Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Appellate Division

In the Case of:	
Evergreene Nursing Care Center,	DATE: March 8, 2007
Petitioner,	Civil Remedies CR1337 App. Div. Docket No. A-06-12
- v. -	Decision No. 2069
Centers for Medicare & Medicaid Services.	

FINAL DECISION ON REVIEW OF ADMINISTRATIVE LAW JUDGE DECISION

The Centers for Medicare & Medicaid Services (CMS) appealed the August 18, 2005 decision of Administrative Law Judge (ALJ) Steven T. Kessel, Evergreene Nursing Care Center, DAB CR1337 (2005) (ALJ Decision). This matter arose after CMS decided, on the basis of a May 2005 compliance survey, to terminate the Medicare participation of Evergreene Nursing Care Center (Evergreene), a Virginia skilled nursing facility (SNF). In his August 18, 2005 decision, the ALJ overturned CMS's determination that Evergreene was not in substantial compliance with Medicare participation requirements at the time of the May 2005 survey. Accordingly, the ALJ concluded that CMS lacked a legal basis to terminate Evergreene's participation in the Medicare program.

CMS contends in this appeal that the ALJ's decision is based on errors of law and is not supported by substantial evidence. CMS also contends that the ALJ abused his discretion when conducting the evidentiary proceeding and evaluating the record.

For the reasons discussed below, we affirm parts of the ALJ Decision but reverse his ultimate conclusion that CMS lacked a basis to terminate Evergreene's Medicare participation. In particular, we find, as a preliminary matter, that the ALJ failed to adhere to the well-established framework for allocating the

burden of proof on the issue of whether a SNF is in substantial compliance with Medicare requirements. Nonetheless, we affirm the portions of the ALJ Decision that address Evergreene's alleged noncompliance with three Medicare participation requirements – 42 C.F.R. §§ 483.13(a), 483.20(k)(2), and 483.25 – because the burden of proof error was harmless in those instances.

However, we decide that the ALJ's findings and conclusions that Evergreene was in compliance with two other participation requirements – 42 C.F.R. §§ 483.25(a)(2) and 483.25(h)(2) – are not supported by substantial evidence and are based on errors of law (including the burden of proof error). Accordingly, we vacate those findings and conclusions and substitute findings and conclusions of our own that uphold CMS's determinations of noncompliance. We conclude, in particular, that CMS made a prima facie showing that at the time of the May 2005 survey, Evergreene was not in substantial compliance with sections 483.25(a)(2) and 483.25(h)(2) and that Evergreene failed to rebut or overcome CMS's prima facie case by a preponderance of the evidence. Because we uphold CMS's determination that Evergreene was not in substantial compliance at the time of the May 2005 survey, we also sustain CMS's decision to terminate Evergreene's participation in the Medicare program.

Legal Background

To participate in the Medicare program, a SNF must comply with the requirements for participation found in 42 C.F.R. Part 483, subpart B. 42 C.F.R. §§ 483.1, 488.3. Compliance with these participation requirements is verified by surveys conducted by state health agencies. 42 C.F.R. Part 488, subpart E.

Survey findings are reported in a Statement of Deficiencies. The Statement of Deficiencies identifies each "deficiency" under the regulatory requirements, citing both the regulation at issue and corresponding "tag" numbers used by surveyors for organizational purposes.

If a survey finds that a SNF is not in "substantial compliance" with Medicare participation requirements, CMS may impose one or more enforcement remedies, including termination of the SNF's program participation. 42 C.F.R. §§ 488.402(c), 488.406. A SNF is not in "substantial compliance" if it has a deficiency that creates at least the potential for more than "minimal harm" to residents. See 42 C.F.R. § 488.301 (defining "substantial compliance" to mean the level of compliance such that "any identified deficiencies pose no greater risk to resident health

or safety than the potential for causing minimal harm"); The Windsor House, DAB No. 1942, at 2-3, 61 (2004). CMS's regulations (and we) use the term "noncompliance" to refer to "any deficiency that causes a facility to not be in substantial compliance." 42 C.F.R. § 488.301.

In addition to permitting termination whenever a facility is not in substantial compliance, the law requires termination from the Medicare program if a facility has been out of substantial compliance for six months following a survey in which noncompliance is found. 42 C.F.R. §§ 488.412(a) and (d), 488.450(d); see also Georgian Court Nursing Center, DAB No. 1866 (2003).

Case Background[1]

A survey completed on December 1, 2004 found that Evergreene was not in substantial compliance with Medicare participation requirements in 42 C.F.R. Part 483. CMS Ex. 1. A January 2005 revisit survey found continuing noncompliance. CMS Ex. 2.

In February 2005, based on the findings of the January 2005 revisit survey, CMS imposed a denial of payment for new admissions (DPNA) on Evergreene. CMS Ex. 3. CMS also advised Evergreene that its Medicare participation would be terminated on June 2, 2005 if it did not achieve substantial compliance.[2] Id.

A second revisit survey in March 2005, and a third revisit survey completed on May 26, 2005 resulted in additional findings of noncompliance. CMS Exs. 4 and 5. The Statement of Deficiencies for the May 2005 survey reported that Evergreene was in noncompliance with each of the following five participation requirements: 42 C.F.R. § 483.13(a), 42 C.F.R. § 483.20(k)(2), 42 C.F.R. § 483.25, 42 C.F.R. § 483.25(a)(2), and 42 C.F.R.

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[1] The information in this section is drawn from the ALJ Decision and the record before the ALJ, and is presented to provide a context for the discussion of the issues raised on appeal. Nothing in this section is intended to replace, modify, or supplement the ALJ's findings of fact.

[2] Evergreene had the right to appeal the findings of noncompliance that resulted in the DPNA but did not do so. See CMS Ex. 3, at 2; 42 C.F.R. § 498.3(b)(13) (providing a right to appeal findings of noncompliance that result in the imposition of a remedy specified in section 488.406); 42 C.F.R. § 488.406 (listing available remedies, including a DPNA).

§ 483.25(h)(2). At no point between the December 2004 and May 2005 surveys did surveyors find that Evergreene was in substantial compliance.

On June 8, 2005, CMS notified Evergreene by letter that its Medicare participation would be terminated effective June 27, 2005 because of noncompliance with program participation requirements. CMS Ex. 6.

On June 14, 2005, Evergreene requested an expedited ALJ hearing to challenge CMS's decision to terminate its Medicare participation. The parties subsequently submitted written direct testimony and documentary evidence. The ALJ then held an in-person hearing to allow the parties to conduct cross-examination and offer rebuttal testimony. The parties agreed that, for purposes of the hearing, the five previously mentioned deficiency findings from the May 2005 survey – finding noncompliance with 42 C.F.R. §§ 483.13(a), 483.20(k)(2), 483.25, 483.25(a)(2), and 483.25(h)(2) – were the bases for CMS's termination decision.[3] See CMS Ex. 9; Petitioner Evergreene Nursing Care Center's Prehearing Br. at 1-2 & n.3 (July 8, 2005); Respondent's Pre-Hearing Br. at 3 n.3 (June 30, 2005). Evergreene raised a dispute about each of these five findings.

The ALJ concluded, in the decision that CMS now appeals, that the evidence of record failed to support the five disputed May 2005 deficiency findings. ALJ Decision at 5-26. Accordingly, the ALJ determined that CMS lacked a legal basis to terminate Evergreene's participation in the Medicare program. Id. at 26.

Standard of Review

We review a disputed finding of fact to determine whether the finding is supported by substantial evidence, and a disputed conclusion of law to determine whether it is erroneous. *Guidelines - Appellate Review of Decisions of Administrative Law*

[3] During the ALJ hearing, CMS rescinded a sixth deficiency finding from that survey, involving the requirement at 42 C.F.R. § 483.20(k)(3)(i). ALJ Decision at 5; Tr. at 2-3. The state survey agency identified a seventh deficiency found during the survey, involving 42 C.F.R. § 483.75(j), as not serious enough to warrant a finding of noncompliance. CMS Ex. 9, at 22 (indicating that the deficiency labeled tag F502 was at scope-and-severity level B); State Operations Manual, CMS Pub. 100–07, § 7400E (available on CMS's website at http://www.cms.hhs.gov/Manuals/IOM/list.asp).

Judges Affecting a Provider's Participation in the Medicare and Medicaid Programs (at http://www.hhs.gov/dab/guidelines/prov.html); South Valley Health Care Center, DAB No. 1691, at 2 (1999), aff'd, South Valley Health Care Center v. HCFA, 223 F.3d 1221 (10th Cir. 2000).

Discussion

CMS contends with respect to each of the five disputed findings of noncompliance that the ALJ Decision is not supported by substantial evidence or is based on prejudicial legal errors. CMS Br. at 8-37. CMS also contends that the ALJ abused his discretion in various respects. Id. at 37-56. For these reasons, CMS asks that we reverse the ALJ Decision and sustain the termination of Evergreene's Medicare participation. Id. at 57. Evergreene responds that the ALJ Decision is legally correct and supported by substantial evidence, and that the ALJ properly conducted the hearing in this case.

Before discussing the ALJ's findings of fact and conclusions of law, we address two issues of general significance that arose from our consideration of the parties' arguments. The first concerns the legal bases for CMS's decision to terminate Evergreene's Medicare participation. Under its regulations, CMS has the discretion to terminate a SNF's participation whenever it determines, on the basis of a survey, that the SNF is out of substantial compliance with one or more participation requirements.[4] In its pre-hearing brief to the ALJ, CMS claimed that its termination decision was mandatory under 42 C.F.R. § 488.412(a) because Evergreene had been in noncompliance for a period of six continuous months beginning in December 2004.[5] See CMS Pre-Hearing Br. at 1-2 (June 30, 2005). The ALJ found, however, that because the regulations gave CMS discretion to

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[4] 42 C.F.R. § 488.456(b)(1) (CMS may terminate a SNF's provider agreement if the SNF "[i]s not in substantial compliance with requirements of participation, regardless of whether or not immediate jeopardy is present"); see also Rosewood Living Center, DAB No. 2019 (2006) (noting that "[a] single deficiency is sufficient to warrant termination if the deficiency causes the facility to be out of substantial compliance").

[5] Although CMS's June 8, 2005 termination notice refers to findings of noncompliance from surveys performed prior to May 26, 2005, the notice does not state that CMS's decision to terminate Evergreene's participation was mandatory under section 488.412(a) because of six continuous months of noncompliance.

impose termination based on the most recent (May 2005) survey findings, he did not have to determine whether Evergreene had been out of substantial compliance for six consecutive months. ALJ Decision at 4. The ALJ stated that he needed to ascertain only if Evergreene was in substantial compliance at the time of the May 2005 survey because if Evergreene was not in substantial compliance at the time of that survey, then CMS was legally authorized to terminate its Medicare participation, regardless of whether noncompliance existed at the time of prior surveys or for six consecutive months. Id.

