Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Sundance Inn Health Center
(CCN: 67-6191),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-12-1279

Decision No. CR3020

Date: December 11, 2013

DECISION

Petitioner, Sundance Inn Health Center (Petitioner or the facility), is a long term care facility in New Braunfels, Texas, that participates in the Medicare program. Based on a survey completed on July 5, 2012, the Centers for Medicare & Medicaid Services (CMS) determined that Petitioner was not in substantial compliance with Medicare participation requirements. CMS imposed against Petitioner a civil money penalty (CMP) of $7,000 per day effective June 10, 2012 through June 12, 2012 ($21,000), and a CMP of $500 per day effective June 13, 2012 through July 5, 2012 ($11,500), for a total CMP of $32,500.

Petitioner appealed, and CMS moves for summary judgment.

For the reasons set forth below, I grant summary judgment in favor of CMS. The undisputed evidence establishes that the facility was not in substantial compliance with Medicare requirements, and CMS's determinations of immediate jeopardy were not clearly erroneous. I also find that the CMP that CMS imposed is reasonable.

I. Background

The Social Security Act (Act) sets forth requirements for nursing facilities' participation in the Medicare program and authorizes the Secretary of the U.S. Department of Health

and Human Services (Secretary) to promulgate regulations implementing those statutory provisions. Act § 1819. The Secretary's regulations are found at 42 C.F.R. Part 483. To participate in the Medicare program, a nursing facility must maintain substantial compliance with program requirements. To be in substantial compliance, a facility'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.

The Secretary contracts with state agencies to conduct periodic surveys to determine whether skilled nursing facilities are in substantial compliance. Act § 1864(a); 42 C.F.R. § 488.10. Each facility must be surveyed once every 12 months, and more often if necessary, to ensure that identified deficiencies are corrected. Act § 1819(g)(2)(A); 42 C.F.R. §§ 488.20(a), 488.308.

Surveyors from the Texas Department of Aging and Disability Services (state survey agency) conducted a survey of Petitioner that ended on July 5, 2012. Based on their findings, CMS determined that the facility was not in substantial compliance with 42 C.F.R. §§ 483.10(b)(11) (notification of changes-physical consultation), 483.13(c) (prevention of abuse and neglect), and 483.25 (quality of care). CMS also determined that the facility's noncompliance posed immediate jeopardy to resident health and safety. CMS imposed against the facility a CMP of $7,000 per day effective June 10, 2012 through June 12, 2012, and a CMP of $500 per day effective June 13, 2012 through July 5, 2012. CMS found that the facility returned to substantial compliance on July 6, 2012.

On September 13, 2012, Petitioner timely requested a hearing contesting all findings of noncompliance and related remedies set forth in the CMS notices issued on July 31, 2012 and August 24, 2012. The case was assigned to me for hearing and decision. On October 3, 2012, I issued an Acknowledgment and Initial Pre-hearing Order (Pre-hearing Order) establishing a briefing schedule. In accordance with the schedule, on January 2, 2013, CMS submitted its prehearing exchange, consisting of its prehearing brief (CMS Prehearing Br.), exhibit and witness lists, and 16 exhibits (CMS Exs. 1-16). On February 6, 2013, Petitioner timely submitted its prehearing exchange, consisting of its prehearing brief (P. Prehearing Br.), exhibit and witness lists, and three exhibits (P. Exs. 1-3). On February 14, 2013, CMS filed a motion for summary judgment and memorandum (CMS Br.). On March 15, 2013, Petitioner filed a response in opposition to CMS's motion for summary judgment (P. Response).

II. Issues

Whether the undisputed evidence establishes that:

- Petitioner was not in substantial compliance with Medicare requirements;

- If Petitioner was not in substantial compliance, whether CMS's determination that the deficiencies posed immediate jeopardy to resident health and safety was clearly erroneous; and

- The penalties CMS imposed are reasonable in amount and duration.

III. Findings of Fact and Conclusions of Law

A. Summary judgment is appropriate.

CMS moves for summary judgment relying on the following facts, which are undisputed unless otherwise noted. Resident 1 (R1), a 70-year-old female with diagnoses that included atrial fibrillation, chronic obstructive pulmonary disease, and hypertension (P. Ex. 1, at 2, 49; CMS Ex. 8, at 1, 5-7), had blood pressure readings, over the period June 10-12, 2012, that Petitioner reported as significantly low.[1] On June 10, Petitioner's staff noted that R1 had a blood pressure of 97/56 mm/Hg. On June 11, Petitioner's staff noted R1's blood pressure was 100/50 mm/Hg. On June 12, Petitioner's staff noted R1 had blood pressures of 94/52 mm/Hg, 85/52 mm/Hg, and 67/45 mm/Hg. CMS Ex. 8, at 1, 9, 11, 16, 18.

