Department of Health and Human Services
DEPARTMENTAL APPEALS BOARD
Appellate Division

Pleasant View Center
Docket No. A-12-109
Decision No. 2488
December 6, 2012

REMAND OF ADMINISTRATIVE LAW JUDGE DECISION

Pleasant View Center (Pleasant View) appealed the decision by an Administrative Law Judge (ALJ) granting summary judgment to the Centers for Medicare & Medicaid Services (CMS). *Pleasant View Center,* DAB CR2546 (2012)(ALJ Decision). The ALJ sustained the imposition of a civil money penalty (CMP) of $3,500 per day for two days, December 2 and 3, 2010, based on her conclusions that the undisputed evidence establishes that Pleasant View was not in substantial compliance with the regulatory requirement at 42 C.F.R. § 483.13(c), that CMS's determination that the noncompliance posed immediate jeopardy was not clearly erroneous, and that the amount of the CMP is reasonable.

For the reasons explained below, we conclude that the ALJ erred both procedurally and substantively in concluding that this matter could be resolved appropriately through summary judgment. We therefore vacate the ALJ Decision and remand the case for further development.

Case Background

Pleasant View is a long-term care facility, located in Concord, New Hampshire, that participates in the Medicare program. As such, it is subject to surveys by the state survey agency to ensure that it remains in substantial compliance with Medicare participation requirements at 42 C.F.R. Part 483. Social Security Act §§ 1819 and 1866; 42 C.F.R. Part 488, subpart E. The New Hampshire state survey agency conducted a survey of Pleasant View from November 30 through December 3, 2010. The surveyors reported their findings on a statement of deficiencies (SOD).

The surveyors found that Pleasant View was not in substantial compliance with two participation requirements at the immediate jeopardy level – section 483.25(c)(pressure ulcers) and section 483.13(c)(staff treatment of residents). "Immediate jeopardy" means "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. "Noncompliance" means "any deficiency that causes a facility to not be in substantial compliance." *Id*. A determination of immediate jeopardy affects the range of CMPs that may be imposed per day for noncompliance with one or more participation requirements. 42 C.F.R. § 488.438(a). CMS's determination of the level of noncompliance (including immediate jeopardy) must be upheld unless that determination is clearly erroneous. 42 C.F.R. § 498.60(c).

Based on the findings in the SOD for the December 2010 survey, CMS imposed a CMP of $5,500 per day. Pleasant View requested a hearing and the case was assigned to the ALJ. The parties exchanged pre-hearing briefs, as well as exhibits and written direct testimony of witnesses, pursuant to the ALJ's pre-hearing order, with CMS making its submission first. Among other things, Pleasant View submitted evidence that a wound on the left shin of a resident (identified as R11 in the survey) was a venous stasis ulcer, not a pressure sore, evidence about the nature of a venous stasis ulcer, and documentation regarding the care and treatment Pleasant View provided for R11's wound, as well as evidence about the pressure ulcers of two other residents cited in the SOD.

In the pre-hearing conference held by the ALJ, CMS indicated that it was withdrawing the finding of noncompliance with the pressure sore requirement and reducing the CMP amount to $3,500 per day and that it intended to move for summary judgment on the remaining noncompliance finding – Pleasant View's alleged failure to implement its policies and procedures prohibiting neglect. CMS subsequently issued a revised SOD and determination letter and moved for summary judgment. With its response opposing the motion, Pleasant View submitted the declarations of two new witnesses, a photograph, and a copy of the decision by the state survey agency after informal dispute resolution. Pleasant View argued that it had good cause for not submitting this evidence with its pre-hearing submission.

Summary Judgment

Whether summary judgment is appropriate is a legal issue that we address de novo. *Lebanon Nursing and Rehabilitation Center*, DAB No. 1918 (2004). We review disputed conclusions of law for error. Departmental Appeals Board Guidelines -- Appellate Review of Decisions of Administrative Law Judges Affecting a Provider's Participation in the Medicare and Medicaid Programs, http://www.hhs.gov/dab/guidelines/prov.html; *Golden Age Nursing & Rehabilitation Center*, DAB No. 2026, at 7 (2006).

The Board has laid out the process and standards for resolving a summary judgment motion by CMS in a nursing facility case in which, as here, the ALJ has informed the parties that she will be guided by the principles of Rule 56 of the Federal Rules of Civil Procedure. *Kingsville Nursing and Rehabilitation Center*, DAB No. 2234, at 3-4 (2009); *see also Crestview Parke Care Center*, DAB No. 1836 (2002), *aff'd in part, Crestview Parke Care Ctr. v. Thompson*, 373 F.3d 743 (6th Cir. 2004).

Summary judgment is appropriate when the record shows that there is no genuine issue as to any material fact, and the moving party is entitled to judgment as a matter of law. *See Celotex Corp. v. Catrett*, 477 U.S. 317, 322-25 (1986). The party moving for summary judgment bears the initial burden of demonstrating that there are no genuine issues of material fact for trial and that it is entitled to judgment as a matter of law. *Celotex*, 477 U.S. at 323. If a moving party carries its initial burden, the non-moving party must "come forward with 'specific facts showing that there is a genuine issue for trial.'" *Matsushita Elec. Industrial Co. v. Zenith Radio*, 475 U.S. 574, 587 (1986). To defeat an adequately supported summary judgment motion, the non-moving party may not rely on the denials in its pleadings or briefs, but must furnish evidence of a dispute concerning a material fact -- a fact that, if proven, would affect the outcome of the case under governing law. *Id*. at 586, n.11; *Celotex*, 477 U.S. at 322. In order to demonstrate a genuine issue, the opposing party must do more than show that there is "some metaphysical doubt as to the material facts. Where the record taken as a whole could not lead a rational trier of fact to find for the nonmoving party, there is no 'genuine issue for trial.'" *Matsushita*, 475 U.S. at 587. In making this determination, the reviewer must view the evidence in the light most favorable to the non-moving party, drawing all reasonable inferences in that party's favor. *See, e.g., U.S. v. Diebold, Inc.*, 369 U.S. 654, 655 (1962).

In *Lebanon*, the Board reversed an ALJ decision granting summary judgment, holding that a disputed fact may be material not only if that fact would make a difference regarding any alleged noncompliance, but also if that fact would make a difference regarding other issues in the case, such as the reasonableness of the amount of a CMP. The Board also noted that the ALJ had found survey findings to be immaterial, even though CMS's motion had treated those findings as essential elements of its case and had relied on surveyors' opinions based on those findings. The Board said that this raised a question about whether the facility fairly knew it needed to address how those facts were material to the outcome and that cross-examination of the surveyors would serve the purpose of sorting out whether the surveyors' opinions would change if their factual assumptions were wrong. *Lebanon* at 5, 7-8. Similarly, in *Venetian Gardens*, DAB No. 2286 (2009), the Board said that, if a facility did not have prior notice of the legal theory on which the ALJ relied, it did not have an adequate opportunity to identify disputes regarding facts material under that theory, nor to address legal issues related to that theory. *Accord Columbia Care and Rehabilitation Center,* DAB No. 2348 (2010).