Evergreene does not challenge the ALJ's characterization of the determinative legal issue. In particular, Evergreene does not dispute that CMS may terminate its participation based solely on one or more findings of noncompliance from the May 2005 survey, nor does Evergreene contend that CMS was required to prove lack of substantial compliance at the time of prior surveys.[6] Although Evergreene argued before the ALJ that the termination decision should be reversed because it came back into substantial compliance before the effective date (June 27, 2005) of that decision (see infra fn. 6), Evergreene does not renew that argument in its appeal briefs; thus, we need not address it.[7]

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[6] Evergreene's presentation to the ALJ focused entirely on the May 2005 survey. In its pre-hearing brief to the ALJ, Evergreene identified the "two main issues" in the case as the following: "The first is whether CMS can present evidence sufficient to establish a prima facie case that the Facility was not complying with certain Medicare COPs as set forth in the May 2567 [Statement of Deficiencies] . . . . The second issue is whether CMS can present evidence sufficient to establish a prima facie case that Evergreene was not complying with certain Medicare COPs as set forth in the May 2567 as of the date of termination on June 27, 2005." Petitioner Evergreene Nursing Care Center's Prehearing Br. at 4 (July 8, 2005).

[7] However we note that the Board rejected a similar argument in Carmel Convalescent Hospital, DAB No. 1584 (1996). There the Board relied on the statute and regulations providing that compliance (or noncompliance) is determined by surveys and on the regulation providing that a facility cannot enter the Medicare program any earlier than the date on which an onsite survey establishes its compliance. Based on those provisions, the Board concluded, "when the facility's participation is terminated because of alleged noncompliance, the critical date for establishing compliance is the survey date, not the

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For these reasons, we accept the ALJ's formulation of the determinative issue, which is: was Evergreene out of substantial compliance at the time of the May 2005 survey? If Evergreene was out of substantial compliance at the time of that survey, then CMS had a sufficient legal basis to terminate Evergreene's participation in the Medicare program.

The second general issue we address concerns the burden of proof. The ALJ Decision does not adhere to the well-established framework for allocating the burden of proof on the issue of whether the SNF was out of substantial compliance. Under that framework, which the Board adopted based on the applicable statutory and regulatory provisions, CMS has the burden of coming forward with evidence related to disputed findings that is sufficient (together with any undisputed findings and relevant legal authority) to establish a prima facie case of noncompliance with a regulatory requirement. If CMS makes this prima facie showing, then the SNF must carry its ultimate burden of persuasion by showing, by a preponderance of the evidence, on the record as a whole, that it was in substantial compliance during the relevant period. See Hillman Rehabilitation Center, DAB No. 1611 (1997), aff'd, Hillman Rehabilitation Ctr. v. HHS, No. 98-3789 (GEB) (D. N.J. May 13, 1999); Batavia Nursing and Convalescent Inn, DAB No. 1911 (2004), aff'd, Batavia Nursing and Convalesent Center v. Thompson, No. 04-3687 (6th Cir. 2005); Guardian Health Care Center, DAB No. 1943 (2004); Fairfax Nursing Home, Inc., DAB No. 1794 (2001), aff'd, Fairfax Nursing Home v. Dep't of Health & Human Srvcs., 300 F.3d 835 (7th Cir. 2002), cert. denied, 2003 WL 98478 (Jan. 13, 2003).

CMS makes a prima facie showing of noncompliance if the evidence CMS relies on is sufficient to support a decision in its favor absent an effective rebuttal. Hillman Rehabilitation Center, DAB No. 1663, at 8 (1998), aff'd, Hillman Rehabilitation Ctr. v. HHS, No. 98-3789 (GEB) (D. N.J. May 13, 1999); see also Guardian Health Care Center. A facility can overcome CMS's prima facie case either by rebutting the evidence upon which that case rests, or by proving facts that affirmatively show substantial compliance. Tri-County Extended Care Center, DAB No. 1936 (2004). "An effective rebuttal of CMS's prima facie case would mean that at the close of the evidence the provider had shown that the facts on which its case depended (that is, for which it

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[7](...continued)
subsequent effective date of the termination." DAB No. 1584, at 12-14.

had the burden of proof) were supported by a preponderance of the evidence." Id. at 4 (quoting Western Care Management Corp., DAB No. 1921 (2004)).

In this case, the ALJ's analysis did not keep the parties' respective burdens separate. For example, the ALJ concluded that "CMS did not prove a prima facie case that [Evergreene] failed to comply substantially with" 42 C.F.R. § 483.13(a). ALJ Decision at 6. However, the ALJ considered – and weighed – the facts and evidence relied upon by both parties in deciding whether CMS had made its prima facie case. By reaching his conclusion on that issue based on a weighing of all the evidence, the ALJ effectively required CMS to carry the burden of persuasion on the ultimate issue of Evergreene's alleged noncompliance and thus rendered the burden of proof framework irrelevant. As discussed, the SNF has the burden of persuading the ALJ that it was in substantial compliance, provided CMS has made a prima facie showing of noncompliance. CMS does not have the burden of proving that the SNF was not in substantial compliance. Weighing the evidence is appropriate only for determining whether the SNF has carried its ultimate burden of persuasion, not for determining whether CMS has made its prima facie case.[8] See Vandalia Park, DAB No. 1940 (2004) ("the question being asked in evaluating whether CMS met the initial test of presenting a prima facie case is whether the facts on which CMS relies made out a legally-sufficient case, even were CMS's case not challenged by any evidence from the facility"), aff'd, Vandalia Park v. Leavitt, No. 04-4283 (6th Cir. Dec. 8, 2005); Hillman Rehabilitation Center, DAB No. 1663, at 8 (indicating that an ALJ weighs all relevant evidence once the facility presents evidence opposing CMS's prima facie case).

Other findings suggest that the ALJ misallocated the burden of persuasion to CMS. With respect to the survey findings alleging noncompliance with sections 483.25, 483.25(a)(2), and 483.25(h)(2), the ALJ concluded, "The *preponderance of the evidence* does not support a finding that Petitioner *failed to*

[8] Evergreene alleged that CMS had not carried its initial burden of making a prima facie showing of noncompliance; thus, the ALJ was required to specifically address that issue, applying the appropriate burden of proof framework as discussed above. However, when a SNF does not dispute the existence of CMS's prima facie case, then the ALJ may resolve the ultimate issue – i.e., whether the SNF has proved substantial compliance by a preponderance of the evidence – without discussing whether CMS carried its evidentiary burden.

comply" with these participation requirements. ALJ Decision at 16, 21, and 23 (italics added). The ALJ's language – referring to proof of a failure to comply, rather than proof of substantial compliance, and indicating that failure to comply had not been proven by a "preponderance" of evidence – strongly suggests that the ALJ required CMS to carry the burden of persuasion on the issue of Evergreene's alleged noncompliance.

In short, it appears that the ALJ placed the burden of persuasion on the wrong party. As we discuss below (in section C), that error was harmless with respect to the ALJ's decision to overturn three of the five disputed May 2005 survey findings – namely, the findings that Evergreene was not in substantial compliance with sections 483.13(a), 483.20(k)(2), and 483.25. The error was harmless in those instances because, in each case, either CMS failed to make a prima facie showing of noncompliance, or Evergreene carried its burden of proving substantial compliance by a preponderance of the evidence.

However, the burden of proof error was not harmless with respect to the ALJ's decision to overturn the disputed survey findings involving sections 483.25(a)(2) and 483.25(h)(2). For that reason and others (discussed below in sections A and B), we vacate the portions of the ALJ Decision that address those two survey findings and in their place issue our own findings of fact and conclusions of law.[9] We conclude, in sections A and B below, that CMS made a prima facie showing that Evergreene was not in substantial compliance with sections 483.25(a)(2) and 483.25(h)(2), and that Evergreene failed to overcome CMS's prima facie case by a preponderance of the evidence.

A. *Evergreene was not in substantial compliance with 42 C.F.R. § 483.25(a)(2) at the time of the May 2005 survey.*

CMS alleged before the ALJ that Evergreene was not in substantial compliance with 42 C.F.R. § 483.25(a)(2) because it failed to

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[9] When the Board finds that an ALJ's decision is based on factual or legal errors, the Board may issue a new or modified decision or remand the case to the ALJ for that purpose. See 42 C.F.R. § 498.88(a); Western Care Management Corp. In this case, neither party indicated that remanding the case would be necessary in the event that we overturned the ALJ Decision in whole or part. Consequently, we have elected to resolve this matter by issuing our own findings and conclusions where necessary.

implement a February 23, 2005 physician's order to provide "restorative dining" to Resident 310. Respondent's Post-Hearing Br. at 13-14 (Aug. 5, 2005). Section 483.25(a)(2) provides that a SNF "must ensure" that a resident "is given the appropriate treatment and services to maintain or improve" his ability to perform the activities of daily living specified in section 483.25(a)(1), including the ability to eat (which is specified in section 483.25(a)(1)(iv)).[10]

The ALJ concluded that a preponderance of the evidence failed to establish that Evergreene was not in substantial compliance with section 483.25(a)(2). ALJ Decision at 21. The ALJ based his decision largely on his conclusion that "[i]t is unclear what the resident's physician meant by 'restorative dining.'" Id. The ALJ noted that the term was not defined in Resident 310's treatment record and stated:

> CMS has offered no evidence to establish that the term is a term of art that is widely accepted and understood in the nursing profession to encompass a particular set of services. Consequently, it is very difficult to decide, on the basis of the evidence offered by CMS, whether Petitioner did or did not provide all of the elements of 'restorative dining' to Resident #310 that

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[10] The following is the full text of sections 483.25(a)(1) and 483.25(a)(2):

> (a) Based on the comprehensive assessment of the resident, the facility must ensure that –
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> (1) A resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's ability to –
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> (i) Bathe, dress, and groom;
> (ii) Transfer and ambulate;
> (iii) Toilet;
> (iv) Eat; and
> (v) Use speech, language, or other functional communication systems
>
> (2) A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (a)(1) of this section[.]

> were contemplated by the resident's physician when she issued her order.

Id. The ALJ then concluded:

> In the absence of a definition of the term 'restorative dining,' what I decide is whether Petitioner implemented the physician's specific instructions concerning nutrition – i.e., instructions as to the type or quantity of food that was given to the resident – and whether Petitioner complied with applicable standards of nursing care in providing nutrition to the resident. In these regards I find that the preponderance of the evidence establishes that Petitioner's staff implemented the physician's orders and did all that it reasonably could be expected to do to provide nutritional care for Resident #310. The record therefore does not show that Petitioner neglected the resident's nutritional care in any significant respect.

Id. at 22.

