Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

The Villas of Mount Pleasant,
(CCN: 67-6241),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-13-139

Decision No. CR3370

Date: September 12, 2014

DECISION

Petitioner, The Villas of Mount Pleasant (Petitioner or facility), is a long-term care facility located in Mount Pleasant, Texas, that participates in the Medicare program. Based on the findings of two complaint surveys completed on September 19 and October 22, 2012, the Centers for Medicare & Medicaid Services (CMS) determined that Petitioner was not in substantial compliance with Medicare participation requirements. CMS imposed against Petitioner four per instance civil monetary penalties (PICMPs) in the amounts of $1,950, $2,500, $4,500, and $6,000, and a denial of payment for new Medicare admissions (DPNA) for the period of noncompliance, which CMS determined to be October 18, 2012 through December 8, 2012. CMS Exhibit (Ex.) 1, at 3-6, 10. Petitioner appealed, and CMS moved for summary judgment. I grant summary judgment in favor of CMS because the undisputed evidence establishes that the facility was not in substantial compliance with Medicare requirements. I also find that the penalties CMS imposed are reasonable, and Petitioner did not effectively dispute that it was not in substantial compliance during the period of the DPNA that CMS imposed.

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 (42 U.S.C. § 1395i-3). The Secretary's regulations are found at 42 C.F.R. Part 483. To participate in the Medicare program, a 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 U.S.C. § 1395aa(a)); 42 C.F.R. § 488.10. Each facility must be surveyed once every 12 months, and more often if necessary, to ensure it corrects identified deficiencies. Act § 1819(g)(2)(A) (42 U.S.C. § 1395i-3(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 recertification survey and incident investigation of Petitioner on September 19, 2012. Based on their findings, CMS determined that the facility was not in substantial compliance with 14 participation requirements, but only two of the deficiencies from the September survey resulted in the imposition of PICMPs.[1] The state survey agency conducted a revisit and complaint survey on October 22, 2012, and it found Petitioner to be still out of compliance and also cited Petitioner for noncompliance with two additional participation requirements.[2]

CMS provided notice that it would be imposing a PICMP of $1,950 for Tag F226 and a PICMP of $4,500 for Tag F309 from the September 19, 2012 survey; a PICMP in the amount of $2,500 for Tag F281 and a PICMP of $6,000 for Tag F309 from the October

[1] The two findings of noncompliance resulting from the September 2012 survey at issue in this case are 42 C.F.R. §§ 483.13(c) (Tag F226), relating to abuse prevention, at a scope and severity of "F," indicating no actual harm with the potential for more than minimal harm; and 483.25 (Tag F309), relating to the quality of care for Resident 18, at a scope and severity of "H," indicating a pattern of actual harm that is not immediate jeopardy. CMS Ex. 1, at 4.

[2] The two findings of noncompliance resulting from the October 2012 survey at issue in this case are 42 C.F.R. §§ 483.20(k)(3)(i) (Tag F281), relating to the quality of comprehensive care plans; and 483.25 (Tag F309), relating to the quality of care for Resident 6, both at a scope and severity level of "J," indicating isolated immediate jeopardy to resident health and safety. CMS Ex. 1, at 4.

22, 2012 survey; and a DPNA for the period of noncompliance, October 18, 2012 through December 8, 2012. CMS Ex. 1, at 4-6, 10.

On November 19, 2012, Petitioner timely requested a hearing to contest CMS's findings of noncompliance and the proposed remedies. The case was assigned to me for hearing and decision. On November 28, 2012, I issued an Acknowledgment and Initial Pre-hearing Order establishing a briefing schedule. In accordance with that schedule, CMS submitted its prehearing exchange, consisting of a motion for summary judgment and brief in support of the motion (CMS Br.), exhibit and witness lists, and 53 exhibits (CMS Exs. 1-53). Petitioner responded with its prehearing exchange, consisting of its response to CMS's motion for summary judgment and prehearing brief (P. Br.), exhibit and witness lists, and 5 exhibits (P. Exs. 1-5).

