Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Appellate Division

In the Case of:	DATE: October 1, 2009
Aspen Grove Home Health, Petitioner,	
	Civil Remedies CR1878
	App. Div. Docket No. A-09-62
- v. -	Decision No. 2275
Centers for Medicare & Medicaid Services.	

FINAL DECISION ON REVIEW OF ADMINISTRATIVE LAW JUDGE DECISION

Aspen Grove Home Health (Aspen Grove) appealed the January 7, 2009 decision of Administrative Law Judge (ALJ) Keith W. Sickendick, DAB CR1878 (2009) (ALJ Decision), which upheld the determination by the Centers for Medicare & Medicaid Services (CMS) to terminate Aspen Grove's Medicare provider agreement, effective November 28, 2006. The ALJ concluded that there was a basis to terminate Aspen Grove's provider agreement because Aspen Grove was not in substantial compliance with a condition of participation under 42 C.F.R. § 484.30 as a result of Aspen Grove's failure to furnish required skilled nursing services to three patients.

Because the ALJ's findings are supported by substantial evidence in the record and his legal conclusions are not erroneous, we affirm the ALJ Decision.

Applicable Law

A home health agency (HHA) is a public agency or private organization that provides skilled nursing and other health care services to patients in their homes. Social Security Act (Act), § 1861(o).[1] The Act sets forth requirements for home health agencies participating in the Medicare and Medicaid programs, and authorizes the Secretary of Health and Human Services (Secretary) to promulgate regulations implementing the statutory provisions. Act, §§ 1861(m) & (o), and 1891. An HHA may participate in the Medicare program as a provider of services if it meets the statutory definition and complies with certain requirements, called conditions of participation. Act, §§ 1861(o), 1891; 42 C.F.R. Part 484; 42 C.F.R. § 488.3.

The conditions of participation in part addresses the services an HHA must provide. 42 C.F.R. Part 484, subpart C. Each condition of participation is contained in a single regulation, which is divided into subparts called standards of participation. Id. Compliance with a condition of participation is determined by the manner and degree to which the provider satisfies the standards within the condition. 42 C.F.R. § 488.26(b); CSM Home Health Services, DAB No. 1622, at 6-7 (1997). If standard-level deficiencies are of such character as to "substantially limit the provider's . . . capacity to furnish adequate care or which adversely affect the health and safety of patients," the provider is not in compliance with a condition of participation, which is a basis to terminate a Medicare provider agreement. 42 C.F.R. § 488.24(b).

For HHAs, compliance with Medicare participation requirements is determined through surveys performed by state agencies under agreements with CMS. 42 C.F.R. § 488.10. The state survey agencies make and document findings with respect to the HHAs' compliance with each of the conditions of participation, and each of the standards of participation set forth in the conditions governing Medicare participation. See 42 C.F.R. §§ 488.11, 488.12, 488.18 to 488.28.

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

Section 484.30 contains the condition of participation for HHAs involving the provision of skilled nursing services by or under the supervision of a registered nurse (RN) and in accordance with the plan of care. Section 484.30(a) is the standard of participation applicable to the duties of an RN working for an HHA and provides, among other things, that the RN "regularly reevaluates the patient's nursing needs, initiates the plan of care and necessary revisions, [and] furnishes those services requiring substantial and specialized nursing skill . . . ." Another condition of participation provides that the "HHA and its staff must operate and furnish services in compliance with all applicable Federal, State, and local laws and regulations." 42 C.F.R. § 484.12(a). An additional condition of participation provides the "HHA and its staff must comply with accepted standards and principles that apply to professionals furnishing services in an HHA." 42 C.F.R. § 484.12(c).

CMS may terminate an HHA that is not in substantial compliance with program requirements, and failure to meet one or more conditions of participation is considered a lack of substantial compliance. Act, §§ 1866((b)(2)(B), 1861(o)(6); 42 C.F.R. § 489.53(a)(3). If CMS decides to terminate an HHA's Medicare provider agreement because it does not meet a condition of participation, the HHA has the right to appeal that determination pursuant to section 1866(h) of the Act and 42 C.F.R. Part 498. See 42 C.F.R. §§ 498.1, 498.3(b)(8). The right of appeal includes a hearing before an ALJ (subpart D of Part 498), and, if the HHA seeks it, review of the ALJ decision by the Departmental Appeals Board (subpart E of Part 498).

Factual Background

The following undisputed facts are drawn from the ALJ Decision and the record below.

Aspen Grove was an HHA located in Twin Falls, Idaho that was authorized to provide home health services to Medicare eligible beneficiaries and to receive reimbursement for those services from Medicare. ALJ Decision at 1. On August 30, 2006, the Idaho Bureau of Facility Standards (the state agency) completed a recertification survey of Aspen Grove and determined that Aspen Grove was not in substantial compliance with nine conditions of participation. Id.; CMS Ex. 1. On October 5, 2006, Aspen Grove submitted a plan of correction and allegation of compliance to the state agency, which were subsequently rejected on October 10, 2006. ALJ Decision at 1; CMS Exs. 1, 39. In a letter dated November 3, 2006, CMS notified Aspen

Grove that based on the findings of noncompliance, Aspen Grove's provider agreement would be terminated effective November 28, 2006. ALJ Decision at 1-2; CMS Ex. 2.

Aspen Grove submitted a revised plan of correction dated November 12, 2006, and allegation of compliance dated November 13, 2006, which was accepted by CMS in a letter dated November 15, 2006. ALJ Decision at 2; CMS Ex. 2. CMS also notified Aspen Grove that an unannounced revisit survey would be conducted before the proposed termination date. Id. From November 20 through 22, 2006, CMS and state agency surveyors conducted a revisit survey and concluded that Aspen Grove was out of substantial compliance with three conditions of participation: 1) 42 C.F.R. § 484.14 (Organization, Services and Administration); 2) 42 C.F.R. § 484.18 (Acceptance of Patients, Plan of Care and Medical Supervision), and 3) 42 C.F.R. § 484.30 (Skilled Nursing Services). ALJ Decision at 2; CMS Exs. 3 and 4. CMS further concluded that Aspen Grove was not in substantial compliance with nine HHA standards of participation involving the care related to seven patients. Id. In a letter dated December 7, 2006, CMS notified Aspen Grove of its decision to terminate Aspen Grove's provider agreement, effective November 28, 2006. ALJ Decision at 2; CMS Exs. 1 and 3.

