Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Appellate Division

In the Case of:	
The Residence at Salem Woods,	DATE: October 31, 2006
Petitioner,	Civil Remedies CR1341 App. Div. Docket No. A-05-103
- v. -	Decision No. 2052
Centers for Medicare & Medicaid Services.	

FINAL DECISION ON REVIEW OF ADMINISTRATIVE LAW JUDGE DECISION

On August 25, 2005, Administrative Law Judge (ALJ) Keith W. Sickendick issued a decision upholding a civil money penalty (CMP) imposed by the Centers for Medicare & Medicare Services (CMS) on The Residence at Salem Woods (Salem Woods), an Ohio skilled nursing facility (SNF). The Residence at Salem Woods, DAB CR1311 (2005) (ALJ Decision). In upholding the CMP, the ALJ found that Salem Woods had been out of substantial compliance with Medicare participation requirements between January and March 2002. Based on that finding, the ALJ determined that CMS could collect a $250 per day CMP for the 49 days of noncompliance from January 26, 2002 through March 15, 2002.

Both Salem Woods and CMS appeal the ALJ Decision on various grounds. For the reasons discussed below, we affirm all of the ALJ's findings and conclusions, except for his finding that the CMP started to accrue on January 26, 2002. We agree with CMS that the period of noncompliance to which the CMP was applicable began on January 25, 2002, not January 26, 2002. Accordingly, we modify the ALJ Decision to state that CMS may collect a $250 per day CMP for the 50 days from January 25, 2002 through March 15, 2002.

Legal Background

To participate in the Medicare program, a SNF must comply with the requirements for participation found in 42 C.F.R. Part 483, subpart B. 42 C.F.R. §§ 483.1, 488.3. Compliance with these requirements is verified by surveys conducted by state health agencies. 42 C.F.R. Part 488, subpart E. The state agency reports its survey findings in a Statement of Deficiencies. The Statement of Deficiencies identifies and describes each failure to meet a participation requirement (deficiency). Deficiencies are identified with "tag" numbers that correspond to the participation requirements violated.

If a survey finds that a SNF is not in "substantial compliance" with Medicare participation requirements, CMS may impose one or more enforcement remedies, such as a CMP. 42 C.F.R. §§ 488.402(c), 488.406. A SNF is not in "substantial compliance" if (1) it has one or more deficiencies, and (2) the deficiency or deficiencies are of sufficient severity that they create at least the potential for more than "minimal harm" to residents. See 42 C.F.R. § 488.301 (definition of substantial compliance); The Windsor House, DAB No. 1942, at 2-3, 61 (2004). CMS's regulations (and we) use the term "noncompliance" to refer to "any deficiency that causes a facility to not be in substantial compliance." 42 C.F.R. § 488.301.

CMS may impose a CMP on a "per day" basis – that is, for each day that the SNF is found to be out of substantial compliance – or, in the alternative, for "each instance" of noncompliance. 42 C.F.R. § 488.430(a).

Case Background[1]

During a survey completed on January 25, 2002, the Ohio Department of Health (state survey agency) determined that Salem Woods had 12 deficiencies and was out of substantial compliance. See CMS Ex. 19. CMS concurred with the state survey agency's determination and imposed a $600 per day CMP (among other remedies) effective January 25, 2002. CMS Ex. 4. CMS later reduced the CMP to $450 per day after the state survey agency

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

rescinded three of the 12 deficiency citations during informal dispute resolution. CMS Exs. 2 and 9.

A revisit survey found that Salem Woods came back into substantial compliance on March 16, 2002. CMS Ex. 9. CMS thereafter notified Salem Woods that all remedies previously imposed, including the $450 per day CMP, had been terminated as of that date. Id. CMS also informed Salem Woods that it owed a CMP totaling $22,500, or $450 per day "for 50 days beginning on January 25, 2002 and continuing through March 15, 2002." Id. at 1.

