Department of Health and Human Services
DEPARTMENTAL APPEALS BOARD
Appellate Division

Nightingale Home Healthcare, Inc.
Docket No. A-16-100
Decision No. 2784
April 14, 2017

FINAL DECISION ON REVIEW OF ADMINISTRATIVE LAW JUDGE DECISION

Nightingale Home Healthcare, Inc. (Nightingale), a Medicare home health agency (HHA) located in Indiana, appeals the May 9, 2016 decision of an Administrative Law Judge (ALJ) which sustained the determinations of the Centers for Medicare & Medicaid Services (CMS) to terminate Nightingale's participation in the Medicare program and impose civil monetary penalties (CMPs) in the amount of $10,000 per day for the period beginning November 9, 2015 through December 10, 2015. *Nightingale Home Healthcare, Inc.*, DAB CR4605 (2016) (ALJ Decision).

These remedies were imposed after two surveys in Fall 2015 which found that Nightingale's patients were placed in immediate jeopardy of serious harm from Nightingale's failure to comply with conditions of participation relating to providing skilled nursing (SN) services in conformity with physician orders and plans of care. Nightingale argues that the ALJ's findings are not supported by substantial evidence and that the ALJ failed to address its concerns about the conduct of the surveys.

As explained below, we affirm the ALJ Decision and sustain the termination and CMPs imposed by CMS.

Relevant Legal Authorities

The Medicare program was established under Title XVIII of the Social Security Act (Act) to reimburse health care providers and suppliers for the medical care and services they furnish to Medicare beneficiaries.[1] Act §§ 1811, 1812, 1831, 1832 (42 U.S.C. §§ 1395c, 1395d, 1395j, 1395k). Section 1861(o) of the Act defines "home health

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

agency," in relevant part, as an organization "primarily engaged in providing skilled nursing services and other therapeutic services[.]" To have a Medicare provider agreement, an HHA must, among other things, meet the other conditions of participation at section 1891(a) of the Act, and the implementing regulations at 42 C.F.R. Part 484. HHAs' compliance with Medicare participation requirements is determined through surveys performed by state agencies under agreements with CMS. 42 C.F.R. § 488.10.

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

CMS is authorized to terminate or impose alternative sanctions on HHAs that are not in compliance. *Id*. § 488.800. When CMS determines that noncompliance at an HHA poses immediate jeopardy to its patients, the regulations provide for the following actions:

> Immediate jeopardy. If there is immediate jeopardy to the HHA's patient health or safety –
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> (1) CMS immediately terminates the HHA provider agreement in accordance with § 489.53 of this chapter.
> (2) CMS terminates the HHA provider agreement no later than 23 days from the last day of the survey, if the immediate jeopardy has not been removed by the HHA.
> (3) In addition to a termination, CMS may impose one or more alternative sanctions, as appropriate.

Id. § 488.825(a). If immediate jeopardy is not present, CMS may still terminate an HHA if a condition-level deficiency is present (after 15 days' notice, whereas only two days' notice is required for immediate jeopardy terminations) and may also impose alternative sanctions, but must terminate after six months if the deficiency has not been removed. *Id*. § 488.830. "Immediate jeopardy" is defined as "a situation in which the . . . noncompliance with one or more requirements of participation has caused, or is likely to cause serious injury, harm, impairment, or death to a patient(s)." *Id*. § 488.805.

An HHA may seek ALJ review of a termination under the procedures set out at 42 C.F.R. Part 498. *Id*. § 488.865(e). Where an HHA challenges a finding of immediate jeopardy, that finding may be overturned only upon a showing that CMS's determination is clearly erroneous. *Id*. § 498.60(c)(2).

Available alternative sanctions include CMPs. *Id*. § 488.820. The amounts of per-day CMPs that may be imposed are divided into three ranges as follows:

> **(3)** *Upper range of penalty*. Penalties in the upper range of $8,500 to $10,000 . . . per day of noncompliance are imposed for a condition-level deficiency that is immediate jeopardy. The penalty in this range will continue until compliance can be determined based on a revisit survey.
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> **(i)** $10,000 . . . per day for a deficiency or deficiencies that are immediate jeopardy and that result in actual harm.
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> **(ii)** $9,000 . . . per day for a deficiency or deficiencies that are immediate jeopardy and that result in a potential for harm.
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> **(iii)** $8,500 . . . per day for an isolated incident of noncompliance in violation of established HHA policy.
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> **(4)** *Middle range of penalty*. Penalties in the range of $1,500-$8,500 . . . per day of noncompliance are imposed for a repeat and/or condition-level deficiency that does not constitute immediate jeopardy, but is directly related to poor quality patient care outcomes.
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> **(5)** *Lower range of penalty*. Penalties in this range of $500-$4,000 . . . are imposed for a repeat and/or condition-level deficiency that does not constitute immediate jeopardy and that are related predominately to structure or process-oriented conditions . . . rather than directly related to patient care outcomes.

Id. § 488.845(b)(3)-(5) (references to authority for updating the ranges omitted). An HHA may request an ALJ hearing on "the determination of the noncompliance that is the basis for imposition" of a CMP. *Id*. § 488.845(c)(2).

Although CMS cited Nightingale, based on a survey ending November 5, 2015, for noncompliance with eight conditions of participation based on deficiencies in numerous standards, the ALJ Decision primarily relied on immediate jeopardy findings of noncompliance with the following conditions of participation set out in part 484 (ALJ Decision at 4):

Section 484.18. Condition of participation: Acceptance of patients, plan of care, and medical supervision.

Patients are accepted for treatment on the basis of a reasonable expectation that the patient's medical, nursing, and social needs can be met adequately by the agency in the patient's place of residence. Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine.

> ***(a) Standard: Plan of care***. The plan of care developed in consultation with the agency staff covers all pertinent diagnoses, including mental status, types of services and equipment required, frequency of visits, prognosis, rehabilitation potential, functional limitations, activities permitted, nutritional requirements, medications and treatments, any safety measures to protect against injury, instructions for timely discharge or referral, and any other appropriate items. . . .
> ***(b) Standard: Periodic review of plan of care.*** The total plan of care is reviewed by the attending physician and HHA personnel as often as the severity of the patient's condition requires, but at least once every 60 days or more frequently when there is a beneficiary elected transfer; a significant change in condition resulting in a change in the case-mix assignment; or a discharge and return to the same HHA during the 60-day episode. Agency professional staff promptly alert the physician to any changes that suggest a need to alter the plan of care.
> ***(c) Standard: Conformance with physician orders.*** Drugs and treatments are administered by agency staff only as ordered by the physician . . . .

Section 484.30. Condition of participation: Skilled nursing services.

The HHA furnishes skilled nursing services by or under the supervision of a registered nurse and in accordance with the plan of care.

> ***(a) Standard: Duties of the registered nurse***. The registered nurse makes the initial evaluation visit, regularly reevaluates the patient's nursing needs, initiates the plan of care and necessary revisions, furnishes those services requiring substantial and specialized nursing skill, initiates appropriate preventive and rehabilitative nursing procedures, prepares clinical and progress notes, coordinates services, informs the physician and other personnel of changes in the patient's condition and needs, counsels the patient and family in meeting nursing and related needs, participates in in-service programs, and supervises and teaches other nursing personnel.

> ***(b) Standard: Duties of the licensed practical nurse***. The licensed practical nurse furnishes services in accordance with agency policies, prepares clinical and progress notes, assists the physician and registered nurse in performing specialized procedures, prepares equipment and materials for treatments observing aseptic technique as required, and assists the patient in learning appropriate self-care techniques.

Case Background[2]

The state survey agency conducted a complaint survey of Nightingale from October 26 – November 5, 2015 (November Survey). This survey resulted in finding noncompliance at the level of immediate jeopardy with two conditions of participation, as well as six additional condition-level deficiencies that did not rise to immediate jeopardy. CMS Ex. 4 (revised statement of deficiencies (SOD) for November survey; November SOD). The four complaints were found to be substantiated, and the complaint survey was converted to an extended survey on October 30, 2015. Nightingale Request for Hearing (RH) Ex. 2,[3] at 1 (November IJ SOD). Immediate jeopardy was identified on November 2, 2015 when it was discovered that one patient (Patient 4) had not received any SN visits for approximately three weeks and ultimately died. *Id*. at 1-2. During the survey, Nightingale sought repeatedly to develop a plan to remove the immediate jeopardy but was not able to produce an acceptable plan of correction. *Id*. at 2; CMS Ex. 37, at 2-18.

CMS notified Nightingale by letter dated November 17, 2015 that the survey had identified noncompliance with two conditions of participation serious enough to present immediate threats to patient health and safety. RH Ex. 1, at 1. CMS also stated that Nightingale had not provided an acceptable plan for removing the immediate jeopardy. *Id*. at 1-2. As a consequence, the letter explained, CMS would terminate Nightingale's provider agreement unless it achieved substantial compliance by December 10, 2015 and would also impose a CMP of $10,000 per day beginning on November 9, 2015. *Id.* at 2.

Nightingale proffered further plans after the survey ended with immediate jeopardy still present. RH Ex. 2, at 2; CMS Ex. 37, at 20-31. Ultimately, on December 7, 2015, Nightingale produced an acceptable plan of correction to remove the immediate jeopardy conditions. CMS Ex. 37, at 32-75.

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[2] We have drawn the factual material in this section from the ALJ Decision and the record below and provide it for the benefit of the reader but do not intend to make any new factual findings. We discuss and resolve any relevant factual disputes in our analysis below.

[3] Nightingale submitted a number of attachments with its request for hearing (RH) to the ALJ which it numbered as exhibits. We cite to these as "RH Exs" to distinguish them from the numbered exhibits submitted with Nightingale's later briefing, which are cited as "P. Exs."

A follow-up survey revisit was then conducted on December 8-9, 2015 (December survey) to determine if Nightingale had successfully implemented this plan and removed the immediate jeopardy. CMS Ex. 38, at 1-2 (December SOD). The surveyors concluded that the Nightingale had not corrected the immediate jeopardy to patients. *Id*. at 2.

