Department of Health and Human Services
DEPARTMENTAL APPEALS BOARD
Appellate Division

Columbus Nursing and Rehabilitation Center
Docket No. A-13-1
Decision No. 2505
March 28, 2013

FINAL DECISION ON REVIEW OF ADMINISTRATIVE LAW JUDGE DECISION

The Centers for Medicare & Medicaid Services (CMS) appeals the July 27, 2012 decision by Administrative Law Judge Keith W. Sickendick (ALJ), *Columbus Nursing and Rehab. Ctr.*, DAB CR2574 (2012). The ALJ issued that decision on remand from a June 2011 Board decision (DAB No. 2398). In general, the ALJ concluded that Columbus was in a state of noncompliance with Medicare participation requirements from June 4 through August 3, 2007, and that its noncompliance with two requirements (42 C.F.R. §§ 483.25(c) and 483.25(i)(1)) was at the immediate jeopardy level of seriousness from June 4 through June 13, 2007.

CMS challenges the following conclusions made by the ALJ on remand: (1) that CMS clearly erred when it determined that Columbus's noncompliance with an additional requirement (42 C.F.R. § 483.25) was at the immediate jeopardy level from June 4 through June 13, 2007; (2) that certain instances of resident neglect did not warrant an inference that Columbus had violated 42 C.F.R. § 483.13(c); (3) that Columbus was in substantial compliance with 42 C.F.R. § 483.10(b)(11)(i)(B) during an August 2007 revisit survey; and (4) that an $8,800 per day civil money penalty (CMP) for Columbus's 10 days of immediate-jeopardy-level noncompliance (based on its noncompliance with requirements other than section 483.25) was unreasonable. We discuss each of these issues below to the extent necessary to our decision.

For the reasons stated below, we (1) reverse the ALJ's conclusion that CMS's immediate jeopardy determination regarding the facility's noncompliance with 42 C.F.R. § 483.25 was clearly erroneous; (2) reverse the ALJ's conclusion that Columbus was in substantial compliance with section 483.10(b)(11)(i)(B) during the August 2007 revisit survey; (3) conclude that Columbus was not in substantial compliance with Medicare participation requirements from August 3 through September 4, 2007; (4) reinstate the DPNA and $200 per-day CMP that CMS had imposed for the period August 3 through September 4, 2007; and (5) uphold the ALJ's reduction of the CMP amount to $3,050 per day for the immediate jeopardy period.

Background

The following facts are undisputed. During June 2007, the Wisconsin Department of Health and Family Services (state survey agency) performed a recertification and complaint survey of Columbus. That survey found that from June 4, 2007 through June 13, 2007, Columbus was noncompliant at the immediate jeopardy level with the following Medicare participation requirements: ***section 483.13(c)***, which requires a SNF to develop and implement written policies and procedures that prohibit resident abuse and neglect; ***section 483.25***, which requires a SNF to provide each resident with "necessary care and services" to enable the resident to "attain or maintain" his "highest practicable physical, mental, and psychosocial well-being"; ***section 483.25(c)***, which requires a SNF to provide "necessary treatment and services" to prevent and treat pressure sores; and ***section 483.25(i)(1)***, which requires a SNF to provide services that enable each resident to "[m]aintain acceptable parameters of nutritional status" (such as weight). The June 2007 survey also found that Columbus remained noncompliant (below the level of immediate jeopardy) after June 13, 2007 with these four and several other requirements, including section 483.10(b)(11)(i)(B), which requires a SNF to consult a physician when a resident experiences a "significant change" in health status.

The June 2007 survey's findings of immediate-jeopardy-level noncompliance concerned a single resident – Resident 3. In general, the surveyors found that Columbus had failed to provide care and services to keep Resident 3 as free of pain as possible (in violation of section 483.25); failed to take adequate measures to prevent Resident 3 from developing pressure sores on her heels and right foot or to promote healing of those wounds (in violation of section 483.25(c)); and failed to provide Resident 3 with care and services to prevent Resident 3's weight loss between January and June 2008 (in violation of section 483.25(i)(1)). The surveyors also found that Columbus was noncompliant with section 483.13(c).

During a revisit survey in August 2007, the state survey agency found that Columbus had corrected most of the previously cited deficiencies (including deficiencies found during a July 2007 complaint survey that are not at issue before us). However, the state survey agency determined that Columbus remained noncompliant with section 483.10(b)(11)(i)(B) based on findings concerning Resident 2. The state survey agency also found that Columbus remained noncompliant with section 483.25 based on findings concerning Resident 22. The state survey agency conducted another revisit survey in September 2007 and found that Columbus was back in substantial compliance with all requirements as of September 5, 2007.

Concurring with the state survey agency's findings, CMS imposed an $8,800 per-day CMP that ran from June 4 through June 13, 2007, the period during which the state survey agency had found Columbus's noncompliance to be at the immediate jeopardy level. CMS also imposed a $200 per-day CMP that ran from June 14 through September 4, 2007. In addition, CMS denied payment for Columbus's new admissions from July 20 through September 4, 2007.

Columbus appealed CMS's noncompliance findings and the related enforcement remedies to the ALJ, who held a two-day hearing in February 2009 in which he received testimony from, among others, Surveyor Tina Lubick, R.N., Bruce Kraus, M.D. (Resident 3's treating physician), Daniel Berlowitz, M.D. (CMS's medical expert), and Martin Metten.

On September 10, 2010, the ALJ issued a decision (DAB CR2241) in which he concluded, based on evidence concerning Resident 3, that Columbus was noncompliant with sections 483.25(c) and 483.25(i)(1) at the immediate jeopardy level from June 4 through June 13, 2007. The ALJ also concluded – based again on evidence concerning Resident 3 – that Columbus was noncompliant with section 483.25 during June 2007 but that CMS had committed clear error in finding that this noncompliance was at the immediate jeopardy level. In addition, the ALJ concluded: (1) Columbus had not violated section 483.13(c); (2) Columbus was in substantial compliance with sections 483.10(b)(11)(i)(B) and 483.25 during the August 2007 revisit survey; and (3) Columbus had come back into substantial compliance with all Medicare requirements as of August 3, 2007.

