Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Countryside Rehabilitation and Healthcare Center
(CCN: 10-5587),

Petitioner,

v.

Centers for Medicare & Medicaid Services,

Respondent.

Docket No. C-14-1485

Decision No. CR4547

Date: March 15, 2016

DECISION

Countryside Rehabilitation and Healthcare Center (Countryside or Petitioner) challenges the Centers for Medicare & Medicaid Services' (CMS) determination that it was not in substantial compliance with the Medicare program participation requirement that a skilled nursing facility (SNF) must not admit residents with mental illnesses or intellectual disabilities without an assessment as to the residents' need for the SNF's services. 42 C.F.R. § 483.20(e), (m). Countryside does not challenge CMS's finding of substantial noncompliance with 42 C.F.R. § 483.60(b), (d), (e) (label, storage, and records of drugs and biologicals). However, Countryside does challenge the penalties imposed, which are a $200 per-day civil money penalty (CMP) from March 7, 2014, through May 1, 2014, and the denial of payment for new admissions (DPNA) from April 24, 2014, through May 1, 2014.

For the reasons explained below, I reverse CMS's finding that Countryside was not in substantial compliance with 42 C.F.R. § 483.20(e), (m), affirm CMS's finding that Countryside was not in substantial compliance with 42 C.F.R. § 483.60(b), (d), (e),

modify the duration of the $200 per-day CMP that CMS imposed on Countryside to April 17, 2014, through May 1, 2014, and affirm CMS's imposition of a DPNA from April 24, 2014, through May 1, 2014.

I. Background

The Social Security Act (Act) sets forth requirements for an SNF's participation in the Medicare program and a nursing facility's (NF) participation in the Medicaid program, and authorizes the Secretary of Health and Human Services (the Secretary) to promulgate regulations implementing those statutory provisions. 42 U.S.C. §§ 1395i-3, 1396r. The Secretary's regulations are found at 42 C.F.R. Parts 483 and 488. To participate in the Medicare program, an SNF must maintain substantial compliance with program requirements. To be in substantial compliance, an SNF's deficiencies may "pose no greater risk to resident health or safety than the potential for causing minimal harm." 42 C.F.R. § 488.301. "Noncompliance" means "any deficiency that causes a facility to not be in substantial compliance." 42 C.F.R. § 488.301.

The Secretary contracts with state agencies to conduct periodic surveys to determine whether SNFs are in substantial compliance. 42 U.S.C. § 1395aa(a); 42 C.F.R. § 488.10. The Act authorizes the Secretary to impose enforcement remedies against SNFs that do not comply with Medicare participation requirements. 42 U.S.C. § 1395i-3(h)(2). The regulations specify enforcement remedies that CMS may impose if a facility is not in substantial compliance those requirements. 42 C.F.R. § 488.406. Among other enforcement remedies, CMS may impose a per-day CMP for the number of days a facility is not in substantial compliance or a per-instance CMP for each instance of the facility's noncompliance. 42 C.F.R. § 488.430(a). A per-day CMP, which CMS imposed in this case, may range from $50 to $3,000 per day for less serious noncompliance. CMS may also impose a DPNA. 42 C.F.R. § 488.417. If CMS imposes a CMP based on a noncompliance determination, then the facility may request a hearing before an administrative law judge to challenge the noncompliance finding and enforcement remedy. 42 U.S.C. §§ 1320a-7a(c)(2), 1395i(h)(2)(B)(ii)); 42 C.F.R. §§ 488.408(g), 488.434(a)(2)(viii), 498.3(b)(13).

Countryside is a long term care facility located in Palm Harbor, Florida, which participates as an SNF in the Medicare program and an NF in the Medicaid program. Hearing Request ¶ 1. CMS determined that Countryside was noncompliant with Medicare program participation requirements based on three surveys that the Florida Agency for Health Care Administration (survey agency) conducted, which were completed on January 14, 2014, February 19, 2014, and April 17, 2014. CMS Exhibits (Exs.) 1, 6-8; Petitioner (P.) Exs. 7, 8. Based on the January 2014 survey and the February 2014 revisit survey/complaint survey, CMS issued an initial determination on April 9, 2014, in which it imposed a $200 per-day CMP effective January 14, 2014; the per-day CMP continued until Countryside returned to substantial compliance. CMS Ex.

