Department of Health and Human Services
DEPARTMENTAL APPEALS BOARD
Appellate Division

Plott Nursing Home
Docket No. A-11-66
Decision No. 2426
December 6, 2011

FINAL DECISION ON REVIEW OF ADMINISTRATIVE LAW JUDGE DECISION

Plott Nursing Home appealed the February 17, 2011 decision of Keith W. Sickendick holding that Plott was not in substantial compliance with two requirements for participation in the Medicare program at 42 C.F.R. § 483.25(c) and (d). *Plott Nursing Home*, DAB CR2326 (2011) (ALJ Decision). The ALJ sustained the imposition of a civil money penalty (CMP) of $500 per day from September 24 through December 3, 2008 and $100 per day from December 4 through 15, 2008, and the denial of payment for new Medicare admissions (DPNA) for the period November 22, 2008 through December 15, 2008.

For the reasons stated below, we uphold the ALJ's determination that Plott was not in substantial compliance with both requirements as determined in the survey ending September 24, 2008, but reverse his determination that the noncompliance with section 483.25(c) constituted actual harm. We also reverse his conclusion that Plott was not in substantial compliance with section 483.25(d) as found in the survey ending December 4, 2008. Accordingly, we modify his determination that the noncompliance continued through December 15, 2008. We thus sustain the imposition of a CMP of $500 per day from September 4 through December 3, 2008, reverse the imposition of the $100 per-day CMP beyond that date, and reverse the DPNA for the period December 4 through December 15, 2008.

Applicable Law

The Social Security Act (Act) and federal regulations provide for state agencies to conduct surveys of long-term care facilities that receive Medicare and Medicaid funds to evaluate their compliance with the participation requirements of those programs. Act §§ 1819, 1919; 42 C.F.R. Parts 483, 488, and 498.[1] A facility's failure to meet a participation requirement constitutes a "deficiency." 42 C.F.R. § 488.301.

[1] The current version of the Social Security Act can be found at http://www.socialsecurity.gov/OP_Home/ssact/ssact.htm.

"Noncompliance" is defined as "any deficiency that causes a facility to not be in substantial compliance." *Id*. "Substantial compliance" means a level of compliance such that "any identified deficiencies pose no greater risk to resident health or safety than the potential for causing minimal harm." *Id*. The seriousness of noncompliance reflects its "severity" (whether the noncompliance has created a "potential" for "more than minimal" harm, resulted in "actual harm," or placed residents in "immediate jeopardy") and its "scope" (whether the noncompliance is "isolated," constitutes a "pattern," or is "widespread"). 42 C.F.R. § 488.404(b); CMS State Operations Manual (SOM), CMS Pub. 100-07, App. P – Survey Protocol for Long Term Care Facilities (available at http://www.cms.hhs.gov/Manuals/IOM/list.asp), § IV. Surveyor findings are reported in a statement of deficiencies (SOD), which identifies each deficiency under its regulatory requirement and states its scope and severity. 42 C.F.R. § 488.404; SOM App. P, § V.

A nursing facility found not to be in substantial compliance may be subject to various enforcement remedies, including CMPs, DPNAs, and termination. 42 C.F.R. §§ 488.402, 488.406, 488.408. CMS may impose a CMP for each day or each instance of noncompliance, with per-day CMPs ranging from $50-$3,000 per day for noncompliance that does not pose immediate jeopardy. 42 C.F.R. §§ 488.402(c), 488.406, 488.408, 488.438(a), 488.440(a)(1), (b).

Background

Plott participates in the Medicare program as a skilled nursing facility (SNF). The California Department of Public Health (State agency) conducted a survey of Plott that ended September 24, 2008 and issued a 161-page SOD. CMS Ex. 1. The surveyors found 33 deficiencies constituting noncompliance with specific Medicare requirements in 42 C.F.R. Part 483, and determined that four constituted actual harm to Plott's residents. *Id*. CMS notified Plott by letter dated November 7, 2008 that as a result of the survey findings it was imposing a CMP of $500 per day effective September 24, 2008 and a DPNA effective November 22, 2008, both remedies to remain in effect until CMS determined that the facility was again in substantial compliance. CMS Ex. 3. Plott requested a hearing before an ALJ to appeal CMS's determination. The State agency subsequently deleted one of the deficiencies identified in the September 2008 survey as a result of an informal dispute resolution review. CMS Ex. 67.

The State agency conducted a follow-up survey ending December 4, 2008 and made only one noncompliance finding. CMS Ex. 68. CMS notified Plott by letter dated February 10, 2009 that it had attained substantial compliance on December 16, 2008 and that CMS was imposing CMPs of $500 per day for the period September 24 through December 3, 2008 and $100 per day from December 4 through December 15, 2008, and a DPNA for the period November 22 through December 14, 2008. CMS Ex. 5. Plott again

requested a hearing, and the ALJ subsequently consolidated both appeals. ALJ Decision at 2. The ALJ conducted an in-person evidentiary hearing on December 7 through December 10, 2009. At the hearing, CMS confirmed that it had dropped five additional noncompliance findings from the survey ending September 24, 2008, for which CMS had presented no evidence. Tr. at 647-50.

The ALJ Decision addressed and sustained two of the 27 remaining noncompliance findings from the September 2008 survey (noncompliance with 42 C.F.R. § 483.25(c) and (d)), and the one noncompliance finding from the December 2008 survey (noncompliance with 42 C.F.R. § 483.25(d)).[2] The ALJ concluded that "it is not necessary to address all the other alleged deficiencies from the September 2008 survey" because the findings of noncompliance with section 483.25(c) and (d) "establish that Petitioner was not in substantial compliance during the period September 24 through December 15, 2008" and "provide a sufficient basis for the enforcement remedies that CMS proposes. " ALJ Decision at 6. The ALJ also sustained as reasonable the CMPs and DPNA that CMS proposed.

Standard of Review

We review a disputed finding of fact to determine whether the finding is supported by substantial evidence on the record as a whole, and a disputed conclusion of law to determine whether it is erroneous. *Guidelines-Appellate Review of Decisions of Administrative Law Judges Affecting a Provider's Participation in the Medicare and Medicaid Programs*, www.hhs.gov/dab/divisions/appellate/guidelines/prov.html; *Batavia Nursing and Convalescent Inn*, DAB No. 1911, at 7 (2004) (*Batavia*), *aff'd*, *Batavia Nursing & Convalescent Ctr. v. Thompson*, 143 F. App'x 664 (6th Cir. 2005).

Analysis

I. We sustain the ALJ's determination that Plott was not in substantial compliance with 42 C.F.R. § 483.25(c) based on the September 2008 survey but we reverse his determination that the noncompliance constituted actual harm.

A. The ALJ's determination that Plott was not in substantial compliance with 42 C.F.R. § 483.25(c) in its care of Resident 6 was supported by substantial evidence and free of legal error.

[2] Plott's statement that CMS made "96 allegations of noncompliance," RR at 20 n.12, refers to the fact that for some deficiencies, the SOD from the September 2008 survey cited several examples of noncompliance with the individual regulatory requirement.

CMS determined that Plott was not in substantial compliance with section 483.25(c) in its care of Resident 6. The regulation, titled "Pressure sores," states:

> Based on the comprehensive assessment of a resident, the facility must ensure that—
> (1) A resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and
>
> (2) A resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.

As the ALJ acknowledged, the Board has concluded that this regulation requires that "the facility must ensure no resident develops pressure sores unless clinically unavoidable" and "should go beyond merely what seems reasonable to, instead, always furnish what is necessary to prevent new sores unless clinically unavoidable, and to treat existing ones as needed." *Koester Pavilion*, DAB No. 1750, at 31, 32 (2000) (emphasis in original); ALJ Decision at 7-8.

Background

At the time of the survey ending September 24, 2008, Resident 6 was 81 years old with diagnoses including Alzheimer's disease and dementia, history of urinary tract infections, and a wound of her scalp infected with methicillin resistant staphylococcus aureus (MRSA). She was incontinent of bowel and bladder and was totally dependent upon staff for activities of daily living including bed mobility. A long-term care plan for skin breakdown dated June 28, 2007, the date of her initial admission to the facility, contained interventions including providing good perineal care with each episode of incontinence; keeping her skin as clean and dry as possible; placing her up in her geriatric chair each day; and providing her a pressure relief mattress. ALJ Decision at 9, citing P. Ex. 11, at 256; *see also* P. Ex. 11, at 251 (date of admission).

In December 2007, Resident 6 developed a pressure ulcer over the area of her lower sacrum or coccyx and thereafter suffered from what Plott concedes was a "recurrent" and "persistent" pressure ulcer or wound in that region.[3] P. Request for Review (RR) at 4.

[3] Plott states that "the record makes clear that the Resident had only a single recurring wound in what Petitioner will call her 'sacral area.'" RR at 20 n.11. The ALJ noted that Plott's records describe ulcers over both the sacrum and coccyx and found that "[w]hether Resident 6 had an ulcer over the coccyx or the sacrum or both does not affect my decision." ALJ Decision at 9 n.7.

The ALJ cited facility records showing a pressure ulcer described as open or reopened from December 26, 2007 to February 29, 2008, March 13 to March 20, 2008, May 23 to May 30, 2008, June 5 to June 18, 2008, June 26 to August 21, 2008, and August 27 to September 22, 2008.[4] ALJ Decision at 9-10, 12-13. The ALJ also noted the development of a new ulcer on the resident's left lower buttock on September 18, 2008, in addition to the coccyx/sacrum wound.[5] *Id*. at 10-11, 14.

The ALJ Decision

The ALJ determined that Plott was not in substantial compliance with section 483.25(c) essentially because Plott, in response to the repeated development of open pressure ulcers on the resident's sacrum and coccyx region, failed to engage in care planning and implement interventions to prevent new ulcers from developing, as opposed to treating the ulcers as they appeared.

