets mucous plugs[.]" *Id.* at 18.

The evidence just recounted amply supports the ALJ's finding that Resident B needed tracheal suctioning to prevent or remove mucus plugs and maintain a clear airway. The ALJ found that Autumn Ridge's staff (including Dr. McCann) did not meet that need, in violation of section 483.25(k), and that finding too is supported by substantial evidence. That Resident B developed mucus plugs on at least three occasions during his residency (on October 7, October 31 and November 25) supports an inference that Autumn Ridge's staff did not suction Resident B's tracheostomy when needed or take other adequate measures to keep his airway clear. Autumn Ridge's own records strengthen that inference. Although Resident B's Medication Administration Record (MAR) for October 2010 reflects the September 2010 admission order for tracheal suctioning as needed, there is no clear indication on the MAR that the nursing staff suctioned Resident B's tracheostomy in the hours or days leading up to his first hospitalization on October 7, 2010.[7] *Id.* at 62, 65. According to daily nursing notes, the only reported instance of the nursing staff suctioning Resident B's tracheostomy prior to the first hospitalization occurred on September 29, 2010. *Id.* at 97. Resident B was also suctioned on November 12, 2010, although the nurse who performed the procedure indicated that she did not "go into [the] stoma." *Id.* at 137. The MAR and daily nursing do not indicate that Resident B was suctioned by Autumn Ridge staff at any other time. *Id.* at 61-66, 89-91, 93-139.

The ALJ's finding that Autumn Ridge did not suction Resident B's tracheostomony when needed is also supported by evidence that Dr. McCann (or others) countermanded outside physicians' orders to provide that service. According to the September 2010 MAR, the

[7] The October MAR shows orders for humidified oxygen and suctioning combined in a single entry. CMS Ex. 84, at 65. The nursing staff initialed the log for this combined entry on October 29, October 30, and October 31, but it is unclear whether that initialing signified that both orders were followed on those dates, or only the order for humidified oxygen. The latter is more likely because the suctioning-as-needed order appears by itself in another, separate entry – the daily log for which is entirely unmarked. *Id.* Furthermore, while the daily nursing notes for the last week of October routinely note the administration of oxygen, they do not indicate that staff ever suctioned Resident B's tracheostomy. *Id.* at 117-21.

September 2010 admission order for suctioning-as-needed was "discontinued" (by whom it is unclear) on September 29, 2010. CMS Ex. 84, at 61. On November 1, 2010, the day after Resident B's second hospitalization, from which he returned with a physician's order for periodic tracheal suctioning, Dr. McCann issued a telephone order to "d/c [discontinue] suction qid [four times daily] & prn." *Id.* at 31. On November 10, 2010, Dr. McCann issued another telephone order to "DC [discontinue] stoma suctioning due to facility policy." *Id.* at 33.

The reasons for the "policy" mentioned in Dr. McCann's order are not clear. Autumn Ridge did not produce any document setting forth the policy or its rationale. There is some evidence that the policy was merely an informal decision by the nursing staff not to perform tracheal suctioning in the absence of formal guidance from Autumn Ridge's corporate owner concerning that procedure. *See* CMS Ex. 3, at 12. Other evidence suggests that the nursing staff felt uncomfortable about suctioning an uncannulated stoma or believed it could not do so competently without traumatizing the resident. *Id.* (reporting a statement by the DON that it was "too traumatic to go down an open stoma").

Whatever the actual reason(s) for the policy, the existence or lack of a tracheal suctioning policy does not excuse Autumn Ridge's failure to comply with its obligation under section 483.25(k)(5) to ensure residents receive proper tracheal suctioning when needed. If Autumn Ridge's nursing staff lacked the training or expertise to perform tracheal suctioning in Resident B's circumstances, then Autumn Ridge was legally obligated to arrange for that nursing service to be performed by a competent outside medical professional (such as a respiratory therapist). *See* 42 C.F.R. § 483.75(h). Autumn Ridge failed to demonstrate that it did either. More fundamentally, it failed to produce evidence that it assessed Resident B's need for tracheal suctioning (or the implications of not providing that service). On October 18, 2010, eleven days after Resident B's first hospitalization, Autumn Ridge's staff instituted a plan of care which recognized that Resident B's tracheostomy had the potential to cause complications. CMS Ex. 84, at 73. Although the plan directed staff to do several things,[8] it nowhere mentions Resident B's need for tracheal suctioning or indicates how the staff intended to prevent or remove mucus plugs.

