Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

River City Care Center,
(CCN: 67-5896),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-13-1071

Decision Number: CR3327

Date: August 12, 2014

DECISION

I sustain the determination of the Centers for Medicare & Medicaid Services (CMS) to impose the following remedies against Petitioner, River City Care Center:

- Civil money penalties of $4050 per day for each day of a period that began on April 23, 2013 and that ran through May 6, 2013; and

- Civil money penalties of $250 per day for each day of a period that began on May 7, 2013 and that ran through June 24, 2013.

I. Background

Petitioner is a skilled nursing facility that operates in the State of Texas. CMS determined that Petitioner failed to comply substantially with Medicare participation requirements governing skilled nursing facilities and it determined to impose the remedies that I cite above. Petitioner requested a hearing. I held a

hearing on April 7 and May 20, 2014.[1] I received into evidence from CMS exhibits that are identified as CMS Ex. 1 – CMS Ex. 16 and CMS Ex. 18 – CMS Ex. 24. I received into evidence from Petitioner exhibits that are identified as P. Ex. 1 – P. Ex. 23.

II. Issues, Findings of Fact and Conclusions of Law

A. Issues

The issues are whether: Petitioner failed to comply substantially with Medicare participation requirements; CMS's determination of immediate jeopardy level noncompliance is clearly erroneous; and, the remedies imposed by CMS are reasonable.

B. Findings of Fact and Conclusions of Law

CMS asserts that Petitioner failed, at the immediate jeopardy level of noncompliance, to comply substantially with the following Medicare participation requirements: 42 C.F.R. §§ 483.10(b)(11); 483.13(c); 483.20(k)(3)(i); and, 438.25. I will discuss below CMS's allegations and Petitioner's defenses concerning these sections. However, all of the allegations and defenses involve essentially the same facts addressing the care that Petitioner gave to a single resident, identified as Resident # 2. Resident # 2 was a gravely ill individual at the time of the events at issue. Her illnesses included infection with Human Immunodeficiency Virus (HIV), anemia, dementia, a schizoaffective disorder, and a delusional disorder. CMS Ex. 9 at 115.

The resident did not suffer from significant respiratory deficiencies prior to April 23, 2013. Tr. 4/7 at 119. Prior to that date the resident did not demonstrate a need for and had not received a physician's order that she receive supplemental oxygen. *Id.*; CMS Ex. 9 at 105.

The resident's condition deteriorated on April 23. Beginning at 3:45 a.m. on that date the resident complained of shortness of breath and manifested congestion. CMS Ex. 9 at 123. The resident's oxygen saturation level declined markedly at that time to 84 percent. *Id.* Petitioner's nursing staff responded by administering supplemental oxygen to the resident via nasal cannula. *Id.* As I have discussed, there was no physician's order for this treatment. The staff did not consult with a physician before beginning to administer it. The resident again complained of shortness of breath at 11:00 a.m. on April 23 and only then, more than seven hours

[1] Where I cite to the transcript in this decision I cite to date and page. Thus, an excerpt from the April 7 transcript will be cited to as "Tr. 4/7 at (page number)."

after the resident first manifested breathing difficulties and the staff began administering oxygen on its own volition, did the staff consult with the resident's treating physician. CMS Ex. 9 at 123 – 124.

The physician ordered a "stat" (immediate) chest x-ray. CMS Ex. 9 at 123 – 124; 134. The x-ray results showed that the resident was manifesting mild pulmonary edema and congestive heart failure. The staff attempted to communicate these results to the resident's physician but he was unavailable and did not receive them immediately. *Id.*

Resident # 2's breathing problems continued and, in fact, significantly worsened over the next few days. On the afternoon of April 23, 2013, the nursing staff took the resident off supplemental oxygen for 30 minutes in order to determine whether she could breathe independently. Staff took that action without consulting the resident's physician and there is no order authorizing it to do so. The resident's blood oxygen saturation level dropped to 76 percent and, as a result, the staff not only resumed supplemental oxygen but also increased the rate of oxygen flow from two liters to four liters per minute. The resident continued to show signs of respiratory distress including heavy use of her accessory muscles for breathing. CMS Ex. 9 at 124. On the evening of the 23rd the resident was lethargic and ate none of her dinner.