On June 10, 2012, Petitioner's staff responded to R1's low blood pressure by withholding R1's blood pressure medication. CMS Ex. 8, at 9. Petitioner's staff did not consult with R1's physician regarding R1's low blood pressure or the decision to withhold her medication. On June 11, 2012, Petitioner's nursing staff responded to R1's low blood pressure by again withholding her blood pressure medication. CMS Ex. 8, at 11. Petitioner's nursing staff again did not immediately consult R1's physician. On June 12, 2012, nursing staff on the day and evening shifts again did not immediately consult with R1's physician regarding low blood pressure readings. After noting that R1's blood pressure was 67/45 mm/Hg around 5:45 p.m., nursing staff left a voice mail message for R1's physician's nurse practitioner. Neither the Physician nor the Nurse Practitioner returned the call. Around 10:00 p.m., R1 experienced symptoms of troubled breathing, tingling in her left arm, numbness in her tongue, and blurred vision. Staff found her unresponsive and called for emergency assistance. R1 was transported to the hospital, where she was pronounced dead at 11:05 p.m. CMS Ex. 7, at 1, 4, 5; CMS Ex. 8, at 18, 19, 21, 32.

Summary judgment is appropriate when a case presents no issue of material fact, and its resolution turns on questions of law. *See Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 247-48 (1986); *Livingston Care Ctr. v. United States Dep't of Health and Human Servs.*,

[1] According to MedlinePlus Medical Encyclopedia, "[m]ost normal blood pressures fall in the range of 90/60 millimeters of mercury (mm Hg) to 130/80 mm Hg." *See* CMS Ex. 13, at 1.

388 F.3d 168, 173 (6th Cir. 2004). *See also Illinois Knights Templar Home*, DAB No. 2274, at 3-4 (2009) (*citing Kingsville Nursing Ctr.*, DAB No. 2234, at 3-4 (2009)). The moving party may show the absence of a genuine factual dispute by presenting evidence so one-sided that it must prevail as a matter of law, or by showing that the non-moving party has presented no evidence "sufficient to establish the existence of an element essential to [that party's] case, and on which [that party] will bear the burden of proof at trial." *Livingston Care Ctr.*, 388 F.3d 168, 173 (quoting *Celotex Corp. v. Catrett*, 477 U.S. 317, 322 (1986)). To avoid summary judgment, the non-moving party must then act affirmatively by tendering evidence of specific facts showing that a dispute exists. *See Matsushita Elec. Indus. Co. v. Zenith Radio Corp.*, 475 U.S. 574, 586 n.11 (1986); *see also Vandalia Park*, DAB No. 1939 (2004); *Lebanon Nursing and Rehab. Ctr.*, DAB No. 1918 (2004). To defeat an adequately supported summary judgment motion, the non-moving party may not rely on the denials in its pleadings or briefs, but it must furnish evidence of a dispute concerning a material fact. *Illinois Knights Templar Home*, DAB No. 2274, at 4; *Livingston Care Ctr.*, DAB No. 1871, at 5 (2003).

In examining the evidence for purposes of determining the appropriateness of summary judgment, I must draw all reasonable inferences in the light most favorable to the non-moving party. *Brightview Care Ctr.*, DAB No. 2132, at 2, 9, 10 (2007); *Livingston Care Ctr.*, 388 F.3d at 168, 172; *Guardian Health Care Ctr.*, DAB No. 1943, at 8 (2004); *but see Cedar Lake*, DAB No. 2344, at 7 (2010). However, drawing factual inferences in the light most favorable to the non-moving party does not require that I accept the non-moving party's legal conclusions. *Cedar Lake*, DAB No. 2344, at *7; Guardian Health Care Ctr.*, DAB No. 1943, at 11 ("A dispute over the conclusion to be drawn from applying relevant legal criteria to undisputed facts does not preclude summary judgment if the record is sufficiently developed and there is only one reasonable conclusion that can be drawn from those facts.").

CMS alleges that Petitioner violated the following participation requirements: 42 C.F.R. § 483.10(b)(11); 42 C.F.R. § 483.13(c); and 42 C.F.R. § 483.25. It is not disputed that the principal violation at issue is whether Petitioner failed to immediately consult with R1's physician when she had a significant change in medical condition, in violation of 42 C.F.R. § 483.10(b)(11), and the other deficiencies are derivative violations. *See* P. Response at 8.

My Pre-hearing Order required each party to present all arguments and evidence at the time it filed its pre-hearing exchange. I instructed the parties that "I may exclude an argument and evidence that relates to such argument if a party fails to address it in its pre-hearing brief." Pre-hearing Order, ¶ 7. As stated above, both parties submitted prehearing briefs as part of their pre-hearing exchanges. However, Petitioner tendered no evidence challenging any of the citied deficiencies. Petitioner's prehearing brief also did not present any arguments addressing the factual allegations reported in the Statement of

Deficiencies (SOD) that formed the basis of CMS's determination of substantial noncompliance.

