Department of Health and Human Services
DEPARTMENTAL APPEALS BOARD
Appellate Division

Dumas Nursing and Rehabilitation, L.P.
Docket No. A-10-72
Decision No. 2347
December 3, 2010

FINAL DECISION ON REVIEW OF ADMINISTRATIVE LAW JUDGE DECISION

Dumas Nursing and Rehabilitation, L.P. (Dumas), a Texas skilled nursing facility (SNF), appeals the May 4, 2010 decision of Administrative Law Judge (ALJ) Carolyn Cozad Hughes, *Dumas Nursing and Rehabilitation, L.P.*, DAB CR2127 (2010) (ALJ Decision). At issue before the ALJ was a determination by the Centers for Medicare & Medicaid Services (CMS) that Dumas was not in substantial compliance with several Medicare participation requirements. The most serious allegations of noncompliance concern the response of Dumas's nursing staff to Resident 1's episode of respiratory distress on February 27, 2009.

Based on the undisputed facts related to the February 27 incident involving Resident 1 and other undisputed facts, the ALJ granted CMS's motion for summary judgment, concluding that Dumas was noncompliant with Medicare participation requirements from February 27 through April 16, 2009. The ALJ also upheld CMS's determination that Dumas's noncompliance had placed residents in "immediate jeopardy" from February 27 through March 13, 2009. In addition, the ALJ sustained the civil money penalties that CMS had imposed on Dumas for the alleged noncompliance.

For the reasons below, we affirm the ALJ Decision.

Legal Background

In order to participate in Medicare, a SNF must comply with the participation requirements in 42 C.F.R. §§ 483.1-483.75. Compliance with these requirements is verified by nursing home surveys conducted by state health agencies. 42 C.F.R. Part 488, subpart E. Survey findings are reported in a document called a Statement of Deficiencies. A "deficiency" is "any failure to meet a participation requirement." 42 C.F.R. § 488.301.

CMS may impose enforcement remedies on a SNF if it determines, on the basis of survey findings, that the facility is not in "substantial compliance" with one or more participation requirements. 42 C.F.R. § 488.402(b). Under the regulations, the term "noncompliance" means "any deficiency that causes a facility to not be in substantial compliance." 42 C.F.R. § 488.301. A facility is not in substantial compliance when it has a deficiency that creates the potential for more than minimal harm to one or more residents. *Id.* (defining "substantial compliance" to mean the "level of compliance with the requirements of participation such that any identified deficiencies pose no greater risk to resident health or safety than the potential for causing minimal harm").

The remedies that CMS may impose for a SNF's noncompliance include per-day civil money penalties (CMPs). 42 C.F.R. § 488.408(b). When CMS elects to impose a CMP, it sets the CMP amount based on, among other factors, the "seriousness" of the SNF's noncompliance. 42 C.F.R. §§ 488.404(b), 488.438(f). "Seriousness" is a function of the deficiency's "severity" (whether it has created a "potential for harm," resulted in "actual harm," or placed residents in "immediate jeopardy") and "scope" (whether it is "isolated," constitutes a "pattern," or is "widespread"). 42 C.F.R. § 488.404(b); State Operations Manual (SOM), CMS Pub. 100-07, App. P, sec. IV.[1]

The most severe noncompliance is that which puts one or more residents in "immediate jeopardy." *See* 42 C.F.R. §§ 488.404 (setting out the levels of scope and severity that CMS considers when selecting remedies), 488.438(a) (authorizing the highest CMPs for immediate jeopardy); SOM § 7400.5.1. If a per-day CMP is imposed for immediate jeopardy-level noncompliance, the CMP must be set within the range of $3,050 to $10,000 per day. 42 C.F.R. §§ 488.408(d)(3)(ii), 488.438(a)(1)(i).

Case Background

The Texas Department of Aging and Disability Services (state survey agency) performed a compliance survey of Dumas from March 7 through March 16, 2009 and later issued a Statement of Deficiencies (SOD) containing its survey findings. *See* CMS Ex. 1-3. The SOD sets out seven deficiency citations, four of which concern the following incident:

> On 2/27/09, Resident #1, a resident with a tracheostomy, experienced an incident of respiratory distress. LVN "B" [Nurse B], who was the only nurse on duty, failed to immediately respond to requests to assist Resident #1, failed to assess Resident #1, and failed to remain with Resident #1 during her time of respiratory distress. [Nurse B] instead left Resident #1 in the care of two nurse aides and a medication aide to call 911. [Nurse B] did not return to Resident #1's room until after EMS arrived and had assumed care of Resident #1. Approximately 10 minutes elapsed between

[1] The SOM is available on CMS's website at http://www.cms.hhs.gov/Manuals/IOM/ list.asp.

> the time staff first notified [Nurse B] of Resident #1's change in condition and the arrival of EMS. Resident #1 was transferred by ambulance to a local hospital.

CMS Ex. 3, at 44-45.

Based largely on this incident, the state survey agency cited Dumas for noncompliance with the participation requirements in 42 C.F.R. §§ 483.13(c), 483.13(c)(2)-(4), 483.20(k)(3)(i), and 483.25(k). CMS Ex. 3, at 10-11, 25-26, 44, 63, 83-84. The state survey agency also determined that Dumas's noncompliance with these requirements placed residents in immediate jeopardy from February 27 through March 13, 2009, and that the noncompliance continued at a lower level of severity after March 13. *Id.* at 10-12, 25-26, 28, 44-45, 63-64, 82-84. In addition, based on findings unrelated to Resident 1, the state survey agency cited Dumas for noncompliance with sections 483.13(a), 483.25(h), and 483.75(l). *Id.* at 1-2, 78, 103-04. In July 2009, the state survey agency determined that Dumas had come back into substantial compliance with all requirements as of April 17, 2009. CMS Ex. 2, at 1.

Concurring with the March 2009 survey findings, CMS imposed the following remedies on Dumas: a $7,050 per-day CMP from February 27 through March 13, 2009; and a $700 per-day CMP from March 14 through April 16, 2009. CMS Ex. 2, at 1, 4.

Dumas requested a hearing before the ALJ to contest the deficiency citations and the resulting CMPs. CMS responded with the motion for summary judgment, which the ALJ granted.

The ALJ Decision

In granting CMS's motion for summary judgment, the ALJ first sustained the deficiency citations that alleged noncompliance with section 483.13(a) (governing use of physical restraints), section 483.25(h) (obligating a SNF to keep the facility free of accident hazards and to adequately supervise residents to prevent accidents), and section 483.75(l) (imposing standards for maintaining clinical records). ALJ Decision at 3. The ALJ found that Dumas had "waived" any challenge to those citations by failing to address them in its response to CMS's motion for summary judgment. *Id.*

The ALJ then turned to the deficiency citations stemming from the February 27, 2009 incident involving Resident 1. Based on what she found to be undisputed facts concerning that incident and its aftermath, the ALJ concluded that Dumas:

- was noncompliant with section 483.13(c) because it "did not implement its policies and procedures that prohibit resident neglect" (ALJ Decision at 11);

- was noncompliant with section 483.13(c)(2)-(4) because it failed to investigate whether Resident 1 was a victim of "neglect" on February 27, 2009 (*id.* at 14).
- was noncompliant with section 483.20(k)(3)(i) because the nursing care furnished to Resident 1 on February 27, 2009 did not meet professional standards of quality (*id.* at 8-9); and
- was noncompliant with section 483.25(k) because it failed to ensure that Resident 1 received proper treatment and care for her tracheostomy and respiratory distress on February 27, 2009 (*id.* at 11).

