Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Falfurrias Nursing and Rehabilitation, L.P.,
(CCN: 67-5630),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-14-605

Decision No. CR3397

Date: September 30, 2014

DECISION

I sustain the determination of the Centers for Medicare & Medicaid Services (CMS) to impose the following civil money penalty (CMP) remedies against Petitioner, Falfurrias Nursing and Rehabilitation:

- $5550 per day for each day of a period that began on November 10, 2013 and that ran through November 25, 2013; and

- $1000 per day for each day of a period that began on November 26, 2013 and that ran through December 19, 2013.

I. Background

Petitioner is a skilled nursing facility doing business in the State of Texas. It participates in the Medicare program. CMS determined to impose the remedies that I describe above based on its conclusions that Petitioner failed to comply with several Medicare participation requirements and that its noncompliance was so egregious as to comprise constitute immediate jeopardy for Petitioner's residents. Petitioner requested a hearing in

order to challenge CMS's determination and the case was assigned to me. I directed the parties to file briefs and proposed exhibits. The parties complied. The parties then informed me that they did not require an in-person hearing. I allowed them to file a final round of briefs.

CMS filed 36 proposed exhibits that it identified as CMS Ex. 1 – CMS Ex. 36. Petitioner filed four proposed exhibits that it identified as P. Ex. 1 – P. Ex. 4. I receive these exhibits into the record.

II. Issues, Findings of Fact and Conclusions of Law

A. Issues

The issues in this case are: whether Petitioner failed to comply substantially with Medicare participation requirements; whether CMS's determination of immediate jeopardy level noncompliance was clearly erroneous; and whether CMS's remedy determinations are reasonable.

B. Findings of Fact and Conclusions of Law

CMS's noncompliance and remedy determinations center around the care that Petitioner gave to a resident who is identified as Resident # 1. Petitioner admitted the resident, a 69-year old man, on August 12, 2013. The resident had several medical problems and, in addition, suffered from mild cognitive impairment. CMS Ex. 12 at 102. The resident came to the facility with an indwelling Foley Catheter, which had been prescribed to address problems that the resident had with urination caused, apparently, by benign prostatic hypertrophy (enlargement of the prostate gland). *Id.* at 90, 106, 134.

On November 8, 2013, Resident # 1 told Petitioner's staff that he was sick. The staff noted that the resident's catheter was emitting a foul odor, that that there was blood in the resident's urine, and that the urine was concentrated. CMS Ex. 12 at 76; CMS Ex. 34 at 8; P. Ex. 1 at 19. The staff notified the resident's physician, who ordered a urinalysis and a culture and sensitivity test for the resident. CMS Ex. 12 at 156. On November 10, the resident called for a nurse and explained that he was in so much pain that he removed his catheter. *Id.;* P. Ex. 1 at 10-20.

By November 16, 2013, Resident # 1's family noticed profound changes in the resident's mental state (including hallucinations and severe lethargy) and demanded that the resident be transferred to a hospital. CMS Ex. 12 at 49; P. Ex. 1 at 31-32. He was transferred later on that date and the hospital staff's admitting assessment included findings that the resident suffered from acute hypotension (low blood pressure) and probably septicemia, obstruction prostatitis, and a urinary tract infection. CMS Ex. 12 at 48. The resident died on November 22, 2013. *Id.* at 198.

CMS alleges that Petitioner failed in several respects to assure that the resident's medical needs were attended to during the period commencing on November 10, 2013, when the resident pulled out his catheter. All of these assertions focus on the risk that Resident # 1 might retain urine in his bladder after he pulled out the catheter. That was an obvious risk given that the catheter had been inserted to begin with because the resident was retaining urine. Urinary retention is potentially a grave medical problem because it can lead to severe adverse and even fatal consequences including bladder distention, kidney failure, and sepsis. CMS Ex. 32 at 5. Moreover, these consequences can come on suddenly when urine is retained. *Id.* Thus, it is critically important that staff effectively and accurately monitor any resident who is at risk for urine retention.

