

**Department of Health and Human Services
DEPARTMENTAL APPEALS BOARD
Appellate Division**

Avalon Place Trinity
Docket No. A-16-108
Decision No. 2819
September 15, 2017

**FINAL DECISION ON REVIEW OF
ADMINISTRATIVE LAW JUDGE DECISION**

Avalon Place Trinity (Avalon or Petitioner), a long-term care facility, appeals the decision of an Administrative Law Judge (ALJ) upholding the determination of the Centers for Medicare & Medicaid Services (CMS) to impose sanctions against Avalon for violating numerous requirements in 42 C.F.R. § 483.1 *et seq.* The ALJ concluded that Avalon was not in substantial compliance with various resident health and safety requirements in 42 C.F.R. §§ 483.13, 483.20, 483.25, and 483.75 from March 28, 2013 through May 9, 2013, and that the noncompliance with most of those requirements was at the immediate jeopardy (IJ) level, for three days, from March 28, 2013 through March 30, 2013. The ALJ also upheld CMS's determination to impose on Avalon a civil money penalty (CMP) of \$6,550 per day for three days of IJ-level noncompliance, and a CMP of \$1,550 per day from March 31, 2013 through May 9, 2013 for noncompliance at less than IJ level. *Avalon Place Trinity*, DAB CR4601 (2016) (ALJ Decision).

For the reasons set out below, the Board upholds the ALJ Decision.

Legal background

To participate in the Medicare program, a long-term care facility must be in “substantial compliance” with Medicare participation requirements in 42 C.F.R. Part 483, subpart B. 42 C.F.R. §§ 483.1, 488.400.¹ Under agreements with the Secretary of Health and

¹ In October 2016, the requirements for long-term care facilities in subpart B of Part 483, including those at issue here, were revised effective November 28, 2016. Final Rule, *Medicare and Medicaid Programs; Reform of Requirements for Long-Term Care Facilities*, 81 Fed. Reg. 68,688 (Oct. 4, 2016); 82 Fed. Reg. 32,256 (July 13, 2017) (technical corrections). We rely on the regulations in effect when the state agency performed the survey(s) that formed the bases for CMS's determination of noncompliance. *Carmel Convalescent Hosp.*, DAB No. 1584, at 2 n.2 (1996) (the Board applies the regulations in effect on the date of the survey and resurvey).

Human Services, state survey agencies conduct onsite surveys of facilities to verify compliance with the requirements. 42 C.F.R. §§ 488.10(a), 488.11; *see also* Social Security Act (Act)² §§ 1819(g)(1)(A), 1864(a).

A state survey agency reports any “deficiencies” it finds in a Statement of Deficiencies (SOD), which identifies each deficiency under its regulatory requirement and the corresponding “Tag” number. A “deficiency” is any failure to comply with a Medicare participation requirement, and “substantial compliance” means “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.” 42 C.F.R. § 488.301 (also defining “noncompliance” as “any deficiency that causes a facility to not be in substantial compliance”). “Immediate jeopardy” is “a situation in which the [facility’s] noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident.” *Id.*

Under authority of 42 C.F.R. Part 488, subpart F, CMS enforces compliance with Part 483, subpart B requirements. Enforcement “remedies” for facilities found to be not in substantial compliance with those requirements include per-day CMP(s) in amounts that vary depending on factors specified in the regulations, which include the “seriousness” of the facility’s noncompliance. 42 C.F.R. §§ 488.404(b), 488.438(f). “Seriousness” is a function of the noncompliance’s scope (whether it is “isolated,” constitutes a “pattern,” or is “widespread”) and severity (whether it has created a “potential for” harm, resulted in “actual harm,” or placed residents in “immediate jeopardy”). *Id.* § 488.404(b). The most serious noncompliance is that which puts one or more residents in “immediate jeopardy.” *See id.* § 488.438(a) (highest CMPs are imposed for immediate-jeopardy-level noncompliance); *Woodland Oaks Healthcare Facility*, DAB No. 2355, at 2 (2010) (citing authorities). A per-day CMP may accrue from the date the facility was first out of substantial compliance until the date it is determined to have achieved substantial compliance. 42 C.F.R. § 488.440(a)(1), (b). CMS’s determination on the level of noncompliance is upheld unless it is clearly erroneous. *Id.* § 498.60(c)(2).

² The current version of the Act can be found at http://www.socialsecurity.gov/OP_Home/ssact/ssact-toc.htm. Each section of the Act on that website contains a reference to the corresponding United States Code chapter and section. Also, a cross-reference table for the Act and the United States Code can be found at 42 U.S.C.A. Ch. 7, Disp Table.

Case overview³

In March 2013, the Texas Department of Aging and Disability Services, the state agency, conducted annual health and Life Safety Code (LSC)⁴ surveys at Avalon. The state agency found numerous instances of noncompliance with various resident health and safety requirements. Based on the survey findings, CMS determined that Avalon was not in substantial compliance with Medicare participation requirements, including those at issue here, as set out in 42 C.F.R. §§ 483.13, 483.20, 483.25, and 483.75. CMS imposed CMPs of \$6,550 per day for three days of IJ (March 28, 2013 through March 30, 2013) and CMPs of \$1,550 per day for 40 days (March 31, 2013 through May 9, 2013) for the period during which Avalon remained out of substantial compliance after abatement of IJ. ALJ Decision at 1-5; CMS Ex. 4. CMS also informed Avalon that it would deny Avalon payment for new admissions from April 27, 2013 through May 9, 2013. CMS Ex. 4, at 1.

Avalon appealed, requesting a hearing before an ALJ. As the ALJ noted, the parties had resolved their disputes in part, through informal dispute resolution (IDR). ALJ Decision at 3 n.1, citing CMS Exs. 1 and 6. Before the ALJ, Avalon did not challenge any of the LSC deficiencies. ALJ Decision at 1, 5. Avalon challenged most of the 31 health violations that still remained in dispute. *Id.* at 1, 3-5. On August 26, 2014, the ALJ held a video-teleconference hearing at which two witnesses for CMS and two witnesses for Avalon testified. *Id.* at 5-6; Transcript of ALJ hearing (Tr.).

In her decision, the ALJ discussed the following five health violations, all but one of which CMS cited at the IJ level of scope and severity (S/S)⁵:

³ This section is presented to provide a context for the discussion of the issues raised on appeal.

⁴ The LSC refers to fire protection requirements. The LSC is made applicable to the regulation of long-term care facilities by certain provisions in 42 C.F.R. § 483.70, “Physical environment,” which implements section 1819(d)(2)(B) of the Act. *See generally* State Operational Manual (SOM), CMS Pub. 100-07, Ch. 2, § 2470 *et seq.* and Ch. 7, § 7410 *et seq.*

⁵ The ALJ identified the LSC violations (not appealed) and the 31 health violations in dispute after IDR (two of which were not appealed to the ALJ), by reference to the regulation(s) under which the violations were cited and the Tag number, along with a brief description and the S/S level of the violation. ALJ Decision at 2-5. Noting that the parties did not address all of the deficiencies in dispute, the ALJ stated that “[b]ecause the deficiencies [she] affirm[s] more than support the penalties imposed, [she] need not and do[es] not address all of the deficiencies cited.” *Id.* at 3 n.2. (All of the violations the ALJ identified but did not separately discuss in her analysis were cited at less than IJ level.) The ALJ’s determination not to address all disputed deficiencies is not inconsistent with Board precedent. *Carrington Place of Muscatine*, DAB No. 2321, at 20-21 (2010) (ALJ committed no prejudicial error in not addressing and adjudicating certain cited deficiencies where the ALJ determined that those deficiencies the ALJ did address were on their own sufficient to support the remedies imposed). In any case, Avalon does not assert that the ALJ would have had to uphold any or all of the deficiencies she did not address to also uphold the imposed sanctions (including the CMP amounts). It does not state that it was prejudiced in some way by the ALJ’s determination to address only certain deficiencies.

- 42 C.F.R. § 483.13(c), Tags F224 and F226, concerning staff treatment of residents, S/S level K (pattern of noncompliance that posed IJ to resident health and safety)
- 42 C.F.R. § 483.20(g)-(j), Tag F278, concerning resident assessment, accuracy/coordination/certification, S/S level K
- 42 C.F.R. § 483.25(h), Tag F323, concerning quality of care, accident prevention, S/S level K
- 42 C.F.R. § 483.25, Tag F309, concerning quality of care, S/S level H (pattern of noncompliance that caused actual harm)
- 42 C.F.R. § 483.75, Tag F490, concerning administration, S/S level K

ALJ Decision at 3, 4, 5, 6-10.

The ALJ determined that Avalon was not in substantial compliance with 42 C.F.R. §§ 483.13(c), 483.20(g)-(i), 483.25(h), 483.25, and 483.75 because its staff failed to accurately assess its residents, prevent resident neglect, and provide residents with supervision and assistive devices as needed to prevent accidents. *Id.* at 6-23. The ALJ also determined that CMS's determination that the facility's noncompliance with 42 C.F.R. §§ 483.13(c), 483.20(g)-(i), 483.25(h), and 483.75 (i.e., all of the above violations other than Tag F309, S/S level H) posed IJ to resident health and safety was not clearly erroneous. *Id.* at 23-24. Further, the ALJ determined that, from March 28, 2013 through May 9, 2013, Avalon was not in substantial compliance with Medicare program requirements and, for three days within this period, March 28 through March 30, the deficiencies posed IJ to resident health and safety. *Id.* at 1-2, 26. Finally, the ALJ determined that the CMPs imposed were reasonable. *Id.* at 2, 24-26.

Standard of review

The Board's standard of review on a disputed conclusion of law is whether the ALJ's decision is erroneous. The Board's standard of review on a disputed finding of fact is whether the ALJ's finding is supported by substantial evidence in the record. *Guidelines – Appellate Review of Decisions of Administrative Law Judges Affecting a Provider's Participation in the Medicare and Medicaid Programs (Guidelines)*, accessible at <http://www.hhs.gov/about/agencies/dab/different-appeals-at-dab/appeals-to-board/guidelines/index.html?language=en>.

Analysis

In its brief in support of its request for review (RR), Avalon asserts numerous factual and legal errors in the ALJ's analysis of the five health violations, including the ALJ's upholding of CMS's IJ determination as not clearly erroneous. Avalon asserts, moreover, that the CMP amounts are unreasonable. Lastly, Avalon asserts numerous procedural and evidentiary errors in the ALJ proceedings, and complains of ALJ bias.

Below, in sections A.1 through A.5, we address the five violations and Avalon's arguments related to those violations, explaining why we find the ALJ's determination supported by substantial evidence and legally sound. In section B, we explain why we agree with the ALJ that CMS's IJ determination was not clearly erroneous. In section C, we address the reasonableness of the CMPs. Lastly, in section D, we explain why we reject Avalon's arguments of procedural and evidentiary errors and bias.⁶

A. The ALJ's conclusion that Avalon was not in substantial compliance with 42 C.F.R. §§ 483.13(c), 483.20(g)-(i), 483.25(h), 483.25, and 483.75 is supported by substantial evidence and is free of legal error.

1. 42 C.F.R. § 483.13(c) (Tags F224 and F226, failure to implement policies to prevent resident neglect; both S/S level K)

a. Background, survey, and the ALJ's analysis

This deficiency (and others discussed below) arose from alleged facility neglect of Resident 73 (R73), a man in his 80s who was on oxygen and experiencing the late effects of cerebrovascular disease and anemia, and whose functional ability with respect to activities of daily living (ADLs) was declining, related to muscle insufficiency and deficits in balance and coordination. Documentation in the record on which the ALJ relied indicated that R73 was at risk for falls and needed staff supervision. ALJ Decision at 10-13. Early in the morning of March 28, 2013, a nurse aide (B. Ratliff) was assisting R73 to get ready for breakfast and was present when he indicated he needed to use the bathroom (located within his room), but, according to Ratliff, R73 said he did not need assistance and took himself to the bathroom. According to Ratliff, she left R73 alone to

⁶ Avalon asked the Board to hold oral argument "to further clarify [its] arguments as to why the ALJ's decision should be reversed" because the "issues in this case are complex." RR at 40. By letter dated July 11, 2016, the Board instructed Avalon to explain in more detail, at the latest when it files its reply brief (should it choose to file one), why it believes the issues presented are complex. Avalon did not file a reply brief and did not ask for more time to do so; nor did Avalon further communicate with the Board about its earlier request for oral argument. In the absence of further communication from Avalon, and having considered whether oral argument would aid our decision-making, we have decided to proceed to decision based on the written submissions.

go to the bathroom on his own, at his request, but left the bathroom door open, left the room, closed the room door behind her, and was away for a few minutes. She returned to find him on the floor in his room at the entrance to the bathroom, with his face on the floor and blood pooling around his head. The nursing staff determined that R73 must have fallen while trying to ambulate out of the bathroom, and noted skin tears, including on his left shoulder and left elbow. The facility called emergency medical services and had R73 transported by ambulance to a hospital, where he was assessed with a fall with intracranial bleeding and subdural hematoma, anemia, renal insufficiency, and lacerations and skin tears on the left elbow, left hand, and left temple. R73 was later transferred to a regional hospital by air, and passed away late in the evening on March 28, 2013. CMS Ex. 6, at 9, 12-13, 19, 22-23; ALJ Decision at 13-14 (citations to the record omitted).

The regulation at 42 C.F.R. § 483.13(c) provides: “The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.” “Neglect” is defined as the “failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness.” 42 C.F.R. § 488.301. A facility’s failure to implement and follow its anti-neglect policy can result in a finding that it is not in substantial compliance with the regulation, and may be demonstrated by a failure to follow other policies and procedures that define what the facility has determined are goods and services needed to avoid such harm. *Avalon Place Kirbyville*, DAB No. 2569, at 9 (2014).

The surveyors determined that Avalon violated subsection 483.13(c) by failing to implement its policy and procedures prohibiting neglect. According to the SOD, that failure and, specifically, the failure to supervise R73, who was at risk for falls and needed supervision, “contributed to” his fall resulting in injury and death. Avalon was cited with Tags F224 and F226, as violations of subsection 483.13(c). CMS Ex. 6, at 8-9, 15-16, 18-19.

