Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Appellate Division

In the Case of:	DATE: March 19, 2009
Life Care Center of Bardstown,	
Petitioner,	Civil Remedies CR1818 App. Div. Docket No. A-08-133
	Decision No. 2233
- v. -	
Centers for Medicare & Medicaid Services.	

REMAND OF ADMINISTRATIVE LAW JUDGE DECISION

The Centers for Medicare & Medicaid Services (CMS) requested review of the decision of Administrative Law Judge (ALJ) Richard J. Smith in Life Care Center of Bardstown, DAB CR1818 (2008) (ALJ Decision). Life Care Center of Bardstown (LCCB) is a skilled nursing facility (SNF) located in Bardstown, Kentucky. The ALJ Decision reversed the April 20 and May 1, 2007 determinations by CMS to impose on LCCB civil money penalties (CMPs) of $4,050 per day from January 3, 2007 through March 27, 2007 and $100 per day from March 28, 2007 through April 9, 2007. The CMS determinations were based on survey findings made by the Division of Health Care Facilities and Services for the State of Kentucky (State agency). The ALJ concluded that LCCB was in substantial compliance with the Medicare and Medicaid participation requirements and that there was no basis for the imposition of CMPs.

For the reasons detailed below, we remand this case to the ALJ for further action consistent with this decision.

Legal Background

To participate in Medicare and Medicaid, long term care facilities, including SNFs, must comply with the requirements in 42 C.F.R. Part 483, subpart B. A facility's compliance with the participation requirements is assessed through surveys performed by state health agencies. Sections 1819 and 1919 of the Social Security Act (Act)[1]; 42 C.F.R. Parts 483, 488, and 498.

"Substantial compliance" means a level of compliance such that "any identified deficiencies pose no greater risk to resident health or safety than the potential for causing minimal harm." 42 C.F.R. § 488.301. "Noncompliance," in turn, is defined as "any deficiency that causes a facility to not be in substantial compliance." 42 C.F.R. § 488.301.

CMS may impose remedies against a facility that is not in substantial compliance with the participation requirements. 42 C.F.R. §§ 488.408, 488.440(a). CMS determines the seriousness of each deficiency found during a survey in order to select the appropriate remedies, if any, to impose on the facility. See 42 C.F.R. § 488.404. The level of seriousness is based on an assessment of scope (whether the deficiency is isolated, a pattern, or widespread) and severity (the degree of harm, or potential harm, to resident health and safety posed by the deficiency). Id. The highest level of severity is "immediate jeopardy," defined at section 488.301 of the regulations as "a situation in which the provider's noncompliance . . . has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident."

CMS may impose a CMP for "either the number of days a facility is not in substantial compliance" (a per day CMP), or "for each instance that a facility is not in substantial compliance" (a per instance CMP). 42 C.F.R. § 488.430(a). If a per day CMP is imposed for noncompliance at the immediate jeopardy level, the CMP must be in the range of $3,050 to $10,000 per day. 42 C.F.R. § 488.438(a)(1)(i). If the noncompliance is less serious, the CMP must be set within the lower range of $50 to $3,000 per day. 42 C.F.R. § 488.438(a)(1)(ii).

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[1] The current version of the Social Security Act can be found at www.ssa.gov/OP_Home/ssact/comp-ssa.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.

To determine the amount of a CMP, CMS considers the following factors: The facility's history of noncompliance (including repeated deficiencies), its financial condition, its degree of culpability for the cited deficiencies, the seriousness of the noncompliance, and the relationship of one deficiency to the other deficiencies resulting in noncompliance. 42 C.F.R. §§ 488.404, 488.438(f).

Under 42 C.F.R. § 488.454(a), a per day CMP continues to accrue until "[t]he facility has achieved substantial compliance, as determined by CMS or the State based upon a revisit or after an examination of credible written evidence that it can verify without an on-site visit." A "plan of correction" is a plan developed by the facility and approved by CMS or the state agency describing the actions the facility will take to correct its deficiencies. 42 C.F.R. § 488.401. The plan of correction also specifies the date by which the deficiencies will be corrected. Id.

Factual Background

The following undisputed facts are drawn from the ALJ Decision and documents in the record. We leave for our analysis below the discussion of the relevant factual issues that remain in dispute on appeal.

- Resident 1 was an 87-year-old woman who was initially admitted to LCCB in the Summer of 2006. ALJ Decision at 7; LCCB Ex. 7; CMS Ex. 17. Resident 1 had diagnoses that included Alzheimer's disease, hypothyroidism, diabetes, and hypertension. Id.

- Following a brief hospitalization in mid-November 2006, Resident 1 was readmitted to LCCB on November 17, 2006, at which time her treating physician ordered, among other things, oxygen saturation readings to be monitored "daily," and vital signs "routinely." CMS Ex. 17, at 9.

- On the evening of January 2, 2007, Resident 1's granddaughter, Ms. Donna Wherry, visited her grandmother at LCCB. ALJ Decision at 7.

- Resident 1 vomited profusely at approximately 8:30 p.m. on the evening of January 2, 2007. ALJ Decision at 7-10,

citing CMS Ex. 17, at 30-31; Tr. at 38, 215-216.[2]

- At approximately 1:00 a.m. on January 3, 2007, Resident 1 was observed by LCCB staff to have a "sm[all] amount of emesis" on her night clothes. CMS Ex. 17, at 31; CMS Ex. 3, at 6.

- At approximately 4:00 a.m. on the morning of January 3, 2007, LCCB certified nursing assistants (CNAs) and the licensed professional nurse on duty, Natalie Suffoletta, found Resident 1 in bed, unresponsive and with unstable vital signs. Nurse Suffoletta attempted to call the on-call physician about Resident 1's condition, but she was unable to reach the physician. Nurse Suffoletta then called LCCB's Director of Nursing (DON), who ordered Resident 1 be sent to the hospital emergency room. ALJ Decision at 7-8.

- At approximately 4:15 a.m. on January 3, 2007, Nurse Suffoletta called emergency medical services (EMS). CMS Ex. 18, at 1. Emergency medical technicians (EMTs) arrived at LCCB at approximately 4:20 a.m. to transport Resident 1 to the hospital. Id.

- Resident 1 was thereafter transferred and died at the hospital at approximately 7:10 a.m. on January 3, 2007. CMS Ex. 18, at 3.

Procedural History

On April 20, 2007 CMS issued a notice of determination imposing on LCCB a CMP of $4,500 per day effective January 3, 2007, based on a survey completed on April 3, 2007. CMS Ex. 5. The statement of deficiencies (SOD) from the survey identified three deficiencies at the immediate jeopardy level of severity. CMS Ex. 3; LCCB Ex. 2. Those deficiencies involved the physician consultation requirement at 42 C.F.R. § 483.10(b)(11) (Tag F 157); the quality of care requirement at 42 C.F.R. § 483.25 (Tag F 309); and the facility administration requirement at 42 C.F.R. § 483.75 (Tag F 490). CMS Ex. 3; LCCB Ex. 2. The SOD also identified one deficiency at scope and severity "D" (isolated, posing no actual harm but the potential for more than minimal harm that is not immediate jeopardy). Id. The D-level

[2] We discuss later evidence related to other times when emesis may have occurred outside this undisputed time.

deficiency (Tag F 280) involved the comprehensive care plan requirements at 42 C.F.R. §§ 483.20(d)(3) and 483.10(k)(2).

On May 1, 2007 CMS issued a notice to LCCB stating that a revisit survey completed on April 23, 2007 revealed that LCCB continued not to be in substantial compliance with the participation requirements. CMS Ex. 9. The May 1 determination further stated that:

> As a result of [the] facility's continued noncompliance as evidenced by the findings of the April 23, 2007 revisit survey . . . the CMP will continue to accrue, but at a lower rate. Effective March 28, 2007, the CMP will accrue at the revised rate of $100.00 per day. The CMP will continue at this rate until CMS determines that your facility has achieved compliance with program participation requirements . . . .