By letter dated December 23, 2015, CMS notified Nightingale that the December survey found immediate jeopardy as to the same two conditions of participation found in the November survey, as well as noncompliance with other conditions of participation. RH Ex. 4, at 1. CMS confirmed that Nightingale's participation in Medicare as an HHA and its provider agreement were terminated on December 10, 2015. *Id*. at 2. Moreover, the $10,000 per-day CMP was in effect for thirty days from November 9, 2015 through December 10, 2015, for a total of $300,000. *Id.*

Nightingale timely requested a hearing before an ALJ.

ALJ Decision

The parties agreed that the ALJ could decide the case based on the written record and neither party sought to cross-examine any witness for whom a written declaration was presented in lieu of in-person testimony. ALJ Decision at 2. The ALJ found overwhelming evidence that Nightingale was not in compliance with section 484.18, including the following observations:

> [Nightingale's] staff frequently failed to conduct patient visits according to the patients' care plans and physicians' orders. CMS Ex. 3 at 222-350. These frequent failures to provide care not only were derelictions of the condition requiring [Nightingale] to meet patients' nursing needs but they harmed or placed patients at great risk for harm. For example, [Nightingale's] staff neglected Patient 4 egregiously in direct violation of his physician's orders. It failed to provide the patient with prescribed home health visits for a period of nearly a month, failed to ensure the patient's certification for home health was up-to-date, failed to provide him with prescribed care, and failed to carry out the patient's physician's orders. When [Nightingale] finally sent a nurse to visit the patient he was discovered to be suffering from a life-threatening infection (sepsis).

Id. at 4. The ALJ inferred that the inadequate care Nightingale provided to Patient 4 caused actual harm by contributing to the development of his infection. *Id.* at 7. The ALJ also found "numerous other instances in which [Nightingale's] staff failed to conduct scheduled or ordered patient visits," affecting Patients 1, 5, 10, 11, 12, 13, and 14. *Id*. at 2, citing CMS Ex. 50 ¶¶ 69, 229, 346, 395, 420, 452; CMS Ex. 51 ¶¶ 16, 29;

and CMS Ex. 55, at 20. Moreover, the ALJ concluded that Nightingale repeatedly "failed to provide its patients with care that conformed to the residents' written care plans and physicians' orders," most notably by failing "to monitor the effects of the anti-coagulant Coumadin on Patient 1 and to notify the patient's physician that the patient was experiencing extremely adverse effects from administration of Coumadin." ALJ Decision at 2.

The ALJ concluded that Nightingale was also noncompliant with section 484.30 because it failed to provide "ordered care including wound care to patients, with the consequence that patients were put at grave risk for serious harm," most evidently "in the case of the care that [Nightingale's] staff provided to Patient 5." *Id*. at 7. The ALJ described the documentation of the care of this patient as so deficient that "it is impossible to discern from [Nightingale's] own records exactly what care the staff provided to him," "how many wounds the patient was suffering from," "the condition of these wounds," or even "precisely what treatment the patient was receiving for them." *Id*., citing CMS Ex. 50 ¶¶ 197-237. The ALJ stated that such poor documentation supported a conclusion that adequate care was not provided, thus placing the patient at elevated risk of infection. ALJ Decision at 8. The ALJ also found that Nightingale failed to rebut CMS's findings that its staff provided "unauthorized treatments to various patients," probably because they did not promptly report new issues to the patients' physicians. *Id*., citing CMS Ex. 50 ¶¶ 206, 208, 440 and CMS Ex. 10, at 77.

Finally, the ALJ agreed with CMS that the December survey disclosed that Nightingale had not corrected the immediate jeopardy. ALJ Decision at 9. Its continued noncompliance was demonstrated by continued failure to document wound care, to perform laboratory tests as ordered, to visit patients as scheduled, and to comply with the plan of correction. After reviewing specific examples of such failures relating to Patients 28, 29, 30, and 31, the ALJ concluded that the evidence of immediate jeopardy amply justified the remedies imposed. *Id*. at 9-12.[4]

Standard of Review

We review a disputed finding of fact to determine whether the finding is supported by substantial evidence, and a disputed conclusion of law to determine whether it is erroneous. *See* Departmental Appeals Board, Guidelines for Appellate Review of Decisions of Administrative Law Judges Affecting a Provider's Participation in the Medicare and Medicaid Programs, "Completion of the Review Process, ¶ (c), available at https://www.hhs.gov/about/agencies/dab/different-appeals-at-dab/appeals-to-board/guidelines/index.html.

[4] The ALJ noted that Nightingale's termination was enjoined by a federal bankruptcy court and that the order was under appeal. ALJ Decision at 2 n.1. Neither party has notified us of the present status of the bankruptcy matter.

Analysis

1. **Nightingale's overarching arguments are without merit**.

Before reaching Nightingale's challenges to specific findings, we must address several arguments that Nightingale repeats throughout its briefing and that reflect fundamental misunderstanding of the issues and processes of appealing remedies resulting from noncompliance found during surveys.

a. *Because Nightingale agreed to decision on the written record, our review of factual findings is for substantial evidence, not to determine whether material facts are in dispute*.

Nightingale's briefing on appeal muddles the applicable standards in several respects. While acknowledging that it consented to decision on the written record, Nightingale suggests that the ALJ Decision is improper because "facts material to the determination remain in dispute." Request for Review (RR) at 4. Moreover, Nightingale complains that the ALJ "largely ignore[d]" Nightingale's evidence and instead "substitute[d] CMS' assertions as undisputed facts." *Id*. at 5. Nightingale then requests that the Board remand the matter to the ALJ "for a hearing to review the cause based on its merits." *Id*. These arguments are misplaced.

The case has already been decided on its merits. Moreover, the ALJ did not grant summary judgment and, hence, was not restricted to relying on "undisputed facts" or required to accept Nightingale's evidence as true. The question before us is not whether material facts remain in dispute, as it would have been had the matter been decided on summary judgment, but whether the ALJ's findings are supported by substantial evidence.

This appellate standard of review for substantial evidence after a decision on the record is significantly more deferential than the de novo review of a grant of summary judgment. Thus, the Board has recently reiterated that the evidence sufficient to support a factual finding under the substantial evidence standard need only be "more than a mere scintilla," that is to say, at least "such relevant evidence as a reasonable mind might accept as adequate to support a conclusion." *The Peaks Care Ctr.*, DAB No. 2564, at 5 (2015), quoting *Richardson v. Perales*, 402 U.S. 389, 401 (1971), and quoting *Consolidated Edison Co. v. NLRB*, 305 U.S. 197, 229 (1938). Under the substantial evidence standard, the reviewer must examine the record as a whole and take into account whatever in the record fairly detracts from the weight of the decision below. *Id.*, citing *Universal Camera Corp. v. NLRB*, 340 U.S. 474, 488 (1951). The reviewer does not, however, reweigh the evidence or substitute his or her judgment for that of the initial decision-

maker. *Id.*, citing *Casias v. Secretary of Health & Human Servs.*, 933 F.2d 799, 800 (10th Cir. 1991). Thus, the Board concluded, its review "must not displace a 'choice between two fairly conflicting views,' even though a different choice could justifiably have been made" if the review had been de novo. *Id.*, quoting *Universal Camera*, 340 U.S. at 488. The Board would reverse an ALJ's factual findings only when it "'cannot conscientiously find that the evidence supporting that decision is substantial, when viewed in the light that the record in its entirety furnishes, including the body of evidence opposed to the [ALJ's] view.'" *Id.*

This is the standard we apply here in considering the evidence in the record as to the ALJ's factual findings.

b. *We defer to the ALJ's assessment of the credibility and weight of evidence absent compelling reasons not to do so*.

Nightingale argues that the ALJ Decision was too "conclusory" because the ALJ failed to "appropriately consider" Nightingale's arguments and witness statements submitted in support of them. RR at 4-5. While the ALJ, and the Board in reviewing whether substantial evidence supports the ALJ's factual findings, must indeed consider conflicting evidence, the ALJ was not obliged to accept assertions by Nightingale's witnesses as true. In this case, the record contained the underlying medical records of patients which the ALJ was able to review and rely upon directly. Much of the evidence to which Nightingale cites as rebutting the surveyors' findings amounts to conclusory assertions by the Director of Nursing (DON) Michelle Olson. *See, e.g.*, RR at 8 ("ALJ Kessel failed to take into consideration the evidence of the provision of care in conformity with the residents' care plans and physical orders provided by the Petitioner. Olson Declaration ¶¶ 23-37.").

In its reply brief, Nightingale acknowledges that the ALJ had no duty "to adopt the veracity of evidence submitted" by Nightingale, and states that Nightingale only expected "the ALJ to fully inquire into all the matters at issue and receive into evidence all testimony and evidence that is relevant and material as required by 42 C.F.R. § 498.60(b)." Reply Br. at 2. Indeed, Nightingale recognizes that "evaluating the credibility and persuasiveness of witness testimony" is a core task of the ALJ (*id*. at 6, citing *Madison Health Care, Inc.*, DAB No. 2049, at 7 (2006)), but still insists that the ALJ did not properly evaluate Nightingale's evidence. Nightingale has not identified any testimony or documents which it proffered but which the ALJ declined to receive into evidence. As noted, Nightingale agreed that the matter should be decided on the written record, and that record included its proffered witness declarations and other exhibits. Nightingale's real objection thus appears instead to be that the ALJ did not accept or credit much of what Nightingale's witnesses asserted.

The Board has long held that it will defer to an ALJ's findings on "weight and credibility of witness testimony (oral or written) unless there are 'compelling' reasons not to do so." *River City Care Ctr.*, DAB No. 2627, at 13 (2015), citing *Van Duyn Home & Hosp.*, DAB No. 2368, at 10-11 (2011) and *Koester Pavilion*, DAB No. 1750, at 16, 21 (2000). We discuss specific testimony and other evidence in relation to particular critical factual findings later in this decision. We here make the overarching observation that Nightingale has not demonstrated any compelling reason not to defer to the ALJ's evaluation of the witnesses or evidence generally.