8 at 1-3. The notice also informed Countryside that CMS would impose a discretionary DPNA beginning April 24, 2014, if it did not return to substantial compliance before that date, and termination from the Medicare program, if it did not return to substantial compliance by July 14, 2014. CMS Ex. 8 at 2.

The survey agency completed a second revisit survey/standard survey on April 17, 2014. The surveyors determined that Petitioner corrected the deficiencies, cited during the January and February 2014 surveys, as of March 7, 2014. CMS Ex. 30; P. Ex. 9. Therefore, the initial period during which CMS imposed enforcement remedies was January 14, 2014, through March 6, 2014. However, this CMP was resolved when Petitioner waived its right to appeal these enforcement remedies in exchange for a 35% waiver reduction in the CMP amount imposed from January 14 through March 6. Joint Stipulation of Facts and Issues at 3.

CMS also conducted a standard survey on April 17, 2014, and identified three new deficiencies:

1. 42 C.F.R. § 483.20(e), (m) (preadmission screening requirements) (F-Tag 285, scope and severity (s/s) of E (pattern, no actual harm with potential for more than minimal harm that is not immediate jeopardy));

2. 42 C.F.R. § 483.35(i)(3) (disposing of garbage properly) (F-Tag 372, s/s of C (widespread, no actual harm with potential for minimal harm)); and

3. 42 C.F.R. § 483.60(b), (d), and (e) (label, storage, and records of drugs and biologicals) (F-Tag 431, s/s of D (isolated, no actual harm with potential for more than minimal harm that is not immediate jeopardy)).

CMS Ex. 1; Joint Stipulation of Facts and Issues at 1.

On May 13, 2014, CMS issued another initial determination stating that, based on Petitioner's noncompliance identified during the April 17, 2014 survey, the previously imposed CMP of $200 per day, would continue to accrue at $200 per day, effective April 17, 2014. CMS Ex. 6. The notice also informed Petitioner that the DPNA, which went into effect on April 24, 2014, would remain in effect. CMS Ex. 6 at 2.

On June 2, 2014, the survey agency conducted a revisit survey and, based on this survey, CMS determined that Petitioner returned to substantial compliance on June 2, 2014. CMS Ex. 5. However, CMS subsequently changed the substantial compliance date to May 2, 2014. CMS Ex. 3.

Petitioner timely requested a hearing challenging the deficiencies cited in the April 17, 2014 survey, and the associated $200 per-day CMP and discretionary DPNA remedies

imposed. I issued an Acknowledgement and Prehearing Order that established a prehearing exchange schedule for the parties. Prior to the initial prehearing exchanges, counsel for the parties filed a very helpful joint stipulation concerning facts and issues in the case. In relevant part, the parties stipulated that the enforcement remedies in dispute are the $200 per-day CMP from March 7, 2014, to May 2, 2014, and the DPNA from April 24, 2014, to May 2, 2014. Further, Petitioner only disputes the noncompliance finding under 42 C.F.R. § 483.20(e), (m), but no longer disputes deficiencies under 42 C.F.R. §§ 483.35(i)(3) and 483.60(b), (d), (e). Joint Stipulation of Facts and Issues at 3.

CMS filed its pre-hearing brief (CMS Br.) along with 30 exhibits (CMS Exs. 1-30) and Petitioner filed its pre-hearing brief (P. Br.) and 10 exhibits (P. Exs. 1-10). In compliance with my prehearing order, the parties filed written direct testimony for their proposed witnesses. CMS offered a state surveyor (CMS Ex. 29) as a witness. Petitioner offered its Administrator (P. Ex. 1) and Admissions Coordinator (P. Ex. 2) as witnesses. The parties requested to cross-examine these witnesses.

II. Decision on the Record

I admit all of the proposed exhibits into the record because neither party objected to any of them.

I scheduled a hearing in this case for July 28, 2015. However, just prior to the hearing, counsel for the parties waived cross-examination of the opposing party's witnesses and requested that I issue a decision on the written record. I cancelled the hearing and set a final briefing schedule. The parties filed closing briefs (CMS Closing Br. and P. Closing Brief). Petitioner confirmed its waiver of its right to an oral hearing. P. Closing Br. at 1. Therefore, I issue this decision based on the written record. 42 C.F.R. § 498.66.