The ALJ also concluded that Dumas was noncompliant with sections 483.20(k)(3)(i) and 483.25(k) on March 7, 9, 10, and 11 because nursing staff did not use sterile techniques to perform tracheal suctioning, failed to comply with a physician order concerning the care of Resident 1's tracheostomy tube, and falsified a treatment record concerning tracheostomy care. ALJ Decision at 12-13.

In addition, the ALJ sustained, as being not clearly erroneous, CMS's determination that Dumas's noncompliance with sections 483.13(c), 483.13(c)(2)-(4), 483.20(k)(3)(i), and 483.25(k) was at the level of immediate jeopardy from February 27 through March 13, 2009. ALJ Decision at 15-16. Finally, the ALJ concluded that the per-day CMP amounts imposed by CMS – $7,050 per day for the period of immediate jeopardy, and $700 per day for the post-immediate-jeopardy period of noncompliance (March 14 through April 16, 2009) – were reasonable. *Id.* at 16-18.

The Summary Judgment Standard

Summary judgment is appropriate when the record shows that there is no genuine issue as to any material fact, and the moving party is entitled to judgment as a matter of law.[2] *Kingsville Nursing and Rehabilitation Center*, DAB No. 2234, at 3 (2009) (*citing Celotex Corp. v. Catrett*, 477 U.S. 317, 322-25 (1986)). The party moving for summary judgment bears the initial burden of demonstrating that there are no genuine issues of material fact for trial and that it is entitled to judgment as a matter of law. *Id.* To defeat an adequately supported summary judgment motion, the non-moving party may not rely on the denials in its pleadings or briefs, but must furnish evidence of a dispute concerning a material fact – a fact that, if proven, would affect the outcome of the case under governing law. *Id.*; *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 248 (1986).

[2] Although the Federal Rules of Civil Procedure (FRCP) are not binding in this administrative appeal, the Board is guided by those rules and by judicial decisions on summary judgment in determining whether the ALJ properly granted summary judgment. *See Thelma Walley*, DAB No. 1367 (1992). Consistent with published Civil Remedies Division procedures, the ALJ told the parties that she would rely on the principles of FRCP 56 in deciding any motion for summary judgment. Acknowledgment and Initial Pre-Hearing Order at 4-5; *Civil Remedies Division Procedures* (eff. July 6, 2009), ¶ 7 (available at http://www.hhs.gov/dab/divisions/civil/procedures/divisionprocedures.html).

In determining whether there is a genuine dispute of material fact, the tribunal must view the evidence in the light most favorable to the non-moving party, drawing all reasonable inferences in that party's favor. *U.S. v. Diebold, Inc.*, 369 U.S. 654, 655 (1962). In addition, it is appropriate for the tribunal to consider whether a rational trier of fact could regard the parties' presentations as sufficient to meet their evidentiary burdens under the relevant substantive law. *Anderson v. Liberty Lobby*, 477 U.S. at 255 ("in ruling on a motion for summary judgment, the judge must view the evidence presented through the prism of the substantive evidentiary burden"); *Wade Pediatrics*, DAB No. 2153, at 17 n.7 (2008) ("While the non-moving party does not have to prove its case to avoid summary judgment, the evidentiary burdens borne by the parties under the applicable substantive law are a factor in evaluating whether a rational trier of fact could find in favor of the non-moving party."). In *Batavia Nursing and Convalescent Center*, DAB No. 1904 (2004), *aff'd, Batavia Nursing & Convalescent Ctr. v. Thompson*, 129 Fed. App'x 181 (6th Cir. 2005), the Board, based on its analysis of the Medicare act and regulations, set forth the parties' respective burdens in a hearing under 42 C.F.R. Part 498 to challenge an initial determination of noncompliance resulting in imposition of a remedy, assigning the ultimate burden of persuasion to the SNF.

Standard of Review

Whether summary judgment is appropriate is a legal issue that we address de novo. *Lebanon Nursing and Rehabilitation Center, DAB No. 1918,* at 7 (2004).

Discussion

In its request for review, Dumas challenges the ALJ conclusions on the following issues:

- whether it was noncompliant with sections 483.13(c), 483.13(c)(2)-(4), 483.20(k)(3)(i), and 483.25(k);
- whether CMS's immediate jeopardy determination was clearly erroneous; and
- whether the CMPs were reasonable.

See Request for Review (RR) at 2-3. As we discuss below, the ALJ committed no error in granting summary judgment to CMS on those issues.

1. *There are no genuine disputes of material fact.*

As noted, the issues raised in this appeal mainly concern the February 27, 2009 incident involving Resident 1. Relying on the SOD (incorporated by reference into CMS's motion), surveyor affidavits and the facility's own records, CMS alleged facts about that incident that we set forth below and that the ALJ found undisputed in any material respect.

Resident 1 was a 57-year old woman with multiple medical problems, including morbid obesity, anxiety, diabetes, coronary artery disease, and chronic obstructive pulmonary disease (COPD). Following abdominal surgery in 2007, she had difficulty becoming weaned from a ventilator and underwent a tracheostomy, a procedure in which an opening in the neck was made to provide a direct airway into her trachea via a tracheostomy or "trach" tube. ALJ Decision at 6 and n. 4, citing CMS Ex. 5, at 9, 94; CMS Ex. 3, at 65. Resident 1's plan of care instructed nursing staff to keep the "trach . . . in place and open" in order to keep her blood oxygen (or "oxygen saturation") level in the 90 percent-plus range. The plan of care also instructed the nursing staff to administer oxygen at a rate of two-to-three liters per minute "as needed." In addition, the plan of care, treatment sheets and a print-out of physician orders instructed the nursing staff to suction Resident 1's airway every four hours, or every two hours "as needed," in order to keep it clear of secretions or other potential obstructions. ALJ Decision at 6, citing CMS Ex. 5, at 74-75, 78 and 97.

At 2:30 p.m. on February 27, 2009, Resident 1 complained of difficulty breathing, and a nurse suctioned her. ALJ Decision at 6. This procedure was repeated at 4:00 p.m. and 5:20 p.m. after Resident 1 continued to complain of difficulty breathing. *Id*. at 6-7, citing CMS Ex. 5, at 60. Nurse C did the suctioning all three times. P. Ex. 1, at 34; CMS Ex. 16, at 3 (cited in ALJ Decision at 11 n. 7).

Nurse C stated that she telephoned the assistant director of nursing (ADON) at around 7:30 p.m. on February 27 to obtain permission to leave her shift early, complaining that Nurse B had refused to suction Resident 1 on three occasions. ALJ Decision at 11 n. 7, citing CMS Ex. 10, at 95, CMS Ex. 16, at 3.

