Department of Health and Human Services
DEPARTMENTAL APPEALS BOARD
Appellate Division

Golden Living Center – Foley
Docket No. A-13-8
Decision No. 2510
May 6, 2013

FINAL DECISION ON REVIEW OF ADMINISTRATIVE LAW JUDGE DECISION

Golden Living Center – Foley (Golden) challenges the September 27, 2012 decision of an Administrative Law Judge (ALJ) upholding the determination of the Centers for Medicare & Medicaid Services (CMS) that it was not in substantial compliance with three program participation requirements involving accidents and supervision, quality of care furnished to one of its residents, and physician and family notification set forth at 42 C.F.R. §§ 483.25, 483.25(h), and 483.10(b)(11). *Golden Living Center – Foley*, DAB CR2625 (2012) (ALJ Decision). The ALJ also sustained CMS's imposition of a civil money penalty (CMP) of $4,050 per day for the period January 30, 2011 through March 4, 2011, and a CMP of $100 per day beginning March 5, 2011 through at least April 3, 2011. Golden argues on appeal that it was in substantial compliance with program requirements and that, if there was any noncompliance, it returned to substantial compliance during the second week of February 2011.

For the reasons explained below, we affirm the ALJ Decision.

Legal Background

The Social Security Act (Act)[1] sets forth requirements for nursing facility participation in the Medicare or Medicare programs and authorizes the Secretary of Health and Human Services to promulgate regulations implementing those statutory provisions. Act § 1819. The Secretary's regulations are found at 42 C.F.R. Part 483. To participate in the Medicare program, a nursing facility must maintain substantial compliance with program requirements set out in the Part 483 regulations.

The Secretary contracts with state survey agencies to conduct periodic surveys to determine whether skilled nursing facilities (SNF) are in substantial compliance. Act

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

§ 1864(a); 42 C.F.R. § 488.20. The regulations require that each facility be surveyed once every twelve months, and more often if necessary, to ensure that identified deficiencies are corrected. Act § 1819(g)(2)(A); 42 C.F.R. §§ 488.20(a), 488.308. Survey findings are reported in a Statement of Deficiencies (SOD). A "deficiency" is a defined as a "failure to meet a participation requirement specified in the Act or [42 C.F.R. Part 483]." 42 C.F.R. § 488.301. Section 488.301 defines "substantial compliance" as "a 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." *Id.* Any "deficiency that causes a facility to not be in substantial compliance" constitutes "noncompliance." *Id.*

CMS may impose various remedies on a facility that is found not to comply substantially with the participation requirements, including per-day CMPs for the number of days that the facility is not in substantial compliance, and a denial of payment for new Medicare admissions (DPNA) during the period of noncompliance. 42 C.F.R. §§ 488.406, 488.417, 488.430(a). A per-day CMP may accrue from the date the facility was first out of substantial compliance until the date it is determined by CMS to have achieved substantial compliance. *Id.* § 488.440(a)(1), (b). For noncompliance determined to pose immediate jeopardy, CMS may impose per-day CMPs in amounts ranging from $3,050-$10,000 per day. *Id.* § 488.408(e)(2)(ii). For noncompliance at less than the immediate jeopardy level, CMS may impose per-day CMPs in amounts ranging from $50-3,000 per day. *Id.* § 488.408(d)(1)(iii).

In general, when a facility has been found not to be in substantial compliance with the participation requirements, the facility must submit a plan of correction (PoC) that is acceptable to CMS or the state survey agency. 42 C.F.R. §§ 488.402(d), 488.408(f). If CMS accepts a noncompliant facility's PoC, the facility must then timely implement all of the steps that it identified in the PoC as necessary to correct the cited problems. *Cal Turner Extended Care Pavilion*, DAB No. 2030, at 18-19 (2006); s*ee also Meridian Nursing Ctr.*, DAB No. 2265, at 20-21 (2009), *aff'd, Fal-Meridian, Inc. v. U.S. Dep't of Health & Human Servs.*, 604 F.3d 445 (7th Cir. 2010); *Lake Mary Health Care*, DAB No. 2081, at 29 (2007). A noncompliant facility "is not considered to be [back] in substantial compliance until a determination has been made, through a revisit survey or based on 'credible written evidence' that 'CMS or the State can verify without an on-site visit,' that the facility returned to substantial compliance." *Omni Manor Nursing Home*, DAB No. 2431, at 6 (2011) (*citing and quoting* 42 C.F.R. § 488.454(a)(1)), *aff'd*, *Omni Manor Nursing Home v. U.S. Dept. of Health & Human Servs.*, No. 12-3223, 2013 WL 323001 (6th Cir. Jan. 28, 2003); *Oceanside Nursing & Rehab. Ctr.*, DAB No. 2382, at 20 (2011)).

The Board has previously held that the noncompliance found during a survey is "presumed to continue until the facility demonstrates that it has achieved substantial compliance." *Taos Living Ctr.*, DAB No. 2293, at 20 (2009). The regulations and prior

Board decisions also make clear that a facility's "noncompliance is deemed to be corrected or removed only when the incidents of noncompliance have ceased and the facility has implemented appropriate measures to ensure that similar incidents will not recur." *Florence Park Care Ctr.*, DAB No. 1931, at 30 (2004) (emphasis in original); *see also Oceanside Nursing & Rehab. Ctr.* at 20. Moreover, the facility "bears the burden of showing that it returned to substantial compliance on a date earlier than that determined by CMS," and the Board "has rejected the idea that CMS must establish a lack of substantial compliance during each day in which a remedy remains in effect." *Owensboro Place & Rehab. Ctr.*, DAB No. 2397, at 12 (2011).

Factual Background[2]

Golden is a long-term care facility located in Foley, Alabama that participates in the Medicare program. The issues in this case concern an accident involving Resident 22 (R22) on January 30, 2011. R22 was a long-term resident of Golden, having first been admitted on December 8, 2008. At the time of the accident, she was 71 years old, and her diagnoses included obesity, dementia, status-post stroke, schizophrenia, hypertension, hypothyroidism, and contractures. R22 was unable to speak, was bed-and-wheelchair-bound, and required extensive assistance with all activities of daily living, including transfers. CMS Ex. 7, at 6-7, 19; CMS Ex. 8, at 1, 34; P. Ex. 4, at 1; P. Exs. 5-8; P. Ex. 9, at 5, 13-16.

On January 30, 2011, a Certified Nursing Assistant (CNA) with the initials of NJ was attempting to transfer R22 by using a "Sara" lift device, which requires the resident to stand on a platform.[3] Normally, R22 would be transferred by two staff members. However, when CNA NJ attempted to find someone to help her transfer R22, everyone was busy, and she attempted to transfer R22 by herself. During this process, R22 slipped off of her bed and fell, landing on the foot platform of the Sara lift. Instead of following facility policy and alerting the licensed nursing staff so that a nursing assessment of R22 could be done, CNA NJ herself checked R22 for any injury. She then lowered the bed

[2] The factual information in this section, unless otherwise indicated, is drawn from undisputed findings of fact in the ALJ Decision and undisputed facts in the record and is presented to provide a context for the discussion of the issues raised on appeal. Nothing in this section is intended to replace, modify, or supplement the ALJ's findings of fact or conclusions of law.

[3] As summarized in the ALJ Decision, there are two different kinds of lifts which Golden's staff employed, the Sara lift and the "Marisa" lift (also called a Hoyer lift). ALJ Decision at 8, citing Hearing Transcript (Tr.) at 381-382. According to the facility's Director of Nursing (DON), a Marisa lift "is extremely safer" than the Sara lift. Tr. at 570. The Sara lift is used to transfer patients in a standing position whereas the Marisa lift is used to transfer patients in a seated, slightly reclined position. CMS Ex. 11, at 10, 21-24; CMS Ex. 12, at 14. The Sara lift has hand bars that the resident holds on to and requires the resident to be able to stabilize himself or herself in either a sitting or a standing position. Tr. at 54, 285. The Sara lift is for "limited-assist, weight bearing individuals" who can grasp a handlebar and are able to follow simple directions. P. Ex. 19, at 1; P. Ex. 20, at 17; Tr. at 285; P. Br. at 10. It should not be used for residents who are not able to bear weight. CMS Ex. 12. The Marisa lift provides greater support for such residents. Depending on the circumstances, the lifts can be used with one or two persons and have additional supportive straps or accessories to increase safety based on the particular patient's needs.

and used the Sara lift to move R22 back into bed. CNA NJ then located another staff member who assisted her in transferring R22 back to the wheelchair. At that point, CNA NJ claims that she reported the fall to the nurse in charge, CS, who either did not hear or understand what CNA NJ was saying. Either way, the facility's nursing staff did not assess R22 for injuries after the fall. Golden also did not notify R22's physician doctor or family representative. CMS Ex. 16, at 1, 3. The facility also did not document the fall in its 24-hour report or prepare an incident report. *Id*. In addition, there are no nursing notes at all relating to R22 for four days following her fall.

On the afternoon of February 1, 2011, a different CNA, CD, reported to Nurse FK that R22's left knee was bruised and swollen. Nurse FK conducted an assessment and determined that R22 was not in any pain and concluded that the bruising and swelling were consistent with R22's arthritis. P. Ex. 15, at 2. Later that evening, the same CNA reported to Nurse CH that R22's knee was bruised and swollen. Nurse CH conducted an assessment of R22 and reached the same conclusion. CMS Ex. 9, at 61, 73; P. Ex. 15, at 2. On the morning of February 2, 2011, two different CNAs reported to Nurse SC that R22 had a bruise on her left inner thigh. Nurse SC conducted an assessment and found "nothing significant" but reported the bruise to Nurse CD. CMS Ex. 9, at 15. Nurse CD subsequently conducted an assessment of R22 and concluded that she had "old bruises" on her thigh and behind her right knee but was not experiencing any pain. *Id.* at 9. None of the four nurses documented the results of their assessments of R22. On the morning of Thursday, February 3, 2011, Nurse CD reported her assessment to Nurse SC, who subsequently reported the matter to the facility's Assistant Director of Nursing (ADON). The ADON consulted with the Director of Nursing (DON), who then contacted R22's physician during the afternoon of February 3.

The physician ordered an x-ray of R22's left femur and knee on February 3, 2011. CMS Ex. 8, at 11, 17. The results were faxed to Golden at 9:57 p.m. that evening. The x-ray report indicated that R22 had an "impacted supracondylar fracture of the femur" (i.e., a comminuted fracture of the hip that contained four fragments). *Id.* at 5; Hearing Transcript (Tr.) at 434. Golden waited approximately nine hours before acting on that report. Golden did not immediately contact R22's physician, address pain issues, or otherwise take any action based on the x-ray report. Golden's staff did not notify R22's physician about the x-ray results until about 6:38 a.m. the following morning. CMS Ex. 8, at 17. After being informed about R22's multiple hip fractures, her doctor ordered that the facility immediately transfer R22 to the emergency room (ER) for evaluation and treatment. *Id.* At the hospital, R22 received intravenous morphine for treatment of pain associated with her fractured hip. The treating ER physician concluded that the fracture was the result of a traumatic event such as a fall.