The Board has also stated that, in considering what facts are material, it looks "not only at the facts that CMS alleged in setting out its prima facie case but at the entire picture presented not only by [a facility's] disputes as to those facts but also its assertions of other facts and evidence which may impact what inferences may reasonably be reached on the ultimate issues." *Madison Health Care, Inc.,* DAB No. 1927 (2004).

Finally, the Board has remanded a case in which the Board concluded that factual disputes an ALJ said were immaterial could affect the outcome of the case because they went to the likelihood of serious harm from the noncompliance and therefore to the immediate jeopardy issue. *Innsbruck Healthcare Center*, DAB No. 1948, at 5-8 (2004). In doing so, the Board agreed with CMS that, because evaluating the severity of a deficiency cannot be reduced to mathematical judgments, the regulations grant surveyors "flexibility and deference in applying their expertise in working with these less than perfectly precise concepts." *Innsbruck*, at 6. "For that very reason," the Board said, "it is material in evaluating the immediate jeopardy determination to consider the factual underpinnings on which the surveyors relied to apply their expertise." *Id*.

CMS's Motion for Summary Judgment

Both the initial and the revised SOD from the December 2010 survey included under section 483.13(c) (Tag 224) the surveyors' findings that Pleasant View had failed to follow its own policies for monitoring and documenting pressure ulcers. CMS's motion for summary judgment recognized that Pleasant View had disputed these findings. Thus, CMS moved for summary judgment on the basis of the following subset of survey findings CMS said were undisputed by Pleasant View:

1. On July 20, 2010, a physician progress note from an Advanced Registered Nurse Practitioner ("ARNP") mentioned an issue with the "left shin area" of Resident No. 11 ("R11"). R11 is a 91-year old resident with limited mobility who requires the use of a wheelchair.
2. Upon examination, the ARNP found an "ulcer dime sized open approx. .5cm depth with scabbed, necrotic undermining from 600-1200." The ARNP's progress note explained that the location of the "[w]ound [was] directly parallel to [a] plastic hard tie with point sticking out, around bar on [R11's] wheelchair, [and] probably started from there."
3. In her July 20, 2010 progress note, the ARNP directed: "pressure ulcer – remove plastic tie that is tied around pt's wheelchair close to her wound."
4. This plastic tie was located on the left side of R11's wheelchair, at about mid-calf height, and fastened around an angled bar that attached to the wheelchair's foot pedals.
5. On July 26, 2010, six days after she had directed staff to remove it, the same ARNP removed the "plastic tag on [wheelchair] that was parallel to the ulcer."
6. R11's ulcer deteriorated from July 20, 2010 onward, growing in size, depth, and developing a serious methicillin-resistant staphylococcus aureus (MRSA) infection.

7. Pleasant View used these plastic "zip" ties as part of a housekeeping system to match wheelchair footrests and wheelchairs, and they were not supposed to be positioned near a resident's body. The packaging for these ties showed they were suitable for uses such as securing a tomato plant and holding electric wires together.
8. Pleasant View continued to use these plastic ties on approximately two dozen wheelchairs until December 2, 2010, during the survey at issue in this case. At this time, approximately 19 weeks after the ARNP first observed R11's ulcer and directed removal of the plastic tie from her wheelchair, surveyors observed these ties still in use on the wheelchairs of other residents.
9. Pleasant View's "Abuse Prohibition" policy states that "Genesis HealthCare Centers will prohibit abuse, neglect, involuntary exclusion, and misappropriation of property for all residents" by screening employees prior to hiring, training employees, preventing occurrences, *identifying potential incidents or allegations needing investigation*, and *investigating incidents*, amongst other measures."
10. The policy also explains that "[a]ctions to prevent abuse, neglect, exploitation, involuntary seclusion, injuries of unknown origin, and misappropriation of property" will be taken. An "injury of unknown origin" is defined as an injury where "[t]he source of the injury was not observed by any person or the source of the injury could not be explained by the resident," and "[t]he injury is suspicious because of the extent of the injury or the location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma)." Additionally, "[i]njuries of unknown origin will be investigated to determine if abuse or neglect is suspected."
11. Pleasant View did not investigate the ARNP's theory that the plastic tie on R11's wheelchair was the cause of R11's left calf ulcer, contrary to its policy to investigate wounds of unknown origin. Pleasant View also did not check other residents in wheelchairs equipped with plastic ties for similar injuries, or evaluate them for the risk of similar injuries.

CMS MSJ at 3-6 (citations and footnotes omitted from quote; italics in original).[1]

[1] The plastic tie is also called an "identification tag" or "multipurpose tie" or "zip tie."

CMS took the position that these were the only facts material to its determinations that Pleasant View was not in substantial compliance with section 483.13(c) and that its noncompliance was at the immediate jeopardy level because “it neither followed the ARNP’s July 20, 2010 resident care order, nor implemented and followed provisions of its anti-neglect policy, leading to the neglect of multiple residents.” *Id*. at 6.

CMS recognized that Pleasant View had argued that the development of R11’s wound was unavoidable because R11 had a venous insufficiency so that even a minor trauma could cause a wound to open. CMS said this was irrelevant, for the following reason: “Even assuming for purposes of this motion and memorandum that R11’s initial trauma was unavoidable, at issue is the facility’s failure to remove the plastic tie after the ARNP identified it as the probable source of R11’s ulcer.” *Id.* at 9. CMS argued that, because of R11’s limited mobility, “the likelihood was present during the six-day period prior to the tie’s removal that R11’s leg could have come into contact with the plastic tie again – and either exacerbated her existing ulcer, or triggered a new one” and “these circumstances were capable of reoccurring with respect to other similarly situated residents, given that Pleasant View did not conduct an investigation of the plastic tie on R11’s wheelchair, or the plastic ties on other residents’ wheelchairs.” *Id*.

According to CMS, the failure to remove the plastic tie evidences a “breakdown by the facility’s nursing staff to adhere to standards of practice” because it constituted a failure to follow the ARNP’s “order.” *Id*. Based on this assertion, CMS contended that this failure therefore constituted neglect as defined in Pleasant View’s policy because it “result[ed] or could [have] resulted in the deprivation of essential services or supports necessary to maintain [R11’s] minimum mental, emotional, or physical health and safety.” *Id*. at 10. CMS’s motion also relied on evidence that the ties were not meant “for medical use” to support its view that Pleasant View disregarded its anti-neglect policy in multiple respects by failing to investigate or assess “whether other residents had sustained or were susceptible to similar injuries.” *Id*. at 13-14. CMS’s motion also asserted that R11 had developed MRSA not long after she sustained the initial injury and averred that, because of the risk posed by the ties, Pleasant View’s “failure to remove the tie from R11’s wheelchair left her vulnerable to ‘serious injury, harm, or death’ . . . for an extended period of time.” *Id*. at 15.