As the ALJ recognized, Resident B's unique clinical circumstances may have provided good reason(s) not to suction his tracheostomy. However, the ALJ found, and our review confirms, that Dr. McCann and the nursing staff failed to document any such reasons in

[8] The October 18th plan of care directed staff to: "observe for congestion at trach stoma site"; "observe for symptoms of infection" around the stoma; "observe for shortness of breath"; administer oxygen as ordered; notify the physician of symptoms of infection, unrelieved shortness of breath, or increased edema; and "observe for and treat symptoms of anxiety related to shortness of breath." CMS Ex. 84, at 73.

Resident B's treatment records. More important, the November 10th telephone order indicates that the rationale for the ordered action was "facility policy," rather than a medical reason. The only other relevant written entry by Dr. McCann in Resident B's medical records from the period is a progress note dated November 4, 2010. There, Dr. McCann stated that the nursing staff "are restricted by nursing home policies and are not allowed to suction his [tracheostomy],"[9] and that staff "unfortunately . . . can't directly clean it out," referring to Resident B's tracheostomy. CMS Ex. 84, at 40. Dr. McCann now states that "management had never had restrictions on suctioning" and that "I know now that the facility in fact had policies which would allow for suctioning." P. Ex. 1, ¶ 9 (emphasis added). The ALJ could reasonably find this testimony not to be credible. At minimum, it suggests that Dr. McCann, in his capacity as Autumn Ridge's Medical Director, was mistaken or ignorant about applicable resident care policies and may have provided incorrect advice to the nursing staff about those policies (to Resident B's detriment). Dr. McCann may understand now that Autumn Ridge's policies did not prohibit tracheal suctioning. But as the facility's Medical Director, he was obligated to know in October and November 2010 what those policies were and to ensure that they were implemented to maximize Resident B's well-being in the facility. *See* 42 C.F.R. §§ 483.25 (requiring a SNF to provide necessary care and services to enable the resident to attain his "highest practicable . . . well-being") and 483.75(i) (stating that a SNF's medical director is "responsible for . . . [i]mplementation of resident care policies" and "coordination of medical care in the facility").

Autumn Ridge contends that Dr. McCann's testimony established that tracheal suctioning was "not appropriate" for Resident B under any circumstances, implying that the procedure's risks outweighed its potential benefits. RR at 1. But Dr. McCann did not express such an opinion in his testimony. Instead, Surveyor Mankell testified (and Dr. McCann did not deny) that Dr. McCann told her during his survey interview that "he actually wanted Resident B to be suctioned, since Resident B had thick secretions and was not able to cough them all out of his stoma." CMS Ex. 96, ¶ 42.

Dr. McCann testified that it was Autumn Ridge's Director of Nursing (DON), not he, who made the "professional judgment" that suctioning was "unsafe" for Resident B due to his "numerous complex diagnoses." P. Ex. 1, ¶ 8. But there is no evidence of that judgment in Resident B's nursing records, and the DON told Surveyor Mankell that it was Dr. McCann who did not want the resident to be suctioned due to Resident B's history of cancer. CMS Ex. 96, ¶ 41. The conflicting statements by Dr. McCann and the DON leave the impression that no one on Autumn Ridge's staff – including the Medical Director – assumed responsibility to provide or arrange for the tracheal suctioning that Resident B evidently needed.

[9] The November 4th progress note actually states that the nursing staff was not allowed to suction [Resident B's] pharynx," but Dr. McCann testified that the word "pharynx" was a "typo" and that he "meant to say larynx or tracheal suctioning." P. Ex. 1, ¶ 9.

Although Dr. McCann did not say that tracheal suctioning was medically inappropriate for Resident B, he vaguely suggested, in various statements, that tracheal suctioning was unnecessary or of limited utility in Resident B's circumstances. More specifically, Dr. McCann asserted:

- Resident B's hospitalizations on October 7th and October 31st were due to sudden and "acute respiratory events" – namely, flare-ups of his chronic bronchitis "causing increased secretions with diminished capacity to cough it out" – that were "not attributable to anything done or not done by the facility." P. Ex. 1, ¶¶ 6-7.

- Prior to Resident B's hospitalizations, he "exhibited no significant symptoms which were indicated from the assessments or the O2 SATS [oxygen saturation levels]," and that "[n]othing based on [Resident B's] condition at this time would have suggested that suctioning would be required prior to these events." P. Ex. 1, ¶ 7.

- "The removal of a mucus plug is usually not successful with suctioning," other measures (saline aerosols, warmed moistened air, or albuterol) "can help thin the mucus," and a patient "will eventually cough the obstructing plug." P. Ex. 1, ¶ 7.

- The "increases of mucus levels . . . were attributable to" Resident B's voluntary leaves of absence from the facility (to be with family), when he did not have access to humidified oxygen, and were "clearly not attributable to any conduct on behalf of the facility or its staff." P. Ex. 1, ¶ 13.