According to CMS, Petitioner's first failure was that its staff failed to seek clarification of a telephoned physician's telephone order given to Petitioner's staff on November 10, after the resident pulled out his catheter. In that order the physician directed that the staff not reinsert the catheter immediately, that it observe the resident for retention of urine, and that it could reinsert the catheter if the resident retained more than 300 milliliters (ml) of urine. CMS Ex. 12 at 76. CMS argues that the order was vague in that it did not: clearly state the circumstances under which the staff should (as opposed to might) reinsert the catheter; specify the frequency of checks that the staff should perform to determine whether the resident was retaining urine; or, order an appropriate method for the staff to assess retention. CMS argues that the staff should have identified these ambiguities and that it should have asked the physician to clarify his order to resolve those ambiguities.

Second, CMS contends that Petitioner failed to satisfy the professionally recognized standard of care for dealing with residents who are at risk for urine retention. CMS asserts that the standard of care is to use either ultrasound, or a "straight catheter" (quick placement of a catheter in and out of the urethra) in order to measure the quantity of urine that drains from the individual's bladder. CMS Ex. 32 at 6. Additionally, the susceptible individual's input and output of fluids should be monitored. *Id.* CMS argues that Petitioner's staff did none of this. Petitioner's monitoring of Resident # 1 – to the extent that any monitoring was done – consisted of relying on certified nursing assistants to inform the staff about whether Resident # 1 was retaining urine. CMS Ex. 30 at 5; CMS Ex. 35 at 2 – 3; CMS Ex. 36 at 2 – 4.

Third, CMS asserts that Petitioner failed to follow the resident's physician's order that the resident be catheterized if he retained more than 300ml. of urine. CMS asserts that, in fact, Petitioner's staff never recorded how much urine the resident retained and failed to employ any systematic or accurate measure for determining urine retention. CMS closing brief at 10 – 11.

Finally, CMS argues that Petitioner never assessed Resident # 1 consistently for urine retention. CMS argues that the clinical records that Petitioner's staff maintained for the resident fail to show any consistent monitoring. CMS closing brief at 11 – 12.

The record strongly supports these four allegations of misfeasance. To begin with, I agree with CMS that the physician's November 10 order was vague in that it did not specify how or how precisely Petitioner was supposed to monitor the resident for urine retention. As I find, above, urine retention is a potentially life-threatening condition. The staff knew that Resident # 1 was at high risk for urine retention, not only because the resident's physician had expressed concern in ordering that the resident be monitored, but also because the resident had a history of urine retention that necessitated that he have an indwelling catheter. Given that, the staff should have asked for precise orders about how to monitor the resident. At the very least, the staff should have planned what it was going to do to protect Resident # 1 and that would have entailed asking the physician to be more specific. But, the staff did nothing of the kind.

Petitioner does not rebut CMS's allegations concerning the need for clarification of the physician's order. As I shall discuss in more detail below, Petitioner recites at length the care that it provided for Resident # 1. But, on the issue of interaction with the resident's physician Petitioner says nothing that responds to CMS's allegations. Indeed, Petitioner concedes that the order was "poorly written," a concession that is reinforced by the testimony of Petitioner's own expert. Petitioner's pre-hearing brief at 11; P Ex. 3 at 3. But, given that Petitioner's staff received a poorly written and ambiguous order from the resident's physician, it imposed on the staff the duty to clarify the order and get more precise instructions. Petitioner's staff failed to do so and Petitioner offers no excuse for that failure.

Likewise, Petitioner does not provide any meaningful rebuttal to CMS's assertion that it failed to comply with professionally recognized standards of care in providing care to Resident # 1. It does not offer evidence showing that the standard of care is other than what CMS contends it to be. It does not deny that ultrasound or a straight catheter can and ought to be used to determine whether a resident is retaining urine.

Petitioner goes to some lengths to assert that measuring urine output is an exercise in futility and, from that, it argues that it would have been useless for its staff to attempt to do so in the case of Resident # 1. Thus, according to Petitioner: "In an incontinent patient, it is not possible to measure urine output precisely, since the urine is not collected in a container." Petitioner's pre-hearing brief at 19. From this, Petitioner argues that it was reasonable for Petitioner's staff to conclude that if the resident was passing any urine he was not experiencing an obstruction.

Petitioner's argument boils down to this: it was difficult to measure the resident's output so it was useless to try to do it. That is no excuse, particularly with a resident such as Resident # 1 who is at high risk for urine retention and potentially lethal consequences. Petitioner never explains why, if it could not collect and measure urine from the resident, it did not employ ultrasound to determine whether there was urine being retained in the resident's bladder. Nor does Petitioner explain its failure to use a straight catheter to determine whether the resident was retaining urine.