Around 8:00 p.m. on February 27, a certified nurse aide (CNA), whom the surveyors referred to as "CNA H," sent another nurse aide (identified as CNA I) to find Nurse B, the only nurse on duty in the facility, to inform him that Resident 1 was complaining of difficulty breathing. ALJ Decision at 7; CMS Ex. 16, at 2. (It is unclear whether CNA I actually communicated with Nurse B at that time about Resident 1's condition.[3]) After a few minutes, by which time Resident 1's lips were turning blue, CNA I went a second time to notify Nurse B. ALJ Decision at 8; CMS Ex. 16, at 2. Nurse B left the medication room (after some additional time had passed) and went to Resident 1's room.[4] *Id*. Nurse B stood in the doorway to Resident 1's room but did not enter the

[3] A medication aide, who was with Nurse B in the medication room, recalled that she heard a knock at the room's door but found no one there when she opened the door. CMS Ex. 16, at 2.

[4] The ALJ noted that Dumas had not come forward with any evidence suggesting a dispute about her findings, based on interviews with and written statements by Dumas's staff, that the CNAs made two or three trips to summon Nurse B before he responded. On appeal, Dumas says that the CNAs "summoned [Nurse B] one, two or three times." RR at 4. Dumas does not challenge the ALJ's statement that it put on no evidence to counter its staff's statements that they made multiple attempts to summon Nurse B.

room and did not check Resident 1's airway, take vital signs, or provide oxygen. ALJ Decision at 7, citing CMS Ex. 16, at 2; CMS Ex. 17, at 6. Instead, Nurse B asked Resident 1 to lie down in case he needed to perform CPR.[5] *Id*., citing CMS Ex. 5, at 60; CMS Ex. 16, at 3. Nurse B then called 911, leaving Resident 1 in the care of CNA H and CNA I. *Id*. at 7, 8, citing CMS Ex. 5, at 60; CMS Ex. 10, at 91, 92; CMS Ex. 16, at 2; CMS Ex. 17, at 6. In the meantime, Medication Aide G went to Resident 1's room, where she found her "slumped over in her wheelchair . . . her eyes were big, her lips were purple and she was sweating profusely. . . . [W]hite foam [was] coming out of her tracheostomy." *Id*. at 8, citing CMS Ex. 16, at 2; CMS Ex. 17, at 7; CMS Ex. 10, at 92. Nurse B did not return to Resident 1's room until he escorted Emergency Medical Services (EMS) paramedics there. CMS Ex. 3, at 13.

A report by Monroe County EMS indicates that it received Nurse B's 911 call at 8:09 p.m.[6] Paramedics reached Resident 1's room at 8:13 p.m. They found her sitting in a wheelchair in respiratory distress. According to the EMS report, Resident 1's breathing was labored, her blood oxygen level was 84 percent, and her "trach was clogged." CMS Ex. 5, at 1; P. Ex. 1, at 60. The paramedics immediately administered medication (through a nebulizer) and oxygen (via high concentration mask). They also suctioned her en route to the hospital until the "trach clog came dislodged." *Id*., cited in ALJ Decision at 7. At the emergency room, Resident 1 was described as being in respiratory distress with cyanosis (blue discoloration of the skin and mucous membranes caused by lack of oxygen in the blood). Examination also revealed bilateral pleural effusion (accumulation of fluid between the layers of tissue that line the lungs and chest cavity), blood oxygen level of 86 percent, and mild to moderate congestive heart failure. ALJ Decision at 7, citing CMS Ex. 5, at 9.

In addition to these undisputed facts about the incident, the record contains undisputed facts about the facility's response to that incident. Nurse C, who had left her shift shortly before the incident on February 27, indicated that she learned about it on February 28, and that she called the ADON that day to express her concern that Nurse B had left Resident 1 during her episode of respiratory distress with only the CNAs to tend to her. CMS Ex. 3, at 42. The director of nursing (DON) met with certain nursing staff on March 3, 2009, and staff complained about Nurse B not assessing Resident 1 on the night of February 27, 2009 and "refusing to suction Resident #1 on multiple prior occasions."

---

[5] According to one of the CNAs who was present during the incident, Resident 1 tried to tell Nurse B that she was unable to get into bed but her words were "barely coming out of her mouth due to her inability to breathe." CMS Ex. 16, at 2; CMS Ex. 3, at 13.

[6] The ALJ found that members of the nursing staff first notified Nurse B of Resident 1's respiratory distress at 8:10 p.m. ALJ Decision at 7. The ALJ later found that Nurse B's call to 911 was placed at 8:09 p.m. *Id.* The finding that Nurse B was first notified about Resident 1's condition *after* he placed the call to 911 is an obvious but apparently inadvertent error. As discussed, the evidence of record, including uncontested summaries of nursing staff interviews, establishes that Nurse B was first notified of Resident 1's respiratory distress some minutes before he placed the 911 call. *See, e.g.*, CMS Ex. 3, at 12-15; CMS Ex. 16, at 2-4.

Id. at 36-37. Nurse B stated during the meeting that "he did not feel comfortable suctioning Resident #1 because he didn't know how." *Id*. at 36. During the meeting, Nurse F and Nurse C "questioned [Nurse B] regarding why he had not tried to use the Ambu bag [to ventilate the patient] or why he had not suctioned Resident #1 before calling 911." *Id*. The DON responded that "she would have done the same thing [Nurse B] did, that she too would have left the resident to call 911." *Id*. CNAs H and I and Medication Aide G did not attend the March 3, 2009 staff meeting. *See* CMS Ex. 3, at 20; CMS Ex. 16, at 3. The administrator did not learn about the February 27 incident until March 3, 2009. CMS Ex. 3, at 43.

During a March 7, 2009 interview with surveyors, the DON "confirmed that [Nurse B] should not have left Resident #1's room during the incident of respiratory distress, but added that [Nurse B] had told her it was 'his call'." CMS Ex. 3, at 36-37. The DON then stated that she 'would have done the same thing,' and that she agreed with [Nurse B]." *Id*. The DON also stated that Nurse B had not been "counseled" about the February 27 incident, and that "neither [Nurse B] nor any other nurses hired since the last in-service had received training regarding trach care and suctioning." *Id*. at 24. A review of the facility's "in-service" training records found that nurses received training on tracheostomy care on June 14, 2007 and July 20, 2007; Nurse B was hired on February 12, 2009, two weeks before the incident involving Resident 1. CMS Ex. 3, at 24.

The above facts are undisputed in any material respect. After CMS filed its motion for summary judgment, Dumas filed a "Prehearing Brief" (Nov. 19, 2009) that did not acknowledge CMS's motion for summary judgment or claim that genuine factual disputes warranted denial of the motion. Dumas's request for review is similarly vague about that issue, and any alleged disputes it cites are either not genuine disputes or are immaterial.

Dumas asserts, for example, that "witness testimony" and other evidence were "inconsistent" about when and where Resident 1 became short of breath on the evening of February 27, the number of times employees alerted Nurse B to her respiratory distress, and the number of times Nurse B came to Resident 1's room before paramedics arrived. *See* RR at 4. However, Dumas does not pinpoint the sources of the alleged inconsistencies or explain how resolving them in its favor would affect the conclusions we might draw about its compliance status.

