Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Nightingale Home Healthcare, Inc.
(CCN: 15-7474),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-16-254

Decision No. CR4605

Date: May 9, 2016

DECISION

I sustain the determination of the Centers for Medicare & Medicaid Services (CMS) to impose the following remedies against Petitioner Nightingale Home Healthcare, Inc.:

- Termination of Petitioner's participation in the Medicare program effective December 10, 2015.

- Imposition of civil money penalties in the amount of $10,000 per day for each day of a period that began on November 9, 2015, and ending December 10, 2015.

I base my decision on evidence establishing that Petitioner violated regulatory conditions governing its participation in Medicare and that the level of its noncompliance was so egregious as to put Medicare beneficiaries at immediate jeopardy.

I. Background

Petitioner requested a hearing to challenge CMS's remedy determinations.[1] The parties agreed that the case could be heard based on their written exchanges. CMS submitted a brief (CMS Br.) plus 56 proposed exhibits that it identified as CMS Ex. 1 – CMS Ex. 56. Petitioner submitted a brief (P. Br.) plus 20 proposed exhibits that it identified as P. Ex. 1 – P. Ex. 20. It also submitted seven additional exhibits consisting of written declarations of witnesses and related documents that it did not identify. I identify these as follows: declaration of Sharon Kennell – P. Ex. 21; declaration of Michelle Olson – P. Ex. 22; declaration of Barry Mathis – P. Ex. 23; declaration of Piper Brar (with attached documents) – P Ex. 24; declaration of Toshia Hicks – P. Ex. 25; declaration of Joseph V. Basile – P. Ex. 26; and curriculum vitae of Sharon Kennell – P. Ex. 27. I receive into the record CMS Exs. 1-56 and P. Exs. 1-27.

II. Issues, Findings of Fact and Conclusions of Law

A. Issues

The issues are whether Petitioner failed to comply with one or more conditions governing Medicare participation of home health agencies at a level of noncompliance that comprises immediate jeopardy for patients under Petitioner's care, and whether CMS's remedy determinations are authorized by applicable regulations.

B. Findings of Fact and Conclusions of Law

In order to participate in Medicare a home health agency such as Petitioner must comply with conditions of participation that are established at 42 C.F.R. Part 484. Failure by an agency to comply with even one condition of participation is grounds for CMS to terminate that agency's Medicare participation. Social Security Act (Act) § 1866(b)(2); 42 C.F.R. § 489.53(a)(3). If there is a finding of immediate jeopardy-level noncompliance then CMS will terminate an agency's participation no more than 23 days from the last day of the survey at which the finding of immediate jeopardy was made. 42 C.F.R. § 488.825(a).[2] The term "immediate jeopardy" is defined by regulations to

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[1] A federal bankruptcy court enjoined CMS's imposition of a remedy. I understand that the bankruptcy court's order is presently under appeal.

[2] In fact, CMS may terminate a home health agency's participation in an immediate jeopardy situation with less than 23 days' notice. The regulations authorize "immediate" termination where immediate jeopardy is found. 42 C.F.R. § 488.825(a)(1). Where termination of participation is imposed because of immediate jeopardy CMS may give the home health agency only two days' notice of the termination. 42 C.F.R. § 489.53(d)(2)(B)(iii). Thus, termination on 23 days' notice in an instance of immediate

mean "a situation in which the . . . [home health agency's] noncompliance with one or more requirements of participation has caused, or is likely to cause serious injury, harm, impairment, or death to a patient(s)." 42 C.F.R. § 488.805. Where there is a finding of immediate jeopardy and a home health agency challenges that finding, the finding may be overturned only where there is a showing that CMS's determination is clearly erroneous. 42 C.F.R. § 498.60(c)(2).

The regulations authorize imposition of remedies in addition to termination of participation in the instance of a home health agency's noncompliance with participation requirements. These remedies include civil money penalties. 42 C.F.R. § 488.820(a). Penalties may be imposed for each day of an agency's noncompliance regardless whether there is a finding of immediate jeopardy. 42 C.F.R. § 488.845(a)(1). Penalties of up to $10,000 per day may be imposed where there is immediate jeopardy that results in actual harm to residents. 42 C.F.R. § 488.845(a)(3)(i). There are additional regulatory factors that may be considered in determining the appropriate amount of a civil money penalty. 42 C.F.R. § 488.815(a)-(f), including: the extent to which deficiencies pose immediate jeopardy; the nature, incidence, manner, degree, and duration of deficiencies or noncompliance; the agency's overall compliance history and the presence of repeat deficiencies; the extent to which deficiencies are directly related to the failure to provide quality patient care; the extent to which an agency is part of a larger organization with performance problems; and, an indication of any system-wide failure to provide quality care.