The ALJ concluded that the record established a "prima facie showing of a violation of 42 C.F.R. § 483.25(c) because Petitioner did not do all that was necessary to prevent Resident 6 from developing new pressure sores" and that "[t]he evidence does not show that the effectiveness of interventions was assessed or that new interventions were implemented when Resident 6 developed new or reopened ulcers in December 2007, May 2008, or late June 2008." *Id*. at 14. More specifically, he found that Plott's care planning team failed to:

- evaluate effectiveness of the interventions in the June 2007 care plan to address the open pressure ulcer noted on December 26, 2007, the development of which "should have alerted the care planning team that existing interventions were inadequate or that new interventions were required;"

- address issues related to the resident's sliding about or scooting (Tr. at 821) in the bed, which put pressure on the coccyx area. and her noncompliance with turning and repositioning to relieve pressure, prior to the development of an ulcer on March 13, 2008;

[4] The ALJ inferred that the pressure ulcer noted on June 5, 2008 was the same ulcer reported on May 30, 2008. ALJ Decision at 13. Neither party disputes that inference.

[5] Plott does assert that the additional wound to the resident's left lower buttock noted in September 2008 was the same recurrent wound repeatedly observed over the resident's sacrum or coccyx. P. Reply at 8-9. Substantial evidence in the record as a whole, however, supports the ALJ's finding that there was at least one new ulcer in September. First, Plott's wound care evaluation records could be read as indicating the presence of two wounds in September 2008, rather than as containing measurements of the same ulcer on different occasions, as Plott asserts. P. Ex. 11, at 295. In addition, the surveyor reported having seen three individual pressure sores on Resident 6 during the September survey. Tr. at 69; CMS Ex. 1, at 54 (SOD stating "3 Stage 2's to the left of the Sacral/Coccyx area observed" on September 17, 2008).

- evaluate the effectiveness of the interventions from the June 2007 care plan as updated through March 18, 2008, and propose and implement new interventions based on the development of a new ulcer on about May 23, 2008, which "should have alerted the care planning team that existing interventions were inadequate or that new interventions were required"; and

- update the care plan prior to June 18, 2008, when an ulcer reported over her coccyx on June 5, the day of her return to the facility from an acute care hospitalization beginning May 30, 3008, was still open.

ALJ Decision at 12-13.

The ALJ found that the development of new ulcers in December 2007 and on May 23, 2008 "triggers the inference that Petitioner was not doing all that was necessary" to prevent ulcers, as did Plott's failure to address, prior to development of another pressure ulcer on March 13, 2008, the resident's sliding in bed and her known noncompliance with turning and repositioning, where the facility already knew that she was at risk for skin breakdown. *Id*.

The ALJ further found that Plott did not provide the resident with a pressure relief mattress when ordered in the resident's care plan of June 2007, and "does not present credible evidence as to why the pressure relief mattress was not actually listed [again] on Resident 6's care plan until October 2008," when a "late entry" to the care plan dated October 4, 2008 stated that the mattress had been added as an intervention on June 9, 2008. *Id*. at 13, 14. The ALJ also found that Plott did not provide the "low air loss mattress" subsequently ordered for the resident on August 7, 2008 until around September 24, 2008, at the end of the survey. *Id*. at 14. He further faulted Plott for failing to "explain why a nutritional supplement was not added as an intervention until June 2008." *Id*. at 13.

Discussion

Plott does not dispute the ALJ's findings of repeated, open pressure ulcers over the resident's coccyx or sacral region. Plott confirms that the resident developed a wound in her "sacral area no later than December, 2007" that "healed no later than January 28, 2008, but then . . . persistently reopened, and then rehealed, every few weeks thereafter through the date of the survey in the late Summer of 2008." RR at 22; *see also* RR at 20 (Resident 6 had a skin breakdown over her sacral area that "repeatedly opened and closed over a period of more than a year"). Instead, Plott argues that the repeated recurrence of a pressure ulcer was an unavoidable consequence of measures the facility implemented to treat Resident 6's most serious health condition, the MRSA-infected surgical wound on

her scalp. The facility's "management of the head wound," Plott states, "was complicated by the fact that the Resident picked at the infected wound so much that her hands had to be restrained for her own safety," first with "mittens" ordered on October 31, 2007, and then with wrist restraints that the physician ordered upon the resident's return from an acute care hospital on June 5, 2008. RR at 4, 22; P. Ex. 11, at 228, 223. Plott criticizes the ALJ Decision for not addressing the argument that the use of restraints "limited the Resident's ability to change positions, and, combined with her agitation, caused recurring shear injury to the skin over her coccyx." RR at 4.

The ALJ correctly determined that Plott had not established that the resident's pressure ulcers were unavoidable. ALJ Decision at 14. Section 483.25(c)(1) requires a facility "to ensure" that a resident who enters a facility without pressure sores does not develop pressure sores "unless the individual's clinical condition demonstrates that they were unavoidable[.]" The Board has held that "clinically unavoidable" in this context "means not just unsurprising given the clinical condition of the resident, but incapable of prevention **despite appropriate measures taken in light of the clinical risks**." *Harmony Court*, DAB No. 1968, at 11 (2005) (emphasis added), *aff'd*, *Harmony Court v. Leavitt*, 188 F. App'x 438 (6th Cir. 2006). Moreover, "[a] facility cannot meet its burden of proof on the issue of whether a pressure sore is unavoidable merely by establishing that the resident's clinical condition heightens the risk that pressure sores will develop." *Id*., quoting *Ivy Woods Health Care and Rehabilitation Center*, DAB No. 1933, at 9 (2004), *aff'd, Ivy Woods Health Care & Rehabilitation Ctr. v. Thompson*, No. 04-4164 (6th Cir. Oct. 19, 2005); *see also Edgemont Healthcare*, DAB No. 2202, at 7 (2008) (finding no error in an ALJ's statement that "Inevitability [of a pressure sore] may be a defense in the circumstance where a facility takes *all* reasonable measures to protect a resident and the resident develops a sore in spite of those measures" (emphasis added) but "is *never* a defense where a facility has failed to discharge its regulatory obligations" (emphasis in original)).

Plott has not met its burden of showing that Resident 6's pressure ulcers were unavoidable. First, the record shows that Resident 6 had the physiological resources that enabled the ulcers to heal, once opened. Tr. at 853-54 (surveyor testimony). The ALJ properly considered this to be some evidence that Plott could have prevented the reopening of the sores had it implemented proper interventions. ALJ Decision at 14, citing Tr. at 853-54. Second, as the ALJ concluded and as we explain below, Plott did not demonstrate that it took all appropriate measures to prevent the resident from developing new pressure ulcers, including timely long-term care planning and implementing needed interventions.

Plott argues that it did respond appropriately with evaluations and interventions. Plott asserts that after the resident's June 5, 2008 return from the hospital, "staff created a series of 'long term' and 'short term' care plans to address the Resident's risk for skin breakdown generally, and the existing scalp and sacral wounds specifically" and that "[t]hose care plans set forth typical interventions, including frequent evaluation of skin condition, hygiene, and turning and repositioning, as well as specific interventions such as the wrist restraints." RR at 23. Plott also asserts that "the interdisciplinary care planning team reevaluated the efficacy" of the interventions ordered to address the sacral wound, as evidenced by notes of the meetings on June 18 and September 24, 2008 that refer to the sore on the resident's coccyx. *Id*.; P. Ex. 11, at 239-240. Plott points out that it documented the condition and treatment of the resident's wounds on an ongoing basis in wound care evaluation and treatment records (P. Ex. 11, at 281-324) and notes that the resident was seen by an outside wound care physician beginning in late July 2008. RR at 23. "Notwithstanding all these interventions," Plott states, "the sacral wound simply kept reopening, and then healing again — a total of six times between December, 2007 and September, 2008." *Id*.

The problem with these arguments is that Plott did not show that it responded appropriately and promptly to the development of the pressure ulcer in December 2007, or that it thereafter timely reconsidered its measures to prevent ulcers or implemented all of the needed interventions. That Plott engaged in short-term planning to treat the pressure ulcer over the sacrum/coccyx when it reopened does not establish that Plott engaged in sufficient long-term care planning to minimize the risk of that ulcer reopening and new ulcers developing. In particular, we note that --

- As early as June 2007 the facility determined that Resident 6 was at risk for skin breakdown secondary to decreased mobility and developed a care plan to address that risk, with the goal that the resident would have no skin breakdown. P. Ex. 11, at 256. Notwithstanding that care plan, in December 2007 the resident developed a pressure sore that persisted until late February 2008. P. Ex. 11, at 283-85, 298, 307-08 (wound care evaluation records). Although the facility treated that ulcer (*id*. at 202), it did not in response assess whether the care plan to prevent skin breakdown was sufficient given her admitted agitation, and did not revise the care plan until five days after the ulcer reopened again on March 13, 2008. *Id*. at 258, 309.

- When the pressure ulcer reopened on or about May 23, 2008, the facility did not update the care plan to prevent skin breakdown until June 18, 2008, almost two weeks after the resident returned from the hospital on June 5, 2008. *Id*. at 245, 301. Even then, the care plan added only one new intervention – that the resident receive a nutritional supplement with every meal – and otherwise repeated

interventions already noted in the long-term care plans from June 2007 and March 13, 2008. *Id*. at 245; *see also id*. at 256, 258 (care plans). Plott does not dispute the ALJ's finding that a nutritional supplement was not ordered until the care plan of June 18, 2008, notwithstanding that a pressure ulcer noted on December 26, 2007 persisted until late February 2008 and recurred or reopened again on March 13 and May 23, 2008. ALJ Decision at 11, 13; P. Ex. 11, at 194-95 (June 11, 2008 nutritional assessment and review ordering "Prosource 30 qd").