In particular, we note that Nightingale's disappointment that the ALJ rejected many of its arguments does not in itself constitute a compelling reason to disregard the ALJ's evidentiary assessments. Moreover, while the ALJ did not in every instance describe specific testimony that he rejected or discounted, he clearly communicated that he considered the bulk of the testimony of Nightingale's witnesses misdirected in focus – either directed at critiquing the survey procedures (which we discuss in the next section) or amounting to "red herrings" – while failing to engage or rebut the specific evidence that, in his view, established the noncompliance. *See, e.g.*, ALJ Decision at 6-7.

For these overarching reasons, as well as those we discuss in weighing specific evidence and testimony about noncompliance in later sections, we do not find a compelling basis to disturb the ALJ's evaluation of Nightingale's witnesses and evidence.

c. *The ALJ correctly focused on what the evidence in the record showed about Nightingale's compliance with conditions of participation rather than on its complaints about the conduct of the surveys.*

Nightingale also contends that the ALJ should have addressed its complaints about the survey process, pointing to: "the general lack of compliance by the surveyors with survey protocol; the creation of specific information in the [SOD] that was not in the surveyor notes . . . ; the material failure to provide information . . . concerning the nature and specifics of the cited IJs until nearly the proposed Termination Date which resulted in Petitioner having to essentially guess at what to include in the Plan of Correction . . . ; the lack of exit interviews by the surveyors to provide the Petitioner information concerning the alleged IJ deficiencies . . . ." RR at 16 (citations to Nightingale's brief to the ALJ omitted). The ALJ found these complaints largely irrelevant. The ALJ described Nightingale as mostly "picking nits with the surveyors' findings," or "finding fault with the procedures used by the surveyors, their manner of obtaining evidence, or in identifying alleged minor errors that the surveyors made," without actually undercutting the evidence supporting the ALJ's "central findings" about the deficiencies manifested by Nightingale at the November survey. ALJ Decision at 6.

This flaw in Nightingale's evidence is especially apparent in the testimony of Sharon Kennell, a nurse consultant with a company advising post-acute services providers, who testified that she was once a surveyor. P. Ex. 21 (Kennell Decl.). Ms. Kennell is presented as an expert witness, offering no first-hand experience to shed light on the treatment of any of the patients at issue. To the extent she discusses specific patients' care or records, the ALJ (and we) can review those records independently. She couches many comments, however, in terms of whether the surveyors "adequately investigated" various points of contention. *See, e.g.*, Kennell Decl. ¶ 16 ("With respect to whether there is any truth to the complaints in the November SOD allegedly made by Patient 4's spouse, it does not appear that the surveyors adequately investigated those complaints."). The adequacy of the surveyors' investigation was not an issue before the ALJ.

Moreover, the ALJ was not obliged to defer to Ms. Kennell's expressed opinions about the weight or credibility he should assign to evidence collected or recorded by the surveyors. *See, e.g.*, Kennell Decl. ¶ 43 ("[M]y review of the agency's treatment of Patient 1 shows that the findings in the November SOD discussed in CMS's brief grossly mischaracterize the facts in several respects and should be given no weight whatsoever."), ¶ 54 (opining that "discrepancies between findings in the December SOD and the surveyors' contemporaneous notes cast significant doubt on the truth, accuracy or completeness of the deficiency statements in the December Survey as well.").

Many of Nightingale's arguments reflect a basic misunderstanding of the purpose of these proceedings. The applicable appeal procedures set out in part 498 do not provide for a review of surveyor performance. Instead, the provider's appeal right is only from an "initial determination" by CMS, in this case the termination under section § 489.53 and the imposition of CMPs. 42 C.F.R. § 498.3(b)(8). In determining whether the evidence adduced before the ALJ supports the appealed initial determination, the Board has held, evidence about the survey process is not relevant where the provider "has not shown how any alleged defects in the conduct of the survey . . . undercut or impeach the evidence of noncompliance offered by CMS." *Rosewood Care Ctr. of Swansea*, DAB No. 2721, at 7 (2016) (internal quotation marks omitted), citing *Rosewood Care Ctr. of Swansea*, DAB CR4408, at 7 (2015). Once CMS had come forward with evidence sufficient to set out a prima facie case that Nightingale was not in compliance with applicable conditions of participation, the burden was on Nightingale to demonstrate compliance with the identified conditions by the preponderance of the evidence in the record. *See, e.g., Golden Living Ctr. – Superior*, DAB No. 2768, at 6 (2017). Hence, the ALJ did not err in disregarding any complaints about the survey process itself that did not relate to evidence concerning the facts of Nightingale's compliance status.

Nightingale especially stresses its complaint that it was not provided with sufficient information at the time of the November survey, even about the reasons for immediate jeopardy. Reply Br. at 7-11. CMS offered contrary evidence that Nightingale was made aware of the seriousness of the findings during the November survey; indeed, Nightingale was already proffering plans to try to remove its immediate jeopardy conditions as early as November 5, 2015. *See, e.g.*, CMS Ex. 2, at 7-8. The record indicates that Nightingale repeatedly failed, however, to develop an acceptable plan despite receiving detailed feedback. *See, e.g.*, CMS Ex. 37, at 7-12. Nightingale was able to eventually provide an acceptable plan claiming it would remove the immediate jeopardy by November 23, 2015 (even though it had not yet received the completed SOD). CMS Ex. 4. As we discuss below, the December survey demonstrated that Nightingale nevertheless did not succeed in actually removing the immediate jeopardy by the time of the revisit.

It is true that preparing and providing the completed SOD after the November survey took longer than is usual. CMS explained that the delay was the direct result of the "large number of findings," which ultimately resulted in a full SOD of an extraordinary 549 pages. Response Br. at 2, citing CMS Ex. 3. The survey agency did provide to Nightingale on November 17, 2015 a partial SOD (itself well over 100 pages) detailing all noncompliance creating immediate jeopardy. CMS Ex. 4. Nightingale argues that even this partial SOD took longer than the time frame of 10 days after a survey set out for state agencies in CMS manuals. Reply Br. at 8. None of Nightingale's arguments, however, explain how the time taken writing up the deficiencies found during the November survey has any relevance to the evidence that the cited deficiencies were in fact present. As the ALJ pointed out, CMS would have been within its authority to have terminated Nightingale without providing an opportunity to correct these deficiencies. ALJ Decision at 2, 8, citing Act § 1866(b)(2) and 42 C.F.R. § 489.53(a)(3).

Nightingale further objects to CMS not following through on a plan to appoint a temporary manager. Reply Br. at 11-12; RH Ex. 3. Imposing temporary management is an "alternative sanction," as are CMPs, available to CMS "[i]n addition to termination." 42 C.F.R. § 488.820; *see also* 42 C.F.R. § 488.835. Nightingale now says it would have "welcomed" such an appointment and seems to believe that this would have served as an alternative to delay its termination. Reply Br. at 11-12. The appointment of a temporary manager is a remedy within CMS's discretion and has no effect on CMS's authority to terminate Nightingale for immediate jeopardy or its authority to impose other remedies such as the CMP.[5] Neither the ALJ nor the Board is empowered to review CMS's choice about alternative sanctions to be imposed on a provider. 42 C.F.R. § 498.3(d)(11).

[5] On February 29, 2016, the bankruptcy court appointed a temporary manager, at the request of Nightingale and without objection from the government, to manage the debtor's day-to-day operations. P. Ex. 20. This court order does not purport to be a regulatory remedy, however.

We turn next to Nightingale's challenges to the ALJ's specific findings regarding first the November survey and then the December re-survey.

2. Nightingale's challenges to the ALJ's findings regarding the November survey are without merit.

a. *Patient 4*

The ALJ concluded that the findings from the November survey, which he found supported relating to Nightingale's care of Patient 4, showed egregious neglect and put Patient 4 in immediate jeopardy (although, contrary to Nightingale's arguments, as we discuss later, the noncompliance and immediate jeopardy found at that survey extended well beyond the inadequate care of Patient 4). ALJ Decision at 4, 6.

Patient 4 suffered from progressive palsy, obstructive emphysema, and gouty arthritis, among other diagnoses, and was placed under a home health plan of care in March 2015 for multiple issues, including use of a urinary catheter and feeding tube. CMS Ex. 9, at 29. His care plan was recertified for the period July 10 – September 7, 2015 and called for one visit a week by a registered nurse and one visit a week by a home health aide. *Id*. at 30. On September 1, 2015, he received a visit from his regular nurse at which she changed his catheter, reporting sediment present (the catheter had also required changing on August 20, 2015 with sediment noted). *Id.* at 27-28. The nurse noted a small wound on his buttocks, and recorded her observations of his condition, as required for skilled assessment of signs or symptoms of illness, including depression, infection and urinary tract infection (UTI), dyspnea, skin breakdown, and other disease processes. *Id*. at 24, 27-28. That nurse apparently had a medical emergency and was not available for several weeks. ALJ Decision at 5 n.3.

The ALJ found that Nightingale failed to update or recertify Patient 4's care plan for skilled nursing (which expired during that time) and failed to send any nurse to see the patient until October 5, 2015, despite repeated calls from the patient's wife to the agency. ALJ Decision at 4-5. The ALJ noted that Nightingale failed to provide care to Patient 4 even though he used a Foley catheter which required changing, that he had orders for bladder irrigation, that he had a history of UTIs, and that he had not been discharged from Nightingale's care despite the failure to provide nursing visits. *Id*. On October 5, 2015, after Patient 4 developed a fever and his doctor ordered prompt urinalysis, Nightingale finally sent out a nurse in response to his wife's calls. *Id*. at 5. He was determined to be "in severe distress" and immediately hospitalized with a diagnosis of sepsis. *Id*., citing CMS Ex. 9, at 60, 124.