II. Issues

The issues in this case are:

A. Whether summary judgment is appropriate;

B. Whether Petitioner was in substantial compliance with 42 C.F.R. §§ 483.13(c) (Tag F226) and 483.25 (Tag F309) with regard to Resident 18; and 483.20(k)(3)(i) (Tag F281) and 483.25 (Tag F309) with regard to Resident 6;

C. Whether Petitioner is entitled to a hearing with regard to the duration of its DPNA; and

D. Whether the PICMPs that CMS imposed are reasonable.

III. Findings of Fact and Conclusions of Law

A. Summary judgment in favor of CMS is appropriate.

Summary judgment is appropriate if "the record shows that there is no genuine issue as to any material fact, and the moving party is entitled to judgment as a matter of law." *Senior Rehab. & Skilled Nursing Ctr.*, DAB No. 2300, at 3 (2010) (citations omitted). The moving party must show that there are no genuine issues of material fact requiring an evidentiary hearing and that it is entitled to judgment as a matter of law. *Id.* If the moving party meets its initial burden, the non-moving party must "come forward with 'specific facts showing that there is a genuine issue for trial."' *Matsushita Elec. Indus. Co. v. Zenith Radio*, 475 U.S. 574, 587 (1986). "To defeat an adequately supported summary judgment motion, the non-moving party may not rely on the denials in its pleadings or briefs, but must furnish evidence of a dispute concerning a material fact − a fact that, if proven, would affect the outcome of the case under governing law." *Senior*

Rehab., DAB No. 2300, at 3. To determine whether there are genuine issues of material fact for hearing, an ALJ must view the evidence in the light most favorable to the non-moving party, drawing all reasonable inferences in that party's favor. *Id.* As discussed more specifically below, this case presents no genuine disputes of material fact and therefore may be decided as a matter of law. Although Petitioner disputes some facts, they are not material to the outcome of this decision.

CMS maintains that for the September survey findings there are no material facts in dispute that Petitioner did not conduct criminal history and background checks on several identified employees prior to their employment at Petitioner's facility. CMS Br. at 17. CMS claims that these undisputed facts support that Petitioner was not acting in accordance with its own abuse policy and procedures, and these actions violate 42 C.F.R. § 483.13(c) (Tag F226). CMS Br. at 17. CMS claims further that there is no dispute that Petitioner failed to properly assess and monitor Resident (R)18's mouth pain that resulted from several tooth extractions, in violation of 42 C.F.R. § 483.25 (Tag F309). CMS Br. at 17.

As for the October survey findings, CMS maintains that there is no dispute that Petitioner failed to provide the care and services to R6 that met professional standards of care, in violation of 42 C.F.R. § 483.20(k)(3)(i) (Tag F281). CMS Br. at 17. CMS also maintains there is no dispute that Petitioner failed to provide this resident with the quality of care that 42 C.F.R. § 483.25 (Tag F309) required. CMS Br. at 17-18.

I conclude that summary judgment for CMS is appropriate as Petitioner has shown no genuine issue of a disputed material fact, and application of the law to the undisputed material facts establishes that CMS must prevail as a matter of law on the issues of Petitioner's noncompliance with 42 C.F.R. §§ 483.13(c), 483.25, and 483.20(k)(3)(i). My specific findings of undisputed facts and conclusions of law are set forth in the bold italicized headings and supported by the discussions in the sections below.

B. The undisputed evidence establishes Petitioner was not in substantial compliance with 42 C.F.R. § 483.13(c) (Tag F226) because Petitioner's employee files did not contain documentation that Petitioner performed criminal background and reference checks on all its employees prior to hiring.

A facility must not employ individuals whom a court of law has found guilty of abusing, neglecting, or mistreating residents nor employ individuals who have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property. 42 C.F.R. § 483.13(c)(ii)(A), (B). A facility must also "develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property." 42 C.F.R. § 483.13(c). Accordingly, Petitioner's "Abuse Policy" required that "[w]hen

an employee is being considered for employment, previous work places and references will be checked. Documentation will be maintained either separately or the information will be documented on the application." Petitioner's policy also instructs that "[b]efore a person can be hired the facility will conduct a criminal history check within 24 hours by accessing the Texas Department of Public Safety web site . . ." and "[a] copy of the findings will be printed from the web site and will be maintained by the facility to verify that the facility did request the criminal background screening for the appropriate employees." CMS Ex. 31, at 57.

CMS argues Petitioner violated the requirements of 42 C.F.R. § 483.13(c) when 11 of the 19 facility employee files the surveyors reviewed, from the period January through August 2012, did not contain documentation that Petitioner conducted criminal history checks and reference checks prior to their hiring. CMS Br. at 4; CMS Ex. 4, at 1-3. The positions of these employees were: the Director of Nursing, Occupational Therapist, Speech Therapist, Dietician, Activity Director, Certified Nurse Aides, and Licensed Vocational Nurses (LVNs). CMS Ex. 4, at 2. CMS maintains that Petitioner's "Abuse Policy" requires that "references and a criminal history check" occur "prior to employment." CMS Br. at 4, 8; CMS Exs. 31, at 56-58; 46, at 2-3. According to CMS, Petitioner failed to adhere to its own policy and procedures in screening potential employees. CMS Br. at 4, 8.