Based on his initial analysis of the relevant factors, the ALJ concluded that the $8,800 per-day CMP for the period June 4 through June 13, 2007 was unreasonable. He further concluded that a $3,050 per-day CMP was reasonable for that period. Finally, in accordance with his finding that Columbus had come back into substantial compliance with all Medicare requirements as of August 3, 2007, the ALJ concluded that CMS's other remedies – namely, the $200 per-day CMP and denial of payment for new admissions – should cease accruing on that date.

CMS appealed DAB CR2241 to the Board, taking issue with following conclusions by the ALJ: (1) that CMS had committed clear error in finding that Columbus's noncompliance with section 483.25 from June 4 through June 13 was at the immediate jeopardy level; (2) that Columbus had not violated section 483.13(c); (3) that Columbus was in substantial compliance with section 483.10(b)(11)(i)(B) during the August 2007 revisit survey; and (4) that a $8,800 per-day CMP for the immediate jeopardy period

(June 4 through June 13, 2007) was unreasonable and that a $3,050 per-day CMP for that period was reasonable. The Board held that the findings and analysis supporting each of the challenged conclusions were inadequate or failed to show that the ALJ had applied correct legal standards. The Board therefore remanded the case to the ALJ for additional findings and analysis.

On remand, after giving the parties an opportunity to submit additional briefs (neither did so), the ALJ reaffirmed, based on modified or supplemental analysis, each of the previously appealed conclusions. CMS believes that these conclusions are still unsound and asks us to reverse them.

Standard of Review

The Board's standard of review concerning a disputed finding of fact is whether the finding is supported by substantial evidence on the record as a whole. *Guidelines – Appellate Review of Decisions of Administrative Law Judges Affecting a Provider's Participation in the Medicare and Medicaid Programs*, http://www.hhs.gov/dab/divisions/appellate/guidelines/index.html. The Board's standard of review concerning a disputed conclusion of law is whether the conclusion is erroneous. *Id.*

Substantial evidence means "such relevant evidence as a reasonable mind might accept as adequate to support a conclusion." *Richardson v. Perales*, 402 U.S. 389, 401 (1971), *quoting Consolidated Edison Co. v. NLRB*, 305 U.S. 197, 229 (1938). Under the substantial evidence standard, the Board does not re-weigh the evidence or overturn an ALJ's "choice between two fairly conflicting views" of the evidence; instead, the Board determines whether the contested finding could have been made by a reasonable fact-finder "tak[ing] into account whatever in the record fairly detracts from the weight of the evidence" that the ALJ relied upon. *Universal Camera Corp. v. NLRB*, 340 U.S. 474, 488 (1951); *see also Allentown Mack Sales & Service, Inc. v. NLRB*, 522 U.S. 359, 377 (1998); *Golden Living Ctr. – Frankfort*, DAB No. 2296, at 9-10 (2009), *aff'd*, *Golden Living Ctr. – Frankfort v. Sec. of Health & Human Servs.*, No. 10-320 (6th Cir. Aug. 31, 2011).

Discussion

1. *The ALJ erred in overturning CMS's finding that Columbus's noncompliance with 42 C.F.R. § 483.25 from June 4 through June 13, 2007 resulted in immediate jeopardy to one or more residents.*

As indicated, the Board in its prior decision summarily affirmed the ALJ's conclusion that Columbus was noncompliant with 42 C.F.R. § 483.25, which requires a SNF to provide each resident with the care and services necessary to enable the resident to attain or maintain his "highest practicable physical, mental, and psychosocial well-being" in

accordance with the resident's comprehensive assessment and plan of care. The ALJ based that conclusion on his findings concerning Resident 3, which we briefly summarize.

Resident 3 was admitted to Columbus in January 2007. DAB CR2574, at 12. She had late-stage Alzheimer's disease and diagnoses of dementia, depression, myofascial pain, osteoarthritis, anxiety, and psychological pain disorders. *Id.* at 12, 25, 34. Columbus's staff assessed Resident 3 as suffering from pain. *Id.* at 28. An April 2007 pain assessment indicated that Resident 3 had chronic, generalized joint pain due to osteoarthritis, and that this pain was worse in the morning. *Id.* A follow-up assessment dated June 12, 2007 noted increasing complaints of discomfort and pain at different times and in different areas. *Id.* Columbus's nursing staff reported that Resident 3 often moaned or cried out to the staff. *Id.* at 29-30. The record for June 4, 2007, for example, indicates that Resident 3 cried out all night. *Id.* at 30. Similar behavior was noted by the nursing staff to have occurred on June 5, 6, 7, and 14, 2007, and Surveyor Lubick observed the behavior on June 12 and 13, 2007. *Id.* at 31-32. Surveyor Lubick testified that Resident 3 was suffering from "unrelieved" (or unresolved) pain. DAB CR2574, at 49; *see also* Tr. at 47, 48, 52, 67, 81. With respect to her mental distress, Dr. Kraus, Resident 3's treating physician, indicated that she experienced an increase in her agitation, anxiety, and moaning when her anti-anxiety medications were reduced (in April and May 2007). *See* DAB CR2574, at 29-30, 34.

The ALJ rejected Columbus's theory that Resident 3 was not suffering pain, explaining his findings as follows:

> Resident 3's clinical record . . . shows that she had diagnoses that included a psychological pain disorder, myofascial pain, and osteoarthritis. [Columbus] has not presented credible medical evidence that rules out either a psychological pain disorder or myofascial pain syndrome as a basis for pain. The care plan dated February 1, 2007, addressed Resident 3's diagnosis of arthritis, required that the pain be assessed every shift and as necessary; required that Tylenol (Acetaminophen) be administered as ordered; required observation of the resident for non-verbal pain indicators; and established the goals that the resident be pain free or at an acceptable level of pain and able to participate in [activities of daily living] without pain. The care plan was updated on June 6, 2007, with the intervention to use Vicodin as necessary if pain was severe. The care plan was further updated on June 15, 2007, with the intervention to administer narcotics as ordered. The care plan did not include non-pharmocological interventions for pain. However, a Care Conference Checklist dated April 24, 2007,

> indicates that the resident should be repositioned as needed for pain. Thus, not only did Resident 3 have diagnoses that established a medical basis for her pain, [Columbus] had adopted and modified a care plan to address the resident's pain secondary to arthritis. . . . .
>
> The clinical record shows that from the resident's admission in January 2007 to the time of the survey, there were many instances when the resident complained of pain or displayed behaviors consistent with pain, and the resident apparently received relief from pain medications. The record shows Dr. Kraus continued to treat the resident as if she had pain, despite his testimony at hearing that he had come to believe that the resident's calling out and agitation were due to dementia rather than pain. The documents show that prior to the survey he questioned whether the resident's behavior was due to pain or dementia, but he elected to attempt to find an appropriate mix of pain, anti-anxiety, and psychotropic medication. Thus, Dr. Kraus's testimony that the resident's behaviors were due to dementia rather than pain, at least to the extent that he suggested that this was his opinion during and before the survey, is not weighty or persuasive. Dr. Kraus's testimony is also considered not weighty due to his admission that he had not reviewed the resident's record prior to the hearing.