Id. at 2. The referenced April 23, 2007 revisit survey findings, set forth in the SOD from that survey, identify only the comprehensive care plan deficiency (Tag F 280) that had been identified during the first survey, which was again cited at scope and severity level "D." CMS Ex. 11; LCCB Ex. 3. A second revisit survey of LCCB, completed May 11, 2007, found that LCCB had achieved substantial compliance with the comprehensive care plan requirements as of April 10, 2007. CMS Ex. 13. On May 18, 2007, CMS notified LCCB that the second revisit survey of May 11, 2007 determined that LCCB was in substantial compliance with all Medicare participation requirements for SNFs effective April 10, 2007. CMS Ex. 24.

CMS's post-certification revisit reports for the two revisit surveys and LCCB's plans of correction for the deficiencies identified in the April 3, 2007 and April 23, 2007 surveys show that the corrections for the immediate jeopardy level deficiencies were completed March 28, 2007, while the corrections for the comprehensive care plan, D-level deficiency, were completed April 10, 2007. CMS Exs. 3, 10, 13.

On May 25, 2007, LCCB requested an ALJ hearing to contest the findings of noncompliance underlying the April 20, 2007 and May 1, 2007 CMS determinations and the CMPs imposed by CMS. May 25, 2007, Request for Hearing at 1.

The ALJ Decision

The ALJ concluded that LCCB "was in substantial compliance with Medicare and Medicaid participation requirements based on the

survey of [the] facility completed on April 3, 2007" and that there was "no basis for [CMS] to impose remedies against" LCCB. ALJ Decision at 1; see also ALJ Decision at 2, 6. The ALJ made the following numbered findings of fact and conclusions of law (FFCLs):

> 1. Petitioner established by a preponderance of the evidence that it was in compliance with 42 C.F.R. § 483.10(b)(11)(Tag F 157).
>
> 2. Petitioner established by a preponderance of the evidence that it was in compliance with 42 C.F.R. § 483.25 (Tag F 309).
>
> 3. Petitioner established by a preponderance of the evidence that it was in compliance with the requirements of 42 C.F.R. § 483.75 (Tag F 490).
>
> 4. CMPs of $4,050 and $100 per day respectively, are unreasonable based on the facts of this case as there are no violations and therefore no basis for the imposition of CMPs.

In reaching these findings and conclusions, the ALJ stated that he found CMS's prima facie case of noncompliance "to have been sufficiently developed **to require discussion of all the evidence,** and in particular, to require discussion of the persuasive evidence developed by" LCCB. ALJ Decision at 6 (emphasis added). The ALJ added that his "evaluation of **all** the evidence, and . . . specific assignment of weight and credibility to **all** components of that evidence" were based on his observations of the witnesses who testified at the hearing, their "opportunities to observe the events and phenomena they described, their observed care, candor, and completeness in testifying, their training and experience in the subjects on which they gave testimony, and the presence or absence of any interests" that might impact their testimony. Id. (emphasis in ALJ Decision).

Standard of Review

Our standard of review on a disputed conclusion of law is whether the ALJ decision is erroneous. Our standard of review on a disputed finding of fact is whether the ALJ 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), http://www.hhs.gov/dab/guidelines/prov.html.

Analysis[3]

I. The ALJ erred in concluding that the $100 per day CMP was "unreasonable based on the facts of this case as there [were] no violations and therefore no basis for the imposition of CMPs." FFCL 4.

CMS argues that "at an absolute minimum," the ALJ should have determined that LCCB "was responsible for a $100 per day CMP." CMS Br. at 2. CMS contends that LCCB admitted at the hearing that it failed to comply substantially with 42 C.F.R. §§ 483.20(d)(3) and 483.10(k)(2), which require facilities to develop, periodically review, and revise a comprehensive care plan for each resident based on a comprehensive assessment of that resident. Further, CMS argues, this deficiency was "cited at sufficient scope and severity to form the basis for a CMP." Id. CMS claims that although the ALJ recognized that LCCB did not challenge the comprehensive care plan deficiency, "it was necessary for the ALJ to recognize that . . . [it] formed the basis for a CMP." Id. at 21. CMS also contends that the ALJ should have determined that the $100 per day CMP assessed for the comprehensive care plan deficiency was a reasonable penalty. Id.

CMS's argument is well-founded. LCCB's May 25, 2007 request for an ALJ hearing appealed "the certification of noncompliance and related sanctions set forth in" the CMS determinations dated April 20, 2007 and May 1, 2007. LCCB Request for Hearing at 1. In the hearing request, LCCB predominantly addressed the deficiencies cited at the immediate jeopardy level of severity, stating that it was "not clear whether CMS ha[d] imposed any remedy for [the comprehensive care plan] deficiency" at "F280." Id. at 4. In its August 9, 2007 case readiness report, LCCB again focused on the immediate jeopardy citations, but stated that it was challenging "the accuracy and appropriateness of the deficiencies cited following the April 3, 2007 survey, and alleg[ing] that it was in substantial compliance with **all applicable regulatory requirements at all pertinent times."** LCCB Case Readiness Report at 3-4 (emphasis added).

In response, CMS stated in its pre-hearing brief that the legal issues presented by LCCB's request for an ALJ hearing involved all of the survey findings referenced in, and penalties imposed

[3] Bardstown has made arguments on appeal in addition to those specifically addressed in our analysis. We conclude that those additional arguments have no merit or are irrelevant.

under, the April 20, 2007 and May 1, 2007 CMS determinations, which included the immediate jeopardy level deficiencies as well as the comprehensive care plan, D-level deficiency. CMS Pre-hearing Br. at 2-3. CMS's pre-hearing brief further clarified that the April 23, 2007 revisit survey determined that "the facility had removed [the] immediate jeopardy," but that "there was still an issue of compliance with Tag F-280," the D-level deficiency. Id. at 12. Thus, the ongoing non-compliance for which the $100 per day CMP was assessed was tied to the comprehensive care plan, D-level deficiency. Notably, that deficiency was based on findings that LCCB failed to revise Resident 1's comprehensive care plan to reflect the physician orders for "routine vital signs and daily oxygen saturation readings to be done." CMS Ex. 3, at 11-12. The deficiency findings also stated that a review of the resident's treatment records "revealed the vital signs and oxygen saturation readings were not obtained as ordered." Id.

At the February 19, 2008 ALJ hearing, LCCB's counsel, addressing the ALJ, stated in opening remarks:

> There are a number of issues before you, Judge, that you're going to have to decide in this case. . . . There is a D level deficiency in the case. We did not contest that, so we would expect that you will impose some civil money penalty, I think it's $100 a day, relating to that D. Yes, it is true that the documentation of the resident's breathing status was not done in a way that was ordered. We're not contesting that, and you can address that.

Tr. at 17, 22. Thus, LCCB explicitly admitted that it failed to substantially comply with the comprehensive care plan program requirements at sections 483.20(d)(3) and 483.10(k)(2), and that this admission provided a basis for CMS to impose a CMP.

The ALJ stated at page six of his decision that LCCB "does not challenge [the] allegations of noncompliance with Tag F 280, and therefore I will not address it . . . or the corresponding CMP that CMS determined to impose as a result of the deficiency." At the same time, however, in numerous other parts of the ALJ Decision and in FFCL 4, the ALJ concluded that LCCB was in substantial compliance with the program requirements cited in connection with the April 3, 2007 survey and that, consequently, there was no basis for CMS to impose any CMP against LCCB, including the $100 per day penalty. ALJ Decision at 1, 2, 6, 13, FFCL 4.