The ALJ's legal analysis is flawed, not only because the ALJ applied the wrong burden of proof framework, but because, as we explain below, the ALJ failed to determine Evergreene's compliance status under the relevant regulatory requirement, section 483.25(a)(2). He committed the latter error by treating the issue of Evergreene's compliance with section 483.25(a)(2) as a nutritional issue. As indicated above, section 483.25(a)(2) addresses a SNF's obligation to provide services that maintain or improve each resident's ability to eat, not its obligation to maintain acceptable parameters of nutrition for each resident. The obligation to provide adequate nutrition is imposed by a separate quality of care regulation, section 483.25(i). The guidelines issued by CMS to help surveyors apply section 483.25(a)(2) further illuminate what is clear on the face of that regulation — that it deals with how a resident eats on a day-to-day basis, not on what the resident eats or what constitutes acceptable nutrition for that resident. See State Operations Manual (CMS Pub. 100-07), App. PP, *Guidance to Surveyors for Long Term Care Facilities* (Survey Guidelines) (stating that the term "eating" refers to "how a resident ingests and drinks (regardless of self-feeding skill)").[11] As Evergreene notes in its appeal

[11] The State Operations Manual, which Evergreene cited in (continued...)

brief, "the intent of the regulation 'is to stress that the facility is responsible for providing maintenance and restorative programs that will not only maintain, but improve [a resident's ability to do ADL's], as indicated by the resident's comprehensive assessment to achieve and maintain the highest practicable outcome.'" Evergreene Br. at 42, quoting Survey Guidelines (parenthetical added). Certainly there is a relationship between providing adequate nutrition and providing services that help to maintain or improve a resident's ability to eat. However, the noncompliance alleged here was that Evergreene had failed to do the latter, not the former. Moreover, as discussed below, a preponderance of the evidence indicates that restorative dining is a nursing service whose purpose is to help a resident maintain or improve his ability to eat. Accordingly, the determinative issue is whether Evergreene provided the restorative dining program ordered by Resident 310's physician — a program that would help maintain or improve Resident 310's ability to eat — not whether it provided adequate nutrition to Resident 310. Because the ALJ did not address that determinative issue under the appropriate burden of proof framework, his decision to overturn CMS's finding of noncompliance with section 483.25(a)(2) is an error of law. Accordingly, we are compelled to issue our own factual findings and legal conclusions regarding that survey finding.

We disagree with the ALJ's conclusion that the record is inadequate to determine whether Resident 310 was receiving the restorative dining program ordered by the physician. The facts asserted in the Statement of Deficiencies, without more, set out at least a prima facie case that Evergreene's staff understood what restorative dining was and that no restorative dining was provided to Resident 310, regardless of how that term is defined. A prima facie case consists of evidence that, if unrebutted, demonstrates lack of substantial compliance with a regulatory requirement. The facts alleged in the Statement of Deficiencies include the following. Resident 310's closed clinical record contained a physician's order for a "Restorative Dining Program."[12] CMS Ex. 9, at 16. The physician signed the order

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[11](...continued)
its appeal brief, is available on CMS's public website, at http://www.cms.hhs.gov/Manuals/IOM/list.asp.

[12] The review was a closed record review because the resident died on May 19, 2005. CMS Ex. 9, at 16. Surveyor Jo-Ann Bonesteel explained that the surveyors looked at Resident
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that is in the record on May 4, 2005, but as indicated on that document, the order first went into effect on February 23, 2005. Id. at 16. During an interview on May 25, 2005, facility staff told the surveyors that the nurse aides responsible for providing restorative nursing services were no longer providing them due to a lack of staffing. Id. at 16. Also, during an interview on May 26, 2005, the surveyor asked Evergreene's administrative staff if the order for restorative dining had been followed for Resident 310. Id. at 17-18. Evergreene's corporate consultant responded that Resident 310 had returned from the hospital on May 12, 2005 as a hospice patient and for that reason was not receiving restorative dining. Id. at 18. When asked whether Resident 310 had received restorative dining services prior to his hospitalization, the consultant did not respond directly but stated that he had not been eating very well and had been refusing food. Id. The surveyor then asked Evergreene for evidence that Resident 310 had received restorative dining prior to his hospitalization (that is, between February 23 and May 3, 2005, since records show that the resident was admitted to the hospital on May 4, 2005). Id. Evergreene provided no such documentary evidence. Id. In short, the Statement of Deficiencies on its own shows that Evergreene never implemented the physician's February 23, 2005 order for Resident 310's restorative dining program.

Other evidence corroborates the facts and staff statements reported in the Statement of Deficiencies. A treatment administration record for May 2005 reflects the physician's order for a Restorative Dining Program with a February 23, 2005 start date. CMS Ex. 24, at 24; P. Ex. 16-C, at 3. However, there are no initials, checkmarks, or notations on this record indicating that restorative dining was provided on any day that month.[13] In

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[12](...continued)
310's closed record because he had been identified on a prior survey as having been injured in a fall and because he was one of 14 residents named in a complaint that the state survey agency had received from the Virginia Department of Social Services on April 15, 2005. CMS Ex. 29, at 41-42.

[13] As discussed below, Resident 310 was hospitalized on May 4, 2005 and was put into hospice upon his readmission to Evergreene's facility on or about May 12, 2005. Accordingly, in reaching our decision, we have not considered the absence of initials, checkmarks, or notations on the treatment administration record for the days after May 3, 2005. Standing
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addition, Surveyor Bonesteel gave sworn direct testimony (by declaration) that she reviewed Resident 310's clinical record but found no documentation that he had received restorative dining services, even though he should have been receiving such services prior to his May hospitalization pursuant to his doctor's orders. CMS Ex. 29, at 44, ¶ 11. In addition, Surveyor Bonesteel stated that she had repeatedly asked Evergreene for documentation that the nursing staff provided restorative dining to Resident 310 prior to his hospitalization in early May 2005 but that Evergreene failed to provide any. Id. at 45-47. Surveyor Bonesteel also testified that members of the nursing staff responsible for providing restorative dining services told the survey team in a May 26, 2005 interview that restorative dining had not been provided in the facility for more than one month because of a staffing shortage. Id. at 45, ¶ 14. Surveyor Bonesteel also identified by name a certified nurse aide (CNA) and restorative aide who told her that there had been no restorative dining for the past month and that she had been "'pulled'" from her position as restorative aide a month before the survey ... due to staffing shortages." Id. at 45, ¶ 12. Ms. Bonesteel also stated that she had been approached by a Nurse Practitioner working for two doctors who had patients at Evergreene who expressed concern that residents were not receiving appropriate care because of staffing shortages and staff "burnout." Id. at 45, ¶ 13. This is significant information since the Survey Guidelines pose the following question as one of the probes for determining whether a facility is in compliance with section 483.25(a)(2) as it relates to eating: "Is there sufficient staff time and assistance provided to maintain eating abilities (e.g., allowing residents enough time to eat independently or with limited assistance)?" Survey Guidelines (guidelines for tag F311).

The ALJ stated that he did not find the staff statements to Surveyor Bonesteel to be "persuasive proof" that Evergreene had

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[13](...continued)
alone, the absence of initials or checkmarks for three days in May may not have much significance. However, this evidence, together with the fact that Evergreene has not presented any treatment records indicating that restorative dining was provided during February, March, or April 2005, tends to corroborate Surveyor Bonesteel's testimony. It is reasonable to assume that if Evergreene had documents that contradicted Surveyor Bonesteel's statements about the lack of evidence in Resident 310's record that restorative dining services were being provided, it would have put those documents into evidence.

abandoned its restorative dining program, in part because he regarded the statements as unverifiable hearsay. ALJ Decision at 23. However, during the hearing, the facility did not dispute the veracity of those statements, seek to exclude them from the record as unreliable, or attempt to subpoena the declarants. Moreover, the ALJ did not find that Surveyor Bonesteel was not a credible witness. In addition, Evergreene did not cross-examine Surveyor Bonesteel about the statements; neither did it put on testimony rebutting her statements regarding staff comments to her or regarding the absence of documentation that the facility had implemented a restorative dining program for Resident 310 or any other resident for whom such a program had been ordered. Accordingly, we see no reason not to accept those statements as evidence that Evergreene was not providing restorative dining during at least part of the time period covered by the doctor's order for Resident 310.[14] Florence Park Care Center, DAB No. 1931, at 10 (2004) (holding that hearsay is admissible when it has sufficient indicia of reliability); Guardian Health Care Center at 14-15 (2004) (indicating that CMS may make a prima facie showing of noncompliance based on the factual allegations in the Statement of Deficiencies if those allegations are specific, undisputed, and not inherently unreliable).

In this appeal as well, Evergreene does not dispute any of the facts alleged in the Statement of Deficiencies or Surveyor Bonesteel's declaration. Indeed, Evergreene tacitly admits that it did not provide a restorative dining program for Resident 310 by arguing in its brief that, "not only was a formal restorative dining program irrelevant, it was unwarranted," Evergreene Br. at 43, and "the evidence clearly demonstrates that as early as 2-4 months prior to the survey, this Resident was no longer

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[14] The ALJ stated that he chose not to rely on the statements in part because they contained no "specific information about what Petitioner and its staff did for Resident # 310." ALJ Decision at 23. However, it is unclear to us how the declarants' failure to exhibit their familiarity with Resident 310 renders their statements unreliable. Whether or not the declarants were familiar with Resident 310's care or case, the statements are relevant to the compliance issue because they indicate that Evergreene was not providing restorative dining to any resident in the facility because of staff shortages. They also indicate that facility staff understood what a restorative dining program would entail. Thus, even if Resident 310's medical status somehow excused the staff from following his physician's order, as the ALJ seemed to think, the statements still reveal a compliance problem.

appropriate for a formalized restorative dining program," id. at 45. If Evergreene's nursing staff thought that restorative dining was inappropriate, the contemporaneous medical records do not reflect that judgment. In fact, those records do not say why the order for a restorative dining program was not implemented. Evergreene's position that restorative dining was not appropriate is based on Dr. Mary Preston's testimony that Resident 310 "was declining as of the date of his admission to the Facility." Evergreene Br. at 42. (Resident 310 was admitted to Evergreene's facility on November 16, 2004; he died on May 19, 2005. CMS Ex. 9, at 16.) However, Dr. Preston did not state that restorative dining was inappropriate for Resident 310 prior to his hospitalization. Moreover, Dr. Preston was not Resident 310's physician. P. Ex. 30, at 2. Resident 310's physician presumably considered a restorative dining program appropriate treatment since he ordered it.[15] P. Ex. 16-A, at 5. Even if Resident 310's physician was wrong about Resident 310's ability to participate in and benefit from a restorative dining program, there is no evidence that Dr. Preston or any other member of Evergreene's staff had the authority to refuse to implement that order. There also is no evidence that the staff discussed with Resident 310's physician any concerns they might have had as to the appropriateness of the order.