DAB CR2574, at 36-37 (footnotes and citations omitted).

The ALJ also found that prior to the June 2007 survey, Columbus did not "develop[ ] a care plan for addressing [Resident 3's behavior of moaning, yelling, or calling or crying out] or for systematically assessing and tracking the behavior to attempt to distinguish between behaviors due to pain and those due to dementia or some other cause." *Id.* at 28. He further found that "Surveyor Lubick's unrebutted testimony shows that during the survey there were instances when Resident 3 acted as though she might be in pain, but staff did not respond as required by her care plan." *Id.* at 36. The ALJ concluded that Columbus was not in substantial compliance with the quality of care requirement, finding that Resident 3 suffered "actual harm in the form of pain *or* mental distress." *Id.* at 53 (italics added).

At issue here is not whether the facility's failures constitute noncompliance with section 483.25 (the ALJ having already found that they did) but whether CMS's determination that the noncompliance was at the immediate jeopardy level was clearly erroneous, as the ALJ concluded. "Immediate jeopardy" is defined as "a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident." 42 C.F.R. § 488.301. Actual harm is not a prerequisite for an immediate jeopardy finding; immediate jeopardy may exist when the noncompliance is "likely to cause" death or serious injury, harm, or

impairment. *Id.*; *Life Care Ctr. of Tullahoma*, DAB No. 2304, at 58 (2010), *aff'd, Life Care Ctr. of Tullahoma v. Sebelius*, No. 10-3465 (6th Cir. Dec. 16, 2011). CMS's immediate jeopardy finding "must be upheld unless it is clearly erroneous." 42 C.F.R. § 498.60(c)(2); *Maysville Nursing & Rehab. Facility*, DAB No. 2317, at 11 (2010). "The 'clearly erroneous' standard means that CMS's immediate jeopardy determination is presumed to be correct, and the burden of proving the determination clearly erroneous is a heavy one." *Mississippi Care Ctr. of Greenville*, DAB No. 2450, at 14 (2012), *aff'd, Mississippi Care Ctr. of Greenville v. U.S. Dept. of Health & Human Servs.*, No. 12-60420 (Feb. 7, 2013); *see also Yakima Valley School*, DAB No. 2422, at 8 (2011) (citing decisions and stating that the clearly erroneous standard is "highly deferential" and "places a heavy burden on the facility to upset CMS's finding regarding the level of noncompliance").

On appeal, CMS contends that the ALJ did not correctly apply the clearly erroneous standard in concluding that Columbus met its burden to overturn CMS's determination of the level of Columbus's noncompliance with the quality of care requirement. We do not need to address all of CMS's arguments, and we do not necessarily adopt every aspect of CMS's analysis. We do conclude, however, that the ALJ erred in concluding that Columbus met its burden to show that CMS's immediate jeopardy determination was clearly erroneous. The ALJ relies on Dr. Kraus's testimony that, in his opinion, "there was no risk for serious harm or injury or death and there was no potential for more than minimal harm." ALJ Decision at 49. The ALJ suggests that, unlike his testimony on whether Resident 3 suffered any pain, Dr. Kraus's testimony that she did not suffer serious harm or a likelihood of such harm is consistent with the contemporaneous record. This analysis is difficult to reconcile with the ALJ's explanation of why, based on that record, he concluded that Resident 3 suffered actual harm and is otherwise flawed.

First, Dr. Kraus's opinion that Resident 3 was not at risk for more than minimal harm is at odds with the ALJ's conclusion that there was **actual harm.** Second, the ALJ discussed whether Dr. Kraus's opinion was consistent with the contemporaneous record on the issue of whether there was any trauma or any change in Resident 3's **osteoarthritis** that was causing her serious pain, not addressing parts of the record from which CMS could reasonably conclude that immediate jeopardy existed. DAB CR2574, at 35, 38-39, 45, 49. The contemporaneous evidence shows that Dr. Kraus had prescribed medication (Vicodin) for "severe" pain, to be administered when Resident 3 was "moaning" or exhibiting other "indicators" of pain, but the ALJ did not address this evidence. *Id.* at 28, 30. CMS could reasonably infer that Resident 3's pain was severe from the evidence that the physician continued his orders for strong pain-killers during June 2007 and that the staff did sometimes assess the resident as needing the additional medications prescribed to be given as needed for severe pain. The ALJ points to nothing

in the record that undercuts that inference. Columbus presented no testimony from the nurses who gave Resident 3 the medications prescribed as needed for severe pain to establish that they had not observed grimacing or other objective signs of severe pain at the time.

Furthermore, the ALJ did not explain how Dr. Kraus's conclusion that Resident 3's pain from her osteoarthritis was only mild pain is consistent with his prescription of medications for severe pain. But, in any event, even if the ALJ found that her pain from her osteoarthritis was only mild, Dr. Kraus's testimony did not address other possible sources of pain, such as her pressure sores and ill-fitting Theraboots. Moreover, the ALJ himself found that Columbus "has not presented credible medical evidence that rules out either a psychological pain disorder or myofascial pain syndrome as a basis for pain." ALJ Decision at 36. In his contemporaneous note about trying to evaluate Resident 3's behaviors, Dr. Kraus stated only that he was "**not certain** that this patient is experiencing significant pain." P. Ex. 1, at 106 (emphasis added). This certainly indicates that, at the time, he had some reason to believe she **was** experiencing significant pain.