In light of LCCB's statement at the hearing that it would not contest the "D level deficiency," its admission that "the documentation of the resident's breathing status was not done in a way that was ordered," and counsel's representation that LCCB "expect[ed]" the ALJ to impose "some civil money penalty" for the deficiency, we conclude that the ALJ's finding in FFCL 4 that there were "no violations and therefore no basis for the imposition of CMPs" is erroneous. LCCB admittedly was not in substantial compliance, albeit at less than the immediate jeopardy level of severity, with the requirements governing the development, revision and implementation of comprehensive care plans at sections 483.20(d)(3) and 483.10(k)(2) of the regulations.

Accordingly, we vacate FFCL 4 and reverse the ALJ's conclusion that there was no violation of the participation requirements and no basis for the imposition of any CMP. We conclude, based on LCCB's admission, that LCCB was not in substantial compliance with the comprehensive care plan requirements at sections 483.20(d)(3) and 483.10(k)(2) of the regulations for the period January 3, 2007 through April 9, 2007. Since noncompliance with any participation requirement provides a basis for imposing a remedy, 42 C.F.R. § 488.402, we further find that this violation formed a basis for the imposition of a per day CMP of at least $50 for that period. 42 C.F.R. § 488.438(a)(1).

When the Board reviews an ALJ decision it may either issue a decision or remand the case. 42 C.F.R. § 498.88(a). Since LCCB did not contend that the regulatory factors to be considered in determining a penalty amount warranted a reduction of the $100 per day CMP imposed by CMS for the comprehensive care plan deficiency, we have no basis to conclude that the per-day amount of this CMP should be revised. <u>Coquina Center</u>, DAB No. 1860, at 32 (2002) ("[T]here is a presumption that CMS has considered the regulatory factors [in sections 488.438(f)] in setting the amount of the CMP and that those factors support the CMP amount imposed by CMS. Unless a facility contends that a particular regulatory factor does not support that CMP amount, the ALJ must sustain it"). Further, since LCCB has not disputed that it failed to substantially comply with the comprehensive care plan requirements during the entire period under review, it is reasonable to conclude that the $100 per day CMP for the D-level deficiency was effective on the first day remedies were imposed, January 3, 2007, and extended until April 10, 2007, when the corrections for that deficiency were completed.

Accordingly, we vacate FFCL 4 and conclude that the $100 per day CMP amount imposed by CMS for the comprehensive care plan deficiency is reasonable and applies to the entire period of time

for which LCCB conceded the existence of that deficiency, January 3, 2007 through April 9, 2007.

II. The ALJ Decision fails to address material evidence that conflicts with the factual findings supporting FFCLs 1, 2 and 3; FFCLs 2 and 3 also reflect errors of law.

As stated above, our standard of review on a disputed question of fact is whether substantial evidence on the record as a whole supports the ALJ's finding. Board Guidelines. Under this standard, our role is not to re-weigh the evidence or to substitute our own evaluation of the evidence for that of the ALJ. Odd Fellow and Rebekah Health Care Facility, DAB No. 1839, at 4 (2002), citing Lake Cook Terrace Center, DAB No. 1785 (2001); Beverly Health and Rehabilitation - Spring Hill, DAB No. 1696, at 40 (1999), aff'd, Beverly Health & Rehab. Servs. v. Thompson, 223 F.Supp.2d 73 (D.D.C. 2002). Moreover, "as an appellate body, we do not disturb an ALJ's assessment about the relative credibility of testimony by witnesses who appear in person at the hearing absent a compelling reason to do so." Koester Pavilion, DAB No. 1750, at 15 (2000). Thus, absent clear error, the Board defers to an ALJ's findings on the credibility of testimony. See, e.g., Hallmark House Nursing Center, DAB No. 2226, at 9 (2009); Sunbridge Care and Rehabilitation for Pembroke, DAB No. 2170, at 18 (2008); Lakeridge Villa Health Care Center, DAB No. 1988, at 19 n.14 (2005).

At the same time, our role in determining whether the ALJ's factual findings are supported by substantial evidence on the record as a whole is not a mere formality. We must examine the arguments, exhibits and testimony "and take into account whatever in the record fairly detracts from the weight of the decision below." Britthaven, Inc., DAB No. 2018, at 2 (2006), citing Universal Camera Corp. v. NLRB, 340 U.S. 474, 488 (1951). In so doing, we must consider "whether conflicting evidence in the record has been addressed by the ALJ and whether the inferences drawn by the ALJ are reasonable." Britthaven at 2, citing Barry D. Garfinkel, M.D., DAB No. 1572, at 5-6 (1996), aff'd, Garfinkel v. Shalala, No. 3-96-604 (D. Minn. June 25, 1997). Thus, we have previously concluded that "a decision may not be upheld based solely on the evidence 'which in and of itself justified it, without taking into account contradictory evidence or evidence from which conflicting inferences could be drawn.'" Barry D. Garfinkel, M.D. at 5-6, citing Universal Camera, 340 U.S. at 487. Relying on these principles, the Board vacated an ALJ decision that reversed CMS's imposition of a CMP "because the ALJ did not address evidence in the record that conflict[ed] with his finding

. . .” Estes Nursing Facility Civic Center, DAB No. 2000, at 1-2 (2005).

On review of the record in this case, we conclude that the ALJ’s analyses of the deficiencies cited by CMS at the immediate jeopardy level of severity fail to address evidence, testimony and admissions that conflict with a number of the ALJ’s factual findings. The lack of acknowledgment of this evidence in the ALJ Decision, or indication of any grounds for its rejection, leaves us unable to determine whether the ALJ duly considered and reasonably rejected, or simply overlooked, this evidence in reaching FFCLs 1, 2 and 3. We further conclude that FFCLs 2 and 3 of the ALJ Decision reflect additional errors of law. For these reasons, which we discuss in detail below, we conclude that FFCLs 1, 2 and 3 of the ALJ Decision should be vacated and that remand of this appeal to the ALJ is necessary for further deliberations, further development of the record if necessary, and a revised decision.

Furthermore, should the ALJ determine on remand that LCCB was not in substantial compliance with the physician consultation, quality of care, or administration requirements of 42 C.F.R. §§ 483.10(b)(11), 483.25, and 483.75, the ALJ must then evaluate whether CMS’s determinations that the deficiencies posed immediate jeopardy to facility residents were “clearly erroneous.” The ALJ must also address the duration of the noncompliance and the reasonableness of the CMP based on the factors at 42 C.F.R. §§ 488.438(f) and 488.404.

Below, we address in turn FFCLs 1, 2 and 3 of the ALJ Decision. We explain in detail why we are unable to conclude based on the ALJ’s present discussion of the evidence that each FFCL is supported by substantial evidence on the record. We also discuss our conclusions that the ALJ’s findings reflect other errors of law. Finally, we describe the evidence and questions that the ALJ should consider and address in a revised decision.

A. We vacate FFCL 1 and remand for reconsideration of whether LCCB was in substantial compliance with the physician consultation requirement at 42 C.F.R. § 483.10(b)(11).

i. Summary of the ALJ’s analysis

The physician consultation requirement at 42 C.F.R. § 483.10(b)(11) provides in pertinent part:

> Notification of Changes. (i) A facility must immediately . . . consult with the resident's physician
>
> . . . when there is—-
>
> > . . .
> > (B) 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)[.]