Nightingale makes several arguments challenging these findings about Patient 4's care. We address each in turn. To begin with, Nightingale contends that the patient's wife was not actually calling to request or complain about care, and even suggests that she refused nursing visits. RR at 7; Reply Br. at 3. Nightingale asserts that the ALJ failed to give sufficient consideration to the audio recordings and transcripts which it submitted of the wife's calls to the agency during the month in question as demonstrating this claim. *Id*.

This argument is both unfounded and illustrative of Nightingale's failure to understand its fundamental responsibilities. Nightingale's duty to provide nursing visits to Patient 4 did not depend on the patient or his wife requesting a visit or complaining about the failure to visit. It arose instead from Nightingale's commitment to provide care in accordance with the plan of care established with Patient 4's physician.

Tellingly, Nightingale reveals the reactive nature of its services to Patient 4 when it states that "[f]ollowing the September 25th call, when the DON learned that the spouse mentioned on the call that Patient 4 had not had a nurse visit in three (3) weeks, she sent an LPN [licensed practical nurse] the next day." RR at 8. Thus, Nightingale admits no nurse visited for at least three weeks before September 26, 2015 and that it only took note of that fact when the wife alerted the agency. Yet the most recent plan of care called for SN visits once a week. CMS Ex. 9, at 32.[6] In short, not only did Nightingale fail to provide the care that the physician had determined Patient 4 needed, Nightingale's DON was apparently unaware or unconcerned about this neglect of the patient's needs until after she was informed of a call from his wife pointing it out. Moreover, Nightingale does not provide any evidence contradicting the ALJ's findings that the alleged visit on September 26, 2015 was recorded as having been made only by a licensed practical nurse (not a registered nurse) and involved only checking on supplies for the feeding tube, not providing any care for the Foley catheter. ALJ Decision at 6, citing P. Br. to ALJ at 6.

[6] Nightingale contends that this plan, which lapsed on September 5, 2015, was superseded by an "addendum" which did not address SN visits at all but only home health aide care. P. Ex. 22 (Olson Decl.) ¶ 11; P. Ex. 2, at 17-22 (Patient 4 plan of care and addenda). The ALJ rejected this claim, finding that Nightingale was responsible for ensuring that the plan was recertified and that the addendum was likely "just that," i.e., revising those elements it addressed but not altering the assessed needs otherwise. ALJ Decision at 5 n.4. Nightingale has given us no reason to disagree with the ALJ that the record shows no planned termination or reduction of nursing services. The only support Nightingale cites to for its allegation that the addendum changed the skilled nursing to as-needed or "PRN" is an interview note in a surveyor's worksheet that an unidentified person made the claim that they "had orders for PRN." Olson Decl. ¶ 11, citing CMS Ex. 9, at 6. This notation hardly establishes a change in the plan for SN care that does not appear in any executed plan of care or addendum. In other words, far from an excuse for the lack of nursing visits, the failure to have a current plan of care in place is a further indicator of Nightingale's neglect of its responsibilities to Patient 4. Indeed, the ALJ's interpretation is further supported by the fact that similar addenda limited to home health aide care were in place during the same period as the skilled services plan of care that ended September 5, 2015, yet Nightingale never suggests that those addenda somehow supplanted the plan of care under which SN care was provided prior to September 5, 2015. *See* P. Ex. 2, at 17-22 (Patient 4 plan of care and addenda). Were they so read, the care actually provided would have been unauthorized.

Instead of recognizing this, Nightingale recounts the recorded calls from the patient's wife in terms of whether the transcripts show that she complained or reported the presence of the UTI that was ultimately identified when he had to be hospitalized on October 5, 2015. RR at 7-8, citing transcripts and audiofiles of calls on September 16, 2015 (P. Ex. 3), September 21, 2015 (P. Ex. 4), September 25, 2015 (P. Ex. 5), and October 5, 2015 (P. Ex. 7). The nurse who took that September 25th call reported that the patient's wife wanted a call from DON Olson as soon as possible and indicated that the wife felt she was "being put off." November SOD (CMS Ex. 4, at 4); P. Ex. 5. Nightingale argues that the records of the call do not show that the "spouse was upset" or "said she 'felt she was being put off.'" RR at 7. We disagree. During the call, Patient 4's wife recounts that his feeding tube had been replaced temporarily by a Foley after the tube's balloon burst and that she has "been trying to get it arranged" for the nurses to replace the proper tube, that his physician said that a nurse should be able to replace it and should call the physician's office to get the supplies, and that she had already talked to DON Olson about it "at least 3 times" and did not "understand what is taking such a long time." P. Ex. 5, at 2. The wife went on to point out that no nurse had visited in three weeks which was "another issue," that she had told DON Olson about both issues, and that DON Olson had been "supposed to call me back several different times and she's not doing it." *Id*. at 2-3. (The calls on September 16th and 21st support her assertion that DON Olson had told the wife that she would arrange replacement of the feeding tube in a day, and plainly had not done so. P. Exs. 3 and 4.) The nurse then apologized and promised a call back from DON Olson that day. P. Ex. 5, at 3. We find that the audio and transcript record amply support the nurse's interpretation that the wife felt frustrated, upset, and "put off."

Nightingale also relies on the declaration of Sharon Kennell for its position that the complaints of Patient 4's wife, and the surveyor's interviews with her, should be disregarded. Kennell Decl. at ¶¶ 13-29, referencing comments reported in the November survey SOD at CMS Ex. 4, at 5. For example, Ms. Kennell addresses the wife's statement that Patient 4 required changing of his "Foley catheter every 2-3 weeks due to leakage and blockage because the patient tended to have a lot of sediment that required flushing of the catheter." *Id*. ¶ 17, citing CMS Ex. 4, at 5. Ms. Kennell claims that her own review of the records of Patient 4's care prior to the period at issue (i.e., July 10 – September 1, 2015) does not support this description of his needs. She says she reviewed notes of ten SN visits, five of which indicate that "the catheter was 'patent and draining without odor . . . .'" *Id*. ¶ 18. However, she also acknowledges that the catheter was changed on the first visit of each month, was irrigated on July 21st, and was changed again due to a leak on August 20th. *Id.* Thus, even assuming Ms. Kennell accurately describes the records from that timeframe, they are consistent with the patient's catheter requiring attention every three weeks. Moreover, Ms. Kennell failed to mention that, on

September 1, 2015, at the last visit of the patient's regular nurse before her medical leave, Patient 4 again required a change in the Foley catheter and was noted to have sediment present. CMS Ex. 9, at 28. This was less than two weeks after the change needed on August 20th. Thus, the wife's reported description of the recurring problems with Patient 4's catheter is supported by the patient records. Moreover, concern about Nightingale's failure to have a nurse check the catheter appears particularly well-founded given that sediment forced another catheter change just before the care gap.

Ms. Kennell also suggests that Patient 4's wife could not really have believed that Nightingale's actions placed her husband's "life in jeopardy" or she would have objected to Nightingale's efforts to arrange to care for him again when he was expected to be released from the hospital. Kennell Decl. ¶¶ 20-22. While Ms. Kennell may have formed this opinion, the ALJ was not obliged to find that the absence of immediate objection by Patient 4's wife to Nightingale's inquiry about providing further care undercut the credibility of her concerns, especially given indications that Patient 4 and his wife had been satisfied with the care of his regular nurse prior to that nurse's medical leave. *See, e.g.*, CMS Ex. 6, at 11 (Regular nurse was "fabulous.").

Nightingale continues to assert "the fact that Patient 4 refused care while his primary care nurse . . . was on leave" as an explanation of its neglect of the patient's needs and a rebuttal for the evidence that its staffing was simply inadequate to meet the needs of the patients it undertook to serve. Reply Br. at 2. Not one of the calls from Patient 4's wife for which Nightingale submitted records contains a single reference to not wanting nursing visits to continue in the absence of the regular nurse. P. Exs. 3-7. To support its supposed "fact," Nightingale relies on the declaration of DON Olson. Reply Br. at 2. The claim is implausible for multiple reasons. First, the declaration does not assert that the regular nurse told the DON that the wife wished no other registered nurse to visit but, rather, only states that the wife "wanted to wait to do another catheter change" until that nurse's return and the wife would call for other visits. Olson Decl. ¶ 12. Second, the DON's report is, on its face, self-serving double hearsay. Third, it lacks indicia of reliability which would be expected were it accurate. For example, a refusal to accept care in accordance with the physician-approved plan of care should have been documented in the patient's records, yet no such refusal is documented in Patient 4's records. Finally, the claim that DON Olson had been told that Patient 4 wished no nursing visits until the regular nurse recovered and returned to work seems inconsistent with Ms. Olson's assertion, discussed above, that she sent a nurse to visit Patient 4 on September 26, 2015 because she learned that no nurse had visited in three weeks. This information would not have triggered action by her had she truly understood the patient to have refused visits during that time. We thus find no compelling evidence to disturb the ALJ's choice to give little or no weight to Ms. Olson's testimony that Patient 4 refused care.

Much of Nightingale's attention is directed at denying that its failure to provide skilled nursing in accordance with the plan of care actually resulted in Patient 4's urinary infection becoming septic or led to his hospitalization and ultimate death. Ms. Kennell challenges the report in the November SOD that Patient 4's spouse was told by the hospital physician that the patient "was admitted for urinary sepsis" which "could have been avoided by the agency if someone had came [sic] to the home sooner." CMS Ex. 4, at 6; Kennell Decl. ¶¶ 23-26. Ms. Kennel argues that this report does not appear in the surveyors' notes of interviews with Patient 4's wife. Kennell Decl. ¶ 24. However, the hospital diagnosis does not depend on the wife's report, as the record includes the hospital record showing that Patient 4 arrived showing "sepsis with fever, hypotension, leukocytosis likely secondary to UTI [urinary tract infection] in patient with indwelling foley." CMS Ex. 9, at 124. Moreover, laboratory results confirmed Escherichia coli (E. coli) in the blood and Proteus Mirabilis in the urine. *Id*. at 114. Nightingale's further claim that the ALJ relied only on the wife's claim in finding sepsis is thus also unfounded. *Cf*. Reply Br. at 4.