Moreover, Dr. Kraus, in rendering his opinion, did not fully address the actual or probable effects on the resident of the noncompliance the ALJ in fact found. Neither the ALJ nor Dr. Kraus directly addressed whether there was serious harm or the likelihood of serious harm from the facility's failure to systematically evaluate the resident's behaviors. Had Columbus done such an evaluation, it might have more quickly sought to increase the Clonazepam and Seroquel again to address her obvious mental distress and to reduce the symptoms of anxiety and agitation. A more comprehensive approach in the care plan to the non-pharmacological interventions available to address her anxiety and agitation may also have reduced the behaviors. As the ALJ mentioned, there were recorded instances of Resident 3's moaning and crying out for extended periods of time. CMS could reasonably view this as having a serious adverse effect on her quality of life.

Moreover, the fact that staff were not (or at least not consistently) assessing her for objective signs or symptoms of pain according to her care plan means that staff could miss signs of some change in the physical bases for her pain. Before the physician noted he was not certain she had significant pain, staff requested that he order x-rays in recognition that her legs may have been injured. Later, if they failed to assess her pain symptoms per the care plan, they could miss grimacing or other signs of a physical cause for increased pain.

Thus, we conclude that the ALJ erred in determining that Columbus met its burden to show that CMS's immediate jeopardy determination is clearly erroneous, and we reinstate CMS's determination.

2. *We decline to reach the issue of whether Columbus was in substantial compliance with 42 C.F.R. § 483.13(c).*

Section 483.13(c) states that a SNF "must develop and implement written policies and procedures that prohibit . . . neglect" (and other types of mistreatment). "Neglect" means a "failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness." 42 C.F.R. § 488.301. In his decision on remand, the ALJ found that Columbus had "neglected" Resident 3 by failing to provide care and services to (1) address her complaints of pain (the basis for the ALJ's finding that Columbus was noncompliant with section 483.25), (2) prevent pressure sores on her right foot, and (3) prevent the unplanned weight loss she experienced during the first half of 2007. *See* DAB CR2574, at 20. However, the ALJ concluded that these "instances of neglect" were "not sufficient in number or significance to trigger a reasonable inference that [Columbus] failed to implement its policy prohibiting neglect." *Id.* at 14. CMS challenges that conclusion in this appeal. Columbus argues that CMS did not timely allege that that it failed to implement its policy. Even if we concluded that Columbus was noncompliant with section 483.13(c), however, that conclusion would not affect our determination (discussed below) regarding the reasonableness of the CMP for the relevant period. More specifically, a conclusion that Columbus was noncompliant with section 483.13(c) would not cause us to impose a CMP higher than the amounts found reasonable by the ALJ for the relevant periods.

Accordingly, we decline to review the ALJ's conclusion regarding Columbus's compliance with section 483.13(c).

3. *The ALJ's finding that Columbus was in substantial compliance with 42 C.F.R. § 483.10(b)(11)(i)(B) during the August 2007 revisit survey is not supported by substantial evidence in the whole record.*

Section 483.10(b)(11)(i)(B) provides, in relevant part, that a facility must "immediately . . . consult with the resident's physician" when there has been "[a] *significant change in* the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life-threatening conditions or *clinical complications*)" (italics added). CMS's official interpretation of section 483.10(b)(11)(i)(B) is set out in Appendix PP to CMS's State Operations Manual (SOM).[1] *See Stone County Nursing & Rehab. Ctr.*, DAB No. 2276, at 5-6 & n.3 (2010).

[1] Appendix PP to the State Operations Manual is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf.

In relevant part, Appendix PP states:

> For purposes of § 483.10(b)(11)(i)(B), life-threatening conditions are such things as a heart attack or stroke. *Clinical complications* are such things as development of a stage II pressure sore, onset or recurrent periods of delirium, recurrent urinary tract infection, or onset of depression. . . .

SOM (CMS Pub. 100-07), App. PP (interpretive guidelines for tag F157) (italics added).

Based on survey findings and other evidence, CMS alleged that Resident 2 experienced a "significant change" in health status on August 9, 2007, requiring Columbus to consult immediately with a physician, but that Columbus did not do so. CMS Ex. 60, at 1-7. There is no apparent dispute about the relevant facts, which the Board summarized in its 2011 decision:

> R2 [Resident 2] was diagnosed with multiple sclerosis and suffered from severe contractures. R2 had a history of urosepsis and septic shock. On August 9, 2007 at 12:30 pm, the nursing staff documented that R2 had a two by one centimeter hard, rough mass protruding from the vaginal opening one centimeter that was "grey in color, painful [with] slight touch," and a white discharge was noted. [Nursing notes refer to the discharge as "yellow, white," and also indicate that there was a "foul odor" associated with the discharge. DAB CR2574, at 85 (citing CMS Ex. 68, at 4).] At 1:35 pm, facility staff called R2's physician about the mass and left a message with the physician's nurse, but they did not follow up on that call. That evening R2 refused her evening meal, which was not uncommon for her, and she had no complaints of pain or discomfort. The next morning, R2 was assessed with a temperature and the on-call physician was notified at 9:45 am about the mass, elevated temperature and R2's refusal of food and fluids. The physician ordered R2 sent to the emergency room. At the emergency room, a vaginal examination was deferred due to R2's excruciating discomfort from trying to position her for examination. The emergency room physician determined that sedation to examine R2 was required; after sedation, the mass was extracted from R2's vagina. The physician ordered intravenous antibiotics due to a severe urinary tract infection (UTI) and to avoid any complications due to the mass. R2 was discharged from the hospital the following day and returned to the facility.

DAB No. 2398, at 13-14 (citations omitted).