- The evidence shows that the facility did not provide the resident with either the pressure relief mattress or the low air loss mattress until well after they had been identified as needed interventions. A "pressure relief mattress" was required by the June 2007 care plan but was not implemented until at least June 9, 2008, according to a late care plan entry on October 4, 2008 stating "LE for 6/9/08 pressure relief mattress." P. Ex. 11, at 247, 256; Tr. at 853. The surveyor testified that she examined the resident's mattress during the survey in September 2008 and found it to be a pressure relief mattress that she said was "a standard facility mattress," consistent with the testimony of Plott's nurse witness and "special project person" that "the pressure relieving mattress used at the facility" was on Resident 6's bed at the time of the survey. Tr. at 64, 104, 787, 819. The surveyor also testified that during the survey she did not see the September 24, 2008 care plan entry for a "low air loss mattress," while the facility nurse testified that the low air loss mattress was in use "around" September 24, 2008. Together, their testimony suggests the low air loss mattress was entered in the care plan as an intervention and implemented only after the survey was underway. Tr. at 69-70, 107, 853; P. Ex. 11, at 247 (2008 care plan entry stating "9/24 Low Air Loss Mattress"). The ALJ could thus reasonably reject Plott's argument that the notation to "[c]ontinue low air loss mattress" on Wound Care Assessments of August 7 and 14, 2008 indicates that the low air loss mattress was actually in use at that time. P. Ex. 11, at 232-35; ALJ Decision at 10, 14. Plott argues that the ALJ's findings are confusing because he found that "only on October 4, 2008 did a nurse make a 'late entry' on a care plan document to the effect that the **pressure relieving mattress** was in use as of June 9, 2008" but, "[a]t another point, the ALJ seems to have found as a matter of fact that **the mattress** was not instituted until **September 24, 2008,**" the date that the care plan first referenced the low air mattress. RR at 24 n.16 (emphasis added). We disagree. The September 24 reference was clearly to the low air loss mattress, which the evidence shows was different from the standard pressure relief mattress provided earlier. Tr. at 103-04, 107. While Plott relies on the fact that it obtained the consultations from the outside wound care physician in August as showing it was taking needed interventions, Plott provided no evidence to explain why it did not timely provide the low air loss mattress the physician obviously thought was needed for the resident, given that she was in wrist restraints by August.

- As the ALJ found, Plott did not address the resident's noncompliance with efforts to turn and reposition her, as provided by the June 2007 care plan, until after a pressure ulcer opened again on March 13, 2008. ALJ Decision at 12-13. While the ALJ did not discuss Plott's assertion that the pressure ulcers were unavoidable because the resident was placed in wrist restraints, we note that the wrist restraints were not ordered until the resident returned from the hospital on June 5, 2008, and are thus irrelevant to the issue of whether Plott should have taken steps earlier to prevent recurrence of the pressure ulcer on the sacrum/coccyx. Plott criticizes as an "unworkable" suggestion that "causes shivers" to contemplate the surveyor's suggestion that the resident could be positioned on her side and cushions used to relieve pressure on her coccyx/sacrum while the wrist restraints were in use. RR at 25 n. 17. Plott cited no evidence to support this characterization, however. The care plans and Wound Care Assessments, moreover, do not reflect any discussion of the anticipated impact of restraints on her risk for pressure ulcers or any consideration of potential interventions to minimize that impact. In any event, the challenges in relieving pressure on the resident's coccyx and sacrum posed by the use of wrist restraints made all the more important the need for the low air loss mattress, which Plott failed to timely obtain for the resident.

- Finally, while the record shows that Resident 6 was difficult to manage, we reject Plott's suggestion that it could justifiably fail to provide services to prevent the recurrence of pressure ulcers because Resident 6's MRSA infection was a more significant problem. Infection is one of the risks of an open sore. Thus, the resident's MRSA infection and her tendency to touch the infected head wound made it even more incumbent on Plott to take steps to prevent the reopening of the pressure ulcer on the sacrum/coccyx and the development of any new pressure ulcers.

As discussed above, the ALJ reasonably rejected Plott's argument that the pressure ulcers over the resident's coccyx or sacrum and left buttock were unavoidable, given Plott's failure to have responded appropriately with assessments and care planning aimed at preventing future pressure ulcers and to have timely implemented all of the needed interventions. Additionally, the contemporaneous medical record nowhere reflects a considered determination that the recurrence of the pressure sore was unavoidable.

B. We reverse, as beyond the ALJ's authority in this instance, his determination that Plott's noncompliance with 42 C.F.R. § 483.25(c) constituted actual harm.

Although the ALJ concluded that Plott violated section 483.25(c) based upon the example of Resident 6 as CMS determined, he rejected CMS's determination as to the scope and severity of Plott's noncompliance.

CMS determined that the scope and severity of Plott's noncompliance with section 483.25 was at the "D" level, meaning an isolated deficiency that constitutes "no actual harm with potential for more than minimal harm that is not immediate jeopardy." CMS Ex. 1, at 49 (SOD); 59 Fed. Reg. 56,116, 56,183 (Nov. 10, 1994); SOM § 7400.5.1, scope and severity grid (Sept. 10, 2010; previously at § 7400E). The ALJ nonetheless stated that "Resident 6 developed open sores on her coccyx or sacrum which I conclude is actual harm with or without specific indication that the resident suffered pain or discomfort to any particular degree," and found that "[i]n this case, the surveyor's conclusion that there was no actual harm is clearly and plainly in error as a matter of fact [because the] evidence shows open ulcers and they amount to actual harm because any open wound has associated pain, risk for infection, and other complications." ALJ Decision at 15 and n.10.

On appeal, CMS neither asserts that the noncompliance constituted actual harm nor addresses the ALJ's determination that it did. CMS merely describes this deficiency as "having the potential for more than minimal harm that does not amount to immediate jeopardy," as opposed to the deficiency under section 483.25(d), which CMS described as "a deficiency that involves actual harm that does not amount to immediate jeopardy." CMS Br. at 21.

The ALJ was without authority in this case to review CMS's determination of the level of Plott's noncompliance with section 483.25(c). The regulations governing these proceedings state: "Administrative actions that are **not** initial determination[s] (and therefore **not subject to appeal** under this part) include . . . a determination by CMS as to the facility's level of noncompliance" with two exceptions not applicable here. 42 C.F.R. § 498.3(d)(10)(ii) (emphasis added). Those exceptions provide that initial determinations that are subject to review include –

> The level of noncompliance found by CMS in a SNF or NF but **only** if a successful challenge on this issue would affect—
>
> (i) The range of civil money penalty amounts that CMS could collect (The scope of review during a hearing on imposition of a civil money penalty is set forth in § 488.438(e) of this chapter); or
> (ii) A finding of substandard quality of care that results in the loss of approval for a SNF or NF of its nurse aide training program.

42 C.F.R. § 498.3(b)(14) (emphasis added). The $500 per-day CMP imposed for the noncompliance found in the September 2008 survey is already in the lower of the two ranges available for per-day CMPs, $50 to $3,000 per day versus $3,050 to $10,000 per day for deficiencies that pose immediate jeopardy. 42 C.F.R. § 488.438(a)(1). Thus, the first exception does not apply.

The second exception permitting review of CMS's determination of scope and severity is also absent here. There is no evidence in the record that Plott had a nurse aide training program or was seeking approval for one.[6]

We also note that this case is not analogous to *Lake City Extended Care Center*, DAB No. 1658 (1998), where the Board sustained the ALJ's determination to change the scope of a deficiency (from "widespread" to "isolated") based on different findings of facts than those on which the surveyors relied. *Lake City Extended Care Center* at 13-14 n.16 ("We see nothing in the regulations that precludes the ALJ from making a new finding as to the scope of a deficiency where the ALJ findings are different from the survey findings."). In *Lake City*, "[t]he original determination of widespread scope was based on the surveyors' finding that there were numerous incidents that violated the standard of care while the ALJ properly found that the standard of care was violated in only one of the alleged incidents." *Id*. Here, by contrast, the ALJ found actual harm based on facts also found by the survey, the presence of recurrent open pressure ulcers. ALJ Decision at 15 and n.10; CMS Ex. 1, at 49-55 (SOD noting the presence of an open area on the resident's coccyx in December 2007 and open ulcers on the resident's coccyx/sacrum in February, March, May, June, August and September 2008; surveyor's observation of stage 2 ulcers during the survey). The ALJ's findings regarding Plott's failures with respect to the care of Resident 6 also track the survey findings. The ALJ was not permitted under the regulations to substitute his judgment for that of CMS regarding the level of noncompliance evidenced by these facts.

Because we conclude that the ALJ was without authority in this instance to review CMS's determination of the level of Plott's noncompliance with section 483.25(c) with respect to Resident 6, we reverse without further discussion the ALJ's determination that the noncompliance constituted actual harm.

Accordingly, we sustain the ALJ's determination that Plott was not in substantial compliance with 42 C.F.R. § 483.25(c) based on the survey completed September 24, 2008, and reverse his determination that the noncompliance constituted actual harm.

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[6] Plott's request for review of the ALJ Decision incorrectly states that CMS's notice dated February 10, 2009 imposed the "loss of the right to offer a nurse aide training and competency evaluation program ('NATCEP')" in addition to the CMP and DPNA. RR at 7, citing CMS Ex. 5. CMS's February 10, 2009 notice contains no reference to NATCEP or nurse aide training. CMS Ex. 5. CMS's November 7, 2008 notice imposing a CMP and DPNA following the survey ending September 24, 2008 states that the deficiencies would require withdrawal of NATCEP approval and that "you will receive further notification from the State in this connection." CMS Ex. 3, at 3-4. No such notification from the State is in the record, however, and neither party has asserted that Plott had such approval or that such approval had been withdrawn.