Petitioner concedes to the lack of documented criminal background checks in the employee files. P. Br. at 4. Petitioner argues, however, that its staff completed them, but they had not been properly documented in the employee files. P. Br. at 4. An undisputed lack of documentation still violates Petitioner's policy though. Further, I do not assume for purposes of summary judgment that Petitioner completed, but did not document, the background checks because Petitioner did not come forward with any evidence to support its assertions.[3] To defeat CMS's motion for summary judgment, Petitioner must do more than make assertions or bold denials. *Matsushita Elec. Indus. Co.*, 475 U.S. 574, 586 (finding the opposing party must do more than show that there is "some metaphysical doubt as to the material facts."). Therefore, I do not accept Petitioner's unsupported assertions as true for summary judgment purposes. I find the inference Petitioner is asking me to make is unreasonable and not supported by any evidence.

[3] A surveyor interviewed the facility business manager who was responsible for conducting the background checks, and she reportedly stated that she was not aware that the reference checks were required. CMS Ex. 4, at 3. She also reportedly stated that the criminal background checks for the 11 employees were not done because she was off from work when those employees were hired. CMS Ex. 4, at 3.

C. The undisputed evidence shows Petitioner was not in substantial compliance with 42 C.F.R. § 483.25 (Tag F309) because Petitioner did not provide necessary care and services to R18 in accordance with her comprehensive assessment and plan of care.

The quality of care regulation, 42 C.F.R. § 483.25, requires that "[e]ach 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 Board has held that failure to follow a resident's plan of care that is based on the comprehensive resident assessment is a clear case of failing to meet the requirements of 42 C.F.R. § 483.25. *Cedar Lake Nursing Home*, DAB No. 2288, at 6-7, 10 (2009), *aff'd, Cedar Lake Nursing Home v. U.S. Dep't of Health & Human Servs.*, 619 F.3d 453 (5th Cir. 2010); *Spring Meadows Health Care Ctr.*, DAB No. 1966, at 17 (2005).

CMS maintains that R18 had a doctor's order that required Petitioner's staff to conduct a weekly pain assessment and administer 50 mg. of Tramadol to R18 every 4-6 hours, as needed, for pain. CMS Br. at 9; CMS Ex. 28, at 56. CMS maintains further that R18's plan of care provided interventions for her pain management. CMS Br. at 9; CMS Ex. 28, at 16. CMS states that R18 was not assessed for pain and did not receive any interventions to relieve the pain, and this resulted in R18 suffering with unrelieved mouth pain for an undetermined period during September 2012. CMS Br. at 10-11; CMS Ex. 28, at 10, 14-15. CMS argues further that Petitioner did not conduct weekly pain assessments of R18 per Petitioner's own policies. CMS Br. at 11.

The undisputed evidence shows that at the time of the September 2012 survey R18 was 93 years old. CMS Ex. 28, at 5. She had been admitted to Petitioner's facility on May 18, 2010. CMS Ex. 28, at 5. From December 7, 2011 through July 10, 2012, R18 had multiple teeth extractions and two debridement procedures. CMS Ex. 28, at 53-54. On July 24, 2012, R18's doctor ordered "weekly pain assessment on Tuesday r/t routine pain rx using pain scale. . . ." CMS Ex. 28, at 56. Her September 7, 2012 plan of care noted that she was at risk for pain related to arthritis and recent dental work. CMS Ex. 28, at 16. Some of the interventions listed in the plan of care to deal with R18's pain required that staff ensure the appropriate pain management flow sheet was used to determine R18's intensity of pain or discomfort, that a weekly pain assessment be completed, and that the family and the resident's doctor be made aware of changes that indicated pain. CMS Ex. 28, at 16.

Further, Petitioner's "Pain Assessment" policy required that for residents who were on routine pain medications, as was R18, staff assess and rate the level of a resident's pain daily for the initial week and then weekly thereafter. CMS Ex. 28, at 8. The protocol also required staff to document the results of the pain assessment rating on the resident's Medication Administration Record. CMS Ex. 28, at 8.

During the September survey, on September 17, 2012, while in the dining room during lunch, R18 reported to a surveyor that she had difficulty chewing because of her teeth and stated that the roof of her mouth "hurts so badly." CMS Ex. 4, at 13. At the dinner meal, R18 again complained to the surveyor that she was experiencing mouth pain. CMS Ex. 4, at 13. The surveyor intervened, and LVN C examined R18's mouth and found an ulcerated area on R18's gum line, red and swollen lower gums, and teeth impacted with food at her gum line. CMS Ex. 4, at 14. When the surveyor reviewed R18's record later that day, she noticed that the examination LVN C conducted was not documented, and there also was an absence of documentation that R18 had expressed mouth pain. CMS Ex. 4, at 14.