In FFCL 1, the ALJ reversed CMS's determination that LCCB violated section 483.10(b)(11) by failing to immediately notify Resident 1's physician when the resident had repeat vomiting episodes and a change in status during the evening and early morning of January 2-3, 2007. CMS Ex. 3, at 3-11. The ALJ stated that LCCB relied on the criteria of its physician notification policy, which was based on American Medical Directors Association guidelines, to support the facility's argument that Resident 1 did not have a change in status requiring immediate physician consultation prior to 4:00 a.m. on January 3, 2007. ALJ Decision at 8. The ALJ further stated that CMS did "not challenge the applicability or validity of the policy or guidelines." Id. The policy provides that a physician must be notified immediately when a resident has "repeat episodes of vomiting (i.e. greater than 1 episode within 24 hours)," or the vomiting "is accompanied by abdominal pain and changes in vital signs." ALJ Decision at 8, citing LCCB Ex. 29, at 20; LCCB Ex. 30, at 2. The policy further provides that a "one time episode" or "single episode" of vomiting may be reported to the physician on the "next office day." LCCB Ex. 29, at 20; LCCB Ex. 30, at 2.

Applying the facility's policy to the evidence and testimony, the ALJ found first, "as a matter of fact that there was one intermittent episode of emesis, extended over a limited time." ALJ Decision at 9. According to the ALJ, the episode began at approximately 8:30 p.m. on January 2, when "Resident 1 vomited, paused for a very short time, then vomited again in large quantity." ALJ Decision at 9-10, citing CMS Ex. 17, at 30-31; Tr. at 38, 215-216. To support this finding, the ALJ relied principally on Nurse Suffoletta's nursing notes from the evening and early morning of January 2-3, Nurse Suffoletta's hearing testimony, and his understanding of the meaning of "episode," which is not defined under the facility's policy. Specifically, the ALJ found that, "[i]t is not uncommon that when one vomits, there is an initial release followed by a more significant release shortly thereafter." Id. at 10. Although here Resident

1 had "two releases," the ALJ wrote, given the short period of time between the two, I consider this to be one episode of vomiting or emesis." Id. The ALJ added that his understanding of what constituted an episode of vomiting was "consistent with the common understanding" and dictionary definition of the word "episode," as "an event that is distinctive and separate although part of **a larger series**." ALJ Decision at 1 (emphasis in ALJ Decision), citing Merriam-Webster's Collegiate Dictionary (10th ed. 2001).

The ALJ further stated that two subsequent "incidents" cited by CMS as separate episodes of emesis were "much less clear." ALJ Decision at 9. According to the ALJ, "Ms. Wherry's reference to the two vomiting incidents," and her testimony that a short time after the 8:30 p.m. episode, she heard a sound from her grandmother's throat and Resident 1 vomited again, were "actually . . . reference[s] to the first vomiting incident." Id. at 9-10, citing Tr. at 38, CMS Ex. 17, at 30. Further, the ALJ concluded that the "third incident, when a small amount of emesis was observed on Resident 1's night clothes at 1:00 a.m. [did] not amount to a separate episode of emesis at all." ALJ Decision at 10. Rather, the ALJ stated, "[i]t can be fairly characterized only as uncertain of time or nature, but the most likely explanation of [i]t is that it was the final, much-less-serious, manifestation of the episode that had begun earlier in the evening." Id.

This conclusion, the ALJ wrote, was consistent with Nurse Suffoletta's hearing testimony, wherein she stated that she "did not believe that Resident 1 had vomited again [at 1:00 a.m.]" or that Resident 1's "condition had worsened between the hours of 8:00 p.m. and 4:00 a.m." ALJ Decision at 10, citing Tr. at 192-193, 219-220. Thus, the ALJ found, "Nurse Suffoletta reasonably – and for purposes of this decision, correctly – concluded both that Resident 1 had not vomited at 1:00 a.m., and that she was not required to notify the physician immediately." Id.
The ALJ next rejected CMS's argument that changes in Resident 1's mental and physical condition before 4:00 a.m. on January 3 required immediate notification of the physician. Id. at 10-11. The ALJ stated that CMS's argument was based on Ms. Wherry's testimony that Resident 1's "demeanor had changed negatively, that her body had become cold and rigid, and that her legs were discolored." Id. at 11, citing Tr. at 33-38. The ALJ discounted this testimony because Ms. Wherry was "not a trained health care professional, and thus her observations [were those] of a lay person." ALJ Decision at 11. Further, the ALJ stated, the "nurses notes do not indicate that the LPN or CNAs observed any

significant change in Resident 1's condition until 4:00 a.m." Id.

"More importantly," the ALJ stated, the facility policy requires immediate notification when a resident experiences an "episode of emesis **and** a change in vital signs." Id. (emphasis in ALJ Decision). The ALJ concluded that the testimony and evidence established that there was no change in Resident 1's vital signs prior to 4:00 a.m. Specifically, the ALJ stated, "Nurse Suffoletta testified that she checked Resident 1's vital signs twice between 8:00 p.m. and 2:00 a.m., and found them to be stable." Id. citing Tr. at 217, 227. Further, the ALJ stated, while CMS "complains that Nurse Suffoletta failed to document Resident 1's vital signs and criticized [LCCB] for utilizing a 'documentation by exception' system,"[4] CMS "never disputed whether Nurse Suffoletta or [LCCB's] staff actually took Resident 1's vital signs . . . ." Id. citing CMS Br. at 11, 14-15; Tr. at 261. Accordingly, the ALJ found "as a matter of fact that Nurse Suffoletta did take those unrecorded but normal vital signs." ALJ Decision at 11. Notably, the ALJ based his assessment of Nurse Suffoletta's credibility on "her demeanor and candor while testifying, the consistency of her testimony with all other written and oral evidence, her own experience and training, and the absence of any impeaching evidence whatsoever on the point." Id.

ii. The ALJ's characterization of what may be considered a single "episode" of emesis is not substantiated, and his reliance on Nurse Suffoletta's hearing testimony fails to take into account conflicting evidence.

On review of the record, we conclude that the ALJ's finding that Resident 1 had a single vomiting episode that began at approximately 8:30 p.m. on January 2, 2007, is premised on an unsubstantiated and ill-defined impression of what constitutes an "episode" of vomiting. As noted above, the ALJ found that Resident 1 had only one vomiting episode based on the nursing notes, Nurse Suffoletta's hearing testimony describing what she observed on the night of January 2, 2007, and the ALJ's own view that it "is not uncommon that when one vomits, there is an initial release followed by a more significant release shortly thereafter" and that "two releases" separated by a "short period of time" may be considered a single "episode." ALJ Decision at

[4] According to LCCB, in these circumstances "documentation by exception" is the practice of recording data "only if vital signs are abnormal." LCCB Br. at 22, citing Tr. at 261.

10. The ALJ did not, however, cite any authority or evidence in the record to support his understanding of the physiological process of vomiting, nor did he define what constituted a "short period of time" between releases. Moreover, the ALJ did not rely upon any standard of care in defining the term "episode" as used in the facility policy. Instead, the ALJ relied upon what he considered common knowledge without articulating the basis for this conclusion.

In support of the ALJ's finding, LCCB argues that what constitutes an episode of emesis "not only allows, but requires, some degree of nursing judgment regarding the context of a resident's illness." LCCB Br. at 18, 40, citing Tr. at 196, 251. In this case, LCCB argues, the ALJ properly determined that Nurse Suffoletta "made a reasonable judgment that the Resident had experienced only one episode of vomiting" and did not undergo "a significant change in condition" prior to 4:00 a.m. on January 3, 2007. Id. at 40-41. Moreover, LCCB contends that CMS "offered no evidence at all . . . that her judgment was so unreasonable or outside any standard of care as to constitute a regulatory violation." Id. at 40.