As the ALJ noted, Avalon has in place multiple written policies that, among other things, prohibit resident “neglect” as the term is defined in section 488.301, and define the “goods and services” needed to protect its residents from harm. Included within those “good and services” policies are policies specific to fall risk management. Among the fall risk management policies are a written document headed “Fall Risk Assessment & Management” and a list headed “policy interpretation and implementation” setting out specific factors to be considered or included in evaluating residents (e.g., relevant resident history such as history of prior falls; fall risk factors; interventions to manage fall risk; functional impairments). Additional measures are required for those residents who have high fall risk and continuing falls, under the “Falling Star Program” policy. Avalon also has a policy on “activities of daily living” (bathing, transfers, ambulation, toileting, eating), which, among other things, calls for observation of residents for signs of change

and periodic comprehensive resident assessments; electronic documentation by nursing staff of residents' involvement in basic ADL care and services rendered; and assessment to determine deterioration to ensure that residents receive necessary care and services. ALJ Decision at 8-10, citing CMS Exs. 24; 30, at 2, 3; and P. Exs. 2; 3, at 2, 3; 15, at 7-9.

The ALJ determined that CMS properly cited Avalon with a violation of section 483.13(c)'s neglect-prohibition requirements because, "[n]otwithstanding R73's well-documented need for supervision when standing, walking, toileting, and performing other [ADLs], [nurse aide Ratliff, who was] caring for him on the morning of March 28, left him alone in the bathroom" and, "[a]t about 7:15 a.m., she returned to find him lying on the bathroom floor" suffering from the injuries of which he later died. *Id.* at 13-14 (record citations omitted). The ALJ found "overwhelming documentary evidence" of R73's need for supervision, particularly as a fall precaution, which the ALJ said was not provided to R73. *Id.*

The ALJ recounted R73's documented history from the date of his transfer from a hospital and admission to Avalon (March 13, 2013) and shortly thereafter relevant to his risk for falls and functional deficit establishing a need for assistance and supervision for ADLs. Of note, the evidence the ALJ described in her decision included the following:

- March 13, 2013 hospital transfer records showing that R73 needed help with all "self-care," including sitting, standing, walking, and toileting, and that physical, occupational, and speech therapists were supposed to evaluate and treat R73.
- March 13, 2013 admission plan of care directing the physical therapy staff to evaluate R73 for safety issues, particularly related to falls.
- March 13, 2013 physical therapy care plan describing R73's functional decline in transfers, gait, and bed mobility, and indicating that R73 was a fall risk.
- March 13, 2013 occupational therapy care plan stating that R73 was to toilet with supervision.
- March 13, 2013 fall risk assessment score of 7 where a total score of 10 or higher means high risk.
- Various outpatient rehabilitation and nursing records describing R73 as a fall risk with balance deficits, unsteady gait, weakness, and decreased movement in the lower extremities, as needing support for toileting; and as ambulating with a wheelchair.

Id. at 10-12 (citations to the record omitted).

The ALJ also considered evidence indicating that R73's condition had "deteriorated significantly" since his admission. *Id.* at 12. That evidence included the following:

- March 27, 2013 physical therapy note describing R73 as very weak and struggling to get in and out of the bathroom, and stating that he could not participate in balance or gait activities.
- March 27, 2013 occupational therapist's note stating that R73 had significant decline in functional mobility; that R73 called multiple times for help to use the bathroom and at one point his lower extremity gave out as the therapist was returning him to bed and he ended up sitting on her lap at the edge of the bed. The therapist indicated she spoke to R73's nurse, and the assistant director of nursing, and multiple nurse aides about R73's mobility. The therapist specified to the staff that R73 must be supervised and assisted with mobility and that it was not safe to leave him alone.
- On April 1, 2013, a licensed vocational nurse wrote that, on March 26, 2013 R73's wife asked staff to speak to the director of nursing (DON) A. Bianco about her husband's declining condition; that she saw R73's wife enter the DON's office; that the DON later spoke to staff about the conversation with R73's wife and that the DON said she would later ask R73's physician, Dr. D. Mandel, to see R73. Dr. Mandel ordered a Procrit® injection, administered on March 27, 2013. The licensed vocational nurse also wrote that, on March 27, 2013, physical and occupational therapists told her that R73 did not seem as strong as he had been since admission.

Id. at 11-13 (citations to the record omitted).

Avalon relied on nurse aide Ratliff's statement that R73 required no special fall precaution, and that on the morning of March 28, 2013, R73 insisted on using the bathroom alone with the aid of a rolling walker while asking the nurse aide to close the door to his room and wait outside the room. RR at 10-11; P. Ex. 10, at 14. The ALJ, however, found these claims less than credible. ALJ Decision at 14. In particular, the ALJ was "skeptical" about the nurse aide's claim that, on the morning of March 28, she reminded R73 to use the call light for help if needed while she waited outside R73's room, noting that the nurse aide had not made such a claim before the appeal. *Id.* Moreover, the ALJ found "odd" that R73 was documented to have "actively sought assistance throughout the day on March 27" but yet supposedly "refused all help the following morning." *Id.* The ALJ also noted that the incident report indicated that R73's rolling walker was not in use when R73 fell. *Id.* The ALJ further observed that, based on the information in Avalon's computerized documentation system, it appeared that the level of assistance R73 was given depended more on the nurse aide who cared for him than on his identified need for assistance. *Id.* Some nurse aides provided R73 little or no

supervision or assistance for toileting, whereas two nurse aides (initials TT and SJW), the ALJ noted, “consistently assisted him.” *Id.* at 14-15, citing P. Ex. 1, at 2. But the ALJ observed that Ratliff in particular had “minimal contact” with R73, which suggested to the ALJ that Ratliff “would not have been familiar with his needs unless some other source informed her what they were, and, of course, the facility should have had procedures in place to convey to staff such vital information.” *Id.* at 15. The ALJ noted that “system entries reflect just one instance of Nurse Aide Ratliff interacting with R73 prior to the date of his accident: at 8:23 a.m. on March 26, she provided him with ‘setup’ help for eating.” *Id.*

We defer to the ALJ’s conclusions about witness credibility and the weight to accord to specific evidence, absent compelling reasons not to do so. *See, e.g., Brenham Nursing & Rehab. Ctr.*, DAB No. 2619, at 13 (2015); *aff’d, Brenham Nursing & Rehab Ctr. v. U.S. Dep’t of Health & Human Servs.*, 637 F. App’x 820 (5th Cir. 2016); *Van Duyn Home & Hosp.*, DAB No. 2368, at 10-11 (2011). The ALJ has explained clearly why she discounted Ratliff’s account and Avalon has given us no compelling reason to disagree with that analysis.

The ALJ also explained why she found Avalon’s assessment of R73’s need for supervision and assistance inaccurate and inadequate.⁷ Importantly, the ALJ said, staff records did not include critical input from the physical and occupational therapists for purposes of assessing R73’s functional status and fall risk and failed to communicate clearly his needs to his caregivers. ALJ Decision at 15-16; *see also id.* at 12-13. Moreover, the ALJ observed, despite Avalon staff’s notation, on admission, of gait problems, neuromuscular weakness, and limitations in lower extremity mobility, the fall risk assessment assigned no points for gait problems and decreased muscular coordination. Overlooking critical information like the therapists’ input and failing to ensure that such information is factored into assessing R73’s accident risk and need for supervision and assistance, in the ALJ’s view, created the potential for more than minimal harm and, ultimately, contributed to Avalon’s lapses in its section 483.20 assessment responsibilities. *Id.* at 16.

Avalon’s explanation for why it did not consider therapists’ input in assessing R73’s functional capacity, in essence, was that the therapists – who were not Avalon employees but were providing therapy services to Avalon by arrangement with a separate company – had manufactured two weeks’ worth of records and put them into R73’s charts sometime after his accident, but before the surveyors reviewed the record and, thus, Avalon argued, the therapy records were not legitimate and could not be relied upon for care-planning

⁷ This discussion is also relevant to Avalon’s compliance with subsections 483.20(g)-(j)’s resident assessment provisions. *See* subsection A.2, below.

and assessment purposes. *Id.* at 17. The ALJ rejected this argument. The ALJ said, “If [it] were true [that therapy documents had been fabricated], the facility’s problems were significantly more serious than those CMS has alleged.” *Id.* The ALJ reasoned that if the therapists had not performed the ordered assessments, did not provide ordered services, did not participate in R73’s care planning, and manufactured treatment records after R73’s accident, Avalon effectively is conceding that *it* violated multiple program requirements. *Id.* Importantly, in the ALJ’s assessment, Avalon’s theory revealed a more fundamental problem, i.e., “the facility simply had no systematic means by which to convey [therapists’] recommendations to the staff members who needed that information” so that they could be promptly associated with R73’s charts and integrated into care-planning and implementation. *Id.* at 18 (ALJ’s emphasis), 20. The ALJ thus concluded:

Because the facility did not convey – in a consistent and reliable way – critical information that direct-care staff needed in order to provide necessary services to vulnerable residents, staff did not provide R73 with the services he needed to avoid physical harm. This represents a serious breakdown in the facility’s implementing its anti-neglect and other policies, and puts the facility out of substantial compliance with 42 C.F.R. § 483.13(c).

Id. at 20.

The ALJ also observed that the therapy records “fabrication” theory indicated Avalon’s belief that it is not responsible for the therapists because the therapy services were being provided by arrangement with a separate company. She reasoned that she was not bound to Texas administrative code provisions Avalon relied upon in support of the position, but was bound instead to subsection 483.75(h), which provides that, if a facility does not employ a qualified professional to furnish needed services, it must furnish the services by arrangement with an outside source, and such an agreement must state that the facility assumes responsibility for obtaining the services that meet applicable standards and principles that apply to the professional(s) providing the services at the facility, and the timeliness of the services. *Id.* at 17-18, citing 42 C.F.R. § 483.75(h); Act § 1861(w). Moreover, noted the ALJ, subsection 483.20(k)(3)(i) requires that the services a facility provides must meet professional standards for quality, whether provided by facility staff or arranged by the facility. *Id.* at 18. The ALJ also went on to explain that, while the final therapy records may not have been associated with R73’s chart until after the accident, she was satisfied that the bulk of the documents, including the initial assessments and treatment notes, were genuine. *Id.*

- b. *The regulations govern the determination of whether CMS properly cited Avalon for a deficiency.*

Avalon first asserts that CMS erred in citing it with Tag F224 as a violation of subsection 483.13(c) because “State Operations Manual [SOM] surveyor interpretive guidelines make it clear that F224 **does not** apply to policy implementation” and “expressly reserve[]” policy implementation for Tag F226. RR at 3 (emphases in original), 16-17. According to Avalon, if “it [Tag F224] does not have regulatory support (which Avalon shows) it should be deleted from the [SOD].” *Id.* at 3. As for Tag F226, Avalon maintains that the ALJ has not identified any specific policy Avalon allegedly failed to implement, and Avalon has in place an “aggressive abuse/neglect prohibition program” and has properly discharged its policy implementation responsibility. *Id.* at 17-18.

The ALJ correctly rejected the argument that “CMS improperly cited certain neglect deficiencies under Tag F224 instead of Tag F226” as “irrelevant,” stating that the relevant inquiry is whether the facility has complied with binding authority, subsection 483.13(c). ALJ Decision at 6-7 n.4. We agree with the ALJ that the question is whether the facility violated the regulation, which by its plain language requires facilities to develop and implement, as applicable here, written anti-neglect policies and procedures. Avalon cites no binding authority (and we are not aware of any) that restricts CMS to citing a subsection 483.13(c) violation using a certain Tag number, or prohibits it from citing the violation under two Tags, F224 and F226, as it did here. RR at 3. SOM provisions are merely CMS’s interpretive guidance to surveyors on the applicable law and regulations; they are not themselves substantive authorities with the force and effect of law and therefore do not define any legal mandate as a regulation does. *See, e.g., Kindred Transitional Care & Rehab – Greenfield*, DAB No. 2792, at 16 (2017); *Cedar Lake Nursing Home*, DAB No. 2344, at 6 (2010); *Foxwood Springs Living Ctr.*, DAB No. 2294, at 9 (2009); *Beverly Health & Rehab. Servs., Inc. v. Thompson*, 223 F. Supp. 2d 73, 99-106 (D.D.C. 2002), *aff’g, Beverly Health & Rehab. – Spring Hill*, DAB No. 1696 (1999). Avalon does not identify any specific language in the SOM supporting the theory that failures of policy implementation must only be cited under Tag F226, and we find none. More to the point, however, arguing over which tag surveyors used does nothing to aid Avalon in carrying its burden to establish that the facts on which CMS relied in citing it with a violation of subsection 483.13(c) are inaccurate.

The core question is whether the facts surrounding R73’s fall exposed an underlying failure by Avalon to carry out its policy to prevent neglect of its residents’ needs by ensuring that staff are aware of and provide appropriate services to meet those needs. The ALJ’s determination that Avalon indeed failed is amply supported by the evidence.

c. *Avalon's reliance on a 2006 ALJ decision is misplaced.*

Avalon asserts that the surveyors improperly used Tag F224 to support a “generalized allegation of neglect” on the premise that an “isolated allegation of neglect constitutes an overall failure” to implement Avalon’s neglect prohibition policies.⁸ RR at 3-4, citing *Heron Pointe Health & Rehab. Ctr.*, DAB CR1401 (2006). Avalon further contends, again relying generally on the SOM and citing *Heron Pointe*, that Tag F226 is “essentially identical to [Tag] F224, except [Tag] F226 does pertain to policy implementation,” and that “[l]ike [Tag] F224, [Tag] F226 is not a ‘generalized neglect’ tag” *Id.* at 16-17.

The ALJ rejected this argument. ALJ Decision at 7 (The Board “has explicitly rejected the *Heron Pointe* reasoning and has repeatedly disallowed the use of a “quantitative analysis” to determine whether a facility failed to implement its anti-neglect policy”), citing *Avalon Place Kirbyville*, DAB No. 2569, at 12 (2014), (citing *Oceanside Nursing & Rehab. Ctr.*, DAB No. 2382, at 11 (2011) and *Columbus Nursing & Rehab. Ctr.*, DAB No. 2247, at 27 (2009)) and *W. Tex. LTC Partners, Inc., d/b/a Cedar Manor*, DAB No. 2652, at 9-10 (2015).⁹

The Board in *West Texas* rejected the same argument that Avalon raises here. DAB No. 2652, at 9. In *West Texas*, the Board said that “the quantitative analysis the ALJ used in *Heron Pointe* (stating [the ALJ] would not infer a failure to implement an anti-neglect policy from the single incident on ‘neglect’ alleged) has been rejected by the Board in a number of cases.” *Id.* Avalon denies relying on *Heron Pointe* as authority, but argues that the ALJ should have valued the other ALJ’s reasoning in *Heron Pointe*. According to Avalon, the ALJ’s rejection of its arguments based on *Heron Pointe* is “back-handed criticism” of another ALJ’s reasoning and reflects the ALJ’s belief that *Heron Pointe* “has no value at all because it was not appealed.” RR at 4.