Dumas also asserts that certain employees were "wrong" about how much time elapsed between the moment that Nurse B was first notified about Resident 1's respiratory distress and his 911 call. RR at 13. However, as the discussion below will make plain, the amount of time it took Nurse B to call 911 is immaterial to an analysis of the relevant compliance issues.

Dumas also asserts that the evidence does not support a finding that Resident 1's trach was clogged on the evening of February 27. Reply Br. at 4. In support of this claim,

Dumas points to the affidavit of its expert witness, Karl E. Steinberg, M.D., who stated that when the ER technicians arrived at the facility, "Resident #1 was found to have a mildly reduced oximetry reading of 84% (normal is 90% or above), with no evidence of tracheal obstruction hence no compelling need for immediate suctioning." P. Ex. 2, at 3. Dr. Steinberg's affidavit gives no basis for his assertion that there was "no evidence of tracheal obstruction." As the ALJ noted, Dr. Steinberg's affidavit was based not on any personal knowledge of the events in question but on his review of the SOD and medical record, and he did not refer to any medical evidence on which he relied for his statement.[7] *See* ALJ Decision at 10, n. 7. Dr. Steinberg's affidavit notably does not discuss the unambiguous statements in both the SOD, which Dr. Steinberg states he reviewed, and the EMS report, which he does not state he reviewed (*see* P. Ex. 2, at 2), that there was a "clog" or "blockage." *See* CMS Ex. 3, at 1 (SOD stating "tracheostomy tube was clogged"; CMS Ex. 5, at 1; P. Ex. 1, at 60 (EMS report stating "trach was clogged," "Blockage in Trach" and (after EMS suctioned) "trach clog came dislodged". Given Dr. Steinberg's failure to cite any evidence for his assertion and the unambiguous evidence that Resident 1's trach was clogged, Dr. Steinberg's assertion cannot reasonably be read as creating a genuine dispute of fact. But even if we were to find otherwise, our decision would not be affected because our conclusion that noncompliance existed does not rest on a finding that the trach was clogged but, rather, on the undisputed findings that staff did not provide Resident 1 with the tracheostomy care required by her care plan, treatment sheets, physician orders and Dumas' policies during the incident.

1. *Dumas was noncompliant with 42 C.F.R. §§ 483.20(k)(3)(i) and 483.25(k) in its care of Resident 1 on February 27, 2009.*

Section 483.20(k)(3)(i) requires a SNF to ensure that its nursing care meets "professional standards of quality." The Board has held that, absent contrary evidence, it is "reasonable to presume" that a facility's resident care policies reflect professional standards of quality. *Sheridan Nursing Care Center*, DAB No. 2178, at 32 (2008).

CMS produced three written resident care policies that were triggered by the February 27 incident. The first policy, entitled "Change of Condition; Observing Reporting and Recording," provided that when a resident experienced a "significant change" in her physical status, the nursing staff was obligated to obtain the resident's vital signs and to "observe" for "alterations in consciousness," generalized weakness, cyanosis, and other

[7] If Dr. Steinberg was suggesting by his reference to the oxygen readings that either the trachea itself or the tracheal tube (it is unclear to which he was referring) was not completely blocked, that is irrelevant, because CMS did not allege a complete blockage of either. If by characterizing the oximetry reading as "mildly reduced" Dr. Steinberg intended to raise an inference that Resident 1 was not in respiratory distress, such an inference is unreasonable in light of Dr. Steinberg's subsequent statement – when acknowledging Nurse B "probably could have managed the situation . . . better" – that Resident 1 "was starting to show respiratory distress . . . ." P. Ex. 2, at 4. Furthermore, the undisputed evidence of record – e.g., staff observations that she was turning blue, Nurse B's recognition that he needed to call 911, the EMS Report of the resident's condition and the hospital statement that she "was brought in with increasing respiratory distress and cyanosis" (P. Ex. 1, at 12) – leaves no room for a genuine dispute that Resident 1 was in respiratory distress.

signs or symptoms. CMS Ex. 15, at 116-17. The change-of-condition policy also instructed: "Do not leave the resident alone when a change of condition is identified until the licensed nurse has determined that the resident is not in danger in any way related to their medical or mental changes in condition." *Id.* at 117.

A second policy, entitled "Emergency Care," required the nursing staff to, among other things, "provide emergency care as necessary" and to obtain, report, and record vital signs "when a resident's condition has changed." CMS Ex. 5, at 114. Finally, Dumas had a tracheal suctioning policy that stated: "It is the policy of this facility that residents needing trachael suctioning will have this procedure completed without complication." *Id.* at 101. The policy specified how suctioning should be performed and states that "[f]requency of suctioning is determined by presence of mucus in trachea and/or stoma." *Id.*

CMS alleged, and the undisputed facts plainly show, that Resident 1's condition during the episode on February 27 was a "significant change" in her physical status, requiring oxygen and tracheal suctioning.[8] Her difficulty breathing was also a medical emergency and treated as such by Nurse B, as evidenced by his 911 call. Despite these circumstances, Nurse B failed to comply with the change-of-condition, emergency care, and tracheal suctioning policies because he did not : (1) obtain and record Resident 1's vital signs during the episode; (2) provide or attempt to provide emergency care; (3) observe Resident 1 for changes in consciousness, cyanosis, and other signs or symptoms of deterioration; or (4) stay with Resident 1 in order to make an informed judgment, based on her vital signs and a physical assessment of her trach tube, that she was "not in danger in any way related to" her change in condition. These undisputed facts establish that Dumas was noncompliant with its obligation under section 483.20(k)(3)(i) to ensure that each resident received nursing care that met professional standards of quality. *See Sheridan Nursing Care Center* at 32.

The undisputed facts also demonstrate that Dumas was noncompliant with section 483.25(k), which requires a SNF to "ensure" that residents "receive treatment and care for certain special services" listed in that regulation, including tracheal suctioning and respiratory care. 42 C.F.R. § 483.25(k)(4), (5), and (6). As indicated, Resident 1's plan of care instructed the nursing staff to keep the "trach . . . in place and open" in order to keep her blood oxygen (or "oxygen saturation") level in the 90 percent-plus range. CMS Ex. 5, at 78. The plan of care also instructed the nursing staff to administer oxygen at a rate of two-to-three liters per minute "as needed." *Id.* In addition, the plan of care instructed the staff to suction Resident 1's airway every two hours "as needed" to keep it clear of secretions or other potential obstructions. *Id.* Dumas does not dispute that at around 8:00 p.m. on February 27, Resident 1 needed supplemental oxygen to help relieve her respiratory distress, yet Nurse B made no attempt to administer oxygen. Nurse B also

[8] Dumas's change-of-condition policy stated that a "significant change" was something "such as a deterioration in health . . . status, in life-threatening conditions or clinical complications." CMS Ex. 15, at 116.

admitted to surveyors that he did not know that an "Ambu bag" could have been placed over Resident 1's tracheostomy in order to administer oxygen. CMS Ex. 3, at 22. Even though Resident 1's plan of care instructed the nursing staff to perform tracheal suctioning every two hours "as needed," and even though the incident in question occurred *more than two hours* after Resident 1 had undergone that procedure (at 5:20 p.m.), Nurse B made no attempt either to assess Resident 1's need for tracheal suctioning or to perform that procedure. During a March 3, 2009 meeting, the summary of which is uncontested, Nurse B admitted not knowing how to perform tracheal suctioning. CMS Ex. 3, at 20.