During the night of April 23 Resident # 2 increasingly used her accessory muscles to breathe. CMS Ex. 9 at 130. Her lethargy continued and she exhibited diminished breath sounds. *Id.* The resident continued to receive oxygen at four liters per minute. *Id.* These problems continued on April 24. On that date the staff removed the resident's nasal cannula and replaced it with a simple oxygen mask, increasing the rate of oxygen flow to seven liters per minute. CMS Ex. 9 at 131.

The resident continued to deteriorate over the course of the next two days. The staff increased the flow of oxygen to eight liters per minute. CMS Ex. at 132 – 133. The resident continued to refuse to eat and she continued using her accessory muscles to breathe. CMS Ex. 9 at 126 – 129. The staff identified coarse rales in the resident's lungs, sounds that are indicative of breathing difficulty. *Id.* at 131 – 132. On April 26 the resident exhibited lethargy and failed to produce any urine. CMS Ex. 9 at 127. On April 27 the resident's family removed her from the facility.

CMS alleges that Petitioner failed to comply with the requirements of 42 C.F.R. § 483.10(b)(11) by failing to consult with Resident # 2's treating physician during the period from April 23 – 26, 2013. Among other things this regulation mandates

that a facility "immediately" consult with a resident's treating physician in the event that there is a significant change in the resident's physical condition. It explains that a significant change constitutes:

> a deterioration in health . . . in either life-threatening conditions or clinical complications.

42 C.F.R. § 483.10(b)(11)(i)(B). CMS argues that Petitioner's staff was remiss in failing to consult immediately with Resident # 2's physician on April 23, 2013 when the resident first manifested breathing problems and subsequently, as the resident's condition deteriorated seriously. The weight of the evidence plainly supports these arguments.

It would be incorrect to say that there were no discussions between Petitioner's staff and Resident # 2's treating physician about the resident's condition. The staff advised the physician on April 23 about the resident's breathing problems and the physician's orders on that date reflect the discussions that he had with Petitioner's staff. However, staff delayed consulting the physician on April 23 for more than seven hours after the resident's condition began to deteriorate. The resident first complained of breathing difficulties at 3:45 a.m. on that date and it was not until 11:00 a.m. that staff consulted the physician. Moreover, the record also makes it clear that the staff did not consult additionally with the physician about the specific problems that the resident manifested – her increasingly labored breathing, her anorexia, her lethargy, and her ceasing to urinate – as the resident's condition deteriorated after April 23.

Petitioner contends that there was no need for its staff to consult with the resident's physician prior to 11 a.m. on April 23 and thereafter. First, according to Petitioner, the physician left orders with the staff that effectively covered the resident's condition and obviated the need for consultation. These, according to Petitioner, included a long-standing order for p.r.n. (as needed) use of a nebulizer in the event that the resident developed breathing problems. In addition, according to Petitioner, the physician issued an order on April 23 allowing the staff to increase the flow of oxygen to the resident on an as needed basis.

However, the order for a nebulizer on a p.r.n. basis did not address the severity of the resident's breathing problems. Even without consulting the physician Petitioner's staff recognized that it would take more than a nebulizer to remediate the breathing problems that Resident # 2 began to experience early on the morning of April 23. The staff identified a very serious deterioration in the resident's condition, one not covered by a standing physician's order, and it reacted to that change. What the staff did not do – and what it was required to do – was to consult with the physician immediately when the resident's distress became

apparent. Instead, the staff delayed consultation for more than seven hours. It is unclear why the staff failed to consult. But, the fact that the staff acted on its own, without physician authorization, not only is a violation of sound practice but it is a violation of the regulation. The requirement to consult immediately means just that. "Immediate" does not mean delaying necessary communications with a physician for hours.

