Department of Health and Human Services
DEPARTMENTAL APPEALS BOARD
Appellate Division

Apollo Behavioral Health Hospital, L.L.C.,
Docket No. A-14-12
Decision No. 2561
March 19, 2014

FINAL DECISION ON REVIEW OF ADMINISTRATIVE LAW JUDGE DECISION

Apollo Behavioral Health Hospital, L.L.C. (Apollo), a psychiatric hospital, appeals the August 29, 2013 Administrative Law Judge (ALJ) decision granting summary judgment in favor of the Centers for Medicare & Medicaid Services (CMS). *Apollo Behavioral Health Hospital, L.L.C.*, DAB CR2908 (2013) (ALJ Decision). The ALJ sustained the January 25, 2013 CMS reconsideration determination that Apollo failed to meet the requirements for participation in the Medicare program, thereby upholding an effective date of February 8, 2013. Apollo argued on appeal of the reconsideration determination that it was entitled to an earlier effective date of August 20, 2012.

For the reasons discussed below, we sustain the ALJ Decision.

I. Legal Background

The Social Security Act (Act) defines "psychiatric hospital" to mean an institution that is "primarily engaged in providing, by or under the supervision of a physician, psychiatric services for the diagnosis and treatment of mentally ill persons."[1] Act § 1861(f). In order to participate as a provider in Medicare, a psychiatric hospital must meet the conditions and requirements specified in the Act and regulations and enter into a provider agreement with CMS. Act §§ 1861(e)(3)-(9), 1861(f), 1866; 42 C.F.R. § 489.10.[2]

[1] The current version of the Social Security Act can be found at http://www.socialsecurity.gov/OP_Home/ssact/ssact.htm. Each section of the Act on that website contains a reference to the corresponding United States Code chapter and section. Also, a cross-reference table for the Act and the United States Code can be found at 42 U.S.C.A. Ch. 7, Disp Table.

[2] Unless otherwise noted, all citations to regulations are to the version in effect at the time of the September and October 2012 surveys and related CMS determinations.

The "conditions of participation" that a psychiatric hospital must meet in order to begin and continue to participate in Medicare are set forth in 42 C.F.R. Part 482. Each condition of participation represents a general health or safety requirement codified in a single regulation, which is composed of subpart "standards." A provider is not in compliance with a condition of participation "where the deficiencies are of such character as to substantially limit the provider's . . . capacity to furnish adequate care or which adversely affect the health and safety of patients; . . . ." 42 C.F.R. § 488.24(b). Whether an entity is in compliance with a particular condition of participation "depends upon the manner and degree to which the provider . . . satisfies the various standards within each condition." 42 C.F.R. § 488.26(b). The Secretary may "refuse to enter into an agreement" with a provider that "fails to comply substantially" with the provisions of the provider agreement, the Act, or applicable regulations. Act § 1866(b)(2).

Generally, before entering into a Medicare provider agreement, a provider must be surveyed by a state survey agency to ascertain whether it complies with the conditions of participation and other statutory and regulatory requirements. Act § 1864; 42 C.F.R. Part 488. A "certification" is a recommendation by the state survey agency on the compliance of a provider with the conditions of participation. 42 C.F.R. 488.1. Based on a state survey agency's findings and recommendations, CMS determines whether the provider qualifies to participate in Medicare and to enter into a provider agreement. 42 C.F.R. §§ 488.12, 488.330, 489.11-12.

As an alternative to the state agency survey process, CMS may "deem" a prospective provider to have met the requirements if it demonstrates through accreditation by an approved national accreditation organization (such as the Joint Commission) that all applicable Medicare conditions are met or exceeded. Act § 1865(a); 42 C.F.R. §§ 488.5, 488.12; 76 *Fed. Reg.* 10,598 (2011)(Final Notice of Approval of the Joint Commission for Deeming Authority for Psychiatric Hospitals effective February 25, 2011 through February 25, 2015). However, if CMS finds that a provider "has significant deficiencies," the provider shall "be deemed not to meet the conditions" the hospital has been treated as meeting. Act § 1865(c).

