Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Appellate Division

In the Case of:	DATE: March 27, 2002
Pacific Regency Arvin, Petitioner,	Civil Remedies CR792 App. Div. Docket No. A-01-104
- v. -	Decision No. 1823
Centers for Medicare & Medicaid Services.	

FINAL DECISION ON REVIEW OF
ADMINISTRATIVE LAW JUDGE DECISION

On October 1, 2001, after receiving an extension of time in which to request review, the Centers for Medicare & Medicaid Services (CMS)[1] appealed the July 10, 2001 decision of Administrative Law Judge (ALJ) Steven T. Kessel. Pacific Regency Arvin, DAB CR792 (2001) (ALJ Decision). The ALJ Decision (1) sustained a finding that immediate jeopardy existed at Pacific Regency Arvin (Arvin) for three days in March 1999, (2) found continuing noncompliance during two succeeding periods (between March 13, 1999 and August 10, 1999) after resolution of the immediate jeopardy, (3) sustained the imposition of civil monetary penalties (CMPs) totaling $97,450 and other remedies, and (4) overturned additional CMPs and remedies which CMS sought to impose for dates after August 10, 1999. The ALJ concluded that CMS had not presented a prima facie case that Arvin failed to comply substantially with applicable participation requirements on any

[1] CMS was previously named the Health Care Financing Administration (HCFA). See 66 Fed. Reg. 35,437 (July 5, 2001).

date after August 10, 1999. The ALJ sustained CMS's determination that Arvin was not in substantial compliance from March 10, 1999 through August 10, 1999, and that the noncompliance presented immediate jeopardy from March 10 - 12, 1999. The ALJ concluded, however, that the amounts of the CMPs imposed between March 13, 1999 and August 10, 1999 were not reasonable and reduced the amounts to yield the total CMP of $97,450.

CMS appealed the ALJ's finding that Arvin was in substantial compliance after August 10, 1999, his finding that CMS failed to prove a prima facie case as to two deficiency findings during the period after immediate jeopardy was removed, and his reduction of the CMP amounts for the two periods. CMS also raised more general challenges to the hearing procedures.

As explained in detail below, we reverse the ALJ Decision as to the period after August 10th and reinstate the penalties imposed by CMS for that period, conclude that CMS made a prima facie case which Arvin failed to rebut as to two challenged deficiency findings, modify the ALJ's reduction of the CMP penalty amounts for the two periods between March 13, 1999 and August 10, 1999, and resolve those procedural disputes which are relevant to the outcome here.

Factual and procedural background

Arvin is a long-term care facility in Arvin, California. The state survey agency conducted three surveys of Arvin which were completed on March 26, 1999, June 7, 1999, and August 11, 1999 respectively. In each case, the surveyors found that Arvin was not in substantial compliance. As a result, CMS imposed CMPs beginning March 10, 1999, as well as a denial of payment for new admissions (DPNA) effective beginning June 5, 1999 and ending August 20, 1999. The CMP amounts imposed by CMS were as follows: $3,050 per day from March 10, 1999 through March 12, 1999; $2,000 per day from March 13, 1999 through June 6, 1999; $500 per day from June 7, 1999 through August 10, 1999; and $500 per day from August 11, 1999 through August 20, 1999. By a revisit survey completed on September 21, 1999, the state survey agency verified Arvin's allegation that it attained substantial compliance as of August 20, 1999. CMS Ex. 39, at 4.

The hearing in this case was held on December 11 - 13, 2000. At the hearing, CMS offered into evidence as CMS Exhibit 57, a declaration by Ms. Beverly Bennett, who was previously employed by the state agency as a surveyor and who had conducted the August resurvey. The ALJ found that this declaration sought to

fill gaps in the allegations set out in relation to Tag 332 (on medication errors) in the August survey statement of deficiencies. ALJ Decision at 2-5. The ALJ ruled that it would be prejudicial to permit CMS to rely on this declaration because it was provided to Arvin only two working days before the hearing and hence gave inadequate notice to Arvin and amounted to an eleventh-hour attempt to supplement the survey report when CMS had had over a year to seek to amend it. The ALJ excluded the declaration.

Neither party excepted to the ALJ's conclusion that Arvin was not in substantial compliance from March 10, 1999 to August 10, 1999 nor that CMS was therefore authorized to impose remedies including CMPs and the DPNA through August 10, 1999. Similarly, neither party disputed the ALJ's conclusion that the noncompliance created immediate jeopardy during the period from March 10 through 12, 1999. We therefore treat these as undisputed facts at this stage of the proceedings.

The ALJ concluded that Arvin was in substantial compliance on and after August 11th, however, and that CMS was hence without authority to impose any remedies after August 10th. He found that, with the Bennett declaration excluded, CMS had failed to make a prima facie case in support of the allegations of a medication error rate deficiency, which was the sole basis for finding noncompliance during the August 10th survey.

Furthermore, the ALJ determined that the amounts of the CMPs imposed for the earlier periods were not reasonable. The ALJ reduced the CMP amounts as follows: $3,050 per day from March 10, 1999 through March 12, 1999 remained unchanged; $2,000 per day reduced to $800 per day from March 13, 1999 through June 6, 1999; and $500 per day reduced to $300 per day from June 7, 1999 through August 10, 1999.

Standard of review

A party, including CMS, dissatisfied with an ALJ decision or dismissal may file a written request for review by the Departmental Appeals Board. 42 C.F.R. § 498.82(a). The request must "specify the issues, the findings of fact or conclusions of law with which the party disagrees, and the basis for contending that the findings and conclusions are incorrect." 42 C.F.R. § 498.82(b). On review, the Board may remand to the ALJ, or may modify, affirm, or reverse the ALJ's decision. 42 C.F.R. § 498.88. The role of appellate review is not to substitute our evaluation of the evidence for that of the ALJ, but to determine whether the factual findings made by the ALJ are supported by

substantial evidence in the record as a whole. See Lake Cook Terrace Center, DAB No. 1785 (2000); Beverly Health and Rehabilitation - Spring Hill, DAB No. 1696, at 40 (1999).

The standard of review on a disputed factual issue is whether the ALJ decision is supported by substantial evidence in the record. Guidelines for Appellate Review of Decisions of Administrative Law Judges Affecting a Provider's Participation in the Medicare and Medicaid Programs; see also Hillman Rehabilitation Center, DAB No. 1611, at 6 (1997)(Hillman), aff'd, Hillman Rehabilitation Center v. HHS, No. 98-3789(GEB), slip op. at 25 (D.N.J. May 13, 1999); Fairview Nursing Plaza, Inc., DAB No. 1715, at 2 (2000); South Valley Health Care Center, DAB No. 1691 (1999), aff'd South Valley Health Care Center v. HCFA, 223 F.3d 1221 (10th Cir. 2000). The standard of review on a disputed issue of law is whether the ALJ decision is erroneous. Id. 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; or a prejudicial error of procedure (including an abuse of discretion under the law or applicable regulations) was committed.