II. We sustain the ALJ's determination that Plott was not in substantial compliance with 42 C.F.R. § 483.25(d)(2) based on the September 2008 survey,

Background

CMS determined that Plott was not in substantial compliance with 42 C.F.R. § 483.25(d)(2) in its care of Resident 5. Section 483.25(d)(2) requires a facility to "ensure that . . . [a] resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible."[7]

Resident 5 was a 79-year-old woman with an indwelling Foley catheter and numerous diagnoses, including a history of urosepsis, history of calculus of the kidney, gastroesophageal reflux disease, diabetes mellitus, hypertension, congestive heart failure, Parkinson's Disease, and urinary retention. ALJ Decision at 16. The September 2008 survey determined that Resident 5 had four symptomatic urinary tract infections (UTIs) from December 2007 to August 2008 as a result of Plott's failures to ensure that she received treatment and services to prevent recurrent UTIs, and to update and revise the resident's care plans to prevent recurrent UTIs.[8] CMS Ex. 1, at 55-56, 68-74.

A long-term care plan from January 2007, for the risk of infection due to the Foley catheter and history of retention of urine, lists interventions including monitoring for signs and symptoms of infection and reporting any noted; daily catheter care and changes as necessary; good perineal care; good hydration; and laboratory testing as ordered. ALJ Decision at 17, citing P. Ex. 12, at 2, 5. Entries to the long-term care plan with dates from October 2007 to June 2008 refer, respectively, to use of a Foley catheter, and to administering antibiotics as ordered. *Id.* Short-term care plans responding to UTIs, from March and December 2007, and March, June, July, and August 2008, list interventions including administering antibiotics, encouraging the increased intake of fluids, monitoring for adverse signs and symptoms and notifying the physician of changes, providing good perineal care, and keeping the resident clean and dry. *Id*. at 16-17, citing P. Ex. 12, at 101-09.

[7] The SOD under this deficiency alleges noncompliance with section 483.25(d), which includes the requirement at paragraph (d)(1) that a resident "who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary." The findings the ALJ addressed with respect to Resident 5 concern only the requirements of paragraph (d)(2).

[8] The survey also found the facility "failed to observe staff providing Foley catheter care and pericare to ensure facility procedure was followed," but the ALJ did not address those findings with respect to this resident. CMS Ex. 1, at 56.

The ALJ found that Resident 5 "had multiple UTIs between December 6, 2007 and August 28, 2008" but that "the long-term care plan reflects no additional interventions during the period except the administration of antibiotics and follow-up laboratory work," and that short-term care plans responding to each UTI contained "nearly identical interventions." ALJ Decision at 18. He found "no evidence that the care planning team assessed the effectiveness of chosen interventions to prevent UTIs or considered alternative interventions to prevent UTIs." *Id.*

Discussion

Plott concedes that "[t]he Resident in fact did suffer persistent UTIs throughout her stay" at Plott. RR at 28; *see also* RR at 29 (stating that Plott did not "argue that Resident #5 did not suffer symptomatic UTIs that required intervention"). Plott asserts that "*this Resident's* UTIs were the unavoidable consequence of an unusual underlying condition," namely the chronic presence of colonized bacteria in her kidney, as evidenced by the "staghorn calculi" for which the resident underwent surgery in January 2007.[9] RR at 27 (emphasis in original); ALJ Decision at 17. Plott presented evidence that staghorn calculi result from such chronic, colonized bacteria, which can cause recurrent UTIs and are not completely eliminated by either surgical removal of staghorn calculi or treatment of UTIs with antibiotics. Plott's Medical Director testified that staghorn calculi "are the result of chronic bacteria in the kidney and they do seed the bladder," that such bacteria can live in the bladder without causing infections, and that this "asymptomatic bacteriuria" is not treated with antibiotics. Tr. at 746-51; *see also* Tr. at 859-61 (testimony of geriatric physician that standard of care is not to treat asymptomatic bacteriuria with antibiotics).

Plott asserts that the ALJ wrongly understood Plott to argue that Resident 5 "had a staghorn calculus that predisposed her to colonization of bacteria," an argument the ALJ rejected because staghorn calculi had been surgically removed in January 2007, well before the UTIs noted in the SOD. RR at 29, quoting ALJ Decision at 18. Plott states that in fact it is the underlying bacteria and not the staghorn calculi that seed the bladder causing UTIs, and that surgical removal of the calculi does not eradicate the colonized bacteria that can continue to cause UTIs. RR at 32, citing Tr. at 749-50. Plott argues that it did "all that it could, in light of the Resident's condition, to minimize her subsequent development of UTIs[.]" RR at 28.

[9] A "staghorn calculus" is a type of kidney stone that resembles a stag's antlers and must be removed surgically. Tr. at 746-51.

Even assuming that the ALJ misunderstood Plott's testimony and arguments, however, Plott did not show that the UTIs all resulted from the same bacteria or that they were caused by the bacteria associated with the staghorn calculus that the resident had in January 2007. Laboratory reports of urine cultures disclose the presence of two strains of bacteria at different times: Escherichia coli on February 28, March 18, June 18, July 1, and August 28, 2008, and proteus mirabilis on December 12, 2007, and on June 18 and August 28, 2008. P. Ex. 12, at 32, 35, 36, 49, 55, 64, 70, 71. Any suggestion that this resident suffered only from asymptomatic bacteriuria not warranting treatment is additionally contradicted by physician's orders and short-term care plans showing that the UTIs were sometimes treated with antibiotics. *See* CMS Ex. 13, at 33, 35, 39, 41, 50, 52 (noted or ordered December 6, 2007, March 4 and 21, 2008, June 17, 2008, July 3, 2008, and August 28, 2008). The fact that Plott in January 2007 developed a long-term care plan for the risk of infection due to the Foley catheter and the resident's history of retention also recognizes the possibility of causes of UTIs other than simply the bacteria associated with the staghorn calculus. P. Ex. 12, at 5. Plott did not point to evidence of a contemporaneous assessment that the UTIs resulted from the same bacteria and that further interventions to prevent UTIs would not be warranted. Moreover, Plott did not present evidence that the presence of asymptomatic bacteriuria meant that it could not take steps to minimize the risk of symptomatic UTIs, which this resident exhibited. *See, e.g.*, P. Ex. 12, at 87 (nursing care note dated June 17, 2008 noting "blood in urine").

Plott's assertion that the UTIs were unavoidable thus affords no basis to overturn the ALJ's conclusion that Plott failed to comply substantially with the regulation by failing to assess the effectiveness of the interventions that had been planned to prevent UTIs or consider alternative interventions to prevent UTIs during the period December 2007 through August 2008 when the resident experienced multiple UTIs. Substantial evidence supports the ALJ's findings that Plott failed to reassess the resident and consider additional interventions to prevent recurrence of UTIs.

Plott argues that in any event it should not be held responsible for failing to consider additional interventions to address repeated UTIs that the surveyor raised at the hearing, such as the use of silver-coated catheters and cranberry tablets, and consultations with specialists in nephrology or urology. Tr. at 538. Plott asserts it was not responsible for the absence of such interventions where the physician chose not to order them. P. Reply at 12-13, 17. This argument fails to acknowledge a facility's responsibility for resident care imposed by the overarching introductory language of section 483.25, which provides that "[e]ach resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care." The Board has held that a facility "was not entitled to simply rely on the treating physician's

orders here after it became apparent that they were ineffective in relieving [the resident's] suffering." *Grand Oaks Care Center*, DAB No. 2372, at 6 (2011). As noted in *Grand Oaks*, the preamble to the final rule implementing the introductory language in section 483.25 responded to commenters (who "[i]ndicated that it is unfair to hold the facility responsible for compliance with requirements involving activities that must be performed by the physician, over whom the facility has little control") by explaining that business and professional codes require facilities to question any orders they consider inappropriate. *Id*. at 7, citing 54 Fed. Reg. 5316, at 5340 (Feb. 2, 1989). Here, Plott did not show that it even considered any additional steps such as those suggested by the surveyor, much less that it recommended any additional interventions to the resident's physician and that the physician rejected them.[10]

Accordingly, we sustain the ALJ's conclusion that Plott was not in substantial compliance with the requirements of 42 C.F.R. § 483.25(d) in its care of Resident 5 as determined in the survey of September 2008. With respect to this noncompliance, the ALJ found "actual harm in the form of multiple UTIs." ALJ Decision at 19. CMS also determined a severity level of actual harm, so we do not review this finding.

III. We reverse the ALJ's determination that Plott was not in substantial compliance with 42 C.F.R. § 483.25(d) in its care of Resident 5 as found in the December 2008 survey and modify the ALJ Decision accordingly.

Background

Section 483.25(d)(2) provides that, based on the resident's comprehensive assessment, the facility must ensure that a "resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections . . . ."

The ALJ concluded that Plott was not in substantial compliance with this requirement based on the following:

- The surveyor observed Resident 5 asleep in bed on December 1, 2008, with her catheter tubing and urine collection bag hanging on the bed side-rail, which was above the level of the resident's bladder.

- The surveyor's unrebutted testimony at hearing was that, even though the bag had an anti-reflux valve, urine in the tubing between the bladder and the valve can flow back to the bladder if the bag and tubing are placed above the bladder and can pose a risk of infection.

[10] While Plott cites testimony of a geriatric physician witness that cranberry juice might not be efficacious in older patients, P. Reply at 17, citing Tr. at 871, Plott's medical director testified that some patients with multiple infections do in fact receive cranberry tablets. Tr. at 743.

- Plott did not deny that the catheter bag should be hung below the level of the resident's bladder.