Salem Woods then sought (and received) a hearing before the ALJ to contest the survey's findings of noncompliance. At issue before the ALJ were nine of the original 12 deficiency citations. These nine disputed citations are designated by tag numbers F274, F280, F281, F309, F311, F312, F316, F324, and F498.

In his decision on Salem Woods's challenge to the CMP, the ALJ overturned two of the nine disputed deficiency citations — namely, tags F274 and F311 – finding that CMS had failed, in both instances, to make a prima facie showing of noncompliance. As for the remaining seven citations — tags F280, F281, F309, F311, F312, F316, F324, and F498 — the ALJ concluded in each instance that Salem Woods was not in substantial compliance with the relevant participation requirement during the January 2002 survey.

Regarding tag F324, CMS alleged that Salem Woods had failed to provide adequate supervision or assistance devices to four different residents in violation of 42 C.F.R. § 483.25(h)(2). See CMS Ex. 19, at 32-36; CMS Post-Hearing Br. at 11-17. The ALJ sustained tag F324 based on evidence pertaining to two of the four residents. ALJ Decision at 32-37. In addition, the ALJ found that one resident (Resident 14) had suffered actual harm as a result of the facility's noncompliance with section 483.25(h)(2). Id. at 35.

Having overturned tags F274 and F311 and upheld tag F324 based on only two of the four alleged examples of noncompliance, the ALJ decided that a reduction in the CMP was appropriate. ALJ Decision at 39-40. He therefore reduced the CMP from $450 per day to $250 per day. Id. In addition, the ALJ found that the period of noncompliance to which the CMP was applicable began on January 26, 2002 — which the ALJ called the "first full day of noncompliance" — and ran through March 15, 2002. Id. at 40.

Standard of Review

In general, we review an ALJ's decision to determine if its factual findings are supported by substantial evidence and its legal conclusions are correct. Guidelines - Appellate Review of Decisions of Administrative Law Judges Affecting a Provider's Participation in the Medicare and Medicaid Programs (at http://www.hhs.gov/dab/guidelines/prov.html); South Valley Health Care Center, DAB No. 1691, at 2 (1999), aff'd, South Valley Health Care Center v. HCFA, 223 F.3d 1221 (10th Cir. 2000).

Discussion

As indicated, both Salem Woods and CMS appeal the ALJ Decision. We discuss the facility's appeal first (in sections I.A. and I.B.), then turn to CMS's appeal (in section II.A. and II.B.).

I. The Facility's Appeal

A. *The facility's general contentions about the ALJ Decision lack merit.*

Salem Woods makes a number of general contentions regarding the ALJ Decision. First, it contends that the ALJ misallocated the burden of proof. Salem Woods (SW) Appeal Br. at 3-6. We disagree. The ALJ adhered to the burden of proof framework laid out in prior Board decisions. Under this framework, which the ALJ accurately described (ALJ Decision at 9), CMS has the burden of making a prima facie showing of noncompliance. If CMS carries this burden, the facility can prevail only if it rebuts or overcomes CMS's prima facie case by a preponderance of the evidence. See, e.g., Batavia Nursing and Convalescent Inn, DAB No. 1911 (2004), aff'd, Batavia Nursing and Convalesent Center v. Thompson, No. 04-3687 (6th Cir. 2005).[2] Salem Woods now argues that placing the ultimate burden of persuasion on the facility violates the Administrative Procedure Act. SW Appeal Br. at 3-6. We have evaluated and rejected this same argument in several prior decisions, and we find no reason to reconsider it here.

[2] This burden of proof framework was initially adopted in Hillman Rehabilitation Center, DAB No. 1611, aff'd, Hillman Rehabilitation Center v. United States, No. 98-3789(GEB) (D.N.J. May 13, 1999), a case involving an outpatient rehabilitation agency. The Board extended the framework to nursing home cases in Cross Creek Health Care Center, DAB No. 1665 (1998) and elaborated further on its reasons for doing so in Batavia Nursing and Convalescent Inn.