Finally, CMS averred that Pleasant View’s failure to investigate the cause of R11’s ulcer, including failure to check other residents in wheelchairs for similar injuries, to assess whether other residents were at risk for similar injuries, or to discontinue use of the plastic ties “placed all facility residents using wheelchairs in immediate jeopardy for over four months.” *Id*. at 15-16.

ALJ Decision and Arguments on Appeal to the Board

The ALJ recognized that Pleasant View had disputed some of the alleged facts on which CMS based its summary judgment motion and that Pleasant View had asserted other facts it said were relevant, but that CMS disputed. The ALJ determined, however, that these disputes were immaterial. Thus, as discussed below, the ALJ granted summary judgment in favor of CMS on a narrower set of facts than those asserted by CMS.

On appeal, Pleasant View argues that the ALJ erred by "applying a new expansive definition of the 'resident neglect' regulation that extends beyond the language of the regulation and existing Board precedent." Request for Review (RR) at 1. Pleasant View also argues that the ALJ erred in granting summary judgment "notwithstanding the voluminous evidence regarding every one of the material factual issues in dispute," by failing to view the evidence in the light most favorable to Pleasant View, the non-moving party. *Id.*[2] According to Pleasant View, CMS's and the ALJ's positions are based on interpretations of documents in the record that are not the only reasonable interpretations. *Id.* at 31.

Pleasant View also challenges the decision on procedural grounds. Among other things, Pleasant View alleges that the ALJ erred by allowing CMS to change course midway through the proceeding and to move for summary judgment on "factual and legal bases . . . completely different from CMS's original allegations and evidence." *Id.* at 10. According to Pleasant View, the proceedings were also unfair because the ALJ treated the plastic tie as a "known hazard," relying on a regulation that CMS had not cited as a basis for imposing the CMP and without providing an opportunity for Pleasant View to respond to the issues that the ALJ "formulated and then answered." *Id.* at 11. Pleasant View also argues that the ALJ erred by not admitting into the record the evidence Pleasant View submitted in response to the motion for summary judgment. *Id.*

Analysis

As we explain below, we conclude that summary judgment was not appropriate and remand this case to the ALJ for further proceedings. First, we set out the analytical framework that applies if CMS alleges, as here, that a facility has failed to implement its anti-neglect policy, as required by section 483.13(c), and then discuss the ALJ's analysis in light of that framework. Next, we discuss whether the undisputed facts establish that Pleasant View was required to investigate R11's wound as what the ALJ termed "potential neglect."

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[2] CMS argues that we should affirm the ALJ Decision because the ALJ's findings are "supported by substantial evidence in the record." CMS Response at 2. The substantial evidence standard does not apply in our review of a summary judgment decision, however.

We then explain why, having found it unnecessary to reach CMS's claim that Pleasant View's staff violated a standard of care with respect to R11 by failing to follow what CMS treated as an "order" by the ARNP, the ALJ needed to more fully explain her basis for finding neglect and for finding more than one instance of neglect. We also explain why we conclude that the evidence, viewed in the light most favorable to Pleasant View, did raise genuine disputes of fact regarding some factual issues the ALJ treated as undisputed, and why other disputed facts may be relevant in evaluating whether any noncompliance caused a likelihood of serious injury or harm to R11 and other residents, depending on how other issues are resolved. Finally, we discuss why we reject Pleasant View's argument that the ALJ committed procedural error by concluding that the evidence Pleasant View submitted in response to CMS's motion is inadmissible.

The requirement for implementing anti-neglect policies and procedures

Section 483.13(c) provides:

> *Staff treatment of residents*. The facility must develop and **implement written policies and procedures that prohibit** mistreatment, **neglect**, and abuse of residents and misappropriation of resident property.
>
> (1) The facility must – (i) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;
>
> (ii) Not employ individuals who have been—
>
> (A) Found guilty of abusing, neglecting, or mistreating…
>
> (B) Have had a finding entered into the State nurse aide registry…
>
> (iii) Report any knowledge it has of actions by a court of law …
>
> (2) The facility must **ensure that all alleged violations involving** mistreatment, **neglect**, or abuse, **including injuries of unknown source**, and misappropriation of resident property **are reported** immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).
>
> (3) The facility must have evidence that **all alleged violations are thoroughly investigated** and must prevent further potential abuse while the investigation is in progress.
>
> (4) The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.

(Emphasis added.) "Neglect" is defined for federal purposes as "failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness." 42 C.F.R. § 488.301.

In *Emerald Shores Health & Rehabilitation Center*, the Board upheld an ALJ's conclusion reversing a finding of noncompliance under section 483.13(c), noting that CMS must establish "some relationship between the failure to provide [the specified] services and a failure to implement polic[ies] or procedures to prevent neglect" in order to support a noncompliance finding under section 483.13(c). DAB No. 2072, at 22-23 (2007), *reversed sub nom. on other grounds*, *Emerald Shores Health Care Associates, LLC v. U.S. Dep't of Health & Human Servs.*, 545 F.3d 1292 (11th Cir. 2008), *accord Britthaven of Havelock*, DAB No. 2078 (2007). That relationship may be established most directly if facility staff failed to follow the specified **procedures** for investigating and/or reporting allegations of abuse or neglect, including injuries of unknown source. *See, e.g., Singing River Rehabilitation & Nursing Center*, DAB No. 2232 (2009)(failure to report to state authorities the results of investigation of suspected abuse); *Tri-County Extended Care Center*, DAB No. 1936 (2004), *aff'd*, 157 F.App'x 885 (6th Cir. 2005)(failure to investigate hip fracture of unknown source).

In cases in which a facility has developed the requisite policies and procedures and there was no direct evidence that facility staff had failed to implement them, the Board has discussed whether an ALJ could reasonably infer (or decline to infer) from the evidence in the record that a facility failed to implement the policies and procedures, as required. Those cases establish that 1) an isolated instance of neglect is not sufficient, per se, to support the inference; 2) the inference is reasonable if the circumstances as a whole demonstrate a systemic problem in implementing the policies and procedures; and 3) an ALJ may reasonably infer from multiple or sufficient examples of neglect, even with respect to one resident, that the facility did not implement its anti-neglect policy. *See Carehouse Convalescent Hospital*, DAB No. 1799, at 34 (2001); *Columbus Nursing & Rehabilitation Center*, DAB No. 2247, at 27 (2009), and cases cited therein.