After Golden learned of R22's fractured hip from the x-ray report, Golden's Administrator and DON conducted an investigation to determine how R22 could have sustained a fracture. *See* Tr. at 455-459; P. Ex. 15. Golden conducted an investigation

and summarized the results in a "Verification Report." P. Ex. 15. The investigation report stated that "a 4 step plan of correction was implemented with emphasis on training staff on timely reporting events to nurses, MD/RPs [i.e, medical doctors and responsible parties], appropriate follow up and documentation, [and] re-assessment of residents as needed." *Id.* at 3. Although it is unclear when the training was completed, the investigation report contained a "goal" date of February 18, 2011. P. Ex. 16.

Responding to a complaint about this incident, the State of Alabama Department of Public Health (state survey agency) completed a survey of Golden on March 5, 2011. The state survey agency determined that Golden's care of R22 was noncompliant with participation requirements involving accidents and supervision set forth at 42 C.F.R. § 483.25(h) beginning on January 30, 2011. The surveyors also determined that the noncompliance was at a level of immediate jeopardy and constituted substandard quality of care. In addition, the state survey agency found that the immediate jeopardy was abated on March 5, 2011 but that Golden remained noncompliant with section 483.25(h) at a lower level of scope and severity. CMS Ex. 1, at 1; P. Ex. 1, at 1.

Based on these events, CMS found Golden not in substantial compliance with participation requirements and imposed a $4,050 per day CMP from January 30, 2011 through March 4, 2011. CMS also imposed a $100 per day CMP beginning March 5, 2011 until Golden returned to substantial compliance and a DPNA beginning April 2, 2011. CMS Ex. 2.

On April 4, 2011, the state survey agency conducted a revisit survey, finding that Golden remained out of substantial compliance. Based on the revisit survey, CMS continued the $100 per day CMP and the already-imposed DPNA until Golden returned to substantial compliance. CMS Ex. 17. Golden waived its right to challenge the imposition of the remedies imposed based on the revisit survey (the $100 per day CMP and DPNA as of the date of the resurvey on April 4, 2012). *Id.* at 5. CMS found that Golden ultimately returned to substantial compliance on April 22, 2011. P. Ex. 2.

Golden requested a hearing by letter dated May 17, 2011. During the prehearing briefing process, CMS alleged two additional deficiencies involving physician and family notification under 42 C.F.R. § 483.10(b)(11) and quality of care under 42 C.F.R. § 483.25(h). ALJ Decision at 6 n. 6.

The ALJ held a hearing in this case in Mobile, Alabama on February 6, 7, and 8, 2012. A 701-page transcript of the hearing was prepared and is part of the record. Three state survey agency surveyors testified on behalf of CMS. Testifying on behalf of Golden were its ADON, DON, and Administrator.

The ALJ Decision

The ALJ found that Golden was not in substantial compliance with three health and safety requirements: the accident hazard and supervision requirements, 42 C.F.R. § 483.25(h); the requirement to consult immediately with R22's physician and to notify immediately R22's family member concerning a significant change in condition, 42 C.F.R. § 483.10(b)(11); and the overarching quality of care requirement, 42 C.F.R. § 483.25. ALJ Decision at 6, 13, 16. In addition, the ALJ found that CMS's determination that Golden's noncompliance posed immediate jeopardy to resident health and safety was not clearly erroneous. *Id*. at 19. The ALJ further found that the noncompliance at the immediate jeopardy level extended from January 30 through March 4, 2011, and that the noncompliance that was not immediate jeopardy lasted from March 5 through at least April 3, 2011 (as noted, Golden did not challenge the noncompliance findings for April 4-22, 2011). *Id*. at 20.

Regarding the issue of immediate jeopardy, the ALJ stated that:

> [B]ecause [Golden's] staff incorrectly transferred R22, she suffered a fall that resulted in her femur fracture. That is actual serious harm. The facility then failed to take any action in response, and did not even assess or treat the injury[,] compounding the seriousness of the harm to R22 and risking others similarly situat[ed]. Even if the fall did not cause R22's fracture, it certainly had the likelihood to cause serious injury, and the staff did nothing about it. Furthermore, once Petitioner's staff was informed of R22's femur fracture, they did absolutely nothing about it for about nine hours. Once the facility contacted R22's physician, he ordered her transferred to the emergency department, indicating that this fracture was a serious medical injury. The fact that they did not report this emergency for about nine hours constitutes a situation of immediate jeopardy to R22's health and safety.

ALJ Decision at 20. Based on these facts, the ALJ concluded that CMS's determination of immediate jeopardy from January 30 through March 4 was not clearly erroneous. Moreover, the ALJ found that after the immediate jeopardy was abated, Golden continued to remain out of substantial compliance as evidenced by the revisit survey team observing "a CNA transferring a resident while using the incorrect lift and with an insufficient number of staff present to assist." *Id*. at 21.

Finally, the ALJ found that the CMPs imposed were reasonable in amount given the "very serious" nature of the noncompliance. ALJ Decision at 21-22. Indeed, the ALJ observed that "[t]hroughout this case, the circumstances surrounding the violations fall on the range of neglect or indifference at the very least." *Id*. at 22.

Standard of Review

The Board's standard of review on a disputed finding of fact is whether the decision is supported by substantial evidence on the record as a whole. *Guidelines for Appellate Review of Decisions of Administrative Law Judges Affecting a Provider's Participation in the Medicare and Medicaid Programs* (Board Guidelines), available at http://www.hhs.gov/dab/divisions/appellate/guidelines/prov.html. The "substantial evidence" standard is deferential. Substantial evidence "does not mean a large or considerable amount of evidence, but 'rather such relevant evidence as a reasonable mind might accept as adequate to support a conclusion.'" *Pierce v. Underwood*, 487 U.S. 552, 565 (1988), *quoting Consolidated Edison Co. v. NLRB*, 305 U.S. 197, 229 (1938); *Johnson v. Comm'r of Soc. Sec.*, 529 F.3d 198, 200 (3d Cir. 2008); *Hartranft v. Apfel*, 181 F.3d 358, 360 (3d Cir. 1999). "Substantial evidence" is "more than a mere scintilla. It 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.*, 305 U.S. at 229. In an adequately developed factual record, substantial evidence may be "something less than the weight of the evidence, and the possibility of drawing two inconsistent conclusions from the evidence does not prevent an administrative agency's finding from being supported by substantial evidence." *Consolo v. Fed. Maritime Comm'n*, 383 U.S. 607, 620 (1966). Under the substantial evidence standard, the reviewer must examine the record as a whole and take into account whatever in the record fairly detracts from the weight of the evidence relied on in the decision below. *Universal Camera Corp. v. NLRB*, 340 U.S. 474, 488 (1951).

The Board's standard of review on a disputed conclusion of law is whether the ALJ's decision is erroneous. Board Guidelines.

Analysis

Golden raises two issues on appeal before us.[4] First, Golden challenges the ALJ's conclusion that it was not in substantial compliance with three regulatory provisions – sections 483.25(h), 483.10(b)(11), and 483.25. Second, Golden contends that if it was noncompliant with these regulatory provisions, it returned to substantial compliance when its investigation and re-training of staff were completed sometime during the second week of February 2011.

Before we begin our analysis a few observations need to be stated. First, Golden's rendition of the "facts" in this case in the "Background" section of its request for review frequently is argumentative, is inaccurate, or misrepresents the record, even though most

[4] Golden does not challenge the ALJ's conclusion that the noncompliance, if present, posed immediate jeopardy to resident health and safety. Nor does Golden challenge the ALJ's conclusion that the CMP amounts chosen by CMS were reasonable.

of the material facts are largely undisputed. Moreover, Golden does not cite to the record to support many of its assertions. Golden also makes little effort in the "Argument" section of its brief to support its general assertion that the ALJ's findings of fact are not supported by substantial evidence in the record. In addition, Golden offers a number of "suggestions" for the Board to change previously adopted interpretations of the regulations, criticisms of how the ALJ and Board analyze cases, and citations to cases that do not support the argument raised. We found none of these "suggestions" or criticisms relevant or material to the issues before us in the present case and therefore do not discuss them further. We stress, however, that we carefully reviewed the record and considered all of Golden's arguments before concluding that they are unpersuasive and do not compel a different result in this case.

A. The ALJ's conclusion that Golden was not in substantial compliance with 42 C.F.R. §§ 483.25(h), 483.10(b)(11), and 483.25 is supported by substantial evidence in the record and is free from legal error.

1. *The ALJ's conclusion that Golden was not in substantial compliance with 42 C.F.R. § 483.25(h) is supported by substantial evidence in the record and is free from legal error.*

Section 483.25(h) is a subpart of the quality of care regulation at section 483.25, which states that "[e]ach resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care." Section 483.25(h) imposes specific obligations upon a facility related to accident hazards and accidents, as follows:

> The facility must ensure that —
>
> (1) The resident environment remains as free of accident hazards as is possible; and
> (2) Each resident receives adequate supervision and assistance devices to prevent accidents.

Numerous Board decisions have explained the requirements under section 483.25(h). For example, the Board has held that section 483.25(h)(1) requires that a facility address foreseeable risks of harm from accidents "by identifying and removing hazards, where possible, or where the hazard is unavoidable because of other resident needs, managing the hazard by reducing the risk of accident to the extent possible." *Maine Veterans' Home – Scarborough*, DAB No. 1975, at 10 (2005). In addition, the Board has held that section 483.25(h)(2) requires that a facility take "all reasonable steps to ensure that a resident receives supervision and assistance devices that meet his or her assessed needs and mitigate foreseeable risks of harm from accidents." *Briarwood Nursing Ctr.*, DAB

No. 2115, at 5 (2007), *citing Woodstock Care Ctr.*, DAB No. 1726 (2000) (*Woodstock*), *aff'd, Woodstock Care Ctr. v. Thompson*, 363 F.3d 583 (6th Cir. 2003) (facility must take "all reasonable precautions against residents' accidents"). A facility must also "provide supervision and assistance devices that reduce known or foreseeable accident risks to the highest practicable degree, consistent with accepted standards of nursing practice." *Century Care of Crystal Coast*, DAB No. 2076, at 6-7 (2007), *aff'd, Century Care of Crystal Coast v. Leavitt*, 281 F. App'x 180 (4th Cir. 2008).