During an interview with the surveyor at 8:45 a.m. the following day, LVN B stated that he was not aware of R18's mouth pain and that he would check the resident. CMS Exs. 4, at 14; 5, at 15. Later that day at 3:30 p.m., LVN B told the surveyor that he had not assessed R18's mouth but he was going to inform the charge nurse for the following shift. CMS Exs. 4, at 14; 28, at 12. The surveyor then intervened and LVN K assessed R18's mouth at 3:35 p.m. LVN K found R18's gumline to be red and swollen, and LVN K reported to the surveyor that R18 had a broken tooth. CMS Exs. 4, at 14; 28, at 12. R18's nursing notes entered at 3:45 p.m. on September 18, 2012, document the assessment, that bone spurs were noted on R18's gumline, and that R18 reported that on a scale of 1-10, her pain when chewing food was an 8. CMS Exs. 4, at 14-15; 28, at 6. During an interview on September 19, a family member told the surveyor that for weeks the resident had been complaining that her mouth hurt. He indicated that on September 18, Petitioner's staff asked him if he wanted to have R18's pain medication increased, but he refused because he wanted R18's teeth fixed and not just to have pain medication administered to her. CMS Ex. 4, at 15. He also told the surveyor, however, that he agreed that the resident should be receiving medication for pain and thought the Tramadol would be helpful. CMS Ex. 4, at 15.

A review of R18's record from September 1 through the survey date of September 19, shows that her "Pain Management Flowsheet" for September 2012 does not contain any staff entries documenting weekly pain assessments, nor is there any documentation on the sheet showing any pain management interventions for R18. CMS Ex. 28, at 13. R18's September 2012 "Medication Sheet" and also her "PRN Medications" sheet have no entries showing that R18 received any Tramadol for pain management. CMS Ex. 28, at 10, 14-15. Prior to surveyor intervention on September 18, R18's nurses' notes for September 2012 show no entries were made regarding assessments or pain medication being administered to R18 in September 2012. CMS Ex. 28, at 6. The first entry showing an assessment of R18's mouth was on September 18, after surveyor intervention. CMS Ex. 28, at 6.

Petitioner argues that the evidence does not establish that facility staff ignored any complaints of pain from R18 nor does it show that staff failed to provide pain medication to R18 when indicated. P. Br. at 5. Petitioner states that staff whom surveyors interviewed recounted that R18 had not reported to them that she suffered from any mouth pain. P. Br. at 4, citing CMS Ex. 4, at 11-16. Petitioner states further that when R18 was assessed on February 18, 2012, she "did not complain of pain" except when she chewed food. P. Br. at 4, citing CMS Ex. 4, at 15. Petitioner states that the resident was not provided with pain medication at the time because she did not complain. P. Br. at 5.

There is no dispute that in September 2012, facility staff was required to conduct weekly pain assessments of R18's mouth and teeth, and despite Petitioner's assertions, Petitioner has not come forward with evidence to dispute the evidence before me. R18's plan of care required, among other things, that Petitioner's staff perform weekly pain assessments using a pain assessment tool and using a pain management flow sheet in order to "determine presence and intensity of pain/discomfort with documentation as utilized." CMS Ex. 28, at 16. Petitioner's Pain Assessment policy specifically required staff to document these assessments and for staff to notify R18's family and her doctor of any changes. CMS Ex. 28, at 8.

Petitioner also states that the resident's family member admitted to the surveyor that facility staff contacted him on September 18, and he refused to agree to the provision of increased pain medication to R18. P. Br. at 5, citing CMS Ex. 4, at 15. Even if I were to assume facility staff contacted a family member who then asked that R18 not receive pain medication as ordered, which I do not after reviewing the cited exhibit upon which Petitioner relies,[4] Petitioner has not come forward with any specific evidence to show what authority the family member might have to invalidate the doctor's order.

I find the undisputed evidence establishes that Petitioner did not follow R18's plan of care interventions, in addition to her doctor's order and the facility's pain assessment policy for pain assessment and pain management. I therefore conclude Petitioner did not provide the quality of care necessary to R18 to comply with the regulatory requirements of 42 C.F.R. § 483.25.

[4] Petitioner cited to the survey's Statement of Deficiencies for support, "He said the facility called him yesterday wanting to increase her pain medication and he refused. He said he wanted the resident to get her teeth fixed not just get pain medication. *He agreed the resident should get something for pain and he thought the Tramadol would be helpful.*" CMS Ex. 4, at 15 (emphasis added).