Issues on appeal

CMS argued that Board review was "imperative" in this case to "correct errors of law and fact in the decision." CMS Br. at 2. Discerning the specific issues on appeal was made more difficult because CMS framed much of its briefing as seeking general "guidance on fundamental and recurring issues," such as the responsibilities of ALJs or the "probative value of sworn testimony." See CMS Br. at 2. We thus address such general complaints only in the context of specific allegations of error in or of exceptions to the ALJ Decision articulated by CMS in the context of the present case.

CMS alleged four legal errors and excepted to three findings of fact and conclusions of law (FFCLs), numbered 2, 5, and 6. Id. at 10-12. Specifically, CMS alleged that the ALJ erred because he failed –

> 1) to base his decision "on substantial evidence, considering the record as a whole, as required by 42

C.F.R. § 498.74(a);[2]

2) to inquire fully, and receive and consider all relevant evidence, as to all matters at issue, as required by 42 C.F.R. § 498.60(b);

3) to review the CMP amounts in the manner required by 42 C.F.R. § 488.438(e) and (f); and

4) to recognize that CMS made out a prima facie case as to the following citations – Tag F246 at the March survey, Tag F332 at the June resurvey, and Tag F332 at the August resurvey.

The full text of the FFCLs to which CMS excepted[3] read as follows:

FFCL 2. CMS did not establish a prima facie case that Petitioner failed to comply substantially with any participation requirement as of August 10, 1999 or thereafter.

FFCL 5. Civil money penalties of $2,000 per day for each day of the period which began on March 13, 1999 and which ran through June 6, 1999 are not reasonable. Civil money penalties of $800 per day for each day of

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[2]The phrasing of this objection by CMS reflects apparent confusion on the part of CMS. Substantial evidence on the record as a whole is, as noted above, an appellate standard which we apply in reviewing factual findings made below. Before the ALJ, the sanctioned facility must prove substantial compliance by the preponderance of the evidence, unless CMS has failed to establish a prima facie case that the facility was not in substantial compliance with relevant statutory or regulatory provisions. See Cross Creek Health Care Center, DAB No. 1665 (1998), applying Hillman, supra.

[3]Since neither party took exception to them, we hereby summarily affirm FFCLs 1, 3, and 4. We note that Arvin in its response brief offered a critique of the time it took the state survey agency to deliver the statement of deficiencies from the March 1999 survey to the facility. Arvin Br. at 14-17. Arvin took no exceptions to the ALJ Decision and failed to explain how this issue could affect any of the issues raised by CMS. We therefore do not address the merits of Arvin's argument on this point.

> that period are reasonable.
>
> FFCL 6. Civil money penalties of $500 per day for each day of the period which began on June 7, 1999 and which ran through August 10, 1999 are not reasonable. Civil money penalties of $300 per day for each day of that period are reasonable.

ALJ Decision at 6, 12, 15 (bold in original omitted).

In its exceptions, CMS also objected to the following two statements in the analysis portions of the ALJ Decision supporting the latter two FFCLs:

> 1) "I find the deficiency findings that were made at Tag 246 not to be substantiated."
>
> 2) "I agree with Petitioner that, in the case of the alleged deficiency that is described at Tag 332, CMS failed to establish a prima facie case of noncompliance."

ALJ Decision at 14, 15.

In support of its exceptions, CMS contended that the ALJ abused his discretion by excluding the Bennett declaration. Further, CMS argued that the ALJ failed to address or evaluate "over 80% of the deficiencies (including four actual harm deficiencies) which constituted a large portion of the substantive basis for the CMP amount," which the ALJ reduced. CMS Br. at 3-4.

Analysis

A. The ALJ's conclusion that CMS did not establish a prima facie case that Arvin failed to comply substantially with the medication error regulation as of the August resurvey is erroneous.

The regulation at issue requires each facility to ensure that it "is free of medication error rates of five percent or greater." 42 C.F.R. § 483.25(m)(1). The ALJ's finding that CMS did not establish a prima facie case that this requirement was violated was based on a number of factors. In part, the ALJ's evaluation of the basis for CMS's allegations resulted from his exclusion from the record of the declaration of Ms. Beverley Bennett, who conducted the August resurvey.

The ALJ found that allowing the declaration (CMS Ex. 57) would be "prejudicial" to Arvin because it elaborated on the allegations made in the August 1999 statement of deficiencies (known as a "2567") that resulted from the August resurvey. The ALJ held that the detailed descriptions in the declaration of the violations Ms. Bennett initially described in the 2567 were "significant" (p. 4) but inadmissable because Arvin was not given adequate and timely notice. Under the umbrella of notice were subsumed two different concerns. First, the ALJ considered it unfair that CMS had not informed Arvin of its intention to submit the testimony of Ms. Bennett in written form or of the content of her testimony until the Friday before the hearing was to begin. Second, the ALJ opined that he would have excluded much of the testimony even had Ms. Bennett appeared in person on the grounds that the information she provided sought to expand the allegations in the 2567 regarding the medication error rate. To do so, the ALJ held, CMS had to have first amended the 2567 in order to give Arvin additional notice of the basis of the charges which it had to disprove.

For the reasons discussed below, we hold that the ALJ committed prejudicial error in refusing to admit Exhibit 57. The declaration was tantamount to written direct testimony and the provision of testimony in written form was appropriate in these circumstances. We find that the exhibits, including the 2567 and particularly the detailed notes of the medication pass contained in Exhibit 38, put Arvin on ample notice as to what type of evidence CMS would be presenting at the hearing. We further conclude that the evidence presented by CMS even without Exhibit 57 was more than sufficient to establish a prima facie case that the medication error regulation was violated. In so holding, we concur in CMS's interpretation that the medication error regulation does not require proof of a statistically valid sampling procedure under the circumstances present here. Viewing the record as a whole, we find that Arvin did not prove by a preponderance of the evidence that it was in substantial compliance with the medication error rate requirement. Finally, we sustain the penalty imposed by CMS for this violation.

The use of written direct testimony is not itself prejudicial, as long as the right to effective cross-examination is preserved. The federal courts, and this Board in other types of cases where it conducts de novo hearings, have allowed, and even strongly encouraged, written direct testimony in a variety of proceedings. Since it is offered under oath, it is generally no less credible in most instances than oral testimony in the hearing room, as long as the witness is subject to cross-examination.