The regulations permit facilities some flexibility in choosing the methods they use to provide supervision or assistive devices to prevent accidents, so long as the chosen methods constitute an adequate level of supervision for a particular resident's needs. *Windsor Health Care Ctr.*, DAB No. 1902 (2003), *aff'd, Windsor Health Ctr. v. Leavitt*, 127 F. App'x 843 (6th Cir. 2005). In choosing its methods, a facility is obligated to anticipate reasonably foreseeable accidents that might befall a resident and take steps – such as increased supervision or the use of assistance devices, for example – calculated to prevent them. *Aase Haugen Homes, Inc.*, DAB No. 2013 (2006).

Section 483.25(h) does not make a facility strictly liable for accidents that occur, but does place an "affirmative duty [on facility staff] to intervene and supervise . . . behaviorally impaired residents in a manner calculated to prevent them from causing harm to themselves and each other." *Vandalia Park*, DAB No. 1940, at 18 (2004), *aff'd, Vandalia Park v. Leavitt*, 157 F. App'x 858 (6th Cir. 2005). As the Board stated in *Josephine Sunset Home*, DAB No. 1908, at 13 (2004), the "mere fact that an accident occurred does not, in itself, prove that the supervision or devices provided must have been inadequate to prevent it." On the other hand, it is not a prerequisite to finding noncompliance under section 483.25(h)(2) that any actual accident have occurred or be caused by the inadequate supervision. *Woodstock Care Ctr.* at 17. The occurrence of an accident is relevant to the extent the surrounding circumstances shed light on the nature of the supervision being provided and its adequacy for the resident's condition. *St. Catherine's Care Ctr. of Findlay, Inc.*, DAB No. 1964, at 12 (2005) (accident circumstances may support an inference that the facility's supervision of a resident was inadequate).

The regulation speaks in terms of ensuring that what is "practicable" and "possible" to do is done. What is thus required of facilities is not prescience but reason and professional judgment in assessing what can be done to make residents (given their special needs) safe, through removing accident hazards, providing appropriate devices, and ensuring adequate supervision. *Josephine Sunset Home* at 14-15; *Briarwood Nursing Center* at 11-12.

The ALJ held that Golden was not in substantial compliance with section 483.25(h). ALJ Decision at 9-12. The ALJ first found that Golden should have used a Marisa lift in transferring R22 instead of a Sara lift because at the time of the fall, R22 lacked trunk

stability, her legs would stiffen during transfer, and she was not able to follow directions. *Id*. at 9-10. Second, the ALJ concluded that after R22's condition declined, Golden failed to reassess R22 for the appropriate type of lift before her fall on January 30. *Id*. at 10. Third, the ALJ found that having decided to use the Sara lift, Golden failed to provide additional protective measures to reduce the foreseeable risk of a fall by R22, such as using two staff members to transfer her and leg straps to help secure her during the transfer process. *Id*. at 10-11. Finally, the ALJ concluded that Golden failed to reassess R22 for the appropriate type of lift even after her fall on January 30. *Id*. at 12.

In summary, the ALJ concluded that by using the less-supportive Sara lift, without a second staff member to aid in R22's safety, and also without the additional support of the leg straps to reduce the risk of an accident, Golden failed to ensure that R22's environment remained as free of accidents and hazards as possible and failed to employ supervision that was reasonable in light of R22's needs, in violation of section 483.25(h). ALJ Decision at 12-13.

Golden argues that: 1) its staff used the correct lift to transfer R22; 2) two staff members were not needed to transfer R22; 3) leg straps were not needed for R22 during the transfer process; and 4) there was no need to reassess R22 after she fell on January 30, 2011. For the reasons explained below, we find that substantial evidence in the record supports the ALJ's conclusion that Golden was not in substantial compliance with section 483.25(h) in at least three material respects.

a. Golden failed to use the correct type of lift in transferring R22.

The evidence shows that R22 weighed nearly 200 pounds and suffered from numerous medical infirmities, including the effects of a stroke and dementia, was essentially bed-and-wheelchair-bound, and required extensive assistance with all activities of daily living, including transfers. P. Exs. 5-8, P. Ex. 9, at 13-14; P. Ex. 10, at 1. R22 was not able to speak as a consequence of her ailments but was able to express pain and discomfort through facial expressions. P. Ex. 6, at 7; P. Ex. 7, at 7; P. Ex. 9, at 5, 16; P. Ex. 12, at 32. Golden acknowledges that when R22 was initially admitted as a resident in December 2008, she was assessed as having a "plainly high" risk for falls. Request for Review (RR) at 31.

The ALJ concluded that Golden should have used a Marisa lift instead of a Sara lift during her transfer on January 30. ALJ Decision at 9. The ALJ observed that the facility's records, "including lift assessments, nursing notes, [R22's] care plan, physician notes, as well as testimony vary as to whether the Sara or Marisa lift was the most appropriate lift for R22." *Id.* As the ALJ accurately observed, "Petitioner's records are inconsistent as to whether R22 could bear weight or follow simple instructions." *Id*. The record contains only four lift/mobility assessment forms that Golden used to document

R22's ability to use a Sara or Marisa lift.[5] CMS Ex. 8, at 6, 7, 9, 10. When R22 was admitted to the facility in December 2008, a member of Golden's nursing staff assessed R22 and determined that a Marisa lift was appropriate to be used for transfers because she could not follow simple instructions or grasp the handlebars of the Sara lift.[6] *Id.* at 10. That lift assessment was documented in the Resident's Initial Care Plan. P. Ex. 12, at l, 7, 16. A second assessment conducted a month later on January 7, 2009 similarly concluded that R22 should use a Marisa lift for transfers for the same reasons. CMS Ex. 8, at 6. However, an assessment two months later on March 8, 2009 indicated that R22 could use a Sara lift because she was able to bear weight on at least one leg, to follow simple instructions, to grip the Sara handle with at least one hand, and to bear moderate pressure in the mid to lower back region. *Id.* at 9, 7. There is no evidence in R22's medical record indicating that there was an improvement in her medical condition during this period that would account for this change in the type of lift used. Nursing notes indicate that in November 2009 and January 2010, R22 was once again transferred using a Marisa lift, though again there is no evidence in the record indicating that R22's medical condition had deteriorated between March and November 2009. P. Ex. 14, at 7, 10.

The last lift/mobility assessment involving R22 was completed on October 18, 2010 (over three months before R22's fall) and reviewed on December 13, 2010. That assessment indicated that R22 could follow simple instructions and that a Sara lift was appropriate to use. CMS Ex. 8, at 7. However, the Minimum Data Set (MDS)[7] for R22 that was also dated December 13, 2010 (i.e., about six weeks before the fall) indicated that R22 "[r]arely/never understands" verbal content. P. Ex. 9, at 5. There is no indication in R22's care plan or other facility records that explains the inconsistency in recording R22's medical condition. In addition, Golden does not point to any information in R22's medical file that shows that R22's condition varied during her two-year residency at Golden in way that warranted these changes from the Marisa lift to the Sara lift, back to the Marisa lift, and then back to the Sara lift. Two of the surveyors who are registered nurses testified that they did not find any documentation in R22's nurses notes explaining why Golden switched from using the Marisa lift to the Sara lift. Tr. at 280-81, 309. The ADON specifically testified that she did not know why the facility stopped using the Marisa lift with R22, even though she would expect to see documentation of the reasons for the change in the type of lift used. Tr. at 411, 415.

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[5] Golden represents that it reassessed its residents on a quarterly basis, but neither party considered it necessary to offer all of R22's historical quarterly assessments. RR at 13, 15.

[6] Other relevant factors used by the facility in its lift assessment include whether a resident can bear weight on at least one leg and whether the resident is able to undergo moderate pressure to the mid to lower back. CMS Ex. 8, at 10.

[7] The MDS is a standard form on which a SNF enters information about a resident's clinical status and functional capacity. *See Oaks of Mid City Nursing and Rehab. Ctr.*, DAB No. 2375, at 19 (2011).

The facility's staff who cared for R22 indicated that a Sara lift was in fact not appropriate because R22 could not balance herself and had stiff legs and that two persons were needed to transfer R22 for resident safety. *See* CMS Ex. 9, at 56, 82, 20, 39, 21, 33, 77. 15. Indeed, about a week before the fall, CNA NJ told Nurse CH "that she thought [R22] should be switched from the Sara lift to the hoyer [i.e., Marisa] lift." *Id.* at 73; *see also id*. at 20 (CNA NJ stated that "I also told [Nurse CH] . . . that I thought [R22] should be [transferred with] a marisa lift instead of a sara lift because she was not able to bear weight and she had no muscle control"); Tr. at 111.[8] CNA NJ also told the surveyors that "a lot of the [CNAs] on [the] evening shift felt that the Sara lift did not best meet the needs of the residents. They felt [R22] need[ed] the hoyer lift [although they] never brought it to the attention of the nursing staff." *Id.* at 22. For example, CNA DF told the surveyors that R22 was "stiff" and "would be hesitant getting on the lift." CMS Ex. 9, at 33. CNA DF also said that R22 could not bear weight and was "total care" and "could not even turn over" in bed. *Id.*

Nurse CH also put a note communicating CNA NJ's concern in the mailbox of the nurse (MC) who was in charge of conducting the lift/mobility assessments. CMS Ex. 9, at 55; Tr. at 169. Nurse MC subsequently spoke to a CNA (though she could not remember who she talked to) who told her that it was getting more difficult to transfer R22 using the Sara lift. Nurse MC told the surveyor that she had intended to watch the CNA use the Sara lift with R22 in order to reassess the continued appropriateness for using the lift, but Nurse MC did not have an opportunity to conduct the reassessment prior to R22 going to the hospital on February 4, 2011. CMS Ex. 9, at 55, 59.

Furthermore, other evidence indicates that R22's condition worsened in the time from the MDS (December 2010) to the fall. For example, LPN CH told surveyors that "[R22's] condition started to decline over [the] last three weeks [before her fall,] and [she] was no longer able to follow directions and balance herself." CMS Ex. 9, at 74; Tr. at 71. Nurse CH further stated that R22 "would stiffen up [and] type of lift should be changed." CMS Ex. 9, at 74. In addition, Nurse CH told the surveyor that she had not agreed with the decision to switch R22 from the Marisa lift to the Sara lift in the beginning. Tr. at 137.

Shortly before the January 30, 2011 fall, R22 was referred for an occupational therapy evaluation. On January 6, 2011, the occupational therapist diagnosed R22 as demonstrating "abnormal posture," with right trunk lateral flexion. P. Ex. 10, at 8. The therapist observed that while seated in her wheelchair, R22 "demonstrate[d] lateral leaning to [the right] side" and recommended to order and fit R22 with a "positioning device in order to reduce risk for falls" and educate nursing staff. *Id.* at 9. The occupational therapist also recommended that R22 undergo therapy for neuromuscular reeducation and wheelchair management two times a week for a period of three weeks. *Id.* at 8.

