Department of Health and Human Services
DEPARTMENTAL APPEALS BOARD
Appellate Division

Hanover Hill Health Care Center
Docket No. A-13-6
Decision No. 2507
April 10, 2013

REMAND OF ADMINISTRATIVE LAW JUDGE DECISION

Hanover Hill Health Care Center (Hanover) appealed the decision by an Administrative Law Judge (ALJ) upholding a determination by the Centers for Medicare & Medicaid Services (CMS) to impose a per-instance civil money penalty (CMP) of $7,500 on Hanover. *Hanover Hill Health Care Ctr.*, DAB CR2617 (2012) (ALJ Decision). The ALJ concluded that Hanover was not in substantial compliance with the regulatory requirements at 42 C.F.R. §§ 483.13(c) and 483.25, and that the amount of the CMP is reasonable.

On appeal, Hanover challenges the ALJ Decision on both procedural and substantive grounds. For the reasons explained below, we reject Hanover's procedural arguments, but remand the case to the ALJ on the merits.

Background

Hanover is a long-term care facility, located in Manchester, New Hampshire, that participates in the Medicare program. As such, it is subject to surveys by the New Hampshire Department of Health and Human Services (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. "Substantial compliance" means "a level of compliance such that any identified deficiencies pose no greater risk to resident health or safety than the potential for causing minimal harm." 42 C.F.R. § 488.301. "Noncompliance" means "any deficiency that causes a facility to not be in substantial compliance." *Id.* "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." *Id.*

The state survey agency completed a survey of Hanover on February 11, 2011. The surveyors reported their findings on a statement of deficiencies (SOD). The state survey agency found that Hanover was not in substantial compliance with two participation requirements – section 483.13(c) (staff treatment of residents) and section 483.25 (general quality of care). Both noncompliance findings relate to a resident referred to as R17, specifically, to Hanover's response after R17 choked while eating. The SOD cited the noncompliance at the immediate jeopardy level.

Based on the survey findings, CMS imposed a per-instance CMP of $7,500. Hanover requested a hearing and the case was assigned to the ALJ. Pursuant to the ALJ's pre-hearing order, the parties exchanged pre-hearing briefs and exhibits, with CMS making its submission first. CMS's submission stated that "CMS has chosen not to submit the names, and corresponding written direct testimony, of any proposed witnesses at this time." CMS 8/1/2011 List of Proposed Exhibits and Witnesses at 2. With its September 2, 2011 submission, Hanover submitted written direct testimony of 10 witnesses. Hanover also indicated, in a letter of the same date, that it would request the ALJ, at the appropriate time, to issue subpoenas to compel the testimony of the surveyors who conducted the February 2011 survey. On December 14, 2011, CMS submitted an additional proposed exhibit and moved for summary judgment.

On the same date, Hanover submitted a request for subpoenas for three of the surveyors. Hanover alleged that facility administrators and/or counsel had spoken with the surveyors and that the surveyors would testify, among other things, that the SOD contained inaccuracies and that the former chief of the state survey agency was later suspended for professional and personal misconduct and routinely pressured the surveyors to "exaggerate fact findings in order to support deficiencies that they believed at the time, and believe now, were unwarranted." P. Request for Subpoenas at 4-6; *see also* P. Ex. 26, at 5-6. Hanover submitted no evidentiary support for its allegations of misconduct by the former chief of the state survey agency, despite their serious nature. CMS objected to the request for subpoenas on the ground that the request did not comply with the requirements of 42 C.F.R. § 498.58.[1] CMS also asserted that the basis for the statements Hanover attributed to the surveyors was "open to question" and submitted sworn declarations of the surveyors "solely for the limited purpose" of supporting CMS's objection to the request. CMS Objection at 1. These declarations (1) acknowledge that one surveyor expressed doubts about the immediate jeopardy determination; (2) explain that this is not unusual and that this surveyor did not object to the survey team's consensus on the level of noncompliance; and (3) indicate that Hanover staff may have misunderstood some things the surveyors said. In addition, Surveyor J.H. specifically attested that the survey team's consensus was reached without any coercion or interference from the former Bureau Chief.

[1] Under this section, a subpoena request must, among other things,"[s]pecify the pertinent facts the party expects to establish . . . , and indicate why those facts could not be established without use of a subpoena," and an ALJ "may" issue a subpoena "reasonably necessary for the full presentation of a case."

By letter dated January 9, 2012, Hanover opposed CMS's motion for summary judgment and submitted two new proposed exhibits (numbered 29 and 30), including additional written testimony from its Director of Nursing (DON). Hanover argued that CMS's motion raised new issues, including an allegation that depended on when a particular intervention ("NO APPLES") was added to R17's care plan. The proposed testimony by the DON was that the facility's electronic record system showed when the intervention was added and that the relevant computer screen had been shown to the surveyors during the survey. CMS objected to the exhibits, arguing that its motion did not raise new issues. In a January 13, 2012 email, Hanover argued among other things that if CMS was really denying that the system date was shown to the surveyors, "then cross-examination of the survey team may be necessary to establish the truth in this case."

In rulings dated January 18, 2012, the ALJ: 1) denied CMS's motion for summary judgment; 2) did not admit Hanover's two new proposed exhibits (29 and 30) because Hanover had "not moved to supplement its pre-hearing exchange, which requires a showing of good cause"; 3) denied Hanover's request for subpoenas on the basis that Hanover had "not shown that the witnesses are reasonably necessary for the full presentation of its case nor that the facts it expects to establish through these witnesses could not be established without the use of a subpoena"; and 4) informed the parties that the hearing scheduled to commence on January 23, 2012 would go forward. In a submission on January 20, 2012, Hanover requested that the ALJ reconsider her rulings on the request for a subpoena for surveyor J.H. and on admission of its Exhibits 29 and 30. Hanover argued that CMS's motion for summary judgment had advanced new factual and legal issues, including CMS's assertion that Hanover had failed to follow R17's care plan because it provided him apples after April 2010. Hanover contended that the testimony would show that Surveyor J.H. had seen the electronic record showing that the dietary intervention was not added until August 12, 2010.

At the January 23, 2012 hearing, the ALJ denied Hanover's reconsideration request, giving two reasons: 1) the motion was too late and the arguments should have been made in Hanover's response to CMS's motion for summary judgment, and 2) CMS did not raise any new arguments in its motion. Tr. at 5-6.[2] During the hearing, CMS cross-examined only one of Hanover's 10 witnesses, R17's attending physician.