> The submission of written direct testimony, especially when not controverted, has shortened trials . . . [it] allows counsel to present direct testimony in a measured and complete manner and reduces the possibility that vital testimony will fail to be presented . . . live cross-examination and live redirect examination of witnesses have provided ample opportunity for this court to assess their demeanor and credibility. When parties have chosen not to cross-examine a witness, credibility of that particular witness has not been in question.

Kuntz v. Sea Eagle, 199 F.R.D. 665 (D. Haw. 2001).

Here, having the benefit of Ms. Bennett's testimony two days before the beginning of the hearing can hardly be deemed prejudicial to Arvin. Normally, the specifics of a witness's direct testimony are not available until that witness actually testifies at the hearing. By having a witness's full direct testimony before the hearing even begins, the opposing party has the benefit of preparing a focused cross-examination. It would have been better practice for CMS to give notice more in advance of the hearing that it was submitting Ms. Bennett's testimony in written form at the hearing. CMS had provided ample notice, however, that she would be a witness and agreed that she would be made available for cross-examination. Under the circumstances of this case, Arvin would, if anything, have had an advantage by receiving Ms. Bennett's testimony two days before the hearing, in terms of time to prepare for cross-examination or rebuttal.

Normally, written direct testimony saves time and increases courtroom efficiency but is conditioned on the presence of the witness for cross-examination. We are not presented with whether in-person presence is required for cross-examination because the right to cross-examination was unequivocally waived by Arvin at the hearing despite CMS's indications that it was attempting to schedule the witness for in-person or telephonic cross-examination. Arvin did so even though the ALJ had not ruled to exclude the declaration at the hearing, but rather had taken it under advisement, and chose not to reserve any option for later cross-examination in the event the declaration were admitted. Tr. at 750. We do note that it is not unusual for testimony to be given by telephone in either hearings before the DAB's ALJs or before the Board itself, and that in fact one of the witnesses at this hearing testified by telephone.

Moreover, the substance of Ms. Bennett's testimony was material and relevant and should have been admitted. The ALJ stated that even if Ms. Bennett testified in person he would still not have

allowed most or all of her testimony, since it contained "many assertions that are not stated in the report of the August resurvey." ALJ Decision at 3. The ALJ stated that CMS attempted to "unfairly ambush" Arvin by using the Bennett declaration to expand on the allegations of the resurvey report, rather than amending the report well before the hearing to include what he characterized as additional allegations. ALJ Decision at 5. Accordingly, he appeared to limit his scrutiny of the evidence supporting the August medication to the four corners of the 2567, and held that based on that document CMS did not meet its burden of putting on a prima facie case.

We find that the ALJ erroneously limited the CMS case by not looking beyond the specifics alleged in the 2567. Further, the ALJ erroneously did not consider specific evidence of the medication pass observations of Ms. Bennett that **were** admitted into evidence as CMS Exhibit 38, evidence which specifically documented the nature of Ms. Bennett's observations, and her calculations in support of the findings that were initially alleged in the 2567. Finally, we hold that the ALJ erred by going well beyond what the regulation requires in imposing a burden on CMS to show statistical validity of its medication pass procedures as part of its prima facie case.

The ALJ appeared to treat the statement of deficiencies as rigidly framing the scope of evidence to be admitted concerning any allegation relating to a cited deficiency, and requiring formal amendment of the 2567 to allow any additional supporting evidence. We find this treatment of the 2567 erroneous. The 2567 is a notice document, and is not designed to lay out every single detail in support of a finding that a violation has been committed. If the opposite were the case, there would not be much of a need for an exchange of documents or, for that matter, a hearing. This approach is consistent with the intention of the regulations governing surveys as embodied in this exchange from the preamble to the regulations –

> Some commenters further suggested that the facility should be provided with full information that supports each citation and the survey agency's decisions including the underlying reason, basis or rationale for the findings of noncompliance with a regulatory requirement.
> Response: We are not accepting this suggestion because we believe that the Statement of Deficiencies and Plan of Correction Form (HCFA-2567) provide facilities with the specific information necessary to formulate an acceptable plan of correction. To include such detailed

> information regarding deficiencies in the notice of noncompliance would be duplicative and administratively burdensome.

59 Fed. Reg. 56,116, at 56,155. This is not to say that an ALJ may not require adequate notice before the hearing of testimony and evidence to be presented, but rather to say that such disclosure is a matter of pre-hearing development of the record and clarification of the issues rather than a matter of amending the 2567.

We share the ALJ's appreciation of the irony of CMS arguing for the more liberal interpretation they are advocating here, in light of repeated CMS contentions in cases litigated under these regulations that a Request for Hearing must contain extremely detailed refutation of the allegations cited in the 2567. We have held in Alden-Princeton Rehabilitation and Health Care Center Inc., DAB No. 1709 (1991), among other cases, that the Request for Hearing requires enough detail to put CMS on notice as to the specific issues being contested and the basis for such contest. See 42 C.F.R. § 498.40(b). The Request for Hearing is not required to contain specification of all facts, arguments, and authorities in support of its contentions. Requiring this level of detail and thoroughness in the absence of any case development would be inconsistent with the short period of time required to file such a request and with the recognized need for the ensuing hearing process.

Just as we do not require a petitioner to fully establish its defense in great detail in the Request for Hearing, anticipating that the issues will be more fully joined in subsequent development of the case, so we hold here that the 2567 is not expected to elucidate in detail every aspect of proof of the violation alleged. It is not intended to serve as the sole basis for CMS's prima facie case. To treat it as such would put an untenable burden on surveyors who are professionals trained to assess compliance with participation requirements but not to necessarily display the drafting skills of attorneys. It would also be inconsistent with the notion that the 2567 be issued promptly after the survey concludes to allow the facility to achieve compliance as quickly as possible.

The ALJ's refusal to allow Ms. Bennett's declaration into evidence is even more puzzling in light of Exhibit 38, which is admitted into the record. This exhibit includes a Medication Pass Worksheet (Form HCFA 677) which includes not only Ms. Bennett's detailed notes on the medication administrations she observed, but instructions which include a detailed methodology

for conducting the medication pass process, as well as the formula for calculating the deficiency rate. This document, admitted into evidence at the hearing, and submitted as a proposed exhibit well in advance of the hearing, properly elaborates on the circumstances regarding this allegation as compared to the information contained in the 2567. In fact, the rejected declaration of Ms. Bennett goes only slightly beyond the information contained in Exhibit 38, merely explaining in more detail and in a more colloquial manner her observations and her methodology. Exhibit 38 clearly names each of the residents observed, the medication being administered, and Ms. Bennett's observations, and further indicates that Ms. Bennett examined the drug order and noted any discrepancies between the order and the actual drug administered. The exhibit contains detailed notes as well as the calculations that led CMS to allege that there was a 6% medication error rate. The exhibit indicates that CMS had a methodology for determining the number of observations, which Ms. Bennett elaborates on in the rejected exhibit.