The only reasonable conclusion that can be drawn from these undisputed facts is that Dumas was not in substantial compliance with sections 483.20(k)(3)(i) and 483.25(k). Dumas does not point to any evidence which tends to show that Nurse B's actions complied with the relevant resident care policies or were consistent with professional standards of quality and Resident 1's plan of care. Dumas's own expert witness, Dr. Steinberg, did not defend Nurse B's inaction but, instead, conceded that Nurse B "probably could have managed the situation . . . better, particularly by staying in the room with the resident . . . ." P. Ex. 2, at 4. Dr. Steinberg did say that Nurse B "used nursing judgment to decide that summoning paramedics would be the top priority and the most appropriate use of his time." *Id*. However, Dr. Steinberg did not claim personal knowledge about the basis for Nurse B's decision, and Dumas proffered no testimony from Nurse B about why he acted as he did. Moreover, Dr. Steinberg did not indicate in his affidavit whether or why he considered Nurse B's judgment to be sound or consistent with professional nursing standards, and in light of Dr. Steinberg's concession that Nurse B should have stayed in Resident 1's room, any inference that Nurse B was compliant with such standards would not be reasonable. In addition, Dumas does not dispute or deny that: (1) its resident care policies, which Nurse B did not follow, reflected professional standards of nursing quality; (2) Resident 1's condition constituted a significant change of status; and (3) Resident 1 needed nursing intervention on the night of February 27 to boost her oxygen saturation level above 90 percent.

Nonetheless, Dumas defends Nurse B's conduct. Dumas's defense can be summarized as follows: Resident 1's respiratory distress on February 27 was the direct result of underlying medical conditions, including COPD and congestive heart failure. Given Resident 1's earlier complaints of breathing difficulty (at 2:30, 4:00, and 5:20 p.m.), Dumas alleges Nurse B correctly deduced that she needed hospital care to address the underlying conditions, and he took immediate action – calling 911 – to ensure that she received that care as quickly as possible. *See* RR at 5-6, 9-10. According to Dumas, Nurse B's call to 911 was evidence that he had assessed Resident 1 and found that she needed emergency medical care. RR at 5. Given Resident 1's complicated clinical condition and history, says Dumas, the ALJ reasonably could – and should – have concluded that calling EMS to hasten Resident 1's transfer was the "essential service" called for by professional nursing standards under the circumstances. RR at 6, 9, 10.

The main problem with this line of argument is that it completely ignores the fact that Resident 1 was already in respiratory distress. In essence, Dumas proposes that it is acceptable nursing practice in a SNF to do nothing to help relieve a resident's respiratory distress while waiting for paramedics to arrive. We see nothing in the relevant regulations, Dumas's resident care policies, Resident 1's plan of care, or the affidavit of Dr. Steinberg to support that proposition. As we indicated, Dr. Steinberg declined to endorse Nurse B's conduct, focusing instead on whether Resident 1 had suffered harm as a result of the incident. *See* P. Ex. 2, at 3-4, 6. Even Nurse B exhibited some awareness that his conduct was unprofessional, admitting to surveyors that he should not have left Resident 1 alone with the nurse aides. CMS Ex. 3, at 21. Moreover, while calling 911 could reasonably be considered an "essential service" as Dumas asserts, Dumas proffers no reason why a nurse aide could not leave to make the call while Nurse B stayed with Resident 1 to provide nursing care, consistent with Dumas' own policies.

Dumas's other arguments are either unfounded or inadequate to demonstrate substantial compliance. Dumas asserts that Nurse B should be excused from failing to administer oxygen because "under the given circumstances the nurse would not have been able to administer the required high concentrations of oxygen safely." RR at 15. However, Dumas points to no evidence that a properly trained nurse could not have administered the necessary concentration of oxygen under the circumstances. Moreover, the surveyors found, and Dumas does not deny, that an "oxygen concentrator" was in Resident 1's room at the time of the incident. CMS Ex. 3, at 15. The fact that an oxygen concentrator was in the room strongly suggests that it was meant to be used.

Dumas also asserts that while Resident 1 might have thought she was experiencing a medical crisis, a competent nurse would properly have viewed it as an "urgent issue that was not immediately life threatening." RR at 10. In other words, Dumas suggests that Nurse B acted appropriately because he correctly viewed the circumstances as not life-threatening. However, it is unreasonable to suggest that the circumstances were not life-threatening given that Nurse B called 911. More important, Dumas does not point to any fact or legal standard that would permit us to conclude that Nurse B's obligation to intervene was contingent on the existence of "immediately life-threatening" circumstances, as opposed to merely "urgent" medical circumstances.

Finally, Dumas asserts that Resident 1 "had a history of seeking out staff and requesting suctioning, even when it was not clinically indicated" and suggested that this history justified Nurse B's failure to provide that service on the evening of February 27. RR at 8. The ALJ gave proper and sufficient reasons for rejecting that argument. *See* ALJ Decision at 9. We note also that the undisputed facts show that Nurse B made no apparent attempt to assess Resident 1 to determine whether or not suctioning was in fact "clinically indicated."

For the foregoing reasons, we affirm the ALJ's conclusion Dumas was not in substantial compliance with sections 483.20(k)(3)(i) and 483.25(k) in caring for Resident 1 on February 27, 2009.

2. *Dumas did not comply with 42 C.F.R. 483.13(c)(2)-(4) when it failed to report and thoroughly investigate the February 27, 2009 incident.*

Paragraphs (2) through (4) of section 483.13(c) provide that: (1) a SNF "must ensure that all *alleged violations involving* mistreatment, *neglect,* or abuse . . . are *reported immediately* to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency)"; (2) a SNF "must have evidence that all alleged violations are *thoroughly investigated* . . . "; and (3) "the *results of all investigations must be reported* to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) *within 5 working days of the incident,* and if the alleged violation is verified appropriate corrective action must be taken." 42 C.F.R. § 483.13(c)(2)-(4)(emphasis added).

We concur with the ALJ that Dumas failed to comply with these requirements in responding to the February 27 incident involving Resident 1. As a preliminary matter, there is uncontested evidence, including interview summaries in the SOD and surveyor affidavits, that during or soon after the incident at least four employees expressed concern about Nurse B's conduct. During the incident, CNAs H and I complained to Medication Aide G about Nurse B's inaction. CMS Ex. 3, at 67. CNA H also told Nurse C about the incident the next day. *Id.* at 66. Nurse C then "made the ADON aware of her concern that [Nurse B] had left Resident #1 alone during respiratory distress so he could call 911, with only the aides to tend to her."[9] *Id.* at 19; CMS Ex. 16, at 3. Medication Aide G, who was working with Nurse B when he was called to assist Resident 1, told surveyors that she discussed the incident the next day with an unidentified nurse, who told her to report her concern to the DON. CMS Ex. 3, at 19; CMS Ex. 16, at 8. Finally, during a nursing staff meeting on March 3, 2009, other employees complained about Nurse B's failure to assess Resident 1 on the night of February 27 and his refusal to suction Resident 1 on prior occasions. CMS Ex. 3, at 20; CMS Ex. 16, at 3. The foregoing evidence demonstrates that members of the nursing staff knew of allegations that a reasonable person would regard as involving possible neglect – i.e., leaving Resident 1 alone and failing to provide needed nursing care. On that basis we hold that the February 27 incident triggered the reporting and investigation requirements of section 483.13(c)(2)-(4).