Instead, Petitioner now claims in its response to CMS's motion that "CMS relies heavily on subjective opinion such as what constitutes a change in condition for a newly-admitted resident that is unfamiliar to the facility staff." P. Response at 15. According to Petitioner, "[e]ven objective evidence cited, such as blood pressure readings, is subject to interpretations of meaning due to multiple variables." P. Response at 15. Petitioner also suggests, based on the surveyor's notes of an interview with R1's nurse practitioner, that R1 died from an enlarged heart and that her death was unavoidable, regardless of whether she had a significant change in condition that required immediate physician consultation. P. Response at 9. However, as discussed below, drawing all reasonable inferences in Petitioner's favor, I find that the undisputed facts lead to only one reasonable conclusion – Petitioner failed to immediately consult R1's physician on several occasions when Petitioner determined R1 exhibited low blood pressure readings and also failed to consult the physician before withholding R1's blood pressure medications.

Petitioner further alleges that the surveyor's "inconsistent findings and findings inconsistent with the final initial determinations are a question of unresolved contradictory facts." P. Response at 10. According to Petitioner, the surveyor cited non-immediate jeopardy level deficiencies at the exit of the survey, only to then reopen the survey the next day, citing immediate jeopardy level deficiencies. P. Response at 9-10; *see* P. Prehearing Br. at 13.

In support of some of its contentions, Petitioner has submitted a written declaration from Petitioner's Administrator during the relevant time period. P. Ex. 3 (Administrator Decl). I find the Administrator's declaration does not create any genuine dispute of material fact regarding R1 and her condition on June 10-12, 2012. Rather, it merely gives a "timeline" of the survey events and also describes the remedial actions the Administrator implemented *after* he was notified of the incident involving R1 on June 12, 2012.

Alleged inadequacies in the survey process also do not relieve Petitioner from meeting all the requirements of program participation and do not invalidate adequately documented deficiencies. 42 C.F.R. § 488.318(b); *Beechwood Sanitarium*, DAB No. 1824 (2002) (finding inadequacies or irregularities in the survey process do not invalidate adequately documented deficiencies or relieve a facility of its obligations to meet all requirements for participation in Medicare and Medicaid). Petitioner's challenges that surveyors did not follow survey protocol or that there were irregularities in the survey process, even if substantiated, do not create a genuine issue of material fact that would preclude granting summary judgment to CMS here where the deficiencies are undisputed.

B. The undisputed evidence establishes, in contravention of Medicare requirements, Petitioner's staff did not immediately consult R1's physician when they determined that R1 had low blood pressure readings.

A facility must immediately inform the resident, consult the resident's physician, and (if known) notify the resident's legal representative or interested family member when there is a significant change in the resident's physical, mental or psychosocial status (i.e., a deterioration in health, mental or psychosocial status in either life-threatening conditions or clinical complications) or a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences or to commence a new form of treatment). 42 C.F.R. § 483.10(b)(11). "Immediately" means "as soon as the change . . . is detected, without any intervening interval of time." *Magnolia Estates Skilled Care*, DAB No. 2228, at 8 (2009); *The Laurels at Forest Glen*, DAB No. 2182 at 13 (2008).

CMS alleges that Petitioner violated 42 C.F.R. § 483.10(b)(11) because Petitioner failed to immediately consult with a physician when R1 had low blood pressure readings over a three-day period. CMS Br. at 9-10; CMS Ex. 1, at 1-4.

R1, a 70-year-old female, was admitted to the facility from the hospital on June 9, 2012. *See* P. Ex. 1, at 57-59, 64. Her diagnoses included atrial fibrillation, chronic obstructive pulmonary disease, hypertension, and hyperlipidemia. P. Ex. 1, at 2, 49; CMS Ex. 8, at 1, 5-7. R1's blood pressure medications included Metoprolol Tartrate twice a day, Amlodipine/Benazepril daily, and Lisinopril daily. P. Ex. 1, at 55-56, 60; CMS Ex. 8, at 8, 10.