⁸ We make a general comment here concerning Avalon’s framing of its disputes in terms of survey or surveyor errors throughout its RR. While state agency surveys and their results are the foundation for any subsequent CMS enforcement action, once CMS does proceed with enforcement action, on appeal, the ALJ does not review CMS’s conclusions or determinations about earlier state agency-level review (which could include IDR if the facility elects it), but rather reviews the record de novo and determines whether the facility was in substantial compliance with applicable requirements. See *Brithaven of Chapel Hill*, DAB No. 2284, at 5-6 (2009) (and cases cited therein). Thus, on appeal, the focus of Board review is on what the ALJ determined, and the ultimate question is whether the ALJ’s decision is legally sound and substantially supported by the evidence in the record as a whole.

⁹ When the ALJ issued her decision in this case (May 2016), appeal of the Board’s decision in *West Texas LTC Partners, Inc., d/b/a Cedar Manor*, DAB No. 2652 (2015), was pending before the United States Court of Appeals for the Fifth Circuit. By decision issued December 15, 2016, the Fifth Circuit upheld the Board’s decision. *W. Tex. LTC Partners, Inc. v. HHS*, 843 F.3d 1043 (5th Cir. 2016).

Avalon mischaracterizes the ALJ's reasoning concerning *Heron Pointe*. It is true that the ALJ noted that *Heron Pointe* was "not appealed" to the Board. ALJ Decision at 7. In so noting, the ALJ recognized that the Board did not endorse the ALJ's approach in that case, since it did not come before the Board. More importantly, the ALJ also recognized that when other facilities had raised a similar argument relying on *Heron Pointe*, the Board expressly rejected that approach. Thus, we read the ALJ's analysis not to mean that the ALJ was rejecting *Heron Pointe* as having "no value"; rather, the ALJ was stating that she was bound by Board decisions rejecting the analysis.

We also reject the broader implication that the ALJ was wrong not to follow another ALJ's rationale. The ALJ who decided this case, like the ALJ who decided *Heron Pointe*, is an independent adjudicator who exercises de novo review authority. An ALJ is not bound to follow any other ALJ's reasoning, though he or she certainly may do so, where it does not conflict with applicable authority. See *Britthaven of Chapel Hill*, DAB No. 2284, at 9-10 (2009) (an ALJ is not bound to follow another ALJ's decision).

Avalon also says that "Board rules and regulations state that if an ALJ decision [referring to *Heron Pointe*] is not appealed to the Board, it becomes a final decision of the Board." RR at 4. An ALJ decision that is subject to appeal to the Board under 42 C.F.R. Part 498 regulations, but is not appealed to the Board, would be the last administrative level determination in that case and would be "binding" on the parties in that case. See 42 C.F.R. § 498.74(b). That, however, does not mean that an unappealed ALJ decision then sets a precedent binding on ALJs or the Board. When the *Board* has not reviewed the ALJ decision, the *Board* has not issued a decision in that case. Regardless of whether an ALJ decision was appealed to the Board, an ALJ decision is not precedential and does not bind the Board, and is relevant in later cases only to the extent its reasoning is on point and persuasive. *John M. Shimko, D.P.M.*, DAB No. 2689, at 5 (2016).

The bottom line is that, in *West Texas* and other cases, the Board has conclusively answered in the negative the question of whether multiple instances of neglect are a prerequisite to finding failure to implement an anti-neglect policy effectively by opining that the nature and surrounding facts, not the number, of staff failures determines whether effective implementation occurred.

d. The ALJ was not required to give controlling weight to the "opinion" of Dr. Mandel, R73's treating physician, whom Avalon did not call as a witness at hearing, and we defer to her determination of what weight was appropriate.

Avalon submitted as an exhibit (P. Ex. 14) a one-paragraph opinion of Dr. Mandel, R73's treating physician. In his opinion, dated April 25, 2013 (almost a month after R73's death), Dr. Mandel recalled that he saw R73 in the hallway on the evening of March 27,

2013, that R73 was then able to ambulate independently and did not appear to have been in any distress, that no one then brought any concerns to his attention, and finally opined that R73 required no supervision for toileting. P. Ex. 14.

Avalon relies heavily on Dr. Mandel’s opinion to challenge the ALJ’s findings that R73 was frail and at risk for falls, and needed staff supervision and assistance for ADLs on the date of the incident. RR at 7, 9-10, 14-15, 18. Avalon asserts that the ALJ erred in “improperly discount[ing]” Dr. Mandel’s “knowledge and opinions” because “[t]here is no better person in the world to describe [R73’s] condition than [R73’s] long time treating physician.” *Id.* at 7. Avalon says that the ALJ who decided this case is not a physician and therefore must not ignore Dr. Mandel’s opinion. *Id.* at 7, 9, 14-15. Pointing out that CMS did not cross-examine Dr. Mandel, Avalon portrays Dr. Mandel’s opinion as “uncontroverted” testimony the ALJ was bound to accept. *Id.* at 7, 15.

We first observe that Avalon appears to be invoking, without stating as much, the “treating physician rule” developed in the context of Social Security disability cases.¹⁰ The Board has rejected the rule’s applicability to nursing home enforcement cases. *Golden Living Ctr. – Frankfort*, DAB No. 2296, at 7 (2009), *aff’d*, *Golden Living Ctr. – Frankfort v. HHS*, 656 F.3d 421 (6th Cir. 2011). The Board made clear that the “inapplicability of the treating physician rule in [nursing home enforcement] cases does not imply that ALJs do not, or should not, consider such factors as a medical source’s personal examination of or long-term experience with a patient in evaluating the weight to give testimony about that patient’s medical condition.” DAB No. 2296, at 7 n.3. “An ALJ may discount a treating physician’s testimony when it is unpersuasive, internally inconsistent, or not ‘consistent with the weight of other substantial evidence.’” *Autumn Ridge Rehab. Ctr.*, DAB No. 2467, at 15 (2012), quoting *Golden Living Ctr. – Frankfort* at 7. Thus, ALJs deciding nursing home enforcement cases are not required to assign controlling weight to a treating physician’s opinion. They may consider what weight should be given to such an opinion, taking into account appropriate factors, such as that physician’s knowledge about the needs of a particular patient gained in the course of treating him or her, as well as whether the opinion is supported or contradicted by other medical or factual evidence. As noted, we generally defer to the ALJ’s assessment of the weight to give evidence.

¹⁰ Under the “treating physician rule” (*see* 20 C.F.R. § 404.1527(c)(2)), if the Social Security Administration finds that a treating physician’s opinion on the nature and severity of a claimant’s impairments is well supported by medically acceptable clinical and laboratory diagnostic techniques and is not inconsistent with the other substantial evidence in the case record, the opinion will be given controlling weight. The rule has not generally been applied outside of Social Security, such as in the context of Medicare claims. Many courts considering the rule have concluded that such opinions should be accorded consideration, but not controlling weight, in Medicare claims. *See generally Cumberland Cnty. Hospital System, Inc. d/b/a Cape Fear Valley Health System v. Price*, slip op., 2017 WL 1047255 at *9-10 (E.D.N.C. Feb. 23, 2017) and authorities discussed therein. Avalon cites no court decision, and we are aware of none, requiring that controlling weight be given to treating physician opinions in nursing home enforcement appeals.

The ALJ indeed considered the weight to be accorded to Dr. Mandel's opinion, and decided to discount the weight to be accorded to it, after considering other evidence that was before her. ALJ Decision at 19-20. The ALJ found a wealth of documentary evidence that came into existence from the time of R73's admission on March 13 leading up to March 28, the date of his accident, indicating that Avalon staff had reason to know, and did know, that R73 was frail, was at risk for falls and not independent for ADLs, and, moreover, that R73's condition was deteriorating over time. *Id.* at 10-13. The ALJ considered, too, various policies that defined the "goods and services" the facility was required to provide its residents and, as relevant to Tags F224 and F226, which addressed the prohibition of staff neglect of residents who, like R73, needed those staff "services" (supervision and assistance, the need of which would be determined by appropriate assessments like assessment of fall risk) to remain safe. *Id.* at 8-10. The ALJ determined that Avalon did not comply with those policies and neglected R73 by not providing him the supervision and assistance the record amply demonstrated he needed. *Id.* at 10-15, 21.

The ALJ explained, also, why she was assigning less weight to Dr. Mandel's opinion, within the context of a "plethora of evidence" that R73 was dependent with his ADLs and could not be left unattended in the bathroom. *Id.* at 19. She noted that Dr. Mandel's opinion suggested he was "completely unaware of the well-documented safety concerns," *id.*, and showed no awareness of the nursing notes, or physical or occupational therapy findings (which he himself had ordered), relying only on a hallway encounter to explain his opinion about R73's independence in toileting. *Id.* at n.11. The ALJ observed, also, that Dr. Mandel did not explain why he ordered Procrit®,¹¹ "a powerful drug with significant side effects," for R73, if Dr. Mandel was indeed unaware of any concerns about the patient. *Id.* Further, the ALJ expressed surprise that Dr. Mandel apparently did not ask to review the results of the therapy assessments even after R73's wife expressed her concerns about her husband's functional decline. *Id.* at 20, citing P. Ex. 4, at 8; P. Ex. 10, at 9; P. Ex. 13; and Tr. at 143.

Repeatedly relying on Dr. Mandel's opinion and the testimonies of its staff during the appeal proceedings that Avalon purports are "uncontroverted" evidence, Avalon offers a narrative of its interpretation of the evidence in an attempt to counter the ALJ's central finding that R73 was not independent in toileting and indeed required staff assistance and supervision, which Avalon failed to provide. Of note, Avalon makes much of the administration of Procrit®, asserting that the ALJ overlooked the fact that R73 had MDS

¹¹ Procrit® (epoetin alfa) is a prescription drug used to treat certain types of anemia (below-normal count of red blood cells). See www.procrit.com. As Avalon notes, R73 had anemia, and was also diagnosed with myelodysplastic syndrome (MDS). RR at 5. MDS is a condition that affects the bone marrow and the blood cells it produces. The bone marrow of individuals with MDS produces low numbers of red blood cells. P. Ex. 6 (printouts of online articles providing general information about MDS).

affecting his strength and stamina and was wrong in concluding that there was no evidence regarding the reason for administering Procrit®. RR at 5, 8. According to Avalon, Procrit®, which is used to treat MDS, includes erythropoietin or EPO as its active ingredient which acts as a “blood booster” to stimulate the production of red blood cells and oxygen capacity in the blood. *Id.* at 9. Avalon says that R73 was given Procrit® on March 27, 2013 with positive results, and that, even if he might have appeared tired or fatigued or pale, Procrit® “would have” given him a “boost” to make him feel much stronger in a short period of time. *Id.*

The ALJ did not overlook the diagnosis of MDS, but rather found the order for Procrit® inconsistent with Avalon portraying R73’s condition as robust enough to justify leaving him unsupervised in the bathroom in light of the full record of R73’s care needs. The ALJ also rejected as unsubstantiated the claim that the single Procrit® treatment so transformed R73’s capacity. She stated:

According to Petitioner, Procrit significantly increases the recipient’s strength and stamina and combats fatigue. P. Br. at 6. Petitioner does not offer any evidence to support its suggestion that one injection of Procrit resolved the resident’s balance, motor control, and other deficits. *See* Tr. 35, 78-79 (explaining that it may take two or six weeks for the body to respond to Procrit). In any event, relying on the possibility of improvement, without further assessment, would be irresponsible and dangerous. *See* Tr. 79.

ALJ Decision at 13. Thus, as stated earlier, the ALJ noted that Dr. Mandel did not address why he ordered Procrit® for R73, and questioned the absence of such a discussion, when he supposedly had no concerns about R73’s functional ability.

We also reject Avalon’s attempt to portray Dr. Mandel’s opinion as “uncontroverted” testimony the ALJ was bound to accept in the absence of cross-examination of Dr. Mandel at hearing. The ALJ instructed the parties to first submit to the ALJ and exchange with one another the direct testimony of any witness it wished to call in the form of an “affidavit made under oath or as a written declaration that is signed by the witness under penalty of perjury for false testimony,” in lieu of in-person direct testimony. July 10, 2013 Acknowledgment and Initial Pre-Hearing Order ¶ 4; *see also* 42 C.F.R. § 498.62 (“Witnesses at the hearing testify under oath or affirmation.”). Dr. Mandel signed and dated his opinion, but the opinion was not in the form of an affidavit or declaration that conformed to the ALJ’s instructions and section 498.62. By not submitting Dr. Mandel’s opinion in such a form, Avalon effectively chose not to offer Dr. Mandel’s opinion as direct testimony. Avalon was free to do that, but a consequence of that choice was that the ALJ would not treat the opinion as hearing testimony. Dr. Mandel’s opinion was, then, one of many pieces of medical evidence in the record.

We note, moreover, that the ALJ expressly told the parties that they must produce at hearing for cross-examination any witness whose written direct testimony that party offers as evidence. Pre-Hearing Order ¶ 6; *see also* 42 C.F.R. § 498.62 (each party “is permitted” to examine his or her own witnesses) and *Vandalia Park*, DAB No. 1940, at 28-29 (2004) (use of written direct testimony in lieu of live testimony at hearing is not itself prejudicial so long as the right to cross-examine is preserved), *aff’d*, *Vandalia Park v. Leavitt*, 157 F. App’x 858 (6th Cir. 2005). Having chosen not to call Dr. Mandel as a witness (by not submitting Dr. Mandel’s written direct testimony), Avalon avoided the possibility that CMS would cross-examine Dr. Mandel at hearing. Within this adversarial context, Avalon was free to choose not to call any particular individual as a witness to first give direct testimony (in writing) if for whatever reason it wanted to avoid subjecting that witness to cross-examination. But the ALJ was not obliged to draw any negative inference from CMS’s not cross-examining a declarant Avalon itself chose not to make available as a witness. Nor was the ALJ obliged to accept Dr. Mandel’s “opinion” as “uncontroverted” truth, as Avalon suggests,¹² under these circumstances. To hold otherwise would mean that the ALJ effectively would have to disregard other evidence in the record that in the ALJ’s assessment is relevant to the issue(s) addressed in the opinion, or which contradicts or is inconsistent with the opinion. The ALJ, as fact-finder, has the authority to, and indeed must, consider and appropriately weigh all of the evidence before him or her regardless of whether a witness was cross-examined.