In a letter dated January 3, 2007, Aspen Grove timely requested a hearing before an ALJ. ALJ Decision at 3. The ALJ conducted a three-day hearing in Boise, Idaho from September 5 through 7, 2007. Id. Prior to the hearing, the parties stipulated that only the deficiencies cited in the survey completed on November 22, 2006, were at issue. Id.; Jt. Stip.; Tr. 15-21. The parties submitted post-hearing briefs, and the ALJ issued a written decision on November 17, 2008.

ALJ Decision

The ALJ concluded that there was a basis to terminate Aspen Grove's provider agreement based upon a condition-level deficiency under section 484.30. ALJ Decision at 5, 15. Specifically, the ALJ found that the evidence involving three of the seven patients at issue (4, 9, and 14) amply demonstrated that Aspen Grove was not in substantial compliance with a condition of participation at section 484.30(a) because its failure to provide the required care substantially limited its capacity to render adequate care and adversely affected the health and safety of these three patients. Id. at 5, 13-15. The ALJ based this conclusion upon the facts relating to his

findings that Aspen Grove violated three standards of participation at section 484.30(a) because: 1) it did not ensure that the needs of patients 4, 9,and 14 were being regularly reevaluated by an RN; 2) Aspen Grove's RN failed to revise Patient 9's care plan as necessary; and 3) Aspen Grove's RN failed to deliver substantial and specialized skilled nursing care to Patient 4. Id. at 7, 9, 11, 12-13, 15.

Standard of Review

We review a disputed finding of fact to determine whether the finding is supported by substantial evidence, and a disputed conclusion of law to determine whether it is erroneous. See Departmental Appeals Board, Guidelines for Appellate Review of Decisions of Administrative Law Judges Affecting a Provider's Participation in the Medicare and Medicaid Programs, ¶4b, http://www.hhs.gov/dab/guidelines/prov.html.

Analysis[2]

On appeal, Aspen Grove does not directly challenge any of the ALJ's findings of fact that he relies upon in reaching the conclusions of law in this case. Nor does Aspen Grove challenge the credibility or substance of testimony by the members of the survey team. Instead, Aspen Grove contends that the ALJ erred in concluding that those unchallenged facts sufficiently demonstrate that Aspen Grove was out of substantial compliance with the three standards of participation at section 484.30(a) evaluated by the ALJ. Specifically, Aspen Grove contends that none of the deficiencies cited by the state agency were "valid" and that the "ALJ has wrongly concluded that there were violations of the various Standards [of Participation]." P. Br. at 13-14. To support this position, Aspen Grove points to additional evidence in the record and broadly asserts that "all documentation of skilled nursing services provided was accurate and in accordance with the plan of care." Id. at 17, 18, 28. Aspen Grove further contends that there can be no condition-level deficiency because the ALJ wrongly concluded that Aspen Grove was noncompliant with three standards of participation. P. Br. at 14. Finally, Aspen Grove raises a number of collateral arguments challenging the ALJ Decision. As discussed

[2] We have fully considered all arguments raised by Aspen Grove on appeal and reviewed the full record, regardless of whether we have specifically addressed particular assertions or documents in this decision.

below, we find that each of Aspen Grove's arguments is without merit.

A. The ALJ's conclusion that Aspen Grove failed to properly reevaluate the nursing needs of Patients 4, 9, and 14 as required under section 484.30(a) is supported by substantial evidence in the record and is not erroneous.

The standard of participation at section 484.30(a) requires that an RN "regularly reevaluate" the nursing needs of patients. The ALJ concluded that Aspen Grove's failure to meet this standard of participation was sufficiently demonstrated by the evidence related to Patients 4, 9, and 14. ALJ Decision at 6-13, 15. The ALJ also concluded that for each of these patients, the RN's failure to regularly reevaluate their nursing needs adversely impacted their health and safety and either harmed or had the potential for harm to each patient. Id. at 13. The ALJ also concluded that the RN's failure limited Aspen Grove's capacity to furnish adequate care. Id.

1. Patient 4

The ALJ relied upon the following undisputed facts to support the conclusion that an RN had not regularly reevaluated the nursing needs of Patient 4:

- Patient 4 was 94 years old and lived in an assisted living facility (ALF). She was admitted to Aspen Grove's care on October 27, 2006. CMS Ex. 4, at 34. Patient 4's plan of care for the period October 27, 2006 through December 25, 2006, required home health services one to two times a week for 60 days (with an authorization for three additional visits as necessary) to manage a wound and hematoma on her right knee and monitoring for congestive heart failure. CMS Ex. 4, at 34; CMS Ex. 25, at 7-8, 10-11. The physician's order directed that the skilled nurse cleanse the area with sterile water, apply DuoDerm (an opaque dressing) with "skin prep" and cover the dressing with tape. CMS Ex. 25, at 27. The dressing was to be changed as needed and the nurse was to monitor for signs and symptoms of infection. Id.

- On November 13, 2006, Aspen Grove's RN visited Patient 4 at her ALF. The RN's notes indicated that the dressing on Patient 4's knee was "in place" and there were no signs of swelling or infection. CMS Ex. 4, at 34. There was no documentation that the wound had been examined or that the

dressing had been changed. Id.; CMS Exs. 4, at 34; 25, at 171-19. In addition, there was no documentation indicating the stage of the wound, its length and width, its depth, whether it was open, whether there was drainage and in what amount, or other similar types of assessments. CMS Ex. 25, at 17-19; Tr. at 342-44, 390-91.

- On November 17, 2006, the RN again visited Patient 4 at her ALF. The RN's notes state that the knee dressing was changed. CMS Ex. 4, at 34. A summary statement indicated that there were no signs or symptoms of infection. Id. A wound measuring guide was attached with a tracing of the patient's wound. Id. However, "[t]here was no documentation of the actual status of the wound, such as wound bed, drainage, odor, condition of surrounding skin, presence of pain or increased temperature in the local area, or evaluation of current size in comparison to previous measurements." Id.; Tr. at 390-91.