The evidence in this case overwhelmingly proves that Petitioner failed to comply with more than one condition of participation and that its noncompliance put its patients in immediate jeopardy. Petitioner was surveyed twice on behalf of CMS – on November 9, 2015, and again on December 10, 2015 – and each survey established immediate jeopardy-level noncompliance. As I discuss above, CMS could have terminated Petitioner's participation on as early as November 9, 2015, based on the noncompliance findings made at the November survey. It had additional, albeit unnecessary, justification to terminate Petitioner's participation based on the evidence of noncompliance unearthed at the December 10 survey. CMS's determination to terminate Petitioner's participation is thus more than supported by the evidence.

Moreover, there is powerful evidence to support imposition of civil money penalties of $10,000 per day against Petitioner for each day of the period beginning on November 9, 2015, and ending on December 10, 2015. Petitioner manifested immediate jeopardy-level noncompliance throughout this period and the noncompliance was particularly egregious in that it harmed patients.

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jeopardy-level noncompliance is a matter of administrative discretion and not a legal requirement.

CMS found that Petitioner violated numerous conditions of participation at both the November and December surveys. I find it unnecessary to address all of these instances of noncompliance. CMS has imposed remedies that are only available upon a finding of immediate jeopardy, including the termination of Petitioner's provider agreement within 23 days of the last survey and a $10,000 per day civil money penalty. *See* 42 C.F.R. §§ 488.825, 488.820. Therefore, I address only the findings of immediate jeopardy-level noncompliance made by CMS at the November survey and evidence establishing that Petitioner failed to eliminate immediate jeopardy as of the December survey. These findings and their supporting evidence, in and of themselves, are sufficient basis for the remedies that CMS elected to impose.

1. Immediate jeopardy-level noncompliance at the November survey.

a. Failure to comply with the condition stated at 42 C.F.R. § 484.18.

The applicable regulation requires that patients of a home health agency be "accepted for treatment on the basis of a reasonable expectation that the patient's medical, nursing, and social needs can be met adequately by the agency in the patient's place of residence" and that care follow "a written plan of care established and periodically reviewed by a doctor . . . ." 42 C.F.R. § 484.18.

Petitioner violated these requirements so egregiously that it caused immediate jeopardy for its patients:

- Its staff frequently failed to conduct patient visits according to the patients' care plans and physicians' orders. CMS Ex. 3 at 222-350. These frequent failures to provide care not only were derelictions of the condition requiring Petitioner to meet patients' nursing needs but they harmed or placed patients at great risk for harm. For example, Petitioner's staff neglected Patient 4 egregiously in direct violation of his physician's orders. It failed to provide the patient with prescribed home health visits for a period of nearly a month, failed to ensure the patient's certification for home health was up-to-date, failed to provide him with prescribed care, and failed to carry out the patient's physician's orders. When Petitioner finally sent a nurse to visit the patient he was discovered to be suffering from a life-threatening infection (sepsis).

  Patient 4 required the use of a Foley catheter and had a history of urinary tract infections. I take notice that a Foley catheter is a catheter that is inserted into a patient's bladder in order to drain the bladder of urine. Patient 4's physician ordered that the catheter be changed monthly and as needed and that the patient receive bladder irrigation with a sterile solution as needed. CMS Ex. 9 at 20. In spite of these orders Petitioner's staff failed to provide care to the resident in

September and early October 2015, not sending a registered nurse to see the patient during a period of about a month. CMS Ex. 9 at 54.[3] Petitioner's staff also failed to reassess the patient during this period and failed to revise the patient's plan of care as needed. CMS Ex. 50 ¶ 136. As of September 7, 2015, Patient 4's certification period ended with no recertification, nor was there any update to Patient 4's care plan for further skilled nursing care.[4] *Id.*; CMS Ex. 9 at 29; P. Ex. 2 at 22. Patient 4 was not discharged from Petitioner's care, either. CMS Ex. 50 ¶ 138; *see* 42 C.F.R. § 484.55(d)(3). Petitioner simply stopped providing skilled nursing visits. By October 5, 2015, Patient 4 had developed a fever and was lethargic. The patient's wife called his urologist who ordered a urinalysis be conducted as soon as possible. The patient's wife then called Petitioner and finally precipitated a home visit. When the nurse arrived on that date she found Patient 4 to be in severe distress. CMS Ex. 9 at 60. The patient was hospitalized and diagnosed to be suffering from sepsis. *Id.* at ¶ 124.