We disagree. LCCB's contention, and Nurse Suffoletta's hearing testimony, that on the evening and early morning of January 2-3, 2007, Nurse Suffoletta adjudged Resident 1 to have only one episode of vomiting before 4:00 a.m. is itself contradicted by other record evidence. Most notably, according to the SOD, in an interview with the surveyor Nurse Suffoletta "revealed the resident vomited again between 12:00am and 1:00am." CMS Ex. 3, at 7. This evidence is consistent with the nurse's note that at 1:00 a.m., the resident was observed to have a sm[all] am[oun]t of *emesis* [on her] night clothes." CMS Ex. 17, at 31 (italics added). The ALJ did not explain why he gave no weight to the evidence that Nurse Suffoletta reported to the surveyor that Resident 1 vomited again between midnight and 1:00 a.m. Indeed, the ALJ Decision does not acknowledge this evidence.

Moreover, other evidence in the record, including summaries of survey interviews set forth in the SOD and the facility's own investigation documents, shows that Nurse Suffoletta's judgment did not meet professional standards of care. Specifically, according to the summary of the February 19, 2007 survey interview with the DON that is set forth in the SOD, the DON "revealed the nurse should have called the physician after the first episode of vomiting [and that the] documentation revealed this was a change of condition for the resident." CMS Ex. 3, at 8. The DON's reported conclusion is consistent with the attending physician's opinion, as reflected in the summary of a

March 14, 2007 survey interview with the doctor. Id. According to the interview summary, the "physician revealed he would have wanted to be called after the first episode of vomiting," and that "he stated he probably would have ordered medication to control" the vomiting. Id. In addition, the physician reportedly told the surveyor that "if he was called after the second episode of vomiting (at 1:00am), he would have sent the resident to the hospital." Id.; see also LCCB Ex. 24, at 7; LCCB Ex. 17, at 2 (written notes dated March 19, 2007 of attending physician stating that "the nurse should have called the M.D. when the person first started profusely vomiting at 8:00 p.m. on 1-2-07" and that "the failure to call when the pt. first started profusely vomiting was an exercise in poor judgment"). The reported opinions of the DON and physician are consistent with the facility's own investigation, which found that Nurse Suffoletta had "failed to act appropriately and use good nursing judgment." CMS Ex. 21, at 2, 4. This evidence, which the ALJ Decision does not address, suggests that Nurse Suffoletta did not exercise sound professional judgment in assessing Resident 1's condition during the evening and early morning of January 2-3, 2007, as LCCB argues.

Accordingly, on remand the ALJ should develop the record as necessary and clarify in a revised decision what constitutes an "episode" of vomiting for purposes of applying LCCB's physician notification policy. The ALJ should make clear the evidence or authority on which he relies. The ALJ also should address Nurse Suffoletta's reported representation to the surveyor, reflected in the SOD, that Resident 1 vomited "again" between midnight and 1:00 a.m. Finally, the ALJ should discuss the above-described evidence relating to Nurse Suffoletta's professional judgment that physician consultation was not required prior to 4:00 a.m. on January 3. The ALJ should explain why, if he considered this evidence, he rejected it or otherwise assigned it little weight.

iii. The ALJ Decision does not address evidence that an additional vomiting incident occurred prior to 8:30 p.m.

The ALJ's analysis also fails to acknowledge documentary and testimonial evidence that a separate vomiting incident took place prior to 8:30 p.m., about which Nurse Suffoletta had been informed. This evidence additionally suggests that there was more than a one-hour gap between the prior vomiting incident and the episode that began at 8:30 p.m. Specifically, the record includes a written statement by CNA Betty Jo Rogers, which appears to have been taken in the course of LCCB's own investigation, that "@ 6pm & 630 pm" the CNA--

> Attempted to toilet [Resident 1], granddaughter asked staff to put her to bed because "she is too sick & weak" Observed [Resident 1 with] what appeared to be "vomit" on her clothing. Cleaned the [resident] & put her to bed. Then reported this to Natalie Suffoletta who was the charge nurse. . . . Granddaughter was present when in room @ approx 630 pm[.]

LCCB Ex. 19, at 1. Consistent with the CNA's statement is the summary in the SOD of a March 14, 2007 survey interview with Ms. Wherry, wherein Ms. Wherry reported that on January 2, "at 6:45pm she found the resident slumped over in her wheelchair and . . . abnormally quiet." CMS Ex. 3, at 5. According to the interview summary, Ms. Wherry then "requested the resident be put in bed," at which time the "resident began to vomit profusely and the granddaughter asked the nurse if the physician should be called." Id. In addition, Ms. Wherry testified at the hearing that the "first time" she observed her grandmother vomiting on the evening of January 21 was at approximately 7:30, when she and a CNA were attempting to transfer Resident 1 from her wheelchair into bed. Tr. at 33-38, 60.

Furthermore, the ALJ Decision does not address Ms. Wherry's testimony about the duration of the period between what Ms. Wherry described as the "first time" Resident 1 vomited, and the "second time," when Resident 1 "had a sound in her throat . . . and she threw up all over again." Id. at 35-39. According to Ms. Wherry's testimony, after the first time her grandmother vomited, Ms. Wherry and staff changed the resident's clothing and bedding, and "g[o]t her all cleaned up." Id. at 36-37, 60. The granddaughter was then left in the room with her grandmother, during which time she sang "Amazing Grace" to her grandmother. Id. Although the ALJ described the period between the first and second vomiting incidents as "a very short time," it is unclear whether the ALJ simply overlooked Ms. Wherry's testimony about the gap between vomiting incidents, whether he considered and rejected this testimony, or whether he determined that the period was "a very short time."

As stated above, we cannot evaluate whether an ALJ's factual findings are supported by substantial evidence on the record as a whole unless the decision includes "not only an expression of the evidence [the ALJ] considered which supports the result, but also some indication of the evidence which was rejected . . . [in order to determine] if significant probative evidence was not credited or simply ignored." Cotter v. Harris, 642 F.2d 700, 705 (3rd Cir. 1981). Here, the ALJ Decision fails to acknowledge the foregoing evidence, which tends to contradict his findings. Nor

does the decision indicate why, if he considered it, the ALJ rejected this evidence. Further, while the ALJ could possibly discount Ms. Wherry's testimony that her grandmother had undergone a change in mental and physical condition on January 2, 2007 on the grounds that Ms. Wherry was not a medical professional, this rationale would not explain why or how the ALJ could reasonably reject Ms. Wherry's testimony about the timing and sequence of events that she personally observed on the evening of January 2, 2007. These types of observations do not require medical credentials. Thus, the ALJ Decision does not discuss "all of the evidence," as the ALJ himself stated was required in this case. ALJ Decision at 6.

The foregoing evidence is material to the question whether Resident 1 had a separate "episode" of vomiting prior to 8:30 p.m. on the night of January 2, 2007. Consequently, the evidence is material to the question whether, under the facility's own policy, the physician consultation requirement of 42 C.F.R. § 483.10(b)(11) would have been triggered prior to 4:00 a.m. on January 3, 2007.

Accordingly, we conclude that remand is necessary for the ALJ to address this additional evidence in a revised decision. In the decision, the ALJ should consider and discuss this conflicting evidence and determine whether the CNA's statement, the SOD, and the above-cited portions of Ms. Wherry's testimony alter his prior conclusion that the physician consultation requirement was not triggered prior to 4:00 a.m., or explain why he gives little or no weight to this evidence.

iv. The ALJ's finding that Nurse Suffoletta took Resident 1's vital signs twice between January 2 at 8:00 p.m. and January 3 at 2:00 a.m. is flawed.