- On November 20, 2006, the RN and the surveyor visited Patient 4 to interview her about her care. CMS Ex. 4, at 34-35. When Patient 4 lifted her leg to show the surveyor her wound, the surveyor "could tell that there was an odor coming from the dressing that was on the knee." Tr. at 342-44; CMS Ex. 4, at 35. The dressing was "in place but there was dark red drainage visible through the dressing, and that was . . . very interesting because that is not a clear dressing, it's opaque, so it would take more drainage for a drainage to be visible." Tr. at 342. Although Aspen Grove's RN acknowledged the odor, she stated that she would change the knee dressing the next day. Tr. at 342-43. At that point, the surveyor requested that the RN change the dressing at that time. Id. After the RN "removed the dressing, a large volume of sanguineous, odorous drainage immediately drained from the wound. The wound bed was covered with slough." CMS Ex. 4, at 35; Tr. at 342-44. The RN replaced the DuoDerm dressing, she "did not measure the wound, palpate the surrounding skin, or inquire about local pain or tenderness." Id.

The ALJ concurred with the surveyor's conclusion that the evidence was consistent with a finding that Aspen Grove's RN did not regularly reevaluate Patient 4's nursing needs. Decision at 7, 9. The ALJ found it particularly important that Patient 4's physician ordered home health services to assist with care for her knee because the ALF was not able to

conduct the necessary treatment and monitoring. Id. at 7. Given that Patient 4 was 91 years old, the ALJ noted that "it was of particular concern that someone be able to cleanse the wound and properly apply a new dressing as well as monitor the wound for signs and symptoms of infection." Id.
Aspen Grove does not directly challenge the facts relied upon by the surveyors or the ALJ in concluding that Aspen Grove's RN failed to regularly reevaluate the nursing needs of Patient 4. Indeed, Aspen Grove's expert witness, a current HHA owner and an RN, testified that he agreed with the surveyor's conclusions regarding the November 13 visit that the RN "obviously" had not done a proper evaluation and assessment of Patient 4's wound. Tr. at 757. This conclusion is supported by the documentation from the visit, which includes a form with a category for "Assess for sing (sic) and symptoms of infection, ie elevating temperature, odor, increase in pain of right knee area or change in attitude of patient" that was not circled as "Done." CMS Ex. 4, at 30. The RN's notes also do not include a measuring grid that describes the size, location, and other characteristics of the wound. Aspen Grove concedes on appeal that "[w]ounds cannot be measured appropriately using a measurement grid without visibly viewing the wound and overlaying the grid on the wound." P. Br. at 17. Aspen Grove's RN similarly acknowledged during an interview with the survey team that "there was no documentation of thorough wound assessments on the 11/13/06 and 11/17/06 home visits." CMS Ex. 4, at 48-49. Finally, Aspen Grove also does not challenge the ALJ's finding that the "record for the November 13, 2006 visit indicates that the DuoDerm dressing was not changed, yet the RN reported that she assessed the wound to the right knee. It would be impossible to thoroughly assess the wound without removing and changing the dressing, as the DuoDerm dressing is not transparent." ALJ Decision at 7, citing CMS Ex. 25, at 18.

Aspen Grove argues, however, that the RN properly reevaluated the nursing needs of Patient 14 during the November 17 visit because the RN indicated on the home visit form that she changed the dressing and that there were no signs or symptoms of infection. P. Br. at 16-17; CMS Ex. 25, at 17-19; Tr. at 390-91, 757. Aspen Grove also claims that the wound was assessed because the nursing notes include a wound measuring grid with a sketch of the patient's wound. P. Br. at 17; CMS Ex. 25, at 16.

We reject this argument. As the ALJ found, the evidence demonstrates that even though wound measuring guide was attached to the nursing notes, the nursing notes themselves do not indicate the staging of the wound, its color, depth, its

drainage, the drainage type, whether there was an odor, erythema, eschar, undermining and/or tunneling, and this information should have been noted when assessing a wound. ALJ Decision at 7-8. This is consistent with the substance of the statements made by Aspen Grove's own RN discussed above and the surveyor's testimony. See CMS Ex. 4, at 46-47; Tr. at 390-91. Furthermore, Aspen Grove does not challenge the ALJ's finding that his comparison of the wound sketch from the November 17 visit with a tracing from a visit on November 9 indicated that the open area of the wound had become bigger. ALJ Decision at 8. Aspen Grove also fails to challenge the ALJ's finding that "the increased open area should have triggered a comment in the home visit documentation or perhaps a consult with Patient 4's physician, but there is no comment in the documents and there was no consultation." Id.

Aspen Grove then asserts that "all documentation" leading up to the November 20 survey visit was "accurate" and "in accordance with the plan of care." P. Br. at 17, 18. The record does not support this contention. For example, neither the RN nor the licensed practical nurse (LPN) testified in this case that the documentation was accurate. Further, this assertion is undercut by the RN's unchallenged statement to the survey team, as previously discussed, that "there was no documentation of thorough wound assessments on the 11/13/06 and 11/17/06 home visits." CMS Ex. 4, at 48-49. Moreover, Aspen Grove's failure to challenge the ALJ's finding that it was "impossible" for the RN to have assessed Patient 4's wound during the November 13 visit would suggest that the RN's statement in her notes from the November 13 visit that the wound was assessed is in fact not "accurate."

Similarly, substantial evidence supports the ALJ's conclusion that the RN failed to assess the nursing needs of Patient 4 on November 20, 2006. For example, Aspen Grove does not challenge the surveyor testimony indicating that the RN did not palpate the wound area to find out the status of the surrounding skin, whether other materials came loose from the wound, whether there was undermining indicating extension of the wound, and whether the local area of the wound was warm, which might indicate inflammation or perhaps infection. ALJ Decision at 8, citing Tr. at 345.

2. Patient 9

The ALJ relied upon the following undisputed facts to support the conclusion that an RN had not regularly revaluated the nursing needs of Patient 9.

- Patient 9 was a 61-year-old male who was admitted for home health services on October 8, 2006 with a primary diagnosis of inoperable lung cancer. CMS Ex. 4, at 35. He also had a diagnosis of chronic obstructive pulmonary disease (COPD) for which he required continuous oxygen. Id. Patient 9 had a poor prognosis with a life expectancy of six months or less. Id.

- The plan of care for the October 8 through December 6, 2006 certification period included a physician's order for skilled nursing to assess Patient 9's pain level at every visit and to teach him and his care-givers about taking his pain medications when his pain exceeded a level four on a scale of one to 10 (10 being the highest level of pain) before his pain became too severe. The skilled nurse was to notify his doctor if there were any concerns with this. CMS Ex. 28, at 49-50, 138-39, 140-41, 161. The plan of care included a goal to keep Patient 9's pain level below a level of five out of 10. Id. Aspen Grove's RN documented that she advised telling Patient 9 to take pain medication any time that his pain exceeded a level of four out of 10. Id. at 161.

