Department of Health and Human Services
DEPARTMENTAL APPEALS BOARD
Appellate Division

NMS Healthcare of Hagerstown, LLC
Docket No. A-15-74
Decision No. 2803
July 20, 2017

FINAL DECISION AND PARTIAL REMAND OF ADMINISTRATIVE LAW JUDGE DECISION

NMS Healthcare of Hagerstown, LLC (NMS, Petitioner), a skilled nursing facility in Maryland, requested review of an Administrative Law Judge (ALJ) decision granting CMS's motion for summary judgment in its favor. *NMS Healthcare of Hagerstown*, DAB CR3772 (2015) (ALJ Decision). Based on findings by the State survey agency, the Centers for Medicare & Medicaid Services (CMS) determined that NMS was not in substantial compliance with Medicare participation requirements from January 22 through June 25, 2014 and that the noncompliance from January 22 through March 27, 2014 posed immediate jeopardy to facility residents. The ALJ upheld CMS's imposition of civil money penalties (CMPs) of $5,650 for each day of immediate jeopardy-level noncompliance and $150 for each day of less than immediate jeopardy-level noncompliance.

NMS argues that the ALJ erred in granting summary judgment for CMS. According to NMS, the ALJ improperly disregarded or excluded evidence proffered by NMS that raises disputes of material fact with respect to the survey findings of noncompliance at both the immediate jeopardy and less than immediate jeopardy levels.

We conclude that it was not appropriate for the ALJ to uphold the CMPs on summary judgment. As discussed below, we conclude that NMS raised genuine disputes of material fact with respect to (1) whether it was in substantial compliance with the three participation requirements as to which CMS alleged noncompliance at the immediate jeopardy level; (2) whether CMS's determination that this noncompliance posed immediate jeopardy was clearly erroneous; and (3) whether it was in substantial compliance with one of two participation requirements considered by the ALJ as to which CMS alleged noncompliance at the less than immediate jeopardy level. Accordingly, we remand this case in part to the ALJ for further proceedings consistent with our decision.

Legal Background

To participate in the Medicare program, a long-term care facility, including a skilled nursing facility, must be in "substantial compliance" with the requirements in 42 C.F.R. Part 483.[1] 42 C.F.R. § 483.1. Under agreements with the Secretary of Health and Human Services, state survey agencies conduct onsite surveys of facilities to verify compliance with the Medicare participation requirements. *Id*. §§ 488.10(a), 488.11; *see also* Social Security Act (Act) §§ 1819(g)(1)(A), 1864(a). In addition to periodic surveys, state survey agencies conduct surveys to investigate complaints that facilities are violating one or more of the participation requirements. 42 C.F.R. § 488.308. A state survey agency reports any "deficiencies" it finds in a Statement of Deficiencies (SOD), which identifies each deficiency under its regulatory requirement and the corresponding "tag" number. A "deficiency" is any failure to comply with a Medicare participation requirement, and "substantial compliance" means "a level of compliance with the requirements of participation such that any identified deficiencies pose no greater risk to resident health or safety than the potential for causing minimal harm." 42 C.F.R. § 488.301 (also defining "noncompliance" as "any deficiency that causes a facility to not be in substantial compliance").

CMS may impose one or more remedies on noncompliant facilities, including per-day CMPs. 42 C.F.R. §§ 488.402(b), (c), 488.406, 488.408(d)(1)(iii), (iv), (e)(1)(iii), (iv); 488.430(a). When CMS imposes a per-day CMP for noncompliance at a level less than immediate jeopardy, it chooses an amount within the $50-$3,000 "[l]ower range" for per-day CMPs. 42 C.F.R. §§ 488.438(a)(1)(ii), 488.408(d)(1)(iii). When CMS imposes a per-day CMP for noncompliance that it has determined poses immediate jeopardy, CMS must impose a CMP within the "[u]pper range" of $3,050-$10,000 per day. 42 C.F.R. §§ 488.438(a)(1)(i), 488.408(e)(1)(iii). Within the applicable range, the regulations provide a number of factors to be considered by CMS in determining an appropriate CMP amount. These factors are the facility's history of noncompliance, its financial condition, its culpability for the cited deficiencies, the seriousness of those deficiencies, i.e., their scope (whether they are isolated, constitute a pattern, or are widespread) and severity, and the relationship between or among the deficiencies. 42 C.F.R. § 488.438(f)(3), incorporating by reference 42 C.F.R. § 488.404.

[1] In October 2016, the requirements for long-term care facilities in subpart B of Part 483, including those at issue here, were redesignated and in some cases revised effective November 28, 2016. 81 Fed. Reg. 68,688, 68,848 (Oct. 4, 2016); 82 Fed. Reg. 32,256 (July 13, 2017) (technical corrections). We cite to the prior provisions, which are applicable in this case.

Case Background[2]

CMS imposed a $5,650 per-day CMP based on its determination that NMS failed to comply substantially with three participation requirements and that this noncompliance posed immediate jeopardy.[3] CMS found violations of provisions in 42 C.F.R. § 483.10(j)(1)-(2), requiring that the facility must provide access to the resident to members of the resident's immediate family and others, subject to the resident's right to deny or withdraw consent; the provision in section 483.13 that the resident has the right to be free from involuntary seclusion; and the provision in section 483.20(k)(3)(i) that services provided or arranged by the facility must meet professional standards of quality. Request for hearing (RFH) Att. 3 (5/22/14 CMS ltr.); CMS Ex. 85 (7/3/14 CMS ltr.). The survey findings giving rise to this determination involve a single resident – Resident #4, or R4, "a woman in her 70s" who had "a number of health problems that include a bipolar mood disorder, chronic obstructive pulmonary disease, hypothyroidism, and hypertension." ALJ Decision at 3. Prior to her admission to NMS, R4 signed a Medical Power of Attorney (MPOA) document dated August 23, 2011 appointing her granddaughter D.G. as her representative and her daughter J.F. as the successor representative if D.G. "is unable, unwilling or disqualified to serve." P. Ex. 1, at 3; P. Ex. 24, at 1.[4] R4 was admitted to NMS on December 5, 2011. CMS Ex. 4 (SOD), at 8. On December 12, 2011, she was certified by two physicians as "unable to understand and sign admission documents and other information"; "unable to understand the nature, extent, or probable consequences of the proposed treatment or course of treatment"; "unable to make rational evaluation of the burdens, risks, and benefits of the treatment"; and "unable to effectively communicate a decision." P. Ex. 2.[5] The certification identified early dementia and depression as reasons for R4's incapacity. *Id.*[6]

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[2] The factual information in this section is drawn from the ALJ Decision and undisputed facts in the record and is presented to provide a context for the discussion of the issues raised on appeal.

[3] The SOD identified the scope and severity of all three deficiencies as "K," meaning a pattern of immediate jeopardy to resident health or safety. CMS Ex. 4, at 6, 12, 20.

[4] At the time she signed the MPOA document, R4 was residing in another facility to which she had been admitted on November 18, 2011. *See* P. Ex. 24, at 1. According to progress notes by a licensed social worker at that facility, the MPOA document became effective on the same date R4 signed it because "[a]t this time resident has been deemed incapable of understanding the nature and implications of health care decisions by psychiatrist and medical director" and "no longer has capacity to make independent health care decisions." *Id*. CMS did not question the validity of the MPOA document based on R4's stated condition at the time she signed that document. As noted later, a Maryland court ultimately upheld the validity of the MPOA document.

[5] The date of the first physician's signature appears to be 12/10/2012, and the second physician's signature is clearly dated 12/12/2011. P. Ex. 2; *see also* CMS Ex. 4, at 8.

[6] According to the SOD, "[w]hile the immediate jeopardy was still in effect, the facility staff clarified that the resident does not have dementia and that this diagnosis was listed in error." CMS Ex. 4, at 21. However, later certifications of R4's incapacity also indicate that R4 had dementia. *See* P. Exs. 6, 11, 12.

From the time she was admitted to NMS until January 2014, R4 "resided continuously in the non-restricted part of" the facility and "was free to come and go within the facility's premises." ALJ Decision at 3. R4 wore a "Wander Guard" that would set off an alarm if she attempted to leave the facility, but apparently did not attempt to elope while she resided on the unsecured unit. CMS Ex. 4, at 15; *see also id.* at 17 ("in all 12 scheduled assessments submitted to QIES [the Federal Quality Improvement Evaluation System] before resident #4 was moved to the secure unit and in all 4 scheduled assessments after . . . facility staff reported that resident #4 had not exhibited wandering behavior.")[7]

R4 was hospitalized on January 17, 2014 due to complaints of chest pain but was diagnosed with, and completed treatment for, a urinary tract infection. ALJ Decision at 4; P. Ex. 7, at 1. The hospital discharge papers for R4, dated January 22, 2014, the date she was discharged, state that "[t]he patient does not want to go to the nursing home" and "Pt having difficulty with return to facility. Pt escalated[.]" P. Ex. 7, at 1-2.[8] They further state that R4's primary care physician, who was also her attending physician at the hospital, "validat[ed] that incapacity concerns remain at this time" and continue:

> "Recommendation for incapacity being honored. Pt not showing ability to make sound decisions and [showing] lack of sense of reality. Pt also demonstrating loss of time, talking about events that are not current, lack of awareness of previous discussions or staff which have been present."

[7] The SOD further states, "Elopement risk for resident #4 was successfully managed for more than two years with the resident on an unsecured unit and with the use of behavioral interventions, an antipsychotic, and a 'Wander Guard' alarm system[.]" CMS Ex. 4, at 23. The SOD acknowledges that "a score over 10 means risk for elopement," and that R4 was assessed with an elopement risk over 10 once - on 5/17/12. CMS Ex. 4, at 17; *see also* CMS Ex. 9, at 117, 126.

[8] Petitioner's exhibit list (submitted 12/2/14) identifies P. Exhibit 7 simply as "Medical records from Meritus Medical Center" although the words "Draft Copy" appear in the lower right-hand corner. The hospital's case management progress notes for 1/22/14 use the same language as P. Exhibit 7 to describe R4's mental state at the time of her discharge. CMS Ex. 68, at 58.

Id.[9]

Upon her return to NMS, R4 was placed on NMS's secure, i.e., locked, unit, where she continued to reside through March 28, 2014. ALJ Decision at 4, 11. CMS found that NMS restricted access to R4 by R4's other daughter, M.A. (sometimes referred to in the record as M.G.), R4's "boyfriend" A.B., and attorney W.W, both before and after R4 was placed on the locked unit. ALJ Decision at 4; CMS Exs. 9 and 67.[10]

CMS imposed a $150 per-day CMP based on its determination that NMS failed to comply substantially at the less than immediate jeopardy-level with five participation requirements other than those for which it found noncompliance at the immediate jeopardy level. The ALJ ultimately addressed only the requirements in section 483.10(k), which requires a facility to provide a resident reasonable access to use of a telephone where calls can be made without being overheard, and section 483.75(*l*)(1), which sets out the requirements for the clinical records to be maintained by a facility on each resident. *Id*. at 14. The alleged noncompliance with the former involved R4 while the alleged noncompliance with the latter involved another resident, R60.

NMS requested a hearing before an ALJ to challenge CMS's determinations of noncompliance and the CMPs imposed. The parties exchanged pre-hearing briefs and proposed exhibits. *Id*. at 1. The ALJ ruled to exclude, either in whole or in part, certain exhibits proffered by NMS to which CMS had objected. Ruling on Motions to Exclude Certain of Petitioner's Exhibits and to Add a Witness (ALJ Ruling), dated 2/4/15.

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[9] The SOD refers to documentation that arguably supports CMS's more benign view of R4's mental condition. According to the SOD, "the hospital record [for R4's hospitalization on January 17, 2104] included documentation that resident #4 was alert, oriented, calm, cooperative, with no confusion, with appropriate behavior, able to understand and consent to anesthesia, able to understand and consent to a clinical procedure, and able to understand why a clinical test was cancelled." CMS Ex. 4, at 15. The discharge papers quoted above state that at the time of admission, R4 "was awake, alert with fair orientation." P. Ex. 7, at 1. In addition, the clinical records for R4's hospital stay include three consent forms signed by R4 (Informed Consent for Anesthesia Services, Consent for Procedure, and Emergency Treatment Consent). CMS Ex. 68, at 15, 17, 39. Further, according to the SOD, in Resident Assessment Instrument/Minimum Data Set assessments completed for R4 on 2/24/13, 9/5/13, and 1/22/14 (at 3:30 p.m.), "the staff documented that resident #4 was 'able to make decisions which are consistent and reasonable.'" CMS Ex. 4, at 21-22; *see also* CMS Ex. 9, at 21. Moreover, the SOD states that attorney W.W. reported to the Maryland Department of Health and Mental Hygiene that when he met with R4 in November and December of 2013, the resident appeared "clear-minded, oriented to time, place and person, and capable of conversing rationally and thoughtfully on matters of concern to [her]." CMS Ex. 4, at 9. However, NMS's Director of Nursing testified, "Sometimes, [R4] appears coherent, but within minutes, it is clear to me that she lacks the capacity to understand or make appropriate and reasoned choices." P. Ex. 17, at 2. Given the stark differences in the descriptions of R4's mental status in the record, resolution on summary judgment was not appropriate and the ALJ should consider the full record on remand and reach conclusions after weighing all the evidence.