Evergreene relies on Dr. Preston's testimony that staff "carried out nearly extraordinary measures to get this man to eat, which I would consider restorative dining," noting that they gave him "extra calories," "extra cereal," "extra feeding" and, on his physician's orders, "extra nutrition." Tr. at 97. However, when asked directly what she meant by the term "restorative dining," Dr. Preston defined it as including particular therapies and nursing interventions such as occupational therapy. Tr. at 100.

Dr. Preston's testimony regarding the therapeutic nature of restorative dining is consistent with other evidence showing that "restorative dining" is a program to maintain or restore functional abilities associated with activities of daily living, e.g., the ability to eat, not a nutritional program. On the Physician's Order Forms, the order for a "restorative dining

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[15] The Physician's Order Forms and other treatment records name Dr. David S. Duani as Resident 310's physician. P. Ex. 16-A, at 8-12. The order form that includes the entry for the restorative dining program appears to have been signed by someone other than Dr. Duani, id. at 5, but no party has argued that the person who signed the order was not authorized to do so by Dr. Duani.

program" appears under the heading "Restorative Orders," whereas the dietary and nutritional measures that Dr. Preston referred to appear under the headings "Diet" and "Supplements." P. Ex. 16-A, at 1, 5. Evergreene's treatment administration charts also list restorative dining as an intervention separate from the reported efforts to feed the resident. See CMS Ex. 24, at 24; P. Ex. 16-E, at 4. In addition, Evergreene's plan of correction for the noncompliance cited under section 483.25(a)(2) refers to a specialized program involving: "screening for restorative dining needs by observation in the assisted dining room"; "in-servic[ing] the licensed nurses and nurse aides on Restorative Dining procedures" by an occupational therapist; and establishing the "Rehab manager[']s" responsibility to observe and document Restorative Dining on a fixed long-term schedule and to "document compliance and progress with Restorative Plans." CMS Ex. 9, at 16-17. Deborah Danford, Director of Clinical Services for HP/Management Services, a company that provides management services to Evergreene, testified that she "played a direct role in developing and implementing Evergreene's Plan of Correction." P. Ex. 28, at 1, 2. Ms. Danford's testimony about the actions taken to correct the noncompliance involving the lack of a restorative dining program confirms the distinctly restorative focus of such a program. Id. at 15-16.

Evergreene implicitly concedes in its appeal brief that restorative dining and the provision of nutrition are distinct (albeit related) services. While noting that its nursing staff monitored Resident 310's meal consumption, implemented physician orders for nutritional supplements, and spoon-fed the resident, Evergreene also asserts, as we have previously noted, that a "formal" restorative dining program was "unwarranted" and "irrelevant" for Resident 310 in light of his overall medical condition. Response Br. at 43, 45. To claim that a "formal" restorative dining program was inappropriate for Resident 310 while simultaneously highlighting staff efforts to bolster Resident 310's nutrition or to feed him clearly suggests that restorative dining involves more than simply providing nutrition.

Dr. Preston suggested that, in her opinion, personally feeding a resident can be, in some circumstances, part of a restorative dining program. Tr. at 101. It appears that Evergreene's nursing staff did, as the ALJ found (ALJ Decision at 22), spoon-feed Resident 310, but there is no evidence that it did so as part of a restorative dining program established for him. We note in this regard that the entry indicating that Resident 310 was fed by spoon more than 50% of the time is on the facility record that tracks resident care (Resident Care Flow Record) under the heading "food intake," whereas the order for

"restorative dining program" is on the facility record that tracks provision of ordered treatments (PRN Treatments) and stands alone, that is, is not listed as a facet of food intake or nutrition. Compare P. Ex. 16-B at 2 with P. Ex. 16-C at 3. Moreover, the fact that Resident 310 sometimes required spoon-feeding is not proof that restorative dining could not have either improved his ability to eat, or helped him to maintain, or slow the deterioration of, whatever ability he possessed in this area of his life.

Evergreene's case relies in part on the fact that Resident 310 was admitted to the hospice program on May 12, 2005, after his return from the hospital, as evidence that a restorative dining program was not appropriate. For purposes of this decision we assume that restorative dining was not appropriate for Resident 310 after he entered hospice. However, that is irrelevant to the issue of whether he should have received, and whether he did receive, the ordered restorative dining services for the months prior to that date, beginning February 23, 2005. As the ALJ noted, under Medicare rules, admission to hospice requires a certification that the individual is in the end-stage of life. Since that certification did not occur until on or about May 12, 2005, it is not evidence that Evergreene could not participate in or benefit from restorative dining prior to that time.[16] See Oak Lawn Pavilion, DAB No. CR474 (1997), aff'd, DAB No. 1638 (1997) (rejecting the nursing home's attempt to justify its failure to provide care and treatment prescribed for the resident before entering hospice based on the resident's subsequent entry into a hospice program).

Implicit in Evergreene's arguments is the theory that there was no potential for more than minimal harm from the nursing staff's failure to provide restorative dining. However, Surveyor Bonesteel testified that Resident 310 should have received restorative dining prior to his hospitalization in early May 2005 and noted that there was nothing in his Minimum Data Set (MDS) assessment (dated April 3, 2005) indicating that this nursing service was inappropriate for him. CMS Ex. 29, at 47, ¶ 20; see also id. at 44, ¶¶ 7, 11 (noting that the MDS assessment identified no problems with Resident 310's memory or behavior). In addition, despite a "poor" rehabilitation potential, an

[16] While Evergreene cites the fact that Resident 310 was in a program called "transitions hospice" from January 5, 2005 forward, P. Ex. 16-A, at 11, it does not argue that transitions hospice is the equivalent of a hospice program or that it requires an end-stages-of-life certification.

interim plan of care dated January 5, 2005 called on the nursing staff to provide "restorative nursing care per protocol." P. Ex. 16-A, at 12. We infer from this evidence — and from the fact that Resident 310's physician took the trouble to order a restorative dining program — that this service had the potential to improve Resident 310's well-being in some more than minimal way. It follows that, because Resident 310 did not receive restorative dining, a potential existed that his ability to eat — and to eat safely and with a measure of independence — was worse than it would have been had he received that service. The quality of care requirement, of which section 483.25(a)(2) is a part, provides, "Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care." 42 C.F.R. § 483.25.[17] Evergreene's failure to provide a restorative dining program for Resident 310 did not accord with the treatment his physician ordered for him and inherently deprived Resident 310 of the opportunity to "attain or maintain [his] highest practicable physical, mental, and psychosocial well-being . . . ." Moreover, even if providing a restorative dining program for Resident 310 would not have avoided a negative outcome for him, the evidence that shortage of staff had led Evergreene to discontinue its restorative services altogether makes it reasonable to infer that the noncompliance had the potential for more than minimal harm to other residents who needed such services. In short, we find that CMS made a prima facie showing that Evergreene's failure to comply with section 483.25(a)(2) created a potential for more than minimal harm.

Evergreene did not rebut that element of CMS's prima facie case. As discussed, Evergreene's case rests primarily on its assertion that restorative dining was "inappropriate" or "unwarranted" because Resident 310's condition, including his ability to eat, had been "declining" since his admission to the facility in November 2004. But Resident 310's declining condition does not, by itself, prove the absence of a potential for harm; it merely raises an issue of whether restorative dining could have significantly improved — or at least helped to maintain or slow the deterioration of — Resident 310's ability to eat. Evergreene

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[17] Dr. Preston acknowledged at the hearing that the goal of restorative dining is "to bring the patient to the best possible situation for that patient." Tr. at 100. Clearly there is no possibility of meeting that goal when, contrary to physician orders, no restorative dining is provided.

presented no persuasive evidence on that issue. There is, for example, no evidence that qualified members of the nursing staff, such as an occupational therapist, evaluated Resident 310 prior to May 2005 to determine his ability to benefit from restorative dining. Furthermore, while Evergreene argues that "as early as 2-4 months prior to the survey, [Resident 310] was no longer appropriate for a formalized restorative dining program" because of his alleged declining health status, its witnesses did not directly challenge the physician order for a restorative dining program or testify that facility staff had raised with the physician any issue regarding the necessity or appropriateness of his order for any part of the relevant time period. Neither did any Evergreene witness specifically testify that a restorative dining program would not have improved or helped to maintain Resident 310's well-being during some or all of the nine weeks between February 23, 2005 and May 4, 2005. There is also no evidence that when the physician issued the order for restorative dining, he was unaware of Resident 310's condition and capacity to benefit from therapeutic services. If Evergreene had determined that restorative dining was unnecessary or inappropriate during that period, it is reasonable to expect that the nursing staff would have documented that determination, and the reasons for it, in Resident 310's treatment records and discussed the matter with the physician who ordered the restorative dining program.

There is some evidence that, for reasons that are not clear, Resident 310 started to refuse food in late April 2005. See P. Ex. 16-I, at 6 (hospital summary indicating that Resident 310 had been refusing food and "p.o. intake" (food intake by mouth) "for the past couple of weeks"); but see P. Ex. 16-B, at 1-2 (showing that Resident 1 generally consumed between 25 and 75 percent of meals during April and the first week of May 2005). However, even assuming it is true that Resident 310 was refusing food as of late April, no Evergreene witness testified that this would justify disregarding a standing physician's order. Furthermore, even assuming staff were justified in ignoring the order for restorative dining during late April and early May 2005, that would not excuse their failure to provide restorative dining in the weeks between February 23, 2005 (when the physician first ordered the service) and the middle of April 2005. We note that Evergreene's pre-May 2005 treatment records do not mention or discuss Resident 310's refusal to eat, nor do the progress notes written by Resident 310's physician during March and April 2005. See P. Ex. 16-G.

Finally, we reiterate that Evergreene never disputed testimony indicating that its nursing staff had, for at least one month

prior to the May 2005 survey, discontinued restorative dining for *all* residents, a serious lapse that by itself proves a violation of section 483.25(a)(2). There is no evidence that this facility-wide failure did not have the potential to cause more than minimal harm.

In summary, CMS made a prima facie showing that Evergreene was not in substantial compliance with section 483.25(a)(2) because it failed to implement a physician-ordered restorative dining program for Resident 310 and had discontinued restorative nursing services for other residents. Evergreene has not rebutted CMS's prima facie case by a preponderance of the evidence or, for that matter, under any other evidentiary standard, since the evidence of record, including Evergreene's tacit admissions, overwhelmingly shows Evergreene's failure to provide the ordered restorative dining program.

