Department of Health and Human Services

# DEPARTMENTAL APPEALS BOARD

## Appellate Division

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| In the Case of: North Carolina State Veterans Nursing Home, Salisbury, | DATE: June 23, 2009 |
| Petitioner, | Civil Remedies CR1855<br>App. Div. Docket No. A-09-31 |
| - v. - | Decision No. 2256 |
| Centers for Medicare & Medicaid Services. | |

FINAL DECISION ON REVIEW OF ADMINISTRATIVE LAW JUDGE DECISION

North Carolina State Veterans Nursing Home, Salisbury (NCVA) appeals the October 20, 2008 decision of Administrative Law Judge Jose A. Anglada, North Carolina State Veterans Nursing Home, Salisbury, DAB CR1855 (2008) (ALJ Decision). At issue before the ALJ was NCVA's challenge to enforcement remedies imposed by the Centers for Medicare & Medicaid Services (CMS) for NCVA's alleged noncompliance with Medicare participation requirements. The remedies included a civil money penalty (CMP) of $6,000 per day for noncompliance that CMS found to be at the level of "immediate jeopardy" from June 18, 2006 through June 23, 2006, and a $100 per-day CMP for alleged noncompliance of lesser seriousness from June 24, 2006 through July 20, 2006.

After an evidentiary hearing and post-hearing briefing, the ALJ concluded that: 1) NCVA was not in substantial compliance with three participation requirements related to abuse of residents

and with one participation requirement related to activities provided for residents; 2) CMS's determination that NCVA's noncompliance with two of the participation requirements related to resident abuse posed immediate jeopardy was not clearly erroneous; 3) CMS correctly determined that the immediate jeopardy was not abated until June 23, 2006; and 4) the CMP amounts were reasonable.

On appeal, NCVA takes exception to all of these conclusions other than the conclusion that it failed to substantially comply with the participation requirement related to resident activities. For the reasons discussed below, we affirm the ALJ's decision to uphold the CMPs imposed by CMS.

Case Background[1]

CMS advised NCVA by letter dated July 26, 2006 that it was imposing the CMPs based on the findings of a survey by the North Carolina Department of Health and Human Services (State survey agency) on June 22, 2006 to June 29, 2006. CMS Ex. 23. The State survey agency reported its findings on a standard form called a "Statement of Deficiencies" (SOD) which identified each participation requirement at issue with a unique survey "tag" number.

The surveyors found that NCVA did not meet the participation requirement at 42 C.F.R. § 483.15(f)(1) (Tag 248) that the facility "must provide for an ongoing program of activities designed to meet . . . the interests and the physical, mental, and psychosocial well-being of each resident." The surveyors also found that NCVA did not meet the participation requirements relating to abuse of residents at 42 C.F.R. §§ 483.13(b) (Tag 223), 483.13(c)(2) (Tag 225), and 483.13(c) (Tag 226). The surveyors determined that Tags 223, 225, and 226 involved noncompliance at the immediate jeopardy level.

[1] The general legal background is set out at pages 2-3 of the ALJ Decision. We identify other relevant provisions where appropriate in the text of this decision. This factual background is drawn from undisputed facts in the ALJ Decision and the case record, which are summarized here for the convenience of the reader but should not be treated as new findings.

By letter dated October 9, 2006, the State survey agency advised NCVA that it had revised the SOD to reflect the decision of the Informal Dispute Resolution (IDR) panel that NCVA's noncompliance under Tag 225 was not at the immediate jeopardy level as the surveyors found and that one of the findings on which this tag was based should be deleted.[2] P. Ex. 5.

Section 483.13 provides in relevant part as follows:

> (b) *Abuse*. The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.
>
> (c) *Staff treatment of residents*. The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.
>
> * * * * *
>
> (2) The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).

In concluding that there was noncompliance under two of the tags relating to resident abuse, Tags 223 and 226, the ALJ relied on the surveyors' findings that incidents of abuse occurred on May 28, 2006 and again on June 18, 2006. In finding noncompliance under the third tag relating to resident abuse, Tag 225, the ALJ relied solely on the findings concerning the May 28 incident.

The June 18 incident involved a 74-year-old male, identified as R2, who had end-stage Alzheimer's disease and who was paralyzed on one side of his body and unable to speak or to sit up on his own. ALJ Decision at 6. The incident occurred after the nurse aide assigned to provide care for this resident, identified as CNA 3, approached him to change his diaper and found him agitated and combative. Id. at 7. R2's care plan indicated

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[2] The revised SOD appears in the record at CMS Exhibit 1 as well as Petitioner Exhibit 1. The ALJ Decision sometimes cites to the original SOD at CMS Exhibit 2. NCVA's plan of correction appears in both Petitioner Exhibit 1 and CMS Exhibit 2.

that he had a history of physically abusive behavior and resistance to care and that if he became combative, staff should re-approach him after he had time to calm down. Id. at 4. CNA 3 left R2 alone for 30 minutes, but then found he was still agitated. She enlisted the assistance of two other nurse aides, CNA 1 and CNA 2, with whom she entered R2's room. Id. The ALJ found that CNA 3—

> witnessed nurse aides # 1 and #2 abuse R2 as soon as they entered the room to assist with his care, and she did not intervene to stop the abuse. [CNA 3] . . . simply stepped out of the room to retrieve supplies. When she returned, the beating perpetrated on the resident had escalated from shoving, pinning him down, and verbal abuse to an unrestrained beating.

ALJ Decision at 8.[3] When R2 sustained a skin tear on his hand as a result of the abuse, CNA 3 "reported to the charge nurse that R2 had become combative and caused injuries to himself." ALJ Decision at 7-8. The nurse supervisor (who had been sent by the charge nurse to check on R2) found that R2 had sustained multiple physical injuries in addition to the skin tear and sent R2 to a hospital emergency room for treatment and evaluation. Id. at 5. Forty-five minutes after the incident, CNA 3 "recanted her story and admitted that she had lied about how the resident was injured. She then revealed the abuse perpetrated by nurse aides # 1 and #2."[4] Id. at 8; see also id. at 6. The

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[3] NCVA acknowledges on appeal that there is no material dispute about the nature of the abuse that occurred on June 18. NCVA Br. at 14. Contrary to what the ALJ found, however, NCVA's description of this incident suggests that no abuse occurred before CNA 3 left R2's room to get supplies and also that after she returned the room and saw CNAs 1 and 2 abusing R2, those CNAs blocked her from leaving the room to report the abuse. Id. at 4-5. The ALJ expressly found that NCVA's version of the events was not supported by the record. ALJ Decision at 8-9. NCVA does not acknowledge the discrepancy between its description and the ALJ's findings, much less allege that the ALJ's factual findings regarding these details of the incident are not supported by substantial evidence. Accordingly, we affirm the ALJ's findings without further discussion.