R1's care plan was dated and signed on June 16, 2012, which was four days after R1's death. Staff noted that, due to R1's diagnosis of atrial fibrillation, R1 "may experience fluctuating/unstable blood pressures related to multiple diagnosis [sic]" and that she was "at risk for decreased cardiac output and experiencing hypo/hypertension." P. Ex. 1, at 88-89; CMS Ex. 8, at 5-6. Regarding R1's hypertension, the care plan noted that R1 "has the potential for change in blood pressure and fluid volume, dehydration, fluctuations in weight and complications [related to] hypertension." P. Ex. 1, at 90; CMS Ex. 8, at 7. The care plan approaches for R1's atrial fibrillation and hypertension diagnoses included: *administer antihypertensive medication as ordered*; obtain and evaluate blood pressure every shift and daily; monitor for headaches and dizziness; monitor for signs and symptoms of exacerbation of tachycardia, irregular heart rate, vertigo, hypotension, altered mental status; monitor vital signs per facility protocol; and *notify the physician of significant changes in blood pressures*. P. Ex. 1, at 88-90; CMS Ex. 8, at 5-7.

On June 10, 2012, at 8:00 a.m., Petitioner's staff recorded that R1's blood pressure was 125/86 mm/Hg. Staff administered R1's morning doses of Amlodipine/Benazepril for high blood pressure and Lisinopril for high blood pressure and heart failure. P. Ex. 1, at

70, 78; CMS Ex. 8, at 10, 12; CMS Ex. 12, at 3. Around 8:00 p.m. on June 10, 2012, however, staff documented that R1's blood pressure was 97/56 mm/Hg. Staff also documented that they withheld R1's blood pressure pills. P. Ex. 1, at 81; CMS Ex. 8, at 9.

On the morning of June 11, 2012, R1's blood pressure was 100/50 mm/Hg. P. Ex. 1, at 78,79; CMS Ex. 8, at 10, 11. Again, staff responded by withholding R1's blood pressure medication. P. Ex. 1, at 79; CMS Ex. 8, at 11.

On June 12, 2012, around 8:00 a.m., R1's blood pressure was 120/72 mm/Hg. Petitioner's staff administered R1 her blood pressure medication. P. Ex. 1, at 78; CMS Ex. 8, at 10; *see* CMS Ex 12, at 3. (The record also contains a "Daily Skilled Nurse's Note," dated June 12, 2012, which shows that, under day shift, R1's blood pressure was 94/52 mm/Hg; under evening shift, R1's blood pressure was 85/52 mm/Hg; and under night shift, R1's blood pressure was 134/59 mm/Hg. There is no time given for any of these readings. P. Ex. 1, at 74; CMS Ex. 8, at 16).

A late entry in the nurse's notes, made at 1:35 p.m. on June 13, 2012, documents that around 5:45 p.m. on June 12, 2012, R1 had complaints of dizziness and said her legs were "shaky" and she felt "woozy." P. Ex. 1, at 76; CMS Ex. 8, at 18; *see* P. Ex. 1, at 54; CMS Ex. 8, at 23, 24, 26. A nurse took R1's vital signs and noted that her blood pressure was 67/45 mm/Hg. P. Ex. 1, at 75; CMS Ex. 8, at 17, 20, 24. The nurse called R1's attending physician's nurse practitioner around 5:45 p.m. and left a voice mail message. P. Ex. 1, at 53; CMS Ex. 8, at 18. Neither the Physician nor the Nurse Practitioner returned the voice mail. The nurse stated that she rechecked R1's vitals approximately every 30 minutes for the next two hours. She stated that R1 "was drinking a lot of water" and her blood pressure went up to 102/70 mm/Hg, then up to168/87 mm/Hg. P. Ex. 1, at 75; CMS Ex. 8, at 17, 20. R1 told the nurse that she was not feeling as dizzy, but she was seeing spots. The nurse checked R1's pupils and found they were equal and reactive. The nurse noted that R1 did not exhibit any weakness on one side and that R1 continued to drink water. P. Ex. 1, at 76; CMS Ex. 8, at 18, 20. According to the nurse's notes, around 7:35 p.m., R1 said she was "feeling okay" and her vitals were "still around the same." P. Ex. 1, at 76-77; CMS Ex. 8, at 18-19.

Around 8:30 p.m., R1 wanted to use the restroom but felt faint when staff placed her in her wheelchair. The nurse and an aide put R1 back in bed. R1's blood pressure reading was 168/87 mm/Hg. P. Ex. 1, at 77; CMS Ex. 8, at 19. The nurse stated that R1 "drank a little water and said she felt better." The nurse gave R1 her scheduled blood pressure medicine as well as her scheduled inhaler. Around 10:00 p.m., according to a nurse aide, R1 had complaints of not being able to breathe, tingling in her arms, a numb tongue, and blurred vision. CMS Ex. 7, at 3, 4. Around 10:20 p.m., an aide reported that R1 said she was dizzy, and, when staff went to her room, they found that the head of R1's bed was elevated, she had labored breathing, and she was unresponsive. P. Ex. 1, at 77; CMS Ex.