The ALJ gave no weight to this and other testimony by Dr. McCann, finding that he was not a credible witness and characterizing his testimony as consisting "entirely of *post hoc* rationalizations and naked assertions that are unsupported by clinical evidence." ALJ Decision at 8. In general, the Board defers to an ALJ's findings on the credibility of witness testimony unless there are compelling reasons not to do so. *Woodland Oaks Healthcare Facility*, DAB No. 2355, at 7 (2010); *Van Duyn Home and Hospital*, DAB No. 2368, at 10-11 (2011); *Columbus Nursing and Rehabilitation Center*, DAB No. 2398, at 4 (2011); *Illinois Knights Templar Home*, DAB No. 2369, at 5-6 (2011).

As indicated, Resident B's nursing records do not indicate any clinical justification for countermanding the outside physicians' orders for tracheal suctioning. Moreover, Dr. McCann's suggestion that suctioning was unnecessary or ineffective is undercut by his statement to the surveyor (which he did not disavow) that he wanted Resident B to be

suctioned in the facility. It is also undercut by the fact that Resident B's tracheostomy

was suctioned in the hospital and that hospital physicians issued orders for tracheal suctioning. For these reasons alone, the ALJ was justified in treating Dr. McCann's testimony as "post hoc rationalizations." We note also that many of Dr. McCann's statements focus on the factors that contributed (or allegedly contributed) to Resident B's risk of mucus plugging (e.g., chronic bronchitis, absences from the facility). However, such factors did not minimize the nursing staff's responsibility. We agree with the ALJ that Autumn Ridge's "obligations to provide appropriate tracheostomy care to the resident were only heightened by the resident's medical conditions that put him at risk for tracheostomy-associated complications." ALJ Decision at 9-10. In other words, Autumn Ridge was obligated to deal with the potentially adverse consequences of Resident B's underlying conditions; according to Dr. McCann, those consequences were thick respiratory secretions that he was unable to expel by coughing.

Autumn Ridge has identified no compelling reason to set aside the ALJ's credibility finding. It asserts that Dr. McCann's testimony deserved deference or conclusive weight because Dr. McCann was Resident B's "treating" physician and was in the "best position to determine whether suctioning [was] appropriate for" him given his "'complex and varying medical diagnoses.'" RR at 4, 5, 6, 8 (quoting P. Ex. 1, ¶17). Autumn Ridge correspondingly asserts that the ALJ "over-relied" on the testimony of Surveyor Mankell. RR at 5, 7-8 (claiming that the ALJ erred by "assigning probative value to surveyor's testimony). According to Autumn Ridge, Surveyor Mankell was in "no position to second-guess" Dr. McCann's medical opinions or "treatment decisions" because she was not a physician (or was otherwise unqualified by training or experience to render an opinion on the medical issues addressed by Dr. McCann), had no "treatment relationship" with the residents, did not personally examine the residents or their stomas, and admittedly failed to consider – or inquire about– facts about the residents' medical condition and actions that were (in Autumn Ridge's view) relevant to a determination of noncompliance. RR at 2, 4, 5-8. Autumn Ridge also suggests that the ALJ's credibility finding violates the spirit of the "treating physician rule" codified at 20 C.F.R. 404.1527(d)(2). RR at 8-9. Autumn Ridge acknowledges that the rule is inapplicable in this type of administrative proceeding but asserts that the Board has cautioned that a treating physician's experience with a patient "<u>should not</u> be ignored." RR at 9 (emphasis in original) (citing *Golden Living Center – Frankfort* at 7). Autumn Ridge contends that this is precisely what the ALJ did – "he ignored Dr. McCann's testimony as it related to whether the residents should be suctioned." RR at 9.

The ALJ did not "ignore" Dr. McCann's testimony. He considered the testimony but found that it was unsupported by "clinical evidence." An ALJ may discount a treating physician's testimony when it is unpersuasive, internally inconsistent, or not "consistent with the weight of other substantial evidence." *Golden Living Center – Frankfort* at 7. We note that Autumn Ridge's appeal to Dr. McCann's status as Resident B's treating physician is inherently weak because Dr. McCann did not testify that he ordered Autumn Ridge's staff not to suction Resident B based on his assessment of the resident's clinical circumstances. Rather, he testified that his orders to discontinue suctioning were based on misinformation from the DON about unspecified nursing policies. P. Ex. 1, ¶ 9. Hence, in countermanding orders for tracheal suctioning, Dr. McCann did not make an individualized treatment decision to which deference might be given.

