Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Lake Country Nursing Center,
(CCN: 37-5310),

Petitioner,

v.

Centers for Medicare and Medicaid Services.

Docket No. C-10-988

Decision No. CR2380

Date: June 6, 2011

DECISION

The Centers for Medicare and Medicaid Services (CMS) has failed to show that Petitioner, Lake County Nursing Center, was not in substantial compliance with program participation requirements based on the survey completed in July 2010. Accordingly, for the July 2010 survey, CMS has not shown a basis for an enforcement remedy and no remedy is reasonable based on that survey. However, Petitioner was not in substantial compliance with program participation requirements based on the September 2010 survey and a $50 per-day civil money penalty (CMP) from September 8, 2010 through September 14, 2010 is required as a matter of law.

I. Background

On July 18, 2010, a survey was concluded to determine whether Petitioner was complying with federal participation requirements. As a result of the July 18, 2010 survey, Petitioner was cited with four deficiencies: F-272, scope/severity (s/s) level D, 42 C.F.R. § 483.20(b), Comprehensive Assessments; F-309, s/s level J, 42 C.F.R. § 483.25, Quality of Care; F-441, s/s level D, 42 C.F.R. § 483.65, Infection Control; and F-514, s/s level E, 42 C.F.R. § 483.75(l)(1), Clinical Records. Another survey was

conducted on September 8, 2010 and Petitioner was cited with one deficiency for F-309, s/s level D, 42 C.F.R. § 483.25, Quality of Care.

By letter dated July 20, 2010, CMS notified Petitioner that it would be imposing the following remedies: termination of its provider agreement unless substantial compliance was achieved by December 18, 2010, a CMP in the amount of $3,050 per-day for June 15 and 16, 2010, a per-day CMP in the amount of $200 beginning June 17, 2010, a denial of payment for new admissions (DPNA) beginning August 4, 2010, and a withdrawal of approval for Nurse Aide training and Competency Evaluation program (NATCEP) and Competency Evaluation Program (CEP).

By letter date October 4, 2010, CMS notified Petitioner that it was imposing a per instance civil money penalty (PICMP) of $10,000 for the instance on March 18, 2010[1] described as deficiency F-309, s/s level J, and a CMP of $50 per-day beginning on September 8, 2010. In addition, CMS notified Petitioner that it was rescinding the $3050 per-day CMP for June 15 and 16, 2010 and the $200 per-day CMP beginning June 17, 2010.

By letter dated October 21, 2010, CMS rescinded the termination of Petitioner's provider agreement and lifted the DPNA as of September 15, 2010. The per-day CMP of $50 was determined to remain in effect from September 8 through 14, 2010, for a total of $350. The combined total of the PICMP and the $50 per-day CMP is $10,350.

By letter dated September 15, 2010, Petitioner timely requested a hearing. By motion dated December 8, 2010, Petitioner stated that an in-person hearing would not be necessary and requested a decision based on written submissions. Accordingly, I set a briefing schedule. CMS submitted 16 exhibits (CMS Exs. 1-16) on December 21, 2010. CMS filed its initial brief (CMS Br.) on January 21, 2011 accompanied by four declarations. I am labeling the declaration of Melissa Lowe concerning the September 8, 2010 survey as CMS Ex. 17, the declaration of Melissa Lowe concerning the July 18, 2010 survey as CMS Ex. 18, the declaration of Rhonda McComas as CMS Ex. 19, and the declaration of Susan LeBlanc as CMS Ex. 20. Petitioner submitted 10 exhibits (P. Exs. 1-10) on December 20, 2010 and filed its initial brief (P. BR.) on January 19, 2011. On February 16, 2011 Petitioner filed its Response Brief (P. Response) accompanied by three additional exhibits marked as rebuttal exhibits (P. Rebuttal Exs. 11-13) and three declarations. I am labeling the declaration of Julieta Laguna as P. Ex. 14, the declaration of Martha Greer as P. Ex. 15, and the declaration of Debra Franklin as P. Ex. 16. By electronic transmission on February 25, 2011, CMS stated that it would not be filing a response brief. I admit into evidence CMS Exs. 1-20 and P. Exs. 1-10, P. Rebuttal Exs. 11-13, and P. Exs. 14-16.