III. Issues

1. Whether Petitioner was in substantial compliance with the Medicare program participation requirement at 42 C.F.R. § 483.20(e), (m).

2. Whether the imposition of a $200 per day CMP from March 7, 2014, through May 1, 2014, is reasonable, and whether a DPNA from April 24, 2014, through May 1, 2014, is appropriate.

IV. Jurisdiction

I have jurisdiction to hear and decide this case. 42 U.S.C. §§ 1320a-7a(c)(2), 1395i(h)(2)(B)(ii)); 42 C.F.R. §§ 488.330(e)(3), 488.408(g)(1), 498.3(a)(3)(ii), 498.3(b)(13).

V. Findings of Fact, Conclusions of Law, and Analysis[1]

1. None of the residents identified in the Statement of Deficiencies suffered from a mental illness or an intellectual disability.

The survey agency's Statement of Deficiencies indicates that Countryside failed to meet 42 C.F.R. § 483.20(e), (m) because, "[b]ased on resident record review and staff interview, [Countryside] failed to ensure ten of ten resident records reviewed (#191, #10, #15, #79, #152, #175, #179, #195, #198 and #199) had completed Level I Pre Admission Screen and Resident Review (PASRR) screens prior to their admission to the nursing facility."[2] CMS Ex. 1 at 1-2; *see also* CMS Ex. 29 ¶¶ 3-5. Countryside's deficiency is summed up in testimony by a survey agency employee:

> [T]he PASRR [Level I] screen is a mandatory pre-admission resident assessment process to determine the appropriateness of the resident's placement and the proper plan of care based on the resident's mental condition. The PASRR screen is required to ensure the safety of the resident being admitted and the other residents already residing in the facility.
>
> [Countryside] failed to comply with this requirement by admitting those 10 residents before completing the PASSR screen. At the time each of these residents was admitted, the facility did not have a comprehensive determination on the mental condition of the resident. For some residents, the PASRR screen was not completed for 10 - 17 days after they had been admitted. Such practice posed potential for more than minimal harm to the residents.

CMS Ex. 29 ¶¶ 6-7.

In response to this deficiency, Countryside agreed that all ten residents' records included PASSR forms completed after Countryside admitted the residents. However, Countryside asserted that all of the identified residents had PASSR Level I forms completed by a discharging provider prior to admission to Countryside, but that the discharging providers had failed to provide the completed PASSR Level I forms to

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[1] My findings of fact and conclusions of law are set forth in italics and bold font.

[2] The acronym PASRR is currently accurate; however, before a 1996 statutory change, the acronym for this review was PASARR. *St. Catherine's Care Center of Findlay, Inc.*, DAB No. 1964, n. 7 (2005).

Countryside. P. Br. at 4-5. The only exception was Resident 79, whose PASSR form was completed on the day of his admission to Countryside. P. Br. at 4 n.2; P. Ex. 1 ¶ 13. Petitioner submitted copies of the completed PASSR Level I forms that it obtained from the discharging providers when it implemented its plan of correction subsequent to receiving the Statement of Deficiencies. P. Br. at 5 n.3; P. Ex. 1 ¶ 12.

In this proceeding, Countryside provided testimony to explain why it did not have copies of timely completed PASSR Level I forms in the residents' records. Countryside normally asks all providers seeking to have a patient admitted to Countryside whether the provider completed the correct PASSR forms, and "[n]o admissions are agreed to by [Countryside's] admission personnel unless they have received assurances that the resident has been screened and is eligible for admission." P. Ex. 1 ¶ 7; *see also* P. Ex. 2 ¶ 7. Countryside asserts that under Florida law, discharging hospitals are responsible for completing the PASSR Level I form. P. Ex. 1 ¶ 7; P. Ex. 4 at 1. However, some providers fail to provide the PASRR Level I form. P. Ex. 1 ¶ 8; P. Ex. 2 ¶ 7. If the provider does not provide a copy of the PASSR Level I form by the day on which the resident is admitted, Countryside continues to request the provider to send it. P. Ex. 1 ¶ 8. Despite this, some providers never provide the completed form. P. Ex. 2 ¶ 7.