We hold that Exhibit 38, together with the 2567, supports a prima facie case that the medication error rate was in excess of five percent. The exhibit documents that three medication errors were observed out of 27 opportunities and that, pursuant to the instructions on the worksheet, an additional 21 opportunities for error were observed, with no further errors. Thus, three errors were observed out of 48 opportunities, for a rate of slightly over 6%, which was rounded down to 6%. The exhibit contains supporting documents, including nurses progress notes, surveyors notes, pertinent physician notes and the record of testing and discipline of the nurse who performed the medication errors.

The calculations which Ms. Bennett made also could be done without reference to her declaration. The simple formula to do so is set out on page 128 of Appendix PP of CMS's State Operations Manual, a public document providing guidance to surveyors, as follows:

> Medication Error Rate = Number of Errors Observed divided by the Opportunities for Errors X 100

See CMS Br., Attach. A (excerpt with relevant pages).

Ms. Bennett's proposed testimony in the rejected Exhibit 57 provides details, along with sworn affirmation of the recorded event, as to the conduct of the medication passes and her findings that are totally consistent with the allegations specified in the 2567 and in the already-admitted Exhibit 38. Her observations are in accord with what one would expect to hear

in live testimony, providing just the type of information on her conduct of the survey that one would expect to hear in a proper direct examination. Her testimony unequivocally establishes that she observed an error rate of over six percent in the administration of medication.

There is no basis for the ALJ's imposing on CMS an additional requirement of a showing of statistical significance to establish a prima facie case that the medication error regulation was violated. The regulation in no way imposes such a requirement. The protocol discussed in Ms. Bennett's declaration and contained on the face of the Medication Pass Worksheet contained in Exhibit 38 spells out a method which assures that at least 40-50 observations are made in order to substantiate an alleged violation of this regulation, so that, for example, a surveyor may not observe just a few instances of medication administration to support a violation. While this methodology is not a part of the regulation itself, the numbers of observations made by Ms. Bennett coupled with the number of errors she observed easily support a prima facie case.[4] If Arvin had a challenge to this methodology on statistical or other bases, it should have availed itself of the proffered opportunity to cross-examine Ms. Bennett or put on its own witnesses. All Arvin did was to establish in argument the obvious – that one fewer error observation would have resulted in a rate of under five percent. Arvin did not contest the factual veracity of the observations actually made, however, so that just as surely the correct result is over five percent. We thus find that CMS established a prima facie case that Arvin violated the medication error rate regulation.

Since Arvin offered no evidence to refute the factual basis of CMS's case, it is clear that Arvin failed to prove substantial compliance. Looking at all the evidence in the record regarding

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[4]This case does not involve a party attempting to establish a fact at issue by the use of statistics. Rather, the element of a "rate" in the regulation establishes a requirement for surveyors to assess some number of medication events and determine whether the number of errors exceeds the minimum error rate that will be tolerated. It is difficult to see how a truly randomized sampling of medication events could be made within the constraints of a normal nursing home survey. Moreover, in response to comments on the error rate provision, the preamble explained that the definition of medication error rate to be used was one that had been in agency guidelines since 1984. See 56 Fed. Reg. 48,826, 48,853 (Sept. 26, 1991), referring to Appendix N of the State Operations Manual; see also 42 C.F.R. § 488.105.

this deficiency, including the Bennett declaration, in light of our resolution above, we therefore reverse the finding of the ALJ as to this deficiency. Given that this is a repeat violation occurring on three consecutive surveys, we have no basis to overturn the imposition by CMS of a CMP of $500 per day and a DPNA for this violation.

B. The ALJ's finding that CMS failed to substantiate the deficiency cited under Tag 246 is not supported by substantial evidence.

The basis for this citation was that one resident had requested but had not been provided a wheelchair that fit her large size, in violation of 42 C.F.R. § 483.15(e)(1). That regulation provides that residents have a right to "receive services in the facility with reasonable accommodation of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered."

The 2567 describes an interview with the resident on March 9, 1999 during which she reported that the wheelchair did not fit and was "too difficult to manoeuver," that she had been measured for a new one a month earlier, and that she had not received any information about it since. CMS Ex. 1, at 7. The 2567 also reports a second interview with the same resident on March 24, 1999 in which she expressed disappointment that she had not received a new chair or any information about when she might expect one. Id. at 7-8. The ALJ found this evidence "unpersuasive," for two reasons. ALJ Decision at 14. First, he considered it "unverified hearsay and not reliable evidence" as to what the facility staff actually did to meet the resident's needs. Id. Second, the ALJ found that this evidence was rebutted by testimony that the facility had provided "the resident with three different wheelchairs during the resident's stay . . . , including an electric wheelchair." Id., citing Tr. at 763, 792.

CMS objected that the ALJ had ignored documentary evidence in the record that established that the facility did not provide an appropriately sized wheelchair for six weeks, which CMS argued firmly established a failure to accommodate the resident's needs. CMS Br. at 34. Further, CMS argued that the ALJ had improperly established a "blanket rule" that residents' reports during a survey are worthless and unreliable hearsay, which CMS considered a violation of the ALJ's obligation under the regulations to "consider all relevant and material evidence" and hence legal error. CMS Br. at 34-35, n.32, citing 42 C.F.R. § 489.60(b).

The documentary evidence referenced by CMS consists of an excerpt of a facility social progress note relating to the resident which reports that "National Seating & Mobility [was] in to evaluate resident for customized possibly motorized wheelchair" on February 9, 1999, as well as nursing notes for the resident. CMS Ex. 6, at 9; Petitioner Ex. 2. The nursing notes cover the period from January 25, 1999 through April 2, 1999. Petitioner Ex. 2, at 11-19. CMS asserted (and Arvin did not dispute in response) that an entry for March 25, 1999 stating that the resident has been notified that an "extra wide w/c will be delivered" that night or the next morning constituted the first evidence in the record of the facility following through on obtaining a suitable wheelchair.[5] Petitioner Ex. 2, at 18. The surveyor reported a follow-up interview with the same resident on March 26th at which the surveyor viewed the new extra-wide wheelchair and noted that it was not customized or motorized and that it came from a different company than the one which had measured the resident in early February. Tr. at 356-57.

The ALJ did not give any reason to disregard this written evidence from the facility's own record, which shows that the resident was evaluated as needing an extra-wide wheelchair on February 9, 1999 but did not receive one until at least March 25, 1999, long after the surveyors interviewed the resident on March 9, 1999 and just before the survey ended on March 26, 1999.