[10] The November 23, 2011 progress notes from the facility where R4 was then residing described A.B. as "a significant other with whom [R4] has been involved…for ten years who has been visiting on a daily basis." P. Ex. 24, at 1.

The ALJ proceeded to schedule an in-person hearing. Shortly before the hearing was to begin, CMS filed a motion for summary judgment (MSJ), which NMS opposed. ALJ Decision at 2. The ALJ entered summary judgment for CMS based on what he found were undisputed material facts: 1) NMS confined R4 in a secure unit against her will and restricted access to her by members of her immediate family and others, including an attorney who sought to provide her with legal counsel; 2) there were no assessments or explanations in R4's treatment records of medical or clinical reasons for these actions; 3) none of the written testimony offered by NMS identifies any clinical facts that would show that NMS actually assessed R4 as needing to be confined or have visitors' access to her restricted; and 4) NMS took the actions in question at least in part at the request of J.F., the daughter R4 named in the MPOA document as her representative if D.G. "is unable, unwilling or disqualified to serve."[11] *Id.* at 4-6. The ALJ concluded that these facts established that NMS was not in substantial compliance with the regulations at sections 483.13, 483.10(j)(1)-(2), and 483.20(k)(3)(i). The ALJ further concluded that CMS's finding that this noncompliance posed immediate jeopardy was not clearly erroneous and that the $5,650 per-day CMP was reasonable in amount. *Id.* at 11-12. In addition, the ALJ upheld CMS's imposition of the $150 per-day CMP, finding that the undisputed material facts established NMS's noncompliance at a less than immediate jeopardy level with the participation requirements at sections 483.10(k) and 483.75(*l*)(1). *Id*. at 13-14. The ALJ stated that establishing noncompliance with even one requirement would be sufficient to sustain the $150 per-day CMP so it was unnecessary to resolve whether NMS failed to comply with other requirements on which also CMS relied in imposing that CMP. *Id*. at 13.[12]

Standard of Review

We review an ALJ's grant of summary judgment de novo, construing the facts in the light most favorable to the petitioner and giving the petitioner the benefit of all reasonable inferences. *See Pearsall Nursing & Rehab. Ctr. – N.*, DAB No. 2692, at 5 (2016), citing *Livingston Care Ctr*., DAB No. 1871, at 5 (2003), *aff'd, Livingston Care Ctr. v. U.S. Dept. of Health & Human Servs*., 388 F.3d 168, 172-73 (6th Cir. 2004). Summary judgment is appropriate when there is no genuine dispute about a fact or facts material to the outcome of the case and the moving party is entitled to judgment as a matter of law. *Celotex Corp. v Catrett*, 477 U.S. 317, 322-25 (1986). The party moving for summary judgment (here, CMS) has the initial burden of demonstrating that there is no genuine issue of material fact for trial and that it is entitled to judgment as a matter of law.

[11] Except where otherwise indicated, all references in the record to R4's power of attorney (POA) appear to be to J.F., not D.G.

[12] The ALJ Decision notes that CMS alleged noncompliance with four participation requirements as a basis for imposing the $150 per-day CMP. ALJ Decision at 13. It appears that the ALJ determined that CMS was not relying on a fifth participation requirement, identified in the MSJ as tag number F-501, because the MSJ listed it as a deficiency but did not discuss it. *See* MSJ at 18-20.

Celotex, 477 U.S. at 323. If the moving party carries that burden, the non-moving party must "come forward with 'specific facts showing that there is a genuine issue for trial.'" *Matsushita Elec. Indus. Co. v. Zenith Radio Corp.*, 475 U.S. 574, 587 (1986) (quoting Rule 56(e) of the Federal Rules of Civil Procedure).[13]

"To defeat an adequately supported summary judgment motion, the non-moving party may not rely on the denials in its pleadings or briefs, but must furnish evidence of a dispute concerning a material fact – a fact that, if proven, would affect the outcome of the case under governing law." *Senior Rehab. & Skilled Nursing Ctr.*, DAB No. 2300, at 3 (2010), *aff'd*, *Senior Rehab. & Skilled Nursing Ctr. v. Health & Human Servs.*, 405 F. App'x 820 (5th Cir. 2010). A party "must do more than show that there is 'some metaphysical doubt as to the material facts . . . . Where the record taken as a whole could not lead a rational trier of fact to find for the nonmoving party, there is no 'genuine issue for trial.'" *Mission Hosp. Reg'l Med. Ctr.*, DAB No. 2459, at 5 (2012) (quoting *Matsushita*, 475 U.S. at 587), *aff'd*, *Mission Hosp. Regional Med. Ctr. v. Sebelius*, No. SACV 12-01171 AG (MLGx), 2013 WL 7219511 (C.D. Cal. 2013), *aff'd sub nom. Mission Hosp. Reg'l Med. Ctr. v. Burwell*, 819 F.3d 1112 (9th Cir. 2016). In examining the evidence to determine the appropriateness of summary judgment, an ALJ must draw all reasonable inferences in the light most favorable to the non-moving party. *Brightview Care Ctr.*, DAB No. 2132, at 2, 9 (2007). Drawing factual inferences in the light most favorable to the non-moving party does not require that an ALJ draw unreasonable inferences or accept the non-moving party's legal conclusions. *Brightview* at 10; *Cedar Lake Nursing Home*, DAB No. 2344, at 7 (2010).

Our standard of review on a disputed issue of law is whether the ALJ decision is erroneous. *Guidelines – Appellate Review of Decisions of Administrative Law Judges Affecting a Provider's Participation in the Medicare and Medicaid Programs*, available at https://www.hhs.gov/about/agencies/dab/different-appeals-at-dab/appeals-to-board/guidelines/participation/index.html#development.

Analysis

Below we address the participation requirements as to which CMS alleged noncompliance in moving for summary judgment, setting out 1) the facts on which CMS relied, 2) which of those facts NMS disputed, and 3) whether the evidence is sufficient to raise a genuine dispute regarding those facts. We first address each of the three

[13] Effective December 10, 2010, Rule 56 of the Federal Rules of Civil Procedure was "revised to improve the procedures for presenting and deciding summary-judgment motions and to make the procedures more consistent with those already used in many courts." Committee Notes on Rules - 2010 Amendment, available at http://www.law.cornell.edu/rules/frcp/rule_56. The revisions alter the language of the rule, but the "standard for granting summary judgment remains unchanged." *Id.* The Federal Rules of Civil Procedure are not directly applicable to administrative proceedings such as this case, but together with related case law, they provide guidance for determining whether summary judgment may be appropriate in administrative proceedings.

participation requirements as to which CMS alleged immediate jeopardy-level noncompliance. We then address the status of the ALJ's determination upholding CMS's finding that NMS's noncompliance with these three participation requirements posed immediate jeopardy. Next, we address the two participation requirements considered by the ALJ as to which CMS alleged less than immediate jeopardy level-noncompliance. Finally, we address NMS's objections to the ALJ's evidentiary rulings and conclude that, with the exception of three exhibits, it was an abuse of discretion for the ALJ to exclude the exhibits at issue. Thus, to the extent that NMS relied on them, we consider the improperly excluded exhibits in our analysis of the substantive issues in the case.

I. NMS raised genuine disputes of material fact with respect to the alleged noncompliance with 42 C.F.R. § 483.13.

A. CMS's motion for summary judgment

Section 483.13, captioned "Resident behavior and facility practices," provides in part:

> (b) *Abuse*. The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.
>
> (c) *Staff treatment of residents*. The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.
>
> (1) The facility must—
>
> (i) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. . . .

(Emphasis added.) In its MSJ, CMS alleged that NMS's placement of R4 in its secure unit when she was readmitted to NMS after a brief hospital stay resulted in her involuntary seclusion, stating in relevant part as follows:

> Petitioner's placement of R4 in the secure unit was against her will as she clearly expressed that she did not want to be there. CMS Ex. 9 at 143; CMS Ex. 67 at 8 (Decl. of V. Macin at ¶12); CMS Ex. 67 at 36 (Decl. of B. Varacalle at ¶11). Indeed, there is no evidence Petitioner involved R4 in any way in its decision to transfer her to the secure unit despite the fact that Petitioner was quite capable of making some of her own decisions.
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> CMS demonstrated that R4 was living in the unsecured part of the facility from her original admission to the facility in December 2011 until Petitioner transferred her to the secured portion of the facility in January 2014. CMS Ex. 9 at 5 (Original admission 12/2011); CMS Ex. 9 at 140 (moved to locked unit 1/22/2014). The clinical record demonstrates that there was no significant change in R4's condition or behavior that would warrant placing her in a secured unit.

> CMS Ex. 81 (MDS assessments for R4 from April 22, 2013 through August 15, 2014). Indeed, the formal assessments completed by Petitioner's staff demonstrated that R4 had experienced no significant change in condition. (CMS Ex. 67 at 49-50, Decl. of M. Paugh at ¶¶9-11).
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> * * * * * * *
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> The facility's policies and procedures state the facility "accepts patient into the secure units when clinically indicated and appropriate based on Hospital assessment. Factors considered are: Hospital [history and physical], Wandering, Other Behaviors, Elopement Risk."[] CMS Ex. 39. Resident 4 did not exhibit changes in any of the criteria the facility had identified as triggering placement in the facility's secured unit. CMS Ex. 9; CMS Ex. 81; CMS Ex. 67 at 49-50, Decl. of M. Paugh at ¶¶9-11.
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> Moreover, ... Petitioner's own policies and procedures required that residents are to be assessed to determine that the resident has a clinical need to be in the secure unit. CMS Ex. 62. In the expert opinion of [CMS witness] Dr. Nay, Petitioner failed to comply with the requirement at F-223 because it failed to perform a proper assessment whether or not R4's placement in the secure unit was clinically necessary. CMS Ex. 87 at ¶¶25-38. . . . .R4's clinical record reveals that staff failed to assess R4 before they placed her in the secured unit to determine whether or not such placement was clinically necessary. CMS Ex. 9. By the admissions of Petitioner's own staff and [] by the admission of the POA [power of attorney], Petitioner placed R4 in a secured unit only because the resident's health care POA requested such placement, . . . not because facility staff had determined it was "proper" or "clinically necessary" to transfer R4 to the secure unit prior to her placement. [multiple citations omitted]

MSJ at 8-11 (emphasis added).

B. NMS's response to CMS's motion for summary judgment

In its response to the MSJ, NMS did not dispute that to prove its compliance with the requirement in section 483.13 that a resident must be free from involuntary seclusion, it must show that, prior to placing Resident 4 in the secure unit, NMS staff assessed her clinical condition as required by its policy on secure units. However, NMS maintained that there are material facts in dispute which preclude summary judgment on this issue. NMS asserted that it did not place R4 in the secure unit only because the daughter who was R4's POA wanted her there. Response to MSJ at 8. Rather, NMS said, facility staff assessed R4 prior to her placement in the secure unit and determined that that placement was clinically beneficial. *Id*. In addition, NMS argued that "[s]imply because there was no contemporaneous documentation of the decision-making process does not equate to no decision-making process." *Id*. According to NMS, several written statements it

proffered in lieu of direct testimony attest to the fact that NMS assessed R4 and demonstrate that it employed a "thoughtful and deliberative. . . decision-making process." *Id*. at 2. In particular, NMS relied on the following testimony of S.C., "the nurse practitioner who cared for Resident 4 bimonthly and more frequently as required":

> I participated in the Interdisciplinary Team that made the decision that it was in Resident #4's best interest after her acute hospitalization to readmit to our facility on that [secure] unit. This was done in concert with the assessment done by our medical director and was agreed to enthusiastically by the Resident's POA. We all believed that this placement was clinically beneficial and in the resident's best interest. This conversation occurred on the date of her readmission to the facility, which is why Resident #4 was placed on the secure unit.

Id. at 3, quoting P. Ex. 28, ¶7 (NMS's emphasis omitted).

NMS also relied on the following testimony of B.S., the Director of Nursing (DON):

> In January 2014, after returning from an acute episode in the Hospital, our Interdisciplinary Team informally determined . . . with input from her POA that it would be in [R4's] best interest for her to be admitted to our secure unit. . . .

Id., quoting P. Ex. 17, ¶13.

NMS further relied on the following testimony of Dr. Waseem, who it identified as "Resident 4's attending physician [who] has cared for her since admission":

> Anytime a resident has been deemed incapable, we always reconfirm that finding at each visit, when we look for changes in condition. . . . The decision [for placement in a secure unit] was made by Resident #4's Interdisciplinary team and in consultation with Resident #4's POA, who was responsible for making healthcare decisions, including where to receive care.

Id. at 4, quoting P. Ex. 32, ¶ 27.

NMS also relied on the testimony of Dr. Crecelius, one of its two medical experts. *Id*. at 5. According to NMS, Dr. Crecelius's testimony "refutes" Dr. Nay's conclusion that NMS did not follow any process or procedure to determine whether it was appropriate to place R4 in the secure unit. *Id*. NMS did not specifically identify the parts of Dr. Crecelius's testimony it considered relevant; however, we note that Dr. Crecelius's testimony relies on much of the testimony of Dr. Waseem, nurse practitioner S.C., and DON B.S. discussed above. P. Ex. 26, ¶ 24 (citing P. Ex. 32, ¶¶ 6-11) and ¶ 25 (citing P. Ex. 28, ¶7; P. Ex. 17, ¶13).