8, at 19, 20-21. She appeared to have vomited on herself. CMS Ex. 7, at 5. The staff called the Nurse Practitioner, 911, and initiated CPR. EMS arrived and transported R1 to the hospital. P. Ex. 1, at 77; CMS Ex. 8, at 19, 20-21. R1 was declared dead at 11:05 p.m. CMS Ex. 8, at 32.

Petitioner suggests, based on the Nurse Practitioner's statement to a surveyor, that R1 died from an enlarged heart and that her death was unavoidable. P. Response at 9. Petitioner also contends that it is only speculation on the surveyors' part "that a delay in calling the physician made a difference or likely would have made a difference." P. Brief at 15. For purposes of summary judgment, I will infer that R1 died from an enlarged heart that was separate from blood pressure complications. I will also accept that Petitioner's delay in calling R1's physician did not ultimately affect R1's condition. However, Petitioner's assertions, even when interpreted in a light most favorable to Petitioner, do not detract from the regulatory requirements. Regardless of how R1 died, and whether or not consulting with R1's physician would have ultimately affected R1's outcome, Petitioner was still required, under 42 C.F.R. § 483.10(b)(11), to immediately consult her physician when she exhibited low blood pressure readings.

Although Petitioner also suggests that blood pressure readings can have "interpretations of meaning due to multiple variables" (P. Response at 15), Petitioner has not disputed that staff withheld blood pressure medication based on their interpretation of R1's blood pressure readings. Further, Petitioner has not come forward with any evidence, such as an affidavit from a medical professional, that raises a challenge to the interpretation of any of the specific blood pressure readings which appear in the facility's own documents. The uncontroverted evidence leads to only one reasonable conclusion – when R1 repeatedly exhibited low blood pressure readings over a three-day period, there was a significant change in condition that should have prompted immediate physician consultation. Given R1's serious cardiac impairments, which were documented in her care plan, it was imperative that staff monitor her vital signs and consult her physician when she exhibited any alarming symptoms, such as abnormal changes in blood pressure.

In response to R1's complaints of dizziness and her blood pressure reading of 67/45 mm/Hg around 5:45 p.m. on June 12, 2012, Petitioner's staff eventually did leave a voicemail message for the Nurse Practitioner of R1's physician. However, neither the Nurse Practitioner nor the Physician ever returned the message. Instead of acting diligently to follow-up and contact the Physician to advise him of R1's condition, Petitioner's staff made no further attempts to contact him and only called the Nurse Practitioner again around 10:20 p.m., when R1 was found unresponsive in her bed.

As well as not qualifying as an "immediate" communication of a significant change of condition, I find that the voice mail message Petitioner's staff left for the Nurse Practitioner also clearly fails to qualify as a physician consultation within the meaning of

42 C.F.R. § 483.10(b)(11). As the Board held in *Magnolia Estates*, "consultation" involves more than just informing or notifying a physician. The Board stated:

> Consultation . . . requires a dialogue with and a responsive directive from the resident's physician as to what actions are needed; it is not enough to merely notify the physician of the resident's change in condition. Nor is it enough to leave just a message for the physician.

Magnolia Estates, DAB No. 2228, at 9.

In sum, over a three-day period, Petitioner's staff believed R1 exhibited low blood pressure readings, which constituted a significant change in condition requiring immediate medical consultation. There is no dispute that Petitioner's staff did not notify R1's physician on June 10 or 11, 2012, regarding R1's blood pressure readings. There is no dispute that Petitioner's staff only left a message for the Nurse Practitioner on June 12, 2012. Because Petitioner's staff failed on multiple occasions to immediately consult R1's physician regarding R1's repeated low blood pressure readings, I find that Petitioner was not in substantial compliance with 42 C.F.R. § 483.10(b)(11).

C. The undisputed evidence establishes, in contravention of Medicare requirements, Petitioner failed to immediately consult R1's physician before withholding R1's blood pressure medication.

A facility must immediately consult a resident's physician when there is a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences or to commence a new form of treatment). 42 C.F.R. § 483.10(b)(11). The undisputed evidence shows that Petitioner's staff responded to R1's low blood pressure readings by withholding R1's physician-ordered blood pressure medication on June 10 and 11.

Petitioner has pointed to nothing in the record to indicate that R1's physician had given orders to withhold R1's blood pressure medications in the event her blood pressure fell to a certain range. Petitioner's staff thus had no physician authorization to deviate from R1's medication regimen. Before Petitioner's staff decided on any course of action regarding R1's medication, they were required to immediately consult R1's physician concerning the need to alter R1's treatment significantly, and their withholding of her blood pressure medications, in contravention of physician orders, constitutes another violation of Medicare requirements.

D. The undisputed evidence demonstrates that Petitioner did not follow its policy, in contravention of Medicare requirements.