- Aspen Grove's pain assessment policy, which was revised October 1, 2006 and effective November 7, 2006, requires that a comprehensive assessment of a patient's plan be done that includes checking intensity, location, frequency, character, current therapy, effectiveness of therapy, and influence of pain on movement and activity. CMS Ex. 20.

- On November 5, 2006, the RN documented that Patient 9 measured his pain as a zero out of 10 but noted that he still experienced pain on a daily basis. CMS EX. 28, at 108. The record does not contain any documentation that Aspen Grove's RN evaluated Patient 9's complaint of daily pain in future visits. Similarly, there is no documentation that the RN assessed the location of the pain when it occurred daily or the effectiveness of Patient 9's pain medication in relieving the pain. Although the RN noted that Patient 9 had a new pressure ulcer over the coccyx, the record does not indicate if Patient 9

complained of pain associated with the ulcer. There is no indication in the RN's notes that she did teaching on managing pain. CMS Ex. 28, at 107-12.

- On November 7, 2006, an LPN visited Patient 9. Although the LPN recorded that she assessed Patient 9's pain level, the nursing record does not show any entries indicating whether or not Patient 9 had any pain or at what level. The nursing note also does not reflect any of the other assessment criteria required in Aspen Grove's pain policy, which became effective that day. CMS Ex. 28, at 102-06.

- On November 15, 2006, after returning from a brief hospital stay on November 14, Patient 9 received a resumption of care assessment by Aspen Grove's RN. The assessment noted that Patient 9 reported his pain level was eight out of 10 and complained that the pain affected sleep, appetite, physical or emotional energy, concentration, personal relationships, emotions, and physical activity. CMS Ex. 28, at 56-57, 64-68, 76-77, 104. The RN further recorded that Patient 9's "main pain is in the coccyx at 8." Id. at 61, 65. The RN's notes do not indicate that she assessed whether Patient 9 had pain in other locations associated with his lung cancer or whether his present medication was effective to keep his pain at an intensity level of less than five. Id. at 64-68, 73-85, 55-60. The record includes a preprinted statement with the word "Done" circled on the list of interventions at the end of the line that requires the nurse to assess pain and do teaching on pain control every visit and to notify the M.D. if there are concerns. Id. at 66, 77. However, the evidence does not include a document reflecting that the RN consulted with the physician on November 15 even though Patient 9 complained of pain at a level of eight out of 10. For example, there is no physician's order dated November 15. A physician's order dated November 17, 2006 does not address pain. Id. at 120.

- On November 20, 2006, Aspen Grove's RN conducted a resumption of care assessment after Patient 9 returned from another brief hospital stay. The RN noted Patient 9 complained of intractable pain at an intensity of 10 out of 10 that was constant, not easily relieved, and affected all functional areas. CMS Ex. 28, at 20. However, the RN did not specify the location of the pain or the effectiveness of pain medication, though she noted that Patient 9's

oxycodone had been stolen on November 17.[3] Id. at 16, 30-34, 38; Tr. 771-72.

Based on these undisputed facts, the ALJ concurred with the surveyors' conclusion that the RN's evaluation of Patient 9's medical and nursing needs related to pain was insufficient between October 23, 2006 and November 22, 2006. ALJ Decision at 9; CMS Ex. 4, at 30, 38; Tr. at 392-94. Patient 9's plan of care specifically required the nurse to assess his pain needs on every visit, to instruct the care-giver and patient on taking pain medication to keep the pain below five on a scale of 10, and to report any concerns to the physician. On two occasions, the RN failed to report the patient's complaint of pain when it was at a level of eight and 10 out of 10. Aspen Grove also failed to present any evidence that, if Patient 9's complaint of severe coccyx pain was ever reported to his physician, the physician responded. The ALJ further concurred with the surveyor's conclusion that Aspen Grove's nursing staff did not follow Aspen Grove's policy for assessment of pain. ALJ Decision at 11; CMS Ex. 4, at 38; Tr. at 392-94. Aspen Grove points to no evidence in the record that it followed its own pain policy in assessing Patient 9 and does not challenge the testimony of CMS's expert witness that Aspen Grove failed to regularly reevaluate the pain needs of Patient 9. Tr. at 392-94. Given that Patient 9 was suffering from terminal lung cancer, the ALJ reasonably concluded that a central component of his plan of care required the RN to manage his pain and to follow Aspen Grove's own pain assessment policy. ALJ Decision at 12-13.

On appeal, Aspen Grove points to evidence and raises a number of arguments that are not relevant to the ALJ's findings and conclusions regarding Patient 9. For example, Aspen Grove states that during interviews with the survey team on November

[3] The ALJ found that "Aspen Grove has presented no evidence that any action was taken to replace the stolen oxycodone." ALJ Decision at 11. However, the record contains a note from Aspen Grove's RN to a physician dated November 20, 2006, in which she states: "Please respond with any orders for refilling his pain med., he does have other MS contlin if pt needed for pain." CMS Ex. 28, at 38. Although this note suggests that the ALJ's statement may have been inaccurate, the statement does not constitute a material error because, as discussed above, substantial evidence supports the ALJ's determination that Aspen Grove's RN did not regularly reevaluate Patient 9's pain needs as required. See Tr. at 392-94.

22, 2006, Aspen Grove's LPN and Director of Patient Care Services (DPCS) "concurred that [the LPN] had not fully documented the patient's respiratory status . . . [and] [t]here was some conversation regarding insufficient supervision to assure that assessment and interventions were meeting this terminally ill patient's changing needs." P. Br. at 19. Aspen Grove argues that CMS "failed to realize that there was no documentation required as the patient and/or caregiver had been instructed on signs and symptoms indicating the need to call the home health agency or physician." Id., citing P. Ex. 54, at 19-39. This argument is not relevant to Aspen Grove's obligation for the RN to regularly reevaluate the pain management nursing needs of Patient 9. The plan of care and Aspen Grove's pain policy required the RN to conduct and record a detailed assessment of Patient 9's pain at each visit and to notify the physician with any concerns.