Staff not only delayed consulting with the physician in violation of the regulation but it failed to consult with the physician as the resident's condition deteriorated. Resident # 2 was gravely ill and her illness rapidly became more acute over the four-day period beginning with April 23, 2013. But, Petitioner's staff did not speak directly with the physician about the resident's deterioration after their initial communications on the 23rd. There is no record of any communication on the 24th, 25th, or 26th of April about changes in the resident's condition even as Resident # 2 steadily went downhill.

Petitioner argues repeatedly that Resident # 2's condition was "stable" after April 23 and from that argument it avers that there was no need for additional discussions with the physician after that date. That assertion is simply unjustified by the evidence. Far from being stable, the resident's condition deteriorated, rapidly, beginning on April 23. Prior to April 23 the resident did not need supplemental oxygen. Beginning with April 23 the resident needed supplemental oxygen and she needed ever-increasing amounts of it with each passing day. On April 23 she received two liters of oxygen per minute. By April 26, 2013, the resident required eight liters of oxygen per minute, four times that which she had been receiving just three days previously. Over the course of a few days the resident stopped eating, became lethargic, and stopped producing urine. Obviously, these were signs of major deterioration in the resident's condition and Petitioner's management recognized them to be so when it referred the resident for hospice care on April 24. I take notice that law reserves hospice care for individuals who are presumed to be approaching death. Management surely knew the rules of hospice care eligibility and it assessed Resident # 2 as deteriorating to the extent that she qualified. That is not "stable."

But, despite this, Petitioner's staff and the resident's physician did not consult after April 23 about this deterioration even though the resident's condition continued to deteriorate. Petitioner contends that Resident # 2's physician issued an order on April 23 that authorized the staff to increase oxygen flow to the resident on a p.r.n. basis. P. Ex. 3 at 5. That may be, but, in fact, the order did not arrive at Petitioner's facility and was not included in the resident's record until May 6, 2013, well after it was issued and after the resident had left the facility. Tr. 5/20 at 119 – 120. The order was a telephone order. The nurse receiving that order should have referred to it in nursing notes or elsewhere in the resident's

record. Without that documentation or without a copy of the order itself there is no guarantee that any other staff member would have known about it. However, there is no discussion of the order in the resident's nursing notes and no amendment to the resident's plan of care showing that the resident had been given an order allowing oxygen to be increased on a p.r.n. basis. I find that the nursing staff could not have known about or acted on the basis of that order given that it was not in the resident's record nor was it corroborated in nursing notes.

But, even if the staff somehow knew about the physician's order, that does not excuse it from failing to consult with the physician after April 23. This resident's demand for supplemental oxygen increased sharply and, more and more, she relied on her accessory muscles to assist her breathing, even with the increased flow of oxygen. Those alarming signs should have prompted the staff to consult with the resident's physician even if the staff knew about the order allowing supplemental oxygen to be increased on a p.r.n. basis. How could the staff know whether there were other treatments that the physician might have ordered had he been consulted? The answer, obviously, is that the staff could not know what the physician might have ordered because it never consulted with him after April 23 about the resident's deterioration.

Furthermore, the resident manifested other signs of distress after April 23 not covered by the physician's order to increase oxygen flow p.r.n. These included: lethargy; loss of appetite; and diminished urine output. All of these changes demanded physician consultation and Petitioner's staff consulted with the physician about none of them.

Petitioner asserts that there was "frequent contact" between Petitioner's staff and Resident # 2's physician in the days following April 23 "as evidenced by the numerous consults and new orders." Petitioner's Closing Brief at 11. The evidence offered by Petitioner establishes that the resident's physician did issue several telephone orders on the 24th and 25th of April. P. Ex. 3 at 5 – 6. None of these orders, however, appear to reflect consultation with Petitioner's staff about the resident's continuing deterioration. Rather, they confirm that the resident was to be admitted to hospice care and they renew prescriptions for various medications. What is lacking from these orders – and what is totally absent from Petitioner's documentation – is any evidence that the staff brought to the physician's attention the resident's steady deterioration and that they discussed the problems that were developing with Resident # 2. For example, there is not a single document showing that the physician was informed that the resident had stopped eating. Nor is there anything showing that the resident had ceased urinating or that she had become lethargic.