With respect to cases in which CMS alleges only that there were multiple (or sufficient) examples of neglect (not that a facility failed to take specific steps required by its procedures), the Board recently said that the focus "is not simply on the number or nature of the instances of neglect (i.e., failure to provide necessary care or services) but on whether the facts found by the ALJ surrounding such instance(s) demonstrate an underlying breakdown in the facility's implementation of the provisions of an anti-neglect policy." *Oceanside Nursing and Rehabilitation Center*, DAB No. 2382, at 11 (2011). Circumstances the Board has found relevant have included factors such how many staff members were involved in incidents of neglect and whether staff members' actions or inactions were directly contrary to directions in care policies adopted by the facility. *See, e.g., Ross Healthcare Center*, DAB No. 1896 (2003); *Liberty Commons Nursing and Rehab Center – Johnston*, DAB No. 2031 (2006), *aff'd*, 241 F.App'x 76 (4th Cir. 2007); Lake Mary Health Care, DAB No. 2081 (2007); *Jennifer Mathew Nursing & Rehabilitation Center*, DAB No. 2192 (2008); *Universal Healthcare/King*, DAB No. 2215 (2008), *aff'd*, No. 09-1093 (4th Cir. 2010). In *Columbus Nursing & Rehabilitation Center*, DAB No. 2398, at 12 (2011), the Board remanded the issue of whether the

facility was in substantial compliance with section 483.13(c) because the ALJ decision discussed neither the number nor the nature of any instances of neglect, nor what circumstances surrounding any such instances the ALJ thought were relevant to his conclusion on this issue.

Lack of clarity in the basis for the ALJ's ultimate finding of noncompliance

The ALJ set out the following general conclusion on the noncompliance issue:

> CMS is entitled to summary judgment because the undisputed evidence establishes that facility staff knowingly exposed at least one vulnerable resident to an easily preventable hazard and made no effort to determine whether other residents were also at risk, violating the facility's own policy and federal requirements prohibiting resident neglect, 42 C.F.R. § 483.13(c).

ALJ Decision at 3.

As discussed above, section 483.13(c) by its plain terms does not "prohibit resident neglect," but requires a facility to develop and implement policies and procedures prohibiting neglect. Yet, the ALJ seems from this statement to be basing her conclusion solely on examples of neglect, and, indeed, she described Board decisions as holding merely that "examples of neglect can demonstrate that the facility has not implemented an anti-neglect policy." ALJ Decision at 5. Instances of neglect may not provide a sufficient basis for concluding that a facility has failed to implement its anti-neglect policies and procedures, however, if the circumstances as a whole do not indicate a systemic problem from which it is reasonable to infer such a failure. The ALJ did not articulate in her analysis what undisputed facts support an inference of a systemic problem here. For example, as discussed below, while the ALJ suggests that more than one staff person was aware that the plastic tie was the probable cause of R11's wound, she does not explain what undisputed facts establish this.

We also cannot discern from the ALJ Decision whether the ALJ was inferring a failure to implement the anti-neglect policies and procedures only from instances of neglect or also determined that Pleasant View failed to follow the required procedures. The ALJ rejected Pleasant View's position that injuries of unknown origin need to be formally investigated only when the injuries by their nature raise a suspicion of abuse. ALJ Decision at 7, n. 4. The ALJ found that the policy also applies to "any injury of unknown origin, and provides that potential neglect must also be investigated." *Id*. The ALJ did not clearly explain, however, whether she was relying on a failure to investigate as a basis for concluding that Pleasant View violated section 483.13(c), and, if so, whether she considered it undisputed that there was either an injury of unknown origin or potential neglect.

The ALJ Decision is also ambiguous about whether the ALJ correctly applied summary judgment standards. For that purpose, the facts that are undisputed may not be viewed in isolation – other facts, which may be disputed, might undercut inferences that otherwise reasonably could be drawn from the undisputed facts. An ALJ must consider whether the record taken as a whole could lead a rational trier of fact to find for the non-moving party, but here the ALJ did not discuss evidence that tends to undercut the inferences she drew. For the reasons explained below, we conclude that the ALJ did not discuss some evidence, including evidence proffered by Pleasant View, that tends to undercut the inferences that she drew.

Whether the facility failed to follow its procedures for reporting or investigating neglect

As indicated above, CMS moved for summary judgment in part on the basis that R11's left shin wound was an injury of unknown source (or origin) which the facility's policy required it to report and investigate. The facility's Abuse Prohibition policy defines the term "injuries of unknown origin" as—

> an injury with **both** of the following conditions:
> - The **source** of the injury was **not observed** by any person or the source of the injury could not be explained by the resident; **and**
> - The **injury is suspicious** because of the extent of the injury or the **location** of the injury (e.g., the injury is located in an area not generally vulnerable to trauma) or the number of injuries observed at one particular point in time or the incidence of injuries over time.

CMS Ex. 5, at 2 (emphasis added). Pleasant View disputed whether the source of the injury was unknown. Pleasant View relied on evidence that, on July 26, the probable cause of R11's wound was identified as the "plastic tie, with point sticking out, parallel to the wound" and that later assessments by occupational therapists (after the wound had been identified as a venous stasis ulcer) determined that the wound was due to a screw or the metal bar on the wheelchair (and provided padding to protect R11's legs). P. Br. at 8-14. Pleasant View also argued that the wound was not an "injury of unknown origin" under its policy because the nature of the wound was not in a category that might trigger a suspicion that the cause was abuse and therefore the Abuse Prohibition policy did not required it to formally investigate the situation. *Id.* at 15.

The ALJ did not directly address whether there was a genuine dispute of fact regarding whether R11's wound was an injury of unknown origin that Pleasant View was required to formally investigate. As noted above, however, the ALJ stated that the facility's policy "provides that potential neglect must also be investigated." ALJ Decision at 7 n. 4. The ALJ did not explain exactly what she meant by "potential" neglect or what she considered to constitute the potential neglect Pleasant View had failed to investigate.

The policy does not expressly use the term "potential neglect" although it does require identification of "possible incidents or allegations needing investigation" and "investigation of incidents and allegations." CMS Ex. 5, at 1. While CMS's summary judgment motion referred to the requirement to identify possible incidents and allegations needing investigation, CMS's motion did not specifically assert that the ARNP's July 20 progress note constituted an allegation of neglect to be reported and investigated nor did it assert that the situation of the plastic tie near to R11's wound constituted an incident under Pleasant View's policy. We also note that, while the policy clearly requires investigation of any injury of unknown origin, the first step provided with respect to a possible incident or allegation is to identify it and to report it to the proper person. CMS Ex. 5, at 3, 21-26. Thus, the duty to investigate pursuant to the policy applies to an injury of unknown origin or to reported incidents and allegations. Here, facts were in dispute about whether the staff should have identified R11's wound as an injury of unknown origin under facility policy, given what was observed and the nature of the injury. Yet, CMS did not argue, nor did the ALJ conclude, that undisputed facts established that Pleasant View failed to investigate a reported incident or allegation, as required.