CMS may use a validation survey, an accreditation survey or other survey-related information to determine that a hospital does not meet the conditions of participation. 42 C.F.R. § 488.5(c)(2). Under section 488.7(a), validation surveys are "conducted on a representative sample basis, or in response to substantial allegations of noncompliance." CMS defines "[s]ubstantial allegation of noncompliance" in section 488.1 as "a complaint from any of a variety of sources" (including a complaint submitted by telephone) "that, if substantiated, would affect the health and safety of patients and raises doubts as to a provider's or supplier's noncompliance with any Medicare condition."

II. Case Background

The following facts are drawn from the ALJ Decision and the record and are not disputed.

On August 8-10, 2012, the Joint Commission conducted an initial survey of Apollo to assess its compliance with the Medicare conditions of participation for psychiatric hospitals. CMS Ex. 1. Based on the survey, the Joint Commission determined that Apollo had deficiencies relating to medical records services, physical environment, and infection control. *Id.* By letter dated August 20, 2012, the Joint Commission notified Apollo that it had determined that the deficiencies found during the survey had been resolved and was "recommending [Apollo] for Medicare certification effective August 20, 2012." *Id.* The letter stated, "Please note that the [CMS] Regional Office (RO) makes the final determination regarding your Medicare participation and the effective date of participation in accordance with . . . . 42 CFR 489.13." *Id.*

On September 14, 2012, the Louisiana Department of Health and Hospitals (state agency) received a telephone complaint from a former Apollo patient who made numerous allegations that Apollo staff violated her patient rights, failed to follow infection control procedures, and failed to provide her adequate care. CMS Ex. 7.

When the state agency informed CMS of the complaint, CMS told the state agency that "although a certification number had been assigned [to Apollo] by CMS, the number had never been issued to the provider." CMS Ex. 7, at 3. In addition, while there was "a draft of a certification letter," it "had not yet been issued." *Id.* CMS advised the state agency that "the certification process would be deferred pending the outcome of a complaint investigation" and instructed the State agency to "conduct an onsite survey to verify compliance of [Apollo] on all the [conditions of participation] before CMS will accept the deeming recommendation of [the Joint Commission]." *Id.*

The state agency conducted a survey of Apollo on September 25-27, 2012. CMS Ex. 6. The surveyors determined that Apollo had multiple standard-level deficiencies and one condition-level deficiency involving infection control. *Id.*

On October 19, 2012, the state agency received a complaint from staff at another hospital regarding a patient who was brought from Apollo to the second facility by the police. CMS Ex. 29. In response, CMS ordered another survey of Apollo, which took place on October 23-25, 2012, and found noncompliance with the conditions of participation relating to patient rights and special staffing for psychiatric hospitals. CMS Ex. 16.

By letter dated November 5, 2012, CMS determined that Apollo did "not meet the requirements for participation in the Medicare program as a psychiatric hospital." CMS Ex. 2. CMS stated that it had received the Joint Commission's approval recommendation

but was not obligated to accept it. CMS explained that its decision was based on the surveys conducted on September 25-27, 2012 and October 23-25, 2012, finding that Apollo had condition-level deficiencies relating to patient rights, infection control, and special staffing requirements for psychiatric hospitals. Apollo requested reconsideration by CMS. CMS Ex. 49.

By reconsideration determination dated January 25, 2013, CMS sustained its earlier action based on review of the September and October survey records and documents that Apollo submitted with its reconsideration request. CMS Ex. 4. Apollo appealed the reconsideration determination to an ALJ.