See Lakeridge Villa Health Care Center, DAB No. 1988 (2005); Vandalia Park, DAB No. 1940 (2004); Tri-County Extended Care Center, DAB No. 1936 (2004); Omni Manor Nursing Home, DAB No. 1920 (2004); Batavia Nursing and Convalescent Inn.

Second, Salem Woods contends that the ALJ applied an overly strict standard of compliance, referring us to Crestview Parke Care Center v. Thompson, 373 F.3d 743 (6th Cir. 2004) (Crestview). The court in Crestview found that the general quality of care regulation, 42 C.F.R. § 483.25, which requires a facility to provide "necessary care and services" to enable a resident to attain and maintain his "highest practicable physical, mental, and psychosocial well-being," is not a "strict liability" regulation. 373 F.3d 743 (emphasis added). The court explained that the word "practicable" suggests that a "'reasonableness' standard inheres in the regulation" and that it would be possible for a facility to show "a justifiable reason" for violating section 483.25. Id. Seizing on Crestview's discussion of that regulation, Salem Woods asserts that a facility may not be cited for a deficiency if it has taken "reasonable measures" to be in compliance. SW Appeal Br. at 7. Salem Woods further asserts that the ALJ enforced absolute, strict, or literal compliance with Medicare's participation requirements and ignored the fact that its nursing staff had taken "all practicable measures to ensure compliance[.]" Id. at 7-8.

We find no merit in these assertions in part because they are based on a misreading of Crestview. The court did not find, as Salem Woods would have us believe, that a facility must do for the resident only what is "practicable" for it to do under the circumstances. The court merely found that section 483.25 does not foreclose the possibility that a violation of section 483.25 could be excused for some "justifiable" reason. Furthermore, as we noted in Ridge Terrace, DAB No. 1834 (2002), the word "practicable" in section 483.25 refers to the resident's condition, not to the care and services that the facility must provide:

> [T]he requirement in section 483.25 that a facility provide to each resident "the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being" means that a facility must provide care and services so that a resident attains the highest level of well-being the resident is capable of attaining, not that a facility is excused from providing such care and services if it

> is not "practicable" to monitor its staff to ensure compliance.

DAB No. 1834, at 8.

In any event, Salem Woods specifies no examples of the alleged legal error: it cites no instance in which the ALJ applied a "strict liability" standard of compliance or found the facility noncompliant because of a failure to take "impracticable" or "unreasonable" actions. In fact, in each instance, the ALJ held the facility to the standards enunciated in the relevant participation requirement.[3] Furthermore, in the instances in which the ALJ found noncompliance, he did so by applying the "substantial compliance" standard mandated by the regulations.

Third, Salem Woods suggests that the ALJ failed to recognize that the testimony of CMS's witnesses was shown to be inaccurate on cross-examination. SW Appeal Br. at 8. The facility also contends that the ALJ "erred by weighing the testimony of the non-practicing surveyors more heavily than the overwhelming testimony of Salem Woods' rebuttal witnesses." Id. at 9. We reject these contentions because Salem Woods does not identify the factual findings implicated by these alleged errors, identify or discuss the evidence supporting its position, or show that it was prejudiced by the alleged errors.[4] To the extent that the

---

[3] As we have said, the quality of care regulations under section 483.25 "hold facilities to meeting their commitments to provide care and services in accordance with the high standards to which they agreed but do not impose strict liability, i.e., they do not punish facilities for unavoidable negative outcomes or untoward events that could not reasonably have been foreseen and forestalled." Tri-County Extended Care Center, DAB No. 1936, at 7 (2004).

[4] As the Board said in Wisteria Care Center:

> [T]he Board may decline to consider an issue that is not identified in the request for review or, if identified, is unaccompanied by argument, record citations, or statements that articulate the factual or legal basis for the party's objection to the ALJ's findings. See Guidelines for Appellate Review (indicating that the Board will review only those portions of the record that are cited by the parties or which the Board considers necessary to decide the

(continued...)

facility is complaining about the ALJ's explicit or implicit credibility findings, we defer to those findings unless they are clearly erroneous since the ALJ had the opportunity to observe the demeanor of the witnesses. Lakeridge Villa Health Care Center, DAB No. 1988, at 19 n.14 (2005); Community Skilled Nursing Centre, DAB No. 1987 (2005). Salem Woods has not demonstrated that any credibility finding is clearly erroneous.