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[1] The October 4, 2010 notice letter incorrectly stated that the PICMP was based on events that occurred on June 18, 2010. The events at issue occurred on March 18, 2010.

II. Issues, Applicable Law, Findings of Fact and Conclusions of Law

A. Issues

The issues in this case are:

1. Whether Petitioner failed to comply with one or more Medicare participation requirements; and

2. Whether the remedies imposed are reasonable.

B. Applicable Law and Regulations

Petitioner is considered a long-term care facility under the Social Security Act (Act) and regulations promulgated by the Secretary of Health and Human Services (Secretary). The statutory requirements for participation by a long-term care facility are found at sections 1819 and 1919 of the Act, and at 42 C.F.R. Part 483. Sections 1819 and 1919 of the Act vest the Secretary with authority to impose civil money penalties (CMPs) and other remedies against a long-term care facility for failure to comply substantially with participation requirements.

Pursuant to the Act, the Secretary has delegated to CMS the authority to impose various remedies against a long-term care facility that is not complying substantially with federal participation requirements. Facilities which participate in Medicare may be surveyed on behalf of CMS by State survey agencies in order to ascertain whether the facilities are complying with participation requirements. 42 C.F.R. §§ 488.10-488.28; 42 C.F.R. §§ 488.300-488.335.

The regulations specify that a CMP imposed against a facility on a per-day basis will fall into one of two ranges of penalties. 42 C.F.R. §§ 488.408, 488.438. The upper range of CMP, $3050 per-day to $10,000 per-day, is reserved for deficiencies that pose immediate jeopardy to a facility's residents and, in some circumstances, for repeated deficiencies. 42 C.F.R. §§ 488.438(a)(1)(i), (d)(2). The lower range of CMP, from $50 per-day to $3000 per-day is reserved for deficiencies that do not constitute immediate jeopardy, but either cause actual harm to residents, or cause no actual harm, but have the potential for causing more than minimal harm. There is only a single range of $1000 to $10,000 for a PICMP. 42 C.F.R. §§ 488.408; 488.438.

The regulations define the term "substantial compliance" to mean "a level of compliance with the requirements of participation such that any identified deficiencies pose no greater risk to resident health or safety than the potential for causing minimal harm." 42 C.F.R. § 488.301. Non-compliance at the level of immediate jeopardy is defined as "a situation in which the provider's noncompliance with one or more requirements of

participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident." *Id.*

A state agency may be required to withdraw a facility's approval to conduct a NATCEP. Pursuant to sections 1819(b)(5) and 1919(b)(5) of the Act, skilled nursing facilites (SNFs) and nursing facilites (NFs) may only use nurse aides who have taken a training and competency evaluation program. Sections 1819(e) and 1919(e) of the Act impose upon the states the requirement to specify what NATCEPs they will approve that meet the requirements established by the Secretary and a process for reviewing and reapproving those programs using criteria set by the Secretary. Pursuant to sections 1819(f)(2) and 1919(f)(2) the Secretary was directed to develop requirements for approval of NATCEPs and the process for review of those programs. The Secretary promulgated regulations at 42 C.F.R. Part 483, subpart D. Pursuant to 42 C.F.R. § 483.151(b)(2) and (e)(1) a state may not approve and must withdraw any prior approval of a NATCEP offered by a skilled nursing or nursing facility that: (1) has been subject to an extended or partial extended survey under sections 1819(g)(2)(B)(i) or 1919(g)(2)(B)(i) of the Act; (2) has been assessed a CMP of not less than $5000; or (3) that has been subject to termination of its participation agreement, a DPNA, or the appointment of temporary management. Extended and partial extended surveys are triggered by a finding of "substandard quality of care" during a standard or abbreviated standard survey and involve evaluating additional participation requirements. "Substandard quality of care" occurs where surveyors identify one or more deficiencies related to participation requirements established by 42 C.F.R. § 483.13 (Resident Behavior and Facility Practices), § 483.15 (Quality of Life), or § 483.25 (Quality of Care) that are found to constitute either immediate jeopardy, a pattern of or widespread actual harm that does not amount to immediate jeopardy, or a widespread potential for more than minimal harm that does not amount to immediate jeopardy with no actual harm. 42 C.F.R. § 488.301.