There were numerous other instances in which Petitioner's staff failed to conduct scheduled or ordered patient visits. Patients who did not receive visits included Patients 1, 5, 10, 11, 12, 13, and 14. CMS Ex. 50 ¶¶ 69, 229, 346, 395, 420, 452; CMS Ex. 51 ¶¶ 16, 29; CMS Ex. 55 at 20.

- Petitioner failed to provide its patients with care that conformed to the residents' written care plans and physicians' orders. This failure was shown most notably in the failure of Petitioner's staff to monitor the effects of the anti-coagulant Coumadin on Patient 1 and to notify the patient's physician that the patient was experiencing extremely adverse effects from administration of Coumadin.

  On August 11, 2015, at an initial assessment, the patient showed a Prothrombin Time/International Normalized Ration (PT/INR) reading of 5.1. CMS Ex. 7 at 121. I take notice that PT/INR is a measurement of the time it takes for an

[3] The evidence establishes that the nurse who had been seeing Patient 4 on a regular basis was injured in early September 2015 and stopped making visits to the patient. *Id.* In the ensuing weeks Patient 4's wife called Petitioner on numerous occasions in an unsuccessful effort to have a nurse come and visit the patient. CMS Ex. 6 at 11.

[4] Petitioner points out that an addendum to Patient 4's care plan was effective between September 8 and November 6, 2015. P. Br. at 6; P. Ex. 2 at 22. That addendum only addressed home health aides, and did not include any other care for Patient 4. The addendum was likely just that – an addition to, not a replacement for, Patient 4's care. Indeed, Petitioner utterly fails to explain or produce any evidence as to why skilled nursing visits would have been eliminated for a patient that was ordered to have routine changes and monitoring of his indwelling Foley catheter, which is undeniably beyond the scope of a home health aide.

> individual's blood to clot. The higher the reading the longer it takes for blood to clot. Therapeutic INR range is between 2 and 3, and anything higher than 3 poses dangers to the patient from potential bleeding. CMS Ex. 50 ¶ 57. The patient's physician was notified and he left orders that Coumadin be withheld from the patient for two days and that the patient's PT/INR then be rechecked. *Id.* ¶ 58. The physician received no response for a week and finally called Patient 1's family directly. He learned that no PT/INR reading had been done for Patient 1 since August 11. *Id.* ¶ 60. A physician's note on August 20, 2015, says that Patient 1 needed a PT/INR test that day, but there is no evidence that test actually happened. CMS Ex. 7 at 159.
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> On August 24, 2015, the physician ordered Coumadin be restarted for Patient 1 and that the patient's PT/INR be read two days later. CMS Ex. 7 at 158. However, a nurse did not attempt to visit the patient until the evening of August 25, contrary to the patient's family's request that visits be made during morning hours. CMS Ex. 50 ¶ 68. A nurse finally checked the patient's PT/INR on August 28, 2015. *Id.* ¶ 72. On August 31, the patient's family informed Petitioner that the patient had been taken to the emergency room with an extremely high INR reading. CMS Ex. 7 at 17. Petitioner's staff did not notify the patient's physician about this situation.
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> On September 7, 2015, Patient 1 returned to the emergency room suffering from Coumadin toxicity. At the emergency room the patient's PT/INR reading was 11, indicating that the patient was at extreme risk for bleeding. CMS Ex. 7 at 222.

Petitioner's response to this evidence consists, in the main, with picking nits with the surveyors' findings. Indeed, Petitioner devotes much of its brief to finding fault with the procedures used by the surveyors, their manner of obtaining evidence, or in identifying alleged minor errors that the surveyors made. These arguments beg the question of Petitioner's compliance because they do not address the central findings that I have discussed above.

In particular, Petitioner does not deny the failure by its staff to provide maintenance of Patient 4's Foley catheter and to assess the resident for signs of infection. It does not deny that there were no visits by a registered nurse to Patient 4 during the period in September and early October 2015. Petitioner argues that on September 25, 2015, it sent a licensed practical nurse to visit Patient 4 to "check on supplies for . . . '[the patient's] feeding tube." P. Br. at 6. But, Petitioner does not assert that a registered nurse visited Patient 4 *at any time* between early September and October 5. Nor does Petitioner contend that its staff actually provided skilled maintenance of the patient's Foley catheter during the early September – October 5 period. Thus, CMS's assertions of immediate jeopardy-level noncompliance are unrebutted.