B. *Evergreene was not in substantial compliance with 42 C.F.R. § 483.25(h)(2) at the time of the May 2005 survey.*

CMS alleged a violation of 42 C.F.R. § 483.25(h)(2), which states that a facility "must ensure that . . . [e]ach resident receives adequate supervision and assistance devices to prevent accidents." The requirements of this regulation have been explained in numerous Board decisions. See, e.g., Lakeridge Villa Health Care Center, DAB No. 1988, at 13 (2005), aff'd Lakeridge Villa Health Care Center v. Leavitt, No. 05-4194, 2006 WL 3147250 (6th Cir. Nov. 3, 2006); Woodstock Care Center, DAB No. 1726, at 28 (2000), aff'd, Woodstock Care Center v. Thompson, 363 F.3d 583 (6th Cir. 2003). Although section 483.25(h)(2) does not make a facility strictly liable for accidents that occur, it does require the facility to take all reasonable steps to ensure that a resident receives supervision and assistance devices that meet his or her assessed needs and mitigate foreseeable risks of harm from accidents. Woodstock Care Center v. Thompson, 363 F.3d at 590 (a SNF must take "all reasonable precautions against residents' accidents").

CMS alleged that Evergreene was not in substantial compliance with section 483.25(h)(2) at the time of the May 2005 survey because it failed to ensure that two residents, Residents 308 and 306, received and used safety alarms to help prevent falls. With respect to both of these residents, we conclude, for the reasons discussed below, that CMS presented a prima facie case of noncompliance, and that Evergreene failed to carry its burden to show by a preponderance of the evidence that it was in

substantial compliance with section 483.25(h)(2) at the time of the May 2005 survey.

1. Resident 308

Undisputed evidence submitted by CMS shows that Resident 308, an 84-year old female, had a history of pelvic and humerus fractures. CMS Ex. 28, at 11, ¶ 21. She had a short-term memory deficit and needed "cues and supervision in her every day life decisions." Id. She needed one person to help her transfer between or from her bed and wheelchair, and the nursing staff assessed her as being at risk for falls. Id. at 8, 11-12. Nursing notes document occasional attempts by Resident 308 to get up out of her wheelchair or to perform other activities without assistance.[18] Due in part to the risk of injury associated with her attempts to self-transfer, Resident 308 had a March 30, 2005 physician's order for a "chair alarm at all times" when she was in her wheelchair. CMS Ex. 23, at 4, 8-9. Resident 308 also had a longstanding order for a "bed alarm." Id. (May 20, 2004 order).

At 9:15 a.m. on May 25, 2005, Surveyor Marilyn Dayton entered Resident 308's room and found her in her wheelchair with a body alarm and seat belt in place. CMS Ex. 9, at 19; CMS Ex. 28, at 13, ¶ 21E. Surveyor Dayton testified that when she looked at Resident 308's bed, she "did not see a bed alarm pad under the sheets," nor did she see "the box to which the bed alarm pad is normally connected."[19] CMS Ex. 28, at 13, ¶ 21F.

In response to Surveyor Dayton's testimony, Evergreene presented testimony by Dr. Preston (Evergreene's medical director), Shelly Palmisano (Evergreene's assistant director of nursing), and Barbara Smith (director of clinical education for the company that provides management services to Evergreene). These witnesses testified that when a resident's physician ordered a "bed alarm" but did not specify the type of bed alarm to use (as Resident 308's physician apparently did not do), the nursing

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[18] See, e.g., CMS Ex. 23, at 8-9 (attempts to get up from wheelchair on March 8 and April 13, 2005; instructed on "dangers of self-toileting" on April 19, 2005; "found taking seat belt off and taking [wheelchair] alarm off and trying to toilet self" on May 18, 2005).

[19] According to a nursing note, Resident 308 had been in bed earlier in the morning on May 25th with a "bed alarm on." CMS Ex. 23, at 10 (4:00 a.m. nursing note for May 25, 2005).

staff's standard practice was to provide the resident with a "personal safety alarm," or PSA. See P. Ex. 29, at 18-19; P. Ex. 30, at 8; P. Ex. 34, ¶ 10. Evergreene's witnesses also testified that a PSA can be used to monitor a resident by strapping or clipping it to either the bed or chair, and that the facility's practice was to move the PSA to wherever the resident happened to be. P. Ex. 34, at 2, ¶¶ 6-8; P. Ex. 30, at 8; P. Ex. 29, at 19, ¶ 44 (indicating that it was "standard practice . . . for the staff to remove the clip alarm from the chair and place it on the bed as a bed alarm"). Unlike the PSA, a "bed pad alarm" is a device designed specifically to monitor a person in bed; it consists of a control unit that is placed under the bed and is attached to a weight-sensitive air mattress. P. Ex. 34, at 2 (¶ 9), 8. Barbara Smith and Dr. Preston testified that, in their opinion, the PSA was effective in alerting the nursing staff whenever Resident 308 tried to get up from her chair or bed without assistance. See P. Ex. 29, at 19; P. Ex. 30, at 8.

Based on this evidence, Evergreene argued that it should not have been cited for a deficiency merely because a bed alarm was not found in Resident 308's unoccupied bed. Evergreene asserts that when Surveyor Dayton inspected Resident 308's bed on May 25, 2005, there was no alarm on the bed because the physician had not ordered a bed pad alarm, whose components would have been connected to the bed even if it was unoccupied, and because Resident 308 was sitting in her wheelchair at the time with a PSA attached.

Assuming for the sake of argument that CMS made a prima facie showing of noncompliance based on the evidence that there was no alarm on Resident 308's bed when Surveyor Dayton inspected it on May 25, 2005, we find (as did the ALJ) that Evergreene overcame that case by a preponderance of the evidence. Evergreene's evidence, which CMS did not challenge or rebut, established that: the nursing staff customarily used a PSA in lieu of a bed pad alarm (whose components might have been present in the bed even if the resident was not); that Resident 308's physician had not ordered a bed pad alarm; that the nursing staff used a PSA to monitor Resident 308 when she was in bed; that the PSA accompanied the resident from bed to chair; and that the PSA was effective in alerting the nursing staff when the resident attempted to get up from her bed or chair unassisted.

Although Evergreene established that Resident 308 had an adequate assistance device in place on the morning of May 25, 2005, Evergreene did not rebut evidence that it failed to apply the ordered safety alarms on other occasions. CMS submitted a chart that purports to document Evergreene's administration of various

"routine treatment[s]" to Resident 308 during May 2005. CMS Ex. 23, at 12. This routine treatment chart is structured as follows: on the left side of the chart is a list of medical items or services ordered for the resident. This list of items and services is linked to a matrix of boxes, with each box representing an eight-hour shift on a single day during the month. The parties do not dispute that checking or initialing a box is supposed to indicate or confirm that an ordered item or service was provided during the designated shift.

Resident 308's routine treatment chart for May 2005 lists separately the physician's orders for a bed alarm and a chair alarm. CMS Ex. 23, at 12. Next to each order is the matrix of boxes representing the three-daily nursing shifts for that month. Id. For the bed alarm order, the chart shows five unmarked boxes for the following dates and shifts:

May 14 (2 p.m. to 10 p.m.)
May 16 (2 p.m. to 10 p.m.)
May 23 (2 p.m. to 10 p.m.)
May 24 (2 p.m. to 10 p.m.)
May 26 (2 p.m. to 10 p.m.)

Id. For the chair alarm order, there are unmarked boxes for these same five dates and shifts. Id.

In discussing CMS's allegations of noncompliance with sections 483.25(h)(2) and 483.13(a), the ALJ found that the unmarked boxes on the May 2005 routine treatment chart were not prima facie evidence of Evergreene's failure to provide items or services ordered by the physician. ALJ Decision at 7-9, 25-26. While the ALJ stated that it was reasonable to infer from the unmarked boxes that the nursing staff had failed to implement the physician's orders during certain shifts, the ALJ found it equally reasonable to infer from that evidence that the nursing staff "simply omitted to complete the paperwork for the shift[.]" Id. at 8-9, 25-26. In drawing the latter inference, the ALJ observed that, for each shift for which there was an unmarked box corresponding to the order for the bed or chair alarm, there were unmarked boxes indicating that the nursing staff had failed to provide every other listed medical item or service during the shift. Id. at 25-26.

Use of the routine treatment charts shows that Evergreene's nursing staff undertook to document whether medical items and services, including bed and chair alarms, had in fact been provided to Resident 308 in accordance with her physician's orders. CMS argues 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. CMS Br. at 12-14 (referring to what it calls the "universally accepted" health care adage: "If it's not documented, it's not done"). Evergreene has expressed no disagreement with that particular argument. Accordingly, we find that the nursing staff's failure to mark or initial blocks on Resident 310's routine treatment chart was prima facie evidence that Evergreene failed, during five shifts in May 2005, to provide Resident 308 with bed and chair alarms that she needed to help prevent falls. See Western Care Management Corp. at 48 (2004) (rejecting the facility's assertion that the facility provided a service that was not documented on resident's treatment records and stating that a fact-finder "is entitled to assume, absent contrary evidence, that a resident's medical records accurately reflect the care and services provided (or not provided)").

We also find that CMS made a prima facie showing that the failure to provide safety alarms created a risk of more than minimal harm. Nursing charts show that Resident 308 sometimes attempted to transfer herself without assistance, behavior that increased her risk for falls. CMS Ex. 23, at 8-9. The evident purpose of the bed and chair alarms was to alert the nursing staff of attempted self-transfers so that the staff could render aid and thereby lessen the risk of falls. It follows that any failure to provide a safety alarm under these circumstances substantially increased the risk of falls and resulting injury – injury that can be potentially serious for an elderly nursing home resident. See Florence Park Care Center, DAB No. 1931, at 27 n.11 (2004) (noting testimony that injuries that commonly result from falls by nursing home residents include hip fractures, head trauma, and concussions). For all these reasons, we conclude that CMS made a prima facie showing that, in caring for Resident 308, Evergreene was not in substantial compliance with section 483.25(h)(2) at the time of the May 2005 survey. See Lakeridge Villa Health Care Center at 13 (surveyors' undisputed observation of resident without a physician-ordered alarm "would be sufficient to find a lack of substantial compliance since [the facility] itself had evaluated the resident as needing an alarm").

Because we find that CMS made a prima facie showing of noncompliance, we next consider whether Evergreene overcame that showing by a preponderance of the evidence. We conclude that

Evergreene did not do so. Evergreene provided no evidence to support the ALJ's finding that the unmarked boxes on the May 2005 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.

Evergreene's case regarding Resident 308 rests entirely on a "resident care flow record" for May 2005. P. Ex. 15-D, at 2. The flow record appears to have the same design and purpose as the routine treatment chart described above. In particular, the flow record contains a matrix of boxes that the nursing staff initials or checks in order to confirm that a particular medical item or service was provided to the resident during a particular shift.