CMS responded to Countryside's position in this case by arguing that: the PASRR Level I forms allegedly completed by discharging providers are not authenticated; Countryside provided no written procedures concerning how it obtains PASRR Level I forms from discharging providers; Countryside provided no evidence that it followed its alleged procedures for obtaining PASRR Level I forms for the residents identified in the Statement of Deficiencies; and Residents 152, 179, 195, and 199 were not directly referred for admission from a hospital. CMS Closing Br. at 6-10.

The following is a summary of the record related to admission dates and completion of PASRR Level I forms for each resident identified in the Statement of Deficiencies.

a. Countryside admitted Resident 10 on March 17, 2014, from a hospital. CMS Ex. 10 at 1; *see also* CMS Ex. 1 at 3. The PASRR Level I documentation located in the resident's record at the time of the survey was not completed until April 1, 2014. CMS Ex. 10 at 3; *see also* CMS Ex. 1 at 3. Countryside obtained PASRR Level I documentation from the hospital dated March 17, 2014, the date of the resident's admission to Countryside. P. Ex. 6 at 6.

b. Countryside admitted Resident 15 on December 20, 2013, from a hospital. CMS Ex. 14 at 1; *see also* CMS Ex. 1 at 3. The PASRR Level I documentation located in the resident's record at the time of the survey was

not completed until December 26, 2013. CMS Ex. 14 at 3; *see also* CMS Ex. 1 at 3. Countryside obtained PASRR Level I documentation from the hospital dated December 15, 2014. P. Ex. 6 at 8.

c. Countryside admitted Resident 79 on April 7, 2013, from a hospital. CMS Ex. 15 at 1; *see also* CMS Ex. 1 at 3-4. There was no PASSR Level I document in the resident's record related to this admission. CMS Ex. 1 at 4. Resident 79 was readmitted to Countryside on January 3, 2014, from a hospital. CMS Ex. 15 at 1; *see also* CMS Ex. 1 at 4. The PASRR Level I documentation located in the resident's record at the time of the survey was not completed until January 14, 2014. CMS Ex. 15 at 3; *see also* CMS Ex. 1 at 4. Countryside obtained PASRR Level I documentation from the hospital dated April 7, 2013, and January 3, 2014. P. Ex. 6 at 11, 31.

d. Countryside admitted Resident 152 on March 18, 2014, following a hospital stay shortly before admission. CMS Ex. 16 at 1; CMS Ex. 1 at 4. The PASRR Level I documentation located in the resident's record at the time of the survey was not completed until April 4, 2014. CMS Ex. 16 at 1, 3; *see also* CMS Ex. 1 at 4. Countryside obtained PASRR Level I documentation from the hospital dated March 11, 2014. P. Ex. 6 at 14.

e. Countryside admitted Resident 175 on December 5, 2013, from a hospital. CMS Ex. 17 at 1; *see also* CMS Ex. 1 at 4. The PASRR Level I documentation located in the resident's record at the time of the survey was not completed until December 10, 2013. CMS Ex. 17 at 3; *see also* CMS Ex. 1 at 5. Countryside obtained PASRR Level I documentation from the hospital dated December 4, 2014. P. Ex. 6 at 17.

f. Countryside admitted Resident 179 on January 23, 2014, from a non-hospital setting. CMS Ex. 18 at 1; *see also* CMS Ex. 1 at 5. The PASRR Level I documentation located in the resident's record at the time of the survey was not completed until January 27, 2014. CMS Ex. 18 at 3; *see also* CMS Ex. 1 at 5. Countryside provided PASRR Level I documentation from "CHCC" dated January 12, 2014. P. Ex. 6 at 19-20.

g. Countryside admitted Resident 191 on March 7, 2014, from an acute care hospital. CMS Ex. 19 at 1; *see also* CMS Ex. 1 at 3. The PASRR Level I documentation located in the resident's record at the time of the survey was not completed until March 17, 2014. CMS Ex. 19 at 3; *see also* CMS Ex. 1 at 3. Countryside obtained PASRR Level I documentation from the hospital dated March 7, 2014, the date of the resident's admission to Countryside. P. Ex. 6 at 3.