Aspen Grove also argues that contrary to the surveyor's findings, a nursing note dated November 13, 2006, which states "demonstrating progress regarding anxiety r/t dyspnea[,]" shows that the LPN documented the patient's dyspnea level. P. Ex. A, at 38. The ALJ did not rely upon the LPN's alleged failure to document Patient 9's dyspnea level on November 13, 2006 in reaching his conclusion that Aspen Grove was not in substantial compliance. This document is also not material to the ALJ's conclusion that an Aspen Grove RN failed to regularly reevaluate Patient 9's nursing needs related to pain management in conformance with the plan of care and its own pain policy.

Aspen Grove contends that a nursing documentation form dated November 13, 2006, shows that Patient 4 had "no complaint" of pain and, therefore, "teaching wasn't done." P. Ex. A, at 39, citing CMS Ex. 28, at 97-98. Even if accurate, the form has no bearing on the sufficiency of the ALJ's finding that Aspen Grove failed to adequately assess Patient 9 for pain on November 15 or November 20 when the pain level was recorded as eight and 10 out of 10, respectively. Indeed, the ALJ did not make a finding that Aspen Grove failed to reevaluate Patient 9's pain needs on November 13.

Aspen Grove also contends that the "MD was notified as noted on the documentation for the nurse dated 11-15-06 CMS Ex. 28 page 160." P. Ex. A, at 40. However, the document cited by Aspen Grove does not support its assertion. Instead, this document is a comprehensive nursing assessment dated October 8, 2006. There is no indication on this two-page document that the physician had been notified about Patient 9's pain on November 15, 2006.

3. Patient 14

The ALJ relied upon the following undisputed facts to support the conclusion that an RN had not regularly revaluated the nursing needs of Patient 14:

- Patient 14 was an 81-year-old female who was admitted to Aspen Grove's care on April 6, 2006. CMS Ex. 4, at 32. The diagnoses listed on her plan of care included a history of urinary tract infection, type II diabetes, a history of hypoglycemia, and malaise and fatigue. Id.; CMS Ex. 31, at 16.

- During the time Patient 14 was under Aspen Grove's care, her blood glucose levels were documented as chronically high with a range from 171 to as high as 585, when the normal range is approximately 70 to 105. CMS Exs. 4, at 32; 31, at 18-25, 102-105; Tr. at 171.

- On October 23, 2006, Aspen Grove's RN visited Patient 14. CMS Ex. 4, at 26, 32. Patient 14's son was her primary care-giver. During the RN's visit he refused to get off the couch and give insulin to Patient 14. Patient 14 also had a home health aide who reported to the RN that she had found Patient 14 sitting in urine earlier that day. CMS Ex. 31, 62-65.

- On November 8, 2006, the home health aide informed the RN during a telephone conversation that Patient 14's blood sugar level was elevated and that Patient 14's son had given her insulin. CMS Ex. 31, at 55. The aide also reported to the RN that Patient 14's blood sugar level was elevated later that day. The aide attempted to wake up the son to give Patient 14 more insulin, but he refused. The RN documented speaking with a social worker regarding her concerns about the lack of medical management by Patient 14's son and "it was decided that Adult Protection needed to again be called with an update." Id. at 54, 55.

- On November 13, 2006, the RN documented that Patient 14's son was sentenced to jail for approximately six months and that Patient 14 would move into her granddaughter's home. CMS Ex. 31, at 43, 56, 110-13. The RN's notes state that "[t]his is on a temporary basis and if it does not work out – [Patient 14] will be moved to a [skilled nursing facility]." The notes also state that the RN would notify

Medicaid, the physician, and Adult Protection. Id. The RN further noted that she spoke with the granddaughter and the social worker. Id. The RN's notes further indicated that she would notify Medicaid, the patient's physician, and Adult Protection. Id. The documentation does not indicate that the RN actually visited Patient 14. See id. at 56, 113.

- On November 14, 2006, the RN notified the physician indicating the social worker would visit with the granddaughter and Patient 14. CMS Ex. 31, at 43. However, the documentation does not indicate that the RN had visited Patient 14. Id.

- On November 17, 2006, the RN updated the physician, noting that she had spoken with the granddaughter before Patient 14 moved into her granddaughter's home. CMS Ex. 31, at 41. The RN's notes indicate that the granddaughter "would like to learn more about diabetes and appropriate diet." Id. The notes also report that Patient 14 was "causing disharmony in [the granddaughter's] home." Id. For example, Patient 14 was having trouble adjusting to her granddaughter's young children and was refusing to allow her granddaughter to help with her care. Id. The RN notes indicate that she "suggested that a meeting be set up" with her, the social worker, and others. Id. However, the notes do not indicate that a meeting was actually scheduled. Id.

- The record shows that Aspen Grove's LPN visited Patient 14 two times per week from October 25 through November 20, 2006. CMS Ex. 4, at 26. The record further shows that the RN reviewed reports made by the LPN and the home health aide.[4] CMS Exs. 4, at 26-27, 33; 31, at 61-62, 66-101.

- The surveyors interviewed Aspen Grove's DPCS on November 22, 2006, who "confirmed that no evaluation of the patient by an RN had occurred since 10/23/06." CMS Exs. 4, at 26, 33-34. The evidence similarly shows that "no documentation of an evaluation of Patient 14 was present after 10/23/06." Id.

[4] The record indicates that the RN also visited Patient 14 on November 3 15, 2006, in order to supervise the LPN's performance. CMS Ex. 4, at 26.

Based on these facts, the ALJ concurred with the surveyors' conclusion that the RN had not reevaluated Patient 14's nursing needs between October 23, 2006 and November 22, 2006, the last day of the survey. ALJ Decision at 12; CMS Ex. 4, at 26-28, 32-35. The ALJ also agreed with the surveyors' conclusion that the RN had not evaluated Patient 14's new living arrangement with her granddaughter and her ability to meet Patient 14's needs, particularly her diet. ALJ Decision at 12; CMS Ex. 4, at 33-34. In addition, the ALJ concurred with the surveyors that a reevaluation of Patient 14 was required by section 484.30, but had not been done by the RN. ALJ Decision 12-13.