Ms. Kennell undertakes to suggest an alternative theory that Patient 4 may have aspirated barium during a swallowing test on September 22, 2015; that, despite being asymptomatic until October 5, 2015, he may have been suffering from dysphagia as a result; and that his death may have been caused by hospital nurses then administering prescribed medication orally. Kennell Decl. ¶¶ 30-40, citing P. Ex. 10 (death certificate citing immediate cause as acute respiratory failure and contributing causes of recurrent aspiration pneumonia, supranuclear palsy, and Parkinson's disease) and CMS Ex. 9, at 105 (post-discharge services referral form listing "difficulty breathing"). She argues that the surveyors failed to "adequately investigate" this possible cause of death. *Id*. ¶ 30.[7]

The ALJ expressly rejected Nightingale's position that it bore no responsibility for Patient 4 developing sepsis, concluding as follows:

> [T]he reasonable inference that I draw from the evidence is that Petitioner's staff's neglect of Patient 4 was a direct and contributing cause to the patient's development of an infection. The obvious reason that the patient's physician ordered regular checks of the patient's catheter and irrigation is that a catheter can be an entry point for infectious germs. Petitioner and its staff utterly disregarded the physician's instructions for a month, at the end of which time the resident had developed an infection later diagnosed as sepsis. That is far more evidence than one needs to infer cause and effect.

[7] Nightingale's attempt to deflect the focus from inadequate care of the patient's urinary catheter needs to problems in his speech therapy is ironic because the record also contains evidence that Nightingale failed to follow up on physician orders for speech therapy. CMS Ex. 31, at 1 (Patient 4's wife's complaint form).

ALJ Decision at 7. The evidence to which Nightingale points does not demonstrate that the ALJ's inference is unreasonable based on the record as a whole. Listing the immediate cause of death as respiratory failure, with a history of aspiration pneumonia as a contributing cause, does not contradict the record that he arrived at the hospital on October 5, 2015 with sepsis associated with an untreated UTI.

Moreover, even were we to have accepted Nightingale's position that aspiration rather than sepsis from a UTI was the primary cause of Patient 4's hospitalizations, which we do not, such acceptance would not make CMS's immediate jeopardy determination clearly erroneous. A determination of immediate jeopardy does not require proof that the noncompliance has in fact resulted in harm or death, but may be based on a finding that such noncompliance "is likely to cause serious injury, harm, impairment, or death." 42 C.F.R. § 488.805; *see also Life Care Ctr. of Elizabethton*, DAB No. 2367, 6-7, 12-13 (2011) (no showing of actual harm necessary to support immediate jeopardy finding in nursing home case). Nightingale offered no evidence that undercuts the conclusion that failing to provide catheter care as required through nursing visits as planned to a patient with a history of UTIs and the many complicating morbidities identified for Patient 4 would be likely to cause infection and other serious harm.

Nightingale further argues that the Olson and Kennell declarations, together with Patient 4's medical records, suffice to show that the agency had a reasonable basis to expect that it would be able to meet his medical, nursing, and social needs when he was accepted for treatment because the care provided during his episodes of care adequately met those needs. RR at 6. This argument fails for three reasons. First, the applicable condition of participation requires not only that a reasonable basis exist to believe the agency capable of meeting the patient's needs but also that the treatment actually provided follow the plan of care. 42 C.F.R. § 484.18. Thus, even were the agency to have reasonably expected it could provide adequate care, we would find this condition not met where the care provided did not follow the patient's plan of care. Second, as matter of factual findings, we have explained above that the record shows that the agency did not meet Patient 4's needs and did not follow his plan of care. Third, as we discuss further below, CMS offered ample direct evidence that Nightingale was persistently inadequately staffed and should have known it could not meet all the needs of all the patients it accepted.

We conclude that substantial evidence supports the ALJ's conclusions that Nightingale's neglect of Patient 4's needs as reflected in his care plan and medical records amounted to condition-level noncompliance with section 484.18 and that this noncompliance placed the patient in immediate jeopardy.

b. *Patient 1*

The ALJ found that Nightingale's staff demonstrated its failure to follow care plans and physician orders "most notably" by neither monitoring "the effects of the anti-coagulant Coumadin on Patient 1 [nor notifying] the patient's physician that the patient was experiencing extremely adverse effects from administration of Coumadin." ALJ Decision at 5. He found that Nightingale's deficient care culminated with the patient arriving in the emergency room on September 7, 2015, "suffering from Coumadin toxicity" and at "extreme risk for bleeding." *Id*. at 6, citing CMS Ex. 7, at 222. He concluded that Nightingale offered no meaningful rebuttal to the evidence of condition-level noncompliance. *Id.* at 7.

As the ALJ recounted, the record shows that the patient had an abnormally high clotting measurement on August 11, 2015; the physician ordered Coumadin withheld for two days and the measurement rechecked then. ALJ Decsion at 5-6, and record citations therein. No reading was done or reported as the physician learned a week later upon contacting the family, and, despite repeated physician notes and orders, the first evidence that Nightingale nurses finally rechecked the measurement was on August 28, 2015. *Id*. Patient 1 ended up in the emergency room with extremely high readings indicating severe bleeding risk on August 31 and September 7, 2015. *Id*. The ALJ concluded that the failures to perform ordered tests and to communicate results to the physician were unrebutted and established noncompliance that amounted to immediate jeopardy. *Id*. at 7.

Nightingale argues that the physician did not actually wait a week or more for the test results. RR at 9. According to Nightingale, the ALJ "failed to acknowledge . . . evidence that demonstrated the physician received the required response the same day." *Id*., citing Olson Decl. ¶¶ 23-37 and Kennell Decl. ¶¶ 43-54. No clinical evidence in the record supports this claim. Ms. Kennell asserts only that patient notes show a Nightingale nurse returned the physician's call on August 12, 2015 and "obtained orders that same day." Kennell Decl. ¶ 44. Obtaining orders does not necessarily demonstrate when the nurse followed the orders or reported the results. We do find records to which Nurse Kennell is presumably referring (she does not identify precisely what she relies on) in which the DON reports that a nurse said that she had returned the call and received orders. P. Ex. 11, at 9-10; CMS Ex. 7, at 122-23. Neither the DON nor Ms. Kennell points to (and we do not find) any records showing that the Coumadin was withheld for two days as ordered, the test was then repeated as ordered, or the results were provided to the physician's office. Hence, this evidence did not rebut the ALJ's finding.

DON Olson points to the same two records mentioned above and notes that the nurse stated that the orders were for laboratory work, including blood clotting tests, for "the week of August 17th," and opines that this conflicts with the facts found by the ALJ. Olson Decl. ¶¶ 28-29 (internal quotation marks omitted). The note for laboratory testing to be done the week of August 17, 2015 does not contradict the order to perform a blood clotting test after two days of withholding Coumadin starting August 12, 2015. DON Olson suggests that a blood clotting test drawn on August 21, 2015 sufficed to comply with the physician's orders. *Id.* ¶ 30, citing CMS Ex. 7, at 89-90 (actual blood clotting results are at CMS Ex. 7, at 112). While this evidence may tend to show that Nightingale did draw blood for testing earlier than August 28, 2015, it does not negate the ALJ's finding that the physician's office ordered Coumadin withheld and Patient 1 re-tested on August 12th and did not receive any results for at least a week (and Nightingale has not established any clear record of when the August 21, 2015 results were received by the physician).

On August 28, 2015, a SN visit was indeed made to Patient 1 and test results taken and reported, as the ALJ recognized. ALJ Decision at 6. CMS contends that this visit was supposed to have occurred on August 24, 2015 and was delayed four days. Response Br. at 13-14. Nightingale, on the other hand, claims that the visit was not ordered to take place until August 26, 2015, and that the delay to August 28, 2015 was caused by the patient's own unavailability. Kennell Decl. at ¶ 45 ("CMS misinterprets the August 24th physician's order which called for another SN visit on August 26th, not August 24th.") Ms. Kennell is mistaken that CMS's position is that the physician's order of August 24, 2015 was the trigger requiring a SN nursing visit for that date. It is clear that both CMS and its surveyor did understand the physician's August 24, 2015 order to be that a new dosage of Coumadin start immediately with a blood draw for testing to be performed on August 26, 2015. CMS Response Br. at 13-14; Ford Decl. ¶ 67. But Patient 1 was already scheduled to receive a regular SN visit on August 24, 2015 (unrelated to the change in dosage ordered that date), and the scheduled nurse was a "no show, no call" on that date. CMS Ex. 31, at 5, 26, 29, 31; Ford Decl. ¶ 69.

Nightingale's own records clearly establish that it was aware that the patient was supposed to have been visited on August 24th and that it took steps to try to ascertain why the nurse failed to make the required visit. The DON herself recorded a contemporaneous complaint by Patient 1's daughter about the nurse's failure to arrive or communicate on that day even though the daughter had specifically confirmed the schedule in advance because the day was a holiday. CMS Ex. 31, at 5. The DON noted that she told the daughter that there had been a "little lapse in communication" and that her research showed that an "input error" had resulted in reducing the patient from two SN visits per week to one. *Id.* Moreover, the DON recorded that the nurse involved was to be given "written counseling regarding issue." *Id.* She also noted, in an August 29, 2015 email to another staff person, that it "sounds like [the nurse] didn't go or call

Monday [August 24, 2015] and then tried to go yesterday afternoon and they want morning." *Id*. at 28. Ms. Kennell's claim that this failure to provide scheduled and ordered nursing care was merely a misunderstanding on CMS's part is thus entirely inconsistent with Nightingale's own contemporaneous documentation, which tends to undercut the credibility of Ms. Kennell's overall assessments of the agency's care.

