Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

In the Case of:	)	
	)	
Dyer Nursing and Rehabilitation Center, (CCN: 15-5220),	)	Date: December 11, 2009
	)	
Petitioner,	)	
	)	
- v. -	)	Docket No. C-09-316
	)	Decision No. CR2044
Centers for Medicare & Medicaid Services.	)	
	)	

DECISION

Petitioner, Dyer Nursing and Rehabilitation Center (Petitioner or facility), is a long term care facility located in Dyer, Indiana, that participates in the Medicare program. Based on a survey completed November 26, 2008, the Centers for Medicare and Medicaid Services (CMS) determined that the facility was not in substantial compliance with 22 Medicare requirements, and imposed a civil money penalty of $100 per day for 126 days of non-compliance, along with a denial of payment for new admissions (DPNA). Petitioner here appeals just one of the deficiencies cited, and CMS has moved for summary judgment.

For the reasons set forth below, I find that CMS is entitled to summary judgment; the facility was not in substantial compliance with Medicare requirements, and I sustain as reasonable the CMP imposed.

I. Background

The Social Security Act (Act) sets forth requirements for nursing facility participation in the Medicare program, and authorizes the Secretary of Health and Human Services to promulgate regulations implementing those statutory provisions. Act § 1819. The Secretary's regulations are found at 42 C.F.R. Part 483. To participate in the Medicare program, a nursing facility must maintain substantial compliance with program requirements. To be in substantial compliance, a facility's deficiencies may pose no

greater risk to resident health and safety than "the potential for causing minimal harm." 42 C.F.R. § 488.301.

The Secretary contracts with state survey agencies to conduct periodic surveys to determine whether skilled nursing facilities are in substantial compliance. Act § 1864(a); 42 C.F.R. § 488.20. The regulations require that each facility be surveyed once every twelve months, and more often, if necessary, to ensure that identified deficiencies are corrected. Act § 1819(g)(2)(A); 42 C.F.R. §§ 488.20(a); 488.308.

Here, the Indiana State Department of Health (state agency) completed the facility's annual survey on November 26, 2008. Based on the survey findings CMS determined that the facility was not in substantial compliance with the following Medicare participation requirements:

- 42 C.F.R. § 483.10(b)(11) (Tag F157 – notification of changes) at an E level of scope and severity (pattern of noncompliance that causes no actual harm with the potential for more than minimal harm);

- 42 C.F.R. 483.13(c)(1)(ii)-(iii), (c)(2)-(4) (Tag F225 – staff treatment of residents) at a D level of scope and severity (isolated instance of noncompliance that causes no actual harm with the potential for more than minimal harm);

- 42 C.F.R. 483.13(c) (Tag F226 – staff treatment of residents) at a D level of scope and severity;

- 42 C.F.R. § 483.15(a) (Tag F241 – dignity) at a D level of scope and severity;

- 42 C.F.R. § 483.15(f)(1) (Tag F248 – activities) at a D level of scope and severity;

- 42 C.F.R. §§ 483.20, 483.20(b) (Tag F272 – comprehensive assessments) at an E level of scope and severity;

- 42 C.F.R. § 483.20(k)(3)(ii) (Tag F282 – comprehensive care plans) at an E level of scope and severity;

- 42 C.F.R. § 483.20(l)(1), (2) (TagF283 – discharge summary) at a D level of scope and severity;

- 42 C.F.R. § 483.25(a)(2) (Tag F311 – activities of daily living) at an E level of scope and severity;

- 42 C.F.R. § 483.25(c) (Tag F314 – pressure sores) at an E level of scope and severity;

- 42 C.F.R. § 483.25(e)(1) (Tag F317 – range of motion) at a G level of scope and severity (isolated instance of noncompliance that causes actual harm that is not immediate jeopardy);

- 42 C.F.R. § 483.25(h) (Tag F323 – accidents and supervision) at an E level of scope and severity;

- 42 C.F.R. § 483.25(i) (Tag F325 – nutrition) at a D level of scope and severity;

- 42 C.F.R. § 483.25(m)(1) (Tag F332 – medication errors) at a D level of scope and severity;

- 42 C.F.R. § 483.35(i) (Tag F371 – sanitary conditions) at a D level of scope and severity;

- 42 C.F.R. § 483.60(a),(b) (Tag F425 – pharmacy services) at a D level of scope and severity;

- 42 C.F.R. § 483.60(b), (d), (e) (Tag F431 – pharmacy services) at a D level of scope and severity;

- 42 C.F.R. § 483.65(a) (Tag F442 – infection control) at a D level of scope and severity;

- 42 C.F.R. § 483.65(b)(3) (Tag F444 – preventing spread of infection) at a D level of scope and severity;

- 42 C.F.R. § 483.75(j)(1) (Tag F502 – laboratory services) at a D level of scope and severity;

- 42 C.F.R. § 483.75(j)(2)(i) (Tag F504 – laboratory services) at a D level of scope and severity; and

- 42 C.F.R. § 483.75(l)(1) (Tag F514 – clinical records) at an E level of scope and severity.