D. The undisputed evidence establishes that Petitioner was not in substantial compliance with 42 C.F.R. § 483.20(k)(3)(i) (Tag F281) because Petitioner's staff member did not provide R6 with an assessment and necessary care and services that met professional standards of quality of care.

The regulation at 42 C.F.R. § 483.20(k)(3)(i) requires that "[t]he services provided or arranged by the facility must . . . [m]eet professional standards of quality." Although the regulation does not define the phrase "professional standards of quality," CMS provides guidance to surveyors, stating that this phrase means that services are provided according to accepted standards of clinical practice which may be found in various sources. State Operations Manual, pub. 100-07 (SOM), app. PP, F281 (iss. 05-21-04).

The material facts are undisputed here. R6, a 94-year-old female, was readmitted to Petitioner's facility from a hospital on October 8, 2012, at 3:09 p.m. with diagnoses of pneumonia, congestive heart failure, and a possible heart attack. P. Ex. 2, at 5; CMS Ex. 43, at 13. Discharge instructions from the hospital directed that facility staff monitor R6 for worsening of congestive heart failure and to call her doctor or return her to the emergency room if her symptoms worsened. CMS Ex. 43, at 7. The discharging physician also ordered Petitioner to check R6 every two hours. CMS Ex. 43, at 11, 19.

R6's plan of care notes that she had a history of falls and indicates the need for a wheelchair and bed alarms to be in place. CMS Ex. 43 at 128. R6's doctor's order required staff to ensure an alarm was on her wheelchair and that staff check every hour that the alarm was in place and that it was operational. CMS Ex. 43, at 12. The facility investigation shows that on the same day as her readmission, at approximately 4:09 p.m., R6 fell out of her wheelchair but did not sustain any injury. P. Ex. 2, at 4; CMS Ex. 43, at 4, 46. Petitioner's nurse did not use R6's wheelchair alarm prior to R6's fall. P. Ex. 2, at 4, 5, 6, 9. Petitioner's nurse also did not notify R6's doctor and family about the fall. P. Ex. 2, at 5.

Around 7:00 p.m. that evening R6 appeared to be in respiratory distress. P. Ex. 2, at 4. R6 was noted as "breathing loud and heavy." P. Ex. 2, at 10. LVN A stated that when she arrived at R6's room, she noticed R6 did not have a pulse and was not able to answer questions. P. Ex. 2, at 14. R6's change in condition related to her respiratory status, and Petitioner's staff did not report it to R6's doctor. P. Ex. 2, at 5, 9. An oxygen concentrator was available in R6's room, but Petitioner's staff did not provide oxygen to R6. P. Ex. 2, at 14. A hospital progress note dated October 5, 2012, states that R6 would become confused when her oxygen was off. CMS Ex. 43, at 20. LVN A pronounced R6 dead after her respirations stopped for 2 minutes. CMS Ex. 36, at 2; *see* P. Ex. 2, at 14. The record shows that R6 died on October 8, 2012, at 7:20 p.m. CMS Ex. 43, at 48. There is no dispute that R6 died due to respiratory issues and not due to the fall she

experienced earlier that day. P. Ex. 2, at 4, 5. Petitioner self-reported the incident and completed an internal investigation. P. Ex. 2.

According to CMS, the charge nurse on duty, LVN A, failed to follow R6's hospital discharge instructions by not monitoring R6, not contacting her doctor when her symptoms worsened, and not returning her to the emergency room. CMS Br. at 16-17; CMS Ex. 43, at 7, 11, 14. Specifically, CMS argues that LVN A did not assess R6's respiratory status, as ordered in the hospital discharge instructions, did not notify R6's physician when the resident's respiratory status changed, and did not attempt to relieve R6 when she was "gasping for air." CMS Br. at 16. CMS maintains that there is no documentation that facility staff assessed R6's cardiac or respiratory status upon her return to the facility from the hospital. CMS Ex. 36, at 6. According to CMS, R6's record contains a neurological assessment that LVN A completed dated October 8, 2012, that shows she assessed R6 for changes every 15 minutes from 4:00 p.m. following her fall until 10:00 p.m. that evening. CMS Ex. 36, at 7. CMS states that according to the neurological assessment, R6's vital signs remained consistent, she was alert and oriented, and her pupils were equal and reactive. CMS Ex. 36, at 7 citing the Neurological Assessment (CMS Ex. 43, at 70). The surveyor questioned the assessment, however, because R6 reportedly stopped breathing at approximately 7:00 p.m. CMS Ex. 52, at 4.