[8] CNA NJ also told the surveyors that Nurse CH put a note in the unit supervisor's box communicating CNA NJ's concerns, but R22 was not reassessed for the appropriate lift. CMS Ex. 9, at 20.

The two registered nurses from the survey team offered opinions that the Marisa lift was a safer lift for Resident 22 because it did not require a resident to bear weight, did not require a resident to follow directions, and did not require a resident to be able to stabilize herself in a standing or sitting position. Tr. at 183-184, 187-188, 278, 283-285.

Based on the evidence in the record about R22's medical condition shortly before her fall, the ALJ found that R22 did not possess trunk stability. ALJ Decision at 11. As the ALJ observed, "R22's inability to support herself while seated in a wheelchair should have raised serious concerns about whether a Sara lift could safely be utilized." *Id.* at 9.

Golden argues that the ALJ should not have relied upon lift/mobility assessments that were over two years old in determining the most appropriate lift to assist R22 during transfers. However, this argument overlooks other testimonial and documentary evidence, including the most current MDS that was completed only six weeks prior to R22's fall, showing that Golden's staff had seen declines in the resident's condition which they should have recognized would make continued use of the Sara lift unsafe. The earlier assessments simply provide context showing that R22 had long had serious problems, especially with bearing weight and following directions, making lift safety important for this dependent resident. The spotty record of assessments casts doubt on whether the facility made adequate efforts to track and respond to her changing condition, even if the use of the Sara lift could reasonably have been considered safe in March 2009. In that context, the ALJ could reasonably conclude that the weight of the evidence established that, at least by January 2011, the facility should have been well aware that continued use of the Sara lift placed R22 at unnecessary risk.

Golden also points out that the ADON testified that she personally observed R22 being transferred with the Sara lift several times and considered it safe for R22 to be transferred in that way. Tr. at 401. The DON also testified that she believed that it was acceptable for CNA NJ to transfer R22 with the Sara lift and that it was not necessary for two staff members to assist in the transfer. Tr. at 483. However, the ADON testified that it was "not my job" to make "daily observations" of R22. Tr. at 413. That responsibility belonged to the CNAs and nurses who took care of her. *Id*. Nor did the DON testify that she was the primary staff caregiver for R22. Furthermore, neither the DON nor the ADON testified that she had observed R22 during the last three weeks before her fall, yet, as also discussed above, R22's medical condition declined in ways that impacted the safety of using the Sara lift to transfer her. Indeed, the ADON testified that she last observed R22 sometime in December 2010. Tr. at 413. Finally, neither the DON nor the ADON testified to observing R22's mental or physical condition on the day that she fell. The ALJ could reasonably give more weight to the opinions of the facility's frontline caregivers, who, as discussed above, clearly did not feel they could safely transfer R22 with the Sara lift.

b. Golden failed to ensure that two staff members were used to assist R22 during transfers.

As the ALJ correctly observed, if Golden's staff decided to use the Sara lift to transfer R22, Golden's responsibility was to at least implement other safety measures to compensate for any diminished effectiveness of that device or to tailor it to meet the specific needs of R22. ALJ Decision at 10; *see also* Tr. at 278-80. The ALJ concluded that two staff members were needed to transfer R22 safely if using the Sara lift. ALJ Decision at 10. We agree with the ALJ that engaging a second staff member to assist in R22's transfer and using leg straps could have helped to compensate for additional risks of using a Sara rather than Marisa lift in R22's situation. *Id*. Yet it is undisputed that Golden took neither step to mitigate a foreseeable risk that R22 would fall due to her fragile medical condition.

The record shows that if a resident lacks "sitting balance," then a second staff person should be used to support the resident when using a Sara lift. P. Ex. 20, at 8, 11; Tr. at 185, 269 (one staff member is used to balance the resident while the second staff member operates the lift control). In addition, as the ALJ observed, instructions in the Sara Lift 3000 Operations Manual "are described as if lifting a patient from a chair. The same operations can be performed effectively when lifting a patient from a wheelchair or sitting position on a bed, **although a second attendant should support the patient if the patient lacks sitting balance."** ALJ Decision at 11, *quoting* P. Ex. 21, at 7 (emphasis added). The Operations Manual further states – "! Caution: If the patient lacks sitting balance and has been returned to sit on the side of the bed a second attendant may be needed to support the patient while the sling is being removed." P. Ex. 21, at 15.

As the ALJ found, R22's medical records, including her most recent MDS, nursing notes, occupational therapy evaluation, and other assessments, along with caregiver interviews and witness testimony, demonstrate that R22 did not have sitting balance, was not stable during surface-to-surface transfers, and needed human assistance to stabilize herself. ALJ Decision at 10. For example, the MDS dated December 10, 2010 indicates that for transfer (i.e., how a resident moves between surfaces including to or from bed, chair, wheelchair, standing position), R22 was coded as a "3" requiring "Two+ persons physical assist" and was coded as a "2" for surface-to-surface transfer (i.e., transfer between bed and chair or wheelchair) indicating that she was "Not steady, <u>only able</u> to stabilize with human assistance."[9] P. Ex. 9, at 13-14 (emphasis in original).

[9] We recognize that the facility's "Kardex," which is a system used by staff to summarize a resident's plan of care for CNAs, included a notation stating "1 Person Assist." P. Ex. 12, at 4. Although the ALJ did not specifically address the Kardex notation, he could reasonably give little weight to this notation because it is undated and unsigned.

In addition, the surveyors testified that all of the CNAs involved with R22's care told them that they used a two-person assist when transferring R22. Tr. at 61, 62; *see also* Tr. at 484. For example, CNA NJ reported that "usually we try to do lift transfer with two people present but sometimes it is done with only one staff member. I did tell [CNA CD] that we should not transfer the residents, especially [R22] by ourselves because it was not safe for the resident. Everyplace I have work[ed,] you are supposed to have two people for a mechanical lift[, and] I told her this before the fall." CMS Ex. 9, at 21. CNAs DA and DF both told the surveyors that they always used a partner when transferring R22 because she had poor balance and was very stiff. *Id*. at 5, 33. CNA CC similarly said that "we never transfer[end] [R22] with just one person because she stiffens up and she is very difficult to move . . . everybody knew that [R22] was a two person assist." *Id*. at 49. LPN SC told the surveyors that "two people [are] needed to transfer [R22] if you are not used to her because she stiffens up [and that] all of my [CNAs] always do a two person assist to ensure patient safety." *Id*. at 15. Nurse MC told the survey team that "due to the fact that [R22] was so stiff and hard to handle[,] I always told the CNAs to use two people [during transfer with the Sara lift] just in case." *Id*. at 57. Nurse CH echoed the same concern as Nurse MC. *Id*. at 73. LPN CD told the surveyors that while some of the CNAs used only one person to transfer R22, "based on [R22's] weight they know (the CNAs) that they should use a two person assist." *Id*. at 9.

It is undisputed that on January 30, 2011, CNA NJ transferred R22 using a Sara lift by herself and that during the transfer, R22 slipped off the bed and landed on the foot platform. Golden argues that CNA NJ did not need a second person to assist her in transferring R22 on January 30 and that CNA NJ could have transferred R22 safely by herself.[10] RR at 17 n.16. The facility has not pointed to any evidence that the ALJ failed to consider that contradicts the reasons given by its own staff for why a second person was needed. For example, Golden did not present evidence indicating that R22 was easy to handle and move, would not stiffen up, could follow simple instructions, had good balance, and was not hesitant about getting on the Sara lift.

Golden also argues that there is no evidence that a two-person assist would have prevented a fall or that a second CNA would have caught R22 when she fell. RR at 31-32. Golden further points out that "it is undisputed that the Resident actually was transferred via the 'Sara' lift without incident for many months thereafter, several times per day, hundreds of times in total, prior to her accident in January, 2011." *Id*. at 17-18. However, that is not the issue. As explained in prior Board decisions, the relevant inquiry for the ALJ is to determine whether Golden took all reasonable steps to mitigate the foreseeable risk of

[10] Golden also argues that "surveyor notes indicate that other CNAs reported that only one person was needed" to transfer R22. RR at 17 n.16, *citing* CMS Ex. 9, at 5, 29. However, the record does not support Golden's assertion. The first citation is to the surveyor's notes of her interview with CNA DA, who told the surveyor that "[y]ou can operate the lift with one person but with this resident [i.e., R22] I felt more comfortable using a two person transfer because [the] resident had poor balance and was very stiff." CMS Ex. 9, at 5. She also said that "I cannot remember how many people were needed to transfer [R22]. I just know I always used a partner." *Id*. The second citation was to the surveyor notes of CNA MS, but the notes do not indicate that the CNA even mentioned the number of people she used in transferring R22. *Id.* at 29.

a resident such as R22 falling. *See e.g., Briarwood Nursing Ctr*. at 11. As the ALJ correctly concluded, substantial evidence in the record shows that it did not. Indeed, CNA NJ told the surveyors that "if two staff members were present during the transfer on [January 30, 2011] that could have prevented the [R22's] fall. [NJ further stated] I was real nervous about having to transfer [R22] with the lift by myself." CMS Ex. 9, at 21-22. CNA NJ also stated that R22 "was very stiff [and] I would have to pull the resident's arms to get them up the handles [and] you have to take your knee to press up against [R22's] leg to get her legs secured in the lift. I knew it would be better with two people." *Id.* at 22.

Golden also argues that R22's condition "waxed and waned" and that the number of people needed to transfer R22 varied from day to day, suggesting that on some days R22 only needed one staff person to be transferred, while on other days she needed two persons. RR at 10, 15, 31. Golden further contends that the facility may rely upon "a nurse's or CNA's observation of and judgment regarding a resident's condition or demeanor at a specific point in time" and that "it is within a CNA's scope of practice to make the judgment to use *greater* assistance than an assessment provides for on a specific occasion. *Id*. at 13, 16 n.15 (italics in original). Golden also argues that R22's "care plan properly allowed CNA NJ to make the judgment that she could complete the transfer in question by herself." *Id*. at 31. In other words, Golden seems to suggest that CNA NJ had exercised her professional judgment in deciding that R22's medical condition on January 30 was such that only one person was necessary to transfer her.