CMS Ex. 2.

Surveyors returned to the facility on February 19, 2009, but, based on the survey findings, CMS determined that the facility's substantial noncompliance continued. CMS Ex. 4. CMS subsequently determined that the facility returned to substantial compliance with certification requirements as of April 1, 2009. CMS has imposed against the facility a CMP of $100 per day for 226 days of substantial noncompliance ($12,600 total). CMS Exs. 3, 4. CMS also denied payments for new admissions to the facility from February 26 through March 31, 2009, and advised the facility that its Nurse Aide Training and Competency Evaluation Program would have to be denied or withdrawn. CMS Ex. 4, 5.[1]

Petitioner now requests a hearing.[2] Petitioner limits its appeal to just one of the deficiency findings: that it was not in substantial compliance with 42 C.F.R. § 483.25(e)(1), which requires that a resident not experience any reduction in his range of motion unless his clinical condition makes is unavoidable.

With its motion for summary judgment and brief (CMS Br.), CMS has submitted sixteen exhibits (CMS Exs. 1-16). Petitioner has submitted a cross-motion for summary affirmance, along with a brief (P. Br.), but no additional exhibits.

II. Issues

As a threshold matter, Petitioner has not appealed the bulk of the deficiencies cited, any one of which would justify the imposition of penalties (*see* discussion below).

Curiously, however, after listing all 22 of the deficiencies cited, CMS virtually ignores the majority of them, asserting that the case presents "no genuine disputes of material fact with respect to at least 4 of the deficiencies cited. . . ." CMS Br. at 1. In fact, because Petitioner appeals only one deficiency here, this case presents *no disputes* (material or otherwise) *of law or fact* with respect to 21 of the 22 deficiencies cited, and presumably CMS would have been entitled to summary judgment on at least those 21. Yet, for

[1] Denial of nurse aide training program approval stems from the denial of payment for new admissions. CMS Ex. 5, at 1; Act §§ 1819(f)(2)(B); 1919(f)(2)(B).

[2] Petitioner timely requested a hearing by letter dated March 2, 2009. On March 4, 2009, it filed a waiver of hearing, opting for a 35% reduction in the CMP. But, in a letter dated April 8, 2009, Petitioner withdrew its waiver and, with CMS's apparent acquiescence, reinstated its hearing request. CMS Exs. 1, 5.

reasons it does not explain, CMS bases its motion for summary judgment on just four of the deficiencies cited, including the only one that Petitioner challenges. Although I find CMS's strategy somewhat baffling, I limit this decision to the deficiencies CMS relies on in its motion.

In any event, Petitioner has not appealed three of the four deficiencies that CMS relies on here. As discussed below, based on those three, CMS's determination that, from November 26, 2008, through March 31, 2009, the facility was not in substantial compliance with Medicare requirements is final and binding, and CMS was authorized to impose penalties. The sole issue before me, then, is whether, based on the three deficiencies, the CMP imposed -- $100 per day – is reasonable.

III. Discussion

A. CMS is entitled to summary judgment because its determinations regarding the unchallenged deficiencies are final and binding and any one of them, by itself, provides a sufficient basis for imposing a penalty. [3]

Summary judgment is appropriate here because this case turns on questions of law and presents no genuine dispute as to any material fact. *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 247-48 (1986); *Livingston Care Center v. United States Department of Health and Human Services*, 388 F.3d 168, 173 (6th Cir. 2004).

CMS's findings of noncompliance that result in the imposition of a remedy are considered initial determinations that an affected party, such as Petitioner, may appeal. The regulations governing such actions dictate that CMS send notice of the initial determination to the affected party, setting forth the basis for and the effect of the determination, and the party's right to hearing. 42 C.F.R. §§ 498.20(a)(1); 498.3; 498.5. The affected party may then challenge the determination by filing a hearing request within 60 days of its receiving the notice. 42 C.F.R. § 498.40. An initial determination is final and binding unless reversed or modified by a hearing decision (or under circumstances not applicable here). 42 C.F.R. § 498.20(b).

In this case, CMS sent the appropriate notice, and Petitioner requested a hearing. In both its hearing request and brief, Petitioner emphasizes that it challenges only the deficiency cited under Tag F317, which corresponds to the regulation governing resident range of motion, 42 C.F.R. § 483.25(e)(1). P. Br. at 1, 6. CMS's determinations as to the other deficiencies cited are therefore final and binding. Petitioner was therefore not in substantial compliance with: 42 C.F.R. §§ 483.10(b)(11) (notification of changes);

[3] My findings of fact/conclusions of law are set forth, in italics and bold, in the discussion captions of this decision.

483.20(k)(3)(ii) (comprehensive care plans); and 483.20(l)(1),(2) (discharge summary). Because we have a final and binding determination that the facility was not in substantial compliance, CMS has the discretion to impose one or more of the enforcement remedies listed in 42 C.F.R. § 488.406, which include the remedies imposed here -- a CMP and DPNA. Act § 1819(h); 42 C.F.R. § 488.402. So long as CMS has a basis for imposing a remedy, I have no authority to review its determination to do so. 42 C.F.R. § 488.438(e). Nor may I review CMS's choice of remedy. 42 C.F.R. § 488.438(a)(1)(ii).