We also conclude that, in finding that Nurse Suffoletta took Resident 1's vital signs twice between 8:00 p.m. on January 2, and 2:00 a.m. January 3, and that those vital signs were normal, the ALJ misstated CMS's position below and failed to address material evidence that directly contradicts this finding. As noted above, the ALJ stated that "CMS never disputed whether Nurse Suffoletta or [the facility's] staff actually took Resident 1's vital signs." ALJ Decision at 11. The allegation of noncompliance with section 483.10(b)(11) in the SOD, however, explicitly states that "the facility failed to ensure that the resident's vital signs and oxygen saturation levels were monitored per physician's orders." CMS Ex. 3, at 4. Further, CMS *did* argue in its Post-hearing Brief and Post-hearing Reply

Brief that "Nurse Suffoletta did not monitor Resident 1's vital signs or oxygen saturation levels." CMS Post-hearing Br. at 13-15; Post-Hearing Reply Br. at 9, citing Tr. at 83-84; see also CMS Br. at 10. Thus, to the extent that the ALJ's finding that monitoring occurred relied on a contrary understanding of CMS's position, that was error.

Furthermore, the record includes additional evidence and testimony, which the ALJ did not address, that neither Nurse Suffoletta nor any other LCCB employee took Resident 1's vital signs during the evening and early morning of January 2-3, 2007 before 4:00 a.m. This evidence includes summaries of survey interviews in the SOD, the surveyors' hearing testimony and Ms. Wherry's hearing testimony. According to the SOD, in the course of two interviews with the surveyors, Nurse Suffoletta herself reported that she did not take Resident 1's vital signs:

> . . . Resident #1's granddaughter came to [Nurse Suffoletta] between 6:30pm and 8:00pm on 01/02/07 to inform her of Resident #1's vomiting. [Nurse Suffoletta] stated when she went into the room to change the resident, upon turning, the resident began to vomit . . . . She revealed **she did not listen to the resident's lungs, take vital signs or check to see if the resident had any medication to control the vomiting** . . . . Further interview with [Nurse Suffoletta] revealed the resident **vomited again between 12:00am and 1:00am. The nurse stated she failed to assess the resident or notify the physician at that time. She stated she was busy that night with other residents and did not think to assess the resident including obtaining vital signs,** listening to the resident's lungs or notifying the physician at 1:00am.
>
> * * *
>
> [Nurse Suffoletta] revealed **she did not obtain Resident #1's vital signs or oxygen saturation on 01/02/07 prior to the resident's vomiting. She stated she did not think to obtain the readings after the resident vomited at 8:30pm because she was busy with other residents. She said she should have, but did not.**

CMS Ex. 3, at 7, 12, 17 (emphasis added). Consistent with the representations **in the SOD** of Nurse Suffoletta's statements to the surveyors (as opposed to her testimony at the hearing), both surveyors Beard and Branham testified that they found no

documentation that Resident 1's vital signs were taken prior to 4:00 a.m. on January 3. See Tr. at 84, 86-87, 115-116, 131-133, 137-138. In addition, the ALJ did not address Ms. Wherry's testimony that during the course of her visit with Resident 1 on the evening of January 2, Ms. Wherry did not observe any member of LCCB's staff taking Resident 1's vital signs. Tr. at 36-37, 66.

We also note that while Nurse Suffoletta testified at the hearing that she took, but did not record, Resident 1's vital signs at approximately 8:30 p.m. on January 2, Nurse Suffoletta's testimony implied that she personally did not take Resident 1's vital signs after that point. Tr. at 216-217, 227, 240. Specifically, Nurse Suffoletta described the extent to which she monitored Resident 1 after 8:30 as follows: "I know I checked on her, like walking by the room, you know, would look in and check on her, make sure she hadn't thrown up. I know I did twice." Tr. at 221. In response to the question whether Resident 1's vital signs were taken any time after 8:30 p.m. but before 4:00 a.m., however, Nurse Suffoletta stated: "**We** checked them again **probably** – between midnight and 2:00." Tr. at 227 (emphasis added). Nurse Suffoletta later confirmed that she "didn't personally check the resident's vital signs each time," and that vital signs were actually taken by CNAs, who reported their findings to the nurse on pieces of paper that had not been saved or otherwise documented in the medical record. Tr. at 240-241. According to the SOD summary of a survey interview with the CNA who cared for Resident 1 in the early morning hours of January 3, however, the CNA "was not instructed to take Resident 1's vitals at 8:30pm or at 1:00am." CMS Ex. 3, at 6, 18-19; see also Tr. at 138-139. Between 2:00-2:30 a.m., the SOD evidences, the CNA performed an "incontinent check" on the resident, during which time "the resident kept her eyes closed and there was no response from the resident." Id. Resident 1's behavior, the CNA allegedly told the surveyors, "was unusual for this resident because she would normally resist removal of the blanket during incontinence care." Id. In addition, the word "probably" used by Nurse Suffoletta in her testimony is not an unequivocal statement that any staff member took the vital signs.

The foregoing evidence thus conflicts with the ALJ's factual finding that Nurse Suffoletta "checked Resident 1's vital signs twice between 8:00 p.m. and 2:00 a.m., and found them to be stable." ALJ Decision at 11. Since this factual finding was a key element of the ALJ's determination that LCCB did not violate its own physician notification policy, we conclude that remand is also appropriate for the ALJ to address the discrepancies between his finding and the above-described evidence. On remand, the ALJ

should consider the SOD interview summaries and hearing testimony cited above and explain whether they change his prior assessment of the weight of the evidence relating to the charge that the facility failed to timely consult Resident 1's physician due to a change in the resident's condition, as required by the facility's policy and 42 C.F.R. § 483.10(b)(11).

We additionally find that the evidence discussed above undercuts the ALJ's assessment of Nurse Suffoletta's credibility and, consequently, calls into question the reliability of the evidence cited by the ALJ to support his findings (including Nurse Suffoletta's testimony). As previously noted, the ALJ assessed Nurse Suffoletta's credibility based on "her demeanor and candor while testifying, **the consistency of her own testimony with all other written and oral evidence, her experience and training, and the absence of any impeaching evidence whatsoever on the point**." ALJ Decision at 11 (emphasis added). Plainly, much of the written and oral evidence described above is not consistent with the portions of Nurse Suffoletta's hearing testimony upon which the ALJ relied. Indeed, the summaries of the surveyor interviews with Nurse Suffoletta indicate that she made prior inconsistent statements that constitute "impeaching evidence . . . on the point." Id. Moreover, the ALJ's assessment of Nurse Suffoletta's "experience and training" appears not to have taken into account the evidence that LCCB terminated Nurse Suffoletta's employment based on its determination, after conducting a full investigation, that she "failed to act appropriately and use good nursing judgment" and "the facility management [did] not have confidence in [her] ability to perform her assigned job." CMS Ex. 21, at 2, 4. Since the ALJ relied almost exclusively on Nurse Suffoletta's nursing notes and hearing testimony to support his factual findings that Resident 1 experienced only one "episode" of vomiting and was properly monitored and assessed on January 2-3, we direct the ALJ on remand to reevaluate and discuss his prior assessment of Nurse Suffoletta's credibility and the reliability of her hearing testimony and nursing notes in light of the conflicting evidence discussed in this decision.

B. We vacate FFCL 2 and remand for reconsideration of whether LCCB was in substantial compliance with the quality of care requirement at 42 C.F.R. § 483.25.

The quality of care regulation at 42 C.F.R. § 483.25 provides:

> 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.

Applying this language, the Board previously has held that a facility's failure to implement physician orders, to comply with its own policies, or to furnish care and services in accordance with a resident's plan of care can constitute a deficiency under section 483.25. Woodland Village Nursing Center, DAB No. 2053, at 9 (2006), citing Lakeridge Villa Health Care Center, DAB No. 1988, at 22 (2005), citing The Windsor House, DAB No. 1942, at 55-56 (2004), Batavia Nursing and Convalescent Center, DAB No. 1904 (2004), aff'd, Batavia Nursing & Convalescent Ctr. v. Thompson, 129 Fed.Appx. 181 (6th Cir. 2005), and Spring Meadows Health Care Center, DAB No. 1966, at 16-17 (2005). The Board also has held that the quality of care provision "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.'" Sheridan Health Care Center DAB No. 2178, at 15 (2008), quoting Spring Meadows at 17.