Further, the ALJ's finding that Pleasant View staff had "failed to act" in response to identification of the plastic tie as the probable cause of R11's wound on her left shin appears overbroad at the summary judgment stage based on the record. ALJ Decision at 8. CMS alleged only that staff did not remove the tie from R11's wheelchair pursuant to the ARNP's "order" **for a period of six days** and failed to investigate the cause of R11's injury. In addition to contesting whether the ARNP had ordered removal of the tie and whether it was required to investigate the cause of the injury, Pleasant View proffered evidence that, after July 20, staff "relocate[d] the tie on R11's wheelchair." P. Ex. 31, at 12. Viewed in the light most favorable to Pleasant View, this evidence, if accepted as true as it must be at summary judgment, indicates that staff did act to remove the danger to R11, if not the tie itself.

Pleasant View also disputed CMS's assertion that staff did nothing to investigate the cause of the injury, pointing to evidence in the record it said showed that two occupational therapists had assessed the cause of the injury, concluding that the injury was due to a screw or the leg rest. For purposes of summary judgment, the ALJ accepted that the occupational therapists had done an "assessment" of the cause of the injury. ALJ Decision at 7. The ALJ concluded, however, that the evidence about the assessments did not establish that the plastic tie posed no risk to R11 since the "therapists assessed the wheelchair's safety more than a week *after* Nurse Practitioner Gorveatt removed the tag" so they "simply had no way of knowing whether the tag caused the wound or posed a risk, because they did not see the tag (although they saw the other risks)." *Id.* (italics in original). The ALJ said that she reached this conclusion, "[e]ven drawing every reasonable inference" in favor of Pleasant View. *Id.*

As we discuss below, however, the ALJ accepted for purposes of summary judgment that Nurse Practitioner Gorveatt had **not** "ordered" removal of the tie, but instead recommended to a nurse that she have someone evaluate whether the tie could have caused R11's wound on her left shin. ALJ Decision at 8, citing P. Ex. 35, at 2, 3; *see, also,* P. Ex. 35, at 2-3 (ARNP testimony regarding therapists' responsibility for wheelchairs); P. Ex. 29, at 20 (facility skin care policy advising staff to "[r]efer to Rehabilitation when a patient presents with or develops safety issues [or] skin impairment" related to seat cushions in wheelchairs). A reasonable inference might be drawn in favor of Pleasant View that the assessment by the therapists was sought by a nurse based on the ARNP's concerns and included consideration of whether the tie was the probable cause of R11's wound, even though the tie was no longer physically present at the time. Given this possible favorable inference, it was inappropriate to exclude this possibility for purposes of summary judgment.

The ALJ also said that "the OT [occupational therapy] evidence supports CMS's claim that the facility inadequately investigated the cause of R11's wound because they examined the wheelchair *two weeks after* the wound appeared, which shows that the facility exposed R11 to a potentially hazardous situation without even assessing the hazard . . . ." ALJ Decision at 7 (italics in original). CMS did not clearly allege, however, that no other staff assessed whether the plastic tie was a potential hazard. Therefore, Pleasant View's silence as to any earlier evaluations does not preclude an inference that staff other than the therapists may have acted sooner to assess the risk and or to address it, such as by relocating the tie.

The ALJ's conclusion that Pleasant View had violated its policy by "[m]aking no effort to identify and prevent" the risk to other residents from the plastic tie also appears overbroad at the summary judgment stage. ALJ Decision at 8. CMS's motion alleged only that it was undisputed that "Pleasant View did not check other residents in wheelchairs for similar injuries or evaluate them for the risk of similar injuries." CMS MSJ at 6. Therefore, Pleasant View was not on notice that it had to show a genuine dispute of fact regarding the broader question of whether it made any effort to identify and prevent any risk to other residents from the plastic tie.

Whether there were instances of "neglect"

As noted above, CMS's motion for summary judgment contended that Pleasant View's failure to remove the plastic tie from R11's wheelchair constituted neglect as defined in Pleasant View's policy and evidences a "breakdown by the facility's nursing staff to adhere to standards of practice" because it constituted a failure to follow the ARNP's "order." The ALJ recognized that Pleasant View had disputed whether the ARNP had, in fact, ordered removal of the plastic tie from R11's wheelchair. ALJ Decision at 8. The ALJ discussed a declaration in which the ARNP (Nurse Practitioner Gorveatt) attests that her statement in the progress note was **not** an order, even though she determined the

declaration was inadmissible. Pleasant View also proffered other evidence that, read in the light most favorable to Pleasant View, could indicate that staff reasonably did not view the ARNP as having "ordered" removal and hence did not violate the standard of practice on which CMS relied.[3]

The ALJ relied instead on the admission by the ARNP in her declaration that she "also orally recommend[ed] to a nurse . . . that she or someone at the facility should evaluate the wheelchair and the plastic tie . . . ." *Id.*, citing P. Ex. 35, at 2, 3. According to the ALJ, the dispute about whether the ARNP had ordered removal of the plastic tie from R11's wheelchair is immaterial because "[n]o matter how you characterize Nurse Practitioner Gorveatt's written and verbal instructions, she unquestionably observed a potential danger and brought it to staff's attention, but staff failed to act." ALJ Decision at 8. As discussed above, there is evidence that, viewed in the light most favorable to Pleasant View, indicates that staff did take some action. Thus, it is not undisputed that staff failed to act.

Moreover, while the ALJ Decision states that facility staff "knowingly" exposed R11 and other residents to preventable risks, it is unclear whether the ALJ concluded that multiple staff members knew or should have known about the risk. Nurse Practitioner Gorveatt's declaration mentions only that she recommended to "a nurse" that that she or someone at the facility should evaluate the wheelchair and the plastic tie. P. Ex. 35, at 2, 3. The ALJ Decision refers to testimony Pleasant View proffered by various staff members attesting that the opening of R11's wound may have been caused by the plastic tie. *Id.* at 6, citing P. Ex. 31(Wareing Decl.), at 2, 6; P. Ex. 33 (Currid Decl), at 3; P. Ex. 20 (Sobelson Decl.), at 1; CMS Ex. 6 (Sobelson consultation note), at 15. The cited evidence indicates, however, that these individuals reached the conclusion that R11's wound was a venous stasis ulcer that could have been caused by any minor trauma either after observing the deterioration of the wound over time (Currid) or after examining R11's record during the survey (Wareing and Sobelson). This evidence thus does not constitute an admission that the potential risk for R11 from the plastic tie had been brought to these staff members' attention before the tie had been removed from R11's wheelchair. Whether

[3] *See, e.g.*, P. Ex. 14, at 1 (7/20/10 "order" form signed by the ARNP certifying the order "is as I gave it" with no mention of the plastic tie); P. Ex. 21, at 2 (7/20/10 Nurses Note recording the contents of the "new order" from the form, with no mention of the tie); P. Ex. 26, at 1 (R11's treatment sheet for July 2010); CMS Ex. 10, at 1 (surveyor note indicating that facility's Medical Director said the ARNP did not write an order to remove the tie); P. Ex. 31, at 2, 26 (written direct testimony of a nurse averring, among other things, that she had reviewed R11's records and expressing her opinion disagreeing "that any aspect of [R11's] care constituted regulatory noncompliance, and certainly not 'neglect' or 'immediate jeopardy'" and expressing her view that Pleasant View "met all applicable clinical and regulatory standards of care" in its care of R11); see also P. Ex. 32, at 5; P. Ex. 33, at 12; P. Ex. 34, at 4.

more than one staff member was aware or should have been aware of the ARNP's concern is relevant to evaluating the circumstances surrounding the facility's actions after R11's injury in terms of whether a failure to implement the anti-neglect policies and procedures has been established. Hence, addressing the question may be material.