In his initial decision, the ALJ found that Resident 2 did not experience a significant change in status on August 9, 2007. DAB CR2241, at 52. The ALJ found that Resident 2 "manifested signs and symptoms consistent with a possible infection" *on August 10*, at which point the "nursing staff immediately consulted with the on-call physician who ordered that the resident be sent to the emergency room for treatment." *Id.* For these reasons, the ALJ concluded that the facility was in substantial compliance with section 483.10(b)(11)(i)(B). *Id.*

The Board determined that the analysis supporting that conclusion was "incomplete [in part] because it [did] not specifically address whether the presence of the mass was a significant change in physical status and failed to discuss whether the evidence (such as the staff notation of four odor and yellow-white discharge) showed signs of infection" *on August 9, 2007*, necessitating immediate physician consultation on that date. DAB No. 2398, at 14. On remand, the ALJ found that his analysis was, in fact, "complete and correct" but that he had not "show[n] all [his] work[.]" DAB CR2574, at 82. He expressly found that the circumstances observed and recorded by the nursing staff on August 9 did not reveal a significant change that required immediate physician consultation. *Id.* at 85.

That finding is not supported by substantial evidence in the record as a whole. The presence of the mass in Resident 2's vagina was manifestly abnormal (and arguably a "clinical complication" in itself, though we do not reverse the ALJ's conclusion on that basis alone). More importantly, Surveyor Ann Angell testified that the yellow-white discharge and foul odor associated with the mass were signs of possible infection. Tr. at 542-47, 549. For some residents, a sign of a potential infection might require only continued close monitoring of the resident's clinical signs or symptoms, but as Surveyor Angell (a registered nurse) testified, Resident 2 was susceptible to infection and had a history of urosepsis (bacterial infection which starts in the urinary tract and which spreads to the bloodstream) and septic shock (a potential, life-threatening complication of infection). Tr. at 546-47. Columbus's own administrator acknowledged the risk, testifying that a urinary tract infection would not be an unusual or unexpected occurrence for Resident 2 due to her neurogenic bladder and suprapubic catheter. Tr. at 844-47. The Board has recognized that a determination of what constitutes a significant change may involve the exercise of a nurse's professional judgment. *See Universal Healthare/King*, DAB No. 2215, at 17 (2008), *aff'd*, *Universal Healthcare/King v. Sebelius*, No. 09-1093 (4th Cir. 2009). Yet, Columbus offered no evidence that any of its nursing staff who were aware of the findings related to the discovery of the mass, in fact, exercised professional judgment on August 9 to determine that immediate physician consultation was unnecessary despite the risk of infection and related complications.

The ALJ set out a lengthy analysis of this compliance issue on remand. We agree with CMS that his analysis ignores – or at minimum fails to evaluate the significance of – the unrebutted evidence of Resident 2's infection risk. The determination of whether an observed change in health status is "significant" within the meaning of section 483.10(b)(11)(i)(B) should account for all of a resident's pertinent clinical circumstances, including the magnitude of any risk of harm to the resident from a delay in consulting with the physician (or delaying a potentially necessary change in treatment). *Cf. Western Care Mgmt. Corp.*, DAB No. 1921 (2004) (sustaining a finding of noncompliance with section 483.10(b)(11)(i)(B) based on evidence that certain skin changes were "significant" in light of the resident's "susceptibility to skin infections").

The ALJ did not find that Surveyor Angell was not a credible witness, but found that her testimony was not "weighty" for several reasons, including that she was not aware of certain facts regarding the resident, such as that it was not uncommon for the resident to refuse to eat and that the nausea she had complained of a few days before the mass was discovered was attributed to a new nutritional supplement. The ALJ also discounted her testimony, however, because it was "not based upon either the regulatory definition [of significant change] or the SOM explanation of the regulatory standard discussed hereafter." DAB CR2574, at 83. According to the ALJ, Surveyor Angell "did not understand the regulatory standard or the SOM guidance when citing the deficiency, which further undermines the weight of her opinions and conclusions." *Id.* at 83-84. As CMS points out, however, Surveyor Angell testified on cross-examination that the standard she was applying was whether the change in Resident 2's condition was "significant." Tr. at 579, 583. But, in any event, the ALJ did not explain how any misunderstanding of the legal standard the surveyor may have had casts doubt on the truth or value of her testimony concerning factual issues within her area of competence (the practice of nursing), specifically the foul odor and discharge as possible signs of infection and the potentially serious consequences of any infection for Resident 2, given her history of urosepsis and septic shock. Her testimony on these factual issues was not questioned or undercut by anyone with medical or nursing knowledge or training.

In support of his ultimate conclusion, the ALJ pointed to the testimony of Roberta Messer, Columbus's administrator (and a registered nurse), and Mary Widner, Vice-President for Clinical Services for Columbus's parent organization. DAB CR2574, at 82. Neither witness was present at the time when the mass was discovered and the nursing staff decided to notify Resident 2's physician. Although these witnesses testified, in essence, that Resident 2's condition did not require immediate physician consultation, the testimony of the first witness was premised on her view that the problem was the resident's contractions, which were a chronic condition, and the testimony of the second witness was premised on her view that the mass was not a change of condition because it "must have been there for a while." Tr. at 844-47, 987. Neither witness indicated that her opinion reflected an assessment of Resident 2's infection risk and history of infection-related complications. Indeed, nothing in their testimony indicates they were

even aware of the presence of the foul odor and discharge. Thus, their testimony is simply not probative on the issue of whether the presence of the foul odor and discharge was a significant change, and the ALJ could not reasonably consider it an adequate rebuttal of Surveyor Angell's testimony on this issue, even if he did not give much weight to her opinion.

The ALJ also found that "[t]he [hospital] records related to the procedure to remove the mass and the follow-up with antibiotics to treat a urinary tract infection, do not describe a life threatening situation or clinical complications similar in magnitude to the illustrations of those phrases used by CMS in the SOM." DAB CR2574, at 87. The ALJ omitted to mention, however, that the examples of "clinical complications" in CMS's interpretive guidelines (which are not exclusive in any event) do include a "recurrent urinary tract infection." The urinary tract infection for which Resident 2 began treatment on August 10 was plainly "similar in magnitude" to a recurrent infection because it occurred in a vulnerable resident with a history of, or susceptibility to, urinary tract infections and their complications (urosepsis and septic shock).