[9] The ADON told surveyors she did not recall receiving a call from any nurse on February 28 or 29, 2009 notifying her of concerns about Nurse B. CMS Ex. 3, at 20. Dumas, however, offers no evidence that would be sufficient to rebut Nurse C's statement that she did inform the ADON of her concerns about Nurse B.

Dumas did not comply with those requirements. First, it did not ensure that the February 27 incident was reported "immediately" to the administrator, as required by section 483.13(c)(2). According to the SOD, the administrator did not learn about the February 27 incident until March 3, 2009. CMS Ex. 3, at 43. Dumas's January 2008 Abuse Policy specified an incident reporting protocol designed to ensure that the administrator received immediate notification of neglect allegations. *See* CMS Ex. 15, at 79-80 (requiring employees to report incidents to a "senior staff member," who would then notify the administrator or the person "on call"). However, Dumas does not allege, or point to evidence, that the nursing staff followed this protocol or, if it did, that the protocol achieved its purpose on this occasion.

Second, Dumas failed to investigate the February 27 incident "thoroughly," as required by section 483.13(c)(3) and its January 2008 Abuse Policy. *See* CMS Ex. 15, at 136. On March 3, 2009, a meeting was held in which staff articulated "complaints" about Nurse B's conduct on February 27. CMS Ex. 3, at 20. Dumas's administrator and the director of nursing attended the March 3 meeting. *Id.* During the meeting, Nurse F and Nurse C questioned Nurse B about the February 27 incident. *Id.*; *see also* CMS Ex. 16, at 3. That questioning clearly did not constitute a *thorough* investigation of the February 27 incident because certain persons who had personal knowledge of the incident – including CNAs H and I and Medication Aide G – were not in attendance, according to the uncontested summary of an interview with the director of nursing. CMS Ex. 16, at 3. There is no evidence, and Dumas does not allege, that it ever interviewed the absent employees, nor is there evidence that, prior to the survey, Dumas implemented the investigatory protocol specified in the January 2008 Abuse Policy, which called on certain employees to obtain written witness statements and prepare a report of investigatory findings. *See* CMS Ex. 15, at 80.

Finally, Dumas submitted no evidence that it reported the results of its (incomplete) investigation to the appropriate state authorities within five days of the incident, as section 483.13(c)(4) requires. *See* CMS Ex. 11 (indicating that the DON reported the incident to the state survey agency on March 12, 2009, thirteen days after the incident).

Dumas contends that there was no need for an investigation because Nurse B did not neglect Resident 1 and because no staff member lodged a complaint of neglect. RR at 12-14. Furthermore, says Dumas, its DON "diligently followed up on rumors as soon as they were brought to her attention, after which she correctly dismissed the rumors as staff complaints against a new co-worker." RR at 14.

These contentions are entirely unfounded. First, as we explained, there is no dispute that allegations of neglect were made at least by March 3 (the date of the staff meeting). We agree with the ALJ that the DON and administrator were "not free to dismiss [those] allegations as unfounded" without performing a thorough investigation. ALJ Decision at 15. Second, Dumas does not point to any evidence supporting its assertion that the DON found the allegations to be unfounded "rumors." Even if the DON reached that

conclusion, she was obligated to report it to the appropriate state authorities within five working days. There is no evidence she did so.

In short, based on undisputed facts, CMS made a prima facie showing that Dumas was noncompliant with section 483.13(c)(2)-(4) because it: (1) did not ensure that an allegation of neglect was immediately reported to its administrator; (2) did not thoroughly investigate the allegation; and (3) did not timely report the results of its investigation to the appropriate state authorities. The potential for significant harm from these types of reporting and investigatory failures is manifest because residents may be exposed to a continuing risk of neglect based on a failure to understand and correct deficient practices. That potential was enhanced in this case by the fact that a nurse who failed to give appropriate care to a resident in respiratory distress and who, by his own admission was not capable of providing that care, remained on duty. *See* CMS Ex. 3, at 25-26, 28 (finding that "[f]ailure to investigate the circumstances placed all 52 residents at potential risk of [Nurse B] failing to provide immediate nursing interventions in emergency situations"). Under any reasonable construction of the evidence, Dumas did not show a genuine dispute of fact material to the noncompliance findings. We thus affirm the ALJ's conclusion that Dumas was not in substantial compliance with section 483.13(c)(2)-(4).

3. *Dumas was noncompliant 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 mistreatment, neglect, and abuse of residents and misappropriation of resident property." The Board has held that multiple or sufficient examples of neglect may support a reasonable inference that a facility has failed to develop or implement policies and procedures that prohibit neglect. *Barn Hill Care Center*, DAB No. 1848, at 10 (2002); *Emerald Oaks*, DAB No. 1800, at 18 (2001); *accord*, *Liberty Commons Nursing and Rehab Center – Johnston*, DAB No. 2031 (2006) (applying holding), *aff'd*, *Liberty Commons Nursing & Rehab Ctr. – Johnston v. Leavitt*, 241 F. App'x 76 (4th Cir. 2007).

Applying this precedent here, there is ample, uncontested evidence that Dumas failed to implement its policies and procedures prohibiting neglect. Dumas had at least two written anti-neglect policies: a January 2008 Abuse Policy (CMS Ex. 15, at 78) and a January 2005 policy entitled "Reporting Abuse, Neglect or Mistreatment" (*id.* at 135-36). These polices required Dumas's staff to (1) "immediately" report a possible or suspected incident of neglect to supervisors and the administrator; (2) investigate the allegation of neglect in accordance with specified guidelines; and (3) timely report the results of the investigation to the appropriate state authorities. As previously discussed, Dumas did not meet those obligations with respect to the February 27 incident. Moreover, the facility's lapses involved multiple employees – from the CNAs who were with Resident 1 during her episode of respiratory distress but who failed to report their concerns to supervisors,

to the DON and the administrator, who failed to ensure that the incident was thoroughly investigated and timely reported.

These undisputed facts together with other undisputed facts support a finding that Dumas did not implement its written anti-neglect policies and procedures. The January 2005 policy affirmatively required "[a]ll staff on an ongoing basis to assure freedom from" abuse and neglect. CMS Ex. 15, at 136. In this context, 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. Here, the "necessary" services for Resident 1 included the services specified in Dumas's emergency care, change-of-condition, and tracheal suctioning policies – all of which were designed to help residents avoid physical or mental harm. However, Nurse B failed to implement these policies. There was also a related, overarching failure by Dumas to ensure that a competent nurse was available to meet Resident 1's special medical needs on February 27. Evidence of that failure can be found in Nurse C's undisputed statements (in her own hand and to surveryors) that she telephoned the ADON *on February 27* to ask for permission to leave her shift early because she was upset that she had to suction Resident 1 three times that day when Nurse C refused to do so. CMS Ex. 10, at 52, 95; CMS Ex. 16, at 5-6, 8. The ALJ found – and Dumas does not dispute – that the ADON "inexplicably" gave Nurse C permission to leave early that evening. ALJ Decision at 11 n.7. Dumas presented no evidence that the ADON contacted Nurse B on February 27 to inquire about his reported unwillingness to suction Resident 1. After Nurse C departed, Nurse B, who had been hired only two weeks before, was the only nurse on duty in the facility, yet, as he later admitted, he did not know how to perform tracheal suctioning. *Id.* at 6.