CMS's reliance on its characterization of the progress note as an "order" had significance not only as the basis for its assertion that staff violated a standard of care, but also as evidence from which one could infer staff awareness that the ARNP wanted the tie removed. The SOD says that other staff members told the surveyors that they were not aware that the ARNP had identified the plastic tie as the probable cause of R11's wound. CMS Ex. 22, at 5. The surveyors made no specific findings regarding which or how many staff members knew, in the six days following July 20, what the ARNP had written in her progress note. As Nurse Practitioner Gorveatt said in her declaration, orders "have clinical and regulatory consequences." P. Ex. 35, at 2. While all nurses responsible for R11's care had a duty to be aware of any orders for her care, CMS did not establish a similar duty to be aware of all progress note entries if they do not constitute orders. The facts as to which staff were, or could be expected to be, aware of the ARNP's progress note before the tie was removed were not undisputed.

Moreover, although the ALJ identified the opening of a skin wound as creating a serious problem for the aged and infirm, CMS's motion specified that CMS was not alleging neglect as a cause of the opening of the wound on R11's left shin. Instead, CMS relied on an alleged deterioration of R11's wound on her left shin and the risk of another wound in the six-day period between Nurse Practitioner Gorveatt's note about the plastic tie and her removal of the tie. Pleasant View's evidence, however, can reasonably be read as showing that between July 20 and 26, 2010, R11's wound actually improved slightly, rather than worsening as CMS alleged. Specifically, the ARNP wrote in her July 26 note: "Wound improved slightly, smaller, more superficial, slough area smaller as well as beefy wound bed to lateral aspect of the ulcer. No signs infection." P. Ex. 16, at 2. Pleasant View also proffered evidence that could be viewed as indicating that staff consistently applied compression hose and ace bandages to R11's legs to address her hypertension, as well as the wound dressings that the ARNP had ordered, and a reasonable inference could be drawn in Pleasant View's favor that such measures would have mitigated any risk of additional harm from the tie. P. Ex. 26, at 2; P. Ex. 31, at 6-7; P. Ex. 16, at 3. In addition, Pleasant View presented documentation of its weekly skin assessments of R11 and wound reports indicating R11 did not develop another wound in the six-day period. P. Ex. 26, at 2; P. Ex. 24, at 1, 2. This evidence, which the ALJ did not discuss, could be viewed by a reasonable trier of fact as relevant in evaluating the nature of any risk to which R11 was exposed in the six-day period and the likelihood of serious harm from that risk.

In any event, having concluded that it was immaterial whether Pleasant View had, as CMS alleged, violated a standard of care by failing to follow a nurse practitioner's order, the ALJ needed to explain what her basis was for finding "examples" of neglect.

The ALJ said at the outset that she was considering the "facility's responsibility to insure that its residents are not exposed to recognized and easily-preventable hazards." ALJ Decision at 1. As Pleasant View points out, this statement of the issue appears to invoke the requirement at 42 C.F.R. § 483.25(h)(1) that a facility ensure that the resident environment "remains as free of accident hazards as is possible." While this regulation arguably sets a standard for achieving the quality of care goal reflected in section 483.25, CMS's motion did not cite this regulation as a basis for concluding that Pleasant View had neglected its residents, nor did the ALJ give timely notice that this standard was at issue. CMS and the ALJ did cite to the definition of "neglect" in Pleasant View's policy as "an act or omission which results or could result in the deprivation of essential services or supports necessary to maintain mental, emotional, or physical health and safety of an incapacitated adult." CMS Ex. 5, at 1. One could reasonably read this definition as evidence that Pleasant View understood that omitting to take an action that could be needed to keep a resident safe might be viewed as neglect, but, again, neither CMS nor the ALJ gave notice that they were reading the definition this way, so Pleasant View did not have notice that summary judgment might be granted based on this reading.

CMS relied on the following allegedly undisputed facts for its conclusion that the plastic tie presented a danger of serious harm: evidence that the plastic tie was not designed for a medical use, the ARNP's July 20 progress note, and the facility's admission that the plastic ties were not supposed to be positioned where they could come into contact with a resident's body. These undisputed facts do not preclude a contrary conclusion in light of evidence about use of the ties proffered by Pleasant View.

In support of its view that the plastic ties do not present a per se hazard, Pleasant View points to testimony it proffered that such ties are "soft plastic ties that are commonly used in health care settings . . . because they are not considered to present any dangerous hazard," that it had been using the ties for nearly two years without any incident or accident involving them, and that "no surveyor or anyone else had questioned their use." P. Ex. 31, at 11-12. The ALJ addressed this evidence by saying that the ties "may be considered safe for most purposes, but, here, they were identified as a potential hazard to certain vulnerable residents, notably R11." ALJ Decision at 8. We agree that the proffered testimony about common usage in health care facilities does not establish that the plastic ties could never be dangerous to a resident. Contrary to what Pleasant View argues, there is evidence from which one could infer that the ties could harm residents such as R11, specifically, evidence that Pleasant View's Rehabilitation Office Coordinator told a surveyor that the ties were not supposed to be positioned near a

resident's body and the ARNP's July 20 progress note. CMS Ex. 21, at 3; P. Ex. 16, at 1. For purposes of summary judgment, however, the ALJ was required to view this evidence in the light most favorable to Pleasant View.

In the July 20 progress note, the ARNP noted that R11's "[w]ound [was] **directly parallel** to [a] plastic hard tie **with point sticking out**, **around bar** on [R11's] wheelchair, [and] probably started from there." P. Ex. 16, at 1 (emphasis added). Read in the light most favorable to Pleasant View, this evidence indicates only that the tie could potentially cause injury if the tie were on the wheelchair, near to a resident's body, with the point sticking out. Perhaps one could infer from the undisputed fact that the ARNP removed the tie from R11's wheelchair on July 26 that she thought it continued to present a potential danger to R11 no matter how or where it was placed on the wheelchair, but this is not a necessary inference properly relied on as a basis for summary judgment. CMS Ex. 21, at 3.