Avalon also says that its “Falling Star Program” policy (which, according to Avalon, applies to residents assessed to be at high risk for falls) cannot be the basis for a subsection 483.13(c) violation here because R73 was not assessed as a high fall risk, and, moreover, the policy is not even an “abuse/neglect” policy. RR at 16, 17. Avalon’s argument is a red herring. Avalon attempts to make much of something that is ultimately irrelevant. The “Falling Star Program” policy was not the basis of any factual finding on which the ALJ based her determination to uphold the violation. The ALJ merely identified the policy as one of several policies that collectively are intended to mitigate accident hazards to which residents like R73 were vulnerable. *See* ALJ Decision at 8-10. The ALJ did not find that R73 should necessarily have been in that particular program. Nowhere in her decision did the ALJ say that Avalon violated the policy as to R73.

¹² Similarly, Avalon states, without reasoned explanation or citation of authority, that the testimonies of its witnesses nurse J. Stephens, DON Bianco, and nurse aide Ratliff are “uncontroverted.” RR at 10-11, 15. (Avalon’s attorneys had these three individuals orally give their sworn direct testimonies on January 16 or 17, 2014, and then submitted the transcripts of their testimonies as exhibits, which the ALJ admitted as Petitioner’s Exhibits 50, 51, and 52.) To the extent Avalon again may be asserting that their testimonies are uncontroverted in the absence of cross-examination, we note that CMS did cross-examine Stephens and Bianco. Tr. at 125, 151. In any case, the fact that a witness was or was not cross-examined does not itself dictate how an ALJ makes factual determinations or what factual findings to make. He or she considers all of the evidence, including all testimonial evidence, weighs all of that evidence, and then makes appropriate factual determinations. Moreover, an opposing party may at times challenge a witness’s statements through other evidence or testimony that impeaches the witness or contradicts the statements, rather than through cross-examination at hearing.

In conclusion, the ALJ found that Avalon staff failed to appreciate the extent of R73's need for supervision and assistance and that this need increased over time, leading up to the day of the accident. That failure, the ALJ also found, was due in significant part to the failure of staff to "convey – in a consistent and reliable way – critical information" about the recommendations of therapists who worked directly with R73 and to ensure that the facility had "reliable systems in place to ensure that all direct-care staff understood and followed the therapists' critically important recommendations." *Id.* at 20. Those lapses together "represent[ed] a serious breakdown in the facility's implementing its anti-neglect and other policies," and ultimately put the facility out of substantial compliance with subsection 483.13(c). *Id.* The ALJ's analysis focuses correctly on whether Avalon failed to assess and plan for R73's needs as shown by the complete record of his care in the facility and by the standards and policies for such care and whether such failure was evidence of a broader failure to effectively implement its own policy to prevent neglect. We therefore find the ALJ's analysis supported by substantial evidence.

2. 42 C.F.R. § 483.20(g)-(j) (Tag F278, resident assessments; S/S level "K")

The regulations in 42 C.F.R. § 483.20, captioned "Resident assessment," require facilities to conduct, initially and periodically, a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity. The assessment must accurately reflect the resident's status (*id.* § 483.20(g)); a registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals (*id.* § 483.20(h)); and the registered nurse must sign and certify that the assessment is completed, and each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment (*id.* § 483.20(i)). Section 480.20(j) authorizes the imposition of CMPs on an individual who willfully and knowingly certifies, or causes another individual to certify, a material and false statement (which does not include clinical disagreement) in a resident assessment.

The surveyors determined that Avalon did not comply with the above requirements because it failed to ensure that R73's nursing assessment accurately reflected his status. CMS Ex. 6, at 38-39. The ALJ determined that Avalon was properly cited for this deficiency based on inadequacies in the facility's assessments of R73. As the ALJ aptly noted, accurate assessments are "critically important because they form the bases for the care that the facility provides." ALJ Decision at 15, citing 42 C.F.R. § 483.20(d), (k). In R73's case, input from his physical and occupational therapists was particularly crucial to assessing accurately R73's functional capacity. *Id.* (record citations omitted). Importantly, the ALJ noted that *Avalon* itself maintained that facility staff neither had nor considered input from the therapists in assessing R73's functional status for fall risk – even though Avalon acknowledged the therapists' input would have been "'critical' and 'mandatory.'" *Id.* at 15-16. In taking such a position, Avalon "all but concede[d] that its assessments of R73 could not have been comprehensive or accurate." *Id.* at 16.

Therefore, the ALJ found, the assessment was “notable for its critical omissions” about certain information related to R73’s gait and muscular coordination problems, among other relevant factors. *Id.* (record citations omitted). The ALJ therefore determined that, “had these conditions been factored in as they should have been, R73 would accurately have been assessed as at high risk for falls” and that “[o]verlooking factors critical to determining a resident’s fall risk creates the potential for more than minimal harm (as this case shows, substantially more than minimal harm).” *Id.* at 16. The ALJ concluded that Avalon therefore was not in substantial compliance with section 483.20 requirements. *Id.*

Again relying only on a vague reference to the SOM, Avalon maintains that Tag F278 relates only to whether the Minimum Data Set (MDS)¹³ nursing assessment is accurate, and does not implicate incident reporting, policy, prohibition of neglect, “or any other related issue.” RR at 19. According to Avalon, the ALJ erroneously assumed, contrary to the SOM, that “assessments” other than the MDS are at issue. *Id.* Avalon asserts that, in any case, it has proven that the MDS, which was completed three days before the incident involving R73, and “all other assessments done by the Avalon staff” for R73 are “accurate and complete,” and that Stephens’ and Bianco’s “not controverted” testimony “confirm[s]” that. *Id.*, citing P. Exs. 50, 51. Avalon moreover questions the ALJ’s reliance on the therapy records, asserting again that they were not created until after R73 died and casting doubt on their authenticity. *Id.* at 19-20. Avalon repeats its mistaken claim that an occupational therapist documented R73 as “self-care” with his ADLs, which Avalon asserts is “consistent with everything else” its nurses, aides, and the treating physician noted about R73, i.e., his independence with most ADLs, including toileting, and independent ambulation using a rolling walker. *Id.* citing P. Exs. 4, 11. According to Avalon, the MDS was not inaccurate in assessing R73’s independence, and R73 “did not suffer any significant change in condition on March 27.” *Id.* at 20. Even had his condition significantly changed on March 27, Avalon says, it “would have had an additional 7 days in which to complete a new, significant change MDS and this time had clearly not yet arrived by the conclusion of the survey (exit date 3/30/13).” *Id.*

Avalon raised a similar argument concerning the MDS below, and the ALJ rightly rejected it. The ALJ said:

Petitioner gratuitously asserts that section 483.20(g) applies to the required minimum data set only. P. Post-hrg. Br. at 16. The minimum data set is just *part* of the federally-mandated process for assessing the functional

¹³ The MDS is a standardized data-collection tool to assess the status of a resident’s health and his or her physical, psychological, and psychosocial functioning. It is the foundation of the “comprehensive assessment” required for all residents of long-term care facilities that participate in Medicare. 42 C.F.R. § 483.20(b); *Oaks of Mid City Nursing & Rehab. Ctr.*, DAB No. 2375, at 19 (2011).

capacity of nursing home residents. As the regulation reflects, the facility also must document summaries of additional assessments in care areas triggered by the findings of the minimum data set. 42 C.F.R. § 483.20(b)(1). *See also* 42 C.F.R. § 483.20(f).

ALJ Decision at 15 n.7 (ALJ's emphasis).

Avalon does not dispute that, *by regulation*, the facility is responsible for documenting comprehensive and accurate summaries of additional assessments based on MDS findings. It does, however, unsuccessfully attempt to revive its argument that it cannot or should not be found at fault to the extent its assessment of R73's functional capacity was inadequate based on a failure to consider therapy input because the therapists and/or their staff manufactured records and put them into R73's charts sometime after his accident but before the surveyors reviewed the record. RR at 19-20.

We have set out in some detail the ALJ's rationale for rejecting Avalon's therapy document "fabrication" theory as implausible and imprudent (ALJ Decision at 16-20), and need not repeat that discussion here. Avalon's disparagement of the therapy records ignores extensive discussion in the ALJ Decision of Avalon's own records that on their own amply demonstrate not only that R73 was dependent for self-care and needed staff supervision, but that his condition was deteriorating over time. *See id.* at 10-13, 18-19, and evidence cited therein. Moreover, we find no basis to disagree with the ALJ's evaluation of the "plethora of [documentary] evidence" that called into question the reliability of after-the-fact statements by Avalon staff (and particularly by Dr. Mandel) during the appeal to the effect that R73 was independent with his ADLs and could have been left alone for toileting. *Id.* at 19-20. We note that the ALJ rejected Avalon's reliance on a "clarification" of a March 13 telephone order of Occupational Therapist Barnes because, contrary to Avalon's assertion, it does not actually establish that R73 was "self care" in his ADLs. The clarified order called for occupational therapy to be provided to achieve "self care" in ADLs; "[s]elf care was not the starting point" and R73's need for therapy as indicated in the clarified order is consistent with the March 13 occupational therapy care plan, which includes short and long term goals for increased independence with ADLs. *Id.* at 20. Furthermore, the ALJ observed that neither Occupational Therapist Barnes nor anyone else would have been in a position to assess R73's functional abilities, let alone pronounce him as being independent with his ADLs, since R73 had not yet been assessed at that point. *Id.* To the extent Avalon questions the ALJ's rejection of its therapy document "fabrication" theory in part on the absence of evidence of direct testimony from the therapy company's staff (*see* RR at 20, in which Avalon wrote that "direct testimony from the therapist/therapy company is conspicuously absent from the record"), we note that if Avalon believed therapy company staff's testimony was material in some way to the question of adequacy of assessment of R73, ultimately, it was up to Avalon to see to it that the testimonies or statements of those individuals were before the ALJ.

The ALJ's findings amply support a violation of 42 C.F.R. § 483.20(g)-(j).

3. 42 C.F.R. § 483.25(h) (Tag F323, quality of care and accident prevention; S/S level "K")

42 C.F.R. § 483.25(h) provides:

(h) *Accidents*. 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.

The surveyors determined that Avalon failed to prevent accidents for multiple residents, including R73 and Resident 24 (R24), both of whom were at risk for falls.¹⁴ CMS Ex. 6, at 87, 88. With respect to R73, the SOD states that the staff failed to supervise R73 for toileting; R73 fell while toileting alone, sustained injuries as a result of that fall, and died the same day. *Id.* at 87. Concerning R24, the SOD states that on March 25, 2013, R24 – who was at “high” risk for falls – attempted to get out of bed, slid out of the bed, and fell to the floor. *Id.* at 57, 88, 99. The surveyors determined that the staff did not ensure that the bed/chair alarm was in place to prevent additional falls. *Id.* at 88, 99-101.

We first address the ALJ's analysis concerning a violation of subsection 483.25(h) as to R73, and Avalon's arguments concerning that analysis. We will then address the ALJ's analysis of this violation as to R24, and Avalon's arguments concerning R24.

R73

We have already discussed the ALJ's analysis of the facility's failures with respect to R73 in some detail, and need not repeat it here. In short, the ALJ found ample evidence that staff neglected R73 despite well-documented need for supervision and assistance and, while unsupervised, R73 fell while toileting and sustained injuries. Based on those factual findings, the ALJ concluded that Avalon was properly cited with a violation of subsection 483.25(h) for failing to provide appropriate supervision to protect R73 from a “fatal accident.” ALJ Decision at 6, 13-14, 21.

¹⁴ The surveyors determined that Avalon failed in this respect as to Residents 4, 8, 10, 19, 24, 32, 42, 61, 64, 66, and 73. CMS Ex. 6, at 87. In addition to a discussion of allegations of multiple facility failures involving R73, the ALJ separately addressed R24 with respect to the subsection 483.25(h) deficiency. *See* ALJ Decision at 21-22.

Avalon asserts that it “properly discharged its responsibility under F323 because at all times relevant to the 3/30/13 survey, the facility was free of accident hazards within the facility’s control” and “the incident in question does not involve an ‘accident hazard’ within the meaning of F323.” RR at 29. Avalon again invokes by general reference the SOM as though its provisions establish the standard for evaluating facility performance. RR at 28-29. Manual guidelines are, as Avalon says, guidelines. They may be considered to the extent appropriate, but they do not themselves define the specific requirements Avalon must meet, and are not substitutes for, or are equivalent to, the regulations and other applicable binding authorities against which Avalon’s performance is evaluated. The question presented here is not, as Avalon purports, whether Avalon had certain physical “accident hazards” of the type discussed in the “F323 surveyor interpretive guidelines”: “equipment not being used in accordance with the manufacturer’s instruction, bathing facilities that do not have nonslip surfaces, defective siderails, physical restraints, and water temperatures that are too hot.” *Id.* As we understand the argument, Avalon would have us conclude that survey guidelines define or establish boundaries in terms of the types of hazards contemplated for this citation and that so long as the record does not evidence the types of accident hazards identified in the guidelines, there is no factual basis to trigger citation under Tag F323. *Id.* at 29. Also, says Avalon, that the SOD does not address such a failure by Avalon is a “glaring omission.” *Id.* It complains that the ALJ “never addressed” this “element of [its] defense.” *Id.*

We see no such omission or failure. Avalon impermissibly attempts to redefine, and thereby narrow the scope of, what it may be held to, by generalized reference to manual provisions. By its plain terms, subsection 483.25(h) requires Avalon to ensure that it is free of accident hazards as is possible. While SOM provisions may provide instructive guidance on the types of hazards likely or commonly encountered in facility environments, the regulation cannot reasonably be read to mean simply that it concerns only the presence or absence of certain *physical* hazards or conditions (of the type interpretive guidelines identify) at a facility at some point in time, when subsection (h)(2) explicitly provides that the facility must provide residents “adequate supervision” (as well as “assistance devices”), contemplating that determining whether a facility “ensure[d]” an environment “as free of accident hazards as is possible” necessarily entails, as well, an assessment of facility staff’s actions or omissions as they affect the quality of a resident’s physical environment. The question, therefore, is whether Avalon’s staff properly discharged their supervisory responsibilities as necessary to protect the facility’s residents from harm associated with accidents.