Petitioner argues that it is unfair to conclude that its staff caused Patient 4 to experience sepsis and subsequently to die through its failure to provide care to the resident. That assertion notwithstanding, the reasonable inference that I draw from the evidence is that Petitioner's staff's neglect of Patient 4 was a direct and contributing cause to the patient's development of an infection. The obvious reason that the patient's physician ordered regular checks of the patient's catheter and irrigation is that a catheter can be an entry point for infectious germs. Petitioner and its staff utterly disregarded the physician's instructions for a month, at the end of which time the resident had developed an infection later diagnosed as sepsis. That is far more evidence than one needs to infer cause and effect.

Nor does Petitioner provide credible rebuttal to the evidence that CMS offered concerning the care that its staff provided to Patient 1. It argues about the number of telephone contacts with the patient's physician and it accuses the surveyors of making inaccurate statements about the communications with members of the patient's family. But, these arguments are red herrings. At no point does Petitioner deny that its staff failed to do PT/INR tests as ordered and that it failed to communicate results to the patient's physician. At bottom, the deficiency asserted by CMS is that Petitioner failed to monitor Patient 1's clotting times closely and thereby allowed the patient to develop Coumadin toxicity. Petitioner offers no rebuttal to that.

b. Failure to comply with the condition stated at 42 C.F.R. § 484.30.

The regulation at issue requires a home health agency to provide "skilled nursing services by or under the supervision of a registered nurse and in accordance with [the patient's] plan of care." 42 C.F.R. § 484.30. CMS asserts that Petitioner's staff failed to comply with this requirement, specifically, in providing ordered care including wound care to patients, with the consequence that patients were put at grave risk for serious harm.

There is overwhelming evidence to support this assertion. That evidence is particularly strong in the case of the care that Petitioner's staff provided to Patient 5. The care that Petitioner's staff provided to this patient is not only poorly documented but it is impossible to discern from Petitioner's own records exactly what care the staff provided to him. One cannot tell from the patient's record how many wounds the patient was suffering from nor can one discern the condition of these wounds or precisely what treatment the patient was receiving for them. CMS Ex. 50 ¶¶ 197-237. For example, nurses used "Wound #1" to describe at least two separate wounds on Patient 5's legs and feet. CMS Ex. 10 at 77, 79. Other notes document a traumatic wound on Resident 5's right shin, while subsequent notes identify what is presumably the same wound on his left shin. CMS Ex. 10 at 79, 80, 83.

Such absent or poor documentation only supports the conclusion that Petitioner did not follow Patient 5's care plan for wound care. Moreover, the dangers posed by improper or poorly documented wound care are obvious. Infection is one obvious likely consequence of poor wound care. In the case of Patient 5 Petitioner's staff left the patient exposed to the risk of infection by failing to document the wound care that it provided to him. That is immediate jeopardy-level noncompliance.

CMS alleges also that Petitioner's staff violated the requirements of the regulation by providing unauthorized treatments to various patients and it offered evidence that strongly supports this assertion. CMS Ex. 50 ¶¶ 206, 440. In part, it appears that this problem stemmed from Petitioner's staff not reporting new issues to patients' physicians. *See, e.g.*, CMS Ex. 10 at 77; CMS Ex. 50 ¶ 208. These actions by Petitioner's staff further jeopardized patients. A home health agency may not provide treatments to residents that are not authorized by a physician.

Petitioner offered no evidence to rebut CMS's assertions. It does not deny that its staff failed to document the wound care that it provided (if it provided care at all) to Patient 5. Nor does it deny that its staff provided unauthorized treatments to some patients. It offers arguments concerning whether some of the care provided by its staff to Patient 5 was, in fact, authorized by a physician. But, whether or not this care was authorized, Petitioner's assertions fail to address the bulk of the evidence of immediate jeopardy-level noncompliance offered by CMS and certainly does not establish that the immediate jeopardy finding was erroneous.