h. Countryside admitted Resident 195 on March 21, 2014, following a hospital stay shortly before admission. CMS Ex. 20 at 1; *see also* CMS Ex. 1 at 5. The PASRR Level I documentation located in the resident's record at the time of the survey was not completed until March 25, 2014. CMS Ex. 20 at 3; *see also* CMS Ex. 1 at 5. Countryside obtained PASRR Level I documentation from the hospital dated March 21, 2014. P. Ex. 6 at 23.

i. Countryside admitted Resident 198 on April 10, 2014, from a hospital. CMS Ex. 21 at 1; *see also* CMS Ex. 1 at 5. The PASRR Level I documentation located in the resident's record at the time of the survey was not completed until April 11, 2014. CMS Ex. 21 at 3; *see also* CMS Ex. 1 at 6. Countryside obtained PASRR Level I documentation from the hospital dated November 13, 2013. P. Ex. 6 at 26.

j. Countryside admitted Resident 199 on April 9, 2014. CMS Ex. 22 at 1; *see also* CMS Ex. 1 at 3. The PASRR Level I documentation located in the resident's record at the time of the survey was not completed until April 10, 2014. CMS Ex. 22 at 3; *see also* CMS Ex. 1 at 3; CMS Ex. 22 at 1. Countryside obtained PASRR Level I documentation from "MPH" dated April 9, 2014. P. Ex. 6 at 6.

Although there are disputes between the parties related to the dates when PASRR Level I evaluations occurred with relation to the residents identified in the Statement of Deficiencies, it is undisputed that none of the ten residents had a mental illness or an intellectual disability that would have affected their admission to Countryside. CMS Closing Br. at 11; CMS Ex. 13 at 3, CMS Ex. 14 at 3; CMS Ex. 15 at 3; CMS Ex. 16 at 3; CMS Ex. 17 at 3; CMS Ex. 18 at 3; CMS Ex. 19 at 3; CMS Ex. 20 at 3; CMS Ex. 21 at 3; CMS Ex. 22 at 3; P. Ex. 1 ¶ 12; P. Ex. 6 at 3, 6, 8, 11, 14, 17, 20, 23, 26, 28, 31. Therefore, I find that none of the ten identified residents were admitted to Countryside with a mental illness or intellectual disability.

2. Petitioner was in substantial compliance with Medicare program participation requirements at 42 C.F.R. § 483.20(m) because none of the residents identified in the Statement of Deficiencies suffered from a mental illness or an intellectual disability.

The Statement of Deficiencies asserts that Countryside violated the following regulation:

> (m) *Preadmission screening for mentally ill individuals and individuals with intellectual disability.*
>
> (1) A nursing facility must not admit, on or after January 1, 1989, any new resident with—

> (i) Mental illness as defined in paragraph (f)(2)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission,
>
> (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and
>
> (B) If the individual requires such level of services, whether the individual requires specialized services; or
>
> (ii) Intellectual Disability, as defined in paragraph (f)(2)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission—
>
> (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and
>
> (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability.
>
> (2) *Definition.* For purposes of this section—
>
> (i) An individual is considered to have *mental illness* if the individual has a serious mental illness as defined in §483.102(b)(1).
>
> (ii) An individual is considered to be *mentally retarded* if the individual is mentally retarded as defined in §483.102(b)(3) or is a person with a related condition as described in 42 CFR 435.1010 of this chapter.

42 C.F.R. § 483.20(m).[3]

[3] The Secretary originally promulgated this provision as section 483.20(f), effective March 23, 1998; however, the Secretary relocated this provision to section 483.20(m). 62 Fed. Reg. 67,174, 67,211 (Dec. 23, 1997); 56 Fed. Reg. 48,826, 48,872 (Sept. 26, 1991).

Although CMS admits that none of the ten residents identified in the Statement of Deficiencies had a mental illness or an intellectual disability, CMS argues that Countryside's failure to have completed PASRR Level I documentation in the residents' records at the time of the state survey supports a violation under 42 C.F.R. § 483.20(m). CMS's argues that the Secretary's regulations implementing the PASRR requirement provide that a state may delegate responsibility to perform PASRR Level I evaluations to NFs and that a Florida regulation obligates NFs to perform the PASRR Level I screening and maintain a record of that screening for several years. CMS Closing Br. at 3-5, 9-11.