On this question, Avalon says that the testimonies of its witnesses Stephens and Bianco prove that R73 was assessed as being only at minimal risk for falls (RR at 30, citing P. Exs. 50 and 51), and purports that the fall assessment was reliable and accurate because it was based on the direct observations of its nurses. *Id.* According to Avalon, “the ALJ [therefore] is in no position to conclude that this personal assessment was wrong.” *Id.*

Moreover, Avalon says, even though R73 was not at high fall risk, it put “interventions” in place “to minimize the slight risk that [R73] did have” (*id.*, citing P. Exs. 1, 8, 13, 14); and it provided R73 physical and occupational therapies to increase his strength and gait stability to mitigate the fall risk, despite that R73 “was so new that therapy had not yet provided any of their assessments or documentation to the facility at the time of [R73’s] accident” (*id.*, citing P. Exs. 10, 50, 51). Avalon says that its staff also provided R73 appropriate oversight through frequent monitoring by nurses and aides; head-to-toe assessment at each daily shift; ordering of laboratory studies, the results of which were given to the physician; carrying out of physician orders; instructing R73 on the use of the call light; and having R73 regularly seen by his physician. *Id.* citing P. Exs. 1, 13, 14.

Avalon selectively and generally touches on several “interventions” it implemented, as though reciting them in such a manner here would suffice to prove that it complied with subsection 483.25(h). The main focus here should not be on the types of “interventions” employed; indeed, the ALJ correctly noted that a “facility is permitted the flexibility to choose the methods it uses to prevent accidents, but the chosen methods must constitute an ‘adequate’ level of supervision under all the circumstances.” ALJ Decision at 8 (citations to Board decisions omitted). The more pertinent question here is whether, regardless of the types “interventions” employed, those “interventions” effectively “eliminate[d] or reduce[d] a known or foreseeable risk of accidents ‘to the greatest degree practicable.’” *Id.* at 8, quoting *Del Rosa Villa*, DAB No. 2458, at 7 (2012), *aff’d*, *Del Rosa Villa v. Sebelius*, 546 F. App’x 666 (9th Cir. 2013) (and citing other Board decisions). Avalon does not squarely or effectively respond to the ALJ’s specific, detailed factual findings on R73’s vulnerability to falls, known to and assessed by Avalon, and Avalon’s failure to effectively eliminate or reduce the risk for injury of the type R73 sustained on March 28, 2013.

We further reject the suggestion that the ALJ should have accepted Stephens’ and Bianco’s testimonies as conclusively establishing “minimal” fall risk, without question, simply because the fall assessments were based on their direct observation. Avalon sidesteps the ALJ’s analysis discussing in detail substantial documentary evidence indicating the extent of known, assessed fall risk (even without the allegedly “fabricated” therapy records). Notably, the ALJ:

- (1) considered a March 13, 2013 “fall risk assessment” score of 7 (where a score of 10 or higher means high risk), which would indicate that, on the day of R73’s admission, staff assessed R73 as having been at risk for falls. ALJ Decision at 11, citing CMS Ex. 63, at 78; P. Ex. 9, at 1; P. Ex. 51, at 8; and Tr. at 130.
- (2) recounted in some detail R73’s documented history from the time of his admission to Avalon, forward, relevant to his risk for falls and functional deficit establishing a need for staff assistance with toileting and other ALJs. *See id.* at 10-12.

(3) considered evidence dated March 27, indicating that R73's condition had "deteriorated significantly" over time since admission. *Id.* at 12-13.

Avalon states that R73 "was so new that therapy had not yet provided any of their assessments or documentation to the facility at the time of [R73's] accident." RR at 30.

We do not find this persuasive. First, as discussed above, information already in Avalon's chart for R73 supports the ALJ's conclusion that his fall risk was improperly assessed even without the therapy notes. As the ALJ stated, Avalon staff's assessment is "notable for its critical omissions," including, for example, the awarding of no points for gait problems or for decreased muscular coordination despite nurses' notes at the time of R73's admission documenting unsteady gait, neuromuscular weakness, and decreased movement in both legs. ALJ Decision at 16 (record citations omitted). Second, Avalon acknowledges (in explaining why Procrit® was prescribed) that an occupational therapist alerted the Assistant Director of Nursing on March 27 that R73 seemed fatigued during therapy. RR at 8. Thus, the nursing staff should have been aware that the therapists had acquired information about R73's condition and should have taken steps to ensure that any relevant information was obtained and shared with caregivers, even if the full records of his therapy had not yet been transmitted to the nursing home chart.

Avalon also argues that R73, who had been seen by the nurse aide caring for him less than five minutes before he fell, was alone at the time of the fall because he had asked for privacy to use the restroom, as was "his absolute right." RR at 31. It disputes the "ALJ's claim" that R73 should not have been left unattended in the bathroom, arguing that it demonstrated that R73 did not require supervision while toileting, and that "[t]here is no documentation whatsoever in the Avalon chart" showing that R73 "required constant supervision while toileting" and given that R73's physician, who was "in the best position to know the needs of his residents," stated that R73 was able to toilet independently. *Id.*

Avalon does not specifically point to what in its own exhibits that it cites proves that R73 required no supervision while toileting, and on the contrary, as the ALJ noted, the record contains evidence that other nurse aides "consistently" assisted R73 in using the bathroom. ALJ Decision at 15, citing P. Ex. 1, at 2. In light of the extensive, detailed discussion in the ALJ Decision of evidence of the existence of fall risk combined with documented functional deficit and need for assistance from March 13, 2013 leading up to the date of the accident – which Avalon does not squarely challenge – Avalon must do more than simply provide a string of exhibit numbers and a conclusory statement that R73 required no supervision for toileting. As we have said, we have been shown no compelling reason to disturb the ALJ's discounting of the credibility of nurse aide Ratliff's account. Moreover, Avalon makes a straw man argument in claiming it was not

required to provide 24/7 one-on-one supervision, since neither CMS nor the ALJ ever stated that such a requirement applied. Avalon was required to accurately assess what level of supervision and/or assistive devices were required to prevent foreseeable accidents based on the resident's individual needs and to provide those services and devices. We find no error in the ALJ's conclusion that leaving R73 alone in the bathroom on March 28 was not calculated to prevent an entirely foreseeable accident.

R24

The ALJ also considered R24, a woman in her 90s who had acute and chronic back pain, required one-person assistance to transfer and to ambulate, and was at high risk for falls (fall risk score of 16 where a score of 10 or above represents high risk). ALJ Decision at 21 (citations to the record omitted). On March 25, 2013, while attempting to get out of bed, R24 fell to the floor. *Id.* The ALJ found no evidence that Avalon assessed R24's fall risk at the time of her admission on March 13, 2013, "except in a most general – and inadequate – way," i.e., by identifying in a document titled "Admission Plan of Care" R24's potential for falls, stating that R24 was to undergo physical therapy screening, and authorizing the charge nurse to use emergency measures (e.g., fall mats) if necessary. However, the ALJ noted, no evidence suggested that Avalon implemented any protective measures at that time, even though an interim care plan provided that R24 required extensive staff assistance for personal hygiene, toileting, eating, and mobility. *Id.* citing P. Ex. 37, at 1, 2 and CMS Ex. 81, at 11, 25. After the incident on March 25, staff placed an alarm on R24's bed and a fall mat next to the bed; on March 27, staff entered into the care plan an instruction to staff to test and reapply the bed or chair alarm. The ALJ noted evidence indicating that the staff did not, however, ensure that R24's bed and chair alarms were in place and functioning. *Id.* at 21-22 (citations to the record omitted).

Rejecting Avalon's attempt to rationalize its failure to address R24's fall risk by pointing out that its formal care plan was not due until 7 days after her initial assessment was completed, and that the assessment was not due until 14 days after her admission, the ALJ said: "But protecting residents from accidents is a requirement that knows no time line. From the moment of her admission, the facility was charged with keeping her safe. It was free to choose its methods, but those methods had to include an adequate level of supervision." *Id.* at 21, citing *Briarwood Nursing Ctr.*, DAB No. 2115, at 5 (2007). Moreover, the ALJ said, the facility failed to provide R24 with the supervision and assistive devices she needed to prevent falls. *Id.* at 22. Accordingly, the ALJ concluded that Avalon was not in substantial compliance with subsection 483.25(h). *Id.*

Concerning R24, Avalon takes issue with the SOD's "claim" that Avalon had no care plan addressing concerns about falls at the time of the survey. According to Avalon, R24 was admitted on March 13, 2013, less than two weeks before the survey, and R24's care plan was not yet due, as it is only required to be prepared within 21 days after admission

or 7 days after completion of the initial MDS. RR at 31. Nevertheless, Avalon says, its interim care plan for R24 clearly addressed falls. *Id.* Avalon says, moreover, that the same allegation concerning R24's care plan was included under Tag F279, which it says is a "care plan tag," that it challenged through IDR and "won" – indicating that the "IDR reviewers were correct in deciding that Avalon's care plans adequately addressed falls, weight loss, and other medical issues." *Id.* Avalon says that it has proven that it had proper fall precautions in place for R24, and that the ALJ's "focus on a bed/chair alarm is a red herring" because an alarm does not prevent falls, "just as smoke detectors do not prevent fires." *Id.* at 31-32. Devices like alarms "simply alert the staff that the resident is moving or is on the floor so appropriate attention may be provided." *Id.* at 32.

The ALJ determined that, notwithstanding the regulations specific to when a formal care plan is to be established, the protection of residents is a facility responsibility that "knows no time line." *Id.* at 21, citing 42 C.F.R. §§ 483.20(b)(2), 483.20(k)(2)(i). Avalon does not allege ALJ error in this regard. Moreover, we do not see how Avalon helps its cause by now stating that its interim care plan addressed falls. The ALJ did not find that Avalon failed to assess R24's fall risk; she acknowledged that Avalon did, but explained why she found the facility's assessment of R24's fall risk at the time of admission was inadequate. *Id.* Avalon says nothing specific to challenge that aspect of the ALJ's analysis, which we find is well supported. Moreover, it is entirely irrelevant for purposes of evaluating the citation of Tag F323 whether Avalon successfully challenged another "care plan Tag" through IDR during the state agency review stage. When the facility appeals to the ALJ CMS's enforcement action after the state agency investigation, IDR review and its outcome are not the issue because the ALJ does not review CMS's determinations about earlier state agency review, but rather reviews the entire record de novo and decides whether the facility was in substantial compliance with the applicable regulations. *See Britthaven of Chapel Hill* at 4-6.

As for the bed/chair alarm, Avalon does not deny that the interim care plan instructed staff to use and test the bed/chair alarm, but yet staff did not ensure that the alarm was in place, on the bed or the wheelchair, as required. ALJ Decision at 21-22 (citations to the record omitted), 24. Avalon itself determined that one way to manage R24's accident risk was to apply an alarm. Once it did so, it had to ensure that the alarm was applied and in place. Its failure to implement its own care plan is not mitigated by its after-the-fact disparagement of the measures it adopted as useless to fully prevent falls. An alarm would no more eliminate the possibility of falls than a mat placed next to the bed would ensure that a resident who falls off the bed onto the mat would incur no injury. Surely Avalon placed the mat next to the bed because it believed that the mat could help minimize injury should R24 fall off the bed onto the mat, not because it believed the mat itself would prevent R24 from incurring any injury if she fell. Similarly, an alarm functions to alert staff to resident movement, so that staff can either attend to the resident

in time to head off a potential fall or injury, or, in the event the alarm was triggered due to a fall already sustained, to go to the resident and provide appropriate care. But, for the resident to benefit from the alarm's function – to alert – the alarm must actually be used or applied. Since the ALJ found that facility did not use or apply the alarm despite its own determination to use it as part of an accident risk management plan, and Avalon does not dispute that, Avalon may be held to the consequences of the failure to use it.

4. 42 C.F.R. § 483.25 (Tag F309, quality of care; S/S level “H” indicating pattern of noncompliance that caused actual harm)

Under the “quality of care” regulations in section 483.25, each resident must receive, and the facility must provide, the necessary care and services to enable a resident to attain or maintain the highest practicable physical, mental, and psychosocial well-being in accordance with the resident’s comprehensive assessment and plan of care. The surveyors determined that Avalon had failed to provide the necessary care and services to four residents.¹⁵ Specifically, with respect to R24, the surveyors determined that the facility did not consistently assess, intervene, or develop a care plan for R24, who had a history of inflammation of the small intestine and acute back pain, and had symptoms of unrelieved pain, and that the failure to do so likely contributed to R24’s uncontrolled pain and weight loss. CMS Ex. 6, at 49-51.

The ALJ agreed, finding that Avalon staff had failed to administer to R24 pain medication (Duragesic patch, transdermal) every three days as ordered on R24’s admission on March 13 by her physician, and again ordered on March 20, until March 25 (12 days after admission). That failure caused R24 to endure pain, as documented in evidence dated between March 14-17, and 21. ALJ Decision at 22 (citations to the record omitted). Accordingly, the ALJ determined, Avalon did not provide R24 with the necessary care she needed to attain her highest practicable physical, mental, and psychosocial well-being, and therefore violated section 483.25. *Id.* at 23.

Citing Texas law, Avalon asserts that surveyors, who are nurses, are not legally qualified to draw the conclusion that R24’s “mental state and chronic pain” “led to [R24’s] weight loss.” RR at 24-25; *see also id.* at 39 (citing Texas law, asserting that while nurses may express certain opinions, such as on nursing standards of care, only physicians may give expert opinions concerning etiology or cause of death).

¹⁵ The surveyors determined that Avalon failed in this respect as to four residents, 24, 25, 46, and 65. CMS Ex. 6, at 49-50. The ALJ, however, addressed only R24 in her discussion of this deficiency. ALJ Decision at 21, 22-23. Avalon states that it therefore addresses only R24 (RR at 21), but later in the same page states that it was in compliance with respect to “each resident cited under F309” (*id.*). It does not then go on to address each resident discussed in the SOD. In any case, Avalon does not specifically raise an issue about the ALJ’s addressing only R24.