Petitioner nevertheless points to section 7400E1 of the State Operations Manual (SOM), and argues that, but for the "G" level deficiency cited under Tag F317, CMS would not have imposed a CMP nor denied payment for new admissions. That section reflects regulatory provisions found at 42 C.F.R. § 488.408.[4] Section 488.408(d)(2), *mandates* that CMS impose a "Category 2" remedy (which includes a DPNA or CMP between $50 and $3000) whenever it finds a deficiency with a scope and severity of "F" or greater (widespread deficiency, causing no actual harm with the potential for more than minimal harm). However, it does not follow that CMS is therefore precluded from imposing such a remedy unless it finds actual harm. To the contrary, section 488.408(d)(3) authorizes CMS to apply any "Category 2" remedy *except when the facility is in substantial compliance* or the deficiencies pose immediate jeopardy (in which case the CMP must be in the higher "Category 3" range). Thus, so long as the facility is not in substantial compliance, CMS may deny payment for new admissions and impose a CMP.[5]

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[4] Although Petitioner did not cite to the regulation, I discuss it here because I am bound by the regulations, although not by provisions of the SOM. The SOM may provide useful guidance as to CMS's interpretations of applicable law, but its provisions do not constitute enforceable, substantive rules. *Beverly Health and Rehabilitation Services v. Thompson*, 223 F. Supp. 2d 73, at 99-106 (D.D.C. 2002); *Oakwood Community Center*, DAB No. 2214, at 16 (2008); *Aase Haugen Homes, Inc.*, DAB No. 2013, at 15 (2006).

[5] Since I find that the three un-appealed deficiencies justify the CMP imposed, I do not consider the facility's compliance with 42 C.F.R. § 483.25(e)(1). I note however, that, even if I were to consider the issue, I have no authority to review the scope and severity findings here because a successful challenge would not affect "the range of civil money penalty amounts that CMS could collect" nor cause the facility to lose approval of its nurse aide training program. 42 C.F.R. § 498.3(b)(14). The regulations provide for only two ranges of CMP amounts – the lower range of $50 to $3000, and the upper range of $3,050 to $10,000. 42 C.F.R. § 488.438(a). The facility loses approval of its nurse aide training program, without regard to scope and severity, because CMS imposed a DPNA. *See* footnote 1.

B. I sustain, as reasonable the CMP imposed.

I next consider whether the CMPs are reasonable by applying the factors listed in 42 C.F.R. § 488.438(f): 1) the facility's history of noncompliance; 2) the facility's financial condition; 3) factors specified in 42 C.F.R. § 488.404; and 4) the facility's degree of culpability, which includes neglect, indifference, or disregard for resident care, comfort or safety. The absence of culpability is not a mitigating factor. The factors in 42 C.F.R. § 488.404 include: 1) the scope and severity of the deficiency; 2) the relationship of the deficiency to other deficiencies resulting in noncompliance; and 3) the facility's prior history of noncompliance in general and specifically with reference to the cited deficiencies.

In reaching a decision on the reasonableness of the CMP, I consider whether the evidence supports a finding that the amount of the CMP is at a level reasonably related to an effort to produce corrective action by a provider with the kind of deficiencies found, and in light of the above factors. I am neither bound to defer to CMS's factual assertions, nor free to make a wholly independent choice of remedies without regard for CMS's discretion. *Barn Hill Care Center*, DAB No. 1848, at 21 (2002); *Community Nursing Home*, DAB No. 1807, at 22 *et seq*. (2002); *Emerald Oaks*, DAB No. 1800, at 9 (2001); *CarePlex of Silver Spring*, DAB No. 1638, at 8 (1999).

CMS has imposed a CMP of $100 per day, which is at the very low end of the penalty range for per-day CMPs ($50-$3000) and, under any rationale, is quite modest. 42 C.F.R. §§ 488.408(d); 488.438(a)(ii).

With respect to facility history, CMS documentation, which Petitioner does not challenge, shows that the facility has a significant history of substantial noncompliance. Throughout 2007, surveys found substantial noncompliance. In January, March, May and August 2008 the facility was again found out of compliance, and the August 2008 deficiencies posed immediate jeopardy to resident health and safety. CMS Ex. 15. The facility history, by itself, is sufficient to sustain these minimal penalties, without regard to any other factor.

Petitioner has not argued that its financial condition affects its ability to pay the penalty.

With respect to the remaining factors, I note that two of the three deficiencies were cited at the "E" level of scope and severity (pattern of noncompliance with the potential for more than minimal harm). These, by themselves, justify a penalty above the regulatory minimum.

The $100 per day CMP is therefore reasonable.

IV. Conclusion

For the reasons discussed above, I find that CMS is entitled to summary judgment; the undisputed evidence establishes that the facility was not in substantial compliance with Medicare program requirements and that the $100 per day penalty is reasonable.

/s/
Carolyn Cozad Hughes
Administrative Law Judge