Board Guidelines for Review of an ALJ Decision

The Board's guidelines for review of ALJ decisions under 42 C.F.R. Part 498 provide:

> The standard of review on a disputed factual issue is whether the ALJ decision is supported by substantial evidence in the record as a whole. The standard of

[2] Since CMS abandoned its argument that Hanover failed to provide care consistent with R17's care plan in regard to apples, any arguable need for Surveyor J.H.'s testimony on the timing of the care plan intervention is moot.

> review on a disputed issue of law is whether the ALJ decision is erroneous. The bases for modifying, reversing or remanding an ALJ decision include the following: a finding of material fact necessary to the outcome of the decision is not supported by substantial evidence; a legal conclusion necessary to the outcome of the decision is erroneous; the decision is contrary to law or applicable regulations; a prejudicial error of procedure (including an abuse of discretion under the law or applicable regulations) was committed.

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.

In *Azalea Court*, DAB No. 2352 (2010), the Board explained that the--

> Board's role is not a mere formality to simply "rubber stamp" an ALJ's decision. In order to properly evaluate whether an ALJ's factual findings are supported by substantial evidence in the record as a whole, the Board reviews all of the arguments and evidence and "take[s] into account whatever in the record fairly detracts from the weight of the decision below." *Britthaven, Inc.*, DAB No. 2018, at 2 (2006), citing *Universal Camera Corp. v. NLRB*, 340 U.S. 474, 488 (1951).

Azalea Court also cited to the Board's decision in *Barry D. Garfinkel, M.D.*, DAB No. 1572 (1996), *aff'd, Garfinkel v. Shalala*, No. 3-96-604 (D. Minn. June 25, 1997). In *Garfinkel*, the Board said that "[s]ubstantial evidence on the whole record means that a decision may not be upheld based solely on the evidence 'which in and of itself justified it, without taking into account contradictory evidence or evidence from which conflicting inferences could be drawn.' *Universal Camera*, 340 U.S. at 487. Thus, the 'substantiality of evidence must take into account whatever in the record detracts from its weight.' *Universal Camera*, 340 U.S. at 488." *Garfinkel* at 6.

Analysis

I. <u>We reject Hanover's procedural arguments</u>.

A. The ALJ's procedural rulings did not deny Hanover due process and were consistent with the governing regulations.

Hanover argues that "the ALJ denied [Hanover] even rudimentary due process by foreclosing any cross-examination of any State or CMS surveyor or official (who may or may not have agreed with the ALJ's opinions)." RR at 5. According to Hanover, "due process concerns obviously *are* implicated when the government seeks to impose a sanction *without* producing *any* fact or expert witness, thus precluding the sanctioned party from *any* opportunity for cross examination, even where the sanctioned party

specifically contests the factual allegations set out in the [SOD]." RR at 35-36 (italics in original). Here, Hanover contends, CMS declined to produce "any of the surveyors who ostensibly cited the deficiencies – or anyone else -- as witnesses," and "the ALJ chose to insulate CMS' (false) factual allegations from challenge …." Hanover argues that recent cases such as *Grace Healthcare of Benton v. HHS*, 598 F.3d 926 (8th Cir. 2009) "make clear that the Board must respect due process principles in cases involving 'quasi criminal' sanctions such as CMPs." *Id.* at 36.

Hanover's argument is based on erroneous premises. Specifically, the argument incorrectly assumes that CMS and the ALJ relied on allegations in the SOD in the nature of testimonial evidence. Testimonial evidence in an SOD could, for example, be an assertion about what surveyors observed or what facility staff or residents said during the survey, such that fairness might require granting a facility the opportunity to cross-examine the surveyors. Hanover's subpoena request did not point to any factual allegation in CMS's pre-hearing brief relying on such testimonial evidence in the SOD. Instead, CMS relied on R17's clinical records for its allegations regarding R17 and on professional publications and Hanover's own policies as establishing the professional standards of quality CMS alleged that Hanover had failed to meet.[3] CMS submitted no written direct testimony by any surveyor or other witness.

Moreover, the ALJ did not broadly foreclose cross-examination of any surveyor, state agency official, or CMS official, as Hanover alleges, but merely ruled that Hanover's request to subpoena the three surveyors did not meet the requirements of section 498.58. Notably, Hanover's request for review does not allege that the ALJ did not correctly apply that section. Thus, under the particular circumstances of this case, we see no due process concern based on denial of Hanover's subpoena request.[4]

Hanover also suggests that CMS may establish noncompliance with federal requirements and applicable standards of care only by presenting expert witness testimony. RR at 11. For this proposition, Hanover cites to the Federal Rules of Evidence (FRE), specifically to "Rules 702 through 705 that permit the finder of fact to consider opinions, even on ultimate issues of fact or law, so long as the *witness* who expresses the opinion" is qualified and "the opinion is based on facts or data actually seen or considered by the witness." *Id*. at 11-12 (italics in original).

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[3] The SOD alleged that two staff members told surveyors that an August 24 nutritional assessment should have been referred to the dietician. CMS Ex. 1, at 16. These individuals signed statements denying this, and CMS did not rely on this allegation before the ALJ. P. Ex. 16, at 1.

[4] To the extent Hanover sought to elicit testimony about how the surveyors or their supervisors determined the level of noncompliance, such testimony would be irrelevant. CMS's immediate jeopardy determination is not subject to review where, as here, it does not affect the applicable range of CMPs that may be imposed and no finding of substandard quality of care resulted in loss of a nurse aide training program. *Aase Haugen Homes, Inc*., DAB No. 2013, at 17-19 (2006). In addition, CMS is not bound by the surveyors' or state agency's determination as to the level of noncompliance.

We disagree. The FRE do not apply to hearings under the procedures at 42 C.F.R. Part 498. Indeed, the regulations specifically permit the ALJ to receive evidence at the hearing "even though inadmissible under the rules of evidence applicable to court procedure." 42 C.F.R. § 498.61.[5] Furthermore, the rules cited by Hanover do not **require** a party to present expert opinion testimony, as Hanover suggests, but simply **permit** such expert opinion testimony to address the ultimate issues before the tribunal. In addition, the Board has long held that a facility's own policy may be sufficient evidence both of professional standards of quality and of what the facility has determined is needed to meet the quality of care requirements in section 483.25. *Spring Meadows Health Care Ctr.*, DAB No. 1966 (2005). The Board has also noted that "a nurse surveyor may be called upon to identify an appropriate standard of care by consulting nursing manuals or textbooks, pronouncements by professional organizations, federal clinical practice guidelines, or professional journal articles." *The Residence at Salem Woods*, DAB No. 2052, at 8 (2006), citing CMS State Operations Manual (SOM), App. PP (guidelines for section 483.20(k)(3)(i)). Based on the SOM guidelines about relevant sources of professional standards of quality, the Board has also held that a "Geriatric Nursing" article constituted a "current professional article" and was thus appropriately considered by the ALJ in determining the applicable professional standard of quality in that case. *Omni Manor*, DAB No. 1920, at 22-25 (2004). Here, CMS relied on both facility policies and articles from professional journals as establishing applicable standards.