[4] Although the original SOD contained a finding of

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police department was called and CNAs 1 and 2 were arrested. Id. at 5. CNA 3 told the surveyor that she did not do anything to prevent the abuse because she was afraid of CNAs 1 and 2 and was in shock from what she had seen. Id. at 8.

The May 23 incident was also reported by CNA 3 and involved a resident, identified as R3, who was admitted to the facility with diagnoses including Alzheimer's and dementia, was hearing and vision impaired, and who displayed behavior including verbal and physical abuse and resistance to care. ALJ Decision at 13. According to CNA 3, on May 28, 2006, the nursing assistants from an earlier shift reported that R3 was combative the previous night. CNA 3 therefore asked CNA 4 to help her care for R3, who began to fight when they entered his room. "In response, CNA 4 grabbed R3's knee and pressed it up against his chest." Id. at 14. CNA 3 did not report this incident to her supervisor when it occurred, nor even to the Director of Nursing (DON) when the DON counseled her on June 19 about the need to immediately report incidents of abuse. CMS Ex. 1, at 36. CNA 3 first reported this incident on June 22 when questioned by the surveyor about the June 18 incident. ALJ Decision at 14; CMS Ex. 1, at 35, 41-42. CNA 3 said she had not reported the incident earlier because she feared that CNA 4 would retaliate against her if she reported the incident. ALJ Decision at 14; CMS Ex. 1, at 42.

The ALJ concluded that NCVA failed to substantially comply with section 483.13(b) (Tag 223) and section 483.13(c)(2) (Tag 226) and that the noncompliance under each of these tags posed immediate jeopardy. Findings of Fact and Conclusions of Law (FFCLs) A.1., A.2., A.3., A.5, B.[5] The ALJ also concluded that

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noncompliance under Tag 225 relating to CNA 3's failure to immediately report the June 18 incident of abuse, the IDR panel subsequently concluded that the fact that CNA 3 did not report the abuse for 45 minutes did not violate the requirement in section 483.13(c)(2) to immediately report all allegations of abuse. P. Ex. 5, at 2.

[5] In FFCLs A.1. and A.2., the ALJ found that NCVA's noncompliance under Tags 223 and 226 posed immediate jeopardy with respect to R2. In FFCLs A.3. and A.5., the ALJ found that

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NCVA failed to substantially comply with section 483.13(c) (Tag 225) and that this noncompliance was at the less than immediate jeopardy level. FFCL A.4. In addition, the ALJ found that NCVA failed to substantially comply with section 483.15(f)(1) (Tag 248) at the less than immediate jeopardy level. FFCL A.6. The ALJ further concluded that the CMPs imposed by CMS were reasonable in amount. FFCL C.[6]

Standard of Review

Our standard of review on a disputed finding of fact is whether the ALJ decision is supported by substantial evidence on the record as a whole. Our standard of review on a disputed conclusion of law is whether the ALJ decision is erroneous. Guidelines -- Appellate Review of Decisions of Administrative Law Judges Affecting a Provider's Participation in the Medicare and Medicaid Programs, www.hhs.gov/dab/guidelines/prov.html.

Analysis

NCVA does not dispute that two of its CNAs abused R2 on June 18, 2006. However, NCVA takes exception to the ALJ's finding that one of its CNAs abused a resident on May 28. NCVA also takes

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NCVA's noncompliance under Tags 223 and 226 was at the less than immediate jeopardy level with respect to R3. The ALJ did not need to determine whether immediate jeopardy was present with respect to each resident as long as the noncompliance under each tag as a whole posed immediate jeopardy. Indeed, the ALJ stated elsewhere that he "sustain[ed] CMS's finding that Petitioner's level of noncompliance for each of these two deficiencies constitutes immediate jeopardy." ALJ Decision at 18; see also id. at 19. Thus, his assessment of the level of immediate jeopardy with respect to the individual residents was harmless error.

[6] As indicated previously, NCVA did not appeal FFCL A.6. Nor did NCVA appeal the ALJ's conclusion that the $100 per day CMP for noncompliance at the less than immediate jeopardy level was reasonable or that the period of noncompliance at that level commenced on June 24, 2006, and ended on July 20, 2006.

exception to the ALJ's conclusion that these incidents established a prima facie case, not overcome by NCVA, that NCVA was in violation of the requirements relating to abuse at sections 483.13(b), 483.13(c), and 483.13(c)(2). NCVA argues in particular that it was not responsible for the actions of its employees unless there was some "deficient practice" on the part of the facility administration or management and maintains that there was no such practice because it did everything it could to prevent resident abuse. NCVA also takes exception to the ALJ's findings of fact and conclusions of law regarding the existence of immediate jeopardy, the duration of the immediate jeopardy, and the reasonableness of the amount of the immediate jeopardy level CMP. Finally, NCVA takes exception to the ALJ Decision based on a number of other arguments that the ALJ declined to consider.

We discuss these arguments in turn below without reference to specific tags, although not every aspect of each argument pertains to every tag. We note that we have fully considered all arguments NCVA raises on appeal, regardless of whether we specifically address particular assertions.

The ALJ's finding that R3 was abused by CNA 4 is supported by substantial evidence.

NCVA argues, as it did before the ALJ, that the record evidence is insufficient to establish that R3 was abused on May 28, as reported by CNA 3. According to NCVA, "it is likely the event didn't happen, or didn't happen as she related it." NCVA Reply Br. at 4. As discussed below, we find that the ALJ reasonably relied on CNA 3's report.

As indicated above, the surveyors found that CNA 3 failed to report until June 22 an incident that occurred on May 28 in which CNA 4 abused R3. Before the ALJ, NCVA argued that when CNA 3 reported the abuse, the facility immediately launched an investigation and found no corroborating evidence that such an incident occurred. The ALJ stated, however, that "it is not surprising that no documentation was found to confirm the incident, because the people involved had chosen not to make it known." ALJ Decision at 14. Noting that "corroboration could only come from" the employees who had knowledge of the abuse, CNA 3 and/or CNA 4, the ALJ stated that CNA 3—

> had already confessed that she witnessed the abuse. She was willing to do this although she was now aware that she had already incurred in a [sic] serious violation of facility policy in a similar matter [when she was reprimanded on June 18 for not immediately reporting the abuse of R2]. Thus, she made a confession knowing that such revelation would place her in a greater negative light than was already the case.