Golden's argument is not supported by any evidence in the record. First, as discussed in the prior section, R22's medical condition had been declining for three weeks prior to the fall, not improving to the point where she was capable of being transferred by only one staff member. Golden's argument is also undercut by the CNA's statement to the survey team that "[t]he nurses tell us how many people are needed for a Sara transfer." CMS Ex. 9, at 5. Finally, the record unequivocally shows that on the day that she attempted to transfer R22 by herself (January 30, 2011), CNA NJ did not in fact exercise any professional "judgment" in deciding to transfer R22 by herself. Instead, as CNA NJ told the survey team, she initially looked for a second staff member to help her transfer R22, but everyone was busy; so she tried to transfer R22 on her own even though she was "nervous" and thought it was unsafe to do so. CMS Ex. 9, at 21-23, 81, 83.

c. Golden failed to ensure that its staff used leg straps to securely fasten R22 during transfers.

The ALJ also found that Golden failed to ensure that its staff used leg straps to securely fasten R22 during transfers in violation of section 483.25(h). ALJ Decision at 11. We agree with the ALJ that the facility could have used leg straps during transfers with R22 to help compensate for the fact that the Sara lift was less effective than the Marisa lift in preventing falls. *Id*.

As the DON recognized, all of Golden's staff involved with R22's care told the surveyors that they used leg straps when transferring R22 with a Sara lift. Tr. at 483-484. For example, CNA DF stated that "when transferring [R22] I would always make sure the [leg] straps around [R22's] legs were fastened because the resident's legs were never straight, and [the strap] was more secure, and it helped prevent [her] from sliding." CMS Ex. 9, at 34. She also stated that "if the belt is not attached especially on [R22] she could slip because [R22] was not able to put weight on her legs." *Id*. CNA CC indicated that staff had to use the leg straps on R22 because if staff did not use them, R22's legs would go out and her feet would turn inward, her feet could slide, or her knee could give out. *Id*. at 49, 51, 53. Nurse CS indicated that "if you do not secure the straps behind [R22's legs] you are not operating the lift safely." *Id*. at 39. Nurse CH stated that the leg straps are needed behind the resident's legs for stability and patient safety. *Id*. at 73, 75. Nurse MC stated that whenever the Sara lift is used to transfer a resident, "you are supposed to buckle up the [leg] straps . . . [b]ecause the straps provide extra support for the [resident's] legs." *Id.* at 57. **Golden did not present testimony from any of R22's direct caregivers indicating that the leg straps were not needed to safely transfer her.** In further support for his finding that Golden's staff needed to use leg straps to reduce the risk of injury to R22, the ALJ observed: "The manufacturer's training check list also advises that leg support straps should be fastened 'if added security is desired or needed.'" ALJ Decision at 11, *quoting* P. Ex. 19, at 1. Thus, the ALJ could reasonably infer that use of the straps for added security was particularly important given R22's documented medical condition.

Despite the manufacturer's recommendation and the practice of other CNAs to use leg straps, it is undisputed that CNA NJ did not use this additional safety precaution as a means to mitigate the foreseeable risk of R22 falling during a transfer with a Sara lift. Golden argues that the leg straps were not **mandatory** to use with the Sara lift and suggests (without any citation to evidence in the record) that using the leg straps could have made R22's injuries worse. RR at 19 n.18. Golden also argues "that the record shows that some staff members used them and some did not." *Id*., *citing* Tr. at 404. In support of its argument, Golden cites **only** to the testimony of the ADON. However, the ADON merely testified that it was her "understanding" based on the manufacturer's manual that the use of leg straps was "optional." Tr. at 404. She never testified that some of the facility's staff members did not use leg straps when transferring R22 with the Sara lift. In any event, the issue before the ALJ was not whether use of the straps is mandatory for all transfers but whether transferring R22 without them constituted a failure to provide her an assistive device she needed for safety, given her physical and cognitive limitations and the facility staff's own view of her needs. Furthermore, the claim that some caregivers thought that she could be transferred safely without straps (or actually did not use the straps with her) is unsupported in the record, since Golden provided no caregiver to testify to that effect. Moreover, Golden did not provide any documentation of an actual evaluation of whether the added security of using the straps was needed in her case, or of any purported countervailing risk to her of their use.

In summary, the ALJ's conclusion that Golden was not in substantial compliance with section 483.25(h) is supported by substantial evidence in the record and is free from legal error.

2. *The ALJ's conclusion that Golden was not in substantial compliance with 42 C.F.R. § 483.10(b)(11) is supported by substantial evidence in the record and is free from legal error.*

As part of its obligation to participate in the Medicare and Medicaid programs, a facility must immediately inform the resident, consult with the resident's physician, and (if known) notify the resident's legal representative or interested family member when there has been an accident involving a resident that results in injury and has the potential for requiring physician intervention; 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); or when there is a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences or to commence a new form of treatment). 42 C.F.R. § 483.10(b)(11); *Magnolia Estates Skilled Care*, DAB No. 2228, at 9 (2009) (consultation with physician must occur at once or without delay after the significant change is detected or observed).

It is undisputed that Golden did not consult R22's physician or notify her family member (i.e., her daughter) for four days after the fall that occurred on January 30 and for two days after bruises and swelling were first observed on February 2. Golden also does not dispute that its staff waited nearly nine hours after receiving the x-ray report showing that R22 had multiple fractures before providing the results to her physician and daughter.

The ALJ concluded that Golden was not in substantial compliance with section 483.10(b)(11) in each of these episodes. ALJ Decision at 13-14. In reaching his conclusion, the ALJ relied on the Board's decision in *Georgian Court Nursing Ctr.*, DAB No. 1866 (2003). As the ALJ stated, in that case:

> [T]he Board upheld the ALJ's finding of noncompliance when the nursing aide knew that he had tried an improper one-person transfer of the resident, when substantial evidence supported the ALJ's finding that the aide had injured the resident in the attempted transfer, and when the resident, who was paralyzed on her left side, complained to the charge nurse that her upper left arm hurt and that the aide had hurt her arm. The charge nurse did not investigate the resident's allegation about the improper transfer or inform the resident's physician or family about the injury until the following morning, when the resident's shoulder was bruised and swollen. The Board stated that there was no dispute that the potential for an injury as serious as a broken arm necessitated treatment by a physician.

Id. at 13-14. The ALJ concluded that, like the improperly transferred resident in *Georgian Court*, R22 had suffered a serious fracture that required immediate physician consultation.[11] *Id*. at 15. The ALJ rejected as "unconvincing" Golden's argument that physician consultation was not required on January 30 because R22 was not displaying any changes in signs or symptoms on that day. *Id.* at 14. We agree with the ALJ that the regulation plainly requires such consultation if a resident was in an accident that might require a physician's care. *See Magnolia Estates Skilled Care* at 9 ("As the regulation's text indicates, Magnolia must perform these tasks when there has been an 'accident' involving the resident that has the potential to require physician intervention . . . .").

In addition, Golden concedes that "[i]n retrospect, . . . the Resident's fall was significant[.]" RR at 21 n.21; *see also* Tr. at 565 (testimony by the DON that an injury from a fall is a significant change). Golden's argument is further undercut by its own policy that clearly requires that a resident's physician and family member be notified after a fall, regardless of whether the resident is injured. CMS Ex. 16, at 1, 3. Golden's own ADON and DON testified on cross-examination that the applicable standard of care required the facility to consult with a resident's physician after a fall and that CNA NJ should have known that R22's January 30 accident involved a "fall." Tr. at 425, 491; *see also* CMS Ex. 9, at 56 (nurse told surveyor that CNA NJ should have known that the accident was a fall even if R22 did not hit the floor and should have notified her physician and family).

Furthermore, section 483.10(b)(11)(i)(A) required the facility to consult with R22's physician and notify the family because the fall did result in an injury that required medical attention. The ALJ specifically found "that because the staff incorrectly transferred R22[,] she suffered a fall that resulted in her femur fracture." ALJ Decision at 20. The ALJ's finding squarely falls within the four corners of the regulation requiring immediate physician consultation and family notification "when there is . . . [a]n accident involving the resident which results in injury and has the potential for requiring physician intervention." 42 C.F.R. § 483.10(b)(11)(i)(A).

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[11] Golden suggests that the ALJ relied on *Georgian Court* "for the proposition that a nurse's assessment that fails to discover a fracture (or, as he put it, 'to understand the magnitude of symptoms') violates Section 483.10(b)(1l)." RR at 36 n.31. Golden argues that *Georgian Court* was wrongly decided because nurses cannot be required "correctly to diagnose" injuries. *Id*. This misstates both the ALJ Decision and the holding in *Georgian Court*. The nurse in *Georgian Court* was not faulted for failing to diagnose the resident's osteoporosis but for failing to consult a physician when the applicable standard of nursing care for so debilitated a resident would have been to recognize the potential for a serious injury with such pain after a reported fall during transfer. The problem is precisely that failing to consult meant that the nurse usurped the opportunity for a physician to make a prompt diagnosis and determine what treatment might be needed. We find no error in the ALJ's conclusion that here, too, a physician should have made the call about whether such a vulnerable resident required medical diagnosis and treatment after a known fall under circumstances that could easily cause injury requiring care. The main difference between the facts in these two cases is that in *Georgian Court*, at least a charge nurse did perform some assessment, although she then failed to appropriately consult a physician, whereas it is undisputed that no nurse from Golden even performed an assessment after R22's fall.

The facility disputes whether it should have known that the fall resulted in an injury to R22. As discussed in the next section, the facility does not contest that R22 fell or that the facility's staff (through CNA NJ) was aware of the fall. The nursing staff admittedly did not provide a medical assessment to determine whether R22 had been injured or was experiencing pain as a result of the fall.

Nevertheless, Golden argues that while "it certainly seems possible that the fall and the fracture were related, two physicians actually expressed skepticism during Golden's investigation that the Resident could have suffered the injury at that time, but did not exhibit even nonverbal symptoms of pain for several days." RR at 25. In support of this argument, Golden points out that its Medical Director stated in a letter submitted by the facility during the informal dispute resolution process that "it is very possible that [R22's] fracture could be a fragile fracture [i.e., non-traumatic in nature] at the time of the discovery of her bruising in the location of the fracture, [that was] not related to the lift chair accident." P. Ex. 17 (cited in RR at 25). Golden also points out that its investigation report states that an orthopedic surgeon told the DON that "I told [R22's] daughter this break could have been caused by a 'sneeze' because her bones were so brittle." P. Ex. 15, at 3 (cited in RR at 25). Finally, Golden contends that R22's "hospital discharge diagnosis (assigned by the hospital) recited that the orthop[aedic surgeon's] assessment was 'spontaneous fracture.'" RR at 25, *quoting* CMS Ex. 8, at 49.