2. Failure by Petitioner to prove that it had removed immediate jeopardy-level noncompliance as of the December survey.

As I discuss above CMS had the authority to terminate Petitioner's participation immediately based on the findings of immediate jeopardy-level noncompliance made at the November survey. It was under no obligation to allow Petitioner the opportunity to correct the deficiencies that had been identified. However, CMS held its imposition of the remedy of termination of participation in abeyance pending its receipt of several plans of correction from Petitioner and the outcome of the December revisit survey. CMS Ex. 37 at 33; CMS Ex. 38 at 1-2; CMS Ex. 50 ¶ 511.

The fact that CMS gave Petitioner the opportunity to correct its immediate jeopardy-level noncompliance did not confer any rights on Petitioner. It remained Petitioner's burden to prove that, in fact, it had eliminated immediate jeopardy. *Meridian Nursing Ctr.*, DAB No. 2265 at 21 (2009), *aff'd sub nom. Fal-Meridian Inc. v. U.S. Dept. of Health & Human Servs.*, 604 F.3d 445 (7th Cir. 2010). As I discuss below, Petitioner plainly failed to meet that burden. It did not prove that it had eliminated immediate jeopardy-level noncompliance as of the December survey.

The evidence strongly supports the conclusion that Petitioner failed to eliminate immediate jeopardy in the following respects: (1) its staff continued to fail to document wound care adequately; (2) the staff continued to fail to conduct PT/INR tests as ordered and to document test results; (3) the staff continued to fail to visit patients as scheduled; and (4) the staff continued to fail to review patient medical records and patient plans of correction in order to sure that all necessary care was being provided to patients as ordered.

For example, Patient 31 was identified in Petitioner's records as having six surgical wounds. CMS Ex. 45 at 12, 19-23, 39. Applicable standards of nursing care required Petitioner's staff to document and assess each of those wounds. CMS Ex. 53 ¶ 13. Clearly, failure to document and assess wounds can put a patient at a grave risk for infection. However, Petitioner's staff failed to assess the patient's wounds during visits on November 21 and 24, 2015. CMS Ex. 45 at 41-44. One of Petitioner's staff nurses visited the patient on December 2 and 3, 2015. However, the nurse failed even to mention the patient's wounds in the nursing notes and failed to assess them.

One element of Petitioner's plan of correction called for staff training on documenting wounds. CMS Ex. 37 at 53. It is obvious from the evidence cited above that, if training was conducted, it was ineffective.

As another example, Patient 29 was scheduled to receive a PT/INR test on November 30, 2015. CMS Ex. 43 at 16, 22, 27-28. But, the patient did not receive the test as scheduled. It was not administered until the following day, December 1, 2015. CMS Ex. 43 at 2, 29, 63; CMS Ex. 52 ¶ 18. Petitioner's failure to administer the PT/INR test timely contravened Petitioner's plan of correction, which specifically required the staff to complete PT/INR tests as ordered on specific dates and times. CMS Ex. 37 at 52.

Evidence obtained at the December survey establishes that Petitioner's staff continued to fail to perform patient visits as scheduled. For example, the nurse assigned to perform patient visits to Patient 30 during the week of November 21-26, 2015, failed to make those visits. CMS Ex. 44 at 12-13. Petitioner's records report that Patient 30 or his or her family refused visits during that week. I find this documentation not to be credible given that Patient 30 denied canceling nursing visits during that week. CMS Ex. 38 at 10; CMS Ex. 44 at 2. Furthermore, if the patient had in fact canceled the visit scheduled for that week, the staff was obligated to notify Petitioner's management and the patient's physician of the cancellation. There is nothing in Petitioner's record showing that such notification was made. CMS Ex. 30 at 80; CMS Ex. 37 at 38-39; CMS Ex. 44 at 12.

The December survey also unearthed numerous failures by Petitioner to follow patient plans of care and physicians' orders. For example, Petitioner failed to update Patient 28's plan of care to show that the patient was receiving a new dosage of Coumadin. CMS Ex. 42 at 7-9; 27; 30. It also failed to provide physician-ordered education to Patient 28

regarding the urinary disease process. CMS Ex. 42 at 10, 13. As another example, Petitioner failed to obtain orders from a physician for treatment of a wound sustained by Patient 30. CMS Ex. 44 at 9-10; CMS Ex. 50 ¶¶ 525-527. A nurse visited Patient 30 on November 27, 2015. However, the nurse failed to assess the patients' lower extremities and to document the treatment (if any) that the nurse provided for the patient's wound. CMS Ex. 44 at 14.