Aspen Grove does not directly challenge any of the facts discussed above. Instead, Aspen Grove argues that "[t]his allegation is absolutely false, as there is a clinical note by an RN dated 11-7-06, (H. Trans page 746-747) in which teaching regarding diabetic issues, were completed." P. Ex. A, at 22-23. Aspen Grove further contends that "[t]his fact negates this finding and should be reconsidered." Id. at 23. However, Aspen Grove's assertions are not supported by any evidence in the record. Although the record contains a note dated November 7, 2006, the typed note was made by Patient 14's home health aide, a CNA, not by the RN. CMS Ex. 31, at 50-51. Moreover, the note does not mention that the home health aide provided any "teaching regarding diabetic issues." Id. The record also contains a physician's order that is dated November 7, 2006, which is clearly not the document referenced in Aspen Grove's Exhibit A or during the hearing. See id. at 33-34; Tr. at 745. Even if the record did contain a document indicating that the RN had provided the granddaughter "teaching regarding diabetic issues[,]" it would not demonstrate that the RN had regularly reevaluated Patient 14's nursing needs, as required under the regulations.

Aspen Grove also contends that "[i]f this agency sent an RN at minimum every 14 days [as required under Idaho state law] . . . the next visit would not have occurred until November 21, 2006." P. Ex. A, at 22. Aspen Grove's argument is without merit. The ALJ correctly found that section 484.30 does not specify that the RN is required to reevaluate a patient's nursing needs only every 14 days. ALJ Decision at 12. Instead, section 484.30 requires that a reevaluation by the RN is to be done regularly, without specifying any frequency, and section 484.12(c) requires the HHA to comply with professional standards of nursing care. Id. Thus, while Aspen Grove had to comply with the Idaho licensing requirement that an RN visit at least once every 14 days, meeting this requirement alone would not have discharged

the HHA of its obligation to regularly reevaluate the patient's nursing needs, consistent with professional standards of care. As discussed above, the surveyor testimony supports the conclusion that the RN should have reevaluated Patient 14 when she moved into her granddaughter's home.

Aspen Grove contends that there is a "nursing note dated 11-14-06" [that] discusses dietary teaching to the [granddaughter], with the [granddaughter] repeating to the LPN which foods patient [14] was eating and which are good for diet for diabetes." P. Ex. A, at 23. Aspen Grove also contends that Patient 14's blood glucose levels were "better." Id. Even assuming these factual assertions are true, they do not demonstrate that the RN regularly reevaluated Patient 14's nursing needs between October 23 and November 22, 2006. Aspen Grove fails to cite to any evidence that the RN actually reevaluated Patient 14's nursing needs during this period. Moreover, there is no evidence in the record that the RN reevaluated the nursing needs of Patient 14 after October 23, 2006. CMS Ex. 31, at 61-62; CMS Ex. 31, at 66-101; P Ex. 8. Indeed, Aspen Grove does not challenge the RN's statement agreeing with the surveyor's assessment that there were no notes documenting any visits between October 23 and November 22, 2006. CMS Exs. 4, at 32; 31, at 5.

Aspen Grove also does not challenge the ALJ's rationale, based on substantial evidence and expert testimony as to the professional standards of care, that the RN should have, but failed to reevaluate the nursing needs of Patient 14 because: 1) the care-giver son had demonstrated his unreliability to get out of bed, to keep Patient 14 clean and dry, and to administer insulin when needed; 2) Patient 14's blood glucose levels widely fluctuated and needed to be monitored; 3) Patient 14's son was incarcerated; 4) Patient 14 had to be moved to a new environment with a new care-giver who had small children; and 5) the granddaughter specifically requested training in how to care for Patient 14. ALJ Decision at 13.

In summary, the ALJ's conclusion that Aspen Grove's RN failed to regularly reevaluate the nursing needs of Patients 4, 9, and 14 as required under section 484.30(a) is supported by substantial evidence in the record and is free from legal error.

B. The ALJ's decision that Aspen Grove's RN failed to initiate revisions to Patient 9's plan of care as required by section 484.30(a) is supported by substantial evidence and is not erroneous.

One of the standards of participation at section 484.30(a) requires that an RN initiate the plan of care for each patient and make any necessary revisions to that plan based on the changing needs or condition of the patient. The state survey agency used Aspen Grove's care of Patient 9 as an example that it was not in substantial compliance with this standard of participation. CMS Ex. 4, at 42-45. The state surveyors cited Aspen Grove for noncompliance of this standard because Aspen Grove did not revise Patient 9's plan of care related to bowel management after he was hospitalized for a fecal disimpaction on November 1, 2006. Id. The ALJ found the evidence demonstrated that the RN needed to evaluate whether a revision of the care plan was necessary but that there was no evidence that the RN considered, with the physician or on her own, whether different interventions might be appropriate revisions to the plan of care. ALJ Decision at 13-14. The ALJ concluded that Aspen Grove's failure to revise Patient 9's plan of care had an adverse impact on the health and safety of Patient 9. Id. at 15.

The ALJ relied upon the following undisputed facts to support the conclusion that an RN failed to initiate revisions to Patient 9's plan of care as necessary.

- As previously discussed, Patient 9 had a prognosis of terminal lung cancer. He had a secondary diagnosis of constipation that was related to the pain medication he was taking.[5] CMS Ex. 4, at 42; Tr. at 375-76. Patient 9's plan of care for the October 8 through December 8, 2006, period required the nurse to assess bowel movements and concerns regarding constipation and to notify the physician with any concerns. CMS Ex. 28, at 140.

- From the beginning of his care with Aspen Grove, Patient 9 experienced problems regarding bowel movements. On October 10, 2006, the RN noted that Patient 9 had not had a bowel movement in four or five days. The RN offered Patient 9 an enema that he refused (which was later given by his wife with no results), instructed his wife to give him warm prune juice and milk of magnesia, and advised the physician that an order for magnesium citrate may be needed. CMS Ex. 28, at 142, 137.

[5] Patient 9 had been prescribed two opiate analgesics, oxycodone and morphine sulphate, which are known to cause constipation. CMS Ex. 4, at 42.

- On November 1, 2006, Patient 9 went to the emergency room with complaints of cramping abdominal pain and no bowel movement for the previous week. CMS Ex. 4, at 42-43. The physician at the emergency room manually disimpacted Patient 9's bowel. CMS Ex. 28, at 113. Upon discharge, the emergency room physician ordered that Patient 9 should continue to use laxatives and stool softeners and follow-up with either his own physician, a physician with the Veteran's Administration, or the emergency room. CMS Ex. 128, at 124.