In this case, the ALJ described CMS's allegations of noncompliance with section 483.25 as "essentially based on the same set of facts and circumstances involving Resident 1." ALJ Decision at 12. "Specifically," the ALJ stated, "CMS alleges that [LCCB] failed to assess Resident 1's change in condition, failed to monitor her oxygen saturation, and failed to monitor her vital signs according to the physician's orders . . . ." Id., citing CMS Ex. 3, at 15. Referring to his prior discussion of FFCL 1, the ALJ next summarily concluded that LCCB had "established that Resident 1 received the necessary care and services in accordance with the regulations." ALJ Decision at 12. Without any analysis of the evidence, the ALJ also concluded that CMS had "not demonstrated . . . that [LCCB] failed to act based on a particular . . . standard of care. Nor has there been any allegation or evidence that [LCCB's] care plans, or assessments failed to meet Resident 1's needs." Id. Moreover, the ALJ stated, as he had found under FFCL 1, LCCB "staff acted in a manner consistent with professional standards of care quality, and there was no failure on the part of [LCCB] to properly monitor or assess Resident 1." Id.

CMS argues that the ALJ did not fully address its allegations "that between the time the resident began vomiting and the time the EMS arrived to transport [Resident 1] to the hospital, the facility did not institute any interventions [to] help her condition or alleviate her symptoms." CMS Br. at 12, citing CMS

Ex. 3, at 13-20, CMS Post-hearing Br. at 13-15; CMS Post-hearing reply Br. at 8-10; Tr. at 137-138. CMS points out, for example, that there is no evidence or testimony that LCCB administered any treatment to the resident between 4:00 and 4:21 a.m. on January 3. Based on Resident 1's physician's orders and generally accepted standards of care for "patients in distress," CMS argues, the facility should have provided suctioning and administered oxygen to the resident during that period. CMS Br. at 13, citing LCCB Ex. 12, Tr. at 147-148. CMS further argues that the ALJ's analysis did not address the facility's failure to implement the physician's November 17, 2006 orders to monitor and record Resident 1's vital signs and oxygen saturation levels regularly. Indeed CMS notes, "[t]hese facts formed some of the basis for [the deficiency] for which the facility accepts responsibility." Id.

We find that CMS's contentions have merit. As a preliminary matter, we note that the ALJ's summary factual findings under FFCL 2, that "Resident 1 received the necessary care and services" and that "there was no failure . . . to properly monitor or assess" Resident 1, were based on the ALJ's evaluation of the evidence and factual findings supporting FFCL 1. Thus, our conclusion that we cannot determine whether the factual findings underlying FFCL 1 are supported by substantial evidence on the record as a whole, and that remand is necessary for further deliberations and a revised decision, applies equally to the ALJ's summary findings of fact supporting FFCL 2. Accordingly, should the ALJ revise his assessment of the weight of the evidence or credibility of the witnesses' testimony relating to FFCL 1, we would expect those changes to be reflected in a revised analysis of whether LCCB was in substantial compliance with the quality of care requirements at section 483.25 of the regulations.

We further conclude, on review of the arguments and evidence presented below, that the ALJ erred by limiting his analysis of whether LCCB complied with the quality of care regulation to essentially the same questions addressed, and resolved in the facility's favor, under FFCL 1. CMS's allegations of LCCB's noncompliance with section 483.25 do, in part, rely on the same evidence proffered with respect to the first deficiency. CMS's allegations of LCCB's noncompliance with the section 483.25, however, were not merely duplicative or derivative of its allegations of noncompliance with the physician consultation requirement, as the ALJ suggests. Nor were the deficiency findings under the quality of care regulation limited to addressing the care and services provided to Resident 1 from the evening of January 2 until 4:00 a.m. on January 3, when she was

found unresponsive. Rather, the SOD findings on which CMS's determinations were based and CMS's allegations of LCCB's noncompliance with section 483.25 included:

- From November 2006 until Resident 1's death, the facility failed to implement the November 17, 2006 physician orders for routine vital signs and daily oxygen saturation readings for Resident 1. The treatment administration records for November and December 2006 showed only 10 oxygen saturation readings from November 17, 2006 through December 31, 2006, and none for January 2007. The records also showed that "the resident's vital signs had not been taken daily as ordered by the physician." CMS Ex. 3, at 14-15, 19-20; CMS Br. at 12-13, citing CMS Exs. 3, 17, LCCB Ex. 12, Tr. at 22, 137-138.

- "Documentation by exception" of vital signs and oxygen saturation levels is not acceptable when there are explicit physician's orders for monitoring those signs and levels. CMS Br. at 13, citing Tr. at 22, 234-240; LCCB Ex. 12.

- Between 4:00 and 4:21 a.m. on the morning of January 3, 2007, the facility failed to suction or administer oxygen to Resident 1, contrary to the physician's orders for oxygen to be administered when Resident 1's oxygen saturation levels fell below 88% and to professional standards of care. CMS Ex. 3, at 13-14, 17; CMS Br. at 13, citing LCCB Ex. 12, Tr. at 147-148.

- LCCB "did not give [EMS] a verbal report of the resident's allergies, recent medical history or that the resident had been vomiting" when EMS arrived to transport Resident 1 to the hospital on January 3, 2007. CMS Ex. 3, at 16.

- The transfer "paperwork prepared by the facility [for EMS and the hospital] did not reveal the resident had been profusely vomiting . . . ." CMS Ex. 3, at 16.

- In a survey interview "with the Attending Physician on-call for the facility on 01/03/07 . . . [h]e stated he reviewed the facility's nursing documentation and the notes . . . . He stated it looked like the facility did not do anything for the resident until they 'found her on death's door.'" Id.

Notably, while LCCB has argued that CMS "press[ed] [the quality of care] tag only cumulatively," LCCB also has presented argument

and evidence to contest many of the above-cited allegations of noncompliance. See, e.g., LCCB Post-hearing Br. at 23; LCCB Post-hearing Reply Br. at 5; LCCB Br. at 21-22, 28-30, 42. The ALJ Decision does not, however, address these material disputes relating to the question whether LCCB was in substantial compliance with the quality of care requirements.

In addition, as discussed above, LCCB has admitted that it did not follow the physician's orders to document Resident 1's oxygen saturation levels. Tr. at 22; see also CMS Ex. 3, at 12 (stating that in a survey interview, the DON "revealed she was unaware the vital signs and oxygen saturation readings were not obtained as ordered. She stated the nurses were to record the resident's vital signs and oxygen saturation on the TAR."). This failure is material to the question whether LCCB was in substantial compliance with the quality of care regulation.

Thus, even if on remand the ALJ affirms his prior factual findings supporting FFCL 1, those findings alone would not provide a sufficient basis for the ALJ to conclude that LCCB was in substantial compliance with the quality of care regulation. Rather, the ALJ must consider LCCB's admitted failure to follow the physician's orders to document Resident 1's oxygen saturation levels in the context of the quality of care requirements. The ALJ must also address the additional allegations to determine whether they are supported by the preponderance of the evidence, and if so, whether they demonstrate noncompliance with 42 C.F.R. § 483.25.