Given Resident 2's history of and susceptibility to urinary tract infections and potentially life-threatening septic shock, we hold that the presence of the vaginal mass with signs of infection on August 9 constituted a significant change in Resident 2's status. Columbus was therefore obligated to consult immediately with a physician about that change. The requirement to "consult immediately" means a SNF must "engage in a dialogue with the physician about an appropriate response to the significant change" as soon as the change is detected and "without any intervening interval of time." *Life Care Ctr. of Tullahoma* at 7 (2010); *Magnolia Estates Skilled Care*, DAB No. 2228, at 9 (2009). No such dialogue occurred on August 9. Although nursing records show that Columbus's nursing staff phoned and left a message with Resident 2's physician on around 1:00 p.m. on August 9, the physician did not return the call, and there is no evidence that the staff made additional, reasonable efforts to reach the physician that day. *See Life Care Ctr. of Tullahoma* at 19 (holding that section 483.10(b)(11)(i)(B) requires a SNF to make "diligent efforts" to contact and consult with the physician). The noncompliance resulting in this delay had the potential for more than minimal harm to Resident 2 as evidenced by the fact that she had a severe urinary tract infection by the time she was hospitalized.

We therefore conclude that Columbus was not in substantial compliance with section 483.10(b)(11)(i)(B) during the August 2007 revisit survey.

4. *Columbus was in a state of noncompliance with a Medicare participation requirement from August 3 through September 4, 2007, and thus the remedies imposed by CMS for that period must be reinstated.*

Our conclusion that Columbus was not in substantial compliance with section 483.10(b)(11)(i)(B) requires that we modify the ALJ's finding about the duration of Columbus's noncompliance and reinstate certain remedies imposed by CMS. As indicated, violations of section 483.10(b)(11)(i)(B) were found during both the June 2007 recertification survey and the August 2007 revisit survey. CMS Ex. 13, at 1; CMS Ex. 60, at 1. CMS determined that after the June 2007 survey, Columbus did not come into substantial compliance with all requirements – including section 483.10(b)(11)(i)(B) – until September 5, 2007. CMS Ex. 3. The ALJ found that Columbus had corrected its deficiencies sooner and that it was in substantial compliance with all requirements on August 3, 2007. DAB CR2574, at 76-77. However, in light of our conclusion that Columbus remained noncompliant with section 483.10(b)(11)(i)(B) after August 3, 2007, the ALJ's finding that Columbus was back in substantial compliance with all requirements on that date cannot stand. Accordingly, we vacate the ALJ's finding that Columbus's noncompliance ceased on August 3, 2007 and conclude that Columbus remained in a state of noncompliance from August 3 through September 4, 2007.

The remedies that CMS imposed on Columbus for the period August 3 through September 4, 2007 were a $200 per-day CMP and a denial of payment for new admissions (DPNA). CMS Ex. 3.[2] The regulations authorize CMS to impose these types of remedies for the number of days that a SNF is not in substantial compliance. 42 C.F.R. §§ 488.417, 488.430. Because Columbus was not in substantial compliance from August 3 through September 4, 2007, CMS lawfully imposed a CMP and DPNA for that period, and we therefore reinstate those remedies.

5. *The ALJ did not err in concluding that the $8,800 per-day CMP imposed by CMS for the immediate jeopardy period was unreasonable and that a $3,050 per-day CMP was reasonable for that period.*

The final issue in this appeal concerns the $8,800 per-day CMP that CMS imposed on Columbus for the immediate jeopardy period (June 4 through June 13, 2007). When CMS imposes a per-day CMP for noncompliance at the immediate jeopardy level, it must set the CMP amount within the "upper range" of $3,050 to $10,000 per day.[3] 42 C.F.R. §§ 488.408(d)(3)(ii), 488.438(a)(1)(i). When appealing a finding of noncompliance, a SNF may also contend (as Columbus did before the ALJ), that the amount of the CMP

[2] The reasonableness of the amount of the $200 per-day CMP is not at issue.

[3] A per-day CMP for noncompliance below the immediate jeopardy level must be set within the "lower range" of $50 to $3,000 per day. 42 C.F.R. §§ 488.408(d)(1)(iii), 488.438(a)(1)(ii).

imposed for that noncompliance was unreasonable in light of its seriousness and other factors. *See Lutheran Home at Trinity Oaks*, DAB No. 2111, at 21 (2007); *Capitol Hill Community Rehab. & Specialty Care Ctr.*, DAB No. 1629, at 5 (1997). An ALJ who accepts that contention may reduce the CMP but not below the applicable regulatory minimum. 42 C.F.R. § 488.438(e)(1); *Somerset Nursing & Rehab. Facility*, DAB No. 2353, at 26-27 (2010).

An ALJ determines de novo whether the amount of a CMP is reasonable based on facts and evidence in the appeal record concerning the factors specified in section 488.438. *See* 42 C.F.R. § 488.438(e), (f); *Senior Rehab. & Skilled Nursing Ctr.*, DAB No. 2300, at 19-20 (2010), *aff'd, Senior Rehab. & Skilled Nursing Ctr. v. Health & Human Servs.*, 405 F. App'x 820 (5th Cir. 2010); *Lakeridge Villa Healthcare Ctr.*, DAB No. 2396, at 14 (2011). Those factors are: (1) the severity and scope of the noncompliance, and "the relationship of the one deficiency to other deficiencies resulting in noncompliance"; (2) the SNF's degree of culpability for the noncompliance; (3) the SNF's "history of noncompliance, including repeated deficiencies"; and (4) the SNF's financial condition – that is, its ability to pay a CMP. 42 C.F.R. §§ 488.438(f), 488.404(b), (c)(1). Regarding a SNF's financial condition, the Board has stated that "the correct inquiry . . . is whether the facility has adequate assets to pay the CMP without having to go out of business or compromise resident health and safety." *Gilman Care Ctr. (Gilman)*, DAB No. 2357, at 7 (2010) (internal quotations marks omitted). Before the ALJ, the burden of proof was on Columbus to prove its inability to pay the CMP by the preponderance of the evidence. *Western Care Mgmt. Corp.* at 91, *citing* 59 Fed. Reg. 56,116, 56,204 (Nov. 10, 1994).