Petitioner argues further that, since Resident # 1 was passing *some* urine after November 10, it was reasonable to conclude that there was no significant obstruction present in the resident's urinary tract. Petitioner's pre-hearing brief at 19. That argument is a red herring. The issue that Petitioner's staff needed to deal with was the possibility that the resident was retaining urine. The fact that he was passing quantities of urine did not mean that he was successfully voiding and the risk to the resident from not successfully voiding was potentially lethal, which is certainly significant, as I have discussed.

Petitioner also has not offered a persuasive response to CMS's allegation that it failed to follow the physician's order to catheterize Resident # 1 if he retained more than 300ml. of urine. At no point after November 10 did Petitioner's staff attempt to catheterize the resident. And, of course, it had no way of knowing whether catheterization was necessary in that the staff wasn't monitoring the resident for urine retention.

Petitioner argues that it could not catheterize Resident # 1 because the resident refused to be catheterized. It characterizes the care that it gave to the resident as merely acceding to the resident's wishes. According to Petitioner, the resident's wishes trump what might be medically most appropriate for the resident. Thus, according to Petitioner, what it could do for Resident # 1 was very much limited by what the resident was willing to allow Petitioner's staff to do for him.

However, Petitioner points to *nothing* in the resident's record that establishes that Petitioner presented the resident with the option of being catheterized and the resident refused. There is no entry in the nursing notes for Resident # 1 offered by Petitioner that establishes that. P. Ex. 1. One would expect that the notes would have reflected the resident's desire that was potentially a life-threatening decision, if it had been voiced. That is particularly the case inasmuch as the staff dutifully recorded other refusals by the resident such as his refusal to receive influenza vaccine. *Id.* at 20.

What Petitioner seems to be relying on as evidence that the resident refused being treated with a catheter is his removal of the catheter on November 10. But, and as Petitioner's records show, the resident acted on that occasion due to his complaints of pain. There is nothing to show that the staff subsequently approached the resident about reinserting a catheter and offered him appropriate pain medication to alleviate his pain. There is likewise nothing to show that the resident would have refused reinsertion of the catheter

under those circumstances. P. Ex. 1. It is evident, and I find, that Petitioner's staff simply never brought up the subject of catheterization after the resident pulled the catheter out on November 10 and never considered that re-catheterizing him might be medically necessary.

There are numerous entries in the resident's nursing notes to the effect that the resident "voided." P. Ex. 1. I do not interpret these entries to mean that the staff actually determined that the resident emptied his bladder. Rather, they signify only that the resident excreted some quantity of urine. In order to determine whether the resident had actually voided the staff would have had to perform some of the tests – ultrasound or straight catheterization – that were devised to determine whether voiding had occurred. Staff never performed these tests, so the assertion that the resident "voided" is, at best, guesswork.

Petitioner did not assign its nursing staff the duty of monitoring the resident for retention of urine. Rather – and astonishingly – it assigned that responsibility to certified nursing assistants, individuals who lacked the necessary professional training. None of these individuals could have performed the kind of tests or treatments, such as an ultrasound or catheterization, which might have been required, because they lacked the qualifications to do so. Moreover, it is clear that Petitioner's nursing assistants had no idea what it was that they were supposed to do in order to monitor the resident systematically for urine retention. That is made evident by the statement of one of Petitioner's nursing assistants, who averred that she measured an incontinent resident's urine output by determining the number of times it was necessary to change the resident's incontinence brief. CMS Ex. 35 at 2; CMS Ex. 36 at 3. The imprecision of that sort of "test" for urine retention is obvious.

The evidence overwhelmingly supports CMS's final assertion of misfeasance, that Petitioner failed to assess Resident # 1 for the possibility that he was retaining urine. As I discussed above, urine retention was a possibly life-threatening condition. It was, therefore, critical, that Petitioner's staff develop and implement a comprehensive approach to determining whether the resident was retaining urine. The staff, obviously, knew that the resident was at grave risk because he had worn a Foley Catheter during his entire stay at the facility in order to preclude urine retention. Beginning November 10, 2013 the resident was without that device and, consequently, exceedingly vulnerable.