Similarly, the evidence that Pleasant View's staff recognized that the tie should not be positioned near a resident's body does not, when viewed in the light most favorable to Pleasant View, amount to a concession that the ties were a danger no matter where or how they were placed. With respect to the actual positioning, moreover, Pleasant View presented testimony that "the tags were always positioned where they could not contact a resident's skin." P. Ex. 31, at 12. The ALJ did not discuss this evidence, but it is clearly relevant to the issue of whether harm to residents from the tie was likely. Such general testimony might not have been sufficient to raise a genuine dispute of fact if CMS had alleged specifically that the ties on the wheelchairs of residents other than R11 were positioned where they could contact a resident's skin, with the point sticking out, but CMS did not do so.

CMS asserted in its motion only that it was undisputed that "Pleasant View continued to use these plastic ties on approximately two dozen wheelchairs until December 2, 2010, during the survey at issue in this case" and "surveyors observed these ties still in use on the wheelchairs of other residents." CMS MSJ at 5. The surveyor's testimony that CMS cited in support of this assertion refers only to the surveyor's observation of "20 pairs of wheelchair leg rests/leg extensions equipped with the colored plastic ties" in a storage area. CMS Ex. 21, at 3. Another surveyor's notes appear to refer to wheelchairs in use by four residents, but the notes do not refer to any of the ties as being positioned where they could come into contact with a resident's body with the point sticking out. CMS Ex. 10, at 27. Neither the initial nor the revised SOD found that any of these plastic ties were placed where they would come into contact with a resident's body. CMS Exs. 1, 22. Perhaps one could infer that the ties were so placed from the surveyors' implicit opinions that Pleasant View should have discontinued use of the ties. Drawing such an inference was not proper at the summary judgment stage, however, particularly because CMS did

not aver specifically that any remaining tie was positioned where it would come into contact with a resident's body with the point sticking out and because Pleasant View proffered testimony that raises questions about the credibility of the surveyors. *See, e.g.,* P. Ex. 32, at 3.

As the ALJ here pointed out, drawing reasonable inferences in the light most favorable to the non-moving party does not require an ALJ to accept the non-moving party's legal conclusions. ALJ Decision at 4, citing *Cedar Lake*, DAB No. 2344, at 7 (2010); *Guardian Health Care Center*, DAB No. 2004, at 11 (2005). In each of the cited cases, however, the facility did not dispute findings about its failures to provide services identified in residents' care plans, physician orders, and/or facility policy as services the residents needed. The facility disputed only whether, as a matter of law, these failures constituted noncompliance with the particular quality of care requirements at issue. In *Lebanon*, the Board distinguished such cases from cases such as *Lebanon*, in which facility records were subject to more than one interpretation and material facts remained in dispute. *Lebanon* at 9. In our view, this case is like *Lebanon*, rather than the decisions on which the ALJ relied.

Whether there was immediate jeopardy

On the immediate jeopardy issue, the ALJ said:

> Here, the tag left on R11's wheelchair probably caused – and certainly was likely to cause – a skin injury. Such an open wound can be especially dangerous to the aged and infirm, subjecting them to risks of infection and other serious consequences. The staff's disregard for the facility's anti-neglect policy, as evidenced by their failure to remove immediately an identified risk to R11 and their failure to determine whether other vulnerable residents were exposed to similar risks shows a situation likely to cause serious injury.

ALJ Decision at 9.

Even assuming that it was appropriate to determine on summary judgment that Pleasant View had failed to implement its anti-neglect policy (which we have concluded was inappropriate), there are disputed facts and evidence which, viewed in the light most favorable to Pleasant View, undercut a conclusion on summary judgment that a plastic tie was likely to be positioned on a resident's wheelchair with the point sticking out where it could come into contact with the resident's skin and cause a skin injury. For example, as mentioned above, Pleasant View proffered testimony that the ties were always positioned where they would not come into contact with a resident's body. Also, CMS did not allege that a plastic tie did, in fact, cause a skin injury to any resident other than R11, even though Pleasant View proffered evidence that the ties had been in use without any problem for almost two years before R11's wound developed on July 20, 2010, and

continued in use until the December 2010 survey. The SOD says that, during the survey, all residents had a complete body check and no new skin concerns were noted. CMS Ex. 1, at 13. Considering this evidence, a reasonable trier of fact could find that the situation regarding R11 was a one-time aberration from Pleasant View's usual practice to place the ties where they would not come into contact with a resident's skin.

We also find it relevant to the appropriateness of summary judgment on the immediate jeopardy issue that the notes of the surveyor who reported that there were four residents' wheelchairs in use with ties on leg rests also indicate that, of those four leg rests, two of them were padded, and describe the ties for at least one of the residents whose leg rests were unpadded as being on the "footrests." CMS Ex. 10, at 27. The other surveyor testified that she observed wheelchair parts only in the storage area, and did not address whether these wheelchair parts would have been padded when in use. CMS Ex. 21, at 3. Presumably, any padding would have reduced any risk of serious harm.

In addition, CMS presented no direct evidence of how many, if any, of the other residents with plastic ties on their wheelchair parts were similarly situated to R11, with her advanced age and many health issues, her lack of skin integrity, her inability to communicate if a plastic tie was placed where it came into contact with her body, and the lack of padding on her wheelchair leg rest until after the wound had developed on her left shin.

Finally, we note that the surveyors and CMS based their determinations about noncompliance with section 483.13(c) and about immediate jeopardy in part on their findings to the effect that facility staff had been neglectful by not following facility policies for monitoring and documenting pressure ulcers with respect to R11 and two other residents – findings which CMS recognized were contested by Pleasant View and on which CMS did not rely as a basis for summary judgment. The ALJ then relied for her decision on only some of the additional findings on which CMS moved for summary judgment.

An ALJ provides a de novo review and is not precluded from concluding there is noncompliance and immediate jeopardy based on a narrower set of facts than those listed in an SOD. Reaching these conclusions at the summary judgment stage based only on inferences from a substantially narrower set of facts is, however, particularly troublesome with respect to the immediate jeopardy determination. The facility at that point has not had any opportunity to question the surveyors about the extent to which their immediate jeopardy determination may have depended on the disputed factual findings the ALJ considered immaterial. In other words, neither the surveyors nor CMS have, in fact, made or communicated a judgment about immediate jeopardy, after applying their expertise to the substantially narrower set of facts on which the ALJ relied.

Whether Pleasant View had good cause for late submission of evidence

Pleasant View alleges on appeal that the ALJ committed procedural error by granting summary judgment to CMS without considering the new evidence Pleasant View submitted in response to CMS's motion for summary judgment. RR at 9.[4] As noted above, the ALJ did discuss the declaration of Nurse Practitioner Gorveatt (the ARNP who wrote the July 20 progress note), and concluded more generally that the assertions in the proffered exhibits "do not establish a material fact in dispute." ALJ Decision at 3. The ALJ also, however, determined that Pleasant View did not show good cause for not submitting this evidence with its pre-hearing exchange. *Id.* Pleasant View's argument that this was procedural error is premised on Pleasant View's assertion that CMS's motion set out a new theory of the case based on findings set out for the first time in CMS's revised SOD, issued after Pleasant View had submitted its written direct testimony and exhibits pursuant to the ALJ's pre-hearing order. This premise is directly contradicted by the record.