NMS further alleged that a "physician's order for a Haldol injection to manage [R4's] escalating behaviors and psychological decompensation" prior to her discharge from the hospital on January 22, 2014 was evidence that R4 "experienced a significant clinical change" and "would elope from the Facility if able." Response to MSJ at 10. NMS stated that the SOD "notes that just prior to discharge from the hospital, Resident 4 'became very upset and was documented as very confused,' and the treating physician ordered one mg of Haldol to be administered intramuscularly." *Id*. at 7 n.3, citing P. Ex. 13, at 14.[14] NMS also quoted the testimony of its medical expert Dr. Haimowitz stating that "[b]ecause of the serious risk of harm from elopement or being taken from the Facility without medical approval, I concur with the other medical opinions that it was entirely appropriate to keep [R4] in a secure unit." *Id*. at 6, quoting P. Ex. 30, ¶ 29 (NMS's emphasis omitted). (Elsewhere in his declaration, but not quoted by NMS, Dr. Haimowitz stated that R4 "required placement in a secure unit when she was readmitted on January 22, 2014, because she was acutely delusional and her psychotic episodes were escalating." P. Ex. 30, ¶26.)

C. The ALJ's holding on summary judgment

The ALJ concluded that there was no genuine dispute that NMS placed R4 in the secure unit without assessing R4's clinical condition because NMS admitted that it did not document any evaluation or assessment of R4 showing that her placement in the secure unit was clinically necessary. *See* ALJ Decision at 5. In the ALJ's view, this admission is dispositive because there was a legal requirement for such documentation. The ALJ Decision states in relevant part:

> An absolutely essential element of a skilled nursing facility's obligation to a resident is that it document the care that it provides to its residents. Failure to do so is grounds to conclude that the care was not provided. *River City Care Ctr*., DAB No. 2627, at 9 (2015); *Evergreene Nursing Care Ctr*., DAB No. 2069, at 25 (2007) citing *Western Care Mgmt. Corp. d/b/a Rehab Specialties Inn*, DAB No. 1921, at 48 (2004). Furthermore, a skilled nursing facility is required by law to prepare a comprehensive plan of care that lays out in precise detail the problems that the resident is experiencing and explains how the facility intends to address those problems. 42 C.F.R. § 483.20. That plan of care must be based on a

[14] The ALJ excluded P. Exhibit 13 on the ground that it was an earlier draft of the SOD. ALJ Ruling at 6. The final SOD, signed by NMS's representative on May 27, 2014, is at CMS Exhibit 4. As relevant here, the final SOD states that "the physician responsible for the resident in both the nursing home and hospital, ordered that hospital staff administer chemical restraint (Haldol 1 mg IM stat) in order to effectuate the transfer back to the nursing home against resident #4's stated wishes." CMS Ex. 4, at 16. Neither party provided a record cite for the physician's order itself, and we could not locate any such order in the record. However, CMS has not disavowed the quoted statement.

> comprehensive and detailed assessment. *Id*. The regulation may not state explicitly that the assessment and care plan must be in writing but it is inconceivable that a facility would develop an oral plan that is not memorialized in writing. That simply defies common sense.
>
> Moreover, in this case Petitioner had a written plan of care for Resident # 4. CMS Ex. 9 at 38-50. That plan is devoid of any mention of Petitioner's decision to confine Resident # 4 . . . .

Id. at 5-6. The ALJ also concluded that "even if there is no legal requirement that a facility memorialize its assessments in writing, Petitioner has offered no facts showing that it actually assessed Resident # 4 and concluded that confinement [in the secure unit] . . . [was] necessary based on actual clinical findings." *Id.* at 6. The ALJ stated that nurse practitioner S.C. "points to zero clinical evidence that supports her conclusion" and "merely avers that there was an assessment without saying what facts were adduced, how they were evaluated, or why the facility's staff came to conclusions that she avers they came to." *Id*. The ALJ also stated that DON B.S. "merely reiterates [S.C.]'s unfounded conclusion." *Id*. at 7. The ALJ further stated that Dr. Waseem "does not recite any specific reason for confining the resident," does not "recite clinical findings about the resident's condition," and "suggests nothing that shows that the resident's condition changed after her hospitalization in a way that necessitated confinement." *Id*. In addition, the ALJ pointed to Dr. Waseem's statement (not quoted by NMS) that "[s]hortly after the placement and since that time, I concurred with the facility's assessment of the placement on the secure unit and believe it was in the patient's best interest." *Id*. (ALJ's emphasis omitted). The ALJ viewed this as an admission by Dr. Waseem that "his evaluation – whatever he might have done – was made after the fact," providing "no support for Petitioner's assertion that it assessed the resident *before* it confined her." *Id*. (emphasis in ALJ Decision).

Finally, the ALJ rejected NMS's argument that the fact that R4 received a prescription for Haldol during her hospital stay is clinical evidence that justified her placement in the secure unit upon her readmission to NMS, stating:

> [T]here is nothing in the facility's records suggesting that the resident's prescription was considered as a reason for confining her. Indeed, none of Petitioner's staff now assert that they decided to confine her for that reason.

Id. at 9.

D. Discussion

1. The ALJ erred as a matter of law in concluding that CMS was entitled to summary judgment in its favor based on the undisputed fact that NMS lacked contemporaneous documentation that, before placing R4 in the secure unit, NMS staff assessed R4's clinical condition as required by NMS's policy on secure units.

As noted, NMS did not dispute that it lacked contemporaneous documentation showing that prior to placing R4 in the secure unit, it assessed her clinical condition and determined that such a placement was appropriate, but asserted that other evidence established that it performed such an assessment. We conclude that the ALJ erred in granting summary judgment in CMS's favor based on the undisputed lack of such contemporaneous documentation. As explained below, neither the regulation nor the Board decisions on which the ALJ relied support the conclusion that such a showing can be made only by contemporaneous documentation. Accordingly, the lack of contemporaneous documentation is not dispositive here.

We note preliminarily that the ALJ did not find, nor did CMS assert in its MSJ, that there is a requirement for contemporaneous documentation in the NMS policies and procedures requiring an assessment to determine if the resident has a clinical need to be in a secure unit. Nor does anything in the language of the policies and procedures suggest that contemporaneous documentation of such an assessment is always required. The ALJ nevertheless concluded that there is a "legal requirement that a facility memorialize its assessments in writing," relying in part on the requirement in 42 C.F.R. § 483.20(k) that a facility have a "plan of care that is based on a comprehensive and detailed assessment." ALJ Decision at 5-6. As noted above, the ALJ acknowledged that the regulation "may not state explicitly that the assessment and care plan must be in writing" but stated that it "defies common sense" to find otherwise. *Id*. at 6. We disagree for the following reasons.

First, the regulation on which the ALJ relied does not refer to the type of assessment at issue here. The "comprehensive assessment" to which section 483.20(k) refers is a "comprehensive . . . assessment of each resident's functional capacity" that is performed "using the resident assessment instrument (RAI) specified by the State." Section 483.20 (lead-in language and paragraph (b)(1)). A comprehensive assessment must generally be performed within 14 calendar days after a resident's admission or a return to the facility following a temporary absence for hospitalization where there has been a significant change in the resident's physical or mental condition. Section 483.20(b)(2)(i). On its face, NMS's policy on secure units does not require this type of assessment, but simply states that "[r]esidents who are being admitted to the facility are assessed for needs by

clinical staff" and that "[i]f it is determined that a resident has clinical need for a secure unit . . . , the resident will be placed on that unit." CMS Ex. 62, at 1. Moreover, CMS did not allege that the comprehensive assessment described in section 483.20(b)(2)(i) is required before a resident may be placed on a secure unit.

Second, the Board decisions cited by the ALJ do not support his conclusion that NMS was required to have contemporaneous documentation of an assessment regarding a resident's clinical need for placement on a secure unit. In each of these decisions, the Board remarked on the lack of documentation in upholding a finding by CMS that an order was not communicated or a service not provided but did not hold that the lack of documentation alone was dispositive. In *River City Care Ctr*., the facility claimed that the resident's physician had given a PRN instruction for oxygen in a telephone order although that instruction was not reflected in the telephone order recorded by the nurse. The Board found no error in the ALJ's finding that no order for oxygen was given, stating: "The Board has generally been unwilling to accept that treatments that are not documented have nevertheless been performed, and similarly here, we are not willing to assume that an order that was not documented at the facility was nevertheless communicated to and complied with by the nursing staff, absent credible evidence of such communication." DAB No. 2627, at 9. In *Evergreene Nursing Care Center*, the Board concluded that the nursing staff's failure to mark boxes on the resident's routine treatment chart for five shifts to indicate that bed or chair alarms were provided was prima facie evidence that the facility failed to provide the resident with those alarms, and further concluded that the facility failed to overcome that prima facie showing by a preponderance of the evidence, stating: "Evergreene provided no evidence . . . that the unmarked boxes on the . . . routine treatment chart represented a mere failure to complete paperwork. It also provided no documents or testimony explaining the procedures that the nursing staff followed, or were expected to follow, to ensure that this chart was accurate and complete. In addition, Evergreene's witnesses did not deny that the nursing staff was expected to make an accurate record of when it provided an ordered safety alarm." DAB No. 2069, at 26. In *Western Care Management Corp. d/b/a Rehab Specialties Inn*, the Board rejected the facility's contention that a nurse flushed a catheter a second time "and simply failed to document this event," stating that a factfinder "is entitled to assume, absent contrary evidence, that a resident's medical records accurately reflect the care and services provided (or not provided)." DAB No. 1921, at 48. Thus, in each case, the Board indicated that alternative forms of evidence might have been used to establish that an order was communicated or a service was performed in absence of documentation directly showing that.[15]

[15] Moreover, in *Evergreene*, the Board noted that CMS had argued that "if a facility routinely maintains (or is obligated to maintain) a treatment record whose purpose is to confirm that a necessary medical item or service has been provided (as ordered) during a particular shift, and that treatment record fails to indicate positively that the item or service was provided during the shift, then the fact-finder may presume, absent credible evidence to the contrary, that the item or service was not provided." *Id*. at 24-25. Thus, in that case, CMS did not take the position that the absence of contemporaneous documentation that an item or service was provided is necessarily dispositive.

In the proceedings before us, CMS relies on other Board decisions which it says "have found that the lack of contemporaneous documentation to support a significant event or an important clinical decision constitutes a failure to rebut CMS' prima facie case." CMS Surreply at 2-3, citing *John J. Kane Regional Ctr. – Glen Hazel*, DAB No. 2068 (2007), *The Laurels at Forest Glen*, DAB No. 2182 (2008), and *Woodstock Care Ctr.*, DAB No. 1726 (2000). However, CMS mischaracterizes the holding in these decisions. In *John J. Kane Regional Ctr.*, the facility argued that its nursing staff stopped CPR because it was apparent that the resident could not be resuscitated. The Board rejected that argument not only because there was no contemporaneous documentation of the nursing staff's reasons for pronouncing death but also on other grounds, including that "none of the witnesses who participated (or may have participated) in the decision to pronounce Resident 1's death provided an account of their decision-making." DAB No. 2608, at 16. In *The Laurels at Forest Glen*, the Board noted that the facility "submitted no contemporaneous documentation . . . indicating that [as argued by the facility] at the time staff considered [the resident]'s symptoms and behaviors attributable to the Percocet or to lack of sleep" but went on to state that the ALJ could reasonably determine that the nurse's testimony that she attributed his condition to these factors "was not reliable." DAB No. 2182, at 26-27. In *Woodstock Care Center*, the facility's former DON testified that a visitor held the door open for a resident who eloped, but the Board noted that contemporaneous nursing notes about the incident contained no mention of staff observing the resident's departure, that other existing documentation was inconsistent with additional facts to which the former DON testified, and that the former DON's account of the incident "was internally inconsistent or vague on a number of details." DAB No. 1726, at 12. The Board concluded that the "ALJ could reasonably credit the facility's own documentation made at a time when litigation was not pending, above the later testimony of a former administrator who did not even claim to have directly observed the events . . . ." *Id*. at 13. Contrary to what CMS argues, these decisions reflect the Board's view that in the absence of contemporaneous documentation of a disputed fact, an ALJ may consider testimonial evidence. An ALJ may, in appropriate circumstances, find that the lack of documentation undercuts the credibility of contrary testimony about what was done or considered. But here in granting summary judgment, the ALJ disregarded testimony and drew negative inferences against the non-movant by giving overriding weight to the absence of contemporaneous documentation.

Thus, in the case now before us, CMS at most made out a prima facie case based on the absence of contemporaneous documentation that NMS staff did not assess R4's clinical condition as required by NMS's policy on secure units, and NMS should have an opportunity to rebut that prima facie case.

2. **The ALJ erred in finding that the written direct testimony proffered by NMS was insufficient to raise a genuine dispute of material fact as to whether, before placing R4 in the secure unit, NMS staff assessed her clinical needs as required by NMS's policy on secure units.**

In essence, CMS's position that NMS violated the prohibition on involuntary seclusion in section 483.13 relied on the following allegations of fact:

- R4 was placed in the secure unit against her will.

- R4 experienced no significant change in condition or behavior that would warrant placing her in a secure unit.

- R4 did not meet any of the criteria for admission to the secure unit identified in NMS's Admission Criteria policy (CMS Exhibit 39).