Evergreene notes in its appeal brief that flow records are maintained by certified nurse aides, and that routine treatment charts are maintained by nurses. Response Br. at 27. Assuming that is true, the working shifts of these two groups of employees are slightly different. Flow records show eight-hour shifts of 7:00 a.m. to 3:00 p.m., 3:00 p.m. to 11:00 p.m., and 11:00 p.m. to 7:00 a.m.; the routine treatment chart shows shifts of 10:00 p.m. to 6:00 a.m., 6:00 a.m. to 2:00 p.m., and 2:00 p.m. to 10:00 p.m. CMS Ex. 23, at 12; P. Ex. 15-D. We do not think this discrepancy is material for purposes of our analysis because the shifts of nurses and nurse aides almost completely overlap. For example, nurse aides work from 7:00 a.m. to 3:00 p.m., while nurses begin and end their shift only one hour earlier.

Because the flow record and routine treatment chart are similarly designed and appear to have the same purpose – namely, to verify that a particular medical item or service has been provided during a given shift – we assume for purposes of this decision that a medical item or service reflected on the chart or flow record was provided during a particular shift if *either* the flow record or the routine treatment chart so indicates (by a checked or initialed box).[20]

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[20] We would not necessarily make the same assumption under different circumstances, for example, if the treatment or service was one that a certified nurse aide was not qualified to provide. Here, however, the service at issue is the placement of safety

(continued...)

As indicated, Resident 308's routine treatment chart for May 2005 contained no indication that a bed alarm or chair alarm was provided to Resident 308, as ordered, during the 2:00 p.m. to 10:00 p.m. shifts on May 14, May 16, May 23, May 24, and May 26. However, the corresponding flow record indicates that the nursing staff provided a bed alarm to Resident 308 during these five shifts.[21] See P. Ex. 15-D, at 2. Accordingly, we find that Evergreene has shown that it provided a *bed* alarm to Resident 308 during the 2:00 p.m. to 10:00 p.m. shifts on May 14, May 16, May 23, May 24, and May 26.

However, we find that Evergreene failed to establish that it provided Resident 308 with a *chair* alarm during those five shifts. Unlike the routine treatment chart for May 2005, which separately listed both the bed and chair alarm orders, the flow record submitted by Evergreene for May 2005 (P. Ex. 15-D, at 2) does not mention the order for a chair alarm, and Evergreene presented no other evidence that its staff provided Resident 308 with a chair alarm during the 2:00 p.m. to 10:00 p.m. shifts on May 14, May 16, May 23, May 24, and May 26, or that there was some good reason it failed to do so, e.g., that the resident was in bed at all times during those shifts.

Additional evidence of Evergreene's failure to implement safety alarm orders can be found in Resident 308's routine treatment chart for April 2005. This chart reflects the physician's order that Resident 308 have a bed alarm. P. Ex. 15-C, at 1. For that item, there are four unmarked boxes corresponding to the following dates and shifts: April 2 (6:00 a.m. to 2:00 p.m.); April 14 (2:00 p.m. to 10:00 p.m.); April 25 (2:00 p.m. to 10:00 p.m.); and April 29 (6:00 a.m. to 2:00 p.m.). Id. As for the chair alarm, although Resident 308's physician had ordered that item on March 30, 2005 (see CMS Ex. 23, at 8), the routine treatment chart for April 2005 makes no mention of the order, and Evergreene has not explained the omission. Evergreene did produce a flow record for April 2005, but that record does not list either the bed alarm or the chair alarm order. P. Ex. 15-D,

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[20](...continued)
alarms, a service that the record indicates a certified nurse aide is qualified to perform.

[21] For the bed alarm order, the flow record has unmarked boxes for the 3:00 p.m. to 11:00 p.m. shift on May 17 and May 19. However, the corresponding boxes on the routine treatment chart are initialed. Accordingly, we find that Evergreene provided a bed alarm to Resident 308 during those two shifts.

at 1. Evergreene has not presented any other evidence that it provided Resident 308 with the chair or bed alarms during April 2005.

For the reasons above, we conclude that Evergreene failed to establish that it was in substantial compliance with section 483.25(h)(2) regarding Resident 308.

2. *Resident 306*

Resident 306, a male resident, had dementia and short-term memory deficits, was wheelchair-bound, and had been assessed by the facility as being at risk for falls. CMS Ex. 28, at 15, ¶ 22. On March 1, 2005, his physician ordered that he wear a bed and body alarm "at all times" and that the nursing staff check for the alarm on all shifts. P. Ex. 14-A, at 1.

It is undisputed that at 8:10 a.m. on May 25, 2005, surveyors observed Resident 306 in the dining room sitting in a wheelchair without a body alarm, even though he was (according to treatment records) at risk for falls, and the physician's order required him to wear the alarm "at all times." CMS Ex. 28, at 16, ¶ 22E. The surveyor's observation of Resident 306 in his wheelchair without the chair alarm is sufficient evidence that Evergreene's nursing staff failed to meet its obligation under section 483.25(h)(2) to ensure that Resident 306 had an assistance device that he needed to avoid falls or other accidents. Given that the purpose of the chair alarm was (as the ALJ said) to protect Resident 306 from fall-related injuries, failing to provide the chair alarm on the morning of May 25, 2005 created at least the potential for more than minimal harm. We conclude, therefore, that CMS made a prima facie showing that Evergreene was not in substantial compliance with section 483.25(h)(2) in its care of Resident 306. See Lakeridge Villa Health Care Center.

Evergreene failed to overcome CMS's prima facie showing of noncompliance regarding Resident 306. In fact, the evidence it submitted tends to bolster CMS's case. It shows that Resident 306 was at "high risk" for falls, had a documented history of falls (or being found on the floor of his room), needed help to perform transfers and other daily activities due to a hip fracture, and had a tendency to remove his alarm at times and attempt to transfer without assistance. P. Ex. 14E, at 1-2 (indicating two occasions when resident was found on floor in bedroom); P. Ex. 14G, at 1 (Feb. 23rd entry referring to "recent fall"); P. Ex. 14G, at 2; P. Ex. 14H (March and April 2005 fall risk assessment); P. Ex. 14I. These circumstances clearly

illustrate the danger to Resident 306 from not complying with the physician's order to keep an alarm on him at all times.

The ALJ found that when the surveyors observed Resident 306 in the dining room on the morning of May 25, 2005, a body alarm "was not a necessary safety feature," and that there was no potential for more than minimal harm because Resident 306 "was in the presence of the staff." ALJ Decision at 25. However, we see no evidence in the record indicating that it was unnecessary for Resident 306 to wear an alarm in the "presence" of staff. The physician's order required that Resident 306 have an alarm on him "at all times" when he was in his wheelchair. Evergreene's witnesses provided no explanation for the nursing staff's failure to keep an alarm on Resident 306 in the dining room on May 25, 2005, nor did they testify that Resident 306 was so closely observed that any attempt to leave his chair could have been thwarted.[22]

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[22] We considered the fact that Evergreene's nursing staff initialed the box on Resident 306's routine treatment chart for the 6:00 a.m. to 2:00 p.m. shift on May 25, 2005. See P. Ex. 14-D, at 1. That evidence, however, does not rebut CMS's prima facie case because Evergreene admits that Resident 306 did not have the body alarm on when the surveyor observed him at 8:10 a.m. during that shift. See Evergreene Br. at 49. The fact that the nursing staff initialed the 6:00 a.m. to 2:00 p.m. box despite the undisputed evidence that the body alarm was not on at all times during that shift also undercuts to some degree the reliability of other entries on the routine treatment chart as evidence that alarms were being used at all times. It leaves open the possibility that staff initialed boxes for other shifts after allowing Resident 306 to be up in his wheelchair without the required body alarm during those shifts. Presumably, on May 25, 2005, a member of the nursing staff initialed the box for the 6:00 a.m. to 2:00 p.m. shift after the body alarm was put back on Resident 306 following the surveyor's observation. There is evidence – for example, CMS Exhibit 28, at 16 – that the alarm had been reapplied by 9:15 a.m on May 25th. We do not know exactly when the nursing staff reattached the body alarm following the surveyor's 8:10 a.m. observation on May 25th. That leaves open the possibility that Resident 306 was in his wheelchair without a body alarm for one hour even after the surveyor made the observation. That possibility provides additional support for our conclusion that the record does not contain substantial evidence supporting the ALJ's finding that there was no potential for more than minimal harm.

In addition to the evidence of Evergreene's failure to keep an alarm on Resident 306 during the morning of May 25, 2005, the record contains evidence — namely, the routine treatment charts for April and May 2005 — that the nursing staff failed to keep an alarm on Resident 306 on other days. Both charts reflect the physician's order for a "bed & body alarm on at all times." P. Ex. 14-D. The routine treatment chart for April 2005 contains no indication that these alarms were provided during the 10:00 p.m. to 6:00 a.m. shift on April 10, or the 2:00 p.m. to 10:00 p.m. shift on April 20. P. Ex. 14-D, at 1. The routine treatment chart for May 2005 contains no indication that the alarms were provided during the 2:00 p.m. to 10:00 p.m. shift on May 25, which is the shift that immediately followed the surveyor's observation of Resident 306 in the dining room. Id. at 2. The corresponding flow sheets for April and May 2005 (which CMS also submitted) do not fully offset the omissions on the routine treatment charts. For example, the April 2005 flow sheet shows that a bed alarm was provided during each shift on April 10 and April 20, but it fails to confirm that a body alarm was also provided. P. Ex. 14-C, at 1. The May 2005 flow sheet does not refer at all to the order for a bed and chair alarm, id. at 2, and Evergreene has provided no other evidence or explanation for the unmarked boxes on the routine treatment charts.

For the reasons above, we conclude that Evergreene failed to establish that it was in substantial compliance with section 483.25(h)(2) regarding Resident 306.

C. *Substantial evidence in the record as a whole supports the ALJ's decision to overturn the May 2005 survey findings alleging noncompliance with 42 C.F.R. §§ 483.13(a), 483.20(k)(2), and 483.25.*

We turn now to the three other survey findings overturned by the ALJ. These findings alleged noncompliance with 42 C.F.R. §§ 483.13(a), 483.20(k)(2), and 483.25.

1. 42 C.F.R. § 483.13(a)

Section 483.13(a) provides that a resident has "the right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms." CMS contended before the ALJ that Evergreene had violated section 483.13(a) by failing to implement a physician's order to release Resident 302's lap buddy (a device that prevents a person from getting out of a

wheelchair) every two hours.[23] See Respondent's Post-Hearing Br. at 2-5 (Aug. 5, 2005). In support of this contention, CMS submitted Resident 302's routine treatment charts for April and May 2005. CMS Ex. 21, at 91, 96. Like the charts discussed in connection with Evergreene's noncompliance with section 483.25(h)(2), Resident 302's routine treatment charts purport to show whether the nursing staff provided various medical items or services during each daily shift. The nursing staff is supposed to confirm the provision of the item or service during a shift by marking the box that corresponds to the shift.