- On November 7, 2006, the RN notified Patient 9's physician about the emergency room visit. However, the RN did not request or recommend further orders to treat his constipation. CMS Ex. 28, at 113.

- On November 10, 2006, Aspen Grove's LPN noted that Patient 9 had not had a bowel movement in three days. CMS Ex. 4, at 43. On November 15, 2006, Aspen Grove's RN noted that he reported not having a bowel movement in two days. Id. However, the RN failed to advise Patient 9's physician of these bowel problems or otherwise seek any orders to treat his condition.

Aspen Grove argues that there was nothing more that could be done about Patient 9's constipation, that Patient 9 was noncompliant, and that Patient 9's physician was aware about the ongoing problem. P. Br. at 24. The ALJ correctly concluded, however, that Aspen Grove's argument "misses the point." ALJ Decision at 14. The standard of participation at section 484.30(a) requires that the RN initiate the plan of care and any necessary revisions as the patient's condition changes. The evidence and testimony amply support the ALJ's conclusion that Patient 9's ongoing severe constipation required the RN to initiate revisions and consider other interventions for the plan of care after his November 1 hospitalization. For example, according to the unchallenged testimony of one member of the survey team, a fecal disimpaction "was very, very serious, and so it needed to be addressed comprehensively to determine what should be done new, different[ly]." Tr. at 395. Nevertheless, Aspen Grove did not initiate a revision to Patient 9's plan of care after his visit to the emergency room. Tr. at 395; CMS Ex. 4, at 42-45.

Aspen Grove's argument is further undercut by the undisputed fact that the RN waited nearly a week to notify Patient 9's physician about the fecal disimpaction at the emergency room

despite the emergency room discharge order for follow-up treatment with the physician. Even when she did notify the physician on November 7, 2006, the RN did not request or recommend further orders to treat Patient 9's constipation. The RN also did not notify Patient 9's physician of the bowel problems he had experienced on November 10 and 15, 2006, or otherwise seek any orders to treat his condition. Despite the emergency room physician's orders for follow-up treatment and Patient 9's repeated problems after discharge from the emergency room, a plan of care signed by the RN on November 19, 2006 and the Patient 9's physician on November 20, 2006, also did not include any new treatment protocol for his constipation. CMS Ex. 28, at 49-53.

Aspen Grove also argues that Patient 9's plan of care was "altered in response to the BM issue[,]" as indicated by the RN's request for a physician's order for magnesium citrate, which was received on October 13, 2006. Exhibit A at 42. This request, however, does not undercut the ALJ's conclusion because it is dated more than two weeks before Patient 9's trip to the emergency room on November 1, 2006. See Tr. at 377-78 (surveyor "was looking at what had happened from 11/12 thereafter").

We further conclude that Aspen Grove's other objections to the ALJ's conclusion that the RN failed to make necessary revisions to Patient 9's plan of care regarding bowel movements are inapposite. For example, Aspen Grove contends that the RN fully assessed Patient 9's lung sounds, that nursing notes dated November 13, 2006, indicate "no complaint" of pain, and that a nursing note dated November 20, 2006, requesting the physician to "please respond with filling pain meds" taken together demonstrate that the survey team "erroneously concluded that there was insufficient supervision to assure that assessment and interventions were meeting this terminally ill patient's changing needs." P. Br. at 21-22. Although this evidence might be relevant to one or more of the cited deficiencies that the ALJ did not rely upon in reaching his conclusions, it is simply not relevant to the issue of whether Aspen Grove's RN failed to make necessary revisions to Patient 9's plan of care relating to the bowel movement issue after his hospitalization on November 1, 2006.

Thus, we conclude that the ALJ's determination that Aspen Grove's RN failed to initiate a necessary revision to the plan of care as required under section 484.30(a) is supported by substantial evidence in the record and is not erroneous.

C. The ALJ's conclusion that Aspen Grove's RN failed to provide substantial and specialized nursing skills to Patient 4 as required by section 484.30(a) is supported by substantial evidence and is not erroneous.

An additional standard of participation at section 484.30(a) requires an RN to furnish those services requiring substantial and specialized nursing care. The state survey agency concluded that Aspen Grove was not in substantial compliance with this standard of participation based upon its care of Patient 4. CMS Ex. 4, at 45-49. The ALJ agreed with the surveyor's conclusion that the care provided to Patient 4 on November 20, 2006, demonstrated that Aspen Grove failed to furnish services requiring substantial and specialized nursing skill because the surveyor had to direct the RN to change the dressing immediately, rather than the next day as the RN proposed. ALJ Decision at 15. The ALJ further concluded that the RN's failure to provide substantial and specialized skilled nursing skills to Patient 4 had an adverse impact upon Patient 4's health. Id.

The ALJ based his conclusion upon the undisputed facts that were previously discussed in section A above, establishing that Aspen Grove's RN did not change Patient 9's knee dressing, despite the emanation of a foul order, until requested by the surveyor. Aspen Grove argues that the "nursing frequencies according to the plan of care [App. Ex. 43 at 7-8] had been followed." P. Br. at 26; P. Ex. A, at 10. Aspen Grove further contends that "[a]ll interventions for the wound care including the use of Duoderm had been used up to the day of the survey." P. Br. at 26. Aspen Grove argues that this "shows that the management of the patient's wound was being adequately managed in accordance with the plan of care and scope of practice of the RN up to the point of the significant change that was discovered upon [the] mutual visit with the surveyor on November 20, 2006." P. Br. at 26, 28; P. Ex. A, at 11. Finally, Aspen Grove contends that the ALJ "overlooked the fact that it is evident from the available record that [Aspen Grove's] RN did everything within her reach and capacity to deliver substantial and specialized skilled nursing care." P. Br. at 27.

These arguments are without merit. Aspen Grove's arguments do not address the conduct that occurred on the November 20 visit and, therefore, are not relevant to the ALJ's finding that substantial and specialized nursing services were not provided to Patient 4 on November 20, 2006. Substantial evidence in the record amply supports the ALJ's finding that the events of November 20, 2006, where the "surveyor had to direct the RN to

change the dressing immediately, rather than the next day as the RN proposed, is a good example of how the RN failed to provide the specialized nursing care required." ALJ Decision at 15. Thus, the ALJ's conclusion that Aspen Grove's RN failed to provide substantial and specialized nursing skills required under section 484.30(a) is supported by substantial evidence in the record and is free from legal error.