Indeed, although the orders show that the resident's physician had received communications from Petitioner's staff about, for example, the decision to transfer Resident # 2 to hospice care, none of the orders or other documents of record show that the staff actually talked to the physician. There are no nurse's notes after April 23, 2013 showing any discussion with the resident's physician about any of the changes that the resident manifested. CMS Ex. 9 at 123 – 129. The term "consult" means more than simply calling a physician's office in order to inform the physician that a resident has been referred for hospice care. Rather, the term envisions a discussion in which the resident's signs and symptoms are addressed and the physician gives his advice and orders as to how to deal with them. I would find actual consultation had occurred had there been nurse's notes that recorded that consultation. In their absence, I draw the opposite inference.

Moreover, even if there was frequent consultation between Petitioner's staff and Resident # 2's physician after 11 a.m. on April 23, that would not excuse the staff's failure to consult with the physician for more than seven hours on the morning of the 23rd. Nor would it excuse the staff's initiation of a treatment – supplemental oxygen – without a physician's order.

Petitioner argues that the resident's lethargy was a desired consequence of the drug regimen that the physician had prescribed to the resident. It contends that the goal was to keep the resident comfortable and induced drowsiness and lethargy helped to achieve that goal. But, there is nothing whatsoever in the resident's clinical record to suggest that they physician and staff concurred that induced drowsiness and lethargy were desired goals. Nor is there anything that suggests that staff ever consulted with the physician about the possibility that the resident's medication regime might be producing these effects. And, of course, the physician wouldn't have known about these effects because no one told him that the resident was experiencing them.

There may be circumstances where it is medically appropriate to induce drowsiness or lethargy in a patient. But, here, there is absolutely nothing to suggest that anyone ever considered that result to be appropriate for Resident # 2. Petitioner's argument is simply a post hoc rationalization.

Petitioner relies on the testimony of Robert W. Parker, M.D. as support for its argument that the resident's condition remained stable after April 23 and for its broader assertion that there were no significant changes in the resident's condition that warranted physician consultation. Additionally, Petitioner, through Dr. Parker, contends that there was, in fact, consultation with Resident # 2's physician on the 23rd and 24th of April as is evidenced by the orders that the physician issued. P. Ex. 22.

However, a careful reading of Dr. Parker's affidavit does not support either the argument that there was no significant change in the resident's condition or that there was frequent consultation between Petitioner's staff and Resident # 2's physician. Dr. Parker's assertion that the resident remained stable is premised on the fact that the resident's oxygen saturation levels remained consistently high as Petitioner's staff increased the flow of oxygen to the resident. But, that assertion does not account for the resident's increased *demand* for oxygen. It is obvious that this resident was becoming sicker and sicker as her demand for supplemental oxygen quadrupled over a period of three days. That decline in status should have been addressed to the resident's physician and it was not. Nor does Dr. Parker explain why the staff did not need to report the resident's anorexia, her lethargy, or her failure to produce urine to the resident's physician. Dr. Parker does repeat that the resident's lethargy was a desired consequence of the medication that the physician had ordered. But, he does not explain why, if that was so, there is nothing in the resident's records that shows that lethargy was a goal and that the medication was being administered for that purpose. His explanation, like Petitioner's is a post hoc rationalization.

Furthermore, I note that the centerpiece of Dr. Parker's testimony is his characterization of the facility's relationship with Resident # 2's physician after 11 a.m. on April 23, 2013 when the staff first consulted with him. Dr. Parker doesn't provide meaningful justification for the failure of the staff to consult with the physician prior to 11 a.m. on that morning nor does he explain how the staff could implement legitimately a treatment – supplemental oxygen – that was not ordered by a physician.

42 C.F.R. § 483.10(b)(11) also requires a facility immediately to notify a resident's legal representative or immediate family member of a significant change in a resident's health status. CMS argues, and I agree, that Petitioner failed to make necessary notifications to Resident # 2's family about the significant changes in the resident's status.