ALJ Decision at 19. The ALJ rejected Plott's argument that the error was not its fault because the catheter bag was improperly positioned by a hospice aide, not a facility staff member, because Plott "cite[d] no authority that recognizes a defense that [a nursing facility] is not responsible for care delivered in its facility by hospice aides who are not employees." *Id*. at 20. The ALJ treated as undisputed Plott's assertion that Resident 5's Foley catheter bag had been placed on the side rail by hospice staff, rather than by facility staff.

The Resident 5 in the December survey is a different individual from the Resident 5 discussed above with respect to the September survey. What little evidence there is in the record regarding the resident at issue here shows she was admitted to the facility on November 21, 2008, as a terminally ill resident authorized to receive hospice care from the Visiting Nurses Association and Hospice of Southern California (VNA). CMS Ex. 69, at 2, 3, 8, 10. She had multiple diagnoses, was receiving nutrition through a tube (which was discontinued at the family's request before the survey), and was admitted with a UTI that was being treated with antibiotic. *Id.* at 3, 7, 8.

The parties' arguments

On appeal, Plott does "not dispute that the surveyor saw what she said she saw." RR at 37. "But," argues Plott, "CMS did not allege, and the ALJ did not find, that [Plott's] staff either hung the bag in question, or that they knew about the problem." *Id.* According to Plott, it is undisputed that the "catheter bag had been hung by a nurse from the hospice that was providing care to the Resident, and that [Plott's] own nurses were unaware of the problem at the point where the surveyor observed it." *Id.*[11] Plott points out that the survey team found no similar problems with other residents or any reason to conclude that Plott's own staff was not properly trained or qualified to provide catheter care. *Id.*[12]

On appeal, CMS does not claim that it did, in fact, dispute Plott's assertion below that the catheter bag was misplaced by the hospice aide. Instead, CMS merely points out that Plott did not call the aide for the hospice to testify about whether she hung the Foley catheter bag as Plott alleged. CMS Br. at 16.

[11] The surveyor's notes indicate she was told that a hospice **aide** had left the Foley catheter hung across the side rail. CMS Ex. 69, at 2. Since the SOD mistakenly refers to a hospice **nurse**, however, the parties' arguments at times refer to a hospice nurse.

[12] Plott also raises other arguments, but, given our conclusions below, we need not reach those issues.

CMS also does not assert that Plott was responsible for care provided by the hospice aide. Instead, CMS argues that, even assuming that the hospice aide and not a member of Plott's staff hung the bag improperly, Plott presented no evidence that its staff would have recognized the hospice aide's error if the surveyor had not brought it to Plott's attention. *Id.* CMS argues that "Plott does not dispute that Surveyor Nichols observed the problem when she entered Resident 5's room with one of Plott's nurses and that she pointed out the problem, to which the nurse responded '[t]he Hospice nurse was here about one hour ago and left the Foley catheter like that.'" CMS Br. at 16, citing CMS Ex. 68, at 4. CMS implies that we should therefore infer that Plott's nurse would not have identified the problem on her own. CMS also points out that, because "the hospice aides and nurses were not present 24 hours a day to provide care, much of the care was to be provided by Plott's staff," and Plott was the "primary caregiver" for the resident. *Id*. at 18. CMS asserts that "Resident 5 had a plan of care for her urinary catheter for which Plott had responsibility." *Id.*, citing CMS Ex. 69, at 11.

Discussion

In its hearing request, Plott clearly asserted that a hospice aide had misplaced the catheter bag at most an hour before the surveyor observed the bag. Mar. 24, 2009 Request for Hearing at 2; *see also* P. Pre-hearing Br. at 43. CMS did not dispute Plott's assertions in its briefs before the ALJ, nor did CMS clearly dispute these assertions on appeal. Moreover, CMS's own evidence supports a finding that the bag was placed on the side rail by the hospice aide at most an hour before the surveyor observed the bag. CMS Ex. 68, at 3-5 (SOD noting that the nurse who escorted the surveyor said that a hospice staff member had provided care about an hour before and "left the catheter like that"); CMS Ex. 69 (Surveyor Worksheet noting that, at 10:22, the nurse escort "stated the Hospice CNA was here providing care about 1 hour ago"; that the husband and resident's physician also referred to the hospice aide, and that the hospice aide was in-serviced by her VNA supervisor with respect to the December 1 incident); *see also* CMS Ex. 68, at 5 (indicating the hospice aide provided care to the resident on 12/1/08 from 8:50 AM until 9:45 AM). At the hearing, the surveyor testified only as to whether placement of the bag had the potential for more than minimal harm, even if the catheter bag had an anti-reflux valve. Tr. at 86-89. She did not testify that she had any reason to disbelieve the facility's assertions about the hospice aide.

Under these circumstances, the ALJ was not required to draw a negative inference from Plott's decision not to present testimony from the hospice aide, and we decline to draw such an inference.

We agree with CMS that hospice aides and nurses are not expected to provide 24-hour care and that Plott was the resident's "primary caregiver," as that term is used in the hospice context. We also agree with CMS (and Plott does not deny) that it was required to provide catheter care in accordance with Resident 5's plan of care. *See* 73 Fed. Reg. 32,088, 32,204 (June 5, 2008). Contrary to what CMS implies, however, nothing in Resident 5's plan of care indicates that Resident 5 would have been expected to receive catheter care or any other type of care from the facility in the time between when the hospice aide left and the surveyor observed the catheter bag. CMS Ex. 69, at 9-11.

In these circumstances, the proper analysis does not turn on the relationship between the hospice and SNF care – Plott does not deny it would have had a duty to move the bag if it was or should have been aware it was incorrectly placed. The issue is how quickly the facility was required to discover and correct an error in catheter placement made by an individual who was neither an employee nor a contractor of Plott (irrespective of whether that individual was a hospice aide, a family member, or another visitor to the facility).

The only evidence in the record regarding when Plott might have been expected to notice the placement of the bag is evidence that the nurse who escorted the surveyor stated that "the direct care staff make resident rounds at least every two hours and the position of the Foley catheter would have been noticed at some point." CMS Exs. 68, at 5; 69, at 7. CMS has not argued in these proceedings that something more than providing direct care every two hours was required by Plott's role as Resident 5's primary caregiver or by some other applicable standard. Nor has CMS argued that the facility had reason to foresee that the bag would be moved or improperly hung such that facility staff should have checked more often than every two hours for Resident 5.

CMS now suggests that the surveyor had to "point out" the misplaced bag to the nurse escort, so we should find Plott's care of Resident 5 deficient by inferring that the nurse failed to notice the bag on her own. The SOD merely says that, during the initial tour conducted with the nurse escort at 10:20 a.m. on December 1, the misplaced bag was observed and that, at the time of the observation, the nurse "confirmed the observation." CMS Ex. 68, at 4; *see also*, CMS Ex. 69, at 2. Nothing in the SOD alleged that the surveyor had to point out the problem to the nurse escort or that the nurse escort should have noticed the problem on her own, but did not. CMS Ex. 68. CMS pre-hearing brief on this issue consists of the following sentence: "Surveyor Nichols observed that R-5's Foley catheter was hanging on her side rail, not below the level of her bladder which increased her risk of a UTI because contaminated urine could flow back into her bladder from the bag or tubing." CMS Pre-hearing Br. at 29. CMS's post-hearing brief argued that "Plott presented no evidence that it would have discovered the hospice nurse's error

had Surveyor Nichols not brought it to Plott's attention . . . ." CMS Post-hearing Reply Br. at 25. CMS, however, identified no evidence establishing that the surveyor had to bring the misplaced bag to the nurse escort's attention and did not ask the ALJ to find that the nurse escort had the opportunity to notice the misplaced bag on her own, but failed to do so.

Given the lack of any timely and adequate notice from CMS that it was asserting any failure by the escort nurse (or any other Plott employee or contractor), Plott had no obligation to present the type of evidence CMS faults it for not presenting. For example, absent any notice that CMS alleged a basis to show that Plott's staff would not have recognized the hospice aide's error, Plott cannot fairly be faulted for "presenting no evidence that its staff would have recognized" the error, even if the surveyor had not recognized it.

Accordingly, we reverse the ALJ's conclusion that Plott failed to meet the requirements of section 483.25(d) for providing appropriate services to its residents to prevent urinary tract infections.

IV. Because we overturn the only finding of noncompliance from the December survey, we overturn the $100 per-day CMP and modify the ALJ's conclusion regarding the duration of the DPNA.

Although the December survey found three deficiencies, only the deficiency cited under section 483.25(d)(2) was cited at a level that constitutes noncompliance. Because we have overturned the noncompliance finding under that section, we also reverse the $100 per-day CMP based on that finding.

The noncompliance finding in the December survey also was the basis for CMS's finding that Plott did not achieve substantial compliance until after the December survey, on December 15, 2008. Thus, because we have overturned that noncompliance finding, we must also address the duration of the $500 per-day CMP, which CMS and the ALJ continued through December 3, 2008, the day before the December survey (reducing the amount to $100 per day thereafter), and the duration of the DPNA, which CMS and the ALJ found should continue through December 15, 2008.

Duration of a per-day CMP is governed by section 488.440. That section provides the CMP is computed "for the number of days of noncompliance until the date the facility achieves substantial compliance or, if applicable, the date of termination . . . ." 42 C.F.R. § 488.440(b). Section 488.440(h) provides:

> (1) If an on-site revisit is necessary to confirm substantial compliance and the provider can supply documentation acceptable to CMS or the State agency that substantial compliance was achieved on a date preceding the revisit, penalties imposed on a per day basis only accrue until that date of correction for which there is written credible evidence.
> (2) If an on-site visit is not necessary to confirm substantial compliance, penalties imposed on a per day basis only accrue until the date of correction for which CMS or the State receives and accepts written credible evidence.