The Assistant Director of Nursing stated to a surveyor that she believed the neurological check values were "made up." CMS Ex. 36, at 7-8, referring to the Neurological Assessment (CMS Ex. 43, at 70). When R6 was reported as "gasping for air" in her room, CMS states that LVN A did not assess oxygen saturation levels and did not apply oxygen to R6. CMS Br. at 16; CMS Exs. 37, at 1; 43, at 71. CMS contends that LVN A admitted in an interview that that she did not assess R6's oxygen saturation levels and did not apply oxygen to R6. CMS Ex. 43, at 71. CMS also alleges further that LVN A acted outside the scope of her license in pronouncing the resident's death. CMS Ex. 36, at 4.

Petitioner does not dispute any of the material facts regarding R6's care. Petitioner agrees that LVN A failed to follow facility policies and failed to follow good nursing practices. P. Br. at 6. Petitioner states that it self-reported the death of R6 and conducted an investigation of the incident the following day. P. Br. at 5. According to Petitioner, its internal investigation concluded that LVN A "failed to use safety devices to prevent a fall by Resident #6 and failed to report the fall to the Resident's family and physician" and when R6 experienced respiratory distress, LVN A did not notify the resident's doctor and "acted outside her license in pronouncing the resident's death (though the resident did have an out-of-hospital do-not-resuscitate order)." P. Br. at 5-6; P. Exs. 1, at 2; 2.

Petitioner avers that the investigation did not reveal a failure in its facility systems. P. Br. at 6; P. Ex. 1, at 2. Petitioner states that LVN A was suspended from work during the investigation, and it promptly terminated LVN A's employment well before the October 22, 2012 survey. P. Br. at 6; P. Ex. 3, at 6. Petitioner also claims that immediately

following the investigation, it reviewed with nursing staff its policies and procedures on dealing with changes in condition, requirements for nursing assessments, readmission requirements, and the scope of a nurse's license in pronouncing a resident's death. P. Br. at 7; P. Exs. 1, at 2; 4. Petitioner maintains that in March 2012, staff had been trained on notifying family members and doctors of changes in condition. P. Br. at 7; P. Ex. 5.

There is no question that upon R6's death, Petitioner acted appropriately in reporting and investigating the incident, immediately suspending LVN A, and then terminating LVN A based on the findings of its internal investigation. However, Petitioner is still responsible for the actions of its employees. Petitioner cannot escape its culpability by disassociating itself from the actions of LVN A here. *See Gateway Nursing Ctr.*, DAB No. 2283, at 8 (2009) (concluding that a facility acts through its staff and cannot disown the consequence of the actions of its employees). The undisputed evidence establishes that a member of Petitioner's staff did not properly assess and provide necessary care and services to R6 in a manner that met professional standards of quality of care.

E. The undisputed evidence shows Petitioner was not in substantial compliance with 42 C.F.R. § 483.25 (Tag F309) because staff failed to provide care and services according to R6's comprehensive assessment and plan of care.

As discussed previously, the regulation at 42 C.F.R. § 483.25 requires that a facility ensure each resident receive necessary care and services to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, in accordance with the resident's comprehensive assessment and plan of care. The Board has held that the language of 42 C.F.R. § 483.25 not only requires skilled nursing facilities to furnish the care and services set forth in a resident's care plan but also to implement doctors' orders, monitor and document the resident's condition, and follow its own policies. *See, e.g., Alexandria Place*, DAB No. 2245 (2009) (upholding this deficiency when a petitioner did not provide care in accordance with a doctor's order); *Oxford Manor*, DAB No. 2167, at 5-6 (2008) (affirming an ALJ's reliance on a facility's policy as evidence of the standard of care the facility expected its staff to provide, noting "if facility staff exercise professional judgment in deciding not to follow facility policy with respect to a particular resident, they document that judgment and give a reason why not. In the absence of such contemporaneous documentation, it is certainly reasonable to infer, when staff do not follow the policy, either they are not aware of it or that they are simply disregarding it."); *Spring Meadows Health Care Ctr.*, DAB No. 1966, at 17 ("[T]he 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. . .").

CMS states that Petitioner's noncompliance with Tag F309 is based on the same facts and evidence as Tag F281. CMS Br. at 16. Specifically, CMS maintains that LVN A did not

properly assess R6's respiratory status, did not provide R6 with oxygen when she was determined to be gasping for air, did not notify R6's doctor as to the change in her respiratory status, did not provide interventions to address the change in her condition, and did not follow hospital discharge instructions for assessing and returning R6 to the emergency room when her respiratory status changed. CMS Br. at 16-17; CMS Exs. 36, at 10-18; 43, at 11, 14; 52, at 5. According to CMS, these failures contributed to the compromise of R6's respiratory status. CMS Ex. 36, at 11.