Resident # 2's sister was the resident's primary caregiver and had a power of attorney to act on her sister's behalf. There is no evidence showing that the facility staff, on its own volition, called the sister to notify her about the resident's respiratory distress. Based on the facility's records, the sister first found out about Resident # 2's condition on April 24, 2013, the day after the resident exhibited distress, when the sister called the facility to find out about the resident's status. P. Ex. 2 at 2. That was more than a full day after the resident began to exhibit respiratory distress. The facility staff failed to communicate test results or the treating physician's orders to the family. On the morning of April 24, 2013, Petitioner's administrator concluded that the resident needed to be enrolled in hospice care. The staff referred the resident for hospice care shortly before 9:30

a.m. on that date. CMS Ex. 9 at 52. However, Petitioner gave no notification of this action to the resident's family. The resident's sister and primary caregiver did not learn about the determination to refer the resident for hospice care and the referral until she called the facility on April 24 to find out about the resident's status. CMS Ex. 9 at 125.

Moreover, there is no record of calls from the facility to the resident's sister/caregiver after April 24 to advise her of continued deterioration in the resident's condition. All of the communications after that date were initiated by the sister/caregiver who was clearly unhappy with the quality of care that Resident # 2 was receiving from Petitioner. She eventually had the resident transferred to a hospital despite opposition from Petitioner.

Petitioner argues that there was no need to remain in communication with the sister/caregiver because Resident # 2 was making her own decisions about her care and because, although the resident had given a power of attorney to sister/caregiver, the resident had not been adjudicated incompetent to make decisions in her own interest. I note that Resident # 2's diagnoses included dementia and schizoaffective disorder, but I also find it unnecessary to decide whether she was competent to make decisions on her own behalf. The notification requirement of 42 C.F.R. § 483.10(b)(11) does not depend on the resident's mental competency. The regulation is explicit. A facility must notify a resident's "immediate family member" of any significant change in a resident's health status. Resident # 2's sister clearly had "immediate family member" status and Petitioner had to keep her abreast of developments in the resident's condition – including all significant changes in the resident's health status – even if the resident was competent and fully capable of making care decisions.

A skilled nursing facility must develop and implement policies and procedures that, among other things, prevent neglect of residents. 42 C.F.R. § 483.13(c). CMS contends that Petitioner failed to comply with this requirement and I find that the evidence strongly substantiates this allegation.

"Neglect" is a failure by a facility to provide necessary services to a resident. Failure by a facility to carry out its regulatory duty to a resident – or that which it imposes on itself via its own policies – is neglect. Neglect occurs when a facility fails to consult with a resident's treating physician about a significant change in a resident's condition or fails to notify a resident's immediate family of such as change. *Universal Healthcare/King*, DAB CR1784 (2008).

Petitioner's internal policy governing residents' rights essentially tracks the regulation verbatim. CMS Ex. 10 at 23; CMS Ex. 1 at 47. So, Petitioner was obligated, not just by the regulation but, by its own policy to consult with Resident

2's treating physician and notify the resident's immediate family about any significant change in the resident's condition. As I discuss above, Petitioner failed to do that.

The neglect that is established here is not confined to a single or isolated incident. Petitioner neglected to provide adequate care to Resident # 2 over a period of several days, as is evidence by the staff's repeated failures to consult with the resident's physician and to notify the resident's immediate family about significant changes in Resident # 2's condition. The resident did not simply become short of breath on April 23, 2013. Her breathing steadily deteriorated over a period of several days and these changes in her condition were accompanied by other changes that appeared over time including anorexia, lethargy, and ceasing to produce urine. There were several points during this process when staff should have consulted and notified but failed to do so. For example, the staff should have consulted with the treating physician each time it found it necessary to increase the flow of oxygen to the resident. Yes, the physician issued an order allowing for oxygen to be increased as needed. But, the existence of that order does not suggest that the need to increase oxygen was not a significant change that mandated additional consultation.

Petitioner argues that 42 C.F.R. § 483.13(c) does not, as a matter of law, apply to prohibit misfeasance that amounts to neglect. I disagree. The regulation plainly addresses not only the creation of policy but also its implementation. Here, there was an obvious failure by Petitioner to implement its own policy as well as to comply with regulatory requirements.