- NMS staff failed to assess R4 before they placed her in the secure unit to determine whether or not that placement was clinically necessary as required by NMS's Secure Units policy (CMS Exhibit 62).

NMS did not dispute that R4 was placed in the secure unit against her will, but argued that this placement did not constitute an "involuntary seclusion" within the meaning of the regulation because it was "requested by the resident's legal representative in combination with the Facility's independent determination" and a "valid POA stands in the shoes of a resident and speaks for that resident." RR at 12-13 (citing definition of "involuntary seclusion" in CMS's State Operations Manual); *see also* NMS's Pre-Hearing Br. at 12 (quoting same). NMS also disputed CMS's other allegations, alleging instead that—

- R4 experienced a change in behavior prior to her discharge from the hospital.

- R4's changed behavior demonstrated that she was an elopement risk, one of NMS's criteria for admission to the secure unit.

- Before placing R4 in the secure unit, NMS's interdisciplinary team assessed R4 and determined that the placement was clinically necessary.

As noted above, to defeat a motion for summary judgment, the non-moving party must show that there is a genuine dispute as to the material facts, viewing the evidence in the record in the light most favorable to it and drawing all reasonable inferences in its favor. We conclude that the testimony of Dr. Waseem, nurse practitioner S.C., and DON B.S.,

together with SOD's description of the circumstances under which Dr. Waseem ordered a Haldol injection for R4 immediately before she was discharged from the hospital, raise a genuine dispute as to material facts identified in the MSJ and that the ALJ therefore erred in concluding on summary judgment that NMS was not in compliance with the requirements of section 483.13.

The ALJ determined that the testimony of Dr. Waseem, nurse practitioner S.C., and DON B.S. was insufficient to raise a dispute of fact because it did not describe R4's clinical condition or explain why the interdisciplinary team decided that placing R4 in the secure unit was appropriate, and, in the case of Dr. Waseem's testimony, did not indicate that he personally participated in the interdisciplinary team's meeting. *See* ALJ Decision at 6-7. However, as noted above, in ruling on a motion for summary judgment, an ALJ must consider whether the record as a whole could lead a rational trier of fact to find for the non-moving party, viewing the evidence in the light most favorable to that party and drawing all reasonable inferences in that party's favor. Based on S.C.'s and B.S.'s testimony that the interdisciplinary team met on the date of R4's readmission to NMS and decided that it would be in R4's "best interest" to place her on the secure unit, the ALJ could have reasonably inferred that the assessment required by NMS's policies and procedures was made. Although Dr. Waseem did not participate in the interdisciplinary team meeting, the ALJ could have reasonably inferred that his testimony reflects what S.C. and/or B.S. told him transpired at the meeting, thus corroborating their testimony.[16] Moreover, the reference in S.C.'s and B.S.'s testimony to a determination of R4's "best interests" could reasonably be viewed as a reference to a consideration of R4's clinical condition. Although neither S.C. nor B.S. identified a specific clinical condition as the basis for the interdisciplinary team's alleged determination that it was appropriate to place R4 in the secure unit, we conclude that that level of specificity was not necessary to raise a dispute of material fact. As the Board has previously stated, "while the ALJ might ultimately find [the facility's] evidence too vague or unreliable without further explanation, the proffer [of such evidence] is enough to raise a dispute of fact . . . ." *Madison Health Care, Inc*., DAB No. 1927, at 11 (2004).

CMS argued in its MSJ that "even when viewing the evidence in the light most favorable to Petitioner, the evidence here is so one-sided that Petitioner has failed to establish that there is a genuine factual dispute. Celotex, 477 U.S. at 323-24." MSJ at 11. CMS pointed to the absence of "contemporaneous documentation [that] Petitioner's staff performed an assessment of R4 to determine whether she was appropriate for the secure

[16] CMS argues that Dr. Waseem's testimony to this effect is inconsistent with S.C.'s testimony that the interdisciplinary team's decision was made "in concert with the assessment done by the medical director [Dr. Waseem]." CMS response to RR at 15-16, quoting P. Ex. 28, at 1-2. However, CMS points to no reason why the interdisciplinary team's assessment could not rely on a prior assessment of R4's clinical condition by Dr. Waseem (e.g., his assessment based on her behavior immediately prior to her discharge from the hospital).

unit." *Id*. at 13. As discussed above, however, testimonial evidence can sometimes properly be used to establish that facility staff took an action for which there is no contemporaneous documentation. CMS also argued that "Petitioner's assertions that it moved R4 to the secure unit because staff determined she had suddenly become an elopement risk are belied by the record." *Id*. According to CMS, for example, "in the multiple MDS assessments of R4, both before and after R4 was placed on the secure unit, NMS repeatedly assessed R4 with no wandering signs and symptoms, an important measure of potential elopement risk." *Id*. at 14. As noted above, however, NMS proffered evidence about R4's behavior immediately preceding her discharge from the hospital to show that she was an elopement risk.[17] Even if there is other evidence in the record that arguably supports a finding that R4 did not experience a change in her clinical condition at that time, it was not the ALJ's role to weigh the evidence in ruling on CMS's motion. *See, e.g.*, *Madison*, DAB No. 1927, at 6 ("the ALJ deciding a summary judgment motion does not 'make credibility determinations, weigh the evidence, or decide which inferences to draw from the facts,' as would be proper when sitting as a fact-finder after a hearing, but instead should 'construe the record in the light most favorable to the nonmovant and avoid [] the temptation to decide which party's version of the facts is more likely true.' *Payne v. Pauley*, 337 F.3d 767, 770 (7th Cir. 2003)."). Accordingly, we conclude that NMS raised a genuine dispute of material fact by proffering testimonial evidence that the interdisciplinary team met prior to R4's placement in the secure unit and determined based on an assessment of R4's clinical condition that placing her in that unit was appropriate.

As noted above, NMS also argued that it was within the POA's scope of authority to consent to R4's placement in the secure unit and therefore the placement did not constitute an "involuntary seclusion" within the meaning of section 483.13. The State Operations Manual (SOM), on which NMS relied, defines "involuntary seclusion" as "separation of a resident from other residents or from her/his room or confinement to her/his room . . . . against the resident's will, or the will of the resident's legal representative." P. Ex. 23, at 3.[18] This definition does not specifically address whether the separation of an incompetent resident in a secure unit would be considered an involuntary seclusion if the resident's legal representative considered it appropriate but the resident did not consent personally. Nevertheless, we conclude that NMS raised a genuine dispute of material fact as to whether R4's placement in the secure unit was involuntary within the meaning of section 483.13. NMS proffered a September 23, 2014

[17] In addition, NMS alleged in its pre-hearing brief that R4 "experienced 'worsening psychiatric symptoms' throughout December 2013 with an increased frequency of delusions." P. Pre-hearing Br. at 12, citing P. Ex. 25 (Mental Health Progress Notes). (NMS actually cited to P. Ex. 24, but this appears to be a typographical error.)

[18] NMS provided an excerpt from the April 4, 2014 revision of Appendix PP of the SOM that included this provision. CMS did not argue that this version of the provision did not apply here.

Order issued by the Circuit Court for Washington County, Maryland holding in relevant part that the Medical Power of Attorney document signed by R4 on August 23, 2011 authorized the POA to "consent to [R4's] medical treatment, including her treatment at NMS . . . , including but not limited to, the decision of which room and unit [R4] may occupy while a resident in that facility[.]" P. Ex. 1, at 1-2. The ALJ could reasonably infer from the holding in the court order - that it was within the POA's scope of authority to consent to R4's placement in the secure unit - that NMS did not violate section 483.13 because it placed her in the secure unit with the POA's consent.

II. NMS raised genuine disputes of material fact material with respect to the alleged noncompliance with section 483.10(j)(1)-(2).

A. CMS's motion for summary judgment

Section 483.10(j) provides in pertinent part:

> (1) The resident has the right and the facility must provide immediate access to any resident by the following:
>
> * * * *
>
> (vii) Subject to the resident's right to deny or withdraw consent at any time, immediate family or other relatives of the resident; and
> (viii) Subject to reasonable restrictions and the resident's right to deny or withdraw consent at any time, others who are visiting with the consent of the resident.
> (2) The facility must provide reasonable access to any resident by any entity or individual that provides health, social, legal, or other services to the resident, subject to the resident's right to deny or withdraw consent at any time.

In its MSJ, CMS alleged that NMS failed to comply with these regulatory provisions based on the following undisputed facts:

> CMS established that the facility was restricting R4's visitors based exclusively on the health care POA's request that certain visitors be entirely prohibited from visiting R4. The facility restricted visitation by one of R4's daughters [M.A.] and R4's boyfriend…. Additionally, the facility restricted visitation by [W.W., an attorney]. . . . The documentation is clear that the reason the facility restricted R4's family visitors is that the health care POA had decided this particular daughter and R4's boyfriend were not allowed to visit R4. . . . Similarly, the documentation is clear that the reason the facility restricted [W.W.] is that the facility determined it would honor the healthcare POA's request that R4 not be allowed to receive certain outside visitors. . . .

MSJ at 4.[19]

In support of its allegations that NMS denied R4's daughter M.A. and R4's boyfriend A.B. access to R4, CMS cited nursing notes dated November 14 and 15, 2012 and a social service note dated November 14, 2012. *Id*. at 4, citing CMS Ex. 9, at 17, 23, 115. The November 14 nursing note states: "resident['s] daughter [M.A.] was in facility and according to the resident['s] POA she isn't allowed to visit resident and unit manager and [Social Services] asked her to leave facility. . . . resident['s] POA was updated about situation. will continue to monitor and report any changes." CMS Ex. 9, at 17. The social service note for the same date states: "Met with family member [M.A.] who is not allowed in the facility without [D.]. [D.] was not with her at this time. … POA stated, Do not allow[] [M.A.] in the facility without her or [D.]. Social Services and Unit Manager asked [M.A.] to leave the facility…." *Id*. at 115. The nursing note for the next day states: "Resident had visitors that wasn't allowed to visit, [R4's boyfriend] and [M.A.]. Family found packing up residents clothing and personal belongings. Week-end house supervisor notified of what was going on and supervisor came and approached family members and made them aware that this was not allowed and they should not be here per [POA]." *Id*. at 23.

In support of its allegation that NMS denied attorney W.W. access to R4, CMS cited an e-mail sent by NMS's Associate General Counsel to W.W. on December 10, 2013. MSJ at 5-6, citing CMS Ex. 82. The e-mail refers to an earlier visit by W.W. to R4 when he was asked by staff to leave and states, "although residents do have rights to visitation and legal counsel," the POA is R4's "duly appointed attorney-in-fact" and NMS must honor the POA's "refus[al] to allow an outside visitor" unless W.W. is "granted authority that supersedes that of" the POA. CMS Ex. 82.

B. NMS's Response to the MSJ

NMS took the position that the "facts regarding visitation are completely in dispute." Response to MSJ at 11. NMS asserted that evidence that M.A. and R4's boyfriend were asked to leave after their "attempted abduction" of R4 more than two years prior to the survey does not establish that any family member or friend was prohibited from visiting R4. *Id*. NMS further asserted that it instead employed "appropriate restrictions" on access to R4 by M.A., by R4's boyfriend, and by W.W. *Id*. According to NMS, "it has the right and the obligation to restrict the visits of an attorney who was in the process of abusing a mentally-incapacitated resident, knowingly or unknowingly, and a daughter who attempted to kidnap her mother." *Id*. at 12. NMS alleged specifically that W.W.

[19] CMS did not expressly cite the regulation but instead stated that NMS was not in substantial compliance with "F-172." F-172 is the tag number used in the SOD to identify deficiencies under section 483.10(j)(1) and (2). *See* CMS Ex. 4, at 6.

"surreptitiously attempted to have this incapacitated resident revoke her valid POA," entering the facility without contacting any staff member. *Id*. at 11-12. NMS asserted that the restrictions it imposed on M.A.'s and W.W.'s access to R4 "were not done 'exclusively on the health care POA's request,' as alleged by CMS." *Id*. at 12. NMS stated that instead--

> [t]hey were based on common sense and the regulatory requirements regarding protecting residents from abuse and neglect. Had the Facility not restricted the visitation of a putative lawyer and an ill-intentioned daughter, it would have violated applicable regulations. As noted by Dr. Haimowitz, "[NMS] did not restrict visitation of [R4]'s attorney since [W.W.] was not recognized as [R4]'s attorney. Nor did [NMS] improperly restrict the visits of a daughter who more than once tried to abduct [R4]." P. Ex. 30 at ¶37. Moreover, as Dr. Haimowitz noted, "It follows logically that if a resident has a right to deny visitors, then . . . an incapacitated resident's representative or valid POA, has the same right." P. Ex. 30 at ¶9. . . .

Id.; *see also id*. at 13 (quoting Dr. Haimowitz's further testimony that "[t]he POA has the valid right to deny or restrict visitation to someone intending harm and it is their responsibility to ensure their charge's safety. P. Ex. 30 at 19.").

C. The ALJ's holding on summary judgment

The ALJ concluded that there was no genuine dispute that NMS improperly restricted visitors' access to R4 because NMS admitted that it 1) imposed restrictions on access by R4's daughter M.A., by R4's boyfriend A.B., and by attorney W.W., and 2) had no contemporaneous documentation that these restrictions were clinically necessary. *See* ALJ Decision at 5. The ALJ concluded that the absence of such documentation was dispositive for the same reasons he concluded the absence of documentation was dispositive with respect to whether NMS violated section 483.13. *See id*. at 5-6.