The opening provision of 42 C.F.R. § 483.25 (quality of care), which implements section 1819(b)(2) (Medicare) of the Act, states:

> 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.

The quality of care legislation and regulatory requirements are "based on the premise that the facility has (or can contract for) the expertise to first assess what each resident's needs are (in order to attain or maintain the resident's highest practicable functional level) and then to plan for and provide care and services to meet the goal." *Spring Meadows Health Care Ctr.*, DAB No. 1966, at 16 (2005). The regulation thus "imposes on facilities an affirmative duty designed to achieve favorable outcomes to the highest practicable degree." *Windsor Health Care Ctr.*, DAB No. 1902, at 16-17 (2003), *aff'd, Windsor Health Care Ctr. v. Leavitt*, No. 04-3018 (6th Cir. 2005). The facility must take "reasonable steps" and " 'practicable' measures to achieve that regulatory end." *Clermont Nursing & Convalescent Ctr.*, DAB No. 1923, at 21 (2004), *aff'd, Clermont Nursing & Convalescent Ctr. v. Leavitt*, 142 F. App'x 900 (6th Cir. 2005).

Accordingly, the Board has held that the language of section 483.25 requires skilled nursing facilities to furnish the care and services set forth in a resident's care plan, to implement doctors' orders, to monitor and document the resident's condition, and to follow its own policies. *See, e.g., Alexandria Place*, DAB No. 2245 (2009) (failing to provide care in accordance with the doctor's order); *Kenton Healthcare, LLC*, DAB No. 2186 (2008) (failing to follow standards in the care plan for supervision); *Spring Meadows*, DAB No. 1966, at 17 ("the clearest case of failure to meet [section 483.25] is failure to provide one of the specific services outlined in the subsections or failure otherwise to follow the plan of care based on the comprehensive resident assessment"); and *St. Catherine's of Findley*, DAB No. 1964, at 13 n.9 (2005) (facility admission that it failed to follow its own supervision care plan may make summary judgment appropriate). Further, a SNF "must develop and implement written policies and procedures that prohibit . . . neglect" (and other types of mistreatment). 42 C.F.R. § 483.13(c). "Neglect" means a "failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness." 42 C.F.R. § 488.301.

Petitioner's policy pertaining to a significant change in resident status states, inter alia:

> A significant change in a resident's status is defined as deterioration or marked improvement in the health, mental, or

> psychosocial status of the resident in either life-threatening conditions, or in incidents of clinical complications. Depending on the scope and severity, examples of life-threatening conditions include, but are not limited to: 1. Cardiovascular or respiratory changes. 2. Fractures. 3. Semi-comatose or comatose state. 4. Choking. 5. Infection. 6. Dehydration.

CMS Ex. 6, at 1. Petitioner's policy goes on to state, "As a significant change in the resident's condition occurs, the charge nurse will notify the physician, family, or other appropriate person/agency, of the significant change immediately. If a question about the seriousness of any significant change in condition exists, the operating philosophy of this facility is always to notify appropriate persons immediately." CMS Ex. 6, at 2. Under Petitioner's own policy, its staff had a similar reporting responsibility to that found under 42 C.F.R. § 483.10(b)(11) when a resident experiences a significant change in condition. As previously discussed, considering the undisputed evidence establishes that Petitioner's staff withheld blood pressure medication in response to R1's blood pressure readings, without immediately consulting R1's physician, I find Petitioner did not follow its policy, in addition to failing to follow R1's care plan instructions and her physician's medication orders. It follows, therefore, that Petitioner was not in substantial compliance with 42 C.F.R. §§ 483.25 and 483.13(c).

E. The undisputed evidence establishes that CMS's determination of immediate jeopardy to resident health and safety is not clearly erroneous.

CMS alleges that Petitioner's violations constituted "immediate jeopardy." Immediate jeopardy exists if a facility's noncompliance has caused or is likely to cause "serious injury, harm, impairment, or death to a resident." 42 C.F.R. § 488.301. CMS's determination as to the level of a facility's noncompliance (which would include an immediate jeopardy finding) must be upheld unless it is "clearly erroneous." 42 C.F.R. § 498.60(c). The Board has observed repeatedly that the "clearly erroneous" standard imposes on facilities a "heavy burden" to show no immediate jeopardy and has sustained determinations of immediate jeopardy where CMS presented evidence "from which '[o]ne could reasonably conclude' that immediate jeopardy exists." *Barbourville Nursing Home*, DAB No. 1962, at 27-28 (2004), *citing Florence Park Care Ctr.*, DAB No. 1931 (2004), *citing Koester Pavilion*, DAB No. 1750 (2000); *Daughters of Miriam Ctr.*, DAB No. 2067, at 7, 9 (2007).