Finally, we conclude the ALJ erred in stating that there was no "allegation or evidence that [LCCB's] care plans, or assessments[,] failed to meet Resident 1's needs." ALJ Decision at 12. CMS's determination that LCCB failed to comply with the comprehensive care plan requirements, discussed in detail above and conceded by LCCB, was based on the finding in the SOD that: "the facility failed to revise [Resident 1's] care plan to reflect the physician orders . . . [for] vital signs to be taken routinely and oxygen saturation readings to be done daily . . . ." CMS Ex. 3, at 11. This finding is supported by other record evidence, which includes the physician orders dated November 17, 2006, the facility records indicating that the orders were not reflected in the resident's plan of care, and the summary of the survey interview with LCCB's DON wherein the DON "stated the care plan should have been revised when new orders were obtained." CMS Exs. 3, at 12; 17, at 9; LCCB Exs. 12-15. In light of CMS's allegations, LCCB's admission of noncompliance, and the record evidence, we conclude that remand is also necessary for the ALJ to consider whether LCCB's failure to

update Resident 1's care plan to implement the physician's orders constituted noncompliance with the quality of care requirement at 42 C.F.R. § 483.75.

C. We vacate FFCL 3 and remand for reconsideration of whether LCCB was in substantial compliance with the administration requirement at 42 C.F.R. § 483.75.

The facility administration regulation at 42 C.F.R. § 483.75 provides:

> A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.

The ALJ rejected CMS's allegations that LCCB failed to substantially comply with section 483.75, stating that "CMS has not established that systemic breakdowns on the part of the administration caused deficient facility practice." ALJ Decision at 13. In reaching this conclusion, the ALJ held that the "administration deficiency is a derivative deficiency based on findings of other deficiencies." ALJ Decision at 12, citing Cross Creek Health Care Center, DAB No. 1665, at 19 (1998). Here, the ALJ concluded, CMS's "case . . . has been refuted as to the predicate issue of the staff's response to Resident 1's episode of vomiting." ALJ Decision at 13. Since "the failure of the predicate case dooms the derivative citation based on the charged administration deficiency," the ALJ concluded, CMS's determination that LCCB failed to substantially comply with the requirements of section 483.75 of the regulations must be reversed. Id.

We conclude that the ALJ erred in his analysis of whether LCCB was in substantial compliance with section 483.75. CMS's determination that LCCB failed to substantially comply with the facility administration regulation was based on the following findings in the SOD:

- The "Administrator failed to take necessary actions to correct deficient practices involving residents with a significant change in condition, and investigate events contributing to the deficient practice."

- "The Administrator failed to assure all staff were properly trained in regard to their policy and procedure of

notification of the physician when a resident experienced a change in condition that required alteration or treatment."

- "The Administrator failed to investigate the incident of 01/02/07-01/03/07 to determine the causative factors related to the care and services that were not provided Resident #1."

CMS Ex. 3, at 20-21. To support the finding that the Administrator failed to ensure staff were properly trained in facility policy and procedures, the SOD cited the facility training records and survey interviews with Nurse Suffoletta, the Administrator, the DON, and the nurse training consultant. CMS Ex. 3, at 3-4, 9-10, 19, 23-24. According to the SOD, the records and interviews revealed that nursing staff had not received training and all materials on the facility's physician notification policies and that the facility did not review whether staff received, reviewed and understood the policies and procedures. Id.

To support the findings that LCCB's Administrator failed to investigate the circumstances surrounding Resident 1's death,[5] the SOD cited, among other things, a March 14, 2007 survey interview with the Administrator who stated that "a thorough clinical review should have been done after the incident [of January 2-3, 2007], but had not." CMS Ex. 3, at 22-23. According to the SOD, only *after* the surveyor interview with the Administrator on March 14, 2007 (at which time this issue was discussed) did LCCB conduct a thorough clinical review of whether "appropriate care and services had been provided." Id. The SOD further provided that the "findings [of that investigation] revealed the nurse did not follow the facility's policy and procedures for change in condition and physician notification." Id.; see also CMS Ex. 21, at 4 (March 21, 2007 LCCB letter to Kentucky Inspector General stating that following its investigation of an allegation of neglect regarding Resident 1, LCCB terminated Nurse Suffoletta's employment because she "failed to act appropriately and use good nursing judgment," and LCCB did "not have confidence in her ability to perform her assigned job.").

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[5] According to the SOD summary of an interview with Resident 1's treating physician, Resident 1's "condition was not terminal and he did not expect her to expire." CMS Ex. 3, at 8, 18; see also CMS Ex. 17, at 32.

In response to CMS's allegations, LCCB argues, among other things, that "before the survey even started," its administrators "*did* investigate the incident" of January 2-3, 2007 "and concluded that Nurse Suffoletta's clinical response was not inadequate." LCCB Br. at 32, citing LCCB Ex. 24; Tr. at 245.[6] Further, LCCB contends, the State agency previously concluded that LCCB's training was effective, and written evidence and Nurse Suffoletta's hearing testimony establish that she received adequate training and, in fact, knew the content of LCCB's physician notification policy. LCCB Br. at 33-34, citing Tr. at 144-146, 222-224.

In prior decisions, including Cross Creek, the Board has held that where a deficiency finding under section 483.75 was derivative, "i.e., was based on the surveyors' identification of other deficient practices," the existence of those separately identified deficiencies "may constitute a prima facie case that a facility has not been administered efficiently or effectively as required by section 483.75." Odd Fellow and Rebekah Health Care Facility, DAB No. 1839, citing Asbury Center at Johnson City, DAB No. 1815 (2002). In other words, a determination that a facility failed to substantially comply with the administration regulation may be derived from findings that the facility was not in substantial compliance with other participation requirements. Neither the regulations nor Board precedent, however, necessarily require all administration deficiencies to be exclusively derived from findings of noncompliance with other, separately identified deficiencies. Indeed, as demonstrated in this case, findings of noncompliance with the administration regulation may be identified in the course of an investigation of other deficiencies, but may not be wholly derived from the separate findings of noncompliance. In such a case, a determination that the facility was in substantial compliance with separately identified requirements does not necessarily "doom" the administration deficiency, as the ALJ suggests. Rather, the reviewer must consider whether any of the allegations of noncompliance with the administration requirement, standing alone, are supported by the evidence and independently constitute noncompliance with the requirements of the administration regulation.

[6] The exhibit cited by LCCB to support its argument is an undated form titled "Incident Investigation Levels III & IV (Root Cause Analysis) Form." LCCB Ex. 24. Contrary to LCCB's characterization of the document, it states: "In conclusion this nurse failed to follow facility policy & procedure of documentation, assessment and physician notification." Id. at 7.

Thus, even if the ALJ concludes on remand that LCCB substantially complied with the physician consultation requirement at 42 C.F.R. § 483.10(b)(11) and the quality of care requirement at 42 C.F.R. § 483.25, this should not end the ALJ's analysis of whether LCCB substantially complied with the administration requirement at section 483.75. Rather, in evaluating whether the facility was "administered in a manner that enable[d] it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident," the ALJ must consider whether CMS's allegations that LCCB failed to conduct a timely and thorough investigation of the circumstances surrounding Resident 1's death and that the facility did not ensure that staff were properly trained in facility policy and procedures are supported by the preponderance of the evidence and, if so, constitute noncompliance with the administration regulation.

Conclusion

For the reasons explained above, we vacate FFCLs 1-4 of the ALJ Decision and remand the case to the ALJ for further proceedings as directed in this decision. We adopt the following FFCLs (which should be included in the ALJ's revised decision):

> FFCL A-1. Petitioner failed to substantially comply with the comprehensive care plan requirements at 42 C.F.R. §§ 483.20(d)(3) and 483.10(k)(2).
>
> FFCL A-2. A CMP of $100 per day, extending from January 3, 2007 through April 9, 2007, is reasonable based on Petitioner's noncompliance with 42 C.F.R. §§ 483.20(d)(3) and 483.10(k)(2).

/s/
Sheila Ann Hegy

/s/
Leslie A. Sussan

/s/
Stephen M. Godek
Presiding Board Member