I do not find that Petitioner persuasively rebutted CMS's allegations of continued immediate jeopardy-level noncompliance. Petitioner argues that only one nurse visited Patient 31 and that the nurse observed the resident for signs of wound infection on each visit. Petitioner suggests that there was no harm inherent in the nurse's failure to document her assessments because of the consistency of care: she would remember from visit to visit whether the patient's wounds were improving or deteriorating. P. Br. at 15. But, this argument misses CMS's point entirely. Petitioner was under a duty to document the condition of its patients' wounds. That duty was not some abstract or sterile requirement. The safety of the patient depended on the condition of the wounds being documented accurately and consistently. Human memory is imperfect and that is why documentation is essential. A nurse – who presumably was assigned patients in addition to Patient 31 – cannot reasonably be assumed to remember precisely what condition a patient's wounds are in from visit to visit. Furthermore, suppose the nurse had become ill and a substitute was needed? How would the substitute know how the patient's wounds were progressing without a documentary record of the wounds? Finally, Petitioner's staff and nurses are not the only individuals who might need access to the patient's record. The patient's physician, for example, needs documentation of the progress of wounds towards healing.

As respects Patient 29, Petitioner effectively admits that its staff failed to perform PT/INR testing timely. It argues, however, that the patient continued to use his own PT/INR test machine. P. Br. at 13. That, apparently, is Petitioner's excuse for its staff not performing the test. I find that argument to be unpersuasive for several reasons. First, Petitioner's staff had a duty to perform PT/INR tests whether or not a patient was performing tests on his own. The staff was obligated to do so pursuant to a physician's orders. Indeed, the staff had no way of knowing – if tests were being conducted in its absence – whether those tests were properly conducted and accurate. Second, the evidence establishes that Resident 29 suffered from an injury to his hand that made it impossible for him to perform PT/INR testing personally. CMS Ex. 52 ¶¶ 11-12. Petitioner asserts that someone was always available to assist the patient. But, in fact, Petitioner had no assurance that was the case and, even if that were true, that did not excuse Petitioner from its obligation to perform PT/INR testing pursuant to a physician's order.

Concerning Patient 30, Petitioner offers nothing to rebut CMS's evidence that Petitioner's staff failed to visit the resident between November 21-26, 2015. Petitioner's staff documented that Patient 30 refused nursing visits on November 24 and 25, but Patient 30 told surveyors that she did not cancel those visits. *See* CMS Ex. 44 at 12-13; CMS Ex. 50 ¶ 523. The patient's statement to surveyors is certainly more reliable that Petitioner's nursing notes, which have been proven to be inconsistent, haphazardly completed, or incomplete. Petitioner also does not dispute the evidence offered by CMS showing that the staff failed to update Patient 28's plan of care to reflect a change in the dosage of Coumadin being administered to the patient. Petitioner argues that the administration of Coumadin to the resident was managed by another entity. P. Br. at 12. This, according to Petitioner, excused it from having to do anything for the patient relating to his anticoagulant therapy besides performing PT/INR testing. I disagree. Petitioner was required to document all medications administered to the patient. That documentation was inherent in its duty as a home health agency but it was also an element of the plan of correction that it had offered to CMS.

Petitioner argues also, that with respect to Patient 28, it did provide physician ordered-education concerning the urinary disease process. P. Br. at 12. It claims that its director of nursing told surveyors during an interview that the staff had, in fact, provided that training and documented it in clinical notes. P. Br. at 12. But, Petitioner never produced those notes. I do not find the representation – if it was made – to be credible absence documentation in the patient's record that the training had been provided pursuant to a physician's order.[5]

3. CMS's authority to impose remedies.

I have discussed above the legal authority by which CMS may impose the remedy of termination of participation in Medicare. I will not revisit that analysis. Petitioner's immediate jeopardy-level noncompliance authorized termination of its participation effective November 9, 2015. CMS gave Petitioner the opportunity correct its immediate jeopardy-level noncompliance but if failed to do so by December 10, 2015. CMS certainly had the authority to terminate Petitioner's participation on or after that date.

[5] Petitioner asserts that one may infer from clinical notes that the training was provided because it is generally referred to in the patient's plan of care. P. Br. at 12; *see* CMS Ex. 42 at 13-16. I have reviewed that document. There is nothing in there that recites that the ordered training was provided to the resident.

As for the civil money penalties, they are amply justified in this case. Petitioner's noncompliance was particularly egregious. As I have found, not only did the noncompliance cause patients to be put at immediate jeopardy but it actually harmed at least one patient, Patient 4.

/s/
Steven T. Kessel
Administrative Law Judge