The ALJ further concluded that "even if there is no legal requirement that a facility memorialize its assessments in writing, Petitioner has offered no facts showing that it actually assessed Resident # 4 and concluded that . . . restrictions on access to visitors were necessary based on actual clinical findings." *Id*. at 6. The ALJ stated:

> [NMS] has offered no facts to support its assertion that these restrictions were necessary or reasonable. It makes a series of characterizations concerning the individuals whose visits were restricted or prohibited without any factual support for them. For example, it asserts that the resident's daughter who assisted the resident in packing her belongings in 2012 was attempting to "kidnap" the

> resident. That characterization contains no support in the record. Petitioner did not investigate the incident, did not prepare a report, and apparently, interviewed no one about it. Whether the daughter was attempting to carry out her mother's wishes or had some other motive is simply unknown. If Petitioner wanted to restrict that individual's visitation rights it was required to explain why it was doing so and to document its explanation. It did not.
>
> Similarly, Petitioner contends that an attorney "surreptitiously" attempted to have Petitioner revoke her POA and it suggests that banning him from visiting the facility was an appropriate response. There are no facts suggesting that the lawyer did something surreptitiously. Petitioner asserts that the attorney failed to contact its administrator, its director of nursing, its general counsel, the resident's physician, its medical director, or the facility social worker before speaking with Resident # 4. But, Petitioner has offered nothing to show that the attorney had a duty to speak to any of these individuals before speaking to the resident. At the time there was no legal impediment prohibiting the resident from consulting with counsel. She was absolutely entitled to speak with the attorney *in private* and without the interference of any of the individuals whose titles are cited by Petitioner.

Id. at 9-10 (italics in original).

D. Discussion

As discussed below, we find that NMS raised a genuine dispute of material fact with respect to the alleged noncompliance with section 483.10(j)(1)(vii) and (viii) (right to access by immediate family and others visiting with the consent of the resident) and with section 483.10(j)(2) (right to access by individuals providing services such as legal services).[20]

We note preliminarily that the ALJ's decision upholding CMS's finding of noncompliance with section 483.10(j) raises a threshold issue similar to that discussed with respect to section 483.13. Here, the threshold issue is whether the ALJ erred as a matter of law in concluding that CMS was entitled to summary judgment in its favor on the issue of NMS's compliance with section 483.10(j) based on the undisputed fact that NMS did not have contemporaneous documentation showing that it actually assessed R4 and concluded that restrictions on her visitors' access were necessary based on clinical findings. We conclude that he erred. Nothing in the language of section 483.10(j), much less any NMS policies and procedures, suggests that contemporaneous documentation of

[20] CMS did not make any findings in the SOD or allege any facts in the MSJ that involved subsections of section 483.10(j)(1) other than (vii) and (viii).

such an assessment was required in order to impose these restrictions. Moreover, as noted in the discussion of section 483.13, the Board has expressed the view in other decisions that in the absence of contemporaneous documentation of a disputed fact, an ALJ may consider testimonial evidence. Here, as with section 483.13, the ALJ in granting summary judgment disregarded testimony and drew negative inferences against NMS by giving overriding weight to the absence of contemporaneous documentation.

Section 483.10(j)(1)(vii). This section requires that a facility provide a member of the resident's immediate family "immediate access" to the resident unless the resident denied or withdrew consent to such visitation. On its face, the regulation permits restrictions on this immediate access based only on the resident's wishes. CMS appeared to read this provision as permitting restrictions on access for reasons other than the resident's wishes.[21] *See, e.g.*, MSJ at 8 (alleging that NMS "prohibited an immediate family member from visiting R4 . . . based only on the resident's healthcare POA request and not based on a determination of necessity") (emphasis added).[22] NMS did not challenge this reading, which the ALJ applied in this case.[23] Thus, we assume for purposes of this case that section 483.10(j)(1)(vii) permits a facility to restrict an immediate family member's access to the resident on a basis not expressly stated in the regulation. Based on that reading of the regulation, we conclude for the reasons discussed below that NMS raised a material dispute regarding the alleged noncompliance with this provision.

As noted above, although NMS admitted that it restricted access to R4 by M.A., a member of R4's immediate family, NMS denied that it did so "exclusively" at the request of the POA, asserting that it also imposed the restrictions because M.A. had attempted to "kidnap" R4. Response to MSJ at 12. This assertion refers to the incident documented in the nursing note for November 15, 2012, which states that M.A. and R4's boyfriend were "found packing up residents clothing and personal belongings" and that facility staff told them "this was not allowed and they should not be here per [POA]." CMS Ex. 9, at 23.[24]

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[21] This interpretation is not reflected in the version of CMS's SOM in effect at the time, which stated in relevant part only that "immediate family or other relatives are not subject to visiting hour limitations or other restrictions not imposed by the resident." SOM, App. PP, guidance on tag F172 (Transmittal 48, dated June 12, 2009).

[22] Although the MSJ at times describes NMS as prohibiting any access to R4 by her daughter, M.A., CMS did not dispute NMS's assertion that it restricted rather than prohibited M.A.'s access to R4, allowing M.A. to visit R4 only when the POA or D. were present.

[23] We note that NMS incorrectly cited to section 483.10(j)(1)(viii), which authorizes "reasonable restrictions" on access by visitors other than immediate family, as support for its assertion that "[i]t was 'reasonable' to restrict the visits of Child #2 [M.A.]." P. Pre-hearing Br. at 7. Section 483.10(j)(1)(vii) does not expressly authorize a facility to place any restrictions on access by the resident's immediate family.

[24] In addition, NMS's Director of Nursing testified that "on more than one occasion, staff, including myself, have found this Resident's other daughter [M.A.], attempting to pack all of her belongings and take her home without permission." P. Ex. 8, at 3.

However, a nursing note and a social services note for November 14, 2012 document that M.A. visited R4 that day and was told by NMS staff to leave the facility because the POA had stated that M.A. was allowed to visit R4 only if the POA or D. was present. CMS Ex. 9, at 17, 115. Thus, NMS imposed restrictions on M.A.'s access to R4 even before what it viewed as an attempt by M.A. to kidnap R4. It is conceivable that NMS decided to continue the restrictions on M.A.'s access based on the purported kidnapping attempt in lieu of (or in addition to) the POA's request, but NMS pointed to nothing in the record showing that was the case. NMS relied on the testimony of its expert witness Dr. Haimowitz that NMS did not "improperly restrict the visits of a daughter who more than once tried to abduct [R4]." Response to MSJ at 12, quoting P. Ex. 30 ¶37.[25] Dr. Haimowitz also testified that "attempting to have the resident leave the facility without medical approval or even her daily maintenance medications would have put her in immediate and serious jeopardy." P. Ex. 30 ¶ 19. However, Dr. Haimowitz did not allege that the attempted kidnapping was the basis on which NMS restricted M.A.'s access to R4, which was a matter as to which he had no independent knowledge.

NMS also appeared to take the position that it imposed the restrictions on M.A.'s access to R4 because M.A.'s visits "exacerbated" R4's "psychiatric conditions," NMS Pre-hearing Br. at 7, citing P. Ex. 17 ¶9 (DON's testimony). CMS did not dispute that, if proven, this would be a reasonable basis for restricting M.A.'s access to R4. *See* MSJ at 5. The DON testified that "[v]isits by [M.A. and Resident 4's boyfriend] seemed to exacerbate [R4's] psychiatric conditions." P. Ex. 17 ¶9. While the DON did not expressly state that NMS restricted M.A.'s access to R4 on this basis, a rational trier of fact could infer this from her testimony. Although CMS asserted that"[t]here is no contemporaneous documentation in the clinical record that [M.A.] exacerbated R4's psychiatric symptoms" (MSJ at 7), as previously discussed, the lack of contemporaneous documentation is not dispositive where there is testimony.

Accordingly, we conclude that NMS raised a genuine dispute of material fact as to whether NMS restricted M.A.'s access to R4 because her visits exacerbated R4's psychiatric symptoms, precluding summary judgment on this ground.[26]

Section 483.10(j)(1)(viii). This section requires that a facility provide other individuals who are visiting with the consent of the resident "immediate access" to the resident "[s]ubject to reasonable restrictions and the resident's right to deny or withdraw consent at any time[.]" R4's boyfriend, A.B., fell in this category. As the preceding discussion

[25] Dr. Haimowitz did not state the basis on which he found that M.A. tried to "abduct" R4 "more than once," nor did NMS point to any attempt to "kidnap" R4 other than the November 15 incident.

[26] NMS also took the position that because M.A.'s visits exacerbated R4's psychiatric symptoms, the POA's request that it deny M.A. access to R4 was a health care decision that the MPOA document authorized her to make. Response to MSJ at 13. However, NMS does not argue that it would have been justified in relying solely on a health care decision made by the POA.

indicates, M.A. and A.B. went together to visit R4 and were subjected to the same restrictions, allegedly for the same reasons.[27] Accordingly, we conclude without further discussion that NMS raised a genuine dispute of material fact as to whether it was in substantial compliance with section 483.10(j)(1)(viii) with respect to A.B.

Section 483.10(j)(2). This section requires that a facility provide any individual "that provides social, legal, or other services to a resident" "reasonable access" to a resident "subject to the resident's right to deny or withdraw consent at any time." As noted above, CMS alleged that NMS denied access to W.W., an attorney, based on the "POA's request that R4 not be allowed to receive certain outside visitors[.]" MSJ at 4. On its face, the "reasonable access" for which the regulation provides is subject only "to the resident's right to deny or withdraw consent at any time" (emphasis added). As in the case of the alleged violation of section 483.10(j)(1), CMS appeared to read this provision as permitting restrictions on access for reasons other than the resident's wishes. *See, e.g.*, MSJ at 8 (alleging that NMS prohibited "other individuals who sought to visit R4 by her own consent based only on the resident's healthcare POA request and not based on a determination of necessity") (emphasis added). NMS did not challenge this reading, which the ALJ applied in this case. Reading section 483.10(j)(2) in this manner, we conclude that NMS raised a genuine dispute of fact regarding the alleged noncompliance. NMS asserted that it had "the right and the obligation" to deny W.W. access to R4 because W.W. "was in the process of abusing a mentally-incapacitated resident, knowingly, or unknowingly" when in November 2013 he attempted to have R4 revoke her appointment of her daughter J.F. as POA. Response to MSJ at 11-12. NMS proffered documents to show that R4 was "repeatedly certified. . . . throughout 2013 and 2014" as "lack[ing] the capacity to comprehend information and make rational decisions." P. Pre-Hearing Br. at 2, citing P. Exs. 2-6; *see also* RR at 3. The proffered exhibits include identical forms signed by two physicians in August 2013 and March 2014 certifying that, "[b]ased on examination," R4 is "unable" to "understand and sign admission documents and other information"; "understand the nature, extent, or probable consequences of the proposed treatment or course of treatment"; "make rational evaluation of the burdens, risks, and benefits of the treatment"; and "effectively communicate a decision." P. Exs. 3, 4. These certifications are consistent with other certifications of R4's incapacity completed both before and after the period for which CMS found noncompliance. *See* P. Exs. 2 (December 2011 certification), 5 (April 2014 certification), 6 (May 2014 certification).

[27] Consistent with the DON's testimony quoted above, progress notes dated November 23, 2011 from the facility where R4 resided before her admission to NMS state: "Family has observed behavior changes in resident during and following [A.B.'s] visits." P. Ex. 24, at 1. The progress notes further state that the POA "has requested that [A.B.] no longer be allowed to visit or contact resident until completion of therapy services due to his observed negative influence on resident" and that "Resident's significant other informed he is not to return per family wishes[.]" *Id.*

NMS's argument appears to be that it acted reasonably in denying W.W. access to R4 for the purpose of providing legal services to her when she lacked the capacity to comprehend information and make rational decisions. In its pre-hearing brief, NMS questions what it describes as the "ethical propriety of an unknown attorney surreptitiously attempting to have an incapacitated resident revoke a valid POA[.]" P. Pre-hearing Br. at 5 n.3. The certifications of incapacity on their face support NMS's position that R4 lacked the capacity to take such an action. Accordingly, we conclude that NMS raised a material dispute of fact with respects to whether it was in substantial compliance with section 483.10(j)(1)(vii) with respect to W.W.[28]

III. NMS raised genuine disputes of material fact with respect to the alleged noncompliance with section 483.20(k)(3)(i).