Petitioner does not dispute LVN A did not notify R6's doctor when the resident experienced respiratory distress. P. Br. at 6; P. Ex. 2, at 4-5. Petitioner states that LVN A did not follow facility policy and procedures and "failed to follow good nursing practices" in regards to R6, and its October 10, 2012 internal investigation concluded that LVN A "failed to confirm MD orders upon admission," P. Br. at 6; P. Exs. 1, at 2; 2, at 4, 5. Petitioner also states that LVN A "acted outside her license in pronouncing the resident's death." P. Br. at 6. Petitioner maintains that it terminated LVN A's employment the day after the incident, and all of its other staff who were involved with R6's care acted appropriately. P. Br. at 6, 7.

As explained previously, Petitioner is responsible for the actions of its employees and cannot disassociate itself from their actions. The undisputed facts I rely upon as material show that Petitioner did not comply with the requirements of 42 C.F.R. § 483.25 for following doctor's orders, care plan provisions, and facility policies. I find, therefore, that as a matter of law, Petitioner was not in substantial compliance because it failed to provide R6 with the requisite care.

F. Petitioner is not entitled to a hearing with regard to the duration of the DPNA and the date upon which it achieved substantial compliance.

CMS may impose an enforcement remedy against a facility for as long as the facility is not in substantial compliance with participation requirements. 42 C.F.R. § 488.430(a). The burden of persuasion regarding the duration of noncompliance is Petitioner's. *Owensboro Place and Rehab. Ctr.*, DAB No. 2397, 12-13 (2011). Substantial noncompliance with only one participation requirement is sufficient to support the imposition of a penalty such as a DPNA. *Beechwood Sanitarium*, DAB No. 1824 (2002).

A DPNA continues until either "(1) [t]he 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" or "(2) CMS or the State terminates the provider agreement." 42 C.F.R. §§ 488.454(a), 488.417(d); Act § 1819(h)(3) (42 U.S.C. § 1395i-3(h)(2)).

Petitioner asserts that the only reason provided in the Statement of Deficiencies from the October 2012 survey as to why it remained not in substantial compliance was because Tag F309 from the September 2012 survey continued to exist. P. Br. at 9, citing CMS Ex. 36 at 10, 18. Further, Petitioner argues, according to CMS records, Petitioner cleared all deficiencies from that September 2012 survey on October 29, 2012. P. Br. at 9, citing CMS Ex. 53, at 2. According to Petitioner, the DPNA should therefore not have continued until December 8, 2012. P. Br. at 9. Petitioner argues that there is no allegation that it remained out of compliance with alleged deficiencies from the October 22 survey. P. Br. at 11.

CMS actually bases the DPNA on all the deficiency tags cited during the September 19 survey, which include: 42 C.F.R. §§ 483.25 (Tag F309); 483.13(c) (Tag F226); 483.15(a) (Tag F241); 483.20(k)(3)(ii) (Tag F282); 483.25(a)(3) (Tag F312); 483.25(g)(2) (Tag F322); 483.25(h) (Tag F323); 483.35(d)(1)-(2) (Tag F364); 483.35(e) (Tag F367); 483.35(f) (Tag F368); 483.65 (Tag F441); 483.70(h) (Tag F465); 483.75(f) (Tag F498); and 483.70(a) (Life Safety Code Tags K27, K29, K51 and K144). CMS Ex. 1, at 3; CMS Br. at 1 n.1; CMS Br. at 3 n.2, 4. However, considering just one deficiency finding is necessary to support a DPNA, CMS addressed only deficiency findings F226 and F309 from the September survey in its brief to support the DPNA remedy. CMS Br. at 1-2 n.1. CMS determined the period of noncompliance to be October 18, 2012 through December 8, 2012. CMS Ex. 1, at 4-6, 10.

The revisit survey that followed the September survey was conducted on October 30, 2012, and the state survey agency found all deficiencies related to the September survey corrected as of October 29, 2012. CMS Ex. 53, at 2. However, the two October survey deficiency findings related to R6, Tag F281 and Tag F309, were still pending. CMS Ex. 53, at 2. On December 10, a revisit survey was conducted at Petitioner's facility to determine whether Petitioner had corrected the October survey deficiency findings. CMS Ex. 53, at 2. During the December 10 revisit survey, the surveyors determined that Petitioner had corrected all deficiencies related to the October survey by December 9. CMS Ex. 53, at 2. Therefore, the DPNA continued until a revisit survey verified Petitioner had achieved substantial compliance. 42 C.F.R. §§ 488.454(a), 488.417(d).