Autumn Ridge contends that CMS could not have met its evidentiary burden unless it produced a physician to rebut the testimony of Dr. McCann. RR at 7. Autumn Ridge misunderstands the applicable evidentiary burdens. *See Batavia Nursing and Convalescent Center*, DAB No. 1904 (2004) (discussing the parties' evidentiary burdens before the ALJ), *aff'd, Batavia Nursing & Convalescent Ctr. v. Thompson*, 129 F. App'x 181 (6th Cir. 2005). Even if CMS had the ultimate burden of persuasion, however, we would conclude that substantial evidence supports the ALJ's findings. Since the ALJ found Dr. McCann not to be credible, the ALJ reasonably accorded no weight to his testimony, relying instead on the undisputed findings in the SOD, the testimony of Surveyor Mankell, and the residents' medical records.

Finally, Autumn Ridge contends that its nursing staff met its regulatory obligation to Resident B by sending him to the hospital emergency room for tracheal suctioning. RR at 1, 18-19. In support of this argument, Autumn Ridge suggests that Resident B required a type of tracheal suctioning – "deep suctioning" – that its staff was not able to perform safely or competently. RR at 1. For that reason, suggests Autumn Ridge, its staff acted reasonably by transferring Resident B to the hospital promptly when his respiratory status began to deteriorate. Autumn Ridge submits that its case is similar to *Glenburney Nursing Center*, DAB CR1217 (2004). RR at 18-19. In *Glenburney*, an ALJ found that the SNF's practice of transferring a resident to the hospital for deep tracheal suctioning was a "reasonable practice":

> Given the very close proximity of the hospital, it is much more prudent to have a hospital perform such a delicate service, especially when a registered nurse would not feel comfortable doing such a service or would not have the requisite routine experience in performing such a service.

DAB No. CR1217, at 20. Autumn Ridge contends that the ALJ should have considered the reasoning in *Glenburney* in light of evidence that its facility is located only "a block and a half" from a hospital. RR at 18-19 (citing Tr. at 55).

This argument has no merit. First, the decision in *Glenburney* is not precedential. Second, it is distinguishable on the facts. In *Glenburney*, the ALJ found, based on his review of the resident's record, that the facility provided the necessary care and services consistent with her doctor's orders and care plan, and credited her doctor's testimony that he never intended for the facility to do "deep suctioning." DAB No. CR1217, at 20. Here, Autumn Ridge submitted no evidence about "deep suctioning," what that procedure entailed, or why the nursing staff could not perform it in Resident B's circumstances. Treatment records do not say that Resident B needed deep suctioning (rather than less invasive suctioning) to prevent airway blockage, and Dr. McCann did not testify that development of a mucus plug was unavoidable or that timely, routine suctioning in the facility would not have helped prevent or reduce the risk of mucus plugs. The outside physicians' orders for tracheal suctioning, and Dr. McCann's statement to the surveyors that he wanted Resident B to be suctioned at the facility, suggest precisely the opposite.

For all these reasons, we hold that substantial evidence supports the ALJ's conclusion that Autumn Ridge was not in substantial compliance with section 483.25(k) in caring for Resident B.

b. Resident C

Substantial evidence likewise supports the ALJ's finding that Autumn Ridge failed to meet its obligation to provide Resident C with necessary tracheostomy care, including tracheal suctioning. Medical records show that at 7:30 p.m. on October 24, 2010, Resident C was transported by paramedics to the hospital. CMS Ex. 86, at 1, 6. Her oxygen saturation was reported to be in the 80 percent-range upon arrival at the hospital. *Id.* at 1. The emergency room physician reported that Resident C "was in respiratory failure at the time of arrival . . . but upon suctioning there [at Autumn Ridge] and suctioning here [at the hospital] upon arrival the patient's respiratory status is better." *Id.* at 3 (emphasis added). The same report indicates that Resident C's oxygen saturation improved after "a lot of thick secretions" were suctioned from her stoma. *Id.* These statements and findings make clear that Resident C's tracheostomy became occluded at Autumn Ridge, that this condition contributed to her respiratory difficulty, and that Resident C needed tracheal suctioning to keep her airway clear. Although the hospital physician reported that Resident C was suctioned at Autumn Ridge, there is no evidence that it was Autumn Ridge's nursing staff – rather than the paramedics – who did so. In fact, there is no evidence indicating that Autumn Ridge's nursing staff assessed Resident C's need for tracheostomy care (including tracheal suctioning) or rendered such care prior to her October 24, 2010 hospitalization.

On October 29, 2010, Resident C was discharged back to Autumn Ridge with an order for "routine trach" care, but there is no evidence that this order was incorporated into Resident C's plan of care or other treatment protocols. *See* CMS Ex. 86. Surveyor Mankell testified, and Autumn Ridge does not dispute, that Resident C's plan of care "did not include any interventions for tracheostomy stoma care or maintaining an open airway to prevent hypoxia." CMS Ex. 96, at 4.