We do not hold here that documentary evidence will necessarily suffice in every case to establish noncompliance, without any testimonial evidence. We do, however, reject Hanover's arguments to the extent they suggest that CMS may never rely solely on documents in a resident's record to establish facts about that resident and must always present expert testimony to establish noncompliance. Accordingly, we conclude that the ALJ's procedural rulings did not deny Hanover due process and were consistent with the governing regulations.

B. The ALJ was not required to find that CMS presented a prima facie case.

Hanover argues that the ALJ erred because she never found that CMS had made a prima facie case that Hanover was not in substantial compliance with federal requirements. RR at 35, 36-38.

[5] Hanover points out that the Board sometimes cites federal rules as guidance for its analysis. Using the rules as guidance in evaluating what procedures are fair or what type of evidence is most reliable does not amount to adopting the rules for every purpose, however.

We disagree. The Board has never required ALJs to address whether CMS made a prima facie case when both parties have submitted their evidence. The ALJ must assess whether CMS failed to present a prima facie case if the provider challenges the legal sufficiency of that case prior to presenting its own affirmative evidence. *Hillman Rehabilitation Ctr.*, DAB No. 1663, at 6 (1997) *(Hillman II), aff'd, Hillman Rehabilitation Ctr. v. U.S. Dep't of Health & Human Servs.*, No. 98-3789 (GEB) at 21-38 (D. N.J. May 13, 1999). Hanover made no such challenge below.

As the Board again clarified in *Oxford Manor*, DAB No. 2167, at 2-3 (2008), once both parties have presented their evidence, the issue before the ALJ "is whether the petitioner showed substantial compliance by a preponderance of the evidence." An ALJ might at that point (depending on the record as a whole) conclude that the evidence supporting CMS's allegations was so weak that, even apart from the provider's rebuttals, no deficiency was established. On the other hand, an ALJ does not err by proceeding to the ultimate question of whether a preponderance of the evidence on the record as a whole when both sides have completed their presentations shows the provider to be in substantial compliance.

C. The Board's standard of review for an ALJ's factual finding is whether the finding is supported by substantial evidence on the record as a whole.

Hanover argues that recent court decisions make "clear that two statutory standards govern the Board's review of CMS decisions – 'substantial evidence in the record, taken as a whole,' *and* the 'arbitrary and capricious' standard set forth in Section 706 of the Administrative Procedure Act." RR at 30-31 (italics in original, footnotes omitted), citing *Friedman v. Sebelius*, 686 F.3d. 813 (D.C. Cir. 2012) and *FAL-Meridian, Inc. v. DHHS*, 604 F.3d 445 (7th Cir. 2010). According to Hanover, the latter standard "substantially changes the ground rules for this Board's review, as it requires a searching review of the entirety of the ALJ's Decision, and not just a narrow determination whether she acted within the scope of her authority and found sufficient bits and pieces of record evidence to support her result." *Id*. at 31.

Hanover is mistaken that the "arbitrary and capricious standard" governs Board review of ALJ decisions. Section 706 of the Administrative Procedure Act (APA) provides that a "reviewing court" shall "hold unlawful and set aside agency action, findings, and conclusions" that the court finds to be "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law . . . ." 5 U.S.C. § 706. Nothing in the APA or the cited court decisions applies the "arbitrary and capricious standard" to Board review of an ALJ decision on behalf of the Secretary, nor would applying that standard make a difference here.

Contrary to what Hanover suggests, moreover, neither the Social Security Act nor the regulations prescribe a standard for Board review of ALJ decisions involving alleged noncompliance with requirements for long-term care facilities. Act §§ 1866, 1128A; 42 C.F.R. Part 498. Instead, the Board has adopted the guidelines set out above for appellate review of ALJ decisions under the Part 498 procedures. Under those guidelines, the standard of review on a disputed factual issue is whether the ALJ's finding is supported by substantial evidence in the record as a whole.

As also set out above, the Board has interpreted and applied the term "substantial evidence in the record as a whole" in a manner consistent with the explanation of that standard in *Gavin v. Heckler*, 811 F. 2d 1195, 1199 (8th Cir. 1987), on which Hanover relies. This is the standard that applies and the standard by which we have reviewed the ALJ's factual findings.

II. We remand the ALJ Decision on the merits.

A. The requirements at issue

Below, we set out the two participation requirements at issue. We note at the outset that the ALJ discussed both requirements together, without clearly explaining why the facts that she found supported findings of noncompliance with respect to each requirement individually. On remand, the ALJ should address each requirement separately.

1. 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) . . .
>
> (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 . . . 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 noted that the plain language of section 483.13(c) refers to developing and implementing policies and procedures and held 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 Ctr.,* DAB No. 2232 (2009)(failure to report to state authorities the results of investigation of suspected abuse); *Tri-County Extended Care Ctr.*, 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, per se, is not sufficient 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 Hosp.*, DAB No. 1799, at 34 (2001); *Columbus Nursing & Rehab. Ctr.,* 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 & Rehab. Ctr.*, DAB No. 2382, at 11 (2011). Circumstances the Board has found relevant have included factors such as 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 Ctr.*, DAB No. 1896 (2003); *Liberty Commons Nursing and Rehab Ctr. – Johnston*, DAB No. 2031 (2006), *aff'd, Liberty Commons Nursing and Rehab Ctr. – Johnston v. Leavitt*, 241 F. App'x 76 (4th Cir. 2007); *Lake Mary Health Care*, DAB No. 2081 (2007); *Jennifer Mathew Nursing & Rehab. Ctr.*, DAB No. 2192 (2008).