But, Petitioner's staff did nothing that would assure that the resident was not retaining urine. It did not obtain clarification from the resident's physician about the circumstances and the methodology for checking the resident for retention nor did it implement measures such as ultrasound tests or straight catheterization that would actually measure the quantity of urine in the resident's bladder. At most, it used ad hoc and primitive measures such as asking the facility's nursing assistants to report whether the resident's incontinence briefs contained urine.

Petitioner asserts that its nursing staff dutifully recorded whether Resident # 1 was retaining urine. Petitioner's pre-hearing brief at 12 – 16. As alleged proof for this assertion, Petitioner points to nursing notes that ostensibly show that the resident was not exhibiting signs of bladder distention and was voiding, and therefore, not retaining urine. P. Ex. 1 at 19 – 33.

I do not find these notes to be persuasive evidence that Petitioner was assessing the resident for urine retention. If anything, the notes prove the opposite; that Petitioner's staff failed to implement the recognized measures that would have answered the question of whether Resident # 1 was retaining urine. As I observe above, the notes frequently contain statements that the resident was voiding. Those statements clearly were based on the fact that the resident's incontinence briefs were at times wet. But – and as Petitioner itself asserts – urine in incontinence briefs is an utterly inaccurate measure of how much urine a resident is producing and how much is retained. Indeed, Petitioner contends that it is impossible to determine urine output by looking at what is in a resident's briefs. Petitioner's pre-hearing brief at 19.

Moreover, palpating a resident's abdomen in order to check for bladder distention is an imprecise and often inaccurate test to determine whether a resident is retaining urine. CMS Ex. 32 at 6. An individual can exhibit no signs of discomfort and distention and still retain significant quantities of urine. *Id.*

Furthermore, the nursing notes show that Petitioner's staff was not even using imprecise measures consistently to determine whether Resident # 1 was retaining urine. Petitioner relies on 26 entries that cover the period from November 10 through November 16, 2013. Petitioner pre-hearing brief at 12-16. But, eleven of them say nothing about whether the resident had urinated or exhibited signs of bladder distention or discomfort. *Id.*; P. Ex. 1 at 20 – 29.

CMS alleges that Petitioner's misfeasance in caring for Resident # 1 constitutes substantial noncompliance with four regulations. These are:

- 42 C.F.R. § 483.13(c), which, among other things, requires a skilled nursing facility staff to develop and implement policies that prevent resident neglect;

- 42 C.F.R. § 483.25, which requires a facility to provide each resident with a quality of care and services necessary to attain the highest practicable physical, mental, and psychosocial well-being in accordance with that resident's comprehensive plan of care;

- 42 C.F.R. §§ 483.20(k)(3)(i) and (k)(3)(ii), which require that a facility provide care that meets professional standards of quality and that care be furnished by qualified persons in accordance with a resident's written plan of care; and

- 42 C.F.R. § 483.75, which requires a facility to be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.

The evidence amply, indeed, overwhelmingly supports CMS's allegations of noncompliance. First, it is evident that Petitioner neglected the needs of Resident # 1. The regulatory definition of "neglect" is "failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness." 42 C.F.R. § 488.301. Petitioner's failure to obtain clarification of the November 10 telephoned physician's order and its failure to implement any systematic measures to determine whether the resident was retaining urine constituted neglect by any measure. Checking the resident systematically for urine retention was absolutely necessary. Petitioner's failure to do so put the resident at risk for extremely grave consequences.

Second, the evidence establishes failure by Petitioner to provide Resident # 1 with a quality of care necessary for him to attain his highest practicable level of functioning. It was not simply important that the resident be monitored for urine retention; it was *critical* that Petitioner's staff perform such monitoring. The staff's failure to do so put the resident at risk.

Third, Petitioner did not provide Resident care that met professionally recognized standards of care. That is made obvious by the staff's failure to use standard measures to monitor the resident's urine output or to clarify the physician's November 10 order.

Finally, Petitioner's management failed utterly to assure that Resident # 1 received care in accordance with recognized standards of care. In any skilled nursing facility it is the facility management that bears ultimate responsibility for assuring that each resident receives care that meets professional standards of quality. The failure by Petitioner's staff to provide such care to Resident # 1, over a period of about a week, shows a disregard by Petitioner's management for the performance of its staff and a failure to assure that the staff did its job correctly.

Petitioner makes several arguments to support its assertion that it complied with regulatory requirements. I have dealt with Petitioner's asserted rebuttals to CMS's allegations of fact and will not repeat them here. But, Petitioner makes some other arguments and I address those now.