Fourth, Salem Woods contends that the nurse surveyors who testified on CMS's behalf at the evidentiary hearing had not practiced nursing in a clinical setting for 10 or more years, were "wholly unfamiliar with contemporary nursing," and were therefore not "competent to assess the modern nursing techniques utilized by Salem Woods' staff because they [were] wholly unfamiliar with contemporary nursing." SW Appeal Br. at 8-9. The facility asserts that CMS had the burden to demonstrate their competency or qualifications but failed to do so. Id. Salem Woods also contends that the ALJ "inappropriately shifted the burden from CMS to Salem Woods to rebut the qualifications" of the nurse surveyors. Id. at 8.

We disagree with Salem Woods's suggestion that CMS failed to establish the surveyors' qualifications to testify about nursing practices and standards. The two surveyors, Debbie Truett and Jackie Kardasz, gave unchallenged testimony that they were registered nurses who, in addition to having 10 or more years of experience as surveyors, had worked in clinical settings as nurses. Tr. at 26-27, 132-33, 140-41. Jackie Kardasz, for example, testified that, prior to becoming a surveyor, she had worked as a nurse in long-term care facilities for more than 10 years. Tr. at 140. This background and experience were adequate to show that the surveyors had the requisite knowledge and skills.

Salem Woods would have us assume that lack of recent clinical experience makes a nurse surveyor unqualified to discuss — or express opinions — about nursing practices or standards. There is, however, no reason to think that experienced clinical nurses

---

[4](...continued)
appeal). In other words, the Board may summarily affirm a factual or legal finding if a party's presentation of an issue regarding that finding is such that the Board cannot discern the legal or factual basis for the party's disagreement with it.

DAB No. 1892, at 10 (2003).

who become surveyors lose their knowledge, judgment, or understanding of good nursing practices merely because they assume a new role outside the clinical setting. If anything, a nurse who becomes a surveyor is likely to increase her understanding of current and evolving nursing practices and standards because survey work involves intensive exposure to the long-term care setting as well as dialogue with practicing nurses. In addition, in deciding whether to cite a facility for violating a participation requirement, a nurse surveyor may be called upon to identify an appropriate standard of care by consulting nursing manuals or textbooks, pronouncements by professional organizations, federal clinical practice guidelines, or professional journal articles. See, e.g., CMS State Operations Manual (Pub. 7), Appendix P, Part II (Guidance to Surveyors - Long-Term Care Facilities), PP 82.4 (guidelines for applying 42 C.F.R. § 483.20(k)(3)(i)). In short, actual nursing experience in the clinical setting is not the only valuable or significant source of a nurse surveyor's knowledge or understanding of professional nursing standards.

Regardless of the assumptions that should or should not be made about a surveyor's qualifications, Salem Woods has failed to allege or show any prejudice from the ALJ's consideration or reliance on the surveyor's testimony. The facility does not, for example, identify which "modern" or "contemporary" standards or practices were or might have been unfamiliar to the surveyors. It also fails to identify any instance in which the ALJ would have reached a different conclusion had he not relied on the surveyor's testimony about a nursing practice or standard. Finally, Salem Woods does not allege that it was denied an opportunity to cross-examine the surveyors about their opinions or present appropriate rebuttal evidence.