2. The quality of care requirement

The opening provision of section 483.25, which implements sections 1819(b)(2) of the Act, states:

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

The quality of care requirements are "based on the premise that the facility has (or can contract for) the expertise to first assess what each resident's needs are (in order to attain or maintain the resident's highest practicable functional level) and then to plan for and provide care and services to meet the goal." *Spring Meadows* at 16. The regulation thus "imposes on facilities an affirmative duty designed to achieve favorable outcomes to the highest practicable degree." *Windsor Health Care Ctr.*, DAB No. 1902, at 16-17 (2003), *aff'd, Windsor Health Care Ctr. v. Thompson*, No. 04-3018 (6th Cir. 2005). The facility must take "reasonable steps" and "all practicable measures to achieve that regulatory end." *Clermont Nursing & Convalescent Ctr.*, DAB No. 1923, at 21 (2004), *aff'd, Clermont Nursing & Convalescent Ctr. v. Leavitt*, 142 F. App'x 900 (6th Cir. 2005), *citing Josephine Sunset Home*, DAB No. 1908, at 14 (2004).

The Board has repeatedly held that section 483.25 requires skilled nursing facilities to furnish the care and services set forth in a resident's care plan and to implement doctors' orders. *See, e.g., Alexandria Place*, DAB No. 2245 (2009) (failure to provide care in accordance with the doctor's order); *Kenton Healthcare, LLC*, DAB No. 2186 (2008) (failure to follow standards in the care plan for supervision); *Spring Meadows* at 17 ("the clearest case of failure to meet [section 483.25] is failure to provide one of the specific services outlined in the subsections or failure otherwise to follow the plan of care based on the comprehensive resident assessment"); and *St. Catherine's of Findley*, DAB No. 1964, at 13 n.9 (2005) (facility admission that it failed to follow its own supervision care plan may make summary judgment appropriate). The quality of care provision also implicitly imposes on facilities a duty to provide care and services that, at a minimum, meet accepted professional standards of quality. *Spring Meadows* at 17; 42 C.F.R. §§ 483.20(k)(3)(i), 483.75.

B. The undisputed facts and ALJ findings

In this section, we set out some undisputed background facts to assist the reader in understanding our analysis below. We then set out the ALJ's findings and conclusions.

R17 was a 69-year-old man who suffered from numerous conditions including stasis wounds on both legs. His physician orders for the month of August 2010 listed multiple diagnoses, including hypertension, hyperlipidemia, uncontrolled diabetes, and peripheral neuropathy. CMS Ex. 6, at 73.[6] A Nutritional History in May 2010 had found he had no problems eating with regular consistency but nonetheless suggested that R17 be reviewed by the facility's Nutrition-At-Risk Committee because of his stasis ulcers and low albumin. P. Ex. 10, at 3-6. The Committee did an initial review of R17 on June 7, 2010 and follow-up reviews every two weeks on dates he was in the facility. P. Ex. 13, at 1. The Committee report forms call for signatures from the Unit Manager, a Registered Dietician, and either his attending physician or the physician assistant (PA) who worked with the attending physician. P. Ex. 13. In July 2010, R17 was identified as independent with meals after set up provided by staff. P. Ex. 7, at 4. He exhibited inappropriate or disruptive behaviors including resisting care, but he ate and drank sufficient amounts with no chewing or swallowing problems identified. *See, e.g.*, CMS Ex. 7; P. Ex 7, 22-24, 25; P. Ex. 8, at 1.

The survey findings centered on what Hanover did or did not do in caring for R17 after August 9, 2010. It is undisputed that on that date a nurse found R17 "choking on lunch" and performed the Heimlich maneuver to clear his airway. CMS Ex. 6, at 47. The PA was notified, but gave no new orders. *Id.* An Incident/Accident report signed by the DON and Administrator the next day identifies the following steps to address the incident: "Speech therapy intervention immediately. Plan of care reviewed and updated" and "Initiated [vital signs] and lung sounds [each] shift x 72 [hrs]." CMS Ex. 6, at 41. The report also shows that the PA was notified. *Id.* The August 9 care plan entry (under "Behaviors") directs nurses to "[c]ontinue to offer medications whole with alternative sources ie: Ice Cream, pudding, or Applesauce despite resident's refusal for alternative source and resident's refusal to accept medications crushed"; "reapproach resident at later time after initial refusal"; and "[a]llow ample time for resident to swallow medication [because R17] often takes a long time to swallow pills secondary to possible swallowing difficulties." CMS Ex. 6, at 23.

[6] CMS asserted that R17 had a diagnosis of Parkinson's disease, but the ALJ made no finding on this issue.

Notes from the speech language pathologist (SLP) who worked for Hanover and assessed R17 on August 9 state:

> Res observed consuming a regular texture with thin liquids. Res tolerating without overt signs/symptoms of aspiration/choking. No coughing, throat clearing or change in subsequent vocal quality. Adequate oral clearance. Choking episode appears to be an isolated event. Rec'd to [nursing] that Res be supervised for next few shifts. Res without any [history] of dysphagia.

P. Ex. 7, at 29. The SLP's notes in an interdisciplinary screen document are similar, but also state: "Res not demonstrating any oral or pharyngeal phase dysphagia." P. Ex. 14. The ALJ rejected CMS's argument that the SLP's August 9 assessment was inadequate and found that Hanover's response to the August 9 episode presented "no apparent problems." ALJ Decision at 7. That finding is supported by substantial evidence in the whole record and was not challenged by CMS, so we do not disturb it.

The ALJ found, however, that, after the August 9 episode, "facility staff did not respond appropriately to growing evidence that R17's swallowing difficulties went beyond an isolated choking incident." *Id.* at 7. On August 12, a further episode was recorded by a nurse called to R17's room who found him in his wheelchair, "reddened in face, attempting to cough with difficulty." P. Ex. 7, at 30. His snack of apples was in front of him and he was able to clear his airway "with thick sputum and apple peels present in vomited remains" and "thick productive cough afterwards." *Id.*

We reject Hanover's contention that the ALJ "made her own clinical judgment" that this episode too showed that R17 was choking. Substantial evidence in the record supports the ALJ's finding that this was a choking incident. The ALJ discounted testimony from the dietician that this was not technically a choking incident because R17's airway was not partially or fully blocked as inconsistent with the contemporaneous record, including the dietitian's own written notes describing the incident as choking. ALJ Decision at 7-8; *cf.* P. Ex. 19, at 3. Evidence cited by the ALJ also supports her finding that other staff also viewed "the August 12 incident as a choking incident." ALJ Decision at 8, citing P. Ex. 20, at 2; R. Ex. 18, at 4; CMS Ex. 6, at 37. Thus, we do not agree with Hanover that the ALJ's finding regarding this episode was unsupported. Moreover, the important point is that Hanover could no longer consider the August 9 episode to be isolated.