Id. The ALJ also observed that NCVA's DON and its administrator each testified that she had contacted CNA 4, but that CNA 4 refused to go to the facility to discuss the alleged abuse, telling the administrator that he preferred to discontinue employment at the facility rather than to discuss the matter. Id., citing Tr. at 162 and 227-232. The ALJ noted that "[t]he administrator stated that [CNA 4's] response to the request to discuss the abuse of R3 was an indication to her that he may very well have been guilty of the alleged abuse." Id.[7]

On appeal, NCVA argues that "[t]he circumstances of [CNA 4's] refusal to return to the facility and discuss his actions are too ambiguous from which to draw inference [sic] of guilt." NCVA Br. at 24. NCVA notes that "[w]e do not know . . . what exactly was said to [CNA 4] to summon him back to the facility." Id. NCVA also asserts that, "[e]ven if innocent, CNA 4 "had reason to be apprehensive at being the subject of an accusation by the same person who had accused CNA #1 and #2, who were led out of the Facility to jail in handcuffs." Id. NCVA's argument ignores the fact that the ALJ relied on the testimony of NCVA's own administrator that CNA 4's response to the administrator's request to return to the facility to discuss the abuse of R3 indicated to her that he may have been guilty of abuse. In addition, NCVA's suggestion that CNA 4 knew that the other CNAs had been arrested for abuse and might have been afraid of being arrested based on a false accusation by the same CNA is sheer

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[7] The ALJ also indicated that his finding of a May 28 incident was corroborated by the fact that NCVA's administrator terminated CNA 3 on the ground that she witnessed CNA 4 abuse R3 and did not report it immediately. ALJ Decision at 14-16, citing P. Ex. 13 and Tr. at 234-235. NCVA asserts that the administrator terminated CNA 3 on other grounds. See NCVA Br. at 23. We need not resolve this dispute since we conclude that the other evidence on which the ALJ relied is sufficient to support his finding that abuse occurred on May 28.

speculation. In any event, the ALJ did not rely primarily on CNA 4's refusal to return to the facility but rather on CNA 3's report of having witnessed CNA 4 abusing R3.

NCVA also suggests that the ALJ erred in finding CNA 3's report credible since CNA 3 "revealed herself to be an unreliable source of information." NCVA Br. at 23. NCVA points out that CNA 3 initially lied to her supervisor about how R2 sustained a skin tear on the morning of June 18, and that CNA 3 told NCVA's DON on June 19 that she had witnessed no abusive acts other than the June 18 incident but then told the surveyor on June 22 about the May 28 incident. It is clear from the ALJ Decision, however, that the ALJ found CNA 3's report reliable as an admission against interest. See ALJ Decision at 14. CNA 3's initial failure to admit to having witnessed the two incidents of abuse does not make her later admission untrustworthy since she had a plausible explanation for her failure.

NCVA also argues that if abuse had actually occurred on May 28, it "likely" would have come to light before CNA 3 made her allegations "because NCVA already had in place a strong program and culture of recognizing and investigating signs of potential abuse." NCVA Br. at 22. According to NCVA, skin assessments were routinely performed on a weekly basis, residents at risk for skin type injuries--including combative residents like R2--were monitored daily by the treatment nurse, and a representative of the Veterans Administration was present daily and monitored and followed-up on complaints. See id. at 23. Even assuming this were true, NCVA does not point to any basis for concluding that the abuse suffered by R3 would have resulted in a noticeable change in his skin condition or that the resident could or would have complained about the abuse. Thus, as NCVA itself recognizes, this argument is highly speculative.

NCVA also asserts that the surveyor testified that CNA 3's allegations concerning CNA 4's abuse of R3 "were not sufficiently supported by other facts and should not have been used as a basis for a citation." NCVA Br. at 24, citing Tr. at 69. The surveyor did testify that the surveyors were unable to corroborate, either through documentation in facility records or through interviews, CNA 3's report that CNA 4 abused R3 on May 28. Tr. at 62-63. However, as the ALJ correctly observed, the lack of corroboration is meaningless under the circumstances here. Moreover, even if the surveyor had unequivocally testified that the SOD incorrectly cited this incident as an

example of abuse under Tag 223 (which she did not), whether CMS correctly based its determination on the finding in the SOD is a legal question to be decided by the ALJ.

Finally, NCVA does not argue that the ALJ failed to consider any evidence in the record which would show that CNA 4 did not abuse R3 as claimed by CNA 3. Nor did NCVA seek to have the ALJ issue a subpoena compelling CNA 4 to testify at the hearing.

Accordingly, we conclude that the ALJ's finding that R3 was abused by CNA 4 on May 28 is supported by substantial evidence in the record as a whole. Thus, the ALJ did not err in relying on this finding in concluding that NCVA failed to substantially comply with the requirements to provide an environment free of abuse (Tag 223), that all alleged abuse be reported immediately to the facility administrator and others (Tag 225), and that a facility develop and implement written policies and procedures that prohibit abuse (Tag 226).

The ALJ did not err in relying on evidence of the actions of NCVA's employees to conclude that the facility failed to substantially comply with section 483.13(b) (Tag 223), section 483.13(c)(2) (Tag 225), and section 483.13(c) (Tag 226).

NCVA maintains that "the central question in this appeal" is whether "the employment status of the perpetrator" of resident abuse is by itself a sufficient basis for concluding that the facility failed to substantially comply with the participation requirements relating to abuse that are at issue here. NCVA Br. at 1. According to NCVA, a facility is not responsible for "the intentional acts of CNAs who knew they were doing wrong" where there is no finding that the facility's management or administration "committed a deficient practice related to the abusive conduct[.]" Id.; see also NCVA Reply Br. at 3.

The ALJ found this argument unpersuasive, stating:

> Petitioner cannot escape responsibility by arguing that the facility was diligent in its hiring practices and the staff understood the facility's abuse reporting and investigation requirements. Contrary to Petitioner's contention, I do not have to look for a deficient facility practice outside the actions of the staff entrusted to act on behalf of the facility. Consequently, the deficient facility practice, in this case, is unequivocally found in the improper

> conduct of those that the facility empowered to act on its behalf. The facility, as a business entity, exists only in contemplation of the law, and can only perform the functions of a long-term care provider through the employees it chooses and empowers to act on its behalf. Acceptance of Petitioner's argument as sufficient justification for a finding of substantial compliance would render the law and regulations applicable here, meaningless.

ALJ Decision at 11.[8]

In reaching this conclusion, the ALJ relied on the Board's analysis in its May 2, 2008 ruling in Beverly Health Care Lumberton, Ruling No. 2008-5 (denying petition for reopening of DAB No. 2156). See ALJ Decision at 10, quoting Ruling No. 2008-5, at 6-7. NCVA argues that Lumberton is distinguishable from this case because in Lumberton, nurses as well as CNAs violated the facility's policy prohibiting abuse. NCVA asserts that "[i]n contrast, at NCVA only the three CNAs present at the incident were found to have violated Facility policy and procedures and engaged in deficient practices."[9] NCVA Br. at 15. NCVA points out that the Board's ruling in Lumberton states that "a facility whose **administration and staff** have been found not to be substantially complying with the federal requirements is itself subject to administrative enforcement remedies." NCVA Br. at 14, quoting Ruling No. 2008-5, at 7 (emphasis added by NCVA). According to NCVA, nurses in nursing facilities are supervisory personnel who "are part of management and the administration of the facility." NCVA Br. at 15. Thus, in NCVA's view, the Lumberton ruling holds that a facility is responsible for the acts of its employees only where individuals who are part of the facility's "management/administration" are

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[8] The State survey agency rejected the same argument raised by NCVA in the IDR process and found that "[t]he facility was responsible for the actions of its employees." P. Ex. 5, at 1, 2.