Although Petitioner states that it was in compliance earlier than what CMS has determined, Petitioner has not come forward with evidence relating to the October 2012 survey to suggest that it was in substantial compliance earlier than December 9, 2012. Therefore, I conclude that Petitioner did not effectively dispute the duration of the DPNA, October 18, 2012 through December 8, 2012.

G. The PICMPs that CMS imposed are reasonable.

CMS imposed PICMPs of $1,950 for Tag F226 and $4,500 for Tag F309 from the September 19, 2012 survey. For the deficiency findings from the October 22, 2012 survey, CMS imposed PICMPs of $2,500 for Tag F281 and $6,000 for Tag F309.

CMS must consider several factors when determining the amount of a CMP (factors an ALJ considers de novo when evaluating the reasonableness of the CMP that CMS imposed): (1) the facility's history of noncompliance; (2) the facility's financial condition, i.e., its ability to pay the CMP; (3) the severity and scope of the noncompliance, the "relationship of the one deficiency to other deficiencies resulting in noncompliance," and the facility's prior history of noncompliance; and (4) the facility's degree of culpability, which includes neglect, indifference, or disregard for resident care, comfort or safety. 42 C.F.R. §§ 488.438(f), 488.404(b),(c).

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 & Rehab. Ctr.*, DAB No. 2446, at 23 (2012). Thus, 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 & Rehab. Ctr.*, DAB No. 2375, at 26-27 (2011). Petitioner does not challenge the PICMPs CMS imposed based on the September survey findings, one in the amount of $1,950 for Tag F226 and another in the amount of $4,500 for Tag F309. P. Br. at 9-10. Here, other than claiming in its brief that it "disagrees" that the PICMPS of $2,500 for Tag F281 and $6,000 for Tag F309 from the October survey are reasonable, Petitioner has not otherwise come forward with any evidence with respect to any of the regulatory factors that warrant a hearing on the reduction of the PICMP amounts. P. Br. at 10.

As to Petitioner's history of prior noncompliance, CMS claims that since May 2010, this is the fourth survey cycle where Petitioner has been noncompliant with regulatory requirements, and this is the second survey cycle where CMS has imposed enforcement actions against Petitioner. CMS Ex. 53, at 9-10. CMS also states Petitioner was previously cited for Tag F309 during an October 5, 2011 recertification survey when CMS determined Petitioner failed to manage pain, indicating a pattern of actual harm. CMS stated further that during a complaint survey on December 16, 2011, CMS found Petitioner failed to assess and intervene timely to a resident's change of condition, indicating a pattern of actual harm. CMS Ex. 53, at 10. Petitioner does not dispute this prior noncompliance. Petitioner also has not come forward with evidence or argument regarding its financial condition or ability to pay the PICMPs.

Petitioner's failure to follow its abuse policy and perform the required criminal background and reference screening for 11 of the 19 employees it hired from January through August of 2012 clearly placed the residents in its facility at serious risk. Additionally, by not implementing R18's plan of care interventions and not following its own pain assessment policy, Petitioner caused R18 to experience severe pain unnecessarily. I find these incidents to be egregious and Petitioner's culpability to be high.

As for the care provided to R6, I find the degree of Petitioner's culpability to also be high. It was Petitioner's duty to provide care for R6 in accordance with the hospital discharge instructions and with R6's doctor's orders. Petitioner failed to do this, and is therefore culpable. R6 had just been discharged from the hospital with specific discharge instructions, and it was Petitioner's staff's duty to carefully follow those instructions and monitor R6's respiratory status. Staff was also remiss in failing to ensure R6 had the necessary safety alarm in her wheelchair as required by her plan of care. As explained above, Petitioner cannot limit its culpability by separating itself from the actions of its employee.

Given the seriousness of Petitioner's noncompliance and its culpability, I find that the PICMPs, which are in the lower to middle part of the allowable PICMP range ($1,000 to $10,000) that CMS could impose for noncompliance, are reasonable for Petitioner's failure to comply substantially with Medicare requirements. *See* 42 C.F.R. §§ 488.408(d)(iv), 488.438(a)(2).

IV. Conclusion

For the reasons set forth above, I grant summary judgment in favor of CMS. I find that the undisputed evidence establishes Petitioner was not in substantial compliance with the participation requirements of 42 C.F.R. §§ 483.13(c) and 483.25 cited from the September 2012 survey; and 42 C.F.R. §§ 483.20(k)(3)(i) and 483.25 cited from the October 2012 survey. I find as reasonable all of the PICMPs that CMS imposed against Petitioner. I also find that Petitioner did not effectively dispute that it did not return to substantial compliance until December 9, 2012, and therefore CMS had a basis to impose a DPNA for the period of October 18, 2012 through December 8, 2012.

/s/
Joseph Grow
Administrative Law Judge