The $500 per-day CMP here was based on the noncompliance findings in the September survey. Given our conclusion that CMS had no legally sufficient basis for determining that Plott was not in substantial compliance at the time of the December survey, the key question regarding duration of the $500 per-day CMP is when Plott corrected the noncompliance from the September survey. The approved plan of correction for each of the noncompliance findings from the September survey (including the two we have upheld above) identified specific corrective actions for affected residents that Plott would take "[o]n or before" October 28, 2008. CMS Ex. 1. In other words, Plott did not allege that it would complete all corrective actions before that date. Nor did Plott present any evidence that, in fact, it completed the corrective actions either generally or with respect to any particular participation requirement prior to October 28, 2008.

CMS and/or the State survey agency obviously determined that a revisit was necessary and thus conducted the revisit in December. The CMS letter of February 10, 2009 to Plott notifying it of the final imposition of the remedies states that "the State Survey Agency returned to your facility to verify your assurances that you had corrected all previously cited deficiencies and were in substantial compliance with all of the federal requirements . . . ." CMS Ex. 5, at 2.

The Board has held that CMS does not need to establish noncompliance on each day for which it imposes a CMP. *See, e.g., Regency Gardens Nursing Center*, DAB No. 1858, at 7-11 (2002) and cases cited therein. As the Board pointed out in *Regency*, the congressional purpose in providing in 1987 for alternative remedies short of termination was to allow CMS to apply pressure to motivate facilities to solve problems quickly and so protect residents without disrupting placements unnecessarily. *See, e.g.*, H.R. Rep. No. 100-391(I), at 470-77 (1987); 59 Fed. Reg. 56,116-17, 56,177-78 (Nov. 10, 1994). Thus, the Board stated that, consistent with that purpose, "a non-compliant facility is required to promptly file for CMS's approval a plan stating when and how the facility will correct the conditions violating participation requirements and is not entitled to have the remedies lifted unless and until the facility demonstrates that substantial compliance has been achieved." *Regency*, at 11, citing 42 C.F.R. §§ 488.401, 488.402(d).

The problem here is that, while Plott successfully challenged the new noncompliance finding from the December survey, there is no evidence in the record regarding when Plott may have achieved substantial compliance following the September survey other than the plan of correction from that survey.[13] Because the plan of correction (signed October 22, 2008) asserts only that Plott will take the identified corrective actions "[o]n or before October 28," it is ambiguous about when Plott was alleging it would complete its corrective actions and achieve substantial compliance. CMS Ex. 1. We also note that the plan of correction for the two noncompliance findings addressed by the ALJ refers to systemic change related to each finding, which Plott assured "will be achieved through the new procedure for monitoring corrective actions and quality assurance." *Id.* at 50, 56-57. The plan of correction describes this procedure as calling for monitoring by the Director of Nursing on a quarterly basis to verify the corrective actions and for her to provide the results to the Quality Assurance Committee for review and evaluation of any further corrective action as necessary. *Id.* Yet, the plan of correction gives no date for when this procedure was or would be implemented.

We note that, unlike some other cases in which a facility presented a revisit survey form identifying for each previously cited noncompliance finding what the state survey agency determined about when the noncompliance was corrected, neither party submitted such a form in this case although it would have been helpful, if it exists. The fact that CMS and the State agency here continued the $500 per-day CMP through December 3, however, indicates that they did not find that Plott had corrected most of the deficiencies before that date.

In any event, Plott made no allegation whatsoever about what the surveyors found on the revisit regarding correction of the findings from the September survey. Nor did Plott elicit any testimony from the surveyor who testified about the December revisit survey regarding any result of that survey other than the one noncompliance finding regarding Resident 5. Tr. at 57-122. Thus, we conclude, Plott did not meet its burden to show that it achieved substantial compliance on a date before the revisit survey.

Accordingly, we determine that the $500 per-day CMP should continue through December 3, 2008, the date before the December 4 revisit.

We also modify the DPNA, which was imposed effective November 22, 2008, to end on December 3, 2008.[14] Since we find that Plott was in substantial compliance at the time of the revisit survey on December 4, we find there is no basis for a DPNA as of that date.

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[13] While there is some evidence of in-service training on Foley catheter care that occurred before October 28, 2008, Plott did not present any evidence to show when that training was completed for all of its staff.

[14] The November 22 date was apparently chosen since it is 15 days after the date of CMS's notice of imposition of the remedy, which was faxed to Plott on November 7. CMS Ex. 3; *see also* 42 C.F.R. § 488.402(f)(4) (requiring notice for a non-immediate jeopardy DPNA 15 days before the effective date).

See 42 C.F.R. § 488.454 (alternative remedies continue until the facility has achieved substantial compliance).

V. We reject Plott's contention that the ALJ erred by failing to address all of the noncompliance findings from the September 2008 survey and conclude that those findings are immaterial to the outcome of the dispute.

Plott raised a number of arguments on appeal broadly related to its contention that the ALJ erred by failing to address all of the findings of noncompliance from the September 2008 survey. Some of these arguments go to whether a facility has a right to an ALJ hearing on a deficiency finding even if it does not result in a remedy. This issue is irrelevant here and is resolved by the regulations, by which we are bound. Many of the other arguments misstate what the Board or courts have held or are based on factual premises that are unsupported.

In this section, we address the key arguments made. We first explain why we conclude that the ALJ was not required to either sustain or set aside every noncompliance finding that Plott appealed. We then explain why we conclude that the unaddressed noncompliance findings are not material to the outcome of this case, including our analysis that a per-day $500 CMP is reasonable in amount based on the findings we have sustained and the relevant factors for determining a CMP amount. We explain why Plott's assertions about CMS's actions regarding deficiency findings do not cause us to reconsider our previous holdings that an ALJ is not required to address noncompliance findings that are immaterial to the outcome of an appeal. Finally, we explain why we conclude Plott's other arguments have no merit.

A. The ALJ was not required to either sustain or set aside every noncompliance finding that Plott appealed.

Plott argues that its request for hearing "challenged all of the allegations of noncompliance CMS specifically stated that it had relied upon as the basis for the sanctions it imposed." RR at 11. According to Plott, it "is well aware that the Board consistently has held that in the interest of 'administrative efficiency' – that is, convenience to *the Board* – an ALJ may vitiate a nursing facility's statutory (and constitutional) appeal rights and need *not cons*ider the actual basis CMS stated for a sanction if the ALJ is able to sustain a sanction on a lesser basis." *Id.* (italics in original).[15] Plott alleges that this approach results in consigning the unaddressed

[15] CMS argues that the Board need not address this issue because Plott did not raise it before the ALJ. CMS relies on the Board's decision in *Life Care Center of Tullahoma*, DAB No. 2304 (2010). In that case, however, CMS had specifically given notice prior to the hearing that it was relying on only five immediate jeopardy findings as the basis for the CMP. Here, in contrast, Plott could have reasonably thought that the ALJ would address all of the findings of noncompliance, except those specifically withdrawn by CMS. Tr. at 641-45.

allegations of noncompliance to "a regulatory limbo, where they remain on [the facility's] record, but have never been determined to be accurate or appropriate." *Id.* at 2. Plott suggests, moreover, that "this result is inconsistent with the plain language of the Social Security Act, as well as many Supreme Court cases that address whether, and to what extent, the Government may impose any sanction, or impair any property or liberty interest, without providing the affected party the right to contest the action before a neutral decisionmaker." RR at 11. Plott bases this argument primarily on the Supreme Court's decision in *Shalala v. Illinois Council on Long Term Care, Inc.*, 529 U.S. 1 (2000), which held that the relevant appeals provisions in the Act require exhaustion of administrative remedies before appeal to court. Plott contends that the Secretary argued in her briefs in that case that the relevant determination that entitles a dissatisfied facility to review is any determination that a provider has failed to comply substantially with the statute, provider agreements, or regulations, whether termination or some other remedy is imposed. Plott asserts that the Court relied on this "representation that administrative review is *always* available to challenge deficiencies (and that one way a facility could do so is simply to refuse t*o submi*t a plan of correction and be assessed a minor penalty, which it could then appeal)." *Id.* at 16 (italics in original). [16]

Plott's arguments misstate what the Board has held. The Board has held that an ALJ need not address noncompliance findings that are not material to the outcome of the appeal. *Batavia*; *Western Care Management d/b/a Rehab Specialties Inn,* DAB No. 1921 (2004) (*Rehab*); *Beechwood Sanitarium*, DAB No. 1824 (2002), *modified on other grounds*, *Beechwood v. Thompson*, 494 F.Supp.2d 181(D.N.Y. 2007). In effect, these decisions hold that the right to a hearing is **not** vitiated where the unaddressed noncompliance findings are not material to the outcome of the case. In *Claiborne-Hughes Health Center v. Sebelius, et al.,* 609 F.3d 839 (6th Cir. 2010), the Court of Appeals explained:

> It is neither arbitrary nor capricious for the agency to conclude that, in the interests of judicial economy, it will review only those deficiencies that have a material impact on the outcome of the dispute.

609 F.3d 847. Plott argues that the issue before the court in *Claiborne-Hughes* was limited to whether the appeals regulations permit an ALJ to base a remedy on narrower grounds than originally cited. RR at 18 n.10. The facility in that case, however, had

[16] Plott describes as "not obviously true today" the Secretary's assurance to the Court that the regulations do not cause providers to suffer more severe penalties in later enforcement actions based on unreviewable findings. Contrary to what Plott suggests, however, the Board has held that findings from an earlier survey that result in a later remedy are reviewable. *Columbus Park Nursing and Rehabilitation Center,* DAB 2316, at 11-12 (2010); *see also* CMS Br. at 18 n.9 ("SNFs have the option of contesting the validity of previously unappealed deficiencies that may be used to determine the reasonableness of a CMP").

made the same argument Plott makes here – that narrowing the basis for the remedy is unfairly prejudicial because the other unreviewed deficiencies will remain in its public record.