Resident 302's routine treatment charts for April and May 2005 reflect the following order: "lap buddy due to diagnosis & inability to recall safety instructions. Release every 2 hours." CMS Ex. 21, at 91, 96. For this order, the charts show seven unchecked boxes indicating a failure to implement the order during seven shifts — two shifts in April 2005 and five shifts in May 2005. CMS contended that the unmarked boxes showed that Evergreene failed to release Resident 302's lap buddy every two hours in accordance with the physician's order and that this failure constituted a violation of section 483.13(a). Respondent's Post-Hearing Br. at 2-5 (Aug. 5, 2005). The ALJ rejected this contention for various reasons. While we do not endorse all of the ALJ's reasoning, we affirm his decision to reject CMS's contention because there is substantial evidence that Evergreene consistently complied with the physician's order to release the lap buddy every two hours.

In addition to the routine treatment charts, the record contains Resident 302's April and May 2005 "flow records," which we assume (for purposes of this decision) serve the same purpose as the routine treatment charts. CMS Ex. 21, at 85-86. In discussing

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[23] The state survey agency identified a different ground for the alleged deficiency. According to the Statement of Deficiencies, the state survey agency found Evergreene in noncompliance with section 483.13(a) because it allegedly failed to carry out an instruction in Resident 302's plan of care to release the lap buddy at meals. See CMS Ex. 9, at 1-4. CMS did not defend that position before the ALJ. Instead, CMS contended that Evergreene was in noncompliance with section 483.13(a) because the nursing staff failed to comply with the physician's order to release the lap buddy every two hours. See Respondent's Post-Hearing Br. at 2-5 (Aug. 5, 2005). Because CMS does not mention or defend the state survey agency's finding that Evergreene failed to release Resident 302's lap buddy at meals, we do not consider it here.

Evergreene's noncompliance with section 483.25(h)(2), we found that Evergreene had provided an item or service during a given shift if *either* a routine treatment chart or a corresponding flow record so indicated (by a checked or initiated box). We do the same here.

Resident 302's flow records, like the routine treatment charts, reflect the physician's order to release the lap buddy every two hours. As noted, Resident 302's routine treatment charts show that Evergreene did not comply with the lap buddy order during two shifts in April 2005 and five shifts in May 2005. CMS Ex. 21, at 91, 96. However, as the following table illustrates, Resident 302's flow records indicate that the lap buddy was released during all but one of these shifts:

Unmarked Boxes – Routine Treatment Charts		Marked Boxes — Flow Records	
April 2	(6 a.m. to 2 p.m.)	April 2	(7 a.m. to 3 p.m.)
April 11	(2 p.m. to 10 p.m.)	April 11	(3 p.m. to 11 p.m.)
May 3	***(2 p.m. to 10 p.m.)***	***No marked box in flow record***	
May 14	(2 p.m. to 10 p.m.)	May 14	(3 p.m. to 11 p.m.)
May 16	(2 p.m. to 10 p.m.)	May 16	(3 p.m. to 11 p.m.)
May 23	(2 p.m. to 10 p.m.)	May 23	(3 p.m. to 11 p.m.)
May 24	(2 p.m. to 10 p.m.)	May 24	(3 p.m. to 11 p.m.)

Id. at 91, 96; P. Ex. 13-D.[24] Under some circumstances, even one unchecked box might be sufficient to find a deficiency with a potential for more than minimal harm. However, CMS did not argue that this was the case here and, in fact, relied on its assertion that there were multiple unchecked boxes on resident 306's April and May 2005 routine treatment charts, an assertion we found rebutted except for one box. See Respondent's Post-Hearing Br. at 2-3. Moreover, we see no other evidence in the record that would indicate the potential for more than minimal harm due to this one lapse. Finally, we note that although Resident 302's flow records have unmarked boxes indicating a failure to

[24] CMS and Evergreene produced copies of the May 2005 flow sheet that differ in some relevant respects. CMS's copy, which CMS presumably obtained during the survey, shows an unmarked box for the 3:00 p.m. to 11:00 p.m. shift on May 24. CMS Ex. 21, at 86. However, this box is initialed on Evergreene's copy of the flow sheet, which purports to be the complete record of services provided up to and including the final day of May 2005 (the survey was completed on May 26th). P. Ex. 13-D, at 2. CMS raised no issue regarding this discrepancy, and for that reason we rely on the copy of the flow record submitted by Evergreene.

implement the lap buddy order during certain shifts, for each of these shifts there is a marked box on Resident 302's routine treatment charts indicating that the lap buddy was released.[25]

2. 42 C.F.R. § 483.20(k)(2)

Section 483.20(k)(2) provides:

> A comprehensive care plan must be —
>
> (i) Developed within 7 days after completion of the comprehensive assessment;
>
> (ii) Prepared by an interdisciplinary team . . .; and
>
> (iii) Periodically reviewed and revised by a team of qualified persons after each assessment.

CMS contended before the ALJ that Evergreene was not in substantial compliance with section 483.20(k)(2)(iii) because it had failed to:

- revise Resident 301's plan of care to reflect an order from the physician to discontinue use of bed side rails; and

[25] The ALJ found that evidence that Resident 302's longtime companion had told Surveyor Bonesteel that the lap buddy was released only at bedtime or when Resident 302 went to the bathroom had "no probative value." ALJ Decision at 7. He did so in part because the companion had dementia and because his statement was hearsay. Id. We emphasize that these reasons alone do not justify the exclusion of, or failure to weigh, evidence. We have held that hearsay, including that of residents, "is admissible and can be probative on the issue of the truth of the matter asserted in it, where sufficient indicia of reliability are present." Vandalia Park at 9 (2004). In addition, we have said that "mental illness alone does not necessarily undercut the veracity or competence of a declarant." Id. at 11. However, we agree with the ALJ that the companion's statement deserved little or no weight given (1) the lack of evidence that the companion had continuously observed or accompanied the resident while she was in her wheelchair, and (2) the facility's records showing that the nursing staff had in fact released the lap buddy every two hours as ordered.

- revise Resident 308's plan of care to reflect a physician's order for a bed alarm.

Respondent's Post-Hearing Br. at 5-9 (Aug. 5, 2005). As an additional ground for this allegation of noncompliance, CMS noted discrepancies between copies of the plan of care for Resident 302's lap buddy. Id. at 10; see also CMS Ex. 9, at 6-7.

The ALJ rejected CMS's case for two reasons. First, he found that section 483.20(k)(2)'s requirements were not triggered because there was no evidence that Evergreene had failed to discharge a duty to perform a "comprehensive assessment" of Residents 301, 302, or 308, or that Evergreene had failed to develop, review, or revise a plan of care in response to the findings of a comprehensive assessment. ALJ Decision at 12-16. Second, the ALJ found that Evergreene's failures to revise plans of care in order to incorporate or reflect physicians' orders had not created a potential for more than minimal harm.[26] Id. at 16.

Although CMS questions whether the ALJ's analysis regarding section 483.20(k)(2)'s applicability is legally correct, we find it unnecessary to reach that issue because of CMS's failure to contest the ALJ's finding on the issue of whether there was a potential for more than minimal harm. To warrant a finding of noncompliance and the imposition of enforcement remedies, a deficiency must create a potential for more than minimal harm. The ALJ found that the alleged violation of section 483.20(k)(2), assuming it existed, did not create a potential for more than minimal harm and therefore did not warrant a finding of noncompliance. ALJ Decision at 16. CMS does not contest that finding in its appeal, and our guidelines state that we will not consider issues that are not raised in the request for review. *Guidelines — Appellate Review of Decisions of Administrative Law Judges Affecting a Provider's Participation in the Medicare and Medicaid Programs*; see also Ross Healthcare Center, DAB No. 1896, at 11 (2003). For this reason, we affirm the ALJ's finding that Evergreene's failure to amend the plans of care did not create the potential for more than minimal harm and, accordingly, the ALJ's conclusion that CMS failed to make a prima facie showing that Evergreene was not in substantial compliance with section 483.20(k)(2) at the time of the May 2005 survey.

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[26] Although the plans of care for Residents 301 and 308 did not reflect the physicians' orders to discontinue bed side rails and provide a bed alarm, there was evidence that these orders were implemented by the nursing staff. See CMS Ex. 9, at 5; P. Ex. 12-B, at 2; P. Ex. 12-D, at 2; P. Ex. 15-C.

3. 42 C.F.R. § 483.25

Section 483.25 provides:

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

CMS contended before the ALJ that Evergreene was not in substantial compliance with section 483.25 because it failed to (1) comply with a physician order to weigh Resident 301 weekly, and (2) monitor Resident 301's intake and output of fluids. Respondent's Post-Hearing Br. at 10-13 (Aug. 5, 2005). The ALJ rejected both grounds for CMS's allegation of noncompliance. ALJ Decision at 16-21. On appeal, CMS's argument focuses exclusively on whether Evergreene complied with the physician's order to weigh Resident 301 weekly. See CMS Br. at 20-27. We therefore do not discuss or disturb the ALJ's findings with respect to Evergreene's monitoring of Resident 301's fluid intake and output.

On the issue of Resident 301's weight, the ALJ made several undisputed factual findings, including the following:

- In November 2004, Dr. Preston ordered Evergreene's nursing staff to begin weighing Resident 301 every week. The physician issued the order because of her concern about the resident's nutritional status.

- Treatment records show that the nursing staff weighed or attempted to weigh Resident 301, a 22 year old woman with cerebral palsy, at weekly or close to weekly intervals beginning in November 2004. For example, the records show weighings on March 30, April 6, April 13, April 22, and April 29, 2005.[27]

- On May 1, 2005, Resident 301 was hospitalized so that her feeding tube could be replaced; she was not weighed in the hospital. Resident 301 returned to Evergreene on May 3, 2005.

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[27] The treatment record contains a notation indicating the April 29th weighing actually occurred on April 27th, but CMS does not contest the ALJ's finding that the resident was weighed on April 29th.

- On May 4, 2005, Dr. Preston reissued the order to obtain Resident 301's weight every week. The nursing staff weighed Resident 301 exactly one week later, on May 11, 2005.

CMS argued to the ALJ that the 11 days between the April 29th and May 11th weighings showed that Evergreene had failed to comply with the physician's order to obtain Resident 301's weight every week and therefore failed to provide a service that was necessary to maintain or enhance Resident 301's physical well-being. Respondent's Post-Hearing Br. at 10-13 (Aug. 5, 2005). The ALJ rejected this argument for two reasons. One reason was that Resident 301's physician, Dr. Preston, had reissued the order for weekly weighings on May 4th (the day after Resident 301 returned from the hospital), and the nursing staff complied with the literal terms of that order by weighing her within one week. Id. at 17-18. This finding is supported by substantial evidence because the May 4th order on its face did not require the nursing staff to weigh Resident 301 immediately. In addition, there is nothing else in Resident 301's medical records indicating that Dr. Preston intended her May 4th order to be interpreted as requiring the staff to weigh the resident immediately, or that Dr. Preston did not intend her May 4th order to supercede her previously issued order for weekly weighings.