For all these reasons, we conclude that the ALJ committed no error in admitting or relying on the surveyors' testimony. See Omni Manor Nursing Home (finding that the ALJ reasonably relied on the testimony of a surveyor about the "standard of practice" for documenting "do not resuscitate" status given that the surveyor was a registered nurse, had worked as a nurse from 1992 to 1999, had five years experience as a surveyor, and had conducted approximately 120 surveys of long term care or assisted living facilities); Ivy Woods Health Care and Rehabilitation Center, DAB No. 1933 (2004) ("[T]he ALJ could reasonably give more weight to the testimony provided by qualified state surveyors than to the testimony of facility staff where the testimony went to questions about the proper standards of professional care."). Because we find that CMS produced sufficient evidence that the surveyors were qualified to testify

about the matters in dispute, we need not address the facility's assertion that the ALJ "improperly shifted the burden from CMS to Salem Woods to rebut the qualifications" of the surveyors.

B. *The ALJ's findings of fact and conclusions of law regarding tags F280, F281, F309, F312, F316, F324, and F498 are supported by substantial evidence and* are *free of legal error.*

As indicated, there were nine deficiency citations in dispute before the ALJ, seven of which — tags F280, F281, F309, F312, F316, F324, and F498 — he upheld. Those seven citations alleged that Salem Woods was not in substantial compliance with the following participation requirements during the January 2002 survey:

> 42 C.F.R. § 483.20(k)(2)(iii) (tag F280), which requires that a resident's comprehensive care plan be periodically reviewed and revised after each assessment of the resident;
>
> 42 C.F.R. § 483.20(k)(3)(i) (tag F281), which requires that a facility's services meet "professional standards of quality";
>
> 42 C.F.R. § 483.25 (tag F309), which requires a facility to provide the "necessary care and services to attain the highest practicable physical, mental, and psychosocial well-being" of the resident, in accordance with the resident's comprehensive assessment and plan of care;
>
> 42 C.F.R. § 483.25(a)(3) (tag F312), which requires the facility to provide "necessary services to maintain good nutrition, grooming, and personal and oral hygiene";
>
> 42 C.F.R. § 483.25(d)(2) (tag F316), which requires the facility to "ensure that . . . [a] resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible";
>
> 42 C.F.R. § 483.25(h)(2) (tag F324), which requires a facility to ensure that each resident receives "adequate supervision and assistance devices to prevent accidents"; and
>
> 42 C.F.R. § 483.75(h) (tag F498), which requires a facility to "ensure that nurse aides are able to demonstrate

> competency in skills and techniques necessary to care for residents' needs[.]"

For each of these seven citations, the ALJ evaluated the evidence submitted by the parties, made relevant findings of fact, and, based on those findings, concluded that Salem Woods was not in substantial compliance with the relevant participation requirement.

Salem Woods now objects to all of the adverse findings and conclusions. We carefully considered each of its objections, but none persuade us that the ALJ erred in upholding the disputed deficiency citations. Most of the facility's arguments on appeal were previously made to the ALJ and are adequately addressed in his decision, where they were properly rejected. The appeal arguments that were not addressed by the ALJ are clearly meritless. We note that, in general, the facility's appeal arguments are not supported by the evidence cited, rely on speculative testimony or on facts that do not undercut the ALJ's conclusions, or ignore factual findings that show that the facility was not in substantial compliance. In several instances, Salem Woods maintains that its failure to provide a medical item or service in accordance with a physician order or the resident's plan of care was justified by the resident's refusal to accept the item or service. However, Salem Woods does not point to any treatment records showing that residents refused treatment that the nursing staff attempted to provide, and it has made no effort to show that it took appropriate action to address the potential adverse consequences of the residents' alleged refusal of care. In short, Salem Woods's arguments fail to persuade us that the ALJ Decision is based on a legal error or on factual findings that are not supported by substantial evidence. For all these reasons, we summarily affirm the ALJ's findings of fact and conclusions of law concerning tags F280, F281, F309, F312, F316, F324, and F498.

II. CMS's Appeal

A. *The ALJ committed no legal error or abuse of discretion in reducing the CMP imposed by CMS from $450 per day to $250 per day.*

CMS faults the ALJ for reducing the CMP imposed by CMS from $450 per day to $250 per day. The ALJ determined that the lesser amount was appropriate and reasonable because he had overturned two of nine disputed deficiency citations (tags F274 and F311) and because he had declined to uphold survey findings regarding two of the four residents at issue under tag F324.