Nightingale also seeks to undercut the ALJ's conclusion that an "extremely high" PT/INR reading was recorded in the emergency room on August 31, 2015 after Nightingale's nurses failed to provide scheduled care. Instead, according to Nightingale, the reading occurred on August 21, 2015 and reflected the physician's having reviewed the results of the nurse's blood draw for laboratory testing that morning and instructed the family to take the patient to urgent care for retesting. Kennell Decl. ¶ 46.

The record does not support this claim. Patient 1's blood was indeed drawn and a reading taken August 21, 2015 at the hospital emergency room, but that blood clotting test actually showed very low, not very high results. CMS Ex. 7, at 112. The ALJ was entitled to credit instead the evidence that the patient's daughter told a social worker that the patient was taken to the emergency room on August 31, 2015 with very high readings. ALJ Decision at 6, citing CMS Ex. 7, at 17. The ALJ's conclusion is also consistent with a contemporaneous Nightingale patient note saying that the social worker reported that Patient 1 had been to the hospital on August 31, 2015. CMS Ex. 7, at 17, 27.

Overall, Nightingale's own records are rife with distressed complaints from Patient 1's daughter (as with other patients mentioned by the ALJ and their families) over the inadequacy of the nursing care provided by the agency. For example, in an email on September 8, 2015, a Nightingale representative reported to the DON that the daughter was at the hospital with Patient 1 and was "extremely upset," stating that Nightingale's nurses were "incompetent." CMS Ex. 31, at 11. Specifically, Patient 1's daughter said that "Some nurses never showed. Some nurses couldn't draw blood . . . . I don't know what's wrong with your company but [the] nurses are incompetent and there is a serious lack of communication and something needs to be done before someone dies." *Id*. Other records suggest that, while calls or visits were sometimes attempted unsuccessfully, these usually occurred in the afternoons, despite the daughter having repeatedly informed Nightingale that she worked in the afternoons and needed prescheduled morning visits. *See, e.g., id.* at 23, 25, 28-29, 32.

Nightingale alleges that the surveyors did not cite Patient 1 as a basis for immediate jeopardy because the November SOD states that the continuation of immediate jeopardy at the close of that survey and "this failure to remove the Immediate Jeopardy affected 1 of 21 sampled patients. (Patient #4)." RR at 8-9, citing CMS Ex. 4, at 2; Reply Br. at 4-5. CMS responds that the November SOD pointed to immediate jeopardy as related to

noncompliance involving blood clotting measurement (which obviously was not based on Patient 4, who did not require such testing), and that, in any case, it identified the noncompliance relating to Patient 1 as presenting immediate jeopardy in its prehearing brief so Nightingale had ample notice. Response Br. at 12. We agree with CMS. The November SOD establishes that the immediate jeopardy extended to failing to follow the plan of care for blood clotting measurements (Patient 1), as well as wound treatments (Patient 5). CMS Ex. 4, at 2. The statement that Nightingale's proffered plans of correction failed to eliminate the immediate jeopardy that affected Patient 4 does not imply that immediate jeopardy had not been present or had not affected additional patients prior to the end of the survey. Nightingale should have been well aware from the SOD that the immediate jeopardy determination involved the findings as to patients in addition to Patient 4, including Patient 1. In any case, Nightingale unquestionably knew this to be CMS's position by the time the case was presented to the ALJ and has not shown it lacked an adequate opportunity to respond to the evidence that the noncompliance relating to Patient 1 constituted immediate jeopardy. The Board has repeatedly held that the issues before the ALJ are not "strictly constrained" to the allegations in the SOD so long as the provider has adequate notice in time to respond, as Nightingale had here. *See, e.g., Laurelwood Care Ctr.*, DAB No. 2229, at 20-21 (2009).

We conclude that substantial evidence in the record as a whole supports the ALJ's ultimate conclusion that Nightingale did not rebut the allegations that "its staff failed to do PT/INR tests as ordered," "failed to communicate results to the patient's physician," and "failed to monitor Patient 1's clotting times closely and thereby allowed the patient to develop Coumadin toxicity." ALJ Decision at 7. These findings also demonstrate that Patient 1 was placed in immediate jeopardy as a consequence of Nightingale's noncompliance.

c. *Patient 5*

The ALJ concluded that "overwhelming evidence" showed that Nightingale failed to follow care plans to treat wounds, most strikingly in relation to a third patient identified as impacted by conditions of immediate jeopardy during the November survey. ALJ Decision at 7. More specifically, as to Patient 5, the ALJ made the following findings:

> The care that [Nightingale's] staff provided to this patient is not only poorly documented but it is impossible to discern from Petitioner's own records exactly what care the staff provided to him. One cannot tell from the patient's record how many wounds the patient was suffering from nor can one discern the condition of these wounds or precisely what treatment the patient was receiving for them. CMS Ex. 50 ¶¶ 197-237. For example,

> nurses used "Wound #1" to describe at least two separate wounds on Patient 5's legs and feet. CMS Ex. 10 at 77, 79. Other notes document a traumatic wound on Resident 5's right shin, while subsequent notes identify what is presumably the same wound on his left shin. CMS Ex. 10 at 79, 80, 83.
>
> Such absent or poor documentation only supports the conclusion that [Nightingale] did not follow Patient 5's care plan for wound care. Moreover, the dangers posed by improper or poorly documented wound care are obvious. Infection is one obvious likely consequence of poor wound care. In the case of Patient 5 [Nightingale's] staff left the patient exposed to the risk of infection by failing to document the wound care that it provided to him. That is immediate jeopardy-level noncompliance.

Id. at 7-8.

Nightingale makes only two statements in response to the ALJ's findings as to Patient 5. First, it asserts that Patient 5, like Patient 1, was not identified as being in immediate jeopardy prior to CMS's briefing before the ALJ. RR at 10. This argument fails for the same reasons set out above in relation to Patient 1. Second, Nightingale makes the flat claim that the ALJ "failed to consider the evidence" it offered, but, even in its reply brief, Nightingale does not proffer a single record citation to any such evidence. *Id*.; Reply Br. at 4.

Surveyor Ford testified at length about the inadequacies of this patient's wound care and its documentation. Ford Decl. ¶¶ 194-241. For example, she noted that an October 16, 2015 SN visit note mentions only one wound although four had been previously documented as present, and no records showed that they had healed before the visit. *Id.* ¶ 228. The documentation for that visit alone had the following inconsistencies: "The wound description says it is to the right leg, but the narrative section says it is to the left leg. The description says it was cleaned with normal saline, the narrative section says it was cleaned with wound cleaner. The narrative section says gauze was applied and the wound description section does not." *Id.*, citing CMS Ex. 10, at 88-89. The record contains Patient 5's care records, and they entirely support the surveyor's testimony. CMS Ex. 10. Neither Ms. Kennell nor DON Olson provided any testimony to rebut or mitigate the seriousness of these inadequacies or otherwise address the findings as to Patient 5.

We conclude that substantial evidence in the record as a whole supports the ALJ's conclusion that Patient 5 was subjected to immediate jeopardy as a result of the inadequate wound care and documentation failures and his conclusion that these constituted condition-level noncompliance with both cited conditions.

d. *Other evidence of dangerously inadequate staffing in November survey*

While the discovery of inadequate care of Patient 4 among the patients sampled in the complaint survey may have been the initial trigger for finding immediate jeopardy, that discovery is far from the only reason that the surveyors and CMS found that immediate jeopardy existed before, during, and even after the survey. The surveyors reported that Nightingale offered plans of correction on November 5 and on November 6, 2015 in an attempt to demonstrate removal of the "immediacy" and both were found unacceptable. RH Ex. 2, at 2. Thus, clearly the death of Patient 4 did not remove the underlying conditions creating immediate jeopardy. Moreover, the surveyors reported that they completed a review of Nightingale records on November 9, 2015 and found that Nightingale was still not complying with plans of care for current patients. *Id*. The surveyors determined that the fundamental cause of the continuing threats to the health and safety of patients was that the agency had inadequate staffing to meet the needs of current patients. *Id*.

The ALJ pointed to additional evidence in the record supporting this conclusion that Nightingale's inadequacies were widespread and reflected an underlying inability to provide nursing visits as ordered. ALJ Decision at 5. In addition to the patients already discussed, the ALJ cited Patients 10, 11, 12, 13, and 14 as not having received visits as ordered. *Id*., citing Ford Decl. ¶¶ 69, 229, 346, 395, 420, 452; CMS Ex. 51 (Surveyor Emery Declaration) ¶¶ 16, 29; and CMS Ex. 55, at 20 (transcript of bankruptcy hearing, testimony on missed nursing visits).

On appeal, Nightingale identified no error in the ALJ's findings as to these additional patients. The repeated failures to provide nursing care as ordered to multiple patients is strong evidence in support of CMS's position that Nightingale was not able to maintain adequate staffing to serve the patients it accepted into its care.

Nightingale did make the broad claim that the testimony of its DON and its nurse expert consultant "directly contradicted CMS's claims of inadequate staffing." Reply Br. at 2, citing Olson Decl. ¶¶ 3-22 and Kennell Decl. ¶¶ 13-29. The cited paragraphs, however, address only the care of Patient 4, discussed above. CMS's evidence went well beyond the failures of care to this one patient to establish that Nightingale's staffing was inadequate. In addition to the failures to provide ordered visits to the additional patients that the ALJ identified, the record included direct evidence concerning Nightingale's staffing problems. For example, the surveyor reported interviews with Nightingale's current and former professionals that reinforced the severity and persistence of the problem. *See, e.g.*, Ford Decl. ¶¶ 504-510, 517, 532, 536-39. A social worker at Nightingale felt she was having to do the job of nurses and stated "that Nightingale was constantly short-staffed and patients repeatedly would complain: 'Who is my nurse?