The Act and regulations make a hearing before an Administrative Law Judge (ALJ) available to a long-term care facility against which CMS has determined to impose an enforcement remedy. Act § 1128A(c)(2); 1866(h); 42 C.F.R. §§ 488.408(g); 498.3(b)(13). The hearing before an ALJ is a *de novo* proceeding. *Anesthesiologists Affiliated, et al*, DAB CR-65 (1990), *aff'd*, 941 F.2d 678 (8th Cir. 1991); *Emerald Oaks*, DAB No. 1800, at 11 (2001); *Beechwood Sanitarium*, DAB No. 1906 (2004); *Cal Turner Extended Care*, DAB No. 2030 (2006)*; The Residence at Salem Woods*, DAB No. 2052 (2006). A facility has a right to appeal a "certification of noncompliance leading to an enforcement remedy." 42 C.F.R. § 488.408(g)(1); *see also* 42 C.F.R. §§ 488.330(e) and 498.3. However, the choice of remedies by CMS or the factors CMS considered when choosing remedies are not subject to review. 42 C.F.R. § 488.408(g)(2). A facility may only challenge the scope and severity level of noncompliance found by CMS if a successful challenge would affect the range of the CMP that could be imposed by CMS or impact the facility's authority to conduct a nurse aide training and competency

evaluation program. 42 C.F.R. §§ 498.3(b)(14) and (d)(10)(i). The CMS determination as to the level of noncompliance "must be upheld unless it is clearly erroneous" (42 C.F.R. § 498.60(c)(2)), including the finding of immediate jeopardy. *Woodstock Care Center*, DAB No. 1726, at 9, 38 (2000), *aff'd, Woodstock Care Center v. Thompson*, 363 F.3d 583 (6th Cir. 2003). The Departmental Appeals Board (the Board) has long held that the net effect of the regulations is that a provider has no right to challenge the scope and severity level assigned to a noncompliance finding, except in the situation where that finding was the basis for an immediate jeopardy determination. *See e.g., Ridge Terrace*, DAB No. 1834 (2002); *Koester Pavilion*, DAB No. 1750 (2000). Review of a CMP by an ALJ is subject to 42 C.F.R. § 488.438(e).

The standard of proof or quantum of evidence required is a preponderance of the evidence. CMS has the burden of coming forward with the evidence and making a *prima facie* showing of a basis for imposition of an enforcement remedy. Petitioner bears the burden of persuasion to show by a preponderance of the evidence that it was in substantial compliance with participation requirements or any affirmative defense. *See Hillman Rehabilitation Center*, DAB No. 1611 (1997), *aff'd, Hillman Rehabilitation Center v. United States Department of Health and Human Services,* No. 98-3789, 1999 WL 34813783 (D.N.J. May 13, 1999); *Cross Creek Health Care Center*, DAB No. 1665 (1998); *Emerald Oaks*, DAB No. 1800; *Batavia Nursing and Convalescent Center*, DAB No. 1904 (2004), *aff'd, Batavia Nursing & Convalescent Center v. Thompson*, 129 F. App'x. 181 (6th Cir. 2005); *Batavia Nursing and Convalescent Inn*, DAB No. 1911 (2004).

C. Findings of Fact, Conclusions of Law, and Discussion

I make findings of fact and conclusions of law to support this decision. I set them forth below as separate headings in italics and bold type, and then discuss each in detail.

1. Petitioner was in substantial compliance with participation requirements based on the July 18, 2010 survey.

The PICMP imposed as a result of the July 18, 2010 survey is based on the events of March 18, 2010 involving Resident 2 (R-2), and cited under the deficiency noted at F-309, 42 C.F.R. § 483.25, Quality of Care.

The regulation at 42 C.F.R. § 483.25 provides:

> Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care.

R-2 was admitted to Petitioner's facility with various diagnoses including diabetes mellitus, anxiety, and airway obstruction. CMS Ex. 2, at 5; CMS Ex. 7, at 5-6. The March 15, 2010 care plan for R-2 states that R-2's blood sugar levels should be within acceptable limits and to report any of the following signs or symptoms to the charge nurse immediately: cold, clammy, change in level of consciousness, hypoglycemia or hyperglycemia. *Id.*; P. Ex. 3, at 1. The March 2010 monthly physician orders were for "Glutose 15 PRN [as needed] per hypoglycemia, please read policy & procedure pm, Glucagon 1 mg IM PRN [by intramuscular injection, as needed] per hypoglycemia, read policy & procedure." CMS Ex. 2, at 6.