On November 2, 2010, Resident C returned to the hospital, where an examining physician noted that she had a "stoma over her neck without a tracheostomy tube which is covered with secretions." CMS Ex. 86, at 26. On November 6, 2010, the hospital sent Resident C back to the facility with an order to suction her stoma as needed. *Id.* at 21. That same day, Dr. McCann phoned in an order to "d/c [discontinue] trach suction." *Id.* at 19. The order implies that Autumn Ridge was suctioning Resident C (when necessary) all along, but we see no evidence that Autumn Ridge's nursing staff ever suctioned Resident C. Her medical records do not indicate why Dr. McCann issued the discontinuation order or indicate how the nursing staff intended to minimize the risk of tracheostomy-related complications, including airway blockage, without performing (or arranging for) tracheal suctioning.

In light of these circumstances, the ALJ reasonably concluded that Autumn Ridge failed to provide Resident C with necessary tracheostomy care and tracheal suctioning in violation of section 483.25(k).

Dr. McCann testified that Resident C did not have "stoma secretions noted for an extensive period of time" and that her stoma was "remarkably smaller than" Resident B's, "contraindicating tracheal suctioning." P. Ex. 1, at 1. He also said that a respiratory therapist had determined that suctioning was "contraindicated" for Resident C because of the size of her stoma.

As we noted, the ALJ gave adequate reasons for finding Dr. McCann's testimony not to be credible. One of those reasons is that Dr. McCann's opinions were unsupported by contemporaneous medical records. That reason holds for Resident C. Nowhere in her nursing records is there a notation that suctioning was "contraindicated" because of the size of her stoma. Moreover, Dr. McCann does not explain why it would have been appropriate for the nursing staff to refrain from suctioning Resident C until her secretions persisted for an "extensive" period. Finally, there is no evidence that Dr. McCann formed his opinions about Resident C based on his own personal and contemporaneous assessment of her need (or lack of need) for tracheostomy care during the relevant timeframe.

Autumn Ridge suggests that Surveyor Mankell and the ALJ improperly substituted their opinions about Resident C's care for Dr. McCann's "treatment decisions." RR at 6. This argument falls flat because there is no evidence that Dr. McCann made a treatment decision concerning Resident C's tracheostomy based on his assessment of her unique clinical needs. The ALJ reasonably inferred from the evidence that Dr. McCann ordered that tracheal suctioning not be performed for Resident C in order to comply with a facility policy, as with Resident B.

For these reasons, we hold that substantial evidence supports the ALJ's conclusion that Autumn Ridge was not in substantial compliance with section 483.25(k) in caring for Resident C.

2. *CMS's immediate jeopardy finding is not clearly erroneous.*

"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. Actual harm is not a prerequisite for an immediate jeopardy finding; immediate jeopardy may exist when the noncompliance is "likely to cause" death or serious injury, harm, or impairment. 42 C.F.R. § 488.301; *Life Care Center of Tullahoma*, DAB No. 2304, at 58 (2010), *aff'd, Life Care Center of Tullahoma v. Sebelius*, No. 10-3465 (6th Cir. Dec. 16, 2011), available at http://www.ca6.uscourts.gov/opinions.pdf/11a0852n-06.pdf.

CMS's immediate jeopardy finding "must be upheld unless it is clearly erroneous." 42 C.F.R. § 498.60(c)(2); *Maysville Nursing & Rehabilitation Facility*, DAB No. 2317, at 11 (2010). "The 'clearly erroneous' standard . . . is highly deferential and places a heavy burden on the facility to upset CMS's finding regarding the level of noncompliance." *Yakima Valley School*, DAB No. 2422, at 8 (2011) (citing cases).

As discussed, substantial evidence supports the ALJ's finding that during late 2010, Autumn Ridge had a policy or practice not to perform tracheal suctioning for residents, like Residents B and C, who were vulnerable to mucus plugging of their tracheostomies. CMS could reasonably determine based on that evidence that Autumn Ridge's noncompliance – its failure to provide or arrange for tracheal suctioning, or to take alternative measures to minimize the risk of a plugged stoma – made it likely that those residents would experience shortness of breath, hypoxia, and other harmful consequences. For Residents B and C, the likelihood of harm materialized into actual harm during their residence at Autumn Ridge. Both residents experienced shortness of breath and hypoxia – Resident B on October 7, October 31, and November 25, 2010, and Resident C on October 24, 2010 – conditions that were alleviated in part by tracheal suctioning at the hospital. Resident B also suffered anxiety during one of the episodes. CMS Ex. 84, at 128.