In addition, the ALJ found that the nursing notes documented R17 having other swallowing difficulties:

- On August 14, R17 took his oral medication "with much difficulty." CMS Ex. 6 at 50. The administering nurse reported that R17 took a couple of minutes to swallow each individual pill," and he "[r]efused to try taking pills with applesauce or anything to aid with swallowing." CMS Ex. 6, at 50.

- On August 15, R17 "took a significant time to swallow each individual pill with difficulty." CMS Ex. 6, at 50. The nurse wrote that R17 "tossed pills around in his mouth and talk[ed] during swallowing." She directed him to "focus on swallowing during med[ication] administration to prevent choking, but [noted that R17 is] forgetful." CMS Ex. 6, at 50. He again "[r]efused to take pills crushed or with applesauce to assist with swallowing." CMS Ex. 6, at 50.

- On August 21, R17 had "difficulty swallowing pills," and was "pocketing them inside of [his] cheek." CMS Ex. 6, at 52. The nurse "[a]dded applesauce to whole pills," which was "helpful in assisting with swallowing." CMS Ex. 6, at 52.

ALJ Decision at 6. The ALJ rejected Hanover's argument and evidence that these incidents were merely part of R17's pattern of resisting care, rather than actual problems swallowing; the ALJ found instead that the contemporaneous notes showed he was having trouble swallowing his pills. ALJ Decision at 9-10. Contrary to what Hanover argues, these findings are not based on interpretations of the notes, but on their plain language, and the ALJ could reasonably give less weight to the post hoc testimony.

The ALJ also relied on an August 24 Malnutrition Risk Assessment as persuasive evidence that staff had "recognized R17's growing problem with swallowing." ALJ Decision at 11. Among other things, this document records "Difficulty swallowing/frequent choking" and shows R17 as high risk for malnutrition for the first time. CMS Ex. 6, at 43. Hanover argues that this language resulted from a "flawed software program" and should not be viewed as evidencing any "clinician" having assessed R17 as having "any mechanical swallowing problem." RR at 15 n.8. The ALJ reasonably inferred that retaining this language in an assessment on which staff was to rely in caring for R17 meant that it did reflect at a minimum an awareness and documentation of swallowing difficulty (whether of mechanical or neurological origin, due to medication, or of other etiology) going beyond a single choking event.

The final episode at issue occurred on August 29 and ended with R17's death. P. Ex. 7, at 37. Hanover disputes that R17 actually choked on that date, presenting testimony on this from a number of witnesses that his presentation was consistent with cardiac arrest. RR at 28-30; P. Ex. 20, at 4-5; P. Ex. 28; P. Ex. 24, at 7-8; P. Ex. 26, at 3-4. Based on the contemporaneous evidence, including the report from the responding paramedics and the death certificate, the ALJ found it "highly unlikely that R17 died from a cardiac event that just happened to coincide with his eating (but not swallowing) a lot of peanut butter on crackers." ALJ Decision at 12. Nevertheless, the ALJ concluded that "this case does not rest on whether R17 choked to death on peanut butter and crackers." *Id.*

The ALJ concluded that, because "the facility took no further action but just relied on what was, by August 12, [the SLP's] outdated assessment," it "failed to implement its policies that required staff to provide him the care and services he needed to avoid

physical harm, in violation of [section] 483.13(c), and it failed to provide him the care and services he needed to maintain his highest practicable physical well-being in accordance with his assessment and care plan, in violation of [section] 483.25." *Id.* at 13. Although the ALJ did not specifically find that Hanover violated any professional standard set out in CMS's Exhibits 9-12, she cited these exhibits in finding that "coughing, while eating, including before swallowing is a sign of dysphagia"; "refusing to swallow may itself signal swallowing problems"; and "it is not uncommon for staff to mistake genuine swallowing problems as the resident's 'deliberately being difficult.'" ALJ Decision at 8, 10.

C. Hanover's arguments on the merits

On the merits, Hanover argues generally that "there is no *evidence* whatsoever in the record that connects CMS' factual allegations with any governing clinical standards." RR at 3 (italics in original). Hanover argues that—

> the ALJ's findings regarding the threshold material *factual* issues in dispute – notably, whether the resident at issue actually suffered from any swallowing disorder, and the standards for assessing and treating his supposed ailments – represent only *the ALJ's* personal opinions on clinical matters, and not the product of weighing conflicting testimony by the parties' witnesses. No surveyor, expert or CMS official ever expressed such opinions on the record (and all of [Hanover's] witnesses disputed them). . . . the ALJ based her findings of fact on her own "de novo" interpretations of medical records, and her own "de novo" opinions about diagnostic and clinical matters. . . . the ALJ's discussion not only is entirely manufactured, but the evidence, taken as a whole, shows that it is wrong.

Id. (italics in original). According to Hanover, the ALJ "picked and chose" among the SOD allegations to construct a different theory of noncompliance. *Id*. at 10. Hanover also alleges that the "ALJ not only misinterpreted many of the pertinent documents, she disregarded undisputed evidence that contradicts her opinion" and selectively took nursing notes and statements from CMS's exhibits out of context. *Id*. at 18-19.

In many respects, Hanover misstates what the ALJ found or misrepresents the record. Hanover also focuses on some matters that are immaterial to the ALJ's conclusions. Nevertheless, our review indicates that some findings that might be material to the ALJ's conclusions are not adequately explained and, in some instances, the ALJ did not discuss why she did not credit evidence that could be viewed as conflicting with her findings.

D. Evidence relating to the ALJ's finding that Hanover staff took "no further action" after the August 12 episode

The ALJ found that "the facility took no further action, but just relied on what was, by August 12, an outdated assessment." ALJ Decision at 13.[7] On remand, however, the ALJ should address the following evidence that could be viewed as undercutting her finding that Hanover took "no further action" after August 12.

On August 12, following the apples episode, the nurse recorded leaving a message with the PA regarding the recent increase in R17's dosage of Oxycontin and "any relation to swallowing issues." P. Ex. 7, at 30; *see also* CMS Ex. 6, at 46 (Aug. 5 note about dosage increase). That night, another nurse noted that the PA had called in orders to cut the dosage of Oxycontin and adjust other medications. *Id*. at 31. The ALJ observed that the PA had reduced the dosage of Oxycontin, but found the PA "did no assessment." ALJ Decision at 8, citing CMS Ex. 6, at 8. While the contemporaneous notes indeed do not show that the PA physically examined R17 on August 12, the ALJ did not discuss whether one could infer from the nurse's notes that the PA had reviewed R17's medications with respect to his swallowing difficulties, and acted in response to an assessment that over-sedation might be the cause of the recurrent problems. Further, the ALJ did not explain whether such an intervention might have been an adequate assessment and response to a second episode.[8] We note that the articles submitted by CMS do suggest that medications that affect a resident's alertness may cause or exacerbate swallowing difficulties. CMS Ex. 12, at 2, 4, CMS Ex. 11, at 14; CMS Ex. 10, at 3, 5.