The ALJ rejected Golden's argument as disingenuous, stating that "[i]f R22 did in fact have bones so brittle that her fractures 'could have been caused by a sneeze,' then it follows that the fall would clearly cause severe trauma to R22 including multiple fractures, such as those sustained." ALJ Decision at 14, *quoting* P. Ex. 15, at 3. We agree for several reasons. First, neither physician identified by Golden actually stated that R22's broken leg was caused by a "spontaneous fracture" due to brittle bones from oesteoporisis. Second, there is no evidence in the record showing that either physician actually examined R22 to determine the cause of her multiple fractures. In contrast, the physician who treated R22 at the emergency room (ER) definitively stated that "R22's bones were fragile but not so fragile that she would have experienced a spontaneous fracture." CMS Ex. 9, at 45. The ER physician further explained to one of the surveyors that:

> The type of fracture that [R22] had was not a fracture that could have occurred just by the resident having turned over in bed. It was caused by some outside force causing pressure. [R22's broken leg was] [c]aused by some acceleration impacting an outside object causing quick deceleration. [R22's broken leg] [c]ould have been caused by hitting [the] leg up against something, but it was **definitely due** to some external force.

Id. (emphasis added). The ALJ could reasonably credit the opinion of the physician who actually treated the injuries about their likely cause rather than the speculation of the

facility's Medical Director. Thus, the ALJ's conclusion that the accident on January 30 resulted in R22's broken leg is supported by substantial evidence in the record.

The ALJ next found that Golden failed to consult immediately with R22's doctor and notify her family when the staff noticed R22's bruising and swelling on her leg. ALJ Decision at 14. Golden contends that its staff was not required under the regulation to either consult R22's physician or notify a family member because its nurses thought that the bruising and swelling were not recent and were related to R22's arthritis. RR at 21-22; Tr. at 493. The ALJ accurately observed that "even Petitioner's DON testified that when the nursing staff first became aware of R22's bruises, they should have notified both her physician and her responsible party." Tr. at 590; *see also* Tr. at 471 (testimony by the DON that after the nurse observed the bruises and swelling, "the nurses are responsible for notifying the physician of any concerns"); CMS Ex. 9, at 56 (nurse told surveyors that R22's physician and family should have been notified). The DON told a surveyor that she implemented training about the need to report bruises to a resident's doctor and family because "[i]f this had been done[,] the fracture may have been detected sooner." CMS Ex. 9, at 67. This evidence undercuts Golden's claims that its staff had no duty to act on the bruising and swelling.

Moreover, Golden's nursing staff failed to document their findings regarding R22's bruising and swelling, even though documentation is required by the standard of nursing care. Tr. at 78, 307; P. Ex. 14, at 33-34. Nothing in the record indicates that R22 had previously displayed bruising and swelling in her legs due to her arthritis or that she had pre-existing bruises. Finally, it is important to note, as the ALJ did, that had Golden's nursing staff been properly made aware of R22's fall, they would have been in a better position to understand the significance of the bruising and swelling. ALJ Decision at 14. Given the location and appearance of the swelling and bruises two days after the fall, R22's physician and family should have been informed to prevent her condition from being further exacerbated. In that case, as Nurse CS said, the fracture might have been discovered earlier because the physician would have ordered an x-ray sooner. CMS Ex. 9, at 38.

Finally, the ALJ concluded that Golden violated section 483.10(b)(11) when it failed to consult with R22's physician and notify her family for approximately nine hours about the results of her x-ray (CMS Ex. 8, at 5) which revealed that R22 suffered an impacted supracondylar fracture of the femur.[12] ALJ Decision at 14-15. The DON testified during

[12] Golden states in its brief that "there is absolutely no evidence in the record to support [the ALJ's] conclusion [that there was a nine-hour delay in notifying R22's physician and family]." RR at 37. This is simply an incorrect statement as reflected by the contents of Golden's own investigation report (discussed in more detail below), the radiology report, and nursing notes. *See* P. Ex. 15, at 7. The record also contains the radiology report with a facsimile date of February 3, 2011 and transmission time of 9:56 p.m. CMS Ex. 8, at 5. The record also contains a nursing note entry dated the next morning at 6:38 a.m. indicating that the emergency room and R22's family had been notified "this a.m." P. Ex. 14, at 34.

cross-examination that an "x-ray report that indicates that a resident has a fracture . . . indicates a significant change" in a resident's condition. Tr. at 556. Such a situation would fall within the scope of section 483.10(b)(11)(i)(B) as a "significant change" in R22's condition.[13]

Before us, Golden acknowledges that a "'significant change' to the Resident's condition was detected in the x-ray - but that was *after* the material report already had been made to the physician (because the Assistant Director of Nurses questioned the bruising)." RR at 37 (italics in original). This point is not persuasive because the bruising and the results of the x-ray each independently needed to be immediately conveyed to R22's physician and family.

Golden also points out that the DON testified that under Golden's Notification of Change in Resident Health Status policy for reporting to physicians, "immediately" specifically means "as soon as possible within 24 hours" unless a situation poses an emergency, and therefore the facility was not required to consult with R22's physician and notify her family upon receipt of the x-ray report any sooner than was done. Tr. at 585; P. Ex. 16, at 11. Prior Board decisions have rejected the argument that the term "immediate" as used in section 483.10(b)(11) would permit a facility to wait up to 24 hours to notify and consult with a resident's physician and notify a resident's family. *See Magnolia Estates Skilled Care* at 8; *The Laurels at Forest Glenn*, DAB No. 2182, at 13 (2008) (discussion of removal of 24-hour waiting period in revised regulation). Furthermore, the regulation is not limited to "emergency" situations.

Golden also contends that CMS never asserted that there was an "emergency" when it received the x-ray report at 10:00 p.m. on February 3, 2011, and that there is no evidence that R22 was in pain or discomfort – or even awake – at that time. RR at 24. This argument is also without merit as demonstrated by the fact that after R22's physician was notified, he immediately ordered R22 to be transferred to a hospital where she was administered intravenous morphine, which clearly indicates that R22 required urgent treatment and was suffering pain that could have been alleviated sooner had the facility immediately consulted with her physician as required by sections 483.10(b)(11)(i)(B) and (C). CMS Ex. 6; CMS Ex. 7, at 1-2, 4-5; CMS Ex. 15.

Golden attempts to minimize the dilatory conduct of its staff by arguing that it was a matter of nursing judgment when to consult the physician and notify the family. The ALJ rejected this argument as "patently-absurd." ALJ Decision at 19. We agree. The only discernible judgment at issue here was that the nurse did not want to call R22's physician at 10:00 p.m. because he may have been sleeping. Golden's investigation report indicates that the charge nurse stated that "[o]n Thursday [February 3, 2011] I had several things

[13] The x-ray report also evidenced a "need to alter treatment significantly" within the scope of section 483.10(b)(11)(i)(C) given that her physician transferred her to a hospital where R22 was administered pain medication once the physician became aware of the report of the fractured femur.

going on didn't call the [doctor or responsible party] with the x-ray results until early [the next] morning." P. Ex. 15, at 7. However, as the ALJ points out, the same nurse told the surveyor that "the 'several things going on' entailed being busy working on a school assignment." ALJ Decision at 19, *quoting* Tr. at 155. This hardly qualifies as a valid nursing judgment, as opposed to mere considerations of personal convenience on the part of the nurse.

Accordingly, the ALJ's conclusion that Golden was not in substantial compliance with section 483.10(b)(11) is supported by substantial evidence in the record and is free from legal error.

3. *The ALJ's conclusion that Golden was not in substantial compliance with 42 C.F.R. § 483.25 is supported by substantial evidence in the record and is free from legal error.*

The opening provision of 42 C.F.R. § 483.25 (quality of care), which implements sections 1819(b)(2) (Medicare) and 1919(b)(2) (Medicaid) of the Act, states:

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

The quality of care legislative and regulatory requirements are "based on the premise that the facility has (or can contract for) the expertise to first assess what each resident's needs are (in order to attain or maintain the resident's highest practicable functional level) and then to plan for and provide care and services to meet the goal." *Spring Meadows Health Care Ctr.*, DAB No. 1966, at 16 (2005). The regulation thus "imposes on facilities an affirmative duty designed to achieve favorable outcomes to the highest practicable degree." *Windsor Health Care Ctr.* at 16-17. The facility must take "reasonable steps" and "practicable measures to achieve that regulatory end." *Clermont Nursing & Convalescent Ctr.*, DAB No. 1923, at 21 (2004), *aff'd, Clermont Nursing & Convalescent Ctr. v. Leavitt*, 142 F. App'x 900 (6th Cir. 2005). The quality of care provision also implicitly imposes on facilities a duty to provide care and services that, at a minimum, meet accepted professional standards of quality "since the regulations elsewhere require that the services provided or arranged by the facility must meet such standards." *Spring Meadows Health Care Ctr.* at 17, *citing* 42 C.F.R. § 483.75; *see also Sheridan Health Care Ctr.*, DAB No. 2178, at 15 (2008); *Greenbrier Nursing and Rehab. Ctr.*, DAB No. 2335, at 7-8 (2010), *aff'd Greenbrier Nursing Rehab. Ctr. v. U.S. Dep't of Health & Human Servs.*, 686 F.3d 521 (8th Cir. 2012).

Moreover, the Board has repeatedly held that as a general matter, a facility's failure to comply with physician orders or to follow its own resident care policies, as well as the

failure to provide services in accordance with a plan of care based on a resident's comprehensive assessment, can constitute a deficiency under section 483.25. *Lakeridge Villa Health Care Ctr.*, DAB No. 1988 (2005), *aff'd Lakeridge Health Care Ctr. v. Leavitt*, 202 F. App'x 903 (6th Cir. 2006); *The Windsor House*, DAB No. 1942, at 55-56 (2004); *Spring Meadows Health Care Ctr.* at 17-18.

In the present case, the ALJ found that Golden was not in substantial compliance with the quality of care provision of section 483.25 because "it is clear that Petitioner failed to provide R22 with the necessary care and services to maintain her highest practicable well-being." ALJ Decision at 17. The ALJ detailed at least four separate ways in which Golden failed to comply with the quality of care regulation, any one of which would establish that the facility was not in substantial compliance. First, the ALJ concluded that the facility staff violated the applicable standard of care by failing to conduct a "head-to-toe assessment" of R22 after her fall and before the staff moved her again. *Id.* Second, the ALJ concluded that the facility staff violated the applicable standard of care to monitor R22 closely for signs or symptoms of injury, such as pain, after her fall. *Id.* Third, the ALJ concluded that Golden's staff failed to reassess the use of the Sara lift for R22 for transfers after it became aware of her bruises and swelling, a failure which "created a serious risk of additional injury and was certainly below the professional standards of care." *Id*. at 18. Fourth, Golden's staff "did not immediately contact R22's physician, address pain issues, or otherwise tend to R22's condition[ ]" for about nine hours after receiving the radiology report, which indicated that she had multiple leg fractures. *Id*. at 19.

a. Golden's nursing staff should have conducted an assessment of R22's medical condition after her fall.