D. The ALJ's conclusion that Aspen Grove's failure to substantially comply with three standards of participation constituted a condition-level violation of section 484.30 and that there was a basis to terminate Aspen Grove's provider agreement is not erroneous.

For the reasons previously discussed in sections A-C above, we conclude that the ALJ's findings of fact are supported by substantial evidence in the record. Similarly, the ALJ's conclusion that Aspen Grove was not in substantial compliance with three standards of participation at section 484.30(a) because it did not ensure that the needs of Patients 4, 9, and 14 were being regularly reevaluated by an RN, did not make necessary revisions to the plan of care for Patient 9, and did not furnish services requiring substantial and specialized nursing services to Patient 4 is not erroneous. ALJ Decision at 13-15.

Based upon the facts underlying these findings, the ALJ concluded that the three standard-level deficiencies under section 484.30(a) constituted a violation of a condition of participation under section 484.30 because the deficiencies were of such a character that the health and safety of these three patients was adversely impacted because the deficiencies either harmed or had the potential to harm each patient. ALJ Decision at 13, 15. For example, one surveyor testified without contradiction that the RN's failure to properly assess Patient 4's knee wound and properly furnish substantial and specialized skilled nursing services created a potential for harm from an infection. Tr. at 391-94. Given that Patient 9 was suffering from terminal cancer, it is abundantly clear that Aspen Grove's failure to follow its pain management policy for, or to initiate revisions to, Patient 9's plan of care after his hospitalization caused actual harm or at least the potential for actual harm, which Aspen Grove does not challenge. Similarly, the RN's failure to regularly reevaluate Patient 14's nursing needs, at the very least, created a potential for harm due to the wide ranging fluctuations in her blood glucose levels. The ALJ further concluded that the RN's failure to regularly

reevaluate the nursing needs of Patients 4, 9, and 14 limited Aspen Grove's capacity to furnish adequate care, which is an alternative basis to find a condition-level deficiency. ALJ Decision at 13, 15. Aspen Grove does not directly challenge the ALJ's conclusion that the standard level deficiencies rose to a condition-level deficiency. Id. Accordingly, the ALJ's conclusion that the standard-level violations of section 484.30(a) constitute a violation of the condition of participation at section 484.30 is not erroneous. Based on the condition-level violation of section 484.30(a), we further conclude that the ALJ's conclusion that there was a basis to terminate Aspen Grove's provider agreement is not erroneous.

E. Aspen Grove's additional arguments are without merit.

Aspen Grove has raised several additional issues. First, Aspen Grove argues that it was in compliance with applicable conditions of participation because "it met all the concerns found under [the] August 30, 2006, Survey." P. Br. at 13. Aspen Grove further argues that "[a]ny problems that may have existed before or after November 20-22, 2006 were 100% resolved and remain to this day resolved, even though proof of said corrective action was presented in detail to the ALJ during the hearing in this matter." Id.

Aspen Grove's argument is not relevant because the parties stipulated before the ALJ that the issue in this case is whether CMS had a basis to terminate Aspen Grove based on the November 22, 2006 survey. See Jt. Stip.; Tr. 15-21. Moreover, CMS is not required to afford a provider the opportunity to correct its failure to comply with a condition of participation before terminating the provider. Excelsior Health Care Services, Inc., DAB No. 1529, at 6-7 (1995). Thus, Aspen Grove's assertion that it had taken corrective action by the survey date or the date its provider agreement was terminated is irrelevant. See Community Home Health, DAB No. 2134 (2007). Even assuming that Aspen Grove had come back into substantial compliance regarding the deficiencies cited in the August 30, 2006, survey, Aspen Grove's failure to be in substantial compliance with a condition of participation identified in the November 22, 2006, survey would be sufficient to constitute a basis for CMS to terminate its provider agreement.

Aspen Grove also claims that "during the November 22, 2006 survey[,] the CMS and Idaho State surveyors over-stated, under reviewed, analyzed each situation with abject subjectivity, and went about their work with only one objective; to presumably put

Aspen Grove Home Health Agency out of business!" P. Br. at 3. Aspen Grove has not cited to any evidence in support of this broad assertion.[6] In any event, surveyor bias is not relevant to the question of whether the HHA is in substantial compliance with Medicare program requirements. See 42 C.F.R. § 488.318(B)(2) and §488.305(b). In an appeal of CMS's imposition of administrative remedies, the ALJ reviews de novo whether the evidence supports CMS's determination of noncompliance. See Jewish Home of Eastern Pennsylvania, DAB No. 2254 (2009). Allegations of surveyor bias in an ALJ de novo review are immaterial "where objective evidence [such as a facility's own records] establishes noncompliance . . . ." Canal Medical Laboratory, DAB No. 2041, at 6 (2006); accord, Vijay Sakhuja, M.D., DAB No. 1958 (2005). In such cases, an ALJ's de novo evaluation of the objective evidence would correct any alleged bias in a surveyor's evaluation of that evidence. Because substantial evidence demonstrates that Aspen Grove was not in substantial compliance with a condition of participation, any possible surveyor bias in this case is not relevant.

Finally, Aspen Grove contends that "[CMS's] proposed Notice of Termination dated November 3, 2006 and also its Letter of Intent dated January 5, 2007 revoking [Aspen Grove's] Home Health Agency license effective February 5, 2007, is inconsistent with sound health policy and the policies of the Social Security Act." P. Br. at 7. Aspen Grove's argument is without merit because the issue is not whether CMS's decision to terminate Aspen Grove's provider agreement is inconsistent with some undefined health policy but whether Aspen Grove was in substantial compliance with the applicable regulations. Moreover, this argument is not factually correct, in part, because it was the State of Idaho, not CMS, who revoked Aspen Grove's Home Health Agency license in 2007.

[6] In contrast, testimony from two members of the survey team that they had no preconceived bias against Aspen Grove and never had any contact with the HHA before the November 20, 2006 survey also contradicts Aspen Grove's allegation. Tr. at 58, 117. Another member of the survey team testified that her personal motive was to assist the state agency in conducting the survey. Tr. at 321, 432-33. There is no indication of surveyor bias from this unchallenged testimony.

Conclusion

For the reasons explained above, we uphold the ALJ Decision and affirm and adopt each of the ALJ's findings of fact and conclusions of law.

/s/
Judith A. Ballard

/s/
Constance B. Tobias

/s/
Stephen M. Godek
Presiding Board Member