We also note that the ALJ stated that she found "no contemporaneous evidence" that facility staff "even **considered** whether further assessment of R17's swallowing function was needed." ALJ Decision at 9 n.5 (emphasis added). However, the ALJ did not discuss in this regard the Nutrition-At-Risk Communication form for the Committee's August 16th review. That form contains a section for identifying Committee recommendations by checking listed interventions. The form for the August 16th review

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[7] Hanover challenges the characterization of the SLP's assessment as "outdated." Reply Br. at 14. The ALJ, however, adequately explained her view that the SLP's evaluation that the August 9 episode was an isolated event was no longer reliable, given R17's further swallowing difficulties.

[8] Hanover argues that the staff was entitled to rely on the SLP's assessment to rule out swallowing problems even after the second choking episode. RR at 23. Hanover points to testimony that, absent an intervening event such as a stroke, one would not expect mechanical ability to swallow to change in a short period. P. Ex. 24, at 6; P. Ex. 28, at 3. The ALJ relied on the SLP's recommendation that staff monitor the resident's meals for some shifts and her testimony that she advised the staff to let her know if follow-up was needed. ALJ Decision at 13; CMS Ex. 6, at 47; P. Ex. 7, at 29; P. Ex. 14. We conclude that the SLP's recommendation and request about follow-up imply that events occurring over a short period of time after an initial incident might be relevant to assessing the nature and cause of the resident's swallowing difficulties. Also, the assessment of an event as isolated might need revisiting when that event proves to be the first in a series, without necessarily meaning that a further deterioration in mechanical ability occurred during the intervening days. We therefore reject Hanover's argument.

contains a check in the box for weighing frequency but no check in the box for "Speech Pathology Consult." CMS Ex. 6, at 37.[9] In appropriate cases, depending on the evidence about facility practice, selective checking of boxes on such a form might be read as indicating that each of the listed actions was considered and only the checked ones were chosen to be implemented. *See, e.g. Tri-County Extended Care Ctr.*, *supra*, at 21-23 (in a case where the nurse filling out a risk form testified that, when a box was not checked, it meant that the risk had been assessed, the Board stated that "the selective checking of risks on the forms is strong evidence that each listed risk was consciously considered"). We do not conclude that the ALJ was obliged to draw such an inference here, but she should address on remand how she evaluates this form in reaching the finding that no further swallowing assessment was even considered. In doing so, she may want to take into account the dietician's testimony (about the "Nutrition at Risk process") averring that "I and other members of the team review the chart of every resident who is identified to be at risk . . . at least every two weeks, assessing improvements or the need for additional interventions." P. Ex. 19, at 1.

Hanover makes repeated arguments that the ALJ failed to view the evidence in a fuller context of R17's ongoing care and general history as a "hearty eater who did not refuse food" and who found "eating . . . one of his few pleasures in life," and who had never been diagnosed with dysphagia. RR at 14. To the extent Hanover is arguing that any evidence of noncompliance is outweighed or should be measured against evidence of adequate care provided on other occasions, we reject that argument. The Board has previously said that it "is not an adequate response [to evidence of noncompliance] to assert that there were many other things done for the resident at other times." *Emerald Oaks*, DAB No. 1800, at 31 (2001). The ALJ, moreover, clearly did not uncritically accept CMS's allegations about R17's care, as, for example, she specifically rejected the claim that the facility's response to the August 9 incident was problematic. ALJ Decision at 7.

We do note, though, that the record contains evidence of some other actions staff took after the August 12 episode that could be viewed as relevant to R17's swallowing issues. Nursing staff again monitored his vital signs (as had been recommended by the SLP after the August 9 incident) and checked his lung sounds on at least some shifts on August 12th to 14th without finding further difficulties. P. Ex. 7, at 30-31; *see* CMS Ex. 12, at 2, 5 (lung crackles/rales may be sign of silent aspiration). The facility had amended R17's care plan to add interventions addressing his difficulty swallowing pills, which the care plan described as "secondary to possible swallowing difficulties." P. Ex. 5, at 23. These interventions included giving him time to swallow his pills and offering alternatives to swallowing the pills with liquids, and the record contains some notes indicating that the staff implemented those interventions in the period after August 12. P. Ex. 7, at 31-33.

[9] We note that the PA signed this form without checking the box for "[a]gree with above recommendations" or describing any other recommendation, but this is a matter for the ALJ to consider in weighing the evidence. CMS Ex. 6, at 37.

The August 24 Malnutrition Risk Assessment that noted his frequent choking/swallowing difficulties did also review whether his dentures fit, whether he was eating and drinking well, and what his mental status was, issues which could arguably be relevant to assessing the causes of the recurring problems. CMS Ex. 6, at 43. There is also some evidence that staff and the PA were considering the possible contribution of increasing lethargy from his uncontrolled diabetes. *See, e.g.*, P. Ex. 7, at 30-37. Again we do not conclude that this evidence compelled the ALJ to alter the inferences which she drew from the record. In addressing on remand the evidence which we pointed to above (relating to the medication changes and possible other assessments after the August 12 event), however, the ALJ may wish to consider these measures as well in her re-evaluation.

On remand, the ALJ should address whether the evidence discussed in this section alters her general finding that Hanover took no further action after the August 12 episode, as well as the specific finding that Hanover did not even consider whether a further SLP consult was needed.

E. Evidence with respect to Hanover's policies.

1. Hanover's Abuse Prevention policy

Hanover's Abuse Prevention Policy tracks section 483.10(c) in some respects, but also contains a section under the heading "Prevention" that states:

> b) The facility will **identify, correct and intervene** in situations in which abuse, **neglect** and/or misappropriation of resident property **is more likely to occur**. We will:
>
> i) Evaluate and correct features of the physical environment that may make abuse and/or neglect more likely to occur, such as secluded areas of the facility.
>
> ii) Deploy staff on each shift in sufficient numbers …
>
> iii) Supervise staff to identify inappropriate behaviors, ...
>
> iv) **Assess, care plan for and monitor residents with needs and behaviors which may lead to** conflict or **neglect** such as residents with aggressive behaviors, residents who have behaviors such as entering other residents' rooms, residents with self-injurious behaviors, residents with communications disorders, those that require heavy nursing care and/or are totally dependent on staff.