The events that form the basis of this deficiency took place on March 18, 2010. At 4:00 p.m., R-2's blood sugar was recorded to be 147 mg/dl. P. Rebuttal Ex. 11, at 1. Pursuant to R-2's physician's order, Humulin N, a long acting insulin,[2] was administered. *Id.* at 2. At 5:00 p.m., a nurse's note documented that R-2 was very agitated and was putting her hands on her forehead. A narcotic pain medication, Lortab, was given by crushing it and mixing it into pudding. R-2 ate the pudding-Lortab mixture and took 120 cc. of water and was "self-mobile" in her wheelchair. At 6:00 p.m., R-2 was still "self-mobile" in her wheelchair and drank 120 cc. of orange juice followed by 120 cc. of water. CMS Ex. 2, at 6; CMS Ex. 7, at 11.

At 10:00 p.m., R-2 was found in her recliner. At that time, she was diaphoretic and she slightly opened her eyes when verbally and tactilely stimulated. R-2's blood glucose level was 41 mg/dl. Orange juice in the amount of 240 cc. was given orally by syringe which R-2 sluggishly swallowed. One tube of glutose was given. R-2's blood sugar level was 39 mg/dl at 10:10 p.m., and 36 mg/dl at 10:20 p.m. The physician was notified at 10:30 p.m.[3] The physician's order was to give 1 amp of 50 percent dextrose by IV push, start an IV, monitor blood sugar level in 15 minutes, then in 30 minutes, and transfer to the emergency room for further evaluation and treatment. At 10:45 p.m., R-2's blood sugar was 225 mg/dl. At 10:45 p.m., R-2 became short of breath with circum-oral cyanosis. Oxygen was given, the nursing staff performed oral pharyngeal suctioning, an ambulance was called, and R-2 was transferred to the emergency room of the local hospital. P. Ex. 4; CMS Ex. 2, at 6; CMS Ex. 7, at 11-12; CMS Ex. 19.

The hospital emergency room admitting diagnosis was respiratory distress after a sudden onset of a hypoglycemic episode and probable aspiration. CMS Ex. 2, at 7; CMS Ex. 7, at 15-21; CMS Ex. 19. On March 21, 2010, R-2 died. The hospital summary of the episode documented aspiration pneumonitis and respiratory distress. *Id.*

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[2] Humulin N is a long-acting insulin with onset usually between four to eight hours and at most 10 to 30 hours. P. Response at 2; P. Rebuttal Ex. 12, at 3.

[3] R-2's physician could not be contacted and another physician issued the order for R-2. P. Ex. 7, 8.

CMS argues that the facility failed to follow its own protocol for diabetic residents with severe hypoglycemic symptoms. The facility's protocol required that the staff provide residents experiencing severe hypoglycemia with 1 amp of 50 percent dextrose IV or glucagon, contact the physician, monitor vital signs frequently and follow up every 15 minutes until blood sugar levels became normal. CMS Ex. 9, at 1. The facility's protocol defines severe hypoglycemia as a blood sugar level of below 40 mg/dl. *Id.* CMS accepted the facility's policies as evidence of the standard of care its staff is to provide and also evidence of the standard of care in the medical community. CMS Br. at 9; *Life Care at Hilton Head*, DAB CR1908 (2009). According to the survey, the staff should have assessed R-2 for hypoglycemia at 5:00 p.m. when she was agitated and putting her hands to her forehead. Instead, at 5:00 p.m. the facility staff determined that R-2 was suffering pain gave her a narcotic pain medication, but she was not assessed for hypoglycemia. CMS argues that Petitioner failed to provide R-2 with the care and services required by the regulations since the Resident was experiencing hypoglycemia symptoms for a five hour period from 5:00 p.m. to 10:00 p.m. CMS Br. at 10.