Correctly applying the principle of judicial economy in this context is not solely for the convenience of the Board, as Plott asserts. Judicial economy can benefit not only the ALJ, the Board, and any reviewing court, but also benefits facilities by enabling an ALJ to issue a decision more quickly and can potentially benefit facility residents through faster imposition of remedies intended to promote compliance.

Plott's argument that the Board's holding in cases like *Batavia* is inconsistent with the Supreme Court's decision in *Illinois Council* and with the statutory hearing provisions discussed in that case (specifically, sections 1128A, 1819(h)(2)(B)(ii),1866(h)(2), and 205 of the Act) has no merit. Plott relies on the fact that the Court in *Illinois Council* referred to the statement in the Secretary's brief that a dissatisfied facility is entitled to review of any determination that the facility has failed to comply substantially with the statute, agreements, or regulations, whether termination or some other remedy is imposed. Plott takes this reference out of context, however. The Court went on to say:

> The Secretary's regulations make clear that she so interprets the statute. See 42 CFR §§ 498.3(b)(12), 498.1(a)-(b) (1998). The statute's language, though not free of ambiguity, bears that interpretation.

529 U.S. at 21. Read in context, the language merely reflects the Court's deference to the Secretary's interpretation that the cited statutory and regulatory provisions entitle a facility not only to a hearing on a **termination** for failure to comply substantially with the applicable requirements, but also to a hearing on **other remedies**, such as a CMP, imposed on the same basis. Nothing in the Court's decision suggests that a hearing granted under the cited provisions must address all noncompliance findings even if they do not result in imposition of a remedy or are immaterial to the outcome.

Moreover, Plott does not point to any specific wording in the statutory provisions discussed in *Illinois Council* to support its position here. The most relevant provision here, section 1819(h)(2)(B)(ii) of the Act, states that the hearing "provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty" imposed on an SNF under section 1819(h)(2)(B)(ii). If anything, the wording of this section supports the Board's holding that it is not necessary to address immaterial noncompliance findings. The wording applies the hearing right to the CMP, not to every noncompliance finding.

Plott does cite to the regulatory provisions at 42 C.F.R. §§ 488.330(d)(1) and 488.402(f), arguing that these sections "require CMS to provide a nursing facility with a very specific notice of the basis for any finding of noncompliance and, thus, any sanction" and that no Board decision purports to harmonize its approach with these provisions. RR at 16. Plott also contends that the "Board has vitiated this very specific requirement with the notion that the ALJ or even the Board may sustain a sanction 'de novo,' i.e., on a basis other than that stated by CMS, essentially on the premise that the Board is not an 'appellate reviewer' of CMS enforcement actions but the 'last step in the enforcement process.'" *Id.* at 16-17.[17] According to Plott, it is "at best questionable whether this result is permissible under the Administrative Procedure Act" and the Supreme Court decision in *Citizens to Preserve Overton Park, Inc. v. Volpe*, 401 U.S. 402 (1970). *Id*. at 17.

Plott misreads the regulations, Board decisions, the Administrative Procedure Act (APA), and the Court's decision.

Section 488.330(d) of the regulations requires a notice of certification of noncompliance (which is a recommendation by a state survey agency) to include the nature of the noncompliance, any remedies to be imposed, appeal rights, and deadlines. Section 488.402(f) similarly requires CMS (or the State if appropriate) to give notice of the remedy, including the nature of the noncompliance, which remedy is imposed, the effective date of the remedy, and the right to appeal. Nothing in either section prevents CMS from providing timely notice of additional findings at a later point. Indeed, the applicable hearing procedures specifically permit an ALJ to add new issues prior to the hearing. 42 C.F.R. § 498.56. More important here is the fact that nothing in either section prevents CMS or an ALJ from ultimately relying on only some of the noncompliance findings to which the notice refers.

Plott's reliance on the APA is also misplaced. The APA itself provides for a hearing in which the ALJ presides at the taking of evidence, and for an initial decision in which the ALJ sets out his/her own findings and conclusions "on all the **material** issues of fact, law, or discretion presented on the record. . . ." 5 U.S.C. § 557 (emphasis added); *see also* § 556 (taking of evidence). Plott points to nothing in the APA that requires an ALJ to make findings on additional issues that are immaterial to the outcome of a dispute.

Moreover, the Court's decision in *Overton Park* dealt with an agency's attempt to present during the court litigation a rationale for its regulatory decision that was not stated as a rationale at the time the decision was issued. Nothing in that decision precludes an agency from modifying its rationale during the course of an administrative proceeding.

[17] Plott cites to no Board decision for this argument, but appears to be referring to the Board's analysis about an ALJ's role in determining the reasonableness of a CMP amount in cases such as *Community Nursing Home*, DAB No. 1807, at 19-24 (2002).

B. The unaddressed noncompliance findings here are immaterial to the outcome of the case.

As the Board pointed out in *Batavia,* cases in which a CMP is imposed on a per-day basis generally present three issues to be addressed by an ALJ: (1) Was there a basis for imposing any CMP (that is, did the provider in fact fail to comply substantially with program requirements)? (2) What was the duration of the period of noncompliance? (3) Was the amount of the CMP reasonable? *Batavia* at 23.

Here, the ALJ correctly concluded that he did not need to address all of the CMS findings in order to resolve the first issue — whether a basis existed to impose a remedy. Under the regulations, one noncompliance finding is a sufficient basis for imposing a remedy such as a CMP. 42 C.F.R. § 488.402(c). Moreover, the noncompliance findings the ALJ made were sufficient to establish the duration of the period of noncompliance for the $500 per-day CMP that we uphold above. Plott did not present evidence that it achieved substantial compliance with respect to these requirements on any date earlier than the date of the revisit.

Thus, the key question is whether the unaddressed deficiencies are material to the determination that the amount of the $500 per-day CMP is reasonable.

In *Rehab,* on which Plott relies, the Board pointed out that the ALJ had not addressed findings of noncompliance to which CMS had assigned a relatively high level of noncompliance (including levels G, E, and F), including findings the survey agency had indicated that it considered as among the most serious and which had been cited in three consecutive surveys. The Board stated:

> In light of these omissions and the size of the penalties, Rehab's contention that the penalties were not justified by the seriousness of its noncompliance required the ALJ to consider carefully whether the deficiencies he addressed were sufficient to support the CMPs imposed, and whether findings favorable to Rehab on the unaddressed deficiencies would have been material to his determination that the amounts of the CMPs were reasonable.

Rehab at 20. Here, like in *Rehab*, the ALJ Decision did not address some findings of noncompliance to which CMS had assigned a relatively high level of noncompliance (including levels G, E, and F). As the Board also said in *Rehab*, however, the—

> potential materiality of unresolved deficiency findings may depend, of course, on whether there are adequate grounds to sustain the amount of a CMP in view of the deficiencies actually addressed. In evaluating reasonableness, the ALJ may, depending on the quality of the evidence and the nature of the deficiencies, attach more significance to certain deficiencies than others, or assign more weight to certain regulatory factors than to others. The ALJ is not obligated to weigh the factors as CMS did and may, if circumstances warrant, find a CMP to be reasonable based on fewer deficiencies than those addressed at the hearing or contained in the SOD.

Rehab at 21, citing *Batavia*, at 24, 59-64.

The Board has long held that the ALJ (or other fact-finder) must make an independent determination about "whether the evidence presented on the record concerning the relevant regulatory factors [in 42 C.F.R. § 488.438(f)] supports a finding that the amount of the CMP is at a level reasonably related to an effort to produce corrective action by a provider with the kind of deficiencies found and in light of the other factors involved[.]" *CarePlex of Silver Spring*, DAB No. 1683, at 8 (1999).

The regulatory factors are "(1) The facility's history of noncompliance, including repeated deficiencies. (2) The facility's financial condition. (3) The factors specified in § 488.404 [including the seriousness of the deficiencies, the relationship of one deficiency to other deficiencies, and the facility's prior history of noncompliance in general and specifically with respect to the cited deficiencies]; [and] (4) The facility's degree of culpability." 42 C.F.R. § 488.438(f). The ALJ considered these factors in light of his finding that there were two noncompliance findings at the actual harm level. Since we have reversed his finding of actual harm with respect to the pressure sores for Resident 6, we must reconsider the reasonableness of the amount of the CMP in light of the regulatory factors to determine if the amount is nonetheless within a reasonable range. *Id*.

In this case, the amount of the CMP is only $500, one-sixth of the permissible amount for non-immediate jeopardy level noncompliance and only one-fifth of the $2,500 per-day CMP in *Rehab*. One of the noncompliance findings is at the "actual harm" level, and both reflect a failure to reassess interventions in long-term care plans in the face of recurrent negative outcomes for a resident (either recurrent pressure sores in the case of Resident 6 or recurrent UTIs in the case of Resident 5). The ALJ found the facility "culpable" for its noncompliance without specifying a degree of culpability. ALJ Decision at 22. "Culpability" for this purpose "includes, but is not limited to, neglect, indifference, or disregard for resident care, comfort or safety." 42 C.F.R. § 488.438(f). While we do not perceive a basis for finding a high degree of culpability under the facts of this case, the evidence shows at least some neglect on the part of Plott's staff of their

duty to assess whether they might prevent (or at least minimize the risk of recurrence of) the reopening of the pressure sore for Resident 6 and the symptomatic UTIs for Resident 5, by adding interventions to their long-term care plans. The staff's unexplained delay in obtaining a low air loss mattress for Resident 6 after she was placed in restraints and therefore had a heightened risk for pressure sores also undercuts Plott's assertion that it was not culpable.