In addition, the ALJ did not explain why this documentation did not corroborate the hearsay report of the interview in which the resident complained of having been waiting since an evaluation on February 9, 1999 without receiving information about the wheelchair problem. Such corroboration is relevant to assessing the reliability of hearsay proffered in an administrative hearing. Therefore, the absence of any discussion of this evidence undercuts the ALJ's rejection of the evidence about the interview as "unverified hearsay." Cf. ALJ Decision at 14.[6]

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[5]The nursing notes for April 2, 1999 indicate further that the resident wanted an electric wheelchair and that an evaluation had been done, with the result that the facility was attempting to get one for her. Petitioner Ex. 2, at 20. It is noted that the resident at that point had an extra-wide wheelchair with elevated leg rest. The facility's plan of correction on this issue asserted that an electric wheelchair had been received by May 16, 1999. CMS Ex. 1, at 7.

[6]While we have concluded that the ALJ erred in rejecting the
(continued...)

Considering the information on the face of the 2567, as well as the surveyor's confirmatory testimony about what the resident told her and how she followed up on the resident's complaints, and the documents discussed above, we conclude that CMS did establish a prima facie case on this deficiency. See CMS Ex. 1, at 7; CMS Ex. 6, at 9; Petitioner Ex. 2; Tr. at 354-58.

The ALJ made a further finding that not only did CMS fail to establish a prima facie case on this deficiency but Arvin successfully rebutted CMS's evidence based on the testimony of Arvin's single witness. ALJ Decision at 14. The witness was a nurse consultant working for Arvin's management company who came into the facility at the end of the March survey to assist in achieving compliance. Tr. at 751-54. She testified that, as of the time the consultant left the facility in June, the resident had had three wheelchairs, which she described as follows:

> She would have had her initial wheelchair. Then she would have had the larger wheelchair that was ordered for her. And now she has an electric wheelchair.

Tr. at 763. The consultant also opined that the resident "used her wheelchairs as an excuse not to get out of bed." Tr. at 792. It is unclear in what sense this testimony can be read to rebut CMS's prima facie case on this point.[7] The consultant did not deny that the original wheelchair was unsuitable, that at the least an extra-wide wheelchair was needed, or that a suitable wheelchair was at least a necessary, if not sufficient, condition for increasing the resident's mobility. She gave no dates as to

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[6](...continued)
interview reports as unverified without considering corroborating evidence, we do not find that the ALJ articulated any "unbending 'rule'" against crediting any resident reports, as CMS alleged. CMS Br. at 35, n.32. We find no reason to question that the ALJ understood that hearsay is admissible and may be accorded appropriate weight, if supported by adequate indicia of reliability, in accordance with our prior decisions and the case law. See generally Carehouse Convalescent Hosp., DAB No. 1799 (2001)(passim); Narendra M. Patel, M.D., DAB No. 1736, at n.9 (2000).

[7]Further, we note that the consultant's testimony, as much as the surveyor's, was based only on hearsay from interviews with the resident and staff and review of the resident's records. Arvin did not choose to present any staff witnesses with first-hand knowledge of the events to contradict the written records.

the receipt of the two replacement wheelchairs (first the extra-wide one and finally the electric one) that would contradict the scenario presented by the documents discussed above. Thus, it is unrebutted that the resident first sought an appropriate wheelchair in early February, the facility recognized the need then, but a wheelchair of the appropriate size was not provided until the close of the survey and only later than that a motorized one.

We conclude that there is not substantial evidence in the record viewed as a whole to support the ALJ's finding that CMS failed to make a prima facie case as to this deficiency. We further conclude that the testimony on which the ALJ relied in finding that Arvin rebutted the prima facie case is not substantial evidence that Arvin was in substantial compliance. Therefore, this deficiency is substantiated.

C. The ALJ's conclusion that a CMP amount of $800 per day is reasonable is not supported by substantial evidence in the record as a whole. A CMP amount of $1,500 per day is reasonable based on substantial evidence in the record as a whole.

CMS sought to impose a CMP of $2,000 per day for the period from March 13, 1999 (when the immediate jeopardy was found to have been abated) to June 6, 1999. CMS Exs. 28, 29. The ALJ found the amount unreasonable and reduced the rate by 60% to $800 per day. ALJ Decision at 12-15. CMS objected to this "drastic reduction" and argued that no "legitimate basis [existed] for lowering the CMP by any amount, much less by $1200 per day." CMS Br. at 24. CMS pointed to the fact that the ALJ sustained 24 of 31 original deficiencies. CMS also asserted that those sustained included all of the most serious deficiencies involving actual harm, the factual bases of which were, in CMS's opinion, egregious enough to demand a relatively stringent penalty. Also, CMS pointed to a pattern of persistent problems and interrelationships among deficiencies, such as numerous inadequacies in the total care of Resident 1. CMS Br. at 28-32, and record citations therein; CMS Ex. 3, at 35-51. Finally, CMS cited to a high degree of culpability in light of the repeated observations of deficient practices in the course of the survey despite warnings from the surveyors, for example, in the case of Resident 1's severe pressure sore for which a "zero pressure order" was obtained but not implemented during the survey. Id.

The ALJ explained the reasoning for his finding that the CMP amount imposed by CMS was unreasonable, as follows:

> I do not find CMS's determination to be reasonable because it is based on an incorrect assessment of the number of deficiencies and the scope and severity of those deficiencies that were established. I am imposing civil money penalties against Petitioner of $800 per day for each day of the March 13 - June 6, 1999 period. My decision to impose penalties in these amounts takes into account my conclusions that there were numerous serious deficiencies present at Petitioner's facility as of the March 1999 survey, but that these deficiencies were fewer in number and less egregious than those that were alleged originally by the surveyors who conducted the March 1999 survey.

ALJ Decision at 12.

The reduced number and scope and severity to which the ALJ referred resulted from two sources. First, an informal dispute resolution (IDR) at the state level eliminated four deficiencies cited by the surveyors and reduced the seriousness of three others to the level of causing only a potential for more than minimal harm. The ALJ emphasized in his decision that CMS did not revise, or even give consideration to revising, the CMP amount after the IDR in light of the reduced deficiencies. Second, the ALJ concluded that CMS failed to establish a prima facie case that Arvin was out of compliance with three requirements, cited as tag numbers F241, F246, and F428. Since he hence eliminated three more deficiency findings, the ALJ concluded that the CMP should not only have been reduced after the IDR hearing but should be reduced further in light of his own findings.