The facility's ADON testified that the standard of care required CNA NJ to notify the nurse in charge on January 30 – Nurse CS – about R22's fall. Tr. at 425. Both the facility's DON and ADON further testified that the standard of care required Nurse CS to immediately conduct a "full-body" assessment of R22 to determine if there were any signs of injury or pain from the fall. Tr. at 490-91, 425-26. They further testified that the standard of care required Nurse CS to notify and consult with R22's physician and family representative. Tr. at 491, 429-30. In addition, the ADON testified that the nurse should have also notified other facility nurses and CNAs caring for R22 that she had fallen. Tr. at 429-30.

The ALJ found that "the record is unclear as to whether or not the CNA truly reported the fall. If the CNA did notify the LPN [CS], then the LPN did nothing in response." ALJ Decision at 18. It is undisputed that Nurse CS did not conduct an assessment of R22 after she fell. Nurse CS admitted to the surveyors that she did not conduct an assessment of R22 after she fell, though she also asserted that she had heard the CNA report that the fall took place. CMS Ex. 9, at 37; Tr. at 490. In addition, both the DON and ADON testified that the nursing assessment should have been documented in R22's medical file. Tr. at 490-91, 430.

There are also no nursing notes in the record indicating that any assessment was conducted. P. Ex. 14, at 33-34; *see also* CMS Ex. 9, at 37.

Golden's written Falls Management policy requires its staff to update the care plan of a resident who has fallen, initiate a quality assurance and risk management report, and record the fall in the 24-hour report to inform an incoming nursing shift of that resident's need for close monitoring. CMS Ex. 16, at 1-3, 5-6; Tr. at 198, 300. In addition, the staff is required to report a resident's fall to the facility's Executive Director and DON. CMS Ex. 16, at 3. Golden's Falls Management policy also requires the licensed nurse to "document the fall and any new orders on the 24-hour report [and conduct] [o]ngoing assessments including neurological, pain and alert[,] charting documentation shall occur per facility policy." *Id*. at 6. Golden's staff did not follow its policy to prepare any of these required documents. In other words, the 24-hour report for January 30, 2011 does not mention R22's fall, no incident report was filed, and there is nothing in the nursing notes documenting the fall or whether a nursing assessment was performed. *See* Tr. at 307-08; P. Ex. 14, at 33; CMS Ex. 8, at 16-17. The record also contains no evidence that Nurse CS notified and consulted with R22's physician or notified her family and other facility nurses and staff about her fall.

b. Golden failed to closely monitor R22 after her fall.

The ALJ also concluded that Golden was not in substantial compliance with the quality care regulation because its nurses failed to follow the applicable standard of care to monitor R22 closely after her fall. ALJ Decision at 17-18. Golden does not challenge the ALJ's finding that "after a resident suffers a fall, it is standard practice for the nursing staff to monitor that resident closely for signs or symptoms of injury and for pain." *Id*. at 17, *citing* Tr. at 200, 299, 306-07, 491. Indeed, Golden's DON and ADON both testified that the standard of nursing care requires a facility to closely monitor a resident who has fallen, even when there are no apparent injuries, and to document the ongoing monitoring. Tr. at 430, 490-91. During the first hour after a fall, a resident should be checked at least every 15-30 minutes and then every 30 minutes on an hourly basis, including taking vital signs such as pulse rate and blood pressure. Tr. at 200, 299, 306-07, 427. The nursing staff should also be looking for any changes in the resident's condition such as bruising, swelling, and pain. Tr. at 307, 426.

The ALJ found "absolutely no credible evidence that Petitioner's staff conducted such monitoring of R22 during that critical period following her fall." ALJ Decision at 17. For example, no nursing notes in the facility's records document R22's medical condition for January 30, January 31, February 1, or February 2. P. Ex. 14, at 33-34. Furthermore, no assessments, nurse/physician communication reports, physician progress notes or orders, or other written evidence document that R22 was monitored at all, let alone closely. ALJ Decision at 17-18, *citing* CMS Ex. 8; P. Exs. 13-14. None of the nurses interviewed by the surveyors reported that they had closely monitored R22 after her fall. The facility's investigation report does not record that any of its nursing staff had done so. *See* CMS Ex.

9; P. Ex. 15. In its briefing before us, Golden does not challenge the ALJ's findings that its staff did not follow the applicable standard of care to monitor R22 closely for 24-48 hours after her fall, which would be sufficient by itself to sustain the ALJ's conclusion that the facility was not in substantial compliance with the quality of care regulation.

c. Golden's staff failed to investigate the cause of R22's bruises and swelling.

The ALJ further concluded that Golden was not in substantial compliance with the quality care regulation because its nurses failed to investigate the cause of R22's bruises and swelling first observed on the afternoon of February 1, 2011, two days after she fell. ALJ Decision at 18.

On February 1, 2011, CNA CD reported to Nurse FK that R22's left knee was swollen. P. Ex. 15, at 2. Nurse FK assessed R22 and saw an "old bruise" and concluded that her knee was swollen and warm to touch consistent with her arthritis. *Id.*; Tr. at 494. Later that day, the same CNA reported to Nurse CH that R22's knee was swollen and bruised. P. Ex. 15, at 2. Nurse CH conducted an assessment and concluded that the bruising and swelling were consistent with R22's arthritis. P. Ex. 15, at 2; Tr. at 495. On February 2, CNAs DA and CC told the survey team that they observed bruising and swelling near R22's left knee and that they reported their observation to Nurse SC. CMS Ex. 9, at 5, 49; P. Ex. 15, at 4-5, 9. Nurse SC told the survey team that she assessed the area and that R22 did not express any pain when the bruised area was palpated. CMS Ex. 9, at 15**.** Nurse SC subsequently reported the bruise to Nurse CD, who did a complete body audit and observed the presence of "old bruises" on R22's thigh and behind her knee but that R22 did not demonstrate any pain on palpation. CMS Ex. 9, at 9.

Golden contends that its staff did not need to investigate the cause of the bruises and swelling on R22's leg any further because four different nurses had assessed R22 over a period of three days and saw "nothing significant" to suggest that R22 had suffered a serious injury or needed immediate intervention at the time. RR at 23. Golden maintains that, on the contrary, two of its nurses concluded that the bruises and swelling were consistent with R22's arthritis. RR at 21-23; P. Ex. 15, at 2.

As the ALJ observed, however, none of the four nurses who purportedly assessed R22 documented their exam in the nursing notes or in the 24-hour report. ALJ Decision at 18. The facility's DON also testified that the standard of care required the nurses to document their assessments, and this was not done here. Tr. at 491-93. Indeed, Golden concedes that there are no nursing notes documenting these assessments, even though "assessments should have been documented." RR at 21 n. 21. Golden attempts to minimize the significance of this failure of the standard of care by arguing that "(except for perhaps Nurse CS) no nurse was aware of the incident for several days." *Id.* While that may be correct, the facility, through one of its employees, CNA NJ, was aware that

R22 had fallen and therefore should have taken action to investigate the cause of the bruising and swelling on her knee. Moreover, Surveyor AC testified without contradiction that it was important for the nurses who looked at R22's bruises and swelling to know about the fall because R22's swelling and bruising could be injuries from the fall. Tr. at 202-203. Under these circumstances, Golden was obligated to determine the cause of the swelling and bruises as well as notify R22's physician. Tr. at 300-01.

The DON testified that the nurses "probably" did not document the swelling and bruises because they thought that it was consistent with R22's chronic arthritis. Tr. at 493. This argument, however, is not supported because the DON also conceded during cross-examination that arthritis does not cause bruising or swelling. *Id*. Similarly, the conclusions reached by Nurses FK and CD that the bruises on R22 were "old" is not significant because the DON further conceded that there really is no way to accurately date a bruise by its color. Tr. at 498; *see also* CMS Exs. 18-19.

d. After receiving the x-ray report, Golden's staff failed to notify R22's physician and family for almost nine hours.

Finally, the ALJ concluded that Golden was not in substantial compliance with section 483.25 because it failed to notify R22's physician and family after it received the x-ray report. ALJ Decision at 18-19.

Golden disputes that its staff was required to inform R22's physician immediately after the facility received the x-ray report. RR at 23-24. Golden argues that Surveyor EJ, who is not a nurse, was not aware of what the standard of care was for nurses to notify a physician about an x-ray report showing a fractured leg. RR at 23; Tr. at 156.

This argument is without merit. Although the ALJ did not explicitly state that Golden had violated the applicable standard of nursing care by failing to notify R22's physician as soon as the facility received the x–ray report, the ALJ did conclude that "Petitioner failed to provide R22 with the necessary care and services to maintain her highest practicable well-being" in this regard. ALJ Decision at 19. There is substantial evidence in the record supporting the ALJ's conclusion that Golden was not in substantial compliance with section 483.25. While Surveyor EJ was not herself trained as a nurse, she testified that she discussed this issue with the survey team, which included a nurse (i.e., CW), and the team concluded that there was an improper delay in treating R22's broken leg because her physician was not immediately notified. Tr. at 155-56. Indeed, Surveyor EJ testified that "it was their opinion that [R22] should have been sent out to the hospital that evening. The nurses should have contacted the doctor to get an order to send her out." Tr. at 156. Thus, the ALJ could reasonably credit the surveyor's testimony about the team's collective opinion about the applicable standard of care.

Furthermore, Surveyor CW testified that based upon her professional nursing experience, "[w]hen a nurse receives a report of any abnormality, the physician should be notified at that time . . . when the report was received." Tr. at 302-03. She further testified that the physician needs to be informed at that point "so [he] . . . can make decisions about the care the resident requires." Tr. at 303. Golden does not challenge, or even address Surveyor CW's testimony. Instead, as previously discussed, Golden simply maintains that there was no need to notify R22's physician under its policy because CMS did not allege that R22's condition constituted an emergency. Moreover, there is no evidence in the record or allegation by Golden that the nurse on duty at the time actually concluded that no emergency existed. Indeed, because the nurse was busy doing a school assignment, it seems more likely that she did not even read the x-ray report when it arrived. In contrast, as soon as R22's physician received and read the x-report the next morning, he immediately ordered R22 to be transferred to a hospital for treatment. This supports a reasonable inference that R22's condition – a fractured femur – required immediate medical care by a physician. This inference is further supported by the undisputed fact that the hospital staff decided to provide R22 with intravenous pain medication immediately upon her arrival to the hospital.

In summary, the ALJ's conclusion that Golden was not in substantial compliance with section 483.25 in at least four material respects is supported by substantial evidence in the record and is free from legal error.