Where is my nurse? When is my nurse coming?'" *Id*. ¶¶ 372-73. The social worker opined that "poor staffing was causing problems for patient care." *Id*. ¶ 374. The surveyor stated that, in her own experience, the "understaffing at Nightingale in these surveys was the worst I have seen in my time working for and surveying home health agencies," noting that "pervasive missing of visits and failure to follow physician orders, especially as to wound care and PT/INR testing, had a high probability of causing patients serious harm," as well as "actual serious harm" at least "to Patient 4 and likely to Patient 1." *Id*. ¶ 510.

We thus find substantial evidence supports the conclusion that Nightingale created a condition of immediate jeopardy to its patients because it accepted patients into its care when it was not adequately staffed to meet their needs.

e. *Conclusion as to November survey*

We conclude that the ALJ did not err in determining that ample evidence supported CMS's determination that Nightingale was out of compliance with conditions of participation set out in sections 484.18 and 484.30 of the applicable regulations at the time of the November survey. We further conclude that the ALJ did not err in concluding that Nightingale failed to show clear error in CMS's determination that the deficient conditions found during that survey rose to the level of immediate jeopardy.

3. Nightingale's challenges to the ALJ's findings regarding the December survey have no merit.

a. *Failure to correct condition-level noncompliance or abate immediate jeopardy*

In reviewing the results of the revisit survey in December 2015, the ALJ concluded:

> The evidence strongly supports the conclusion that Petitioner failed to eliminate immediate jeopardy in the following respects: (1) its staff continued to fail to document wound care adequately; (2) the staff continued to fail to conduct PT/INR tests as ordered and to document test results; (3) the staff continued to fail to visit patients as scheduled; and (4) the staff continued to fail to review patient medical records and patient plans of correction in order to sure that all necessary care was being provided to patients as ordered.

ALJ Decision at 9.

Nightingale acknowledged that the "December SOD identified four (4) patients in" immediate jeopardy, but stated that this was "not as a result of the staffing concern identified in the November SOD." RR at 2. Nightingale did not cite any requirement (and we find none) that CMS show that the same underlying concerns generate the immediate jeopardy conditions at both surveys. Nevertheless, as will be apparent from the examples of patients below, many of the failings found in the December survey in fact echo those apparent in November, and Nightingale remained out of compliance with the same conditions of participation as at the first survey.

Moreover, Nightingale's discussion of immediate jeopardy in regard to the December survey mistakenly focuses on whether a particular patient remained in danger rather than whether conditions that created immediate jeopardy for one or more patients were still present. The definition of immediate jeopardy for home health surveys at section 488.805 parallels that at section 488.301 for long-term care facility surveys. The Board has held that this definition does not depend on viewing the impact on a resident in isolation nor does it depend on finding actual harm to an individual resident but rather the assessment is based on whether the noncompliant conditions present a likelihood of serious harm to <u>any</u> resident (or patient in the case of home health). Thus, the Board explained:

> The term "immediate jeopardy" includes a situation in which the provider's *noncompliance* with *one or more* requirements is likely to cause serious injury or harm to *a resident*. 42 C.F.R. § 488.301. Thus, the focus is not on just an instance of failing to provide care to an individual resident consistent with the regulations, but on whether the noncompliance evidenced by one or more failures to comply with one or more requirements is likely to cause serious injury or harm to a resident if not corrected. To meet its high burden and to overturn a determination of immediate jeopardy that is based on more than one failure, therefore, the facility must demonstrate that all the failures relied upon, *i.e.*, the "totality" of its noncompliance, did not create the likelihood of serious injury or harm to any resident. *See, e.g., Universal Health Care – King*, DAB No. 2383, at 18-19 (2011) (upholding CMS's immediate jeopardy determination based on the "totality" of the facility's noncompliance that resulted in the likelihood of serious harm to residents). Here, Bibb's arguments are flawed in that Bibb addresses its failures individually and only with respect to the risk to one resident. These arguments fail to consider the "totality" of Bibb's noncompliance and do not demonstrate adequate grounds to disturb the ALJ's conclusions.

Bibb Med. Ctr. Nursing Home, DAB No. 2457, at 4 (2012) (emphasis in original), *aff'd, Bibb Med. Ctr. Nursing Home v. Dep't of Health & Human Servs.*, 510 F. App'x 861 (11th Cir. 2013); *see also Liberty Commons Nursing & Rehab. Ctr. – Johnson*, DAB No. 2031, at 19 (2006) ("Immediate jeopardy exists if a SNF's noncompliance is the type of noncompliance that would likely cause serious injury, harm, impairment, or death if not corrected, even if surveyors did not observe or identify a particular resident who was actually threatened with harm during the survey" (emphasis in original)), *aff'd, Liberty Commons Nursing & Rehab. Ctr. – Johnston v. Leavitt*, 241 F. App'x 76, 80 (4th Cir. 2007).

Moreover, the burden of demonstrating that immediate jeopardy has been abated remains on the provider, that is, the provider must show that CMS's determination that immediate jeopardy continued is clearly erroneous because the determination of how long immediate jeopardy remained present is, in essence, a continuing determination as to the level of noncompliance. *Universal Health Care – King*, DAB No. 2383, at 16 (2011); *Azalea Court*, DAB No. 2352, at 17 (2010) (A "facility's burden extends to overcoming CMS's determination as to how long the noncompliance remained at the immediate jeopardy level."), *aff'd, Azalea Court v. U.S. Dep't of Health & Human Servs., Ctrs. for Medicare & Medicaid Servs.*, 482 F. App'x 460 (11th Cir. 2012); *Brian Ctr. Health and Rehab./Goldsboro*, DAB No. 2336, at 7-8 (2010) ("A determination by CMS that a [provider's] ongoing noncompliance remains at the level of immediate jeopardy during a given period constitutes a determination about the 'level of noncompliance' and, therefore, is subject to the clearly erroneous standard of review under section 498.60(c)(2).").

In short, the issue before the ALJ (and hence on our review) is not about whether a particular patient was in or still in danger but whether Nightingale demonstrated that CMS's determination that conditions that made serious harm to any patients likely were still present at the December survey was clearly erroneous. As we explain in the rest of this section, the ALJ did not err in concluding that Nightingale's evidence did not so demonstrate. ALJ Decision at 8.

b. *Patient 31*

The ALJ found that Nightingale continued to fail to document proper assessment and monitoring of wounds in its patients despite having claimed in its accepted plan of correction to have provided wound care training. ALJ Decision at 9, citing CMS Ex. 37, at 53 (inservice training checklist on wound care). The ALJ pointed to Patient 31, who was "identified in Petitioner's records as having six surgical wounds," and found that Nightingale staff failed to assess the patient's wounds during visits on November 21 and 24, 2015 and that nurses who visited on December 2 and 3, 2015 "failed even to mention the patient's wounds in the nursing notes and failed to assess them." *Id.*, citing CMS Ex. 45, at 12, 19-23, 39, 41-44. The nurse who visited on November 24, 2015 merely noted

"surgical incision sites healing nicely"; she provided no specific measurements or description of the status or condition of the wounds. CMS Ex. 45, at 44. The next visit record from November 26, 2015 contained only the even vaguer reference: "Patient healing nicely." *Id*. at 45. As the ALJ commented, the records of visits on December 2 and 3 contain no notation at all about the surgical wounds. *Id*. at 46-48.

Nightingale's response to the ALJ's findings about Patient 31 consists in its entirety of the following statements:

> The documentation issues CMS allege[d] and ALJ Kessel wholly adopt[ed] were not failures of documentation due to the nature of the wound at issue. Petitioner's Brief at 15-16; CMS Ex. 38 at 33-34. The wound in question was a surgical incision wound that did not require treatment, only observation and assessment.

RR at 11. The weakness of this response is apparent from the fact that a mere citation to Nightingale's own brief below is not evidence to support its claim that surgical wounds do not require assessment and documentation. The only other citation is to a passage in the December SOD, which supports the ALJ's conclusion, because it discusses the initial assessment of the patient's surgical wounds and that assessment demonstrates that incisions, like other wounds, can be and are indeed properly measured, assessed and reported:

> The assessment identified the patient had 6 surgical wounds. The assessment evidenced wound number 1 was located on the "lower sternum" and measured 1.905 centimeters (cm) in length and 0.5 cm in width. Wound number 2 was located "below sternum" and measured 1.905 cm in length and 0.5 cm in width. Wound number 3 was located in the "umbilical" area and was "difficult to see, intact, no drainage." Wound number 4 was located "right abdominal" and was 1.905 cm in length and 0.5 cm in width. Wound number 6 was located "left lower abdominal" and measured 1.905 cm in length and 0.5 cm in width.

CMS Ex. 38, at 34.

Nightingale's own training protocol stated that documentation of wounds is to include, among other things, type, location (specific to left or right), stage of wound, characteristics of any drainage, pain levels, and measurements of size at least weekly. CMS Ex. 37, at 53. CMS's nurse-surveyor testified that standards of nursing care required that the condition of the wounds be assessed and documented at every visit. CMS Ex. 53 (Harmon Decl.) ¶ 13. Neither the training protocol nor Nurse Harmon's

testimony indicated that these requirements for wound documentation do not apply to surgical incisions. Furthermore, Nightingale presents no basis to conclude that, even if the surgical sites did not require specific treatment, the nurses were not required to document their observation and assessment of the wounds in accordance with the protocol and standards of care.

Nightingale did not point to any error in the ALJ's finding that "failure to document and assess wounds can put a patient at a grave risk for infection." ALJ Decision at 9. The ALJ rejected Nightingale's argument that documentation was not important given that a single nurse performed each of the visits, explaining the nurse could not be expected to remember the details of the wound from one visit to the next without documentation and other medical professionals might need to rely on the documentation of the course of the wound care. *Id*. at 10. On appeal, Nightingale identifies no error in this finding.

We conclude that the ALJ's findings as to Patient 31 are supported by substantial evidence.

c. *Patient 29*

The ALJ found that Nightingale's failure to correct the conditions creating immediate jeopardy for its patients was also exemplified by the failure to perform a PT/INR test on Patient 29 as scheduled on November 30, 2015. ALJ Decision at 9, citing CMS Ex. 43, at 16, 22, 27-28. Delaying the test until the next day "contravened" provisions of the plan of correction, which specifically required the staff to complete laboratory tests as ordered on specific dates and times. *Id*., citing CMS Ex. 37, at 52.