CMS Ex. 5, at 2 (emphasis added).

The ALJ found that the August 12 episode should have alerted the dietician and others that the August 9 episode "might not have been isolated after all and that R17's situation needed further investigation." ALJ Decision at 8. She concluded that the fact that "staff failed in this regard" violated the "policies requiring staff to 'identify, correct, and intervene' as well as 'assess, care plan for, and monitor' residents with needs and behaviors that might lead to neglect." *Id*. at 8-9.

The ALJ did not explain whether she considered the situation of R17's swallowing difficulties to be a situation in which neglect is more likely to occur so as to trigger the need for particular assessment, monitoring, and care planning under the anti-neglect policy (as opposed to the normal quality of care requirements).[10] The ALJ also did not identify the nature and timing of whatever assessment, monitoring, and care planning she concluded the policy required in response to R17's swallowing difficulties. Moreover, the ALJ's statement that Hanover did no "meaningful" assessment after the August 12 episode seems to suggest she recognized that Hanover engaged in some assessment activities, as does her application to the Malnutrition Risk Assessment of the provision at section 483.20(b)(2)(ii) governing "comprehensive assessments." On remand, the ALJ should clarify whether and how her discussion of inadequate assessments interacts with this provision of the anti-neglect policy.

We recognize that the ALJ may have concluded that Hanover failed to implement its anti-neglect policy, at least in part, based on her findings that Hanover failed to follow its aspiration and nutrition policies, which we discuss below. The ALJ may appropriately consider other policies in addition to the Abuse Prevention Policy when determining whether Hanover complied with section 483.10(c). *See, e.g. Liberty Commons, supra*. The ALJ Decision also notes that examples of neglect might justify an inference that a facility failed to implement its policy, but does not specifically identify any such examples. ALJ Decision at 5. If the ALJ finds noncompliance with section 483.13(c) on remand, she should provide a more complete analysis of the basis for this conclusion, consistent with our discussion above.

2. Hanover's Aspiration Precautions Policy

Aspiration occurs when material moves below the true vocal folds and enters the trachea. CMS Ex. 10, at 4. CMS's pre-hearing brief asserted that "[c]hoking and aspiration are risks associated with dysphagia, or 'abnormal swallowing due to impaired coordination,

[10] R17 did have some of the needs and behaviors specifically identified in the policy, such as aggressive behaviors and resistance to care, but neither CMS nor the ALJ identified any failure by Hanover to assess, care plan, monitor for these needs and behaviors.

obstruction, or weakness affecting swallowing biomechanics.'" CMS Pre-hearing Br. at 9, quoting CMS Ex. 10, at 4 and citing CMS Ex. 9, at 2; *see also* CMS MSJ at 7.[11] Hanover has an Aspiration Precautions policy. CMS Ex. 1, at 13. Under "Policy," this document states generally: "Facility will maintain optimal safe swallow in patients/residents **with identified risk for aspiration.** Facility will **initiate prompt identification** of signs or symptoms of aspiration, changes in swallowing function, and signs and symptoms of aspiration pneumonia." CMS Ex. 5, at 1 (emphasis added). Under "Policy Interpretation and Implementation," the document lists specific interventions that may be undertaken in response to aspiration risks, including "[r]eport changes in signs/symptoms of dysphagia to physician." *Id*.

Hanover argues that the ALJ's discussion of this policy is a "tangent" since the stated purpose of this policy is to maintain safe swallowing "in patients/residents *with identified risk for aspiration.*" RR at 26 (italics in original). Hanover argues that the ALJ "simply disregards this threshold trigger for application of the policy" even though it would make no sense to apply the policy, including intrusive interventions, to all residents potentially at risk for aspiration. *Id*. at 27 n. 16. Hanover presented testimony from its DON that its aspiration precautions "were implemented following a diagnosis by a physician or speech pathologist of dysphagia or other mechanical swallowing problem, which never was the case here." P. Ex. 24, at 4. Hanover points out that it is undisputed that "no one ever diagnosed the Resident with dysphagia or risk for aspiration, or ordered any interventions for those disorders." *Id.* at 11; CMS MSJ at 1 n. 1. Hanover asserts that diagnoses and treatment of dysphagia are typically within the scope of practice of an SLP or physician. *Id*. at 10-11. Hanover points to testimony that neither R17's attending physician nor the PA working with him felt it necessary to implement aspiration precautions at any time from August 9 until R17's death. P. Ex. 15, at 2; P. Ex. 28, at 3.

We note, however, that the policy does not on its face include any prerequisite for a dysphagia diagnosis or requirement that the risk of aspiration may be identified only by a physician or SLP. We also note that the ALJ could infer that the SLP's recommendation to monitor R17 at meals for several shifts represented, among other things, an expression of concern about possibly elevated aspiration risk. The nurses' notes from the shifts after each choking episode that do record monitoring include reports on R17's lung sounds (as noted above). This could be viewed as indicating that the facility staff had indeed understood and identified R17 as at risk of aspiration.

[11] We note that the term "dysphagia" has various meanings in different contexts. *Compare* CMS Ex. 9, at 20; CMS Ex. 10, at 4; CMS Ex. 9; CMS Ex. 12. Hanover argues that the "premise for all of CMS' assertions and arguments – and the ALJ's Decision – is that the Resident suffered from 'dysphagia' as CMS defined it . . . ." RR at 12, citing CMS Pre-hearing Br. at 9. According to Hanover, the "ALJ identified no one – other than herself – who ever rendered such a diagnosis or expressed such an opinion." *Id.* In quoting the Aspiration Precautions policy, the ALJ, however, does not seem to have premised her conclusions on an assumption that R17 suffered from dysphagia as CMS defined it, but rather focused on R17's documented difficulty swallowing and the adequacy of Hanover's response.

Hanover presented testimony, however, that in practice it applied the policy more narrowly and that there was no need for the precautions. The ALJ did not explain why she discredited this testimony. ALJ Decision at 6, 13. The ALJ on remand should more specifically address her basis for concluding that the Aspiration Precautions policy applied to R17.

3. Hanover's Nutrition Policy

The articles submitted by CMS indicate that one of the major concerns for residents with swallowing disorders is the risk of malnutrition. The ALJ found that, under facility policy, the nurse or dietician should have "conveyed" the new information regarding R17's August 24 Malnutrition Risk Assessment to the Nutrition-at-Risk Committee, but failed to do so. ALJ Decision at 11.