Petitioner argues that the PASRR regulations are separate from the regulations governing SNFs and, in any event, they place duties on state agencies and not SNFs concerning the completion of PASSR Levels I and II screening. P. Br. at 5-7. As argued by Petitioner:

> Instead, CMS' proposed deficiency is based entirely on its belief that the other regulatory component of . . . 42 C.F.R. §483.20(m), requires a facility to "ensure" a PASSR [sic] screen is done. Subsection (m)(1) does not mention anything about nursing homes "ensuring" that PASRR screens are completed prior to a resident's admission. It simply prohibits admission of any resident with [mental illness] or [intellectual disabilities] unless such resident has a Level II evaluation.

P. Br. at 7. Therefore, according to Petitioner, "the appropriate inquiry [under section 483.20(m)] would be to determine if the facility admitted a resident with [Intellectual disabilities] or [mental illness]." P. Br. at 8. As explained below, I agree with Petitioner that 42 C.F.R. § 483.20(m) is meant to enforce the requirement that facilities not admit residents who have mental illness or intellectual disabilities without PASRR Level II evaluations that conclude those residents need the services provided by a facility.

The primary statutory provision mandating PASRR is located in section 1919(b)(3)(F) of the Act. 42 U.S.C. § 1396r(b)(3)(F). This statute is nearly identical to the requirements in 42 C.F.R. § 483.20(m).[4] Indeed, the Secretary promulgated 42 C.F.R. § 483.20(m) to implement section 1919(b)(3)(F). 56 Fed. Reg. 48,826, 48,847 (Sept. 26, 1991). Section 1919(e)(7)(A)(i) of the Act requires states to establish PASRR programs that will conduct the necessary evaluations required under section 1919(b)(3)(F). *Id*. § 1396r(e)(7)(A)(i). Significantly, and perhaps emphatically, section 1919(b)(3)(F) and (e)(7)(A)(i) each prohibit states from delegating their responsibility to conduct PASRR evaluations to NFs. *Id*. § 1396r(b)(3)(F), (e)(7)(B)(4).

[4] Although PASRR is a Medicaid requirement, it applies to SNFs that are also Medicaid enrolled NFs. 57 Fed. Reg. 56,450, 56,453 (Nov. 30, 1992). Countryside is such a facility and subject to 42 C.F.R. part 483, subpart B and the PASRR requirement. Hearing Request ¶ 1.

The Secretary promulgated regulations to implement the PASRR requirement. 42 C.F.R. part 483, subpart C. Consistent with the statute, the PASRR regulations make it an obligation of the states to implement a program to ensure preadmission screening of individuals for mental illness or intellectual disabilities before an NF admits them as residents. 42 C.F.R. § 483.104-106. The regulations also created two levels of PASRR functions. *Id*. § 483.128. As described in the regulations:

> The State's PASARR program must identify all individuals who are suspected of having [mental illness] or [intellectual disabilities] as defined in §483.102. This identification function is termed Level I. Level II is the function of evaluating and determining whether NF services and specialized services are needed.

Id. § 483.128(a). Consistent with the Act, the Secretary prohibited states from delegating to NFs the PASRR "evaluation and determination functions." *Id*. § 483.106(e)(1)(iii). As explained in the final rule establishing the PASRR regulations:

> Since nursing facilities have a direct interest in the eligibility determinations that are to be made for those individuals subject to the PASARR requirements, there is a potential conflict of interest in permitting them to make these determinations. Thus, it was the Committee's view in 1987—as it is today—to prohibit nursing facilities (or their related entities) to participate, in any way, in the PASARR process.

57 Fed. Reg. 56,450, 56,460 (Nov. 30, 1992). However, the Secretary placed no prohibition on a state delegating the Level I function to NFs.

> We believe it is necessary to clarify that this new provision in no way impairs our authority to require that NFs conduct Level I screenings. **Level I identification is, in effect, a pre-PASARR activity designed to determine who is subject to PASARR.** We also wish to clarify that the statute prohibits NFs and similar "entities" from conducting PASARR.