Petitioner argues that at 10:00 p.m., the nurse assessed R-2's blood sugar level at 41 mg/dl and immediately followed its policy for moderate hypoglycemia which it defines as blood sugar levels of between 40-60 mg/dl. P. Ex. 6, at 2. Petitioner's policy and procedures for moderate hypoglycemia directs staff to give the resident either eight ounces of orange juice or two tubes of Glutose. *Id.* The nurse administered 240 cc. of orange juice, which is equivalent to just over eight ounces of orange juice. In addition one tube of Glutose was given to R-2. P. Ex. 4; P. Ex. 6, at 2. Petitioner claims that, during the survey, the surveyors were mistakenly given only the last page of three pages of the facility's policy and procedures for hypoglycemia. P. Ex. 10; P. Br. at 4. The last page is for treating residents with severe hypoglycemia, blood sugar levels below 40 mg/dl. Petitioner argues that at 10 p.m. R-2's blood sugar level was 41 mg/dl and therefore the nurse properly followed the procedures for moderate hypoglycemia, blood sugar levels between 40 to 60 mg/dl. Petitioner contends that its nursing staff acted in compliance with its policy and procedure. Petitioner contends that when R-2 did not improve after receiving the orange juice and Glutose, the nurse contacted R-2's physician and new orders were obtained for the Resident which were strictly followed. R-2's treating physician provided a letter in which he stated that the physician's orders on file for the Resident, although given by a physician who was filling in for him, were complied with to his satisfaction. P. Ex. 8. Petitioner argues that R-2's shortness of breath was due to R-2's documented problems with asthma. Petitioner therefore argues that it was in compliance with 42 C.F.R. § 483.25.

According to Petitioner, R-2 had a urinary tract infection (UTI) which was being treated with Macrobid, an antibiotic. Macrobid has side effects including abdominal pain, asthmatic attacks, and pulmonary sensitivity reaction. P. Ex. 14. In addition, a UTI can itself cause pain and agitation. *Id.* According to the declaration of the charge nurse,

Julieta Laguna, R-2's agitation and her activity in placing her hands on her forehead at 5:00 p.m. were signs of pain and not low blood sugar. P. Ex. 14. Nurse Laguna concluded that R-2 was experiencing pain at 5:00 p.m. based on the length of time she had been caring for the Resident. *Id.* Significantly, R-2 could not verbalize the cause of her agitation at 5:00 p.m. because of her dementia. Based on her assessment of the situation — including her acquaintance with the Resident's history at the facility — Nurse Laguna administered pain medication. Shortly afterward, R-2's agitation ceased, which supports the view that Nurse Laguna was correct — or at the very least reasonable — in determining that at 5:00 p.m. R-2 was agitated by pain rather than by hypoglycemia.

Further, Petitioner points out that had R-2 been suffering hypoglycemia at 5:00 p.m., she would not have been "self-mobile" in her wheelchair at 6:00 p.m., when Nurse Laguna administered 120 cc. of orange juice and 120 cc. of water to R-2 to avoid dehydration, because the Resident had not eaten all of her dinner. At 6:45 p.m., R-2 received wound care. P. Ex. 15. At 7:00 p.m., a Certified Nurse Assistant (CNA) provided R-2 with a snack consisting of animal crackers and ice cream approved for diabetics. P. Ex. 16. R-2 was observed to consume her entire snack. *Id.* At 8:00 p.m., she received a cool compress for her eyes. P. Rebuttal Ex. 13; P. Ex. 15. Her room was next door to the medication and medical supply room, and as a consequence, R-2 was observed a number of times during the evening of March 18, 2010 by a staff member who was going to and from that supply room. P. Ex. 16. Petitioner supplied declarations from the staff member who provided the wound care at 6:45 p.m., the staff member who fed R-2 her snack at 7:00 p.m., the staff member who provided the cool compress for R-2's eyes at 8:00 p.m., and Nurse Laguna. All the staff members declared that prior to 10:00 p.m. R-2 exhibited no signs of hypoglycemia. P. Exs. 14; 15; 16.

Inexplicably, but apparently as a matter of tactical choice, CMS failed to file any response to Petitioner's initial brief. This is troubling for many reasons, but it is especially disturbing because CMS's *prima facie* case as set out in its initial brief collapsed as soon as Petitioner documented that the quality of care citation was based on the surveyor's review of incomplete records. As I have noted above, the surveyors were only given the facility's policies and procedures for severe hypoglycemia and not its policies and procedures for moderate hypoglycemia. Petitioner presented evidence, that CMS has not offered to refute, that R-2 was suffering from a UTI and receiving an antibiotic, the side effects of which might well include abdominal pain, asthma attacks, and respiratory problems. Petitioner offered an alternate explanation for R-2's agitation at 5:00 p.m., an explanation that CMS has not attempted to refute or challenge.