First, the ALJ's analysis did not turn specifically on what might have caused R24's weight loss. Second, Avalon's reliance on Texas state law is misplaced. In rejecting another Texas facility's argument in reliance on Texas malpractice cases that Texas law prohibits a surveyor,¹⁶ a nurse, from rendering a medical diagnosis or opinions as to the cause of any medical diagnosis and that only licensed physicians are permitted to make such determinations, the Board said, "Although a nurse may not be qualified to render an expert opinion regarding the legal issue of causation in a medical malpractice case in Texas, the issue of noncompliance in this case is governed by the federal regulation [i.e., 42 C.F.R. § 483.25(k), which requires facilities to meet certain types of special needs, such as tracheotomy and respiratory care], not by Texas tort law." *Cedar Lake Nursing Home*, DAB No. 2390, at 17 (2011), *aff'd Cedar Lake Nursing Home v. HHS*, 481 F. App'x 880 (5th Cir. 2012); *see also Omni Manor Nursing Home*, DAB No. 1920, at 44 (2004) (Part 498 cases differ materially from state tort law concepts), *aff'd, Omni Manor Nursing Home v. Thompson*, 151 F. App'x 427 (6th Cir. 2005). Here, we see no error in the ALJ's treatment of the surveyor's observations about Avalon's undisputed failure to administer pain medication as prescribed to relieve R24's suffering.

Avalon also recounts in detail "numerous interventions" it allegedly undertook to address R24's anxiety, depression, dementia, crying, homesickness, poor appetite and weight loss, and prior history of emotional trauma. RR at 21-28. All of this discussion presumably is intended to show that Avalon made efforts to provide necessary care and services to enable R24 to attain or maintain the highest practicable physical, mental, and psychosocial well-being in accordance with her assessment and plan of care.

But, as stated, the ALJ based her determination on a finding that Avalon did not follow the physician's orders for relieving R24's pain. On this, Avalon does not specifically dispute the ALJ's finding as not supported by the evidence on which the ALJ relied. Avalon does claim that the order for the Duragesic patch was not issued until March 20 (RR at 26), but we find that the ALJ's finding that the physician first ordered the patch earlier, on R24's admission to the facility, is supported by evidence of record. CMS Ex. 51, at 16. Avalon then recounts its staff's efforts to relieve R24's pain using other medications like Lortab and Norco based on a report that R24 may have been allergic to opioid analgesics, morphine and related drugs, which did not sufficiently relieve pain, at which point Duragesic was added. RR at 26-27. But the ALJ considered evidence that

¹⁶ We note that in rejecting another facility's disagreement with an ALJ's finding that medication errors (42 C.F.R. § 483.25(m)) posed a potential for more than minimal harm to a resident mainly on the ground that the surveyor whose testimony on which the ALJ had relied was not qualified as an expert to testify to that because it constituted a medical opinion, the Board observed that "a surveyor does not need to be formally qualified as an expert in order for the ALJ to accord weight to his or her testimony" and that the ALJ "could reasonably infer from the witness's testimony regarding her education, training and experience that she was amply qualified to give an opinion as to whether the medication errors had the potential to cause more than minimal harm." *Palm Garden of Gainesville*, DAB No. 1922, at 6-7 (2004), citing *Omni Manor Nursing Home*, DAB No. 1920 (2004).

other medications were given but were not sufficiently effective to relieve pain and, thereafter, on March 20, the physician again ordered a Duragesic patch. ALJ Decision at 22. She found no evidence that the original order for the patch, on admission, had been discontinued; noted Bianco's concession that the patch was ordered (on March 13), but that the facility did not have a triplicate narcotic prescription, which was required, and therefore did not obtain the medication until March 20; and found no evidence that the patch was actually administered until March 25. *Id.* Avalon does not specifically dispute these factual findings or provide a reasoned explanation why these findings do not or cannot support a violation of section 483.25. We uphold the ALJ's conclusion as to Avalon's violation of section 483.25.

5. 42 C.F.R. § 483.75 (Tag F490, administration; S/S level K)

As relevant here, section 483.75 requires the administration of facilities in a manner that enables facilities to use their resources effectively and efficiently so that each resident can attain or maintain his or her highest practicable physical, mental, and psycho-social well-being. The surveyors determined that Avalon did not comply with section 483.75 as to R73 because its administrator failed to develop or implement policies and procedures to prevent resident injury, and its DON failed to supervise the nursing staff to ensure that safe care was provided. Moreover, the surveyors said, the administrator and the DON together failed to develop or implement policies and procedures to coordinate care between the nursing staff and rehabilitation staff. CMS Ex. 6, at 160-61.

The ALJ agreed that Avalon was properly cited with a violation of section 483.75. The ALJ noted that elsewhere in her decision she found that Avalon's deficiencies posed IJ to resident health and safety, which itself supported that the facility was not in substantial compliance with section 483.75. ALJ Decision at 23, quoting *Asbury Ctr. at Johnson City*, DAB No. 1815, at 11 (2002) (“[W]here a facility has been shown to be so out of compliance with program requirements that its residents have been placed in immediate jeopardy, the facility was not administered in a manner that used its resources effectively to attain the highest practicable physical, mental, and psychosocial well-being of each resident.”), *aff'd*, *Asbury Ctr., at Johnson City v. Dep't of Health & Human Servs.*, 77 F. App'x 853 (6th Cir.), and citing *Odd Fellow & Rebekah Health Care Facility*, DAB No. 1839, [at 15-16] (2002); *Stone Cnty. Nursing & Rehab. Ctr.*, DAB No. 2276, at 15-16 (2009). Moreover, the ALJ said, because Avalon did not have a reliable method for conveying necessary treatment instructions to direct care staff, an administrative responsibility, Avalon was not administered in a manner that complies with section 483.75. *Id.*; *see also id.* at 17-18 (stating that under 42 C.F.R. § 483.75(h), a facility must either employ qualified professionals (e.g., therapists) to provide residents needed services or provide such services through arrangement with outside providers in which case the facility assumes responsibility for ensuring that those outside provider services meet the regulations). The ALJ therefore concluded that Avalon was properly cited with failure to meet its administrative responsibilities under section 483.75. *Id.* at 23.

Avalon asserts, apparently again relying on its interpretation of the SOM, that this deficiency is not a fall prevention or policy implementation tag, and relates only to the allocation of resources. According to Avalon, it did allocate resources properly as it had in place “aggressive, proactive” programs that train its employees at orientation and subsequent in-service on abuse, neglect, supervision, transfers, and fall prevention. RR at 32-33, citing P. Exs. 15, 50, 51. Avalon says that it has shown that it has held numerous in-house training sessions in these areas, “[c]learly” proving that it “was expending resources to properly train its staff regarding abuse, neglect, and fall prevention.” *Id.* at 33, citing P. Ex. 15.¹⁷ Therefore, Avalon says, there is no basis for Tag F490. *Id.*

Avalon also states that “surveyor interpretive guidelines” advise that if a quality of care, quality of life, or facility behavior tag is cited at scope/severity level “G” or higher, then all “administration” tags under section 483.75 should be carefully reviewed for compliance. *Id.* at 32-33. Avalon claims, however, that Tag F490 is to be cited only if another “administration” tag (other than F490) has been cited in association with the same “G” level or higher quality of care, quality of life, or facility behavior tag. *Id.* at 33. Avalon claims that the other administrative tags for which it was cited (F498 and F520) were based on facts unrelated to the incident involving R73 on which the citation under F490 was solely based. *Id.*

Avalon interprets section 483.75 as meaning that the regulation’s central focus is on the *use of resources* and, specifically, use of resources *for purposes of developing and implementing policies and procedures such as those concerning fall prevention*. It then states that, by having various policies in place and training staff on those policies, it has appropriately expended facility resources and thus has complied with section 483.75. By reference to manual guidelines, it then suggests that no administration tag should have been cited with respect to the incident involving R73.

¹⁷ In the part of the RR discussing this deficiency, Avalon states that the facts concerning Tag F490 are identical to the facts related to the other Tags in dispute, and therefore it adopts and incorporates all arguments and evidence submitted for the other Tags as if set in full. RR at 32, 33. Avalon makes similar blanket statements about incorporating arguments by reference at various times in its RR. *E.g., id.* at 19. While there is overlap among the deficiencies addressed in this decision in that the underlying facts concerning, in particular, R73, are common to most of those deficiencies, it is not entirely accurate to then say that the facts are identical. Avalon must articulate with specificity what factual findings in the ALJ Decision it disputes as they relate to the cited deficiencies and why, pointing to evidence relevant or material to each deficiency, rather than attempt to incorporate everything it has said throughout the life of this case by reference to “arguments and evidence submitted.” We note that to the extent Avalon intended to incorporate by general reference arguments made below, Avalon is not permitted to do so. 42 C.F.R. § 498.82(b) (appellant must specify in its appeal to the Board the issues, findings of fact, or conclusions of law with which it disagrees, and the basis for contending that the findings and conclusions are wrong); *Avalon Place Kirbyville*, DAB No. 2569, at 8 n.7 (2014); Board *Guidelines*.

Avalon misses the mark. The central focus of section 483.75 is facility *administration* (as indicated by the regulation’s caption, “Administration”), that is, how a facility manages, oversees, operates, and executes various functional areas as detailed in the regulation. The regulation begins with these words: “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 psycho-social well-being of each resident.” It then sets out various functions under the rubric of facility administration, to include state and federal licensing of the facility, establishment of a governing body that appoints a facility administrator, and the designation of a physician who serves as the facility’s medical director. *See* 42 C.F.R. § 483.75(a), (b), (d), (i). While the regulation refers to the use of resources, the words “use its resources” are preceded by language that conveys the basic intent of the regulation – that the facility must be *administered* in such a way as to enable it to deliver quality care and services so that residents can “attain or maintain the highest practicable physical, mental, and psycho-social well-being.” By its plain terms, section 483.75 does not use the words “use its resources” to refer specifically to resource expenditure for purposes of developing and implementing policies and procedures like accident prevention policies and procedures.

We disagree with the manner in which Avalon employs the regulation’s words “use its resources” in its argument because virtually anything that a facility does to operate surely entails the expenditure of resources of some type. The development and implementation of facility policies and procedures, such as accident prevention policies and procedures, which certainly could affect residents’ well-being, would be no exception. That does not, however, mean that we may simply segregate the words “use its resources” in section 483.75 from the remaining language in the regulation and interpret the regulation to mean that, since the development and implementation of accident prevention policies and procedures entail resource expenditure, a facility must be deemed to have complied with section 483.75 whenever the facility has developed and implemented any such policies and procedures.¹⁸ That would be a misreading of this regulation, the focus of which is on facility *administration*, and would call for reading into the regulation something the regulation does not by its plain language say.

As we said, the ALJ found that Avalon was properly cited for a violation of section 483.75, based on administrative lapses – that is, the failure to have in place a reliable method for conveying necessary therapy treatment instructions to direct care staff. ALJ Decision at 20, 23. Of note, again, the ALJ expressly discussed Avalon’s responsibility under subsection 483.75(h) to either employ qualified individuals who could provide R73 therapy services or provide R73 such services through arrangement with outside

¹⁸ As discussed, Avalon was cited separately under another regulation – 42 C.F.R. § 483.13(c) – that specifically requires the development and implementation of written policies and procedures that prohibit resident neglect. The citation under section 483.75 is based on lapses in administrative responsibilities.

providers. *Id.* at 17-18. Citing 42 C.F.R. § 483.75(h) among other authorities, the ALJ found that Avalon did the latter, in which case Avalon assumed responsibility for ensuring that the services provided under arrangement met professional standards and principles that apply to professionals providing such services and the timeliness of the services. *Id.* Avalon can hardly be said to have “effectively” carried out its administration responsibilities so that R73 “attain[ed] or maintain[ed] the highest practicable physical, mental, and psycho-social well-being” if, as the ALJ determined correctly, Avalon failed to coordinate communication between its direct care staff and therapists who provide services under arrangement with Avalon to ensure that R73 was provided the therapy he needed.

B. The ALJ’s holding that CMS’s determination of immediate jeopardy is supported by substantial evidence and is free of legal error.

“Immediate jeopardy,” the most serious level of noncompliance, is a “situation in which the [facility’s] noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident.” 42 C.F.R. § 488.301. CMS’s determination that a facility’s ongoing noncompliance remained at the level of IJ during a given period constitutes a determination about the level of noncompliance and, therefore, is subject to the clearly erroneous standard of review under 42 C.F.R. § 498.60(c)(2), which is highly deferential and imposes a heavy burden on the facility to upset CMS’s determination on the level of noncompliance. *Yakima Valley School*, DAB No. 2422, at 8 (2011) (and cases cited therein).

The ALJ said that R73, a “vulnerable resident[,] was seriously injured and died as a result of the facility’s noncompliance.” ALJ Decision at 24. Rejecting Avalon’s argument that because R73 died there was no risk of “future or prospective” harm for any other specific resident as “legally unsound and factually unsupported,” the ALJ upheld CMS’s determination of IJ as not clearly erroneous. *Id.*, quoting P. Post-hrg. Br. at 24. As the ALJ noted, if the noncompliance has caused serious harm to a resident, and possibly death in the case of R73, the deficiencies posed IJ and, in accord with well-settled precedent, a facility’s ongoing noncompliance remains at the IJ level until the facility affirmatively demonstrates that it has abated the IJ. *Id.*, citing, inter alia, *Life Care Ctr. of Elizabethton*, DAB No. 2367, at 16-17 (2011). Moreover, the ALJ said, the facts of this case establish that R73 was not the only resident at risk. R24, who, like R73, was at risk for falls, was also vulnerable to serious harm. The ALJ observed that the facility initially took only “minimal, if any,” precautions to keep R24 safe. *Id.* After R24 sustained a fall, only then did the facility ensure that her care plan called for concrete interventions (chair/bed alarms), and yet the facility further failed because its staff did not consistently follow the plan instructions, putting R24 at risk of additional serious injury. *Id.*

Avalon asserts that it was “clearly erroneous” to cite Tags F224, 226, 278, 323, and 490 at the “K” scope and severity level (i.e., pattern of IJ level harm) and urges the Board to “delete[] [the Tags] in their entirety” or to reduce their S/S levels to level “D” (isolated in scope, with potential for more than minimal harm). RR at 34-36. Avalon asserts that there is no evidence of “K” level scope because only one incident involving one resident, R73, was the subject of the IJ citations at issue. According to Avalon, the written direct testimony of J. Stephens (a registered nurse and the corporate director of clinical systems of the owner/operator of Avalon) “confirm[s]” that “one resident/one incident is not enough to constitute a pattern, particularly when no other residents were found to have been affected by the allegedly deficient practice.” *Id.* at 34, citing P. Ex. 50.