Autumn Ridge did not allege (much less demonstrate) that shortness of breath, hypoxia, and anxiety do not constitute "serious" harm in these circumstances, nor did it demonstrate the absence of a causal link between its noncompliance and the actual or threatened harm. Instead, Autumn Ridge contends that the ALJ ignored evidence that the residents were not actually admitted to the hospital for these conditions. That the residents were sent to the hospital on these occasions, however, supports a finding that the conditions were serious, irrespective of whether the residents needed to be admitted to the hospital after the initial treatment in the emergency room.

Autumn Ridge also contends that its noncompliance created only the "mere 'possibility,'" rather than a likelihood, of serious harm. RR at 15. In support of that contention, Autumn Ridge asserts that Resident B "did not experience a respiratory event" during the period in which it was found to be in immediate jeopardy (November 4 through December 12, 2010). *Id.* According to Autumn Ridge, Resident B "was not even present in Autumn Ridge during much of th[at] time" but instead was either in the hospital across the street or "out on 'leave' with his family." *Id.*

This argument does not convince us that CMS's determination about the duration of the immediate jeopardy was clearly erroneous. First, Resident B did experience a "respiratory event" during the immediate jeopardy period – on November 25, when he was sent to the hospital to remove a mucus plug after experiencing shortness of breath and anxiety. *See* CMS Ex. 84, at 128. Second, although Resident B was a resident of Autumn Ridge for only 15 of the 40 days during the immediate jeopardy period, Resident C, who was similarly at risk of harm from the noncompliance, resided at Autumn Ridge for all but two days (November 4 and 5) during that period. *See* CMS Ex. 86. Furthermore, Resident B's leaves of absence to be with family were brief. The sign-out sheet shows five leaves of absence during the immediate jeopardy period. P. Ex. 2, at 2. Three lasted no more than one hour each, and a fourth was for two hours and 40 minutes. *Id.* The fifth absence began at 10:45 a.m. on November 5 (the sign-out sheet does not indicate whether Resident B left in the morning or afternoon, but we assume it was the morning). *Id.* On this occasion, according to the sign-out sheet, Resident B returned to the facility at "10:28," but the return date is illegible, so we cannot determine whether B returned at 10:28 p.m. on November 5 or at 10:28 (a.m. or p.m.) on some subsequent day. *Id.* Autumn Ridge offered no evidence to clear up the confusion, and it is worth noting that no other documented absence (during October and November 2010) lasted more than three hours.

Autumn Ridge further contends that in upholding CMS's immediate jeopardy finding, the ALJ unjustifiably relied on Surveyor Mankell's testimony that staff did not keep oxygen and suctioning equipment close enough to the three residents in question. RR at 9-11, 17-18. Autumn Ridge asserts that the hearing testimony established precisely the

opposite – that the equipment was within "adequate proximity" of those residents. RR at 10-11. The ALJ committed no error here because he did not, in fact, rely on the surveyor's testimony concerning the location of oxygen and suctioning equipment (and neither do we). The ALJ expressly declined to resolve the factual dispute about the equipment's availability, stating that it was "unnecessary to address the issue" because he would have upheld the immediate jeopardy determination even if residents had timely and sufficient access to the equipment. ALJ Decision at 10.

Autumn Ridge also contends that the ALJ improperly inferred the existence of immediate jeopardy from an erroneous finding that it had a policy prohibiting tracheal suctioning. RR at 9. "Why would a facility have such a policy," Autumn Ridge asks, "but yet maintain suctioning equipment throughout the facility?" *Id.* Autumn Ridge asserts that its staff was "well equipped to suction patients if and when needed." *Id.*

The availability of suctioning equipment does not necessarily mean that Autumn Ridge had staff qualified to perform suctioning at the time at issue here. In any event, substantial evidence (discussed at length above and on page seven of the ALJ Decision) supports the ALJ's finding that, during the period in question, Autumn Ridge's nursing staff had a policy or practice not to perform tracheal suctioning.

Finally, relying on Appendix Q of the State Operations Manual (SOM),[10] Autumn Ridge complains that CMS "over-relied on documentary evidence to identify an immediate jeopardy." RR at 2, 11-13. Autumn Ridge asserts that the immediate jeopardy determination was based largely on a "closed record review" of Resident B's stay (since Resident B was no longer a resident at the time of the survey), rather than upon first-hand "observations" of Resident B and the care rendered to him in the facility. RR at 11-13. Autumn Ridge asserts that first-hand observations of Resident B by a surveyor were necessary because "the size of the resident's stomas [was] absolutely relevant to whether suctioning was contraindicated." RR at 12. Autumn Ridge also contends that Surveyor Mankell (or DOH) "failed to conform" to procedures and instructions in Appendix Q by relying on a closed record review to make an immediate jeopardy determination. *Id.*

For several reasons, this argument has no merit. The Medicare statute and regulations do not require that an immediate jeopardy determination be based on a surveyor's personal observation of a resident, nor do they preclude CMS from basing that determination entirely on an assessment of relevant documentation. That is unsurprising because documenting a resident's medical condition and care is a critical nursing function. *See* 42 C.F.R. § 483.75(l) (providing that a SNF must maintain complete and accurate clinical records). Consequently, documents created or maintained by a SNF may be reliable and probative evidence about the quality of a resident's care.