Further, CMS failed to address questions raised by all the care R-2 did receive after 5:00 p.m. There is no documentation that R-2 was exhibiting any signs or symptoms of hypoglycemia at any time prior to 10:00 p.m. if one assumes *arguendo* that her agitation at 5:00 p.m. was caused by pain. This critical assumption was not refuted by CMS, and it

is perfectly consistent with the evidence before me. Nor has CMS discussed Petitioner's suggestion that the Resident could not have been "self-mobile" in a wheelchair at 6:00 p.m. if she had been hypoglycemic and untreated at 5:00 p.m. Petitioner presented declarations from three staff members, which CMS did not attempt to refute, that the Resident was not exhibiting signs and symptoms of low blood sugar prior to 10:00 p.m. (P. Exs. 14, 15, 16). These staff members provided care to R-2 during the time in question. Petitioner has presented evidence, unrefuted by CMS on this record, that its staff complied with its own policies and procedures and complied with R-2's physician's orders. P. Exs. 4, 9, 10. I can see no reason — and CMS has not suggested one — to doubt the credibility or reliability of the representations made by the three staff members (P. Exs. 4, 9, and 10) and supplemented by the declarations attached to its response brief (P. Exs. 14, 15, and 16). R-2's treating physician stated that the physician's orders on file for R-2, although given by a physician standing in for the treating physician, were complied with to his satisfaction by the facility staff. P. Ex. 8. These exhibits effectively refute CMS's *prima facie* case, and for whatever reason, CMS has chosen to leave them unchallenged and uncontradicted. Considering CMS's lack of response to Petitioner's initial and response briefs, I am compelled to find that CMS has not established its *prima facie* case of a deficiency at an immediate jeopardy level, or of any deficiency whatsoever, under the quality of care regulation during the July survey.

2. Petitioner was not in compliance with participation requirements based on the survey of September 8, 2010.

A complaint survey was conducted on September 8, 2010. The surveyors determined that Petitioner was not in compliance with one deficiency, F-309, s/s D, Quality of Care, involving Resident 8 (R-8) during the September 8, 2010 survey. According to CMS, Petitioner failed to ensure that R-8's condition was observed and documented following a sliding scale insulin administration. Further, Petitioner failed to document R-8's blood pressures. CMS Ex. 10, at 1-3.

CMS conceded in its October 8, 2010 Report of Readiness that the only deficiency before me was F-309 from the July survey, discussed above. However, subsequently, by letter dated October 21, 2010, CMS imposed a $50 per-day CMP from September 8, 2010 through September 14, 2010, totaling $350.

CMS discussed the September survey when it filed its initial brief on January 21, 2011. Petitioner failed to discuss the September 2010 survey when it filed its initial brief on January 19, 2011, possibly relying on CMS's October 8, 2010 Report of Readiness. However, once Petitioner received CMS's initial brief, Petitioner was on notice that CMS, based on its subsequent notice letter of October 21, 2010, had put the September survey also at issue in this case. Petitioner had an opportunity to contest the September 8, 2010 survey when it filed its Response brief. Petitioner failed to do so and was completely silent concerning the September 8, 2010 survey. CMS established a *prima*

facie case concerning the September 8, 2010 survey. Petitioner failed to contest the basis for this deficiency or the duration of the CMP imposed. The minimum amount of a CMP is $50 for each day of non-compliance. I do not have authority to reduce a penalty to zero. 42 C.F.R. § 488.438. Therefore, a $50 per-day CMP from September 8 through September 14, 2010 is reasonable as a matter of law.

III. Conclusion

CMS has shown no basis for the PICMP enforcement remedy assessed as a result of the July 2010 survey and therefore no remedy is authorized or reasonable. However, Petitioner was not in substantial compliance with program participation requirements based on the September 2010 survey and a $50 per-day CMP from September 8, 2010 through September 14, 2010, totaling $350, is required as a matter of law.

/s/
Richard J. Smith
Administrative Law Judge