More significant is the undisputed evidence that a prior survey in September 2007 found noncompliance with the same two requirements, with actual harm, and that an earlier survey in March 2005 also found noncompliance with both the requirements. CMS Exs. 62, at 1; 64. The ALJ gave no weight to the evidence CMS presented regarding Plott's history of noncompliance merely because the earlier deficiencies "were apparently quickly corrected and required no enforcement remedies to encourage [Plott] to return to substantial compliance." ALJ Decision at 21-22. This was prejudicial error. As CMS points out, one of the reasons why remedies may be imposed is to prevent "yo-yo" compliance, in which facilities achieve substantial compliance but fail to maintain it. 64 Fed. Reg. 13,354, 13,356 (Mar. 18, 1999). Nothing in the regulations or the related preambles suggests that a history of noncompliance should be discounted if no remedy was imposed at the time of that noncompliance. Moreover, the ALJ should have given additional weight to the history of noncompliance because Plott had been cited for noncompliance with the same requirements in earlier surveys, a factor he was obliged to consider under the regulations. Indeed, Congress specifically provided that the criteria for imposing remedies "shall provide for the imposition of incrementally more severe fines for repeated or uncorrected deficiencies." Act § 1819(h)(2)(B).

With respect to financial condition, Plott did not show that it was unable to pay the total amount originally imposed ($36,700), much less that it is unable to pay the amount as reduced according to our decision.

Given these factors, we conclude that $500 per day is within a reasonable range. Accordingly, we determine that the unaddressed noncompliance findings are immaterial to the outcome of this case.

C. Plott's argument that CMS's use of deficiency findings for other purposes means that the ALJ's failure to address them is a denial of due process has no merit.

Plott argues that "most of the Board's reasoning" regarding unaddressed noncompliance findings predates "recent CMS regulatory initiatives that raise the practical stakes of this short-circuiting of the appeal process." RR at 11. According to Plott, CMS recently "announced that it will use the *existence* of survey citations – whether challenged or not –

as the basis for a new series of enforcement initiatives, including 'Five Star' public ratings, 'Special Focus Facility' designations, and the like" that were not created by Congress or through notice and comment rulemaking, and that are "designed and intended to cause adverse effects on citizens and facilities (and actually are doing so)." *Id.* at 11-12. Plott argues that, contrary to the Board's suggestions in the past, it is not speculative that facilities will be harmed by CMS's actions. *Id.* at 13. Even if the harm is speculative, Plott contends, that is "immaterial to the determination of whether the government may impose *any* burden on even a regulated citizen *without appropriate review*." *Id.* (italics in original).

Plott's concern here is really with how CMS uses cited deficiencies as a basis for taking actions other than issuing a determination to impose a remedy – that is, as a basis for actions other than the initial determinations Plott appealed here. Plott had a statutory and regulatory hearing right that attached to those determinations, but which does not apply to the other CMS actions Plott seeks to challenge.

While the Board may consider constitutional due process issues in certain circumstances, such as where they are relevant to interpreting the procedures under which the Board and ALJs operate, at bottom Plott's constitutional challenge here is not to any interpretation of the applicable hearing procedures. Plott has cited to no case that holds that due process requires an ALJ to make findings on issues that are not material to the outcome of the dispute. Instead, Plott's challenge is based on the fact that CMS takes other actions that may be based on noncompliance findings that were appealed but remain unreviewed and that those actions adversely affect Plott. To the extent Plott is suggesting that it is given no administrative process before CMS takes any of these other actions, we disagree. As CMS points out, Plott had an opportunity to provide information to the surveyors to dispute their findings and also an opportunity during the State informal dispute resolution process to provide information (which resulted in a change in some of the findings). Whether that process is all the process due to Plott before CMS may take actions such as assigning a Five Star rating or designating a facility as a Special Focus Facility is not an issue that is properly before us.

We note, moreover, that the statute requires that information about surveys be made available to the public, and the implementing regulations require CMS to make available "statements of deficiencies and providers' comments," as well as "final appeal results." Act § 1819(g)(5); 42 C.F.R. § 488.325(a). We also note that Plott provided no evidence or legal citations to support its assertion that CMS's actions related to the Five Star and Special Focus Facility programs are "enforcement actions" that have substantial adverse consequences for facilities.

D. Plott's reliance on the court decision in Grace Healthcare of Benton v. U.S. Dep't of Health & Human Servs. is misplaced.

Plott also relies on the court's decision in *Grace Healthcare of Benton v. U.S. Dep't of Health & Human Servs.*, 589 F.3d 926 (8th Cir. 2009), *amended by* 603 F.3d 412 (8th Cir. 2010). Plott contends that the Eighth Circuit held that "where, as here, CMS expressly bases a sanction upon a series of deficiencies, and the petitioner has appealed the factual and legal basis for each allegation of noncompliance that CMS says supports the sanction, then the ALJ and Board *either* must decide each appealed citation one way or the other, or must dismiss any that CMS chooses not to defend during the appeal." RR at 17 (italics in original).

The court in *Grace* did not find that it was improper for the ALJ or the Board to uphold a remedy based on fewer than all of the findings of noncompliance appealed by the SNF. In fact, the court expressly held that it was not rejecting the principle, consistently applied by the Board, that an ALJ may decline to consider or rule on noncompliance findings that are immaterial to the outcome of the appeal. 589 F.3d at 935. The court in *Grace* merely found that the principle had been "misapplied" in that case because the only finding of immediate jeopardy addressed by the ALJ and the Board was not supported by substantial evidence, and the interrelated immediate jeopardy-level findings appealed by the SNF but not addressed by the ALJ or the Board were necessary to support the CMP at the immediate jeopardy level. *Id.*

We recognize that the court in *Grace* went on to say that, if the appellant's assertion that the unreviewed immediate jeopardy findings "remain accessible to the public and can be used to support damage claims against the provider in private litigation" is true, that is "a material adverse impact, in which case all findings of immediate jeopardy that are appealed should either be upheld or reversed by the ALJ or the DAB" because "[o]therwise, the agency's inaction on appeal arguably would deprive an aggrieved party of its statutory right to judicial review." 603 F.3d at 423. These statements are *dicta*, not based on any analysis of the statutory hearing rights at issue. Moreover, this case is distinguishable from *Grace* because it does not involve any immediate jeopardy findings at all.

E. The Board's allocation of the burden of proof does not require a different result.

Plott suggests that the Board's decision in *Hillman* "specifically prohibits" an ALJ from addressing only some of the noncompliance findings. RR at 17. Plott describes that decision as holding that "CMS has the burden *under the statute* to establish a prima facie case of each regulatory violation it cited in support of [a] sanction," then, if CMS fails to do so, "the petitioner prevails with respect to such allegations *even if it offers no evidence at all*." *Id.* (italics in original). Thus, Plott reasons, "when the petitioner avails itself of its

statutory appeal rights, CMS' *allegations* cannot be treated as conclusive *for any purpose*" but that "is precisely the effect of leaving undecided, but on the record, the vast majority of CMS' original allegations *even after the petitioner challenges them*." *Id.* (italics in original).

Hillman is relevant only because it first set out the burden of proof framework that the Board subsequently adopted for long-term care facility appeals based on its analysis of the relevant statutory and regulatory provisions in *Batavia*.[18] The framework that the Board adopted for long-term care facilities in effect held that, at the hearing, 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 that CMS had a legally sufficient basis for the remedy imposed. *Batavia* at 9.[19] Nothing in either *Hillman* or *Batavia* interpreted the statute or regulations to require that, in order for an ALJ to sustain a remedy, CMS must make a *prima facie* case with respect to every noncompliance finding cited in an SOD.

In this case, we would expect CMS to remove from the SOD the noncompliance findings that were withdrawn during informal dispute resolution or the course of the ALJ proceedings. *See* 42 C.F.R. § 488.331(c). Plott does not contend that CMS is still relying on those specific findings for any purpose, however. With respect to the other noncompliance findings, CMS addressed them at the hearing. Plott also chose to address them at the hearing, rather than relying on any alleged failure by CMS to make a *prima facie* case with respect to those findings, so the proper analysis with respect to any of the findings (if they needed to be addressed) would be whether Plott showed by a preponderance of the evidence that it was in substantial compliance with the cited requirement. In any event, our result here is consistent with our past allocation of the burden of proof because we have upheld the ALJ's finding that Plott did not show by a preponderance of the evidence that it was in substantial compliance with two participation requirements cited from the September survey, and noncompliance with even one requirement is legally sufficient to support imposition of a remedy.

[18] Plott also seeks to challenge that holding on burden of proof here. We agree with CMS, however, that that challenge is untimely. The ALJ gave notice to Plott prior to the hearing about how he would allocate the burden, yet Plott did not raise any issue about the burden in its briefs to the ALJ. Prehearing Case Development Order at 13 (Apr. 2, 1989).

[19] Plott argues that an SOD is not evidence because it is a charging document. RR at 9, citing *White ex rel. Smith v. Apfel*, 167 F.3d 369, 375 (7th Cir. 1999). We disagree. The Board has held, based on an analysis of the survey and certification process, that the SOD is both a notice document and evidence of the findings therein. *Oxford Manor*, DAB No. 2167, at 2 (2008); *Jennifer Mathews Nursing & Rehabilitation Center*, DAB No. 2192, at 47 n.22 (2008).

Conclusion

For the reasons stated above, we uphold the ALJ's determination that Plott was not in substantial compliance with 42 C.F.R. § 483.25(c) and (d) as found in the survey ending September 24, 2008, but reverse his determination that the noncompliance with 483.25(c) constituted actual harm. We also reverse his conclusion that Plott was not in substantial compliance with 42 C.F.R. § 483.25(d) as found in the survey ending December 4, 2008.

We sustain the imposition of a CMP of $500 per day from September 4 through December 3, 2008 and reverse the imposition of the $100 per-day CMP beyond that date. We also reverse the DPNA for the period December 4 through December 15, 2008.

/s/
Stephen M. Godek

/s/
Leslie A. Sussan

/s/
Judith A. Ballard
Presiding Board Member