Id. at 56,460 (emphasis added); *see also* 57 Fed. Reg. at 56,482 ("With regard to whether a State may require a facility to perform a Level I screen, we believe it is well within the authority of a State to require that hospitals and nursing facilities identify individuals who require screening under PASARR."). In further response to public comments challenging the Secretary's authority to permit states to delegate the Level I function to NFs, the Secretary stated:

> We do not agree with the commenters who suggest that requiring Level I screens is not within the scope of our authority. We have elsewhere noted, and courts have accepted, the fact that the requirement in section 1919(e)(7) of the Act for screening **presupposes the existence of a mechanism for identifying persons for whom a screening is necessary.** We also believe that it is within the authority of States implementing these regulations to require that this review be done by NFs.
>
> . . .
>
> It is also clear to us that some commenters misunderstood the purpose of the Level I screening step. **Its purpose is to identify for further screening those individuals for whom it appears that a diagnosis of mental illness or mental retardation is likely. . . .** It is the purpose of Level II screening to make the appropriate finding based on an expert evaluation.
>
> . . .
>
> First, OBRA '90 prohibited States from delegating any of their PASARR responsibilities to NFs. We do not believe that this provision in any way hinders States from using NFs to perform Level I identifications. **The actual PASARR is accomplished through Level II.**

57 Fed. Reg. at 485-486 (emphasis added).

Therefore, the Level I function is not actually PASRR screening, but merely a preliminary mechanism for identifying individuals for whom PASRR screening is necessary. As the Secretary stated, it was necessary to establish a method to determine which individuals need a PASRR evaluation. Because the Level I function is not actually PASRR screening, states may delegate to NFs the responsibility to perform that function. If the Level I function were PASRR screening, both the Act and regulations would prohibit that delegation. Because the Level I function is not actually PASRR, an NF's failure to comply with a state requirement that it conduct and keep Level I documentation for the residents it admits is not a violation of 42 C.F.R. § 483.20(m).

A facility only violates 42 C.F.R. § 483.20(m) when it admits a resident with mental illness or intellectual disabilities when no PASRR Level II evaluation has been completed. In the present case, there is no dispute that none of the ten residents identified in the Statement of Deficiencies had mental illness or intellectual disabilities. Therefore, I conclude that Countryside was in substantial compliance with 42 C.F.R. § 483.20(m).[5]

3. Petitioner was in substantial compliance with Medicare program participation requirements at 42 C.F.R. § 483.20(e) because none of the residents identified in the Statement of Deficiencies required PASSR Level II evaluations and, in any event, there is no evidence that any of Petitioner's actions caused duplicative testing or effort.

The Statement of Deficiencies indicated that Countryside was not in substantial compliance with 42 C.F.R. § 483.20(e). The regulations states:

> *Coordination.* A facility must coordinate assessments with the preadmission screening and resident review program under Medicaid in part 483, subpart C to the maximum extent practicable to avoid duplicative testing and effort.

This requirement is primarily aimed at coordinating PASRR Level II evaluations with other testing that is needed for residents with mental illnesses or intellectual disabilities. *See* 62 Fed. Reg. 67,174, 67,200-67,201 (Dec. 23, 1997). As indicated above, this case does not involve PASSR Level II screenings. Further, CMS makes no argument as to how Petitioner failed to be in substantial compliance with this Medicare program participation requirement. Therefore, I conclude that Petitioner was in substantial compliance with 42 C.F.R. § 483.20(e).

4. I conclude that a $200 per-day CMP is reasonable, but modify the duration of the $200 per-day CMP to April 24, 2014, through May 1, 2014, because Petitioner was in substantial compliance with 42 C.F.R. § 483.20(e) and (m).

Based on my findings and conclusions above, I modify the duration of the CMP imposed from March 7, 2014, through April 16, 2014. Because the alleged noncompliance with 42 C.F.R. § 483.20(e), (m) was the only noncompliance cited for the period prior to the April 17 survey, there is no longer any basis to impose a penalty back to March 7, 2014.

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[5] CMS argues that Florida regulations require Countryside to conduct the PASRR Level I screening and keep documentation of that screening in the resident's records for five years. *See* Fla. Admin. Code R. 59G-1.040. It is possible that Countryside violated Florida Medicaid regulations; however, this tribunal has no authority to enforce Florida law.