Nightingale argues that the ALJ "failed to take into account the declarations of Michelle Olson and Sharon Kennell, as well as the patient records," which, it says, show that the patient's "visit schedule" had "flexibility in the days of visits in accordance with the patient's plan of care." RR at 11, citing Olson Decl. ¶ 32 (citing CMS Ex. 43, at 55-56, 11-14). Nightingale's argument and the cited documents fail to squarely address what the record shows about the failure of Nightingale's nurse to perform the PT/INR test as ordered.

DON Olson claims in her testimony that she received a verbal order on November 29, 2015 cancelling the order for a PT/INR test to be performed on November 30, 2015. Olson Decl. ¶ 53, citing P. Ex. 12, at 1. This claim is inconsistent with the patient's records which Nightingale provided at the time of the survey. CMS Ex. 43, at 26. It is also inconsistent with a note dated December 3, 2015 signed by the DON in which she recorded having spoken with the nurse about the PT/INR tests "being done on 12/1 rather than 11/30" and recorded the nurse's explanation that the patient had not yet received the home testing equipment. *Id*. at 29. This note by the DON would make no sense if the

DON had received verbal orders on November 29, 2015 cancelling the order for PT/INR testing. The nurse's recorded explanation does not make sense either, given the DON's testimony that the Nightingale nurse used the agency's own point-of-care equipment. Olson Decl. ¶ 51. Further, the nurse told the surveyor that the reason the visit on November 30, 2015 did not take place was merely that "her visits are planned on Tuesdays and 11/30/15 was a Monday." CMS Ex. 38, at 13. In any event, general flexibility about scheduling patient visits under a plan of care does not justify failing to carry out a physician order to perform a critical laboratory test on a particular day.

We conclude that substantial evidence supports the ALJ's findings about Patient 29.

d. *Patient 30*

The ALJ found that Nightingale failed to provide scheduled visits to Patient 30 between November 21-26, 2015, and he did not find credible notations in Nightingale's records stating that the patient refused nursing visits on November 24 and 25. ALJ Decision at 10-11. The ALJ described as "certainly more reliable" Patient 30's reported statement to surveyors that she did not cancel those visits. *Id.* at 11, citing CMS Ex. 44, at 12-13 and CMS Ex. 50 ¶ 523. The ALJ stated that he had found that Nightingale's nursing notes had "proven to be inconsistent, haphazardly completed, or incomplete." *Id*.

Nightingale argues that the ALJ should not have credited the surveyor's report of the patient's statements because they appeared in the December SOD but were not quoted in the surveyor's interview notes. RR at 11-23, citing CMS Ex. 38, at 10; CMS Ex. 44, at 2; and Kennell Decl. ¶¶ 70-71. Nightingale's argument is not supported on the record.

The December SOD reported the following information obtained from Patient 30 in an interview on December 9, 2015:

> The patient stated he/she had never canceled or refused a skilled nursing visit during the week of Thanksgiving. The patient stated "Why would I cancel my visits." The patient stated no one called him/her to tell him/her that there would be no skilled nurse visit. . . . He/She was told that the agency was closed on the holiday. He/She stated that he/she did cancel a physical therapy visit during the week due to pain issues.

CMS Ex. 38, at 10. In fact, the surveyor's notes of the interview with the patient contain the same basic information reading "Pt. said she only cancelled on PT. Nurse came Friday." CMS Ex. 44, at 2. Thus, the surveyor did record that Patient 30 told her that she did not cancel her SN visits that week, but only a physical therapy visit. Nurse Kennell's

critique of the December SOD report is merely that the surveyor should not have put quotes around the patient's apparently rhetorical question about why she would cancel her nursing visits when the precise language quoted was not in the interview notes. Kennell Decl. ¶¶ 70-71.

Even omitting the quoted language would not undercut the point that the agency's records contained claims by the nurse that the patient or family refused visits which the patient denied were ever cancelled. In any case, the Board has held that the inclusion of a statement in a SOD that is not directly included in surveyor interview notes does not per se require an ALJ to afford it less credibility. *Life Care Ctr. of Bardstown*, DAB No. 2479, at 19 (2012) ("We further agree with the ALJ that the absence of surveyor notes memorializing the surveyors' interviews with [the facility nurse] does not alone impeach the statements in the SOD. As we stated, the SOD itself constitutes prima facie evidence of the facts asserted in it."), *aff'd, Life Care Ctr. of Bardstown v. Sec'y of U.S. Dept. of Health & Human Servs.*, 535 F. App.'x 468 (6th Cir. 2013). We do not find that the inclusion of quotation marks provides a compelling basis for us to disregard the ALJ's express conclusion that the patient's statement is more reliable and credible than the agency record, especially since the ALJ found the record questionable on its face.[8]

We conclude that substantial evidence also supports the ALJ's findings about Patient 30.

e. *Patient 28*

The ALJ found that Nightingale did not rebut evidence that its staff "failed to update Patient 28's plan of care to show that the patient was receiving a new dosage of Coumadin" and rejected Nightingale's defense that a different entity was supposed to manage the patient's Coumadin so Nightingale was excused "from having to do anything for the patient relating to his anticoagulant therapy besides performing PT/INR testing." ALJ Decision at 9, 11. The ALJ concluded that Nightingale's duty as an HHA included documenting "all medications administered to the patient," which Nightingale moreover promised to do in its accepted plan of correction. *Id.* at 11.

The plan of correction required, among other steps, that Nightingale have reviewed all patients' files to ensure that medication records were complete, including recording all medication changes and start dates, and nurses were to have been retrained to document and reconcile all medication changes and changes to plans of care timely. CMS Ex. 37,

[8] As the ALJ observed, the agency's records are questionable on their face as well. ALJ Decision at 11. The nursing notes state: "Appointment for 11/24/2015, cancelled on 11/27/2015 per [name omitted], LPN because Patient/family refused." CMS Ex. 44, at 12. It is not clear what it means that a visit was cancelled three days after it was to have occurred because someone (with no specific person identified) is supposed to have refused it at some point.

at 33, 38-39, 69. Yet Nightingale failed to change the plan of care to record two changes in the dosing pattern for Patient 28's Coumadin treatment. *Compare* CMS Ex. 42, at 7-8 *with* CMS Ex. 42, at 27, 30. If Nightingale was not responsible for tracking the patient's blood thinning medication, as it contends, it has not explained why the dosage was included in its plan of care to begin with or why its nurses were receiving and noting changes in dosage but not updating the plan of care to reflect the information. Nor has Nightingale pointed to any authority to contradict the ALJ's conclusion that it remained responsible for having the plan of care reflect the correct medication dosages notwithstanding the patient's involvement with a Coumadin clinic.

The ALJ also found that Nightingale had failed to follow physician orders in Patient 28's care plan to provide education regarding the urinary disease process. ALJ Decision at 9-10, citing CMS Ex. 42, at 10, 13. He found Nightingale's claim that the training was provided and documented in clinical notes not credible because documentation supporting the claim was not produced. *Id*. at 11 and n.5. Nightingale points to no error in the ALJ findings.

We conclude that the ALJ's findings relating to Patient 28 were supported by substantial evidence.

f. *Conclusion as to the December survey*

We conclude, based on these findings, that the ALJ did not err in determining that Nightingale had not corrected the condition-level noncompliance that posed an immediate jeopardy to its patients as of the time of the December survey and that Nightingale did not show CMS's determination that immediate jeopardy continued to be clearly erroneous.

4. CMS had authority to impose the remedies at issue.

The ALJ found that the immediate jeopardy-level noncompliance authorized CMS to terminate Nightingale's participation agreement by December 10, 2015. ALJ Decision at 11. He also concluded that the CMP imposed was "amply justified" because Nightingale's noncompliance was "particularly egregious," placing multiple patients in immediate jeopardy and having "actually harmed at least one patient, Patient 4." *Id*. at 12.

Nightingale asserts that the immediate jeopardy determination placed it on an accelerated track for termination and that its ability to correct the noncompliance findings was compromised by what it characterizes as inadequate communication by the state survey agency. RR at 2-3. Although Nightingale points to regulations authorizing CMS to wait up to 100 days to terminate a home health agency in the absence of immediate jeopardy, we see no relevance to those regulatory provisions here. RR at 3, citing 42 C.F.R.

§ 488.830(a)(1), (2). First, we have already found that the immediate jeopardy determination was not clearly erroneous. As the ALJ pointed out, CMS could have terminated immediately based on the immediate jeopardy, but was permitted to wait up to 23 days to permit the HHA to try to abate the immediate jeopardy and correct its noncompliance, an opportunity which CMS afforded Nightingale. ALJ Decision at 2 n.2, citing 42 C.F.R. § 488.825(a). Second, even in the absence of immediate jeopardy, CMS is permitted, but not required, to wait 100 days before imposing termination. We find no error in the ALJ's conclusion that CMS was within its authority to terminate Nightingale.

On appeal, Nightingale presents no argument challenging the amount or duration of the CMP, limiting itself to the arguments already addressed above to challenge the bases for imposition of any remedies. We have found those challenges ill-founded and therefore uphold the imposition of a CMS for the stated time period. Section 488.845(b)(3)(i) provides that a $10,000 per-day is appropriate "for a deficiency or deficiencies that are immediate jeopardy and that result in actual harm." The findings we have upheld above clearly establish that such deficiencies were present in this case. We therefore uphold the imposition of a $10,000 per-day CMP from November 9, 2015 through December 10, 2015.

Conclusion

For the reasons explained above, we affirm the ALJ Decision upholding the remedies imposed by CMS.

/s/
Sheila Ann Hegy

/s/
Constance B. Tobias

/s/
Leslie A. Sussan
Presiding Board Member