Here, R1, a resident who was diagnosed with atrial fibrillation, chronic obstructive pulmonary disease, and hypertension, exhibited significantly low blood pressure readings during the period June 10-12, 2012. In response, Petitioner's staff undisputedly withheld

R1's ordered blood pressure medication on June 10 and 11 without physician authorization and failed to consult with her physician immediately regarding her significant change in condition.

In an affidavit of direct testimony that Petitioner does not challenge, a surveyor explained that R1's diagnoses of "irregular heartbeat, heart failure, and high cholesterol . . . typically cause low blood pressure, possible formation of blood clots, kidney damage, liver damage, heart attacks, and/or strokes." CMS Ex. 16, at 3 (Surveyor Decl. ¶ 6). The surveyor explained that "[l]ow blood pressure could be a sign of a heart attack, which could be fatal." CMS Ex. 16, at 3-4 (Surveyor Decl. ¶ 6).

Petitioner also did not challenge the testimony of CMS's nurse consultant, who explained:

> Resident 1's low blood pressures, as well as her complaints of dizziness and feeling "woozy," can also be signs of low cardiac output. Because the atria and the ventricles are not synchronized in a patient with atrial fibrillation, the cardiac output is low which, if left untreated, can lead to heart failure. The resident already had a diagnosis of heart failure; therefore, the resident was at higher risk of cardiac arrest. Thus, it was imperative for the nurse to consult with the physician regarding the low blood pressure readings and the symptoms of dizziness.

CMS Ex. 12, at 3 (Nurse Consultant Decl.).

Petitioner claims that there is no evidence that Petitioner's action caused actual harm or constituted a likelihood of serious harm for R1. P. Prehearing Br at 14. However, CMS was not required to prove actual harm here, and Petitioner has not created an issue of material fact that would preclude summary judgment. Specifically, Petitioner did not come forward with evidence to refute that not alerting her physician to significant drops in R1's blood pressure, or withholding her ordered medications, would likely cause her serious harm or death.

F. The penalty CMS imposed is reasonable.

Petitioner asserts that there is an issue concerning the date when it attained substantial compliance, claiming that the surveyor's declaration failed to contain any information on this issue. P. Response at 10-11. However, the burden rests entirely on a facility to prove that it has attained compliance by a particular date. *Texan Nursing & Rehab. of Amarillo, LLC*, DAB No. 2323 (2010). Where noncompliance is determined, a remedy will remain in effect until:

> The facility has achieved substantial compliance, as determined by CMS or the State based upon a revisit or after an examination of credible written evidence that it can verify without an on-site visit; . . .[2]

42 C.F.R. § 488.454(a)(1); *see* 42 C.F.R. § 488.440(h)(1) (governing duration of civil money penalties). Thus, once a facility has been found to be out of substantial compliance, it remains so until it affirmatively demonstrates that it has achieved substantial compliance once again. *Premier Living and Rehab. Ctr.*, DAB No. 2146, at 23 (2008); *Lake City Extended Care*, DAB No. 1658, at 12-15 (1998). The burden is on the facility to prove that it has resumed complying with program requirements, not on CMS to prove that deficiencies continued to exist after they were discovered. *Asbury Ctr. at Johnson City*, DAB No. 1815, at 19-20 (2002).

According to Petitioner's Administrator, Petitioner submitted a plan of correction to the state survey agency on July 30, 2012. P. Ex. 3, at 2 (Administrator Decl). In the right-hand column of its plan of correction, Petitioner stated the "completion date" for correcting all deficiencies as "7/6/12." CMS Ex. 1; *see* P. Ex. 3, at 2 (Administrator Decl.); *see* P. Response at 10-11.

The surveyors conducted a revisit on August 20, 2012, at which time they determined that Petitioner returned to substantial compliance as of the date of its plan of correction – July 6, 2012. CMS Ex. 5, at 1; P. Ex. 3, at 2 (Administrator Decl.). Petitioner was required to come forward with evidence to establish it was in compliance at an earlier date. However, Petitioner has not come forward with any evidence to suggest that it returned to substantial compliance prior to July 6, 2012. Thus, contrary to what Petitioner argues, there is no genuine issue of material fact suggesting an earlier compliance date, and I summarily sustain CMS's determinations as to the duration of the periods of immediate jeopardy and substantial noncompliance.

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[2] The timing of a revisit survey is wholly within the discretion of the state and CMS and not reviewable in this forum. 42 C.F.R. § 488.308(c); *Cal Turner Extended Care Pavilion*, DAB No. 2030, at 13 (2006).