[9] NCVA admits to only the June 18 incident in its arguments; however, as discussed above, the ALJ properly found that CNA 3 also witnessed abuse on May 28 and failed to immediately report it.

somehow implicated in the employees' misconduct. NCVA Br. at 14.

Contrary to what NCVA suggests, however, nothing in the Board's Lumberton ruling suggests that the actions of facility employees who are not considered part of facility management are not attributable to the facility. The wording in the ruling simply reflects the fact that in that case, both nurses and a CNA were involved. The rationale for holding a facility accountable for the actions of its staff applies equally to all staff members who, in the course of carrying out their assigned duties, fail to act in a manner consistent with the regulations and the facility's policies pertaining to resident abuse. That is, "since the facility elected to rely on them to carry out its commitments," the facility cannot "disown" their "acts and omissions." Lumberton ruling at 7; see also Life Care of Gwinnett, DAB No. 2240, at 12-13 (2009) ("Facilities are responsible for providing care in accordance with federal participation requirements. Facilities perforce carry out this responsibility in part through their selection, training and supervision of their staff. Therefore, only facilities are able to take action to prevent incompetent or dishonest individuals from harming residents.").[10]

NCVA also argues that "there is no regulatory purpose to be served" by citing it for violations of the tags in question because there was no "deficient practice" attributable to its administration or management that contributed to the abuse. NCVA Br. at 13, 15. Not only is this argument unpersuasive but its premise that there was no deficient practice is incorrect, as we explain below.

According to NCVA, CMS found that the facility returned to substantial compliance in July 2006 without requiring NCVA to change its policies and procedures on abuse. See NCVA Br. at 15; id. at 20, citing surveyor worksheets at P. Exs. 47-61 and 63. NCVA asserts that "the evidence in the record is unrefuted that the surveyors closely reviewed every element of NCVA's prevention program - hiring procedures, training program, staff knowledge of abuse policies and procedures, and staff monitoring

[10] Contrary to what NCVA argues, this rationale also applies regardless of whether the actions of facility staff constitute abuse or neglect. See NCVA Reply Br. at 9.

by supervisors - and found no deficient practice by the facility in [these] areas." Id. at 20; see also NCVA Reply Br. at 3. However, even assuming NCVA's policies and procedures on abuse were in theory adequate (a matter we need not address here), they could not serve their intended purpose unless they were implemented.

We note preliminarily that the ALJ could have reasonably concluded based on the testimony of NCVA's DON that NCVA failed to implement its policies and procedures. The DON testified in relevant part that everyone employed by NCVA was responsible for implementing NCVA's policies on abuse. Tr. at 173. Those policies required that facility staff inform their immediate supervisor immediately of any violations of the policy. Id. at 119; see also P. Ex. 13 (NCVA administrator's letter to CNA 3 stating that she "failed to follow the policy by not immediately reporting the witnessed act of alleged abuse to your immediate supervisor") and CMS Ex. 38.[11] Thus, the ALJ could reasonably conclude that CNA 3's failure to immediately report the abuse she witnessed on May 28 constituted not only a violation of facility policy but also a failure by the facility to implement its policies on abuse.

In any event, the ALJ reasonably inferred from the two incidents of abuse that NCVA failed to adequately implement its policies and procedures. As noted, within a one-month period, there were two incidents in which a total of three employees abused a total of two different residents. The June 18 incident, which culminated in an "unrestrained beating" of the resident (ALJ Decision at 8), was particularly egregious. In addition, a fourth employee failed to follow the facility's policy to

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[11] CMS Exhibit 38 is a Policies and Procedure Manual on abuse issued by NCVA in December 2001, with a Letter of Adoption showing that it was reviewed by the facility administrator and others in 2005. The Manual states in relevant part that "[r]esidents/patients within our facility/agency will not be subjected to abuse or neglect by anyone . . ." and that "[a]ny person observing, hearing a complaint of, and/or identifying any signs and symptoms of abuse . . . must immediately report it to the Administrator within 24 hours of the awareness of the occurrence." CMS Ex. 38, at 13. Neither the DON's testimony nor the administrator's letter specifically identify the Policies and Procedure Manual as the applicable policy, however.

immediately report the abuse she witnessed in the earlier incident on May 28. The same employee also failed to ask for help when she left the room shortly after the abuse began on June 18 without either attempting to intervene herself or seeking help from her supervisor. As the ALJ observed, had CNA 3 followed NCVA's policy, the subsequent and more severe beating of R2 may not have even occurred. See ALJ Decision at 8. Thus, the environment at the facility was such that not only did several employees show no compunction about committing abuse, but the employee who witnessed the two incidents was initially unwilling to come forward to report the abuse, much less to try to stop it. On its face, this indicates that whatever actions NCVA took to implement its policies and procedures on abuse were inadequate.

NCVA suggests that it is inappropriate to base an inference that it failed to implement its policies and procedures on what the surveyors determined was "an isolated instance of abuse." NCVA Reply Br. at 10. NCVA maintains that the Board has held "that one isolated instance in a context such as the one presented here does not make out a deficiency under F226." NCVA Br. at 20 (emphasis added). In support of its argument, NCVA quotes the statement in Emerald Oaks, DAB No. 1800 (2001) that section 483.13(c) "addresses adopting effective anti-neglect and abuse policies, not targeting isolated events." NCVA mischaracterizes the facts of its case: there were two incidents of abuse, and, even more significant, a total of four CNAs who either participated in the abuse or failed to report the abuse. Moreover, the fact that the surveyors found that the scope of the noncompliance under both Tags 223 and 226 was isolated did not preclude a finding that the incidents were sufficient to demonstrate a failure to implement the policies and procedures. See 42 C.F.R. §§ 488.438(f) and 488.404(b)(2); see also Liberty Commons Nursing & Rehab Center - Johnston, DAB No. 2036 (2006) (upholding ALJ's conclusion that facility violated section 483.13(c) based on more than a single nursing error although survey cited only one incident), aff'd, Liberty Commons Nursing & Rehab Ctr.-Johnston v. Leavitt, 241 F. App'x 76 (4th Cir. 2007).

Moreover, NCVA cites nothing in the record that rebuts the inference that it failed to adequately implement its policies and procedures. According to NCVA, the survey found "that all staff who were questioned about the policies and procedures were able to give correct answers." NCVA Br. at 15 (citing

surveyor's testimony). However, the surveyor testified that facility staff and supervisors gave appropriate answers when she asked them about NCVA's abuse policy in interviews on June 22-24. Tr. at 84-85.[12] This testimony does not address their understanding of NCVA's abuse policy at the time the incidents of abuse occurred. The surveyor also qualified her testimony by stating that the surveyors "didn't interview every person and every staff because they're not available." Tr. at 85.

