Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Mountain Vista Health Center,
(CCN: 06-5015),
Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-16-554

Decision No. CR4719

Date: October 7, 2016

DECISION

I grant summary judgment in favor of the Centers for Medicare & Medicaid Services (CMS) sustaining its determination to deny payment to Petitioner, Mountain Vista Health Center, a skilled nursing facility, for a period that began on April 6, 2016 and that ran through May 8, 2016.

I. Background

Petitioner requested a hearing in order to challenge CMS's determination to impose a denial of payment for new admissions. CMS moved for summary judgment, filing a brief plus 18 proposed exhibits that it identified as CMS Ex. 1-CMS Ex. 18. Petitioner filed a brief in opposition to CMS's motion (Response) plus five proposed exhibits that it identified as P. Ex. 1-P. Ex. 5. I receive these exhibits into the record for purposes of deciding CMS's motion.

II. Issue, Findings of Fact and Conclusions of Law

A. Issue

The sole issue is whether CMS is authorized to impose a denial of payment for new Medicare admissions against Petitioner for the period that ran from April 6 through May 8, 2016.

CMS predicates its remedy determination on findings that were made at two surveys of Petitioner's facility: a complaint survey completed on March 7, 2016; and, a revisit survey completed on May 9, 2016. At the complaint survey, the surveyor found that Petitioner failed to comply with Medicare participation requirements, most pertinently, 42 C.F.R. § 483.25(c). This regulation requires a facility to: ensure that residents do not develop avoidable pressure sores; and, to provide all residents who have sores with the necessary treatment and services to promote healing.[1] At the revisit survey, the surveyor concluded that Petitioner had not completely corrected its deficiencies prior to midnight on May 8, 2016, despite its assertions that it had corrected all deficiencies as of March 22, 2016.

Petitioner does not challenge the findings of noncompliance that were made at the May 9 survey.[2] It argues only that it corrected all of its deficiencies by March 22, 2016 and that no remedy should be imposed against it.

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[1] In its brief in support of summary judgment, CMS discusses in some detail the findings of errors and omissions of Petitioner's staff that undergird CMS's noncompliance findings. CMS' pre-hearing brief and motion for summary judgment at 4-8. It is unnecessary to discuss these findings here inasmuch as Petitioner does not contest them.

[2] In its hearing request, Petitioner did not challenge the surveyor's findings of noncompliance. However, in their Response, counsel for Petitioner now argues that the surveyor's finding that seat cushions were not correctly inflated is at least erroneous in part by challenging the surveyor's methodology for testing the cushions and also by arguing that the cushions were inflated pursuant to the manufacturer's recommendations. I find this new argument to be irrelevant. As I discuss in detail in this decision, the issue is not whether particular cushions were properly inflated but whether Petitioner had in place a system for insuring that they were. Petitioner offered no facts that address this issue.

B. Findings of Fact and Conclusions of Law

The undisputed facts establish that Petitioner did not correct its noncompliance with 42 C.F.R. § 483.25(c) before May 9, 2016. Consequently, CMS is authorized to impose the remedy of denial of payment for new Medicare admissions for each day of a period beginning on April 6 and running through May 8, 2016.

Petitioner submitted a plan of correction in response to the noncompliance findings that were made at the March 7 survey. State agency authorities initially rejected the plan but ultimately accepted a second, amended plan that Petitioner filed on March 24, 2016. CMS Exs. 13-15. In that plan, Petitioner set forth a number of corrective actions and avowed that it would attain compliance with all participation requirements by March 22, 2016. CMS Ex. 15.

However, and as CMS points out, Petitioner could not have completed some of the corrective actions by March 22 (two days prior to the date when Petitioner filed its amended plan). For example, one of the corrective actions proposed by Petitioner was to have its nursing leadership team conduct weekly audits to assure that all corrective actions dealing with wound care were being implemented. CMS Ex. 15 at 2. Those audits would, in turn, be discussed on a monthly basis at Petitioner's quality assurance meeting and action plans were to be developed as needed. *Id.* Petitioner could not possibly implement this corrective action before some time in the latter part of April 2016 inasmuch as it filed its amended plan on March 24.

CMS also contends – and the undisputed facts support its assertion – that Petitioner did not have in place prior to May 9, 2016 a system for consistently monitoring pressure-relieving cushions that were designed to protect residents from developing pressure sores or from exacerbating existing sores. CMS Ex. 17; CMS Ex. 18. The surveyor who conducted the May 9 revisit found that some of these cushions were not properly inflated. CMS Ex. 18. But, more important, Petitioner's staff was not able to confirm when these cushions had most recently been checked for proper inflation and Petitioner's administrator acknowledged that there was no system in place for checking and documenting the functionality of the cushions. *Id.*

Petitioner also argues that there is a disputed fact issue as to whether the surveyor "totally ignored evidence of Petitioner's system for monitoring . . . ." seat cushions. Response at 9. Notwithstanding this assertion, Petitioner offered no facts showing there was any system in place for regularly checking and monitoring seat cushions. Petitioner asserts that its manager instructed its nursing director to pinch a cushion and, based on her determination that the cushion was leaking, Petitioner ordered a new one. It cites this as evidence of "our process for monitoring these devices for defects or malfunctioning and reporting the need for

a replacement." P. Ex. 5 at 3. But, that is not evidence of a system for checking cushions, but rather only proof that on one occasion, the staff determined that a cushion was leaking. I cannot reasonably infer from such facts that Petitioner actually had a system in place for checking its cushions for proper inflation prior to May 9.