Hanover's policy for "Monitoring Residents/Patients As Having Significant or Health Altering Nutritional Issues" leads with the general Policy Statement: "Residents/patients with significant, health altering nutritional issues will be identified to the Nutrition-at-Risk Committee and a Plan of Action, including a monitoring tool, will be created, reviewed, and revised for each individual." CMS Ex. 5, at 2. Under "Policy Interpretation and Implementation," the policy states that the Committee "will review patients who meet at least one of the following criteria, including "[s]core of 10 or above on malnutrition risk assessment." *Id*. It then states: "Referral will be made, based on these criteria, by the Nurse Manager, Primary Nurse, or Registered Dietician." *Id*.

The ALJ cites to the first two paragraphs of the policy, but does not explain what language in those paragraphs supports her finding that the information on the August 24 assessment should have been "conveyed" to the Committee or requires that such information be conveyed in any particular way or within any particular time period. ALJ Decision at 11. Moreover, the language about "referral" to the Committee could be read to mean initial referral of a patient to the Committee. The policy goes on in additional paragraphs to address what will happen with respect to a patient who has already been referred to the Committee, stating that "[f]ollowing initial review by the committee, the patients who have been determined by the Nutrition-at-Risk Committee as presenting with significant nutritional issues will be followed by the committee, and recommendations will be made to address the nutritional issues." *Id.*

As Hanover points out and the record shows, by August 24, R17 had already been referred to the Committee, which did an initial review in June 2010, was doing follow-up reviews every two weeks (including on August 16), and was not due to meet again on R17 until August 30 (the day after he died). The dietician, who was on the Committee, testified that the Committee procedures called for review of residents' charts, which she did. P. Ex. 19, at 1-2. The ALJ did not address this testimony or whether one could

infer that the nurse who did the August 24 assessment could expect that the Committee would see it when performing its next review of R17, planned for August 30 (less than a week after the assessment was done), and could reasonably rely on this expectation as obviating any need to otherwise communicate with the Committee about her assessment.

On remand, the ALJ should explain the basis for any conclusion that an additional referral to the Committee was required after August 12 and/or that additional information was required to be provided to the Committee prior to its scheduled re-review on August 30.

F. Evidence relating to testimony by Hanover's witnesses

Hanover argues that the ALJ erred by disregarding the testimony by R17's caregivers and rendering "her own 'de novo' opinions about diagnostic and clinical matters." RR at 3. Like Hanover's other contentions, this argument is premised in part on Hanover's misstatements of the ALJ's findings or of the testimony. It was within the ALJ's province to evaluate the weight to give to documentary evidence, including clinical records, and testimonial evidence. As noted above, we do not agree that the ALJ made any diagnosis of R17 as suffering from clinical dysphagia, but rather she considered whether the care provided by the staff met regulatory standards in light of the facility's policies, the professional standards of care, and the documentation of his treatment in the facility records.

Hanover challenged the ALJ's rejection of what it characterized as R17's physician's opinion that R17 did not have mechanical swallowing difficulties or require any interventions or precautions. RR at 11. Hanover argued that its staff reasonably relied on the fact that the physician had visited the facility on August 17 and ordered no new interventions for R17's swallowing, although he ordered some changes in medication and in recording of blood glucose levels. P. Ex. 7, at 32. The physician testified that he would have conducted a detailed review of R17's record on this visit and that he saw nothing requiring any further evaluation or different intervention. P. Ex. 28, at 3. The ALJ found the physician's testimony "on this issue equivocal and generally not credible." ALJ Decision at 12.

The Board defers to ALJ findings on the weight and credibility of testimony, absent a compelling reason to do otherwise. *Woodland Oaks Healthcare Facility*, DAB No. 2355, at 7 (2010); *Gateway Nursing Ctr*., DAB No. 2283, at 7 (2009), *citing Koester Pavilion*, DAB No. 1750, at 15, 21 (2000). Hanover has not provided any compelling reason to disturb the ALJ's credibility determination here. It does appear, however, that one fact to which the ALJ referred in discussing the physician's testimony may have been erroneous. Specifically, she referred to the physician as Hanover's Medical Director, as well as R17's treating physician. ALJ Decision at 12. Hanover denies, and CMS does not appear to disagree, that the physician was not the facility medical director. RR at 39.

If the ALJ concludes that R17's treating physician was not actually associated with the facility, the ALJ may choose to revisit her evaluation of the weight of his testimony.

Also, the ALJ's discussion of the credibility of the physician's testimony appeared in a section of the decision relating to his August 17 review of R17's clinical record and referred only to this testimony "on this issue." ALJ Decision at 12. The ALJ discredited his statements about the review he did on that date of R17's medical records in regard to swallowing problems and the post-August 9 incidents. *Id*. at 12-13. The ALJ did not address what weight, if any, she would give to his testimony on some issues apart from his August 17 review which might be material. For example, the physician testified that he knew about the August 12 event, and that it was reported to the PA who reduced R17's narcotic dose, which the physician called an "appropriately cautious response." P. Ex. 28, at 3. He also testified that he would defer to the dietician's recommendations about R17's diet (presumably meaning the removal of apples after August 12). *Id*. After knowing these facts (whether or not he knew them on August 17), he opined that R17 did not have any swallowing disorder and that the physician found "no evidence in the Resident's chart or anywhere else that the facility staff failed to provide proper care to" R17. *Id*. at 3-4. It is not clear whether the ALJ gave no weight to this testimony based on credibility considerations or for other reasons. The ALJ may address this question on remand if relevant to her decision.

Finally, the physician testified that, based on his view of the resident's "presentation," he did not agree with the death certificate statement that R17 died from asphyxiation caused by choking. *Id.* at 4. Hanover argues that the ALJ's description of the August 29 event "omits most of the material evidence." RR at 28. According to Hanover, its evidence that this event was caused by "cardiac arrest" is material because it shows that CMS erroneously treated the event as "the culmination of some failure to diagnose and address a significant dysphagia." *Id.* We reject this argument. The ALJ expressly did not rely on any findings as to the manner and cause of the resident's death in reaching her conclusions. ALJ Decision at 12.

Conclusion

For the reasons stated above, we uphold the ALJ's procedural rulings, but remand to the ALJ to further consider or explain evidence not fully addressed in her initial decision in light of our discussion above and the record as a whole.

/s/
Sheila Ann Hegy

/s/
Leslie A. Sussan

/s/
Judith A. Ballard
Presiding Board Member