A simple comparison between the original SOD and the revised SOD suffices to show that, with minor exceptions, the same factual findings appear in both the original SOD and the revised SOD under Tag F224, indicating that they were a basis for the conclusion that Pleasant View was not in substantial compliance with section 483.13(c). CMS Exs. 1, 22. Pleasant View had notice of all but these few additional findings from the original SOD, which was incorporated by reference into CMS's determination letter of January 25, 2011. As the ALJ pointed out, CMS had also relied on these findings in its pre-hearing brief, which is dated July 19, 2011, well before Pleasant View made its pre-hearing submission dated August 19, 2011. While neither SOD specifically referred to the ARNP's July 20 progress note as an "order," CMS's pre-hearing brief did. CMS Pre-hearing Br. at 6. In addition, CMS submitted written direct testimony of a surveyor that a failure to follow a nurse practitioner's order is a form of neglect and that she concurred with the survey team that Pleasant View did not comply with "this requirement" because the facility failed to promptly remove the plastic tie attached to R11's wheelchair. CMS Ex. 21, at 5-6.

While there were a few minor additions to the revised SOD, Pleasant View did not specifically identify any of these additions or explain how these additions constituted good cause for its failure to submit the new evidence sooner. The revised SOD adds to the description of a surveyor's interview on December 3, 2010 with a physician

[4] Because we are remanding this case for further proceedings, we do not address additional procedural issues raised by Pleasant View about matters such as the burden of proof that applies.

(identified in the survey as Staff F), adding that it was a telephone interview, that he was R11's primary physician, what he said in that interview regarding whether R11's wound was a venous stasis ulcer, and what he said in an October 11, 2010 progress note in which he referred to the wound as a "venous stasis ulcer." CMS Ex. 22, at 5, 8, 9-10. These changes were consistent with evidence CMS had previously submitted with its pre-hearing exchange about the interview and with the October 11 progress note, which was also submitted. CMS Ex. 6, at 13; CMS Ex. 21, at 4. Also, Pleasant View addressed the content of the interview and note in written direct testimony submitted with its pre-hearing exchange. P. Ex. 34, at 2-3; P. Ex. 32, at 3. Thus, Pleasant View cannot reasonably claim that these minor revisions to the SOD provided new information it had not previously had an opportunity to address.

The revised SOD also restates in a slightly different way some findings related to Pleasant View's monitoring of R11's wound. CMS Ex. 22, at 11-12. But the findings regarding monitoring are not at issue before us since CMS did not rely on them as a basis for its summary judgment motion.[5]

Pleasant View suggests on appeal that a party is normally expected to proffer evidence in response to a motion for summary judgment, as it did here. RR at 4. But the ALJ's pre-hearing order in this case indicated that Pleasant View would be able to supplement its pre-hearing exchange only if it showed good cause why it had not submitted any new exhibit or testimony before. The order also stated (at page 5) that the ALJ would hear and decide each motion for summary disposition "according to the principles of Rule 56 of the Federal Rules of Civil Procedure and applicable case law." This section of the order specifically said that a party moving for summary disposition need not submit affidavits, but did not address whether the non-moving party could do so, stating only that the opposing party "must state its opposition to those material facts that it asserts to be in dispute" and that it "is never sufficient for a party opposing a motion to aver only that it 'disputes' alleged facts or that it demands an in-person hearing." This statement could have been clearer about procedures for a non-moving party's response to a summary disposition motion, but Pleasant View did not allege that it was misled by this statement. Moreover, the summary of the pre-hearing conference call (in which CMS indicated it would move for summary judgment) indicates that the ALJ told Pleasant View it would need to show good cause if it proffered additional evidence in response to a motion summary judgment. There is no indication or allegation that Pleasant View objected at the time.

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[5] If CMS relies on these findings on remand, the ALJ should consider whether to permit Pleasant View to supplement its earlier submission in light of these revisions.

Pleasant View also asserts that it had "good cause" for its late submission because the original SOD "focused" on findings CMS later withdrew. RR at 18. But that focus did not excuse Pleasant View from its obligations under the regulations and the ALJ's order to identify any factual disputes and to timely submit any relevant evidence. Nor would that focus explain why Pleasant View did not, prior to CMS's motion, submit the written direct testimony from its Administrator that it says shows that the allegations in this case had been "deliberately exaggerated by a corrupt State official." RR at 37.

Pleasant View also seeks to characterize the revised SOD as "new evidence" submitted for the first time with CMS's motion and as the "only" evidence of the survey findings under section 483.13(c). RR at 10. This argument also has no merit. First, as discussed above, the revised SOD was essentially the same as the original SOD, containing no new findings that would justify Pleasant View's late submission of the evidence at issue. Second, the exhibits CMS submitted with its pre-hearing exchange included surveyor testimony and other evidence regarding these findings.[6]

While CMS's motion for the first time set out its legal rationale for why a subset of the survey findings showed noncompliance with section 483.13(c), Pleasant View had an opportunity to address that rationale in its response to the motion and does not point to any difference in the rationale that would excuse its failure to submit the new evidence with its pre-hearing exchange. Pleasant View clearly had notice from the SOD, CMS's pre-hearing brief, and surveyor testimony of the issues regarding whether the plastic ties were a danger to residents, whether the ARNP had "ordered" staff to remove the tie from R11's wheelchair, and whether the surveyors were credible. Indeed, Pleasant View included with its timely evidentiary submission evidence relevant to these issues. Therefore, we conclude that the ALJ did not err in excluding the evidence submitted for the first time in response to CMS's motion for summary judgment.

[6] Pleasant View suggests that an SOD is simply a charging document and not evidence at all. RR at 16. Based on the regulatory requirements related to the survey and certification process, the Board has held that the SOD functions both as a notice of the survey findings and as evidence to support those findings. *Oxford Manor*, DAB No. 2167, at 2 (2008). Pleasant View's reliance on *United States v. Menendez*, 48 F.3d 1401, 1414 (5th Cir. 1995) as holding to the contrary is misplaced, for the reasons the Board explained in *Jennifer Mathew Nursing and Rehabilitation Center*, DAB No. 2192, at 46-47 (2008). In any event, CMS did not rely on the SOD alone as evidence of the December 2010 survey findings, but submitted testimony from the surveyors, the surveyors' notes, and documents from facility records.

Conclusion

For the reasons stated above, we reverse the ALJ Decision and remand this case for further proceedings.

/s/
Leslie A. Sussan

/s/
Constance B. Tobias

/s/
Judith A. Ballard
Presiding Board Member