NCVA also refers generally to evidence of its "extensive efforts to develop and implement" its policies and procedures. NCVA Br. at 18. NCVA had an abuse and neglect policy in effect prior to May 28, 2006. See, e.g., P. Ex. 13; CMS Ex. 38. As noted above, however, the mere existence of a policy on abuse is insufficient to show that a facility met the requirement to develop and implement the policy. The record also includes sign-in sheets for in-service training on abuse and related topics on various dates. P. Ex. 32, at 1, 17; P. Ex. 33, at 1; P. Ex. 34, at 1-9; P. Ex. 35, at 1-16; P. Ex. 37; P. Ex. 39, at 1-2; P. Ex. 40; P. Ex. 41, at 1-2. However, only two sign-in sheets, at P. Exhibit 32, are for training prior to the incidents in question (on January 18 and April 28, 2006, respectively), and of those sign-in sheets, only one contains the name of a CNA who was involved in the incidents. See P. Ex. 32, at 17.

We therefore conclude that NCVA's arguments provide no basis for disturbing the ALJ's conclusions that NCVA failed to substantially comply with the requirements to provide an environment free of abuse (Tag 223), for immediately reporting all alleged abuse to the facility administrator and others (Tag 225), and to develop and implement written policies and procedures that prohibit abuse (Tag 226).[13]

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[12] The relevant testimony appears in the transcript on these pages rather than on the pages cited in NCVA's brief.

[13] NCVA also argues that the citation under Tag 226 "is entirely redundant with Tag F223 and . . . should be deleted as surplusage" because the SOD relies entirely on the surveyor's findings regarding the two incidents of abuse as the basis for that tag as well as Tag 223. NCVA Br. at 19. However, the fact that the same findings support both of these tags does not make the tags redundant. As indicated above, the ALJ relied directly

(Continued. . .)

The ALJ did not err in determining that NCVA's noncompliance under Tags 223 and 226 posed immediate jeopardy.

The ALJ concluded that NCVA's noncompliance under Tag 223 as well as Tag 226 posed immediate jeopardy. "Immediate jeopardy," the most serious level of noncompliance, 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." 42 C.F.R. § 488.301. CMS's determination of immediate jeopardy must be upheld unless it is clearly erroneous. 42 C.F.R. § 498.60(c)(2).

NCVA takes the position that the determination of immediate jeopardy was contrary to CMS policy in Appendix Q of CMS's State Operations Manual. See NCVA Br. at 24-26. NCVA points out that Appendix Q identifies various "triggers" associated with failure to protect from abuse. These triggers include "[s]taff striking or roughly handling an individual." P. Ex. 67, at 6. NCVA also points out the following language from Appendix Q:

> Triggers describe situations that will cause the surveyor to consider if further investigation is needed to determine the presence of Immediate Jeopardy. The listed triggers do not automatically equal Immediate Jeopardy.

P. Ex. 67, at 4. NCVA argues that "[b]y listing staff striking a resident as a trigger CMS forthrightly acknowledges that such a situation is not *per se*" immediate jeopardy. NCVA Br. at 25. According to NCVA, moreover, if a trigger applies, then Appendix Q requires that the surveyors investigate the situation to determine whether the three "components" of immediate jeopardy set out in Appendix Q—actual or potential harm, immediacy, and culpability—are present. NCVA argues that the component of culpability was not present here, and there was thus no immediate jeopardy, based on its responses to the following questions listed in the section on culpability:

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(Continued. . .)

on the findings in concluding that NCVA violated Tag 223 and made an inference from the findings based on which he concluded that NCVA violated Tag 226.

a. Did the entity know about the situation? If so when did the entity first become aware?
b. Should the entity have known about the situation?
c. Did the entity thoroughly investigate the circumstances?
d. Did the entity implement corrective measures?
e. Has the entity re-evaluated the measure to ensure the situation was corrected?

Id.; P. Ex. 67, at 13.

We are not persuaded that the determination of immediate jeopardy here is inconsistent with Appendix Q. The surveyors determined not only that staff struck and/or handled residents roughly, but also that staff did so in the course of providing resident care. Thus, the surveyors looked at the circumstances under which the behavior described in this trigger occurred and did not treat the trigger as automatically establishing that immediate jeopardy existed. Furthermore, the definition of immediate jeopardy in section 488.301 does not support NCVA's reading of Appendix Q as providing that culpability is a necessary component of immediate jeopardy. In any event, the questions about culpability merely identify some factors that might lead to a determination of the degree, if any, to which a facility was culpable for noncompliance, i.e., that a facility should have been aware of the situation earlier or failed to thoroughly investigate the situation and implement appropriate corrective measures. Nothing in Appendix Q suggests that the answers to these questions about culpability are determinative or that the surveyors could not rely on other evidence to support a finding of immediate jeopardy. As discussed below, there is substantial evidence in the record to support the ALJ's finding that the actions of NCVA's employees, for which the facility was responsible, reflected a high degree of culpability.[14]

[14] NCVA also argues that basing the findings of noncompliance relating to abuse solely on the actions of its employees is contrary to Appendix Q. NCVA Reply Br. at 2. NCVA does not explain how Appendix Q applies to a determination of noncompliance, however.

Accordingly, we conclude that the ALJ did not err in upholding CMS's determination of immediate jeopardy.

The ALJ did not err in determining that the $6,000 per-day CMP was reasonable and that immediate jeopardy was not abated until June 23, 2006.

ALJ concluded that the $6,000 per day CMP imposed by CMS for immediate jeopardy level noncompliance under Tags 223 and 226 for the period June 18-23 was reasonable. ALJ Decision at 19-20.[15] NCVA contends that the ALJ erred in determining that the amount of the CMP was reasonable and that immediate jeopardy continued until June 23. NCVA Br. at 27-28. For the reasons discussed below, we conclude that the ALJ's conclusions are supported by substantial evidence and are free of error.

The ALJ did not err in concluding that $6,000 per day CMP was reasonable in amount.

If a per-day CMP is imposed for noncompliance at the immediate jeopardy level, the CMP must be in the range of $3,050-$10,000 per day. 42 C.F.R. § 488.438(a)(1)(i). The factors that CMS may consider in determining the amount of a CMP are: the facility's history of noncompliance (including repeated deficiencies); its financial condition; its degree of culpability for the cited deficiencies; the seriousness (i.e., scope and severity) of the noncompliance; and the relationship of one deficiency to the other deficiencies resulting in noncompliance. 42 C.F.R. §§ 488.438(f), 488.404. The term "culpability" is defined as "including, but not limited to, "neglect, indifference, or disregard for resident care, comfort or safety." Section 488.438(f)(4).