[10] Appendix Q of the State Operations Manual, entitled "Guidelines for Determining Immediate Jeopardy," is available at https://cms.gov/manuals/Downloads/soml07apqimmedjeopardy.pdf.

Second, the conduct of the survey is not at issue in this administrative proceeding. The issue before the ALJ (and the Board) is the lawfulness of CMS's determination of noncompliance, and a resolution of any factual issues relevant to that determination "hangs on the ALJ's de novo review of the evidence" submitted by the parties. *Northlake Nursing and Rehabilitation Center*, DAB No. 2376, at 10 (2011). In other words, the fate of CMS's noncompliance determination hinges on the quality of the evidence produced by the parties in this proceeding, rather on a judgment about whether state survey agency complied with program instructions in gathering information supporting its compliance findings.

Third, Dr. McCann did not testify that tracheal suctioning was contraindicated for Resident B because of the size of his stoma, undermining Autumn Ridge's rationale for the necessity of visual observation.

Fourth, while Appendix Q states that "[o]bservation is a key component of any investigation" and that "record review is used to support observations and interviews," it does not say that observations are always necessary to support an immediate jeopardy determination. On the issue of the quantum and quality of evidence needed for that determination, Appendix Q states only that the survey team "needs to have gathered and validated *sufficient information* . . . to begin the decision process." SOM, Appendix Q, sec. V.B. Here, Surveyor Mankell relied on both record review and employee interviews in making her survey findings regarding Resident B. *See* CMS Ex. 3, at 6-12; CMS Ex. 96, ¶¶ 23-43.

Finally, we see nothing in any other part of the SOM or its appendices that expressly precludes a state survey agency from conducting surveys or making compliance findings based on "closed records." Appendix P, which sets out more general guidelines for conducting nursing home surveys, expressly indicates that surveys will involve investigations based on closed records. SOM, Appendix P, sec. II.B. (Task 5 ("Information Gathering"), Sub-Task 5C, ¶ F. In *Beechwood Sanitarium*, DAB No. 1906, at 87-88 & n. 34 (2004), the Board rejected a SNF's argument that CMS could not properly base its noncompliance determination on a review of records. In doing so, the Board noted: "Were surveyors . . . precluded from considering closed records in evaluating the care provided by a facility, they would be unable to take into account problems experienced by residents whose families had removed them or by residents who had died." DAB No. 1906, at 88 n.34.

3. *The ALJ's conclusion that the CMP amounts were reasonable is supported by substantial evidence and free of legal error.*

An ALJ (or the Board) determines de novo whether the amount of a CMP is reasonable based on facts and evidence in the appeal record concerning the factors specified in section 488.438. *See* 42 C.F.R. § 488.438(e), (f); *Senior Rehabilitation and Skilled Nursing Center*, DAB No. 2300, at 19-20 (2010), *aff'd, Senior Rehabilitation and Skilled Nursing Ctr. v. Health & Human Svcs.*, 405 F. App'x 820 (5th Cir. 2010); *Lakeridge Villa Healthcare Center*, DAB No. 2396, at 14 (2011). Those factors are: (1) the SNF's history of noncompliance; (2) the SNF's financial condition – that is, its ability to pay a CMP; (3) the severity and scope of the noncompliance, and "the relationship of the one deficiency to other deficiencies resulting in noncompliance"; and (4) the SNF's degree of culpability. 42 C.F.R. §§ 488.438(f), 488.404(b), (c)(1). Once an ALJ has determined that CMS had a valid legal basis to impose a CMP, the ALJ (or the Board on appeal) may not reduce that CMP to zero or below the regulatory minimum amount. 42 C.F.R. § 488.438(e)(1); *Somerset Nursing & Rehabilitation Facility*, DAB No. 2353, at 26-27 (2010). (As noted above, the regulatory minimum amounts for the per-day CMPs are $3,050 for noncompliance at the immediate jeopardy level, and $50 per day for noncompliance below that level.)

Here, CMS imposed a $3,550 per-day CMP for the period of immediate jeopardy-level noncompliance, and a $100 per-day CMP for the noncompliance after Autumn Ridge abated the immediate jeopardy. The ALJ concluded that the $100 per-day CMP was reasonable, noting that Autumn Ridge had not offered evidence or argument about that penalty's reasonableness. Autumn Ridge is likewise silent about that issue in this appeal. Accordingly, we summarily affirm the ALJ's conclusion that $100 per day is a reasonable amount for Autumn Ridge's noncompliance from December 14, 2010 through January 6, 2011.