The ALJ's second reason for rejecting CMS's argument was that there was, in his view, no potential for more than minimal harm from the alleged deficiency. ALJ Decision at 18. This finding too is supported by substantial evidence — namely, by medical records showing that Evergreene's nursing staff closely and adequately monitored Resident 301's overall nutritional and health status throughout her stay, and that when Resident 301 returned from the hospital on May 3rd, she was in stable condition and able to resume normal tube feedings. See CMS Ex. 20, at 22; P. Ex. 12-B, at 2 (record of food intake); P. Ex. 12-C, at 3 (record of dietary supplements provided); P. Ex. 12-I; P. Ex. 12-L at 2-3 (hospital discharge summary indicating that resident was in stable condition); P. Ex. 27 (testimony of registered dietician Deanne McGhee). CMS contends that failing to weigh Resident 301 immediately after she returned from the hospital on May 3rd was critical because she had experienced a 12 percent weight loss between April 13 and April 29.[28] CMS Br. at

[28] Although Resident 301's weight dropped from 76.6 to 67.4 pounds between April 13 and April 29, 2005, her weight during that period (and afterward) remained within her usual or ideal weight range of 63 to 77 pounds (or 70 pounds plus or minus 10

(continued...)

22-23. Although this weight loss made it imperative that the nursing staff periodically monitor her weight, the record as a whole supports the ALJ's finding that the nursing staff's overall effort to maintain and improve her nutrition adequately ensured that she did not suffer more than minimal harm between May 4 and May 11, 2005, despite the failure to weigh her at the beginning of that one-week period. For these reasons, we affirm the ALJ's decision to overturn the May 2005 survey's finding of noncompliance under section 483.25.

D. *The ALJ did not abuse his discretion in conducting the hearing or evaluating the evidence.*

In addition to asserting that the ALJ's conclusions regarding Evergreene's compliance status were erroneous, CMS contends that the ALJ abused his discretion when conducting the hearing and evaluating the evidence. See CMS Br. at 37-56. First, CMS contends that the ALJ failed to acknowledge that certain documents submitted by Evergreene were "misleading" or "fraudulent." Id. at 37-38. Second, CMS contends that the ALJ should have heeded its concerns about the credibility of certain witnesses. Id. at 39-53; Reply Br. at 27-33. Third, CMS contends that the ALJ failed to allow it a reasonable amount of time to prepare its case. CMS Br. at 54. Fourth, CMS contends the ALJ ignored the fact that the written testimony of two of Evergreene's witnesses was identical in some or all respects. Id. at 56.

We have reviewed each of these contentions but find them to be without merit. Furthermore, CMS made no attempt to show that the alleged errors materially affected the proceeding's outcome, and we find that they did not in fact do so. Regarding CMS's contentions about witness credibility, we do not disturb a fact-finder's credibility finding unless it is clearly erroneous,[29] and CMS has failed to show clear error in this regard.

CMS makes two other contentions that merit brief discussion. One is that the ALJ should have excluded the post-hearing written testimony of Shelly Palmisano, Evergreene's assistant director of nursing. CMS Br. at 53. In this testimony, Palmisano described

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[28](...continued)
percent). See Tr. at 74; P. Ex 12-I, at 2 (indicating an "IWR," or ideal weight range, of "70 ± 10%").

[29] Lakeridge Villa Health Care Center at 19 n.14 (2005); Community Skilled Nursing Centre, DAB No. 1987 (2005).

the features of – and differences between – a personal safety alarm (PSA) and a bed pad alarm. P. Ex. 34. Palmisano also indicated that Evergreene's practice was to use a PSA to monitor a resident in bed, unless the physician specifically ordered a bed pad alarm, in which case the bed pad alarm would be used. Id. at 3, ¶ 10.

The ALJ denied CMS's request to exclude Palmisano's post-hearing testimony, noting that it was responsive to questions he had put to both parties at the hearing, and that CMS had been given an opportunity to rebut the testimony. ALJ Decision at 2-3. We find nothing improper about this ruling. The evidence was clearly relevant to Evergreene's contention that the nursing staff kept a safety alarm on Resident 308 while she was in bed. We therefore do not disturb the ALJ's ruling regarding the post-hearing testimony of Shelly Palmisano.

CMS's final contention is that the ALJ prevented "meaningful" cross-examination at the evidentiary hearing. CMS Br. at 54-56. We find no merit to this contention as well. It is apparent from the hearing transcript that the ALJ was intent on streamlining or maximizing the efficiency of the hearing. Tr. at 4-7. He encouraged the parties to avoid eliciting testimony for the purpose of establishing facts already proved by documentary evidence. Tr. at 6, 80. He also encouraged the parties not to expend energy trying to show that a witness's direct testimony was inconsistent with information contained in the facility's records, reminding them that such inconsistencies could be identified and discussed in their post-hearing written arguments. Tr. at 7, 76. Although the ALJ at one point expressed doubt about the need for in-person testimony, Tr. at 4, we find no evidence that the ALJ forbade or cut off any potentially fruitful line of cross-examination.[30]

[30] In support of its claim that the ALJ impaired the cross-examination of facility witnesses, CMS quotes a passage from the cross-examination of Dr. Preston, Evergreene's medical director. CMS Br. at 54-55 (quoting Tr. at 77-79). The passage suggests that the ALJ refused to allow CMS to ask Dr. Preston for an opinion about whether Resident 301's 12 percent weight loss in April 2005 was "significant." Id. However, other parts of the hearing transcript that CMS did not quote show that the ALJ allowed CMS to pose that question. See Tr. at 77, 83.

E. *Evergreene's motion to strike Exhibits E and F to CMS's reply brief from the record is granted.*

Attached as Exhibit E to CMS's December 2, 2005 reply brief is an unsigned and undated copy of a state court complaint prepared by the Virginia Office of Protection and Advocacy (VOPA). The complaint, which requests injunctive relief, alleges that Evergreene neglected, abused, or otherwise failed to safeguard the health of one or more of its residents between November 2004 and August 2005. According to CMS, the allegations in the complaint stem from an investigation performed by the Greene County Department of Social Services. Reply Br. at 14 n.9. CMS suggests that the VOPA filed the complaint in part because the ALJ had overturned the decision to terminate Evergreene's Medicare participation. Id.

Evergreene has moved to strike the VOPA complaint from the record, asserting that it is irrelevant, immaterial, and unfairly prejudicial.[31] In response to the motion to strike, CMS filed a memorandum as well as a signed, dated, and file-stamped copy of the complaint, which CMS identified as Exhibit F.[32]

The Board "may admit evidence into the record in addition to the evidence introduced at the ALJ hearing . . . if the Board considers that the additional evidence is relevant and material to the issue before it." 42 C.F.R. § 488.86(a).

We grant Evergreene's motion, in part because CMS does not assert, or show, that the VOPA complaint constitutes evidence of any relevant or material fact. By itself, the complaint is little more than a set of allegations, and CMS does not contend that the complaint's contents should be accorded the same evidentiary status as findings in a Statement of Deficiencies, which we have held may constitute proof of noncompliance. See Guardian Health Care Center.

Furthermore, even if the complaint's allegations are true, their relevance and materiality is not apparent. The complaint makes

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[31] Evergreene Nursing Care Center's Motion to Strike Exhibit E to the Center for Medicare and Medicaid Services' Reply Brief (Dec. 29, 2005).

[32] Reply to Evergreene's Motion to Strike Exhibit E to the Centers for Medicare and Medicaid Services' Reply Brief (Jan. 17, 2006); Response to Evergreene Nursing Care Center's Reply to its Motion to Strike Exhibit E (Feb. 28, 2006).

22 factual allegations, but, on their face, none of them relate to the disputed May 2005 survey findings.[33] CMS admits that "the facts asserted in the Complaint filed by VOPA did not form the basis for CMS's decision to terminate Evergreene from the Medicare program,"[34] and the validity of the termination decision is the issue before us.

CMS contends that paragraph 19 of the VOPA complaint, which alleges that Evergreene's nursing staff made "false, misleading or improper entries in patients' medication administration records," bolsters the credibility of CMS witnesses who, in CMS's view, gave testimony showing that Evergreene fabricated or falsified medical records. CMS Response to Motion to Strike at 3-4 & n. 3 (Feb. 28, 2006). However, it is not clear to us how an unproven factual allegation, like the one in paragraph 19 of the VOPA complaint, can serve to bolster (or undermine) a witness's credibility in these circumstances. Furthermore, the relevance of paragraph 19 is doubtful at best because, although CMS has alleged in this appeal that Evergreene made false or misleading entries in resident medical records, CMS Br. at 37-38, that allegation does not involve the medication administration records mentioned in paragraph 19.[35]

For all these reasons, we grant Evergreene's motion to strike and exclude Exhibits E and F from the record of this case. We note that nothing in these two exhibits has contributed to or affected our analysis of the issues in this case.

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[33] CMS asserts that the allegation of "neglect" in paragraph five of the complaint is a reference to Resident 301 and to Evergreene's alleged failure to revise her care plan and to weigh her every week. CMS Response to Motion to Strike at 2 (Feb. 28, 2006). However, paragraph five does not adequately identify the resident involved (only as a patient who was "neglected" and "later died") or provide a factual basis for the allegation of neglect.

[34] CMS Response to Motion to Strike at 2 (Feb. 28, 2006).

[35] While we agree with CMS elsewhere in this decision (at page 29, fn. 22) that the check mark in the box for one shift on May 25, 2005 with regard to Resident 302's body alarm is inaccurate and misleading because he did not have the alarm on at all times during the shift, we see no evidence that the initialing of this box was a deliberate attempt to fabricate or falsify or mislead such as that alleged in paragraph 19 of the VOPA complaint.

Conclusion

For the reasons discussed, we affirm the ALJ's decision to overturn the May 2005 survey's findings of noncompliance under 42 C.F.R. §§ 483.13(a), 483.20(k)(2), and 483.25. However, we reverse the ALJ's decision to overturn the survey's findings of noncompliance under 42 C.F.R. §§ 483.25(a)(2) and 483.25(h)(2). Regarding the latter two survey findings, we conclude, on the basis of our own findings of fact above (in parts A and B of the Discussion section), that Evergreene was not in substantial compliance with sections 483.25(a) and 483.25(h)(2) at the time of the May 2005 survey. Because we conclude that Evergreene was not in substantial compliance at the time of the May 2005 survey, we uphold CMS's decision to terminate Evergreene's participation in the Medicare program.

/s/
Judith A. Ballard

/s/
Leslie A. Sussan

/s/
Sheila Ann Hegy
Presiding Board Member