See CMS Ex. 1 at 2-7, 10-12; *see also* Joint Stipulation of Facts and Issues at 3. However, as explained below, there is a basis to affirm the $200 per-day CMP from April 17, 2014, to May 1, 2014.

As noted earlier, during the April 17, 2014 survey, the surveyors also cited Petitioner with two additional deficiencies that it does not challenge: 42 C.F.R. § 483.35(i)(3) (disposing of garbage properly) (F-Tag 372, s/s of C); and 42 C.F.R. § 483.60(b), (d), and (e) (label, storage, and records of drugs and biologicals) (F-Tag 431, s/s of D). These two deficiencies are now administratively final. 42 C.F.R. § 498.20(b)(2).

The more serious of the two conceded deficiencies is the violation of 42 C.F.R. § 483.60(b), (d), and (e) (label, storage, and records of drugs and biologicals). The Statement of Deficiencies states:

> Based on observation, interview, and record review, [Countryside] failed to store biologicals and medications with current unexpired dating to maintain the pharmaceutical integrity of time sensitive biologicals in two . . . of two treatment carts, three . . . of five medication carts and one . . . of two medication rooms.

CMS Ex. 1 at 9-10. Some of the surveyor observations include expired medications; medication without an open or use by date, and defaced manufacturers expiration date; unopened bottle with expiration date torn off; expired creams which appeared to be in use; topical medications more than seven-months expired; expired inhalant medication; expired suppositories; and expired over-the-counter medication that was yet to be used. Petitioner's own policy and procedure for expired medications instructed that all bottles maintain an expiration date on the label, that the staff should record the date opened on the medication container, and that staff not retain medications or biologicals longer than recommended. CMS Ex. 1 at 12. These findings evidenced Petitioner's systemic failure to properly monitor medications. CMS Ex. 1 at 8-12.

To determine whether a CMP is reasonable, I apply 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. 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 section 488.438(f) factors.

In regard to the amount of the per-day CMP, the deficiencies at 42 C.F.R. § 483.60(b), (d), (e) are sufficient to support the $200 per-day CMP from April 17, 2014, through May 1, 2014. It must be noted that the $200 amount is close to the minimum daily amount that CMS can impose absent immediate jeopardy. 42 C.F.R. § 488.438(a)(l)(ii). Further, just in this case alone, Petitioner has evidenced a history of substantial noncompliance. P. Exs. 7, 8. Further, Petitioner has not made any argument that its financial condition will not permit payment of a $200 per-day CMP lasting approximately two weeks in duration. Petitioner's conduct in relation to section 483.60 appeared to show indifference to ensuring that drugs were properly labeled because there were numerous instances of this violation observed by the surveyors.

5. CMS had a legitimate basis to impose a DPNA from April 24, 2014, through May 1, 2014, because Petitioner was noncompliant with 42 C.F.R. § 483.60, and I do not have authority to reverse that decision.

Petitioner asserts that CMS had no basis to impose a DPNA in this case. However, CMS may impose a DPNA any time there is a breach of substantial compliance. 42 C.F.R. § 488.417(a); *see Ridgecrest Healthcare v. CMS*, DAB No. 2598 (2014) (holding that "42 C.F.R. § 488.417(a)[] authoriz[es] a DPNA when a facility is not in substantial compliance with the participation requirements"). Based on the violations of 42 C.F.R. § 483.60, CMS had a legitimate basis to impose a DPNA, and I have no authority to reverse that discretionary decision. 42 C.F.R. § 498.3(c)(13).

Order

Based on the foregoing, I hereby order the following:

1) CMS's determination that Petitioner was not in substantial compliance with 42 C.F.R. § 483.60(b), (c), (d) is AFFIRMED;

2) CMS's determination that Petitioner was not in substantial compliance with 42 C.F.R. § 483.20(e), (m) is REVERSED;

3) CMS's imposition of a $200 per-day CMP from March 7, 2014, to May 1, 2014, is MODIFIED to be a $200 per-day CMP from April 17, 2014, to May 1, 2014.

/s/
Scott Anderson
Administrative Law Judge