CMS imposed the $8,800 per-day CMP based on what it found to be Columbus's immediate-jeopardy-level violations of sections 483.13(c), 483.25, 483.25(c), and 483.25(i)(1). In his first decision, the ALJ found that $8,800 per day was an unreasonable amount in light of his conclusion that Columbus had not violated section 483.13(c) and his finding that the noncompliance with section 483.25 was below the immediate jeopardy level. DAB CR2241, at 53. The ALJ then selected a daily amount that he thought reasonable based on the applicable regulatory factors, including Columbus's financial condition. *Id.* at 53-54. With respect to that factor, the ALJ found credible the testimony of Martin Metten, executive vice president and chief financial officer of Heyde Companies (a holding company for the limited liability company that owns and operates Columbus). *Id.* at 58; *see also* Tr. at 877. The ALJ indicated that he had also considered evidence of Columbus's history of noncompliance and its culpability for the deficiencies that affected Resident 3. DAB CR2241, at 58. The ALJ concluded that $3,050 per day was a reasonable amount in light of the evidence relating to the regulatory factors. *Id.*

In vacating that conclusion, the Board found that the ALJ had made inadequate findings regarding Columbus's financial condition and other issues and instructed the ALJ to make additional findings on remand. DAB No. 2398, at 15-18. On remand, the ALJ reaffirmed his decision to reduce the per-day CMP for the immediate jeopardy period from $8,800 per day to $3,050 per day (the regulatory minimum). DAB CR2574, at 93-100. In doing so, he discussed the seriousness and relationship among the deficiencies that were found to exist during the immediate jeopardy period. *Id.* at 98. He also found that Columbus "was culpable for its noncompliance related to Resident 3." *Id.* In addition, the ALJ discussed evidence of Columbus's history of noncompliance – namely, Board decisions from 2009 which affirmed noncompliance determinations against Columbus. *Id.* at 99 (mentioning Board decisions 2273 and 2247). The ALJ also reviewed, in greater detail than he had before, the evidence of Columbus's financial condition. *Id.* at 97-98. He found that Mr. Metten's testimony, which was based on his knowledge of the state of Columbus's finances during 2007 and 2008, was "relevant, credible, and unrebutted by CMS." *Id.* at 98. The ALJ further found that $57,500 – the difference between the total CMP amount accrued at $8,800 per day and the total accrued at $3,050 per day – "would have a serious negative impact upon Petitioner's ability to pay staff and vendors, to the extent that Petitioner could no longer sustain business operations." *Id.* at 99. He concluded that Columbus had "met its burden to show by a preponderance of the evidence its financial condition and that its financial condition would be adversely impacted by a CMP." *Id.* at 98. Finally, the ALJ discussed the "relative weight" of the relevant regulatory factors, concluding that he "would not hesitate to impose a daily CMP at the maximum amount" based on the other relevant factors, but that he concluded that a CMP of no more than $3,050 was reasonable, given the evidence of Columbus's financial condition. *Id.* at 99-100.

CMS's appeal focuses largely on the ALJ's findings regarding Columbus's financial condition. *See* RR at 30-38. CMS contends that Mr. Metten's testimony was insufficient as a matter of law to demonstrate Columbus's inability to pay the CMP, asserting that a "facility's burden to prove that payment of the CMP would put it out of business cannot be sustained by mere testimony." RR at 34-35. CMS points to nothing in the applicable regulations or their history indicating that an ALJ is precluded from considering testimony on financial condition, but asserts that "[o]ral testimony [concerning a facility's financial condition] is inherently self-serving," and that Columbus needed (but failed) to submit documentation of its finances to corroborate Mr. Metten's testimony. *Id.* at 33, 35 n.16. CMS also contends that it had no effective means to verify or rebut the truth of Mr. Metten's testimony because the financial or accounting information it needed for that purpose "was not available" (being "proprietary to the facility") and was "within the control of [Columbus]." *Id.* at 34. In addition, CMS contends that it "was deprived of the opportunity to meaningfully cross-examine Mr. Metten about his opinion that payment of the CMP would put the facility out of business because it did not have the documents from 2007 and 2008 . . . upon which [the] witness's opinion was based." *Id.* at 33.

We note that, in its post-hearing briefs, CMS did not argue that witness testimony was insufficient as a matter of law to meet Columbus's burden of proof; instead, CMS argued that Mr. Metten's testimony deserved little "weight" because the information he provided was incomplete or inadequate to demonstrate an inability to pay the CMP and because that information was "uncorroborated with any documents such as certified financial statements." CMS Post-Hearing Br. at 25-29. CMS also could have raised (but did not raise) any due process concerns or otherwise complain, either at the hearing or in its post-hearing briefs, that Columbus's failure to produce financial records deprived CMS of a meaningful opportunity to cross-examine Mr. Metten. Had those issues been raised below, the ALJ might have taken appropriate measures to address CMS's concerns.

In any event, contrary to what CMS suggests, the ALJ did not rely solely on Mr. Metten's testimony. His testimony regarding the facility's losses in 2006 was corroborated by CMS's own exhibit, and CMS conceded the amount of the substantial losses in 2007 and 2008. CMS Ex. 5; Reply Br. at 18-19. Also, contrary to what CMS suggests, nothing in *Gilman* or other Board decisions on financial condition suggests that **only** assets are relevant in evaluating a facility's ability to pay a CMP. The ALJ properly considered the nature of Columbus's assets (which were primarily accounts receivables), as well as its liabilities, cash position, and its ability to borrow. Moreover, CMS points to no compelling reason to overturn the ALJ's credibility determination with respect to Mr. Metten's testimony or the weight the ALJ accorded to that testimony. *Koester Pavilion*, DAB No. 1750, at 15, 21 (2000) (holding that the Board defers to an administrative law judge's findings on credibility of witness testimony unless there are compelling reasons not to do so).

CMS also contends that the ALJ was required to draw an inference adverse to Columbus from its alleged "failure to produce documents under its own control" relating to its financial condition, *citing International Union, UAW v. NLRB*, 459 F.2d 1329, 1339 (1972). RR at 35-36. That case does not support CMS's contention. The court in that case recognized that whether to draw such an inference is generally a "matter of discretion," concluding that such an inference should have been drawn in that case because of the particular circumstances, including a party's failure to comply with a subpoena, even though its motion to quash the subpoena had been denied. Here, in his decision on remand, the ALJ determined that no inference "should be drawn" because CMS had not moved for production of any documents. DAB CR2574, at 97 n.38. CMS contends that this is an inadequate reason not to draw the inference because a "motion for production of documents" is a discovery tool and because the regulations governing hearings on CMS program determinations – 42 C.F.R. Part 498 – do not expressly provide for the use of pre-hearing discovery. RR at 36. The ALJ did not rely on the regulations as authorizing discovery, instead citing section 1128A of the Social Security Act. Contrary to CMS's narrow view of the ALJ's authority, moreover, the Part 498

regulations expressly authorize CMS to request, and the ALJ to issue, a subpoena for documents if such a measure is "necessary for the full presentation of a case." 42 C.F.R. § 498.58. Here, CMS does not allege even that it made an informal request to Columbus for its financial records, much less that it sought a subpoena for those records.