As for the $3,550 per-day CMP for the immediate jeopardy period, the ALJ found it to be "amply justified by the seriousness of Autumn Ridge's noncompliance and also by its culpability." ALJ Decision at 11. The ALJ also noted, accurately, that the per-day CMP amount was "close to the bottom" of the applicable penalty range (of $3,050 to $10,000 per day). *Id.* Regarding Autumn Ridge's culpability, the ALJ stated that the noncompliance "was either a consequence of Petitioner's policy not to provide such care or a consequence of Petitioner's staff's indifference to the needs of the residents." *Id.* In either case, said the ALJ, "Petitioner's culpability for its noncompliance was high." *Id.*

Autumn Ridge now asserts that culpability was the "key factor the ALJ erred on" (RR at 14) but does not make an argument about that factor. Autumn Ridge merely states that the ALJ "simply adopted" a finding by Surveyor Mankell that there were "widespread" deficiencies of care without determining whether the evidence supported that finding. RR at 14. The ALJ did not make or adopt any finding that the noncompliance was

"widespread." Any such finding relates to the scope of the noncompliance, not Autumn Ridge's culpability, which is defined in the regulations to include "neglect, indifference, or disregard for resident care, comfort or safety." 42 C.F.R. § 488.438(f)(4).

The ALJ's culpability finding was clearly justified in any event. Autumn Ridge's nursing staff failed to care plan adequately for residents' tracheostomies and had a policy not to suction residents who were vulnerable to mucus plugging of their tracheostomies, indicating a systemic problem that would affect not only the current residents with tracheostomies, but any similar residents admitted to the facility. The actual reason for the policy is immaterial because the regulations required Autumn Ridge to ensure that residents receive this service if needed to prevent mucus plugging and related complications. The ALJ reasonably inferred from the credible evidence that Autumn Ridge's staff simply waited for mucus plugging (and associated respiratory symptoms) to develop before sending the affected resident to the hospital, where he or she could be suctioned. For some residents the adverse risks of tracheal suctioning may have outweighed the procedure's benefits. But, as the ALJ found, there is no evidence that Autumn Ridge weighed the procedure's risks and benefits for the residents in question. At a minimum, these circumstances demonstrate indifference, disregard, or neglect of those residents' care, comfort, or safety, and we agree with the ALJ that the degree of Autumn Ridge's culpability justified a per-day CMP substantially above the applicable regulatory minimum of $3,050 per day.

Autumn Ridge does not show that any of the other regulatory factors justifies a reduction in the $3,550 per-day CMP. Instead, Autumn Ridge contends that the total penalty imposed – $144,400, for 57 days of noncompliance – was excessive or unreasonable compared with penalties imposed on SNFs with comparable quality of care deficiencies. RR at 15-17 (citing *Dumas Nursing and Rehabilitation, L.P.*, DAB No. 2347 (2010) and *Royal Manor*, DAB No. 1990 (2004)). The ALJ properly rejected that argument. *See* ALJ Decision at 12. The comparisons drawn by Autumn Ridge are unpersuasive, in part because the total (or aggregate) penalty imposed on Autumn Ridge in this case is largely a function of the number of days – 27 – that Autumn Ridge was found to be in a state of immediate jeopardy.[11] *Alexandria Place*, DAB No. 2245, at 31 (2009). In addition, the Board has emphasized that "the regulations give CMS considerable discretion in the amount of a CMP it is permitted to impose based on the regulatory factors in a given case," and that "[i]t would be almost impossible to make any true comparisons of different cases since the underlying facts of noncompliance vary considerably, as do the other factors." *Id.* at 31; *see also Kenton Healthcare, LLC*, DAB No. 2186, at 28 (2008);

[11] The ALJ found that Autumn Ridge did not challenge CMS's determination concerning the duration of the immediate jeopardy-level noncompliance, ALJ Decision at 11, and the facility does not raise any issue regarding that issue on appeal.

Western Care Management Corporation, d/b/a Rehab Specialities Inn, DAB No. 1921, at 94 (2004) (noting that "[c]ase-to-case comparisons generally have little value given the unique circumstances of each case and the myriad factors that must be considered").

For all these reasons, we affirm the ALJ's conclusion that a $3,550 per-day CMP for the immediate jeopardy period was reasonable.

Conclusion

The ALJ's conclusion that Autumn Ridge was not in substantial compliance with section 483.25(k) is affirmed.

/s/
Stephen M. Godek

/s/
Constance B. Tobias

/s/
Judith A. Ballard
Presiding Board Member