Petitioner asserts also that CMS cannot identify any specific component of Petitioner's neglect policy that Petitioner failed to implement. Petitioner's Closing Brief at 15. However, Petitioner's policy specifically directs its staff to consult with a resident's physician and to notify the resident's immediate family in the event of a significant change in the resident's condition. I have explained in detail why Petitioner failed to comply with that policy.

A skilled nursing facility such as Petitioner must provide care that meets professional standards of quality. 42 C.F.R. § 483.20(k)(3)(i). Another regulation, 42 C.F.R. § 483.25, imposes a very similar burden on a facility by requiring it to provide care and services to each resident sufficient to enable the resident to attain or maintain the highest practicable physical, mental, and psychosocial well-being in accordance with the resident's plan of care.

The evidence strongly supports CMS's contentions that Petitioner failed to comply with these regulations. Petitioner's staff failed to comply with 42 C.F.R. § 483.20(k)(3)(i) on April 23, 2013, when it decided on its own volition to administer oxygen to Resident # 2 without an physician's order authorizing that action.[2] As CMS points out, standards of nursing practice in Texas do not allow a nurse to prescribe therapeutic or corrective measures. http://www.bon.texas.gov/nursinglaw/pdfs/npa2013.pdf.

Petitioner's staff failed additionally to comply with the regulation when it failed to consult with Resident # 2's physician about significant changes in the resident's medical condition. The consultation requirement, as a matter of law, embodies a standard of professional quality and a facility that violates that standard is not providing care of professionally accepted quality.

I find also that Petitioner's failures – its staff's determination to administer oxygen to Resident # 2 without a physician's order and its subsequent failure to consult with the resident's treating physician – is substantial noncompliance with the requirements of 42 C.F.R. § 483.25. It is axiomatic that failure by a facility to comply with regulatory requirements governing quality of care also constitutes a failure by that facility to provide care that enables the resident to attain the highest practicable level of functioning as is required by the regulation.

In responding to the allegations of noncompliance with 42 C.F.R. § 483.20(k)(3)(i) Petitioner essentially repeats the arguments that it has made previously. It is unnecessary that I address those arguments again. In responding to the allegations of noncompliance with 42 C.F.R. § 483.25 Petitioner asserts that the regulation applies only to an instance where a facility allegedly fails to implement a specific provision of a resident's plan of care. Petitioner argues that there cannot be a violation here because CMS did not allege any specific care plan violations.

I disagree with Petitioner's interpretation of 42 C.F.R. § 483.25. The regulation is not so narrowly written as to require a link to a specific phrase or section of a resident's care plan. The very purpose of a care plan is to assure that a resident attains his or her highest practicable level of physical, mental, and psychosocial

[2] At times Petitioner seems to argue that the order allowing for a nebulizer to be administered to the resident on an as needed basis authorized the administration of oxygen. But, a nebulizer and oxygen are not the same and an order authorizing the administration of one is in no sense an order authorizing the administration of the other.

well being. That goal is implicit in every care plan. Thus, providing care that does not comply with this standard would in every case constitute a failure to comply with a resident's care plan.

CMS determined that the noncompliance that I have addressed in this decision was so egregious as to comprise immediate jeopardy for Petitioner's residents. "Immediate jeopardy" is defined by regulations to mean a situation in which noncompliance either causes or is likely to cause serious injury, harm, impairment, or death to a resident or residents of a facility. 42 C.F.R. § 488.301. Petitioner has the burden of proving that a determination of immediate jeopardy is clearly erroneous. Petitioner failed to meet that burden here.

The immediate jeopardy in this case does not consist exclusively of the risk or risks that Resident # 2 faced as a result of the facility's noncompliance. There is a broader issue here. The staff's failures to consult with the resident's treating physician were manifold and occurred in the face of a severe deterioration in Resident # 2's condition. Petitioner's staff failed to comprehend its duty to consult and to obtain the advice and orders of a physician when there is a significant change in a resident's health status. Petitioner's staff also failed to comprehend the significance of certain clinical signs demonstrated by Resident # 2 including shortness of breath, reduced oxygen saturation levels, anorexia, lethargy, and failure to urinate. These failures endangered Resident # 2 to be sure but they put at risk all other residents of the facility as well. I infer that, if Petitioner's staff could not comprehend their responsibilities in dealing with Resident # 2, those failures could easily jeopardize any other resident who, like Resident # 2, is gravely ill and whose condition is declining.