Evidence of the facility's failure to implement its anti-neglect policies and procedures can also be found in the fact that the DON admitted during a survey interview (the summary of which is uncontested) that the facility had not trained Nurse B, who was left alone with a resident needing such care, to provide tracheostomy care and tracheal suctioning. CMS Ex. 3, at 24. There is also no evidence that *prior to February 27*, Dumas questioned Nurse B about, or sought to verify, his competence to care for tracheostomy patients. In short, as the ALJ aptly observed, even though Resident 1 needed regular suctioning and had complained of difficulty breathing on February 27, Dumas left her entirely in the hands of a nurse who was unqualified to perform tracheal suctioning and was also ignorant of a critical technique (use of the Ambu bag) for administering oxygen to a resident with a tracheostomy.

Another striking example of Dumas's failure to implement its policies and procedures prohibiting neglect is the DON's statement to surveyors in which she confirmed, on the one hand, that Nurse B should not have left Resident 1's room during the incident but asserted, on the other hand, that she "would have done the same thing [as Nurse B] . . . ." CMS Ex. 3, at 21-22. The facility's policy and procedure governing a change in condition states: "Do not leave the resident alone when a change in condition is identified until the licensed nurse has determined that the resident is not in danger . . . ."

CMS Ex. 15, at 98. Nurse B, the only licensed nurse on duty, had not determined that Resident 1 was not in danger. Thus, he should have stayed with the resident and had another staff member call 911. By stating that she would have "done the same thing" as Nurse B, the DON, who had leadership responsibility for nursing care at Dumas, admitted, in effect, that she too would not have followed the facility's policies and procedures.

We agree with the ALJ that all these lapses – by both supervisory and non-supervisory employees – collectively reveal "systemic problems relating to facility staffing, staff training, and administrative policies" that, in turn, support a conclusion that Dumas had not implemented polices and procedures prohibiting neglect. ALJ Decision at 16. Dumas suggests no other reasonable conclusion based on the undisputed facts. Consequently, we affirm the ALJ's conclusion that Dumas was noncompliant with section 483.13(c). *See Liberty Commons Nursing and Rehab Center – Johnston* at 13-14 (affirming an administrative law judge's conclusion that the facility was noncompliant with section 483.13(c) because of errors or omissions that showed a "systemic" or "overall failure of implementation").

4. *Dumas was noncompliant with 42 C.F.R. §§483.20(k)(3)(i) and 483.25(k) in its care of Resident 1 on March 9, 10, and 11, 2009*.

As previously stated, section 483.20(k)(3)(i) requires that "services provided or arranged by the facility must "[m]eet professional standards of quality," and section 483.25(k) provides that a facility must "ensure that residents receive proper treatment and care for . . . special services [that include] [t]racheostomy care." Based on reported surveyor observations (*see* CMS Ex. 16, at 14-16), the ALJ found that on March 9, 10, and 11, 2009, nurses used non-sterile techniques to provide Resident 1 with tracheostomy care. ALJ Decision at 12. The ALJ based this finding in part on the testimony of Dumas's only witness, Dr. Steinberg, who conceded that the cited techniques "appear to be deficient practices that justifiably would be expected to receive formal deficiencies." *Id.* at 13; P. Ex. 2, at 5. In addition, the ALJ found that on March 7, 2009, a nurse initialed a treatment record indicating that she had completed Resident 1's tracheostomy care when, in fact, she had not. This nurse then stated that another nurse had completed the care but admitted she had not witnessed or verified this. When the surveyor questioned the other nurse, she confirmed that she had not done the care. ALJ Decision at 13. The ALJ stated, "I consider this falsification of a treatment record very serious and find baffling the facility's dismissive attitude toward that falsification," noting the absence of any evidence showing that Dumas had counseled the nurses or taken any other action to ensure the reliability of its records. Based on these findings, the ALJ concluded that Dumas was noncompliant with sections 483.20(k)(3)(i) and 483.25(k). *Id.* at 12-14.

In this appeal, Dumas does not challenge the accuracy of the surveyors' reported observations on March 9, 10, and 11. In addition, Dumas does not dispute that use of non-sterile techniques and failure to comply with a physician order for tracheostomy care

constitute noncompliance with sections 483.20(k)(3)(i) and 483.20(k). Instead, Dumas invites us to infer from all the relevant circumstances that: (1) the techniques observed on March 9, 10, and 11 were clinically acceptable; (2) the failure to provide tracheostomy care on the morning of March 7 was "the result of a misunderstanding between two nurses"; and (3) the alleged deficiencies did not cause actual harm or a create a potential for more than minimal harm. RR at 16-18. However, Dumas cites absolutely no evidence to support the inferences it wishes us to draw, and, as the ALJ correctly found, Dumas's own witness conceded that the nursing staff had used improper techniques in caring for Resident 1's tracheostomy. Under the circumstances, we conclude that no genuine dispute of material fact exists concerning these issues. A party may not avoid summary judgment based on conclusory or speculative statements. Although "[a]ll reasonable inferences arising from the evidence must be resolved in favor of the non-movant" on a motion for summary judgment, "inferences based upon speculation are not reasonable." *Marshall v. City of Cape Coral, Fla.*, 797 F.2d 1555, 1559 (11th Cir. 1986). We thus adopt and affirm the ALJ's conclusion that Dumas was noncompliant with sections 483.20(k)(3)(i) and 483.25(k) based on the care rendered to Resident 1 on March 7, 9, 10, and 11, 2009.

5. *CMS's immediate jeopardy finding was not clearly erroneous.*

CMS determined that the noncompliance associated with the February 27, 2009 incident was severe enough to place Dumas's residents in "immediate jeopardy." 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 (italics added).

A determination by CMS "as to the level of [a SNF's] noncompliance . . . must be upheld unless it is clearly erroneous." 42 C.F.R. § 498.60(c)(2). Immediate jeopardy is a "determination as to the level of noncompliance" and is therefore subject to the clearly erroneous standard of review. *Maysville Nursing & Rehabilitation Facility*, DAB No. 2317, at 11 (2010). "Under the clearly erroneous standard, CMS's immediate jeopardy determination is presumed to be correct, and the facility has a heavy burden to overturn it." *Id.*

Here, CMS determined that Dumas's failure to provide proper tracheostomy care and emergency care to Resident 1 during her episode of respiratory distress, the staff's failure to report the February 27 incident to the administrator, and the facility's failure to investigate that incident thoroughly put Resident 1 and others in immediate jeopardy. The ALJ held: "Because I find that a nurse's refusal and/or inability to provide emergency care to a resident in respiratory distress is likely to cause serious harm or even death, I do not find clearly erroneous CMS's immediate jeopardy determination." ALJ Decision at 16. The ALJ also found that the failure to render necessary care to Resident 1 reflected systemic problems relating to facility staffing, staff training and administrative policies. *Id.* We agree with the ALJ.