The ALJ was not required to defer to Avalon’s attempt to rely on in its own employee’s testimony as establishing what constitutes a “pattern.” The ALJ could reasonably determine that a pattern existed where systemic failures seriously harmed at least one resident (R73), who sustained a “fatal accident,”¹⁹ and left another resident (R24) at risk of further harm after she sustained a fall. ALJ Decision at 21, 24. Given these findings, which are amply supported by the evidence, we find no legal error in sustaining the “K” level of immediate jeopardy even though only one resident suffered fatal injuries.

Avalon asserts, moreover, that the “required elements of [SOM] Appendix Q”²⁰ for finding IJ – harm, immediacy, and culpability – are not established because, as J. Stephens “explained,” no future harm was identified on survey because R73 was the only resident who was the subject of the IJ level Tags under discussion and was R73 “already deceased at the time [IJ] was called; the deficiency was not cited as past noncompliance; and the [SOD] does not reference (in terms of harm or otherwise) any specific resident affected by the surveyors’ allegations.” RR at 34-35. Avalon further asserts that it is not culpable because as soon as the surveyors “called” IJ it implemented its “aggressive” policies and procedures, which were already in place, in response to survey concerns; immediately investigated the incident; and provided notices of the incident. *Id.* at 35 (referring to Appendix Q elements of culpability).

¹⁹ The language Avalon uses suggests that Avalon believes CMS’s determination and the ALJ’s decision were based in part on a specific finding that Avalon caused R73’s death. RR at 12 (“CMS claims that Avalon failed to provide the required supervision . . . to [R73], and that such failure led directly to [R73’s] death (facts sharply disputed by [R73’s] treating physician)” and “[t]he ALJ then erroneously made the same conclusion”). We do not read the ALJ’s decision as having been based on a specific finding that Avalon caused R73’s death, let alone on the medical causation of death. We read the ALJ’s reference to R73’s “fatal accident” (ALJ Decision at 21) to have meant that R73 died on March 28, 2013 after sustaining serious fall injuries earlier that day, which as a factual matter is entirely consistent with the record.

²⁰ At times Avalon appropriately refers to the SOM as “surveyor interpretive guidelines” (e.g., RR at 3), while for purposes of discussion of culpability it refers to SOM Appendix Q provisions as “required elements.” *Id.* at 34. As we said, the SOM does not define applicable standards; the regulations do. “Appendix Q’s purpose is to guide surveyors in applying a regulatory standard, not to define that standard. The immediate jeopardy standard is defined by regulation in 42 C.F.R. § 488.301, and the regulatory definition, not the SOM instructions, binds the Board.” *Pinecrest Nursing & Rehab. Ctr.*, DAB No. 2446, at 19 (2012).

An IJ finding may be based on the actual occurrence or the likelihood of serious harm. Here, there was both. The ALJ found not only actual harm, namely fall injuries sustained by two residents, one of whom sustained injuries serious enough to have been taken to two hospitals and died the same day, but ongoing likelihood of further serious harm to the other resident, to support an IJ finding for a three-day period. Moreover, systemic breakdowns in communication, such as that exposed by the failures to incorporate therapists' findings into assessments of resident needs and to disseminate care needs to the direct caregivers, place any other residents who might be similarly misassessed at jeopardy of having their actual needs neglected. Even were we to accept that Avalon was not culpable within the meaning of 42 C.F.R. § 488.438(f)(4) (which we do not accept, since R73 sustained serious harm during the time he was neglected), the ALJ's findings of actual serious harm and likelihood of future serious harm support the IJ citation.

C. Substantial evidence supports the ALJ's determination that the CMPs are reasonable in amount.

The ALJ noted that the \$6,550 per-day CMP imposed for three days of IJ and the \$1,550 per-day CMP imposed for 40 days during which Avalon was out of substantial compliance below the IJ level were both in the middle of the applicable range of permitted CMPs. ALJ Decision at 25, citing 42 C.F.R. §§ 488.408(d)(1)(iii), (e)(1)(iii), 488.438(a)(1)(i), (a)(1)(ii). After considering the factors in 42 C.F.R. §§ 488.438(f) (facility's history of noncompliance; facility's financial condition; factors set out in 42 C.F.R. § 488.404; degree of culpability) and 488.404 (S/S of the deficiency; relationship of the deficiency to other deficiencies resulting in noncompliance; prior history of noncompliance in general and specifically with reference to the cited deficiencies), the ALJ determined that the CMPs were reasonable. *Id.* at 24-25; *see also* 42 C.F.R. § 488.438(e)(3) (ALJ may not consider any factor other than those specified in subsection 488.438(f) in reviewing the CMP amount). The ALJ said:

The facility concedes that it was . . . not in substantial compliance with five [LSC] requirements. Four of the deficiencies were widespread (scope and severity level F). Petitioner also concedes its substantial noncompliance with two quality of care requirements at scope and severity level E. Based on these uncontested deficiencies, I find it reasonable to impose penalties that are above the lowest ranges.

Add to these the serious problems discussed above. For this elderly and infirm population, failing to supervise a resident can – and, sadly, in this case, did – have serious, even fatal consequences. Yet, physical and occupational assessments, along with nursing assessments and other instructions designed to keep the residents safe, were not disseminated to staff, or, if they were disseminated, staff did not regard them. For this, the facility is culpable and the penalties imposed are reasonable.

ALJ Decision at 25.

Avalon baldly states, with no reasoned explanation, that it has demonstrated that the factors in sections 488.438 and 488.404 were not properly applied and, again, referring generally to the testimony of J. Stephens, argues that the imposition of a total CMP that “approaches 6-figures is not justified, especially when Avalon’s actions did not cause any resident harm.” RR at 36, citing P. Ex. 50.

Avalon does not identify any legal error related to the regulatory factors the ALJ was required to consider and did consider to determine the reasonableness of the CMPs. Nor does it raise any specific disagreement about how the ALJ applied and assessed the regulatory factors to determine that the CMPs imposed in this case were reasonable in amount. The only specific disagreement it raises relates to the ALJ’s statement that Avalon indeed caused resident harm, but it does not cite any error to support its position. We agree with the ALJ that Avalon caused serious resident harm. We find nothing in the testimony of Avalon’s employee that persuades us that the ALJ’s analysis of the reasonableness of the amount of the CMPs imposed was in any way improper.

D. Avalon’s allegations of procedural and evidentiary errors and bias are meritless.

1. June 18, 2014 pre-hearing conference

Avalon complains that the ALJ refused to record the June 18, 2014 telephonic pre-hearing conference despite repeated requests that the ALJ do so to preserve an accurate record for possible appeal. RR at 36. Avalon says that its concerns were “validated” when it received the ALJ’s ruling on Avalon’s objections to CMS’s exhibits, which Avalon says did not accurately restate the “majority” of its objections, and “led to improper admission of exhibits and ultimately an improper decision.” *Id.* at 36-37.

In her June 20, 2014 Order Following Prehearing Conference (June 20, 2014 Order), page 4, the ALJ acknowledged Avalon’s request to have the conference recorded and its concern that without a recording its objections would not be completely and accurately restated in the ALJ’s written post-conference order. The ALJ recounted that she had explained during the conference that “the practice of the Civil Remedies Division is to memorialize in a written order the conference’s agreements, stipulations, objections and rulings” and that a party that believes its views were not accurately represented in the ALJ’s written order has a 10-day opportunity to object under 42 C.F.R. § 498.50(b). June 20, 2014 Order at 4, 6. However, to allay Avalon’s concerns and to resolve evidentiary matters, the ALJ allowed Avalon to raise, in writing, any additional objections to certain CMS exhibits and CMS to respond to those objections. *Id.* at 4.

Section 498.50, captioned “Record, order, and effect of prehearing conference,” does not expressly address recording (whether audio or video) of pre-hearing conferences, but states, in part: “The record may be transcribed at the request of either party or the ALJ.” Thus, the regulation contemplates that the conference discussions may be recorded and reduced to writing (transcribed) on request, but does not require the ALJ to record the conference and order a transcript on request. The ALJ did not violate the applicable regulation in not recording the conference. We find, moreover, that the ALJ then appropriately permitted Avalon to object in writing to preserve its objections for appeal. Avalon availed itself of that opportunity when it filed its June 25, 2014 objections to CMS’s exhibits. Also, on June 30, 2014, Avalon objected to the ALJ’s June 20, 2014 Order, as permitted under subsection 498.50(b). Avalon does not cite any reasonable basis to cause us to question that the ALJ gave Avalon a full and fair opportunity to state its objections, nor does Avalon show any prejudice to it by the ALJ’s denial of its request to have the conference audio-recorded. If anything, permitting a party an opportunity to later state its objections in writing, rather than only state them orally during the course of a pre-hearing conference, could afford that party more time, and more meaningful opportunity, to consider the opposing party’s submissions and reflect on which parts of those submissions the party disagrees with and why. Moreover, Avalon does not allege that there are gaps in the record of the ALJ’s pre-hearing proceedings that would impede our ability to evaluate Avalon’s appeal.

2. The ALJ’s evidentiary rulings

a. SODs - CMS Exhibits 1 and 6

Overruling Avalon’s objections, the ALJ admitted both CMS Exhibit 1, which Avalon says is not the “final” SOD, as it was issued before Avalon challenged the survey findings through IDR, and CMS Exhibit 6, which Avalon says is the “revised,” “correct” SOD issued after certain “deletions” were made following IDR. RR at 37; ALJ Decision at 6 (admitting both exhibits); Petitioner’s Objections to CMS’ Exhibits at 1-2; June 20, 2014 Order at 2-3. Presumably referring to CMS Exhibit 1, Avalon asserts that it was improper for the ALJ “to consider for enforcement purposes deficiencies which no longer exist [after IDR] and/or were found to be invalid as a matter of law.” RR at 37. Avalon moreover asserts that the ALJ erred to the extent that she considered that part of the revised SOD (CMS Exhibit 6) which contains Avalon’s plan of correction that constitutes a subsequent remedial measure that may not be used to prove “culpable conduct” or to establish the existence of a deficient practice. *Id.*, citing Fed. R. Evid. 407²¹ and

²¹ FRE Rule 407, “Subsequent Remedial Measures,” provides that when measures are taken that would have made an earlier injury or harm less likely to occur, evidence of such measures is not admissible to prove negligence, culpable conduct, defect in a product or its design, or need for a warning or instruction. Evidence of subsequent remedial measures may be admitted for other purposes, such as impeachment, proof of ownership or control, or the feasibility of precautionary measures.

Pennington v. Brock, 841 S.W.2d 127, 313-32 (1992). According to Avalon, other ALJs have “recognize[d] this principle and generally admit[ted] the survey report, but agree[d] not to consider the POC [plan of correction] as a subsequent remedial measure to establish the original deficient practice.” *Id.* at 37-38. Avalon says that the ALJ “wrongfully refused” to follow that “principle.” *Id.* at 38.

We first reject the implication that the ALJ erred or abused her discretion because she did not follow the rationale of other ALJs. The ALJ who issued the decision under review, like any other ALJ, is an independent adjudicator. While all ALJs must apply the law governing the cases before them, none are bound to conform to another ALJ’s reasoning, or to rule or decide a particular way because other ALJs did so on similar issues or questions. Moreover, Avalon has not cited the ALJ decisions on which it relies for Board consideration. Even if Avalon had, and even assuming other ALJs have ruled as Avalon represents they had, on appeal, the Board would not be bound to follow the ALJs’ rationale. The Board would consider the persuasive value of any such rationale to the extent the Board determines it is appropriate to do so in a given case.

Second, Avalon’s reliance on FRE Rule 407 is misplaced, and the ALJ committed no legal error in not applying FRE Rule 407.²² Avalon incorrectly assumes that the scope of the ALJ’s authority over determinations on what evidence may be admitted in 42 C.F.R. Part 498 proceedings, such as this case, is defined by the FRE. Because “[e]vidence may be received at the [Part 498] hearing even though inadmissible under the rules of evidence applicable to court procedure[.]” 42 C.F.R. § 498.61, the ALJ was not bound to follow FRE Rule 407. *Lakeport Skilled Nursing Ctr.*, DAB No. 2435, at 6 (2012) (FRE do not control the admissibility of evidence in Part 498 cases). The Board also has observed that FRE Rule 407 “arises in tort, not in the context of statutory and regulatory obligations of skilled nursing facilities to maintain substantial compliance with Medicare participation requirements. Thus, FRE [Rule] 407 provides no clear guidance in the context of an administrative hearing conducted pursuant to 42 C.F.R. Part 498.” *Omni Manor Nursing Home*, DAB No. 1920, at 44 (2004). We therefore disagree that a *state* court decision which, according to Avalon, holds, based on FRE Rule 407, that state survey results may not be evidence of subsequent remedial measures to establish deficient practice or other types of culpable conduct, RR at 37, is authority the ALJ should have considered in determining whether Avalon complied with *federal* long-term care participation requirements.

²² We see no indication that the ALJ considered the POC information in CMS Exhibit 6 as evidence of subsequent remedial measures within the meaning of FRE Rule 407. Nor has Avalon cited authority establishing that POCs are considered subsequent remedial measures in a Part 498 appeal brought by a long-term care facility to challenge CMS’s enforcement action.

Third, Avalon seems to mistakenly assume that the ALJ was unaware of the fact that Avalon underwent IDR that resulted in the “deletion” of certain deficiencies. The implication is that Avalon was somehow at a disadvantage before the ALJ because she approached this case from the perspective that all of the deficiencies identified initially remained before her notwithstanding the IDR review. *See* RR at 37 (stating that to the extent evidence like CMS Exhibit 1 has probative value, “any probative value it does have is substantially outweighed by the danger of unfair prejudice and confusion”). As noted, however, the ALJ clearly identified the “health” violations that remained “following an [IDR],” citing both CMS Exhibits 1 and 6 to indicate her awareness that Avalon underwent IDR, and stated that a “revised” SOD had been issued after IDR. ALJ Decision at 3 n.1; June 20, 2014 Order at 2-3 (acknowledging that Avalon underwent IDR, after which the “revised” SOD was issued). We therefore reject as unfounded Avalon’s apparent position that because the ALJ admitted CMS Exhibit 1 the ALJ then relied on it without regard to the outcome following IDR review.²³ Given that the administrative proceeding does not involve a lay jury, we do not perceive any undue risk of prejudice or confusion from including the full history of the dispute in the record.