The ALJ must make an "independent determination" about whether the amount of the CMP imposed by CMS is reasonable. CarePlex of Silver Spring, DAB No. 1683 (1999). That determination, however, must be guided by the regulatory factors specified in (or cross referenced by) 42 C.F.R. § 488.438(f).[5] Id.; Madison Health Care, Inc., DAB No. 1927 (2004). These factors are the facility's history of noncompliance (including repeated deficiencies), its financial condition, its degree of culpability for the cited deficiencies, the seriousness of the noncompliance, and the relationship of one deficiency to other deficiencies resulting in noncompliance. See 42 C.F.R. §§ 488.438(f), 488.404.

CMS's decision about the amount of the CMP to impose is based on deficiencies found during the relevant survey. If the ALJ subsequently overturns some of the deficiencies upon which that decision is based, the ALJ may legitimately consider whether the CMP amount, as originally imposed, is reasonable for the remaining deficiencies. Cf. Western Care Management Corp., DAB No. 1921, at 20 (2004) (noting that if an ALJ elects not to make findings about certain disputed deficiency citations, the ALJ must also consider whether findings favorable to the facility regarding those unaddressed citations could materially affect a fact-finders's determination about whether the amount of the CMP imposed by CMS was reasonable). The ALJ may, of course, find the CMP amount selected by CMS to be reasonable based on fewer deficiencies than those upon which CMS relied to impose the penalty.[6] CMS hints that the ALJ failed to recognize or consider

---

[5] In CarePlex of Silver Spring, we described the ALJ's proper inquiry as follows: "[T]he authority of the ALJ to review de novo on the record before him whether the amount set by [CMS] was reasonable based on the relevant factors does not authorize an ALJ to simply substitute his or her judgment as to what amount of CMP to impose or what factors to consider. The ALJ is not obligated to presume that [CMS] correctly assessed the evidence and factors, but is bound to follow the regulatory procedures to make an independent determination of whether the amount set by [CMS] is reasonable based on the evidence as fully developed in the hearing." DAB No. 1863, at 17-18.

[6] See Madison Health Care, Inc. at 23 ("We do not preclude the ALJ [on remand] from ultimately finding the same amount [imposed by CMS] to be reasonable even for a single deficiency, after evaluating the facts found against the regulatory factors. It is possible that an amount that was within a reasonable range

(continued...)

this possibility, CMS Appeal Br. at 5-6, but we see nothing in his decision or the record to substantiate that speculation. In any event, our task here is not to discuss what the ALJ could have done but to evaluate what he actually did – in particular, to determine whether his decision to reduce the CMP was based on legal errors, unsupported factual findings, or an abuse of discretion. Given the record before us, we find no basis to disturb the ALJ's decision to reduce the CMP because his analysis shows that he considered all the relevant regulatory factors.

CMS contends that the ALJ failed to consider evidence that some of the deficiency citations he had upheld were "repeated deficiencies" – that is, "deficiencies in the same regulatory grouping of requirements found at the last survey, subsequently corrected, and found again at the next survey." CMS Appeal Br. at 6-7 (quoting 42 C.F.R. § 488.438(d)(3)). However, the ALJ expressly indicated that he considered the facility's "history of noncompliance" (along with the other relevant factors) in determining a reasonable CMP amount. ALJ Decision at 40.

CMS also complains that the ALJ did not consider evidence of the facility's "culpability," which the regulations define as including (but not limited to) "neglect, indifference, or disregard for resident care, comfort, or safety." CMS Appeal Br. at 7-8. However, the ALJ stated that he considered evidence bearing on culpability but found that the evidence failed to establish "significant" culpability or "willful neglect." ALJ Decision at 40. We read this finding to say that the ALJ found the level or degree of culpability to be no higher than ordinary negligence. This assessment by the ALJ was reasonable given the lack of clear evidence of deliberate, intentional, or conscious disregard of resident health and safety.