In challenging the immediate jeopardy determination, Dumas relies on the affidavit of Dr. Steinberg. RR at 18-19. However, Dr. Steinberg's statements on the immediate jeopardy issue consist largely of his legal conclusions with respect to scope and severity. *See* P. Ex. 2, at 3-5. For example, Dr. Steinberg suggested that an immediate jeopardy determination should be reserved for noncompliance that results in the death of a resident, or that involves "grossly negligent practices or equipment in the facility." *Id.* at 5. However, as the ALJ noted, an administrative law judge is not bound by a witness's legal conclusions. ALJ Decision at 15, citing *Guardian Health Care Center*, DAB No. 1943, at 11 (2004).

Dr. Steinberg also asserts that "it is not clear that ***any*** damages were suffered by Resident #1 as the result of [Nurse B's] decision to return to the nurses' station and get everything lined up for an emergency transport to the hospital." P. Ex. 2, at 4 (emphasis in original). However it is not necessary to find actual harm in order to sustain a determination of immediate jeopardy. *Life Care Center of Tullahoma*, DAB No. 2304, at 58 (2010). Immediate jeopardy may exist when the noncompliance is "likely to cause" serious injury, harm, impairment, or death. 42 C.F.R. § 488.301.

Furthermore, the ALJ found that Resident 1 did suffer actual mental harm. ALJ Decision at 10. In an affidavit, surveyor Andrea Mount stated that when she interviewed Resident 1, she "observed the resident to cry as she recounted the details of the night of 2/27/09." CMS Ex. 16, at 5. Based on this uncontested evidence, the ALJ found – and we concur – that the noncompliance caused Resident 1 significant "mental anguish." ALJ Decision at 10. Dr. Steinberg, we note, did not rule out the possibility of mental harm or explain why he thought such harm was not serious in light of Resident 1's overall physical and mental status. Dr. Steinberg merely speculated, without apparent foundation, that surveyors were unduly or improperly influenced by Resident 1's "emotional recounting of her experience" in assigning a level of severity to Dumas's noncompliance. P. Ex. 2, at 5. Dr. Steinberg also asserts that Resident 1 suffered no "permanent" harm, but there is nothing in the regulations which requires that serious harm be "permanent" or non-transitory before an immediate jeopardy determination can be made.

Dr. Steinberg's affidavit, by focusing on details surrounding the February 27 incident, also overlooks the systemic nature of the nursing staff's failings. The Board has held that the validity of an immediate jeopardy determination does not depend on whether any specific resident was harmed or was at risk of being harmed. In *Fairfax Nursing Home, Inc.*, the Board stated that "a finding of immediate jeopardy is not contingent on a finding that each individual incident placed a resident at such a degree of potential or risk of serious harm that there was a likelihood of harm to that specific resident at that particular time. . . . Findings about incidents related to individual residents are not themselves the deficiencies that must be corrected – the deficiency is the underlying failure to meet a participation requirement evidenced by the incident." DAB No. 1794 (2001), *aff'd*, *Fairfax Nursing Home v. Dep't of Health & Human Servs.*, 300 F.3d 835 (7th Cir. 2002), *cert. denied*, 537 U.S. 1111 (2003).

Here, the noncompliance involved nursing staff's failure to ensure that residents received timely and professional nursing care in a medical emergency, to report and investigate suspected resident neglect, and to safeguard residents during an investigation of the suspected neglect. The failure to render aid in a medical emergency is plainly the type of noncompliance that is likely to result in serious harm or even death. So is a failure to report and properly investigate suspected resident neglect, particularly when, as here, an allegation of neglect is made against a direct caregiver who continues to work with residents. As vividly demonstrated by the DON's statements to surveyors, the noncompliance also involved a systemic failure to follow Dumas's own policies and procedures with respect to emergency care and responding to a change in condition. This systemic failure, unless corrected, created a likelihood of serious harm for all residents.

For the foregoing reasons, we sustain CMS's immediate jeopardy determination.

6. *The per-day CMPs imposed by CMS for Dumas's noncompliance were reasonable in amount.*

In addition to appealing a determination of noncompliance, a SNF may contend that a CMP imposed by CMS for its noncompliance is unreasonable in amount. *Lutheran Home at Trinity Oaks*, DAB No. 2111, at 21 (2007). The ALJ or the Board reviews the reasonableness of the CMP amount de novo. *CarePlex of Silver Spring*, DAB No. 1683, at 17-18 (1997). In evaluating the reasonableness of a CMP, an administrative law judge or the Board may consider only those factors specified in section 488.438 of the regulations. *See* 42 C.F.R. § 488.438(e), (f); *Senior Rehabilitation and Skilled Nursing Center*, DAB No. 2300, at 19-20 (2010).

The Board has held that "there is a presumption that CMS has considered the regulatory factors [in section 488.438(f)] in setting the amount of the CMP and that those factors support the CMP amount imposed by CMS." *Coquina Center*, DAB No. 1860, at 32 (2002). Accordingly, the burden is on the SNF to demonstrate, through argument and the submission of evidence addressing the regulatory factors, that a reduction is necessary to make the CMP amount reasonable. *The Windsor House*, DAB No. 1942, at 62 (2004).

Here, the ALJ concluded that the per-day CMPs imposed by CMS were reasonable given the noncompliance she found. ALJ Decision at 16-18. Dumas does not challenge the ALJ's analysis or contend that any specific regulatory factor warrants a reduction in the per-day CMPs. Dumas merely contends that the CMPs are unreasonable because it was in substantial compliance at all times and because any noncompliance, assuming it existed, was not at the level of immediate jeopardy. Because we have rejected the premises of those contentions, and because Dumas suggests no other basis on which to reduce the per-day CMP amounts chosen by CMS, we affirm the ALJ's conclusion that they are reasonable.

7. *Dumas has raised no issue concerning the duration of the immediate jeopardy and noncompliance periods.*

Under CMS's regulations, a CMP may accrue "for the number of days of noncompliance until the date the facility achieves substantial compliance." 42 C.F.R. § 488.440(b). We have concluded that Dumas was first out of substantial compliance, at the level of immediate jeopardy, on February 27, 2009. CMS determined that Dumas abated the immediate jeopardy on March 13, 2009 and returned to substantial compliance on April 17, 2009. Dumas does not contend that it came back into substantial compliance earlier than April 17, 2009; nor does it contend that it abated the immediate jeopardy earlier than March 13, 2009. Consequently, we find no basis to disturb CMS's determination concerning the duration of the immediate jeopardy and noncompliance periods.

Conclusion

For the reasons stated above, we affirm the ALJ Decision.

_____/s/_____
Judith A. Ballard

_____/s/_____
Stephen M. Godek

_____/s/_____
Sheila Ann Hegy
Presiding Board Member