First, Petitioner contends that it made reasonable assumptions about Resident # 1's condition based on the fact that he was passing urine. Petitioner asserts: "It was . . . reasonable to conclude, that since Resident No. 1 is passing urine he does not have a significant obstruction." Petitioner's pre-hearing brief at 19. That was *not* a reasonable assumption, because the fact that the resident passed *some* urine did not mean that he was passing *all* of the urine that accumulated in his bladder. Nor did the fact that the resident

did not have a complete obstruction of his urethra mean that he was passing all of the urine that he accumulated. Petitioner should have known that and its failure to take the possibility that the resident was retaining urine into consideration was an error that put the resident at risk for grave harm or death.

Second, Petitioner argues that the resident was not denied a service by Petitioner's staff. "At worst," according to Petitioner, "he was denied a perfect service." Petitioner's pre-hearing brief at 19. Petitioner asserts that lack of perfection is not neglect. That argument is wrong in fact and as a matter of law. It is wrong in fact because Petitioner was denied a service. Petitioner did *nothing* effective to monitor the resident's urine output or to determine systematically if the resident was retaining urine. It is wrong also as a matter of law because "neglect" has never been interpreted to mean a complete denial of a service. Partial denial of a service or providing shoddy care certainly can constitute neglect if it is significant and if it potentially adversely affects a resident.

Next, Petitioner recites a litany of services that it contends its staff gave to Resident # 1. This, according to Petitioner, proves that its staff was responsive to the resident's needs. The services that Petitioner contends it gave include:

- Antibiotic therapy administered to Resident # 1 after November 12, 2013;
- Honoring the resident's wishes and directive not to be treated with a catheter;
- Monitoring the resident for signs of urine retention;
- Contacting the resident's physician when the resident's family demanded that he be transferred to a hospital; and
- Honoring the resident's initial desire not to be transferred to a hospital.

Some of these services have nothing to do with the issue of whether the staff dealt effectively with the danger that the resident might retain urine. Providing the resident with prescribed antibiotics and acceding to the resident's and the resident's family's wishes about transfer are elements of care that should have been provided whether or not the resident was retaining urine. I have addressed previously Petitioner's assertion that Resident # 1 wished and directed that he not be treated with a catheter after November 10, 2013 and I find that assertion to be unsupported. I also find to be unsupported, for all of the reasons that I have stated, Petitioner's assertion that it monitored the resident for signs of urine retention.

In its final brief Petitioner makes a long argument asserting that it was bound to follow Resident # 1's physician's wishes because to do otherwise would constitute the "corporate practice of medicine," unlawful under Texas law. It then refers to a

declaration by the resident's physician, Jose M. Lozano, M.D., as evidence that "the physician makes clear that he discontinued the catheter and did not expect Petitioner's staff to use a catheter to obtain input and output." Petitioner's closing brief at 8; P. Ex. 4 at 1 – 2. From this, Petitioner suggests that it would have unlawfully engaged in the "corporate practice of medicine" under Texas law if it had, on its own volition, re-catheterized Resident # 1 or taken other measures to determine quantitatively whether the resident was retaining urine.

But, no one has argued, and I do not find, that Petitioner should have violated the resident's physician's orders in providing care to Resident # 1. Petitioner's staff simply needed to seek clarification of Dr. Lozano's November 10, 2013 order. If the physician had directed Petitioner not to catheterize the resident again and ruled out ultrasound or other objective measures for determining whether the resident was retaining urine, this would be a different case.[1]

But, that isn't what happened. Dr. Lozano's order of November 10 was, as Petitioner concedes, ambiguous. It left it to the staff's imagination what measures to take to protect Resident # 1 against possible urine retention. That ambiguity imposed on the staff the absolute duty to discuss in detail the resident's condition and possible problems with Dr. Lozano and they did not do that.

Moreover, despite what Dr. Lozano says now, he *absolutely* left open the possibility that the staff should re-insert the resident's catheter. His order expressly said that the staff should do that if the resident retained more than 300ml. of urine. His assertion now that he did not expect that the resident would be re-catheterized is not credible given the fact that his order envisioned that possibility.

Furthermore, his assertion that the staff was adequately monitoring the resident for urine retention based on the fact that the resident was passing some urine is utterly incredible. How was the staff supposed to know whether the resident was retaining urine if it did no objective measurements? How was the staff supposed to know whether to reinsert a catheter if the resident retained more than 300ml. of urine given that the staff was doing no objective measurements to determine whether the resident was retaining urine? Dr. Lozano doesn't answer these questions.