The ALJ concluded that the $6,000 per day CMP imposed by CMS was reasonable based on "the gross failure [of NVCA] to provide an environment for its residents that is free from abuse." ALJ Decision at 19. The ALJ noted specifically that "two CNAs . . . abusively assaulted a bedridden resident while a third staff

[15] Although the ALJ's FFCL C. states only that "[t]he amount of the penalty imposed by CMS is reasonable," the text that follows discusses both the reasonableness of the CMP amount and the duration of the immediate jeopardy.

member witnessed the shameful beating without intervening to stop it or seek the assistance of a supervisor[.]" Id. The ALJ further noted that "[t]hat same CNA had witnessed a prior incident of abuse a month earlier, and failed to immediately report the incident." Id. The ALJ also stated that "[t]he facility's culpability cannot find sanctuary in [the CNA's] lame excuse" that "she did not do anything to protect the residents or report the abuse for fear of retaliation." Id. In addition, the ALJ referred to NCVA's "failure . . . to implement its policies and procedures against abuse."[16] Id. The ALJ thus based his conclusion that the $6,000 per day CMP was reasonable primarily on two of the regulatory factors related to the June 18 incident that was the principal basis for Tags 223 and 226: the seriousness of the noncompliance and the high degree of culpability for this noncompliance.

NCVA does not deny that the CNAs' misconduct was serious or that it reflected a high degree of culpability, but rather contends that the ALJ erred in attributing the culpability of the CNAs to the facility. NCVA Br. at 28.[17] This is in effect the same argument NCVA made in challenging the ALJ's conclusions that it failed to substantially comply with the requirements relating to abuse and that its noncompliance under Tags 223 and 226 posed immediate jeopardy. For the reasons previously discussed, we conclude that this argument has no merit.

NCVA also points out that CMS imposed the $6,000 per day CMP before the completion of the IDR process, based on which the State survey agency changed the level of noncompliance for Tag 225 from immediate jeopardy to no actual harm with a potential for more than minimal harm that is not immediate jeopardy. In

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[16] The sentence reads in full: "I find that the failure of Petitioner to implement its policies and procedures against abuse demonstrates a systemic problem within the facility." ALJ Decision at 19. We read this to mean that the CNAs' conduct reflected a systemic problem and that the facility therefore failed to implement its policies and procedures.

[17] NCVA asserts that the "surveyor herself testified that NCVA bore no culpability for the acts of the CNAs." Id., citing Tr. at 52, 58. As the ALJ points out, this is a misreading of her testimony, which was instead consistent with his conclusion to the contrary on this legal issue.

NCVA's view, the reduction of the number of immediate jeopardy tags from three to two merited a reduction in the CMP to the minimum permitted by law ($3,050), assuming there were a basis for imposing a CMP. NCVA Br. at 28. Where, as here, an ALJ upholds a CMP based on findings different from those considered by CMS, the ALJ must consider the reasonableness of the amount based on the altered factual findings. Cf. Madison Health Care, DAB No. 1927, at 23 (2004) ("where a CMP is upheld based on a subset of cited deficiencies, it is important that the ALJ make clear how he has independently applied the regulatory factors to arrive at this result despite any changes in the number of and facts underlying the deficiencies upheld compared to those either overturned or unaddressed."). We conclude that the ALJ did so here. The ALJ mentioned the basis for Tag 225--CNA 3's failure to immediately report the May 28 incident--in discussing the reasonableness of the CMP amount; however, he described only the June 18 incident cited under Tags 223 and 226 in terms that indicate that he found NCVA's noncompliance to be very serious and to reflect a high degree of culpability. NCVA offers no reason why the ALJ erred in finding a $6,000 per day CMP reasonable based on two immediate jeopardy deficiencies that reflected a high degree of culpability.[18] Thus, it is simply irrelevant that CMS imposed the same CMP amount based on survey findings that included a third immediate jeopardy deficiency.

Accordingly, we uphold the ALJ's conclusion that the CMP imposed by CMS was reasonable in amount.

The ALJ did not err in determining that the immediate jeopardy was abated on June 23, 2006.

CMS's notice that it was imposing remedies based on the survey stated in relevant part that the survey found "that conditions in your facility constituted immediate jeopardy to residents' health and safety from a period beginning June 18, 2006 through June 24, 2006 when corrective action was taken by your facility to remove the immediate jeopardy." CMS Ex. 23, at 1. The ALJ found that CMS determined that the immediate jeopardy "was

[18] NCVA alleges generally that "its history of program compliance is a strong and good one." NCVA Br. at 28. Even if true, this is irrelevant since the ALJ did not rely on any history of noncompliance in determining that the CMP amount was reasonable.

abated on June 23, 2006, based on the facility's plan of correction showing that on that date it completed a physical assessment on all residents and did not identify any injuries of unknown origin." ALJ Decision at 20. NCVA's plan of correction stated: "The facility staff conducted physical assessments on all residents and did not identify any injuries of unknown origin. Completed 6/23/06." P. Ex. 1 (SOD showing plan of correction), at 6. The ALJ adopted without discussion CMS's determination that the immediate jeopardy was abated on June 23, other than to note that "[t]he burden is on the facility to prove that it has resumed complying with program requirements, not on CMS to prove that the deficiencies continued to exist after they were discovered." ALJ Decision at 20, citing Hermina Traeye Memorial Nursing Home, DAB No. 1810 (2002).

Before the ALJ as well as on appeal, however, NCVA argued that, assuming there was noncompliance that posed immediate jeopardy, the immediate jeopardy ended on June 20 rather than June 23. Petitioner's Reply to CMS' Post-Hearing Brief at 7-8; NCVA Br. at 27. NCVA relies solely on testimony by its DON that "[e]very resident . . . in the building at the time was visually examined . . . [w]ithin two days" of the June 18 incident of abuse (i.e., by June 20). Tr. at 137; see also Tr. at 179.

Immediate jeopardy "is deemed to have been removed only when the facility has implemented necessary corrective measures." Sheridan Health Care Center, DAB No. 2178, at 42 (2008), citing Fairfax Nursing Home, Inc., DAB No. 1794 (2001), aff'd, Fairfax Nursing Home v. Dep't of Health & Human Servs., 300 F.3d 835 (7th Cir. 2002), cert. denied, 537 U.S. 1111 (2003). Moreover, a facility bears a heavy burden to prove that immediate jeopardy was abated earlier than the date determined by CMS. See Fairfax Nursing Home, Inc., DAB No. 1794, at 17 (holding that HCFA (CMS's predecessor) "was not clearly erroneous in concluding that the steps taken . . . were insufficient to abate the immediate jeopardy."); 42 C.F.R. § 498.60(c).