CMS Exhibits 1 and 6 are the SODs that set out in detail the survey findings on which CMS based its enforcement action that is the subject of this appeal and, for this reason, both Exhibits are unquestionably relevant and material evidence. We note that the ALJ stated that “the parties should keep in mind the difference between objecting to the admission of evidence and arguing that it should be afforded little, if any, weight[.]” June 20, 2014 Order at 4, to reinforce her earlier statement in the same order about the basis for admitting evidence (relevance and materiality) and to convey that her decision to admit certain evidence does not necessarily mean that she will assign controlling weight to any particular piece of evidence. We conclude that ALJ did not err or abuse her broad discretionary authority under Part 498 in admitting both CMS Exhibits 1 and 6 as relevant and material evidence and considering them to decide this case.²⁴ June 20, 2014 Order at 2-3; 42 C.F.R. § 498.60(b)(1) (the ALJ admits “relevant and material”

²³ It is worth noting that CMS stated that it “does not intend to pursue any citations deleted by IDR or that do not appear on the final [SOD], proffered as CMS Exhibit 6” and that “no prejudice exists since CMS does not intend to pursue any citations that are not contained in the post-IDR [SOD].” CMS’s Response to Petitioner’s Objections to CMS Exhibits at 1. To the extent Avalon might have remained concerned about the potential for prejudice to its case *before the ALJ* based on inclusion of CMS Exhibit 1 despite CMS’s statement, we see no prejudice. Having considered the record, we conclude that the ALJ admitted both CMS Exhibits 1 and 6 on relevance and materiality grounds, and then proceeded to assess the cited deficiencies well aware that certain deficiencies had been “deleted” following IDR.

²⁴ In fact, the FRE more broadly speak in favor of admitting evidence that is relevant, rather than excluding it, subject to certain exceptions. *See* FRE Rules 402 (relevant evidence is admissible unless the U.S. Constitution, federal statute, FRE, or rules prescribed by the Supreme Court prescribe otherwise) and 403 (relevant evidence may be excluded if its probative value is substantially outweighed by danger of prejudice, confusion, waste of time, or other reasons like needless presentation of cumulative evidence). Thus even under the FRE, the evidence would have been admissible so long as it was not used for the specified purposes.

evidence); *Jennifer Matthew Nursing & Rehab. Ctr.*, DAB No. 2192, at 51 (2008) (“Under 42 C.F.R. § 498.61, an ALJ has broad discretion to admit evidence.”). Lastly on this issue, aside from admission of CMS Exhibits 1 and 6 on relevance and materiality grounds, we cannot find fault with the ALJ for admitting and considering evidence that includes a facility’s plan of corrective action when 42 C.F.R. § 488.408(f) requires facilities to have a such a plan for virtually all deficiencies.

b. Testimonial evidence – surveyors

Avalon asserts that the ALJ misstated its objections to the written direct testimonies (declarations) submitted by CMS and erred in admitting them. Avalon states that it did not object to all of the declarations offered by CMS as the ALJ mistakenly assumed, but rather objected to CMS Exhibits 78 (surveyor Nerren, a registered nurse), 79 (surveyor Walker, a registered nurse), 81 (surveyor Hennington, a social worker), and 82 (surveyor McDaniel, a registered nurse). RR at 38. CMS Exhibits 78, 79, and 81, Avalon says, should not have been admitted because the “affidavits/declarations” were notarized, but not “signed under penalty of perjury.” *Id.* According to Avalon, the Texas Supreme Court and Federal courts sitting in Texas recognize that affidavits for which the affiants did not “positively and unqualifiedly state that the facts stated” therein are “true and correct (so that penalties for perjury attach)” and that “the facts contained therein are specifically within the affiant’s personal knowledge” are not “legally sufficient” “even if [they are] acknowledged by a notary” and, therefore, are “not admissible for any purpose.” *Id.* at 38-39 (citing two cases). As for CMS Exhibit 82, Avalon states that the same courts recognize that a declaration made “on information and belief” likewise is legally insufficient and inadmissible. *Id.* at 39.

The ALJ overruled the objections, determining that the declarations conformed to her instructions in her July 10, 2013 Acknowledgment and Initial Pre-Hearing Order (July 10, 2013 Order) that the parties must submit in the form of exhibits the complete written direct testimony of any proposed witness and that each “witness statement must be [submitted] in the form of an affidavit made under oath or as a written declaration that is signed by the witness under penalty of perjury for false testimony.” June 20, 2014 Order at 3 (quoting July 10, 2013 Order). The ALJ added that affidavits “signed and sworn to before a notary public” are affidavits “made under oath” and accordingly complied with her July 10, 2013 Order. *Id.* We understand this statement to mean that the ALJ also determined that CMS Exhibits 78, 79, and 81, which were “made under oath” in accordance with her instructions, comport with 42 C.F.R. § 498.62, which states, in relevant part, that “[w]itnesses at the hearing testify under oath or affirmation.”²⁵

²⁵ The Board recently stated that language in another ALJ’s pre-hearing order that is similar to that in the pre-hearing order here comported with section 498.62. *HeartFlow, Inc.*, DAB No. 2781, at 16 & 17 n.10 (2017).

Avalon does not take issue with the ALJ's determination that CMS Exhibits 78, 79, and 81 were affidavits "made under oath"; it does not assert that those affidavits do not conform to section 498.62. As for CMS Exhibit 82, surveyor McDaniel's declaration was not signed before a notary, but included the following statement above her dated signature: "In accordance with 28 U.S.C. Section 1746, I declare under penalty of perjury that the foregoing information is true and correct to the best of my knowledge and belief." CMS Ex. 82, at 9. The declaration conforms to the ALJ's instructions and section 498.62, and the quoted statement is substantially similar to the form language permitted by 28 U.S.C. § 1746 for unsworn declarations executed under penalty of perjury (for unsworn declarations executed within the United States, its territories, or commonwealths, "I declare (or certify, verify, or state) under penalty of perjury that the foregoing is true and correct. Executed on (date)."). Avalon asserts that the affidavits made "on information and belief" are legally insufficient and inadmissible. RR at 38-39. To the extent Avalon may be asserting that addition of the words "to the best of my knowledge and belief" to surveyor McDaniel's declaration means that surveyor McDaniel did not testify to facts of which she had personal knowledge, the substance of her declaration indicates the contrary. Surveyor McDaniel recounted in some detail her participation in the March 2013 health survey of Avalon, recounting the specific findings made during that survey on which the majority of the citations at issue (Tags F224, F226, F278, F323, F490) and a few other citations not at issue were based, and expressly stated that she "wrote" those citations based on the survey findings. CMS Ex. 82. Thus, surveyor McDaniel testified, in writing, to those facts of which she had personal knowledge.

We note, moreover, that Avalon ultimately was not harmed by the ALJ's ruling admitting CMS Exhibits 78 and 79 – a ruling with which we agree – because CMS later withdrew the written direct testimonies of Nerren (CMS Ex. 78) and Walker (CMS Ex. 79) and therefore CMS Exhibits 78 and 79 were not in the end a part of the admitted evidence on which ALJ based her decision. CMS's August 22, 2014 Motion to Withdraw Exhibits²⁶; Tr. at 13 (ALJ, stating which CMS Exhibits were being admitted, did not include CMS Exhibits 78 and 79 as those admitted). There is no indication in the ALJ Decision that the ALJ cited CMS Exhibits 78 or 79 or referred to or relied on Nerren's or Walker's withdrawn written direct testimony.²⁷

²⁶ In the same motion, CMS also stated that it was withdrawing its Exhibit 81 (Hennington decl.) as it related to Tags other than Tags F309 and F323, both of which concerned violations of section 483.25. Thus, CMS Exhibit 81 was part of the admitted evidence, but was before the ALJ for her consideration for a limited purpose.

²⁷ Avalon raises other arguments about CMS Exhibit 78 (Nerren decl.). It asserts that the ALJ misunderstood its objection and that Nerren, who is not a physician, may not give medical opinions in judicial proceedings in Texas. RR at 39-40. The ALJ overruled the objection. June 20, 2014 Order at 3. We need not address the specific issue of whether nurse Nerren may be qualified to opine on cause of death or etiology raised in the context of this exhibit because CMS later withdrew this exhibit. While CMS Exhibit 78 remains a part of the administrative record, it was not a part of the evidentiary record on which the ALJ made her decision.

We also note that the ALJ told Avalon in advance that, should Avalon choose to cross-examine any CMS witness for which CMS has submitted written direct testimony, the witness will be sworn in at the hearing to authenticate the veracity of his or her written direct testimony. June 20, 2014 Order at 3. Surveyors Hennington and McDaniel were sworn in at the hearing and first authenticated their written direct testimonies (CMS Exhibits 81 and 82) before testifying further on cross-examination. Tr. at 89-91 (Hennington) and 14-16 (McDaniel). Both responded in the affirmative (“I do”; “Yes”) to the ALJ’s question, “Do you solemnly swear that the testimony that you’re about to give will be the truth and nothing but the truth under penalty of law?” Tr. at 14, 89. We therefore see no ALJ error or abuse of discretion related to the admission of CMS Exhibits 81 and 82, let alone any basis to question the veracity of any part of the testimonies of Hennington and McDaniel, oral or written.

Lastly, Avalon raises a more general argument about surveyor-witness testimonies. It takes issue with the following language in the ALJ’s June 20, 2014 Order (page 3): “Petitioner objected to my admitting any of the witness’s references to the surveyor consulting with his colleagues and reaching conclusions as to the facility’s compliance. Petitioner argued that such opinions ‘violated’ my de novo review. I overruled Petitioner’s objection.” Avalon states that the ALJ misstated its objection; it was objecting on relevance grounds, that is, it was asserting that the question of whether any surveyor or surveyor team agrees as to what constitutes deficient facility practice is irrelevant to the ALJ’s de novo review and determination of whether a facility’s practice was deficient or whether any deficiency posed immediate jeopardy. RR at 40. Avalon urges the Board to “intervene to correct” the ALJ’s incorrect ruling to the extent the ALJ admitted any such evidence, arguing that the ALJ in this case should have ruled “in line” with other “similarly situated” ALJs on this issue to determine that a witness’s opinion on whether that witness, survey team, or agency enforcement representative agrees with a deficiency determination is irrelevant. *Id.*

We disagree that the ALJ’s words “‘violated’ my de novo review” indicates that the ALJ misunderstood the objection (thus implying that, although the ALJ ruled, that ruling was not actually responsive to the specific objection as raised). RR at 40. The ALJ evidently had relevance, fundamental to the question of admissibility, in mind when she overruled the objection, since the ALJ specifically cited relevance and materiality as the bases for admitting the initial and revised SODs over Avalon’s objections. June 20, 2014 Order at 2-3. Those SODs include detailed survey findings about which surveyors would later give testimony. Likewise, citing relevance and materiality, the ALJ admitted Petitioner’s Exhibit 14 (Dr. Mandel’s opinion) over CMS’s objection. *Id.* at 4; *see also id.* at 3 (overruling objection to admit CMS Exhibit 78, Nerren’s declaration), 4 (citing 42 C.F.R. § 498.61, which provides that the ALJ may receive evidence inadmissible in court proceedings and rules on the admissibility of evidence, and noting the difference between

admissibility and weight to be accorded to admitted evidence), and 5 (reminding the parties that the ALJ receives relevant and material evidence). Moreover, as discussed, the ALJ was not bound to rule consistently with other ALJs. That is equally applicable to the evidentiary ruling at issue here.

3. ALJ bias

Avalon complains that the ALJ took almost two years to issue her decision, while CMS held almost \$100,000 of Avalon's money in escrow. RR at 2. Avalon states that "it is well-known" that the ALJ "has an overwhelming propensity to rule in CMS' favor in these types of cases," as shown by the ALJ's rulings in facilities' favor "less than 1% of the time" "over the years." *Id.*

We reject as wholly baseless Avalon's suggestion that the ALJ was biased in favor of CMS, or against long-term care facilities in general or Avalon specifically. Alleged bias, to be disqualifying, must have stemmed from an extrajudicial source and must have resulted in an opinion on the merits on a basis other than what the ALJ learned through presiding over the case. *1866ICPayday.com, L.L.C.*, DAB No. 2289, at 15-16 (2009) (and cases cited therein); *St. Anthony Hosp.*, DAB No. 1728, at 83-84 (2000) (and cases cited therein), *aff'd*, *St. Anthony Hosp. v. HHS*, 309 F.3d 680 (10th Cir. 2002). Avalon has not shown that the ALJ's decision was based on something other than the record in this case and what the ALJ learned about this case in the course of her presiding over it.

Nor are an ALJ's rulings themselves sufficient proof of bias. *St. Anthony Hospital* at 84; *Britthaven of Goldsboro*, DAB No. 1960, at 18-19 (2005); *see also In re Rouse*, 582 F. App'x 132, 133 (3rd Cir. 2014) ("[a]dverse rulings alone generally do not constitute a sufficient basis for holding that a judge's impartiality is in doubt"). Therefore, neither the fact that the ALJ viewed this case differently from Avalon and upheld CMS's enforcement action, nor her rulings in other nursing home cases, prove that the ALJ was biased against Avalon or other facilities, or that she favored CMS. *See Meadow Wood Nursing Home*, DAB No. 1841, at 10 (2002) ("[W]eighing of testimony and evidence in the record is the essential task of an ALJ and can hardly be viewed as a demonstration of bias toward the party that does not prevail on the merits, however disappointed."), *aff'd*, *Meadow Wood Nursing Home v. HHS*, 364 F.3d 786 (6th Cir. 2004).

Conclusion

Based on the foregoing reasons and bases, the Board upholds the ALJ Decision.

_____/s/
Leslie A. Sussan

_____/s/
Constance B. Tobias

_____/s/
Susan S. Yim
Presiding Board Member