B. The ALJ's determination of the duration of CMP is supported by substantial evidence and free from legal error.

The Board has long held that CMS does not need to establish noncompliance on each day for which it imposes a CMP. *See, e.g., Regency Gardens Nursing Ctr.*, DAB No. 1858, at 7-11 (2002) and cases cited therein.[14] The Board in *Cary Health and Rehab. Ctr.*, DAB No. 1771 (2001) explained that noncompliance is presumed to continue until the facility demonstrates by a preponderance of the evidence that it has achieved substantial compliance. Moreover, a facility has to demonstrate not only that it returned to substantial compliance but also that it was capable of remaining in substantial compliance. DAB No. 1771, at 7, *citing* 42 C.F.R. § 488.454(e); *Hermina Traeye Mem'l Nursing Home*, DAB No. 1810, at 12 (2002) (*citing* 42 C.F.R. § 488.454(a) and (e)), *aff'd Sea Island Comprehensive Healthcare Corp. v. U.S. Dep't of Health & Human Servs.*, 79 F. App'x 563 (4th Cir. 2003); *Cross Creek Care Ctr.*, DAB No. 1665 (1998). Furthermore, in

[14] As the Board pointed out in *Regency Gardens*, the congressional purpose in providing for alternative remedies short of termination was to allow CMS to apply pressure to motivate facilities to solve problems quickly and so protect residents without disrupting placements unnecessarily. *See, e.g.*, H.R. Rep. No. 100-391(1), at 470-77 (1987); 59 Fed. Reg. 56,116-17, 56,177-78 (Nov. 10, 1994). Thus, the Board stated that, consistent with that purpose, "a non-compliant facility is required to promptly file for CMS's approval a plan stating when and how the facility will correct the conditions violating participation requirements and is not entitled to have the remedies lifted unless and until the facility **demonstrates** that substantial compliance has been achieved." *Regency Gardens* at 11 (emphasis added), *citing* 42 C.F.R. §§ 488.401, 488.402(d).

Brian Center Health and Rehab./Goldsboro, the Board explained that a "determination by CMS that a [Skilled Nursing Facility's] ongoing compliance remains at the level of immediate jeopardy during a given period constitutes a determination about the 'level of noncompliance' and, therefore, is subject to the clearly erroneous standard . . . ." DAB No. 2336, at 7-8 (2010).

Here, the ALJ first found that Golden's noncompliance at the immediate jeopardy level lasted from January 30 through March 4, 2011. ALJ Decision at 20. Relying on *Brian Center*, the ALJ concluded that CMS's determination that Golden's immediate-jeopardy-level noncompliance continued through March 4, 2011 was not clearly erroneous. *Id.* at 21. Next, the ALJ concluded that after the immediate jeopardy was abated, "Petitioner remained out of substantial compliance from March 5 through at least April 3, 2011." *Id*.

Golden argues that that "if there was any noncompliance at all, it ended when [DON] completed her investigation and retraining by the second week of February, 2011." RR at 40. In support of its position, Golden contends that it designed inservice training programs for the staff members involved in the events surrounding R22's fall and incident, as well as other training for all staff. Tr. at 465-469, 475-476, 650; RR at 26-27. For example, Golden points out that beginning on February 4, the DON provided retraining to all licensed nurses and CNAs regarding: (1) the definition of a "fall" under the facility's policy; (2) the circumstances that require the reporting of changes of a resident's condition; (3) the proper communication techniques necessary between CNAs and licensed nurses; (4) the proper use of written communication tools clearly to communicate concerns; (5) the need to reassess a resident's lift needs as her condition changes; and (6) the need to update a resident's care plan and Kardex. P. Ex. 15, at 1-2; P. Ex. 16, at 1-4, 6-14.

We concur with the ALJ's conclusion that CMS's determination regarding the duration of the immediate jeopardy period was not clearly erroneous, and we also hold that substantial evidence supports the ALJ's finding that Golden did not return to substantial compliance earlier than the date that CMS had determined. We note initially that Golden does not specify a date on which retraining was completed or indicate exactly when it claims that corrective measures were sufficient to abate the immediate jeopardy. The investigation report states that the goal for completing the training was February 18, 2011, but no training sheets show the actual dates, and no testimony specifically addresses when the training was fully completed.

Furthermore, evidence suggests that whatever training occurred was ineffective. The state survey agency completed a revisit survey of Golden on April 4, 2011 "to determine if [the] facility had achieved substantial compliance with the Federal requirements for nursing homes participating in the Medicare and Medicaid programs." CMS Ex. 17, at 1. The undisputed evidence shows that during the revisit survey, the surveyors sought to observe how the facility's staff transferred a resident using a lift. Golden's staff had

previously assessed one of its residents as needing a Marisa lift with two staff members to assist in the transfer. However, the surveyors observed that a CNA used a Sara lift by herself to complete the transfer with the resident.[15] Tr. at 634-636. We agree with the ALJ that this incident makes it "clear that Petitioner's corrective actions were not sufficient to establish substantial compliance with the same regulatory requirements previously cited [from the earlier March 5 survey]." ALJ Decision at 21.

The regulations and prior Board decisions make clear that a facility's "'noncompliance is deemed to be corrected or removed only when the incidents of noncompliance have ceased and the facility has implemented appropriate measures to ensure that similar incidents will not recur.'" *Oceanside Nursing & Rehab. Ctr.* at 20, *quoting Life Care Ctr. of Elizabethton*, DAB No. 2367, at 16 (2011). The errors committed by the CNA during the revisit survey echo the very mistakes that CNA NJ made on January 30, 2011 – i.e., using an inappropriate type of lift and transferring R22 without the assistance of a second staff member. Furthermore, the DON's testimony about the corrective actions put in place prior to the March 2011 survey shows that the topics covered did not include reviewing the type of lifts used for residents or the number of staff assisting with the transfer. Tr. at 166, 472, 498-499, 669-670. An examination of Golden's training materials reveals that Golden did not even provide training about its Post-Fall Assessment policy or its Post-Fall Investigation Summary policy. CMS Ex. 16, at 3, 5-6; P. Exs. 16-17. Yet these issues were central to correcting the initial cited deficiencies and to ensuring that Golden took appropriate steps to keep its residents as safe as possible during transfers. This uncontested evidence demonstrates that during the approximately nine-week period between R22's fall and the April revisit survey, Golden did not train or re-train its staff adequately or take other measures sufficient to eliminate the deficiencies and ensure that incidents similar to R22's January 30, 2011 accident would not recur. Thus, the ALJ could reasonably conclude that Golden had not returned to substantial compliance prior to the date determined by CMS.

Golden argues that the CNA was merely nervous about having to follow proper facility procedures to transfer a resident under the watchful eye of state surveyors. RR at 27 n.26. Golden goes on to argue that the DON testified that "while the timing of that mistake was embarrassing, human errors (especially by nervous CNAs being watched by surveyors) are inevitable, and the mere occurrence of a mistake is not evidence that [the facility's] policies, procedures or staff training were inadequate." *Id.*, *citing* Tr. at 481,

[15] Based upon the revisit survey, CMS determined that Golden "continues not to be in substantial compliance with the Medicare/Medicaid participation requirements." CMS Ex. 17, at 1. In a letter dated June 15, 2011, Golden notified CMS that it had elected "to waive a hearing regarding the finding of noncompliance relating to [the revisit] survey that ended on April 4, 2011." *Id*. at 5. CMS contends that Golden is now estopped from arguing that it was in substantial compliance on April 4, 2011. CMS Br. at 29. We agree. Because Golden did not appeal any of the deficiencies cited during the April 4 revisit survey, CMS's determination that it was not in substantial compliance with Medicare program requirements is final and binding. *See Jewish Home of Eastern Pa.*, DAB No. 2451, at 11-12 (2012) (*citing* 42 C.F.R. § 498.20(b)), *aff'd, Jewish Home of Eastern Pa. v. Centers for Medicare & Medicaid Servs.*, No. 12-2273, 2013 WL 1790307 (3d Cir. Apr. 29, 2013).

635-36. This argument is not persuasive because it does not address the fact that the CNA's errors mirror some of those that occurred during R22's fall on January 30, as we previously explained, and that the training provided by the facility should have addressed these items to ensure that they were not repeated in the future. It is not unreasonable to conclude that these errors occurred again because Golden's training was not effectively implemented rather than because of the CNA's nervousness alone. Moreover, this argument is simply not relevant because, as the DON later acknowledged, the risk of falling created by the improper transfer of the resident is the same regardless of whether the CNA is nervous or not. Tr. at 635-36.

Golden next argues that the "ALJ seems to have held that he can *presume* continuing noncompliance based on a series of (at best unclear and inconsistent) Board Decisions[.]" RR at 38 (italics in original).[16] Golden "suggests that the ALJ should have addressed the issue under the traditional review standard the Board set out long ago in *Hillman Rehabilitation Center*, DAB Dec. No. 1611 (1997)." RR at 39. More specifically, Golden contends that "where the petitioner specifically challenges the 'duration' determination – and, as here, comes forward with evidence and argument *before the hearing* regarding its corrective actions – then CMS has the burden of *proceeding* to come forward with *evidence* at the hearing to rebut the petitioner's evidence, and to support its 'duration' determination." RR at 39-40 (italics in original).

Golden's argument is without merit and reflects a fundamental misunderstanding of the issue before the ALJ, and before the Board on appeal, and the burden of proof on that issue. As stated earlier, the Board has made it clear that when a facility disputes the compliance date determined by CMS, the facility has the burden of proving that it achieved substantial compliance at an earlier date. *See, e.g, Ridgecrest Healthcare Ctr.*, DAB No. 2493, at 2-3 (2013). Indeed, in *Omni Manor,* a decision recently affirmed by the United States Court of Appeals for the Sixth Circuit, the Board stated that it has "'consistently rejected the contention . . . that CMS must affirmatively prove that noncompliance exists on each day that a remedy is in effect after the first day of noncompliance.'" DAB No. 2431, at 6-7, *quoting Chicago Ridge Nursing Ctr.*, DAB No. 2151, at 27 (2008)); *see also Cal Turner Extended Care Pavilion*. As the Board further stated in *Omni Manor*, "the issue is not whether the evidence of record supports CMS's determination that the facility achieved substantial compliance on [a date certain – i.e., here, in the present case, April 3, 2011], but, rather, whether the evidence of record supports [the facility's] assertion that it was in substantial compliance [prior to the date CMS determined – i.e., here, the second week of February]." DAB No. 2431, at 9. Golden has not pointed to any new authority that requires a different result, and we see nothing in the record to suggest one.

[16] However, Golden neither identifies which prior Board Decisions are "unclear and inconsistent" nor explains why those decisions are inconsistent.

Accordingly, the ALJ's determination concerning the duration of the CMP is supported by substantial evidence and is free from legal error.

Conclusion

For all of the foregoing reasons, we affirm the ALJ Decision.

/s/
Leslie A. Sussan

/s/
Constance B. Tobias

/s/
Stephen M. Godek
Presiding Board Member