Section 483.20(k)(3) states in relevant part: "The services provided or arranged by the facility must—(i) Meet professional standards of quality[.]" The SOD identified an immediate jeopardy-level deficiency under this provision based primarily on the underlying facts alleged to support the deficiency findings under section 483.13 and 483.10(j). CMS Ex. 4, at 20-2.[29] In the MSJ, CMS alleged that NMS breached professional standards requiring that: 1) the decision to restrict a resident's rights by placing the resident in a locked unit must be based on a determination of clinical necessity, 2) any decision to abridge a resident's rights must be based on the least restrictive means possible, and 3) decisions by a medical POA be confined to the scope of the authority granted under the POA. MSJ at 17, citing CMS Ex. 87 (declaration of Dr. Nay), at 10-12. According to Dr. Nay, the "absence of a documented rationale and process for restricting [R4's] rights is a violation of the [first] standard of care." CMS Ex. 87, at 10, ¶ 33. Dr. Nay also maintained that the "failure to assess and reassess if [R4's] confinement in a locked unit was the least restrictive intervention is a violation of

[28] As already noted, NMS also asserted that it did not violate section 483.10(j)(2) because W.W. "was not recognized as [R4's] attorney." Response to MSJ at 12, quoting P. Ex. 30, ¶37 (testimony of Dr. Haimowitz). In its pre-hearing brief, NMS pointed to W.W.'s testimony in a Maryland court proceeding on June 11, 2014 that he went to see R4 at NMS in November 2013 after his office "received a phone call that [R4] would like to see a lawyer" and that he "make[s] house calls to nursing homes as requested." NMS Pre-hearing Br. at 5 n. 4, citing CMS Ex. 41; CMS Ex. 41, at 8-9. NMS also asserted that W.W. acknowledged that M.A. requested that he visit R4. NMS Pre-hearing Br. at 9, citing P. Ex. 33 (testimony of K.R., Associate General Counsel of company that managed NMS) at ¶¶ 19-22. It is unclear whether NMS intended to allege that W.W. was not entitled to access to R4 under section 483.10(j)(1)(vii) because R4 had not already retained him as her representative. However, we see nothing in the language of that section that limits its application in that way.

[29] The SOD also refers to the underlying facts alleged to support the less than immediate jeopardy- level deficiency finding under section 483.10(k) that is discussed later in this decision as well as to some of the underlying facts alleged to support a less than immediate jeopardy-level deficiency finding under section 483.10(b)(4) that was not addressed by the ALJ. CMS Ex. 4, at 27-29; ALJ Decision at 14.

the [second] standard of care." *Id*. ¶ 34. Further, Dr. Nay maintained that in "honor[ing] the Medical POA's [non-medical] decisions to restrict Resident 4's visitation by certain family members, friends, and attorney," NMS violated the third "standard of care."[30] *Id*. ¶ 36. In addition, Dr. Nay stated that the Maryland Health Care Decisions Act establishes the professional "standard of care" with respect to the scope of a health care agent's authority. *Id*. ¶36.[31] CMS asserted that NMS "entirely failed to rebut CMS' prima facie case" of a violation of the three professional standards identified above. MSJ at 18. [32]

In its response to the MSJ, NMS asserted that there are material facts in dispute regarding whether NMS violated "standards of care," i.e., professional standards of quality. Response to MSJ at 5-7, citing P. Exs. 26 and 30 (declarations of Dr. Crecelius and Dr. Haimowitz). The cited testimony primarily disputes the factual allegations that were the basis for CMS's finding that NMS failed to meet professional standards of quality. NMS also pointed out that Dr. Crecelius testified that "[t]here is no standard of care promulgated by any reputable organization or medical society that sets forth exact methods of determining the need and timing of placement into a secure unit." Response to MSJ at 5. In addition, NMS argued in its pre-hearing brief that CMS had not shown that NMS "violated a specific standard of care established by a professional organization, licensing board, or accreditation body," and cited to CMS's interpretive guidelines for section 483.20(k)(3), which state that "[s]tandards regarding quality care practices may be published by a professional organization, licensing board, accreditation body or other regulatory agency . . . [and] may also be found in clinical literature." NMS Pre-hearing Br. at 13, 15; P. Ex. 27 (SOM, App. PP, guidance for tag F281).

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[30] Dr. Nay gave as another example of how NMS breached the third professional standard that NMS honored the POA's decision not to allow R4 to go to the funeral of a relative because of the POA's concern that R4 would "act[] up at the services." *Id*. ¶ 36. However, the SOD states that "the facility social service assistant's documentation indicated that on 8/22/13 . . ., [the POA] changed [her] mind and decided [she] would allow resident #4 to attend grandchild #2's viewing." CMS Ex. 4, at 14-15.

[31] CMS's response to the appeal cites to the Maryland Health Care Decisions Act at CMS Exhibit 43. Response to RR at 19. CMS does not identify any published authority for "the applicable standard of care for situations involving the confinement of a resident in a secure unit," but instead asserts that there is no dispute as to what this standard requires "at a minimum." *Id*. at 20.

[32] Relying on Dr. Nay's declaration, CMS also alleged that NMS violated a professional standard requiring that, if there is conflicting information regarding a resident's capacity, the resident be reassessed in order to clarify conflicting information. MSJ at 17. According to Dr. Nay, this professional standard, established by the National Practice Guidelines issued by the Agency for Healthcare Research and Quality, was violated because "the clinical record documents that Resident 4 was, in fact, able to make some of her own health care decisions, such as consenting to evaluation and treatment in the hospital" yet NMS "elected not to reassess Resident 4's capacity to make decisions." CMS Ex. 87 ¶ 35. However, NMS stated in its pre-hearing brief that "[t]here was no 'conflicting information' from any physician who treated Resident 4," and CMS appeared to acknowledge that the facts supporting this alleged violation were disputed. NMS Pre-hearing Br. at 14; MSJ at 18. The ALJ Decision does not refer to this alleged violation. ALJ Decision at 3. Nevertheless, CMS is not precluded from raising this issue on remand.

The ALJ Decision addressed the alleged noncompliance under section 483.20(k)(3)(i) as follows:

> This regulation mandates a skilled nursing facility to provide care that meets professional standards of quality. CMS asserts that this regulation prohibits a facility from confining a resident – as Petitioner allegedly did with Resident #4 – without making a determination of clinical necessity. Any action taken by a facility pursuant to its determination, according to CMS, must utilize the least restrictive means possible. CMS contends that Petitioner contravened the regulatory requirements in that it confined Resident # 4 without making a clinical determination that confinement was necessary and without making any judgment that the means that it resorted to were the least restrictive means necessary to protect the resident's health and safety.

ALJ Decision at 3. The ALJ then stated that the "undisputed material facts unequivocally sustain CMS's assertions" with respect to this requirement as well as the requirements in sections 483.13 and 438.10(j)(1)-(2) and that NMS had offered no "arguments that justify its actions in light of the undisputed material facts." *Id*. The ALJ further stated that "[w]hether or not there was a precise standard of care, Petitioner still was required to assess the resident for the suitability of confinement, to plan her care, and to use the least restrictive means necessary to protect her." *Id*. at 8.

The ALJ found it unnecessary to address the threshold issue raised in NMS's pre-hearing brief of whether Dr. Nay's testimony is sufficient to establish professional standards of quality. However, we conclude that NMS's position that the testimony is insufficient has no merit. The Board has held that the interpretive guidelines in the SOM "do not require that CMS in every case verify the existence of an applicable clinical standard through published sources." *Life Care Ctr. of Tullahoma*, DAB No. 2304, at 33-34 (2010). Other sources of professional standards of quality identified by the Board include a facility's own resident care policies, expert witness testimony, or the testimony of a surveyor who has training, experience and knowledge in the subject field. *See, e.g.*, *Perry County Nursing Ctr.*, DAB No. 2555 (2015); *Life Care Ctr. of Tullahoma, Universal Health Care King*, DAB No. 2383 (2011), *aff'd*, *Universal Health Care/King v. Sebelius*, 499 F. App'x 299 (4th Cir. 2012). Thus, the testimony of Dr. Nay, a medical expert, as to the three standards of care that were violated by the alleged noncompliance with sections 483.13 and 483.10(j) is probative evidence of professional standards of quality within the meaning of section 483.20(k)(3)(i). NMS did not point to any testimony by Dr. Crecelius or Dr. Haimowitz, or any other record evidence, that rebutted this testimony.

Nevertheless, as discussed above, NMS raised genuine disputes of material fact with respect to the alleged noncompliance with section 483.13 and section 483.10(j)(1)-(2) that were also a basis for the alleged noncompliance with section 483.20(k)(3)(i). It would therefore be premature to determine whether NMS violated professional standards of quality based on these alleged facts. If on remand the ALJ concludes that NMS was not in substantial compliance with either section 483.13 or section 483.10(j)(1)-(2), or both sections, he may wish to determine whether, based on the facts underlying that noncompliance, NMS also failed to comply substantially with section 483.20(k)(3)(i).

IV. NMS raised a genuine dispute of material fact regarding whether the alleged noncompliance with sections 483.10(j)(1)-(2), 483.13 and 483.20(k)(3)(i) posed immediate jeopardy.

As already noted, the SOD identified three immediate jeopardy-level deficiencies, involving the requirements at sections 483.10(j)(1)-(2), 483.13, and 483.20(k)(3)(i). In the MSJ, CMS asserted that each of these requirements posed immediate jeopardy. MSJ at 1, 5, 8, 17. In its response to the MSJ, NMS argued that any noncompliance did not rise to the level of immediate jeopardy. Response to MSJ at 14. The ALJ concluded that CMS's immediate jeopardy finding was not clearly erroneous, stating:

> There was a very high likelihood that residents – including Resident 4 – would be harmed by Petitioner's cavalier approach to confinement. . . . A facility may not confine or seclude any of its residents for reasons that are not medically necessary and that are not documented. Nor may it unreasonably restrict a resident's access to the outside world, including visitors.
>
> Any time a facility confines a resident unreasonably it is imprisoning that resident and doing so in a particularly cruel way. Elderly and frail individuals may not be capable of exercising their rights vigorously. Those who are confined against their will or without medical reason may be too feeble to protect themselves. The result is that they suffer the psychological trauma that goes with imprisonment and the hopelessness that comes with the knowledge that there may be no way out.

ALJ Decision at 11. In effect, the ALJ found that the facts underlying the alleged noncompliance with sections 483.13 and 483.10(j)(1)-(2) posed immediate jeopardy to R4 and other residents.

On appeal, NMS takes the position that the ALJ erred in upholding CMS's determination of immediate jeopardy, arguing that determinations by several physicians and a psychologist that R4 lacked mental capacity established that she was placed in the secure unit for her own protection and thus there was no "imprisonment." RR at 5-8. Similarly, NMS disputed CMS's immediate jeopardy finding when it argued before the ALJ that

due to what it alleged was R4's mental incapacity, R4 would have been at risk of serious harm if it had not placed her in the secure unit and restricted certain visitors' access to her. *See, e.g.*, NMS Pre-hearing Br. at 19; *see also* Response to MSJ at 14. We conclude that these arguments raise a dispute of material fact regarding the immediate jeopardy determination. Although the ALJ found that NMS did not place R4 in the secure unit or restrict certain visitors' access to her based on an assessment of R4's clinical condition, he did not specifically address whether R4 in fact lacked mental capacity during the period of immediate jeopardy and, if so, whether she would therefore have been at risk of serious harm if NMS had not placed her in the secure unit or restricted certain visitors' access to her.

Accordingly, on remand, if the ALJ concludes that NMS was not in substantial compliance with either section 483.13 or section 483.10(j)(1)-(2) or both, he should make a new determination as to whether the noncompliance posed immediate jeopardy. In making this determination, the ALJ should, if he deems necessary, address NMS's argument that R4 could not be considered "imprisoned" if she lacked mental capacity to continue safely in an unsecure unit and/or without any restrictions on visitors, given her clinical history and her POA's consent to NMS's actions.

V. The undisputed facts establish that NMS was not in substantial compliance with section 483.75(*l*)(1), but a new determination as to the reasonableness of the CMP amount for noncompliance at the non-immediate jeopardy level is necessary.

Section 483.75(*l*)(1) provides:

> Clinical records. (1) The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are—
> (i) Complete;
> (ii) Accurately documented;
> (iii) Readily accessible; and
> (iv) Systematically organized.

In its pre-hearing brief, CMS stated that the surveyor concluded that NMS did not comply with this requirement because NMS "failed to maintain clinical records on Resident 60 that were accurate and that were maintained in accordance with accepted professional standards." CMS Pre-hearing Br. at 12. CMS stated more specifically that, according to the surveyor, "Resident 60's Maryland Medical Orders for Life-Sustaining Treatment (MOLST) form was internally inconsistent, simultaneously indicating that the resident was to receive CPR and was not to receive CPR." *Id*., citing CMS Ex. 67, at 33.

In the MSJ, CMS alleged that NMS was not in substantial compliance with this requirement, to which it referred by the tag number, F-514. MSJ at 18, 20. According to CMS, there was no genuine dispute of fact with respect to the alleged noncompliance with this section "because Petitioner's Administrator admitted [to the surveyor] that the form at issue was incorrect and that it would be corrected." *Id*. at 20, citing CMS Ex. 67, at 33, ¶ 12. In its response to the MSJ, NMS made a general assertion that CMS incorrectly claims there is no genuine dispute of material fact regarding tag F-514 and the other tag numbers as to which the MSJ alleged less than immediate jeopardy-level noncompliance. Response to MSJ at 15. However, NMS did not identify any disputed facts or point to any evidence to show that there were facts in dispute concerning tag F-514. *See id.* at 15-17. The ALJ found that NMS "has offered no facts challenging CMS's assertions concerning its noncompliance with the requirements of" section 483.75(*l*)(1). ALJ Decision at 14.

On appeal, NMS did not argue that the ALJ erred in making this finding. Accordingly, there is no basis for disturbing the ALJ's conclusion that NMS was not in substantial compliance with section 483.75(*l*)(1).