Finally, CMS contends that the reduction in the CMP amount was inappropriate because the deficiency citations overturned by the ALJ, tags F274 and F311, along with the survey findings he chose not to rely upon in upholding tag F324, were "minor changes." CMS Appeal Br. at 6. It is true that tag F311, a D-level deficiency, was rated as being less serious than other citations upheld by the ALJ. In addition, the findings under tag F324 that the ALJ reversed were arguably less egregious than the two

---

[6](...continued)
of options for CMS to impose for multiple serious deficiencies would also be within a reasonable range to address a single serious repeat deficiency under tag 324 given the particular facts and circumstances found.").

examples he chose to rely upon in upholding that citation. On the other hand, tag F274, which the ALJ also overturned, was an E-level citation that alleged four examples constituting a "pattern" of noncompliance. The rulings favorable to the facility involved seven discrete findings evidencing noncompliance (four under tag F274, one under tag F311, and two under tag F324). Under these circumstances, we cannot say that the ALJ erred or abused his discretion in reducing the CMP. While one might quarrel with the *size* of the reduction, the reduction was within the bounds of reasonableness.

For all these reasons, we affirm the ALJ's decision to reduce the CMP imposed by CMS from $450 per day to $250 per day.

B. *January 25, 2002 was a day of noncompliance to which the $250 per day CMP applies.*

CMS contends that the ALJ erred in determining that the CMP should start accruing on January 26, 2002, even though CMS had decided to make the CMP effective January 25, 2002, the last day of the survey that found Salem Woods out of substantial compliance. CMS Appeal Br. at 10-17. The reason given by the ALJ for altering the starting date of the CMP was that January 26, 2002 was, in the ALJ's view, the "first full day of noncompliance." ALJ Decision at 40 (emphasis added).

The Board addressed essentially the same issue in Cal Turner Extended Care Pavilion, DAB No. 2030 (2006). In that case, we found no basis to preclude CMS from imposing a CMP for a day of noncompliance merely because it was not the "first full day" of noncompliance. DAB No. 2030, at 19-20. We emphasized then that the regulations authorize CMS to impose a per day CMP "'as early as the date that the facility was first out of compliance, as determined by CMS or the state.'" Id. (quoting 42 C.F.R. § 488.440(a)(1))).

Here, CMS determined that January 25, 2002 was the date Salem Woods was first out of substantial compliance. CMS Ex. 4. Accordingly, CMS had the discretion and authority to start the CMP accruing on that date, which is precisely what it did.[7] Salem Woods does not dispute that January 25, 2002 was an appropriate date for the CMP to take effect.

---

[7] See CMS Ex. 4, at 1 (stating that the CMP was "effective January 25, 2002"); CMS Ex. 9, at 1 (informing Salem Woods that the total CMP due was "50 days" of noncompliance "beginning on January 25, 2002 and continuing through March 15, 2002").

Accordingly, we conclude that the correct starting date of the CMP is January 25, not January 26, 2002. This means that the CMP accrued for 50 days, starting on January 25, 2002 and running through March 15, 2002, and that the total CMP for this period of noncompliance is $12,500.

Conclusion

For the reasons stated above, we modify the ALJ Decision as follows. First, we delete the last two sentences of the third paragraph on page 40.[8] Second, we modify the opening paragraph of the ALJ Decision to state: "A civil money penalty (CMP) of $250 per day for the 50-day period of noncompliance, a total CMP of $12,500, is reasonable." We affirm all of the ALJ's other findings of fact and conclusions of law.

/s/
Judith A. Ballard

/s/
Leslie A. Sussan

/s/
Donald F. Garrett
Presiding Board Member

[8] These two sentences are: "In determining the total number of days and penalty, I begin counting with January 26, 2002 (the first full day of noncompliance) and stop counting on March 15, 2002 (the facility was substantially compliant on March 16, 2002). *See* 42 C.F.R. § 488.440. The total number of days of noncompliance was 49 and the total CMP amounts to $12,250."