We do not suggest that absent CMS's request for financial records, by subpoena or otherwise, we would not uphold an ALJ finding that witness testimony without supporting financial documents was insufficient to meet the facility's burden on financial condition. Indeed, the Board has upheld ALJs who have found witness testimony without such documentation insufficient to meet that burden. *See, e.g., Oaks of Mid City Nursing and Rehab. Ctr.*, DAB No. 2375, at 19 (2011) (rejecting the SNF's contention, based on testimony of the parent company's president, that it was unable to pay the CMP and noting that the SNF "proffered no financial statements or business records to back up its claim of destitution"). We recognize that the facility generally has control over documents that support or undercut such testimony, and requiring the facility to come forward with that evidence is not unreasonable and, in some cases, might even be the most reasonable course of action. However, in this case, CMS has not shown that the absence of such supporting documents **alone** is a sufficient reason to overturn either the ALJ's acceptance of Mr. Metten's testimony or the weighing of the record evidence as a whole on the regulatory factors.

CMS also contends, however, that regardless of Mr. Metten's testimony about Columbus's financial condition during 2007 and 2008, Columbus will be able to pay the CMP when this administrative proceeding becomes "final." RR at 36. CMS prefaces that contention by stating that the ALJ should not have considered evidence of Columbus's "losses" during 2007 and 2008 "because they were for years beyond the time frame considered by CMS." RR at 36. CMS then mentions *Gilman*, in which the Board stated that it would "seem" appropriate to consider a SNF's financial condition at the time the "administrative action is final" given that the purpose of that inquiry is to determine whether payment of the CMP would drive the SNF out of business. RR at 36-37; *Gilman* at 9 n.5. In light of this statement in *Gilman*, CMS asks the Board to admit into the record and to consider Columbus's Medicare cost report for 2011, which, CMS says, shows that Columbus will be able to pay the CMP when the administrative action becomes final. RR at 35-37.

The Board "may" admit evidence on appeal. 42 C.F.R. § 498.86(a). For the following reasons, however, we decline to admit additional information about Columbus's financial condition or to address further the issue of what timeframe an ALJ may or must consider in assessing financial condition. First, CMS erroneously assumes that the Board in *Gilman* resolved the issue about the appropriate timeframe. The Board did not, in fact, resolve the issue, and said so. *See* DAB No. 2357, at 9 n.5 (stating that "[w]e need not finally resolve this question"). Second, we do not need to resolve here whether the ALJ should have considered only evidence about financial condition at the time CMS imposed

the CMP (September 2007). CMS does not argue that a holding that the relevant period is September 2007 would make a difference here. Moreover, the evidence the ALJ considered included unrebutted evidence from 2007 showing substantial financial losses and other pertinent information.

In any event, CMS did not pursue the issue regarding the relevant time period during the ALJ proceeding. CMS interposed an objection at the hearing to Mr. Metten's testimony on the ground that it should be confined to Columbus's financial condition at the time CMS imposed the CMP (September 2007). Tr. at 882-83. Yet, CMS did not act on the ALJ's invitation to discuss the issue in its post-hearing briefs. CMS argued in those briefs that Mr. Metten's testimony failed to demonstrate an inability to pay the CMP but did not assert that financial information for certain years was irrelevant. CMS's Post-Hearing Br. at 25-29; CMS's Post-Hearing Reply Br. at 28-30. In addition, we note that CMS has not articulated a consistent or clear position on the issue. At the hearing, CMS indicated that the ALJ could consider evidence of Columbus's financial condition *at the time CMS imposed the CMP*, which was September 2007 (a year about which Mr. Metten testified). Tr. at 882. However, in its appeal brief, CMS suggests that the ALJ should have confined its analysis to the *time period that CMS actually considered* in setting the CMP amount, and that *both 2007 and 2008* were beyond that time period. RR at 36 (asserting that evidence of Columbus's losses in 2007 and 2008 should not have been considered). We see no need to address here an issue that CMS not only abandoned below but on which CMS has not articulated a consistent position.

We have carefully considered all of CMS's other contentions regarding Columbus's financial condition, none of which merit discussion. We also reject CMS's argument that the ALJ gave insufficient weight to relevant factors other than financial condition (such as Columbus's history of noncompliance) in deciding what CMP amount was reasonable for the immediate jeopardy period. This argument ignores the ALJ's statement that, but for the financial condition, he would have upheld a CMP amount even higher than the amount imposed. Giving greater weight to the history of noncompliance and other factors thus would not have made a difference to his decision on remand.

Accordingly, we uphold the ALJ's determination to reduce the CMP amount to $3,050 per day.

Conclusion

For the reasons stated above, we (1) reverse the ALJ's conclusion that CMS's immediate jeopardy determination regarding the facility's noncompliance with 42 C.F.R. § 483.25 was clearly erroneous and therefore reinstate that determination; (2) reverse the ALJ's conclusion that Columbus was in substantial compliance with 42 C.F.R. § 483.10(b)(11)(i)(B) during the August 2007 revisit survey and reinstate CMS's determination that Columbus was not in substantial compliance with that requirement; (3)

conclude that Columbus was not in substantial compliance with Medicare participation requirements from August 3 through September 4, 2007 and, thus, reinstate CMS's determination of noncompliance for that entire period; and (4) reinstate the DPNA and $200 per-day CMP that CMS had imposed for the period August 3 through September 4, 2007; and (5) uphold the ALJ's reduction of the CMP amount to $3,050 per day for the immediate jeopardy period.

/s/
Stephen M. Godek

/s/
Sheila Ann Hegy

/s/
Judith A. Ballard
Presiding Board Member