We conclude that NCVA failed to demonstrate that it abated the immediate jeopardy at any point prior to June 23, 2006. The DON undercut her own testimony that NCVA completed physical assessments of all residents on June 20 when she conceded on cross-examination that the date of completion on the facility's plan of correction should be correct. Tr. at 179-180. The DON's direct testimony is also contradicted by the surveyor's testimony that at the time NCVA terminated CNA 3's employment--

which Petitioner Exhibits 13 and 14 show occurred on June 23, NCVA had assessed only the residents assigned to CNAs 1 and 2, not all the residents in the facility. Tr. at 32-33. Even if NCVA were correct that it completed physical assessments of all residents on June 20, CMS could have reasonably found that the immediate jeopardy was not abated before June 23 because CNA 3 continued to work at the facility caring for residents until that date. See Tr. at 174. Her continued employment endangered all residents since she had demonstrated an unwillingness to protect residents from abuse by intervening in or reporting even very egregious abuse. Indeed, the surveyor testified that CNA 3's continued employment was one of the reasons a plan of correction proposing an earlier correction date was unacceptable. Tr. at 29-30.

We therefore conclude the ALJ did not err in determining that the immediate jeopardy was abated on June 23.

NCVA's other arguments have no merit.

The ALJ stated that NCVA had raised arguments about the long-term survey process that were "beyond" the ALJ's "adjudicatory authority" and that his decision would therefore not address these arguments. ALJ Decision at 17. NCVA argues again on appeal that the long-term survey process is unlawful and also raises other miscellaneous bases for appeal not referred to in the ALJ Decision but raised below. See NCVA Br. at 28-32. NCVA cites little, if any, legal authority for most of these arguments. In addition, for the most part, these are general legal arguments that are not raised by the facts of this appeal and are unrelated to specific issues that we discussed above. Moreover, some of the arguments are based on NCVA's interpretations of its constitutional rights or on claims that Secretarial regulations violate the provisions of the Administrative Procedure Act (APA), 5 U.S.C. §§ 551 et seq. The Board has no authority to consider such arguments. See, e.g., Hermina Traeye Memorial Nursing Home, DAB No. 1810 (2002), aff'd, Sea Island Comprehensive Healthcare Corp. v. U.S. Dep't of Health & Human Servs., 79 F. App'x 563 (4th Cir. 2003). We therefore conclude that none of the arguments provide a basis for reversing or modifying the ALJ Decision. We nevertheless explain briefly below why some of the arguments (most of which NCVA describes as arguments about the validity of the long-term survey process) reflect a misunderstanding of the regulatory scheme.

The regulatory provision for a 35% reduction of the CMP amount for a facility that waives its right to request a hearing is not unconstitutional or a violation of the APA.

Section 488.436(b) of 42 C.F.R. provides that "[i]f the facility waives its right to a hearing . . . , CMS or the State reduces the civil money penalty amount by 35 percent," and that there will otherwise be no reduction in the CMP amount. NCVA contends that, pursuant to the regulation, the amount of the CMP at issue in this case was effectively increased by 54 percent because NCVA did not waive its right to request a hearing. NCVA further contends that this constitutes a penalty enhancement that deprives it of property without due process in violation of the Fifth Amendment, as well as a sanction that is not authorized by law as required the APA (at 5 U.S.C. § 558(b)). Accordingly, NCVA argues, "NCVA's CMP must automatically be reduced by 35 percent as a matter of law." NCVA Br. at 29.

This argument ignores the preamble to the final regulations, which states that the 35% reduction in the CMP amount—

> would reflect the savings to both the government and the provider of costs that would otherwise be incurred to formally adjudicate the dispute. The provider would be free to reject the option to waive the right to a hearing.

59 Fed. Reg. 56,116, 56,243 (Nov. 10, 1994). The regulation thus purports to provide a financial incentive for a facility to waive its right to request a hearing without increasing the overall amount that the facility would have to pay if it unsuccessfully challenged the CMP. NCVA does not point to anything that would undercut the assumption in the preamble that the costs of pursuing an appeal would be equal to 35% of the CMP. In any event, NCVA's view that the penalty amount would effectively increase if a facility requests a hearing overlooks the fact that CMS sets the initial CMP amount, prior to any reduction for the 35%, based on the regulatory factors. NCVA also ignores the fact that a facility may prevail in the hearing and have a reduced CMP or no CMP at all.

The regulations do not improperly limit the review of agency action.

NCVA challenges two unrelated regulations—42 C.F.R. §§ 488.305(b) and 488.408(g)(2)--on the ground that they unlawfully limit the review of agency action and are thus inconsistent with the APA. NCVA Br. at 29-30. However, NCVA mischaracterizes the meaning and effect of both of these provisions.

Section 488.305(b) provides that "[t]he State survey agency's failure to follow the procedures set forth in this section will not invalidate otherwise legitimate determinations that a facility's deficiencies exist." NCVA argues that section 488.305(b) requires "that survey results remain valid even if the surveyor violates the inspection protocol and proceeds to conduct the investigation as dictated by his or her own judgment." NCVA Br. at 30. As the Board has previously stated, however, the ALJ reviews de novo whether the evidence supports CMS's (and the State's) determination of noncompliance. See, e.g., Sunbridge Care and Rehabilitation for Pembroke, DAB No. 2170, at 26-27 (2008); see also, Beechwood Sanitarium, DAB No. 1824 (2002); Hermina Traeye; Golden State Manor and Rehabilitation Center, DAB No. 1597 (1996). Thus, an allegation that a State surveyor failed to follow the procedures set forth in the regulations is irrelevant "where objective evidence [such as a facility's own records] establishes noncompliance . . . ." Canal Medical Laboratory, DAB No. 2041, at 6 (2006); accord, Vijay Sakhuja, M.D., DAB No. 1958, (2005), Vandalia Park, DAB No. 1940 (2004).

Section 488.408(g)(2) provides that "[a] facility may not appeal the choice of remedy, including the factors considered by CMS or the State in selecting the remedy, specified in § 488.404." NCVA argues that this regulation permits CMS to "avoid accountability for failure to comply with its own rules." P. Br. at 31, citing Montilla v. INS, 962 F.2d 162, 166 (3rd Cir. 1991)("the rules promulgated by a federal agency, which regulate the rights and interests of others, are controlling upon the agency"). However, the statute and regulations give CMS and the State wide latitude in selecting a remedy for a facility's failure to substantially comply with the Medicare participation requirements. See section 1819(h)(2)(A) and (B) of the Social Security Act (42 U.S.C. § 1395i-3(h)(2)(A) and (B)); 42 C.F.R. § 488.400, 488.402, 488.404, 488.406, 488.408; Hermina

Traeye at 22 (section 1819(h) of the Act "permits the Secretary to seek multiple remedies, including termination and the imposition of a CMP, against a facility found noncompliant with program requirements"). Thus, section 488.408(g)(2) merely precludes the ALJ and the Board from reviewing CMS's exercise of discretion with respect to the selection of a remedy.

The requirement for a survey does not violate the Fourth Amendment prohibition on unreasonable searches.