Petitioner asserts that a determination of immediate jeopardy is clearly erroneous in this case for two reasons. Petitioner's Pre-Hearing Brief at 21 – 23. First, it contends that its noncompliance, if it existed at all, was confined solely to the care that it gave to Resident # 2. This, according to Petitioner, is at best "isolated" noncompliance and no basis for a conclusion that immediate jeopardy was widespread.

I have addressed this argument. I conclude that the evidence establishes that the failures by Petitioner's staff to consult actively with a physician about Resident # 2's deterioration were systemic, because the evidence establishes a lack comprehension by the staff of its obligations and duties.

Second, Petitioner asserts that the survey that led to the finding of immediate jeopardy was fatally flawed in that surveyors allegedly failed to follow standardized protocol for conducting surveys. That is no basis for me to find that the immediate jeopardy determination is clearly erroneous. The finding of

immediate jeopardy rests on overwhelming evidence of noncompliance. Petitioner has not shown how any ostensible failure by the surveyors to follow survey protocols impeaches that evidence. Furthermore, regulations make it clear that inadequate survey performance – even if established – will not invalidate survey findings of noncompliance if those findings of noncompliance are adequately documented. 42 C.F.R. § 488.318(b)(2).

Petitioner relies on the testimony of Lynn Morgan, RN, to support its assertion that findings of immediate jeopardy are clearly erroneous. P. Ex. 20. Ms. Morgan's testimony does not add anything of substance to the record. She merely repeats arguments that Petitioner made in its brief. Mostly, she challenges the manner in which the surveyors made their findings, an assertion that I have ruled is no basis for me to find CMS's immediate jeopardy determination to be clearly erroneous.

CMS opted to impose civil money penalties of $ 4050 for each day of Petitioner's immediate jeopardy level noncompliance and $250 per day for each day of Petitioner's subsequent non-immediate jeopardy level noncompliance. In its pre-hearing brief Petitioner represented that it would demonstrate that these penalty amounts are unreasonable. Petitioner's Pre-Hearing Brief at 24. However, this general contention aside, Petitioner never offered evidence or argument that addresses the penalty amounts except to rely on Ms. Morgan's assertions that there was no noncompliance or that if there was noncompliance it did not rise to the level of immediate jeopardy. Its closing brief is devoid of any discussion of the issue of penalty amount.

The immediate jeopardy level penalties of $4050 per day fall within the range of from $3050 to $10,000 per day that defines allowable penalties for immediate jeopardy level noncompliance. 42 C.F.R. § 488.438(a)(1)(i). The non-immediate jeopardy level penalties of $250 per day fall within the range of from $50 to $3000 per day that defines allowable penalties for deficiencies that are substantial but are not at the immediate jeopardy level of scope and severity. 42 C.F.R. § 488.438(a)(1)(ii). There are regulatory factors that must be considered in determining what penalty amount is reasonable within each of these ranges. 42 C.F.R. §§ 488.483(f)(1) – (4), 488.404 (incorporated by reference into 42 C.F.R. § 488.438(f)(3)).

I do not address the regulatory factors here inasmuch as Petitioner offered no argument that attacks CMS's penalty amount determination, except to say this: Petitioner's noncompliance was sufficiently serious that I would sustain the penalties imposed against it even if it had failed to comply with only one of the four regulations that it contravened (42 C.F.R. §§ 483.10(b)(11); 483.13(c);

483.20(k)(3)(i); and, 438.25). As I have discussed Petitioner's noncompliance with each of these regulations emanates from the same facts and these facts establish that Petitioner not only jeopardized the health of one resident but put at risk all of the residents of Petitioner's facility.

/s/
Steven T. Kessel
Administrative Law Judge