A skilled nursing facility that is not complying with Medicare participation requirements is presumed to remain out of compliance until it proves that it has corrected its deficiencies. *Taos Living Ctr.*, DAB No. 2293, at 20 (2009). The facility must establish that it has completely corrected all of its deficiencies. The burden of persuasion rests entirely on the facility to show that it has attained compliance. *Owensboro Place & Rehab. Ctr.*, DAB No. 2397, at 12-13 (2011). Mere representation of compliance is insufficient to prove that compliance has been attained. The allegations of compliance in a plan of correction, standing alone, do not prove compliance. A facility must produce actual evidence of compliance in order to prove that it corrected its deficiencies. *Florence Park Care Ctr.*, DAB No. 1931, at 30 (2004).

The undisputed facts establish that Petitioner did not satisfy this burden prior to May 9, 2016. As I have discussed, Petitioner could not possibly have implemented all of its corrective actions by March 22, 2016, as it contends to have done. But, more significantly, Petitioner plainly failed to ensure that its residents were protected from developing avoidable pressure sores by May 9. It did not have in place by that date a system that would assure that protective seat cushions were functional.

Petitioner offers several arguments in opposition to CMS's motion and I find them to be without merit. First, Petitioner contends that CMS's entire case is predicated on a surveyor's allegedly incorrect finding that one or more of the seat cushions that she examined on May 9 were underinflated. Petitioner's Response in Opposition to CMS's Motion for Summary Judgment (Response) at 4; *see* Petitioner's request for hearing. That assertion is incorrect. The surveyor actually found that several cushions were not inflated properly. CMS Ex. 17; CMS Ex. 18. But, Petitioner would not have attained compliance by May 9 even if *all* of the cushions examined by the surveyor on that date were inflated properly. The issue is not whether a cushion or cushions were improperly inflated on a particular date but whether Petitioner had in place a system for assuring that the cushions were inflated correctly.

Second, Petitioner asserts that CMS's entire case rests on the surveyor's allegedly ad hoc procedures for testing whether cushions were inflated properly. Response at 4. That assertion also is incorrect. It is true that the surveyor reached conclusions on May 9 that some of the cushions were not properly inflated. She

didn't base those judgments solely on her own testing of the cushions. Petitioner's staff admitted to the surveyor that some of the cushions were not properly inflated. CMS Ex. 17; CMS Ex. 18. But, even if that were not so, CMS's case does not hinge at all on whether cushions were properly inflated on May 9 but, rather, on whether Petitioner had a system in place for checking these cushions.

Petitioner complains that the surveyor who conducted the May 9 survey failed to interview nurse aides on Petitioner's staff to determine how they were using seat cushions to protect residents. Response at 6. Even if that were so, that does not relieve Petitioner of the burden of producing evidence that it complied with participation requirements. The burden of coming forward with such evidence and proving compliance rests on *Petitioner* and not on CMS. If Petitioner has evidence – consisting of nurse aide testimony – showing that it was compliant as of May 9 then it should have produced it.

Petitioner also contends that, with respect to the specific residents using seat cushions, the surveyor ignored resident care plans that list interventions to be employed in order to protect residents. Response at 6. Again, it is Petitioner's burden to produce care plans, not CMS's burden. If in fact, resident care plans establish compliance, then Petitioner ought to have offered them as evidence. It does not attain compliance by asserting that CMS should have considered these plans.

When Petitioner's arguments are considered, either individually or collectively, they fail to address CMS's central point. Petitioner needed to have some system in place to assure that seat cushions designed to protect its residents from developing or exacerbating pressure sores were being utilized properly and that they were correctly inflated. It offered no evidence prior to May 9, 2016, that it had such a system in place. Consequently, and notwithstanding Petitioner's arguments and assertions, Petitioner has failed to adduce facts showing that it attained full compliance with participation requirements prior to May 9.

CMS is authorized to impose the remedy of denial of payment for new Medicare admissions in the case where a facility manifests any failure to comply substantially with participation requirements. 42 C.F.R. § 488.417. Petitioner's

failure to prove that it attained compliance prior to May 9, 2016, justifies CMS's determination to implement that remedy here.

_____/s/_____
Steven T. Kessel
Administrative Law Judge