NCVA argues that the requirement for a survey to determine whether a facility is substantially complying with the Medicare participation requirements violates the Fourth Amendment prohibition on unreasonable searches because there are no consequences for a surveyor's failure to follow the applicable procedures. NCVA Br. at 30, citing 42 C.F.R. § 488.305(b). As discussed above, the procedures followed by the surveyors are irrelevant. In any event, in adopting the final regulations, the Department specifically rejected the contention that a survey would constitute an unconstitutional search, stating:

> Providers have consented to certification and validation surveys and to complaint investigations by choosing to participate as providers in the Medicare or Medicaid programs, or both. As indicated previously, the Supreme Court has long upheld warrantless searches of closely regulated businesses, and the nursing home industry is no exception.

56 Fed. Reg. 56,159. NCVA has not explained why we should reach a different conclusion here.

The survey protocols in CMS's State Operations Manual are not invalid.

NCVA contends that the survey protocols in Appendix P and Appendix Q of CMS's State Operations Manual (SOM) are inconsistent with the regulations at 42 C.F.R. Part 488, subpart C, and are invalid because they were not published pursuant to the notice and comment provisions in the APA (at 5 U.S.C. § 553). NCVA Br. at 30. This argument is undercut by NCVA's own reliance on Appendix Q of the State Operations Manual to support its position that the ALJ erred in concluding that NCVA was out of substantial compliance and that its noncompliance posed immediate jeopardy. In addition, any inconsistency with

Part 488, subpart C (entitled "Survey Forms and Procedures") is of no consequence since those regulations were rendered inapplicable by the Omnibus Budget Reconciliation Act of 1987. See Golden State Manor and Rehabilitation Center at 15-16. The Board also concluded in that decision that provisions in the SOM that are procedural or interpretive are not required to be published pursuant to notice and comment rulemaking. Golden State at 22-23. Furthermore, as indicated above, even if the surveyors did not follow the correct procedures, that is irrelevant since the ALJ's review is de novo.

CMS's notice of penalty was not deficient.

NCVA argues that the notices of penalty CMS issued in this case were deficient because they did not "include[] . . . [a]ny factors specified in § 488.438(f) that were considered when determining the amount of the penalty," as required by 42 C.F.R. § 488.434(a)(2)(iv). CMS's notice letter to NCVA dated July 27, 2006 (the only CMS notice letter in the record), states in relevant part, "We considered factors identified at 42 CFR 488.434(f) in setting the amount of the CMP being imposed for each day of noncompliance." CMS Ex. 23, at 2. Contrary to what NCVA argues, however, this notice letter complies with section 488.434(a)(2)(iv). In Hermina Traeye, the Board rejected a similar argument, holding that "there is no statutory or regulatory requirement for CMS to detail how it weighed the factors set forth in section 488.438(f) in determining a CMP amount." Hermina Traeye at 16-17, citing CarePlex of Silver Spring, DAB No. 1683 (1999) and Emerald Oaks. The Board also held that in any event, the facility was not prejudiced by CMS's failure to provide it "with a more detailed accounting of the factors it considered in arriving at a proposed CMP amount." Id. at 17-18. Noting that the ALJ resolves de novo the issue of whether the amount of CMP falls within a reasonable range based on the applicable law, the Board found that the ALJ afforded the facility an opportunity to provide evidence regarding the particular factor at issue (its financial condition) and that this factor in the end had no effect on the ALJ's determination of the CMP amount. NCVA does not assert (much less point to any evidence) that the alleged deficiency in CMS's notice letter resulted in any prejudice here.

The regulations do not require an opportunity to correct before CMS imposes sanctions.

NCVA contends that the regulations violate due process by denying facilities an opportunity to correct a deficiency before sanctions are imposed. NCVA Br. at 32. In adopting the final regulations, however, the Department specifically rejected this contention, stating that—

> neither the Act nor the Constitution require that providers have the opportunity to correct deficiencies before sanctions are imposed.

59 Fed. Reg. 56,171. In addition, the Board has held that "there is nothing in the regulations that precludes the imposition of a CMP based on a continuing deficiency before the facility has an opportunity to correct that deficiency pursuant to its approved plan of correction." Lakeridge Villa Health Care Center, DAB No. 1988, at 9 (2005), aff'd, Lakeridge Villa Health Care Ctr. v. Leavitt, 202 F. App'x 903 (6th Cir. 2006). The Board has also held that the statute and regulations permit, but do not require, CMS to delay terminating the provider agreements of noncompliant facilities for up to six months after a survey first finds them out of substantial compliance, if the deficiencies do not pose immediate jeopardy. See Beverly Health and Rehabilitation-Spring Hill, DAB No. 1696, at 30-31 (1999), aff'd, Beverly Health & Rehab. Servs. v. Thompson, 223 F.Supp.2d 73 (D.D.C. 2002).

CMS's long-term care regulations are not unconstitutionally vague.

NCVA contends that the regulations governing long-term care facilities participating in the Medicare program are "unconstitutionally vague and therefore in violation of the Due Process clause of the Fifth Amendment. NCVA Br. at 31. NCVA claims that the terms "substantial compliance," "substandard quality of care," and "immediate jeopardy," as well as other unspecified regulatory terms, "are inadequately defined, thereby rendering the regulation 'unconstitutionally vague as applied for failure to give sufficient guidance to those who may be charged to interpret and apply the standards.'" Id., quoting Georgia Pacific Corp. v. OSHRC, 25 F.3d 999, 1005-06 (11th Cir. 1994). We disagree.

NCVA mischaracterizes the court's holding in Georgia Pacific by quoting only a part of the sentence that is key to the court's rationale in finding an OSHA regulation unconstitutionally vague. The sentence reads in full:

> We find here, that where the Secretary is unable to settle upon a single definition of a critical term or phrase of its own regulation, that the regulation is unconstitutionally vague as applied for failing to give sufficient guidance to those who enforce OSHA penalties, to those who are subject to civil penalties, or to those courts who may be charged to interpret and apply the standards.

Id. (emphasis added). When the sentence, and the court's decision, is read in its entire context and properly applied to the facts of the present case, it is abundantly clear that NCVA's argument has no merit. Unlike the situation in Georgia Pacific where the Secretary of Labor was unable to settle on one regulatory definition of the term at issue and even proposed a new definition during the course of those proceedings, the Secretary of HHS here has promulgated a single, regulatory definition for each of the terms that NCVA complains are "vague." See 42 C.F.R. § 488.301. Indeed, NCVA provides no explanation how these regulatory terms are "inadequately defined" generally or in the context of how they were specifically applied in this case. Moreover, a large body of jurisprudence of cases before the Board and the ALJs has developed over many years involving these regulatory terms, which clearly indicates that the terms have provided sufficient guidance to CMS, State survey agencies, and the administrative tribunals who are charged with interpreting and applying those standards.

Conclusion

For the reasons stated above, we affirm the ALJ's FFCLs and uphold his decision.

/S/
Judith A. Ballard

/S/
Leslie A. Sussan

/S/
Stephen M. Godek
Presiding Board Member