It is clear that determining a reasonable CMP amount is not dictated by any simple numerical formula but rather requires a consideration of and interaction among a number of factors which are specified in the regulations, as follows:

> (1) The facility's history of noncompliance, including repeated deficiencies.
> (2) The facility's financial condition.
> (3) The factors specified in § 488.404.
> (4) *The facility's degree of culpability*. . . .

42 C.F.R. 488.438(f)(italics in original). The factors to be considered in selection of a remedy set out in section 488.404 include first an assessment of the seriousness of the deficiencies found, considering the level of harm presented and how widespread the problem. 42 C.F.R. § 488.404(a) and (b). In

addition, CMS may consider other factors, which include the "relationship of the one deficiency to other deficiencies resulting in noncompliance" and prior noncompliance "in general and specifically with reference to the cited deficiencies." 42 C.F.R. § 488.404(c).

Nevertheless, where the number of deficiencies is reduced by a relatively small percentage (here about 20%) but the ALJ reduces the amount of the CMP by a relatively large percentage (here about 60%), the ALJ must justify the magnitude of the reduction based on consideration of regulatory factors other than simple reassessment of the number of deficiencies. Clear explanation is especially called for when the remaining deficiencies include all of the higher-level, actual harm deficiencies. It is the long-standing practice of the Board to refrain from substituting our judgment for that of the ALJ in assessing the appropriate CMP amount when some deficiency findings have been reversed. We can so defer, however, only when we can discern that the ALJ in fact exercised his judgment based on a review of the whole record before him and articulated a rationale to which to defer.

The ALJ here correctly viewed a significant change in the number of the deficiencies as a reason for reassessing the proposed CMP amount. He was not clear, however, about his basis for determining the magnitude of the reduction. We must therefore review the record to determine whether we can infer his rationale and discern a substantial evidentiary basis to uphold it. As we explain below, we do not find that the CMP amount imposed by the ALJ is supported by substantial evidence in the whole record.

Below, we first discuss the ALJ's reliance on CMS's failure to alter the CMP amount after the IDR resulted in overturning some of the deficiency findings. Second, we address CMS's concern that the ALJ failed to discuss at all 22 of 27 deficiency findings from March survey. Third, we turn to the ALJ's consideration of those deficiencies as to which he found that CMS failed to present a prima facie case, and the effect of our reversal of one of those determinations, in regard to determining the amount of the CMP. Finally, we address whether the CMP reduction was supported by substantial evidence before the ALJ.

In considering the CMP amount, the ALJ appeared to rely in large part on his finding that CMS never even reconsidered the amount of the proposed penalty after the IDR resulted in eliminating four deficiencies. ALJ Decision at 13. His comments appeared to imply that, had CMS shown that it considered those IDR changes in determining the CMP amount, he would have been less concerned that the amounts imposed were not related to the deficiencies

actually upheld. The ALJ based his finding on testimony of CMS's witness Ms. Paula Perse. Id. at 12. The relevant exchange follows:

> A . . . The rules afford the facility the right to an informal dispute resolution that's handled by the state survey agency. HCFA is in no way obligated to hold an enforcement action until the conclusion of that, but we definitely ask to see those IDR's once they're concluded and will make modifications or changes to our recommendation based on that if it appears to be prudent.
>
> Q Now, in this case [referring to the March survey], did you, in fact, make you – or did you impose the civil monetary penalties before the informal dispute resolution took place?
>
> A Yes, we did.
>
> Q And did you do that also with the third survey?
>
> A We do this in each case. We do not hold our enforcement action for IDR.
>
> * * *
>
> Q . . . [Y]ou stated that you will take into account – when you ultimately decide what the civil monetary penalty will be, you review the IDR, you'll take it into account to determine whether or not the civil monetary penalty was appropriate?
>
> A Yes.

Tr. at 639-40. On re-direct, Ms. Perse was asked specifically about whether the IDR results after the March and August surveys in this matter changed "HCFA's determination of the CMP" and she responded that they "did not." Tr. at 646.

The ALJ concluded from this that CMS failed to follow its normal practice of reviewing the IDR results in reference to the CMP amount in this case. Id. at 12-13. We find that the ALJ could not reasonably infer from her testimony that Ms. Perse was saying that CMS's normal practice is to reassess the penalty amount after an IDR changes the deficiency findings, but that that was not done here. Her testimony on its face indicates that CMS reviews the penalty amount in such circumstances and makes

changes if (but only if) CMS considers it prudent to do so, and that CMS did not make changes here after CMS's consideration of the IDR results. From this testimony, we conclude that CMS was indeed aware of and gave consideration to the IDR results but continued to believe that the amount it initially sought to impose was appropriate to address the outstanding deficiencies.

This conclusion, of course, does not resolve fully whether the ALJ appropriately reduced the CMP amount, based on applying the regulatory factors to the deficiencies ultimately found. We have repeatedly held that the ALJ's consideration of the reasonableness of a CMP should focus not on the particular process used by CMS to set the amount but on whether the amount is a reasonable one in light of the purposes of the Act, the factors set in the regulations, and the evidence in the specific case. See South Valley, DAB No. 1691; see also Capitol Hill Community Rehabilitation & Specialty Care Center, DAB No. 1629 (1997); Careplex of Silver Spring, DAB No. 1683 (1990). The ALJ here mixed the two approaches, wrongly inferring that CMS had not reviewed the IDR findings in deciding to press the original amount and then himself evaluating what amount of CMP to impose based on the changed array of deficiencies substantiated. The erroneous inference appears to have led the ALJ to conclude that CMS viewed the $2,000 amount as reasonable only if none of the deficiencies had been eliminated by the IDR and hence to have begun analytically from a lower point. We reject this inference. We therefore turn to the remaining aspects of the ALJ's determination of the CMP amount.

The ALJ stated that CMS failed to provide "any explanation" for the $2,000 per day amount (for the period after resolution of the immediate jeopardy and before the June survey) except to assert that there were still "'numerous serious violations' . . . several of which involved actual harm to residents . . . ." ALJ Decision at 13. We note that the ALJ himself, in explaining his imposition of a CMP of $800 per day, commented only that the deficiencies from the March survey that remained after IDR "were less egregious than those that were found originally by the surveyors," that they were still "numerous," and that three involved actual harm while the rest were "low level deficiencies." Id. at 13. This brief mention of the existence of uncontested deficiency findings does not articulate that he considered the seriousness, scope, or interrelationship of those confirmed deficiency findings in arriving at the reasonable amount of CMP to impose, nor any other regulatory factor. Nor does it explain why several deficiencies causing actual harm along with numerous other serious violations can reasonably support no more than an $800 per day CMP amount.