The CMP range for immediate jeopardy level noncompliance is from $3,050 to $10,000 per day. 42 C.F.R. § 488.438(a)(1)(i). The lower range of CMP, from $50 per day to $3,000 per day, is reserved for deficiencies that do not constitute immediate jeopardy, but they either cause actual harm to residents or cause no actual harm but have the potential for causing more than minimal harm. 42 C.F.R. § 488.438(a)(1)(ii). Here CMS imposed a penalty of $7,000 per day, effective June 10, 2012 through June 12, 2012, during the period of immediate jeopardy, and $500 per day, effective June 13, 2012 through July 5, 2012, during the period of substantial noncompliance not at the immediate jeopardy level.

In considering whether the CMP amounts imposed against Petitioner are reasonable, I apply the factors listed in 42 C.F.R. § 488.438(f): 1) the facility's history of noncompliance, including repeated deficiencies; 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 also 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. I am neither bound to defer to CMS's factual assertions, nor free to make a wholly independent choice of remedies without regard for CMS's discretion. *Barn Hill Care Ctr.*, DAB No. 1848, at 21 (2002); *Cmty. Nursing Home*, DAB No. 1807, at 22 *et seq*. (2002); *Emerald Oaks*, DAB No. 1800, at 9 (2001); *CarePlex of Silver Spring*, DAB No. 1683, at 8 (1999).

In its prehearing brief, Petitioner contends that a CMP in the amount of $32,500 is unreasonable and suggests that the factors specified in 42 C.F.R. Part 488 are "arbitrary and capricious" because CMS had originally imposed a CMP in the amount of $8,000, then increased it to $32,500, almost fifty days after substantial compliance was achieved. P. Prehearing Br. at 13. Petitioner argues that if any CMP is imposed, that it be imposed "at the lowest possible rate under the rules." P. Prehearing Br. at 15. In its response in opposition to CMS's motion for summary judgment, Petitioner contends further that "[t]he reasonableness of the civil money penalty is subject to unresolved factual issues." P. Response at 16.

Although Petitioner argues that the regulatory factors specified in 42 C.F.R. Part 488 are "arbitrary and capricious" and do not support the CMP imposed by CMS, Petitioner has submitted no evidence of its own to show that the regulatory factors, either individually or collectively, warranted a reduction in the CMP amount. In discussing the burden of proof regarding the regulatory factors, the Board has repeatedly held that "an ALJ or the Board properly presumes that CMS considered the regulatory factors and that those

factors support the amount imposed." *See, e.g.*, *Pinecrest Nursing and Rehab. Ctr.*, DAB No. 2446, at 23 (2012) (emphasis in original; citations omitted). Thus, CMS is not required to present evidence regarding each regulatory factor. Instead, the burden is on Petitioner "to demonstrate, through argument and the submission of evidence addressing the regulatory factors, that a reduction is necessary to make the CMP amount reasonable." *Id.*, quoting *Oaks of Mid City Nursing and Rehab. Ctr.*, DAB No. 2375, at 26-27 (2011). Petitioner has not properly contested any of the factors set forth in the regulations that would affect my consideration of the amount of the penalty.

I find that Petitioner's violations were extremely serious. Petitioner's staff failed, on multiple occasions, to consult immediately with R1's physician when R1 exhibited a significant change in condition manifested by low blood pressure readings, and they withheld her ordered blood pressure medication without consulting R1's physician. Petitioner's staff's actions clearly put R1 at risk for serious injury, and I find that Petitioner thus has a high degree of culpability for its noncompliance.

Petitioner also has an undisputed history of noncompliance. According to a report titled "Facility Visit History" generated by the state survey agency, various surveys conducted in September 2009, October 2009, March 2010, May 2010, September 2010, October 2010, and October 2011 resulted in numerous instances of noncompliance with both Medicare participation requirements and the Life Safety Code. CMS Ex. 11, at 1-3, 5, 6, 7-9, 13-14. The facility's history thus justifies a significant penalty. Lastly, although Petitioner states that it requests a CMP at the lowest possible rate if one is imposed, it does not come forward with evidence that its financial condition affects its ability to pay the $32,500 CMP.

The undisputed evidence establishes that Petitioner was in violation of Medicare requirements beginning on June 10, 2012. Petitioner has not effectively challenged that the immediate jeopardy determination was clearly erroneous. Given the seriousness of Petitioner's noncompliance, its culpability, and its history of noncompliance, I find that a CMP of $7,000 per day for the period June 10, 2012 through June 12, 2012, is a reasonable remedy for Petitioner's failure to comply substantially with Medicare requirements at the immediate jeopardy level. Moreover, I find reasonable a CMP of $500 per day for Petitioner's continued noncompliance at less than an immediate jeopardy level, from June 13, 2012 through July 5, 2012.

IV. Conclusion

For the reasons set forth above, I grant summary judgment in favor of CMS and find that the remedy CMS imposed is reasonable.

/s/
Joseph Grow
Administrative Law Judge