NMS's noncompliance with section 483.75(*l*)(1) is sufficient to establish a legal basis for imposing a CMP at the non-immediate jeopardy level. The ALJ also found that either this noncompliance or what he determined to be NMS's less than immediate jeopardy-level noncompliance with the requirement at 483.10(k) (discussed in the next section) was sufficient to sustain the $150 per-day CMP imposed by CMS, observing that the CMP amount "is minimal, comprising only five percent of the maximum allowable penalty amount for non-immediate jeopardy level violations." ALJ Decision at 13. However, we conclude that this rationale is insufficient to establish the reasonableness of the CMP amount. A CMP of $150 per day, although low, is still three times the minimum amount established by regulation for a less than immediate jeopardy-level CMP. In addition, CMS took the position in the MSJ that a CMP of $150 per day was reasonable based on its allegations of noncompliance with four participation requirements, of which the ALJ addressed only two. The Board has observed that "an ALJ's failure to address all of the deficiency findings could affect the remedy imposed by CMS and be prejudicial to the facility . . . when CMS relies on the additional deficiency findings in setting the amount of a CMP above the minimum amounts specified by regulation[.]" *Virginia Highlands Health Rehab. Ctr.*, DAB No. 2339, at 13 (2010) (internal quotations omitted), citing prior Board decisions.[33] Moreover, we conclude

[33] For purposes of evaluating whether summary judgment was appropriate, we must assume that the issue of NMS's noncompliance with the participation requirements on which CMS relied but which the ALJ did not consider would be resolved in NMS's favor. *See Madison Health Care, Inc.*, DAB No. 1927, at 7 (2004).

below that NMS raised a genuine dispute of material fact with respect to the alleged less than immediate jeopardy-level noncompliance with section 483.10(k). Accordingly, on remand, the ALJ should make a new determination as to whether the $150 per-day CMP was reasonable and should provide a further explanation of any determination that is based on noncompliance with fewer than four requirements.

VI. NMS raised a genuine dispute of material fact with respect to the alleged noncompliance with section 483.10(k).

Section 483.10(k) provides: "*Telephone.* The resident has the right to have reasonable access to use of a telephone where calls can be made without being overheard." In its MSJ, CMS alleged that NMS "abridged [R4's] right to phone access, both in her ability to place and to receive calls." MSJ at 19. More specifically, CMS alleged that NMS "allow[ed] only those individuals who provided a 'special code' to facility staff to talk to R4 on the phone" and that "R4 was allowed to make phone calls only by using the Social Work designee's phone and . . . would have to have the Social Work designee place the call for her." *Id.*

In support of these allegations, CMS relied in part on a 2/27/14 social service note. The note contains an entry dated 2/4/2014 that states:

> Resident[']s POA [J.F.] called this morning requesting that this code 0324 be used for security and information regarding resident[]. . . , only the person or persons having this code will be allowed to get information on this resident, social services will continue to provide support.

CMS Ex. 9, at 132 (cited at MSJ at 19). In addition, an entry dated 2/27/2014 states:

> Writer visited resident. And met with [POA] regarding resident using the phones. [POA] does not want her mother to make any outside phone calls if needed we are suppose[d] to call [POA] and relay the message. Social Services will continue to support resident and family as needed[.]

Id. CMS also relied on the declaration of one of the surveyors for the March 2014 survey in which she describes an interview she and another surveyor conducted with a LPN who was "involved in Resident 4's care" in relevant part as follows:

> Surveyor Hypes asked if Resident 4 had access to a phone for making and receiving calls. LPN [F.] explained that if resident wanted to use a phone, she could go to Social worker in the corner and ask to use phone. LPN [F.] clarified that Resident 4 could not dial the call and that the social worker would have to dial for them.

CMS Ex. 67, at 16 (cited at MSJ at 19).

In response to the MSJ, NMS stated that it "vehemently disputes" the assertion "that Resident 4 was not allowed privacy in her telephone calls" and maintained that R4 "had unfettered access to make calls." Response to MSJ at 15. In support, NMS cited the declarations of its nursing home administrator and its DON. *Id*. at 15-16.[34] NMS's administrator stated in relevant part:

> I note that Resident #4 also had unfettered access to a telephone with privacy for her conversations while she was on the [secure] unit. . . . [W]e provide both a phone and privacy for any resident who wants to make telephone calls. The allegation in the Statement of Deficiencies that we did not allow Resident #4 to make telephone calls is not true.

P. Ex. 8, at 2.

The DON stated in relevant part:

> Resident #4's chart indicates that the POA asked facility staff to restrict access to the telephone. While she did request this, we did not honor this request. The note simply reflects the conversation of our social worker with the POA. In fact, I witnessed our Administrator explaining to the POA that we could not restrict access to the telephone.

P. Ex. 17, at 4; *see also id*. at 3-4 ("Residents, as a matter of policy, have a right to use the telephone and be afforded privacy in their conversations. I know from discussing with my unit managers . . . that this was given to our residents and specifically to this particular resident. There are phones available at the nursing stations and a private phone in the unit manager's office.").

The ALJ found that NMS had not denied either that it limited incoming calls to R4 to individuals who had a special access code or that it required R4's outgoing calls to be placed for her. ALJ Decision at 14. The ALJ therefore concluded that NMS was not in substantial compliance with section 483.10(k). *Id*.

[34] NMS also stated: "CMS's own witness, attorney [W.W.], claims that Resident 4 contacted him by telephone. This assertion undermines the claim that the Facility denied Resident [4] access to telephone calls and privacy in those calls." Response to MSJ at 16

We conclude that the ALJ erred in reaching this conclusion on summary judgment. NMS's response to the MSJ did not expressly dispute that NMS required an access code for incoming telephone calls to R4. However, viewed in the light most favorable to NMS, the DON's declaration, which NMS did cite in its response to the MSJ, raises such a dispute. In particular, the "chart" to which the DON's testimony refers could reasonably be read to mean the social services note at CMS Exhibit. 9, at 132. That note refers to requests by the POA that NMS require a code for incoming telephone calls to R4 and that NMS deny R4 access to a telephone for outgoing calls. A rational trier of fact could infer that, in stating that the "note simply reflects the conversation of our social worker with the POA" and that NMS "did not honor" the POA's request "to restrict access to the telephone," the DON was denying that NMS acceded to either that request or the POA's request that it require a code for incoming calls to R4.[35]

In addition, as noted above, the administrator stated that R4 "had unfettered access to a telephone with privacy for her conversations." The ALJ nevertheless concluded that R4 was not afforded the requisite privacy based on CMS's allegation, supported by the surveyor's declaration, that the social worker would have to place calls for R4. However, CMS did not explain in the MSJ why this alleged fact would necessarily deprive R4 of privacy in her telephone conversations. It is conceivable, for example, that R4 provided the social worker with only the telephone number of the person she wished to call and that after calling that number the social worker immediately gave the phone to R4 and left the room.[36] Thus, the ALJ was not justified in disregarding the administrator's testimony in concluding that NMS violated section 483.10(k) in this respect.

Accordingly, we conclude that NMS raised disputes of material fact with respect to the alleged noncompliance with section 483.10(k).

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[35] Consistent with that position, NMS acknowledges before the Board that the POA "requested that a 'special code' be used for individuals seeking information about Resident #4" but asserted that NMS "could not logistically accommodate that request." RR at 31 n.7. NMS also claims on appeal that the "only basis" for the ALJ's finding about the special access code is a statement by a surveyor that the long term care ombudsman told him "that the family makes the staff put a code if you want[ed] to speak to the resident." RR at 30-31, quoting CMS Ex. 67, at 43. NMS takes the position that this statement should be given no weight because it is a "hearsay statement from a surveyor whose veracity was called into question by Petitioner before the ALJ." RR at 31. How much weight to accord to this statement is an issue for the ALJ on remand.

[36] CMS's pre-hearing brief cites Dr. Nay's declaration, which states that NMS was not in substantial compliance with section 483.10(k) in part because "the only phone Resident 4 had available to her for use was a unit phone which she could only use with the assistance of an NMS staff member" and which quotes the statement in the State Operations Manual that "'[r]easonable access' includes placing telephones at a height accessible to residents who use wheelchairs and adapting telephones for use by the residents with impaired hearing." CMS Pre-hearing Br. at 10, citing CMS Ex. 87 ¶ 20-23, citing SOM, App. PP at p. 38. However, the MSJ did not allege that NMS failed to provide R4 reasonable access to a telephone in this sense.

VII. The ALJ abused his discretion in excluding certain testimonial and documentary evidence proffered by NMS on the ground that it was created before or after the period of immediate jeopardy.

As noted above, the ALJ granted CMS's motion to exclude several testimonial and documentary exhibits proffered by NMS. ALJ Ruling dated 2/4/15. An ALJ may properly consider at the summary judgment stage whether proffered documents would be admissible if the matter went to hearing. *Cf. Law Co., Inc. v. Mohawk Const. and Supply Co., Inc.*, 577 F.3d 1164, 1170 (10th Cir. 2009) ("We review a district court's refusal to consider evidence at the summary judgment stage for abuse of discretion.").

NMS objected to the ALJ's partial exclusion of the testimony of NMS's two expert witnesses, Dr. Crecelius and Dr. Haimowitz, and the "wholesale exclusion" of the testimony of three other witnesses, as well as to the ALJ's exclusion of eight documentary exhibits. Response to MSJ at 6 n.1; RR at 7-9, 27-28, 34. As explained below, we conclude that the ALJ abused his discretion in excluding all of this evidence except the testimony of the three witnesses other than the expert witnesses.

A. The ALJ abused his discretion in excluding Petitioner's Exhibits 1, 5, 6, 11, 12, 19, 21, and 22.

NMS contends that it was error for the ALJ to exclude this evidence "as it was both relevant and material to the factual dispute of whether placement in a secure unit and restricting a visitor was appropriate or, as CMS alleges, tantamount to immediate jeopardy." RR at 8; *see also* RR at 7-8. Petitioner's Exhibit 1 is a September 23, 2014 Order issued by the Circuit Court for Washington County, Maryland stating that R4 "lacked the capacity to revoke her Power of Attorney [dated August 23, 2011] . . . at the times that she executed a revocation with the assistance of counsel, and that she continues to lack the capacity to revoke her Power of Attorney now" and J.F., "as attorney-in-fact for [R4],may consent to [R4's] medical treatment, including her treatment at NMS . . . , including but not limited to, the decision of which room and unit [R4] may occupy while a resident in that facility[.]" Petitioner's Exhibit 5 is a "Physician's Certification of Incapacity" for R4 signed by two physicians, on 3/28/14 and 4/2/14, stating that they have examined the resident within two hours of completing the certification and that she is "unable to understand the nature, extent, or probable consequences of the proposed treatment or course of treatment, or alternatives to the treatment" and "unable to make a rationale [sic] evaluation of the burdens, risks and benefits of the treatment." The certification identifies the reasons for R4's incapacity as bipolar disorder and cognitive impairment. Petitioner's Exhibit 6 is a "Physician Certification" signed by two physicians on 5/27/14 stating that R4 is "unable to understand and sign admission documents and other information"; "unable to understand the nature, extent, or probable

consequences of the proposed treatment or course of treatment"; "unable to make rational evaluation of the burdens, risks, and benefits of the treatment"; and "unable to effectively communicate a decision." This certification identifies the reasons for R4's incapacity as bipolar disorder and dementia. Petitioner's Exhibit 11 is a hospital discharge summary, marked "Draft," for a discharge date of April 4, 2014 that describes R4's "final diagnosis" as "Dementia and delirium with behavioral disturbances" and states that R4 "was evaluated by two physicians and was determined to lack capacity to make medical decisions" and "continues to be at risk" of elopement." Petitioner's Exhibit 12 is a "Decisional Capacity Evaluation" signed by a licensed psychologist on 5/27/14 stating that "based on clinical judgment, based on the patient's presentation and available data," R4 does not "possess sufficient decisional capacity to make relevant decisions[.]" It further states that R4's "global cognition is moderately to severely impaired," her "social & practical judgment is severely impaired" and her incapacity is "driven by Bipolar Disorder . . . [and] her dementia[.]" Petitioner's Exhibit 19 is an order issued by the Circuit Court on May 27, 2014 that states that until such time as a hearing can be held, the August 23, 2011 MPOA document is valid "so long as [R4] remains incapacitated as determined by two physicians." Petitioner's Exhibit 21 is a Termination of Power of Attorney signed by R4 on May 23, 2014 revoking the authority of D.G. and/or J.F. "to act on my behalf in any capacity." Petitioner's Exhibit 22 is NMS's undated Emergency Petition for the Construction of Power of Attorney, which the Circuit Court presumably acted on when it issued the order in Petitioner's Exhibit 19.[37]

The ALJ ruled that all of these documents were irrelevant because they were either "generated" after the period for which CMS alleged immediate jeopardy-level noncompliance, January 22 – March 27, 2013, or "there is nothing to show that [NMS] had access to them at any time during" that period. Ruling at 3-4 (unnumbered).