We do not accept CMS's apparent position that an ALJ is always obliged to discuss in detail the specifics of or the evidence supporting every individual deficiency, even those not challenged by the facility. In many situations, where a facility has failed to prove that it was in substantial compliance, little purpose would be served by making detailed findings concerning the nature of unchallenged deficiencies. In the situation where the ALJ determines that the amount of CMP imposed by CMS is not reasonable, however, the ALJ is compelled by regulation to give consideration to the number, scope, and severity of unchallenged deficiencies, as well as those which have been upheld after a hearing. The degree of detailed discussion required to evidence this consideration may depend on the circumstances. The regulation clearly demands that at a minimum the ALJ set out a reasoned basis for why his consideration of the regulatory factors leads to the conclusion that the amount imposed by CMS is not reasonable and that a reduction of a particular magnitude is appropriate in light of the sustained deficiencies and other regulatory factors. Finding that absent here, we consider next whether substantial evidence in the record does support the reasonableness of the reduced amount.

The unchallenged deficiencies included three at the level of actual harm for this survey period, specifically Tags 309, 386, and 223. ALJ Decision at 13. A fourth actual harm deficiency cited under Tag 314 was disputed but upheld by the ALJ (a finding not appealed to us by Arvin and consequently now established conclusively). This tag was based on inadequate treatment of pressure sores observed on two residents. The ALJ found that Arvin had failed to present any evidence to rebut CMS's prima facie showing of a violation as to at least one of the affected residents. ALJ Decision at 13.

CMS argued that these "grave, actual harm deficiencies provided the primary basis for the $2000 per day penalty." CMS Br. at 7, citing Tr. at 628. CMS complained that, even though it prevailed on these deficiency findings, the ALJ's failure to discuss them resulted in his glossing over important evidence in the record beyond the bald rating of each as causing actual harm that demonstrated the egregious nature of the problems at the facility. CMS argued that the ALJ disregarded the testimony of its expert witnesses as to the ill effects suffered by residents as a result of these deficiencies, as well as documentation to that effect. CMS Br. at 24-33. Arvin responded that CMS was merely reciting the "evidence which was found wanting by the ALJ" and seeking to have it evaluated differently on appeal. Arvin Br. at 14.

As noted, we agree with CMS that it is difficult to verify from the ALJ Decision that he evaluated the substance and nature of these most serious deficiencies and the evidence concerning them in reaching his conclusion about the appropriate amount of CMP. He merely gave the number of such deficiencies and pointed out that many other deficiencies were lower level and did not involve actual harm. We therefore conclude that, contrary to Arvin's position, the ALJ did not indicate that he rejected any of CMS's evidence on the seriousness of these deficiencies. We do not find it possible to infer how he may have evaluated that evidence based on anything in his decision. We routinely defer to the ALJ on questions of credibility of witnesses and on determinations about the weight to be attributed to the evidence before him. Here, we simply cannot tell how the ALJ assessed the credibility of these witnesses or the weight to be given their evidence. Nor can we accept Arvin's argument that the ALJ had no "conceivable reason" to discuss the uncontradicted deficiencies. Arvin Br. at 4. On the contrary, evaluating their nature and severity was clearly relevant to the reasonableness of the amount of the CMP even though the factual bases for the deficiency findings were not at issue.

In this case, we have determined that no useful purpose would be served by remanding this case to the ALJ to review the evidence again and revise or explain further the basis for his determination of a reasonable CMP amount. First, since we have reversed above the ALJ's finding overturning one of the deficiencies, the complement of outstanding deficiencies is again altered from that which confronted the ALJ. Second, all the other issues in this case are susceptible of final resolution on the record before us and therefore remanding simply to obtain additional explanation on this one point appears inconsistent with the need for closure and wasteful of the resources of the parties and the administrative system.

The nature of the actual harm deficiencies is set forth clearly in the statement of deficiencies for the March 1999 survey and is supported by documentation in the exhibits to which CMS has directed our attention. We note that Arvin did not point to any specific evidence in the record which might tend to mitigate the severity of the findings or the resultant harm as presented by CMS. CMS pressed on us the ALJ's failure to evaluate the expert testimony presented by CMS to further elucidate this point. The bulk of that testimony highlighted connections between particular harm suffered by the residents involved in each deficiency, the cited actions or omissions of the facility, and the general risks posed by those deficiencies. See, e.g., Tr. at 58-100; (Dr. Hunt regarding effects of poor management of pressure sores); Tr. at

243-277 (Dr. Straube regarding effects of Resident 1's excess weight loss in diuresis). During the hearing, the ALJ made extensive comments about how he might treat testimony by CMS witnesses which went beyond the four corners of description of the deficiency in the 2567. See, e.g., Tr. at 109-110, 264, 278-81. He did not, however, discuss in the ALJ Decision whether or not he rejected some or all of the testimony for that reason, which would not have been supportable based on our discussion of the role of the 2567 above. Neither did he make any findings about the credibility of these witnesses.

For purposes of this section, we have relied only on information that was included in the 2567 and supported by additional written records, and have not ourselves relied on the further elaboration provided by the expert witnesses. We have done so because, even limiting ourselves to the documentary evidence, we are amply persuaded that the ALJ's reduction in the amount of the CMP is improper. Nor would we impose the full amount of the CMP originally imposed by CMS, without regard to the content of the expert testimony, because the amount we have set reasonably reflects the final number and kind of deficiencies involved. We therefore do not find it necessary in this case to make further findings concerning these witnesses.

We summarize here the record evidence on the nature of the four sustained actual harm deficiencies on which the $2,000 per day CMP was largely based, beginning the deficiency cited under Tag 309. Arvin was cited for failure to provide the quality of care required by the regulation at 42 C.F.R. § 483.25 to four residents out of a sample of 22 residents. The first resident (the same Resident 1 mentioned above, whose situation CMS described as the most egregious) lost 47 pounds in a week during which she was on strong diuretics, and ended up hospitalized with metabolic encephalopathy. CMS Ex. 1, at 18-19; CMS Ex. 3, at 29. The surveyors found that the facility had failed to alert her physician to the speed of her weight loss, to assess her hydration needs, or to take appropriate measures to track her liquid input or output for 31 of 42 days. CMS Ex. 1, at 18. In addition, the 2567 recorded failures by the nursing staff to follow prescribed management for the resident's diabetic treatment and numerous deviations in the administration of her medications. Id. at 16-18. Another resident, who had had a craniotomy and was to wear a helmet at all times, had an unwitnessed fall and no helmet was documented. No neurological check was done at the time. He was observed later that day to have become more confused and had a head laceration. He was only sent to the hospital for evaluation six days later, and was found to be more confused and unsteady and to have increased swelling

at the surgical site. Id. at 19-20. Another resident was supposed to receive blood pressure medication when his readings exceeded a set threshold, but repeatedly had higher readings without getting the medication and then did not have any readings taken for two weeks. Id. at 20-21. Finally, he became extremely weak and disoriented, with slurred speech and difficulty swallowing, was found to have blood pressure at 190/80, and was taken to the hospital. Id. at 21. The fourth resident also ended up hospitalized with abnormal vital signs a month after admission to the facility but no vital signs had been entered in the clinical record during that entire stay, despite admission diagnoses of cerebral vascular accident and chronic obstructive pulmonary disease. Id.