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[1] Other quality of care issues might have been raised had Dr. Lozano explicitly ruled out re-catheterizing Resident # 1, depending on Dr. Lozano's relationship with Petitioner. I do not address these possible other issues here.

CMS determined that Petitioner's noncompliance with regulatory requirements put residents of the facility at immediate jeopardy. Regulations define "immediate jeopardy" to be noncompliance that 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.

The evidence strongly supports CMS's determinations of immediate jeopardy level noncompliance. There is no basis for me to conclude that those determinations were clearly erroneous.

It is not necessary for me to find that Petitioner's misfeasance caused Resident # 1 to deteriorate or caused his death in order to find immediate jeopardy level noncompliance. Indeed, I would find immediate jeopardy level noncompliance even if Resident # 1 suffered no adverse consequences during the period between November 10, 2013 and his death. The issue here is whether Petitioner's misfeasance created a likelihood that the resident would suffer from severe adverse consequences and I find that the evidence unequivocally supports a finding that it did.

As I have discussed, urine retention is a potentially life-threatening condition. Retained urine can be a breeding ground for pathogenic organisms. It can lead to septicemia and death. *See* CMS Exs. 32, 34. It was, therefore, critical that Petitioner's staff knew whether the resident retained urine after November 10, 2013. That, it could only determine through objective tests such as ultrasound or straight catheterization. Petitioner's staff failed utterly to provide such care to Resident # 1. It failed to discuss the problem of likely retention with the resident's physician. It failed to consider whether the resident needed more than the ad hoc and haphazard assessments that Petitioner directed its nursing assistants to perform. And, these failures put the resident at grave risk for suffering the consequences of retained urine. Whether or not the resident actually retained urine is irrelevant. It is the failure to rule out that possibility that comprises immediate jeopardy here.

Petitioner has not offered any argument or evidence to challenge CMS's remedy determinations except to assert that they are "punitive" based on its contention that it did not violate regulatory requirements. I find this assertion to be without merit.

Regulations state that civil money penalties for immediate jeopardy level noncompliance must fall within a range of from $3050 to $10,000 per day. 42 C.F.R. § 488.438(a)(1)(i). Civil money penalties for non-immediate jeopardy level noncompliance must fall within a range of from $50 to $3000 per day. 42 C.F.R. § 488.438(a)(1)(ii). Where within these ranges any given penalty should fall depends on the application of factors set forth at 42 C.F.R. §§ 488.438(f)(1) – (4) and 488.404 (incorporated by reference into 42 C.F.R. § 488.438(f)(3)). These factors may include the seriousness of a facility's noncompliance, its culpability, its compliance history, and its financial condition.

Here, the penalties that CMS imposed are modest in terms of their daily amounts.[2] The immediate jeopardy level penalties of $5550 per day imposed by CMS are only slightly more than one half of the maximum permissible amount. The non-immediate jeopardy level penalties of $1000 per day are only one third of the maximum permissible amount.

These modest penalties appear even more modest in light of the seriousness of Petitioner's noncompliance. Petitioner's staff failed completely to deal with the possibility that Resident # 1 was suffering from a potentially life-threatening condition. The staff failed to recognize the problem, it failed to get meaningful treatment orders, and it failed utterly to do the monitoring and assessments that it should have done, thereby jeopardizing the resident's safety and his life. The penalties imposed by CMS are entirely reasonable given this misfeasance.

CMS alleged, and I have found, that Petitioner failed to comply substantially with several Medicare participation requirements and that this noncompliance was so egregious as to put residents of Petitioner's facility at immediate jeopardy. I stress that it is not necessary to find that Petitioner manifested immediate jeopardy level noncompliance with all of the regulations cited by CMS. I would sustain the remedies determined by CMS if Petitioner was noncompliant, at the immediate jeopardy level, with any one of the regulations that CMS cited.

/s/
Steven T. Kessel
Administrative Law Judge

[2] Petitioner offered no argument about the duration of the penalties. In other words, it did not contend that, if it was noncompliant, it re-attained compliance at a date earlier than that was determined by CMS. I do not address the potential issue of duration of noncompliance given that Petitioner has not raised it.