The ALJ's rationale for excluding these documents was, in essence, that NMS could not have relied on them to make a determination, before placing R4 in the secure unit on January 22, 2013, or before imposing restrictions on her visitors, that her clinical condition warranted those actions. While it is certainly true that NMS could not have made these determinations based on documents that did not then exist, or of whose existence NMS was unaware, it does not necessarily follow that the documents are irrelevant. NMS submitted, without objection from CMS, a certification of her incapacity made December 12, 2011, shortly after R4 was first admitted to NMS (P. Exhibit 2). Neither party submitted evidence showing that another formal assessment of R4's capacity was made between December 12, 2011 and March 28, 2014, when the assessment at P. Exhibit 5 was completed. The absence of any other formal assessments

[37] Attached to the Emergency Petition are two documents titled "Physician Certification." The first is the December 12, 2011 certification also submitted by Petitioner as its Exhibit 2. CMS did not object to that exhibit. The date on the other certification, which uses identical language, is illegible.

arguably suggests that R4 experienced only isolated incidents of incapacity, which might undercut NMS's rationale for placing R4 in NMS's secure unit when she was discharged from the hospital on January 22, 2014 or imposing restrictions on her visitors. However, a rational trier of fact could infer from the fact that R4 was certified as incapacitated on four different occasions over a two-month period beginning on March 28, 2014 that R4 remained incapacitated after 2011 and, directly relevant here, was incapacitated at the time NMS placed her in the secure unit and imposed restrictions on her visitors.[38] Similarly, it is true that NMS could not have known before it decided to place R4 in the secure unit and to impose restrictions on her visitors that the Circuit Court would rule that R4's appointment of her daughter M.F. as successor POA remained valid despite R4's attempted revocation of the MPOA document and that it was within the scope of the POA's authority to consent to R4's placement on the secure unit. However, it does not follow that the Circuit Court's rulings to that effect or the associated documents (P. Exhibits 1, 19, 21, and 22) are irrelevant. Instead, a rational trier of fact could infer from these exhibits that it was reasonable for NMS to place R4 in the secure unit and impose restrictions on her visitors based at least in part on the POA's requests.

Accordingly, we conclude that Petitioner's Exhibits 1, 5, 6, 11, 12, 19, 21, and 22 are admissible.

B. The ALJ abused his discretion in excluding the testimony of Drs. Haimowitz and Crecelius, Petitioner's Exhibits 30 and 26.

Before the ALJ, NMS described the testimony of Daniel Haimowitz, MD, CMD (P. Exhibit 30) as follows:

> In this case, Dr. Haimowitz explains that his examination of Resident 4 [on June 19 and 20, 2014] revealed her to be incapacitated and that placement in a secure unit and restrictions on the daughter who attempted to kidnap her were eminently reasonable. Dr. Haimowitz will provide expert medical testimony based on his experience, knowledge and personal examination of Resident 4. Dr. Haimowitz also rebuts the testimony of Dr. Nay, one of CMS' proposed witnesses.

Petitioner's Proposed Exhibit and Witness List (List) (submitted with pre-hearing brief) at 4. NMS described Dr. Crecelius's testimony (P. Exhibit 26) as follows:

> Dr. Crecelius provides expert medical testimony explaining why there were no deficiencies, much less immediate jeopardy-level deficiencies. Dr. Crecelius also rebuts the proposed testimony of Dr. Nay.

[38] This inference is supported by the hospital's 1/22/14 Case Management Progress note, which states in part that the attending physician's "[r]ecommendation for incapacity [was] being honored" and that "Pt not showing ability to make sound decisions and [showing] lack of sense of reality." P. Ex. 7.

List at 5.

With respect to Dr. Haimowitz's testimony, the ALJ stated:

> Dr. Haimowitz' testimony is largely irrelevant because Petitioner has not provided any proof that he assisted Petitioner in making its decisions concerning Resident # 4 during the relevant period. It does not matter that he thinks, after the fact, that Petitioner acted appropriately except to the extent that his testimony addresses what Petitioner had before it during the relevant period and how it assessed that evidence. I will permit his testimony only to the extent that it addresses that issue.

Ruling at 5.

With respect to Dr. Crecelius's testimony, the ALJ stated:

> I exclude that testimony to the same extent that I exclude Dr. Haimowitz' testimony. Dr. Crecelius may testify concerning the appropriateness of Petitioner's actions based solely on the evidence that Petitioner and its staff considered. Opinion based on facts that are outside of the ambit of what Petitioner knew and relied on is irrelevant.

Id. at 5.

The ALJ further explained his ruling in his decision, stating:

> Neither Dr. Crecelius nor Dr. Haimowitz had anything to do with caring for Resident # 4 prior to Petitioner's decision to confine her. They provided no care to the resident and were not consulted about her care. In my February 4, 2015 ruling, I found Dr. Haimowitz' testimony to be largely irrelevant. Petitioner has not shown how his testimony is relevant here. His testimony consists solely of his opinion as to whether Petitioner, viewed from the vantage point of hindsight, acted appropriately. That adds nothing to the facts of this case.

ALJ Decision at 7-8.

Both before the ALJ and on appeal, NMS objected to the ALJ's ruling excluding portions of Dr. Haimowitz's and Dr. Crecelius's testimony. Response to MSJ at 6 n.1; RR at 27-28. NMS explained its objection in its request for review as follows:

> If a medical expert cannot render relevant testimony unless she/he 'cared for' a residents, as the ALJ suggests, that would eliminate virtually all expert medical testimony. Dr. Haimowitz and Dr. Crecelius, based their expert opinions on the complete clinical record of Resident #4. Moreover, Dr. Haimowitz even examined Resident #4 on two occasions [June 19 and 20, 2014].

RR at 28.

The ALJ excluded Dr. Haimowitz's and Dr. Crecelius's testimony to the extent that it was based on their review of R4's clinical record for the period after March 27, 2013, and, in the case of Dr. Haimowitz, on his personal examination of R4 on June 19-20, 2014. Based in part on that examination, Dr. Haimowitz concluded that R4 lacked the capacity to make rational decisions. P. Ex. 30, at 2 ¶¶4-5, 5 ¶26, 6 ¶33. As discussed above, a reasonable inference could be made from such later determinations of incapacity that R4 had been incapacitated since NMS first certified her as incapacitated in December 2011. Thus, Dr. Haimowitz's testimony that his own examination of R4 showed her incapacity was relevant, as was the testimony of Dr. Crecelius and Dr. Haimowitz opining, based on such later determinations of incapacity, that NMS acted appropriately when it placed R4 in the secure unit and imposed restrictions on her visitors.

Accordingly, we conclude that Petitioner's Exhibits 26 and 30 are admissible in full.

C. The ALJ did not abuse his discretion in excluding the testimony of Mr. Pelovitz, Ms. Costa-Nadora, and Ms. Carias, Petitioner's Exhibits 37, 34 and 38.

NMS objected to the ALJ's ruling excluding in their entirety "other sworn witness statements, such as those of Steven Pelovitz, the former Chief Operating Officer and National Director of Survey and Certification for CMS." Response to MSJ at 6 n.1; *see also* RR at 34.

NMS described the testimony of Mr. Pelovitz (P. Exhibit 37) as follows:

> As the CMS official responsible for developing and implementing policy concerning nursing home survey, certification and enforcement matters, Mr. Pelovitz provides testimony explaining why the cited deficiencies are incorrect and that none of the cited immediate jeopardy deficiencies are legally or factually supportable. Mr. Pelovitz is offered as an expert on matters such as CMS' policy, the State Operations Manual's requirements, and how they were not adhered to,

> and the regulatory requirements related to the cited deficiencies. He will explain the intent of the regulations at issue and further explain why there was no regulatory violation. Mr. Pelovitz provides testimony that if he were still the CMS Director of Survey and Certification, he would have rejected the State survey agency's and the CMS Regional Office's findings in this case and determined that [NMS] was in substantial compliance . . . . Mr. Pelovitz explains why the placement of Resident 4 in a secure unit and the reasonable restrictions of visits of abusive visitors were entirely appropriate.

List at 4.

The ALJ's ruling stated:

> CMS moves to exclude [Mr. Pelovitz's testimony] on the ground that it includes legal conclusions that are irrelevant. Petitioner denies that the witness' testimony is being offered as a legal opinion but, rather, as to the issue of whether CMS properly interpreted the State Operations Manual. This is a distinction without a difference. I exclude Mr. Pelovitz' testimony as irrelevant legal opinion.

ALJ Ruling at 4. NMS did not comment on the ALJ's rationale for excluding Mr. Pelovitz's testimony or otherwise explain why it believed that testimony was improperly excluded. Moreover, the Board has previously held that at the summary judgment stage, an ALJ may properly "reject legal conclusions from [a facility's] witnesses." *St. Catherine's Care Ctr. of Findlay, Inc.*, DAB No. 1964, at 41 (2005). Accordingly, we uphold the ALJ's ruling excluding Petitioner's Exhibit 37.

NMS described the testimony of Marie Costa-Nadora, former NMS Nursing Home Administrator (P. Exhibit 34), as follows:

> She provides testimony regarding matters such as the delegation of the POA to [J.F.], Resident 4's daughter. She further provides testimony regarding some of the problems caused by Resident 4's other daughter . . . that exacerbated Resident 4's psychiatric condition. . . .

List at 6.

The ALJ's ruling stated:

> Petitioner employed [Ms. Costa-Nadora] prior to the period that is at issue and [she] was not an employee during the relevant period. She professes to have some knowledge of the resident's condition. However, she has not asserted that

> Petitioner was privy to this knowledge nor does she offer proof that would corroborate her own assertion. I find that Ms. Costa-Nadora's connection to this case is far too tenuous to render her testimony relevant or even facially reliable and I exclude it.

ALJ Ruling at 5.

NMS did not comment on the ALJ's rationale for excluding Ms. Costa-Nadora's testimony. Nor did NMS specifically rely on any of her testimony in its pre-hearing brief or response to the MSJ. The ALJ could reasonably conclude that her testimony about problems that allegedly exacerbated R4's psychiatric condition would not be reliable since it is undisputed that she had no connection to NMS during the relevant period and lacked personal knowledge of this matter. *See Pinecrest Nursing & Rehab. Ctr.*, DAB No. 2446, at 14 (2012) (finding no reason to disturb ALJ's decision to give no weight to testimony of nurse who was not a facility employee and had no personal knowledge of the incident). In addition, the ALJ could reasonably conclude that Ms. Costa-Nadora's testimony about the "delegation of the POA" was irrelevant. As already noted, the MPOA document appointed R4's granddaughter D.G. as her representative and her daughter J.F. as the successor representative if D.G. "is unable, unwilling or disqualified to serve." P. Exs. 1, at 3, 24, at 1. The record includes a document signed by D.G. on January 24, 2014 in which she delegated her authority as POA for R4 to J.F. P. Ex. 1, at 5. The document speaks for itself, and in any event, nothing in the MSJ raises any question about the validity of this "delegation."[39] Accordingly, we uphold the ALJ's ruling excluding Petitioner's Exhibit 34.

NMS described the testimony of Kriscia Carias, NMS's Business Office Manager (P. Exhibit 38) as follows:

> Ms. Carias . . . offers testimony regarding the delegation of the POA to [J.F.], which she witnessed.

List at 6.

[39] We note that although D.G. signed the "delegation" after J.F. began acting as POA for R4, the MPOA document on its face does not require a written delegation.

The ALJ's ruling stated:

> CMS argues that her testimony is irrelevant because she was not part of the clinical evaluation of Resident # 4 nor did she impart information to Petitioner's staff concerning the resident's clinical condition. I sustain CMS's objection as the witness' proffered testimony is clearly irrelevant.

ALJ Ruling at 5.

NMS's request for review does not comment on the ALJ's rationale for excluding Ms. Carias' testimony. Nor did NMS specifically rely on any of her testimony in its pre-hearing brief or response to the MSJ. The ALJ could reasonably conclude that Ms. Carias' testimony about the "delegation of the POA" was irrelevant for the reasons discussed above. Accordingly, we uphold the ALJ's ruling excluding Petitioner's Exhibit 38.

Conclusion

Based on the foregoing analysis, we uphold the ALJ Decision in part and remand it in part. In summary, we conclude as follows:

● NMS raised genuine disputes of material fact with respect to the alleged noncompliance with 42 C.F.R. §§ 483.13, 483.10(j)(1)-(2), and 483.20(k)(3)(i).

● NMS raised genuine disputes of material fact with respect to CMS's finding of immediate jeopardy based on the alleged noncompliance with those three regulatory requirements.

● Undisputed facts establish NMS's noncompliance with section 483.75(*l)*(1) at a less than immediate jeopardy level.

● NMS raised genuine disputes of material fact with respect to the alleged noncompliance with section 483.10(k) at a less than immediate jeopardy level.

On remand, the ALJ should provide an opportunity for further proceedings with respect to the alleged noncompliance as to which we conclude NMS raised genuine disputes of material fact. In addition, the ALJ may, if he deems necessary, provide an opportunity for further proceedings with respect to the alleged noncompliance with the two less than immediate jeopardy-level requirements he did not consider in his decision. The ALJ should make a new determination as to whether any noncompliance posed immediate

jeopardy. If he concludes that there was immediate jeopardy, the ALJ should make a new determination as to whether the $5,650 per-day CMP imposed by CMS is reasonable in amount if he also concludes that NMS was in substantial compliance with at least one of the participation requirements as to which CMS found noncompliance at the immediate jeopardy level. The ALJ should make a new determination as to whether the $150 per-day CMP is reasonable if he relies on noncompliance at the less than immediate jeopardy level with fewer than the four requirements on which CMS relied in imposing the CMP.

/s/
Leslie A. Sussan

/s/
Constance B. Tobias

/s/
Susan S. Yim
Presiding Board Member