Arvin was cited under Tag 386 based on its failure to have Resident 1's total care program properly reviewed and monitored by the physician. The facility is required by 42 C.F.R. § 483.40 to ensure that each resident's medical care is supervised by a physician who must review the total program of care including medications and treatments. The essence of this deficiency was that the physician did not respond to the massive weight loss and changes in condition during aggressive diuretic therapy and did not monitor well enough to catch many errors in her medication regimes. CMS Ex. 1, at 36-37.

The third unchallenged actual harm deficiency resulted from three reported incidents in which demented residents struck or frightened other residents. Arvin was cited under Tag 223 for failing to prevent verbal and physical abuse of residents as required by 42 C.F.R. § 483.13(b).

Finally, Tag 314 involved the facility's inadequate management of pressure sores on two residents. Id. at 21-24; see also CMS Ex. 3; Petitioner Ex. 11. The regulation requires facilities to prevent avoidable pressure sores and properly manage existing ones. 42 C.F.R. § 483.35(h). We referred above to Resident 1 developing pressure sores, which developed on both heels to the point of black blisters and some drainage during her stay. Throughout the survey (between March 9 and March 20, 1999), the surveyors observed that her heels were not placed to remove all pressure as ordered by the physician. CMS Ex. 1, at 23-24. Arvin did not challenge the allegations relating to Resident 1 under this tag and the ALJ sustained them. ALJ Decision at 13.[8]

[8]CMS also alleged that another resident with a stage 4 decubitis ulcer (the most severe type) on the buttock was not

(continued...)

It is evident that Arvin failed these residents in ways that go to the heart of what is expected from a facility entrusted with the care of ailing, elderly persons dependent on their care-takers. It is also evident that the consequent sufferings of these residents not only involved actual harm but harm that amounted to serious injury and pain.

As to the other, less serious deficiencies, Arvin challenged only four of the lower-level deficiency findings remaining after the IDR, specifically Tags 157, 241, 246, and 428, of which the ALJ overturned three. He upheld the deficiency findings at Tag 157, which was based on failure to consult adequately with the physician regarding Resident 1's care. We reversed above the ALJ's decision that the deficiency under Tag 246 was unsubstantiated. CMS did not challenge the ALJ's determination that it had not substantiated Tags 241 and 428. Nineteen other deficiencies were unchallenged in areas as widespread as infection control, significant medication errors, inadequate resident assessments, environmental hazards, inadequate staffing, and poor administration. CMS Ex. 1.

We conclude that there is not substantial evidence in the record sufficient to justify so large a reduction of the CMP amount. At the same time, we agree with the ALJ that some adjustment is appropriate to reflect that the total number and collective seriousness of the substantiated deficiencies is somewhat less than that of the original complement evaluated by CMS. We therefore reverse the ALJ's reduction of the daily CMP amount for this period and sustain a CMP in the amount of $1,500 per day.

D. The ALJ's finding that CMS failed to substantiate the deficiency cited under Tag F332 at the June survey is not supported by substantial evidence.

The ALJ overturned CMS's deficiency finding under Tag 332 on the grounds that CMS's methodology for determining the existence of a medication error rate greater than five per cent was not statistically valid. ALJ Decision at 16. Since we have rejected this rationale in relation to the same deficiency finding in the August 1999 survey, we do not repeat the analysis here. We

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[8](...continued)
irrigated in the manner ordered by the physician. CMS Ex. 1, at 24; see also Arvin Ex. 8, at 6-10. The ALJ did not make any finding in regard to the second resident because he concluded that the undisputed findings about Resident 1 sufficed to demonstrate noncompliance. ALJ Decision at 13-14.

reverse the ALJ's finding. Since Arvin did not challenge either the surveyors' factual observations or the mathematical calculations, we find that Arvin failed to rebut the prima facie case or prove compliance by the preponderance of the evidence. We therefore reinstate the deficiency finding.

E. The ALJ's reduction of the CMP amount for the period from June 7, 1999 through August 10, 1999 was not supported by substantial evidence. A CMP of $500 per day for that period is reasonable.

The June survey resulted in citations of six deficiencies, of which the ALJ sustained five. CMS proposed a CMP amount of $500 per day from the survey date until the August resurvey. CMS argued that this amount reflected its assessment of the reduced number and seriousness of the deficiency findings from those found in the prior survey on which the $2,000 per day CMP had been based. The ALJ further reduced the CMP amount to $300 per day after he overturned the deficiency cited under Tag F332. Since we have reversed the ALJ's finding as to that deficiency above, we also reject that basis for reducing the CMP amount.

Conclusion

For the reasons explained above, we affirm those portions of the ALJ Decision to which CMS did not except; we reverse the ALJ's findings that CMS failed to make a prima facie case that Arvin did not comply with Tag 246 during the March 1999 survey and Tag 322 during the June 1999 survey and find instead that Arvin did not prove it was in substantial compliance with that participation requirement; we modify the ALJ's reduction of the CMP amount for the period March 13, 1999 through June 6, 1999 from $800 per day to $1500 per day; we reverse the ALJ's reduction of the CMP amount for the period June 7, 1999 through August 10, 1999 and reinstate the CMP amount of $500 per day instead; and we reverse the ALJ's finding that Arvin was in substantial compliance as of August 10, 1999 and reinstate the penalties imposed by CMS for the period from August 10, 1999 until August 19, 1999 including the $500 per day CMP.

To implement our decision, **we affirm FFCLs 1, 3, 4** from the ALJ Decision. We reverse FFCL 2 and make the following substitute FFCLs:

> **FFCL 2. Petitioner failed to comply substantially with participation requirements from August 11, 1999 through August 19, 1999. CMS was authorized to impose remedies**

for that period including a DPNA and a CMP of $500 per day.

We also modify FFCLs 5 and 6 as follows –

FFCL 5. Civil money penalties of $2,000 per day for each day of the period March 13, 1999 through June 6, 1999 are not reasonable. Civil money penalties of $1,500 per day for each day of that period are reasonable.

FFCL 6. Civil money penalties of $500 per day for each day of the period June 7, 1999 through August 10, 1999 are reasonable.

/s/
Judith A. Ballard

/s/
Donald F. Garrett

/s/
Marc R. Hillson
Presiding Board Member