At the same time, CMS advised Apollo that it could reapply for certification when it could "fully demonstrate compliance with all the requirements for a psychiatric hospital." *Id.* Apollo reapplied while its appeal of the reconsideration determination was pending. The Joint Commission conducted another survey of Apollo in January 2013, and again found deficiencies. CMS Ex. 48. Apollo submitted evidence to show that it corrected the deficiencies, and based on that evidence, the Joint Commission recommended "Medicare certification effective February 8, 2013." CMS Ex. 3. On March 6, 2013, CMS accepted Apollo's participation agreement effective February 8, 2013. Apollo Ex. 5.

In its appeal of CMS's reconsideration determination, Apollo argued before the ALJ and maintains on appeal before us that it "should have been certified effective August 20, 2012, when it first passed [the Joint Commission] deeming survey as opposed to the later date of February 8, 2013." Apollo Request for Review (RR) at 2.

III. The ALJ Decision

The ALJ sustained CMS's reconsideration determination, granting summary disposition in favor of CMS. The ALJ made the following findings of fact and conclusions of law:

> 1. CMS was authorized to perform the validation survey, and I have no authority to review its decision to do so.
>
> 2. The hospital was not a Medicare-certified provider until February 2013, so the procedures for terminating a Medicare-certified provider, found at 42 C.F.R. § 488.28, do not apply here.
>
> 3. CMS is entitled to summary disposition because the parties agree that the hospital did not meet all program requirements at the time of the September and October surveys, and I have no authority to review CMS's refusal to consider the hospital's corrective action plan.

ALJ Decision at 4-10.

IV. Standard of Review

Summary judgment is appropriate when there is no genuine issue as to any material fact, and the moving party is entitled to judgment as a matter of law. *Mission Hosp. Regional Medical Ctr.*, DAB No. 2459, at 5 (2012); *Celotex Corp. v. Catrett*, 477 U.S. 317, 322-25 (1986). Whether summary judgment is appropriate is a legal issue that we address de novo, viewing the proffered evidence in the light most favorable to the non-moving party. *Community Hosp. of Long Beach*, DAB No. 1938 (2004). Our standard of review on a disputed conclusion of law is whether the ALJ Decision is erroneous. *Guidelines – Appellate Review of Decisions of Administrative Law Judges Affecting a Provider's Participation in the Medicare and Medicaid Programs*, http://www.hhs.gov/dab/guidelines/prov.html.

V. Analysis

Below, we first explain why we agree with the ALJ that under the governing regulations, CMS's decision to order the September and October 2012 surveys was not subject to review. We next describe why we reject Apollo's argument that it is entitled to an effective date of August 20, 2012 based on the procedures at 42 C.F.R. § 488.28. Finally, we explain that CMS is entitled to summary disposition because it is undisputed that at the time of the September and October 2012 surveys, Apollo had standard-level deficiencies, and CMS's refusal to accept Apollo's plan of correction to address its deficiencies was not appealable.

1. *CMS's decision to order the validation surveys was not subject to review.*

Apollo argued before the ALJ and on appeal that CMS was not authorized to order the September and October 2012 validation surveys on which CMS based its reconsidered determination. While Apollo "recognizes that CMS has the ultimate authority, through a validation survey, to verify compliance with the applicable Conditions of Participation," it asserts that "the Medicare regulations only allow the exercise of such authority in two specific instances . . .: 1) on a representative sample basis or 2) in response to a substantial allegation of noncompliance." RR at 2, *citing* 42 C.F.R. § 488.7. According to Apollo, CMS's receipt of "an alleged unsubstantiated patient complaint did not amount to a 'substantial allegation of noncompliance' authorizing CMS to trigger a validation survey." *Id.*

The ALJ concluded, and we agree, that CMS's decision to order the September and October 2012 surveys was not subject to review. ALJ Decision at 4-5. Title 42, Part 498 of the Code of Federal Regulations sets forth the scope of, and procedures for, appeals of CMS determinations involving provider participation in Medicare. Section 498.3

includes a list of administrative actions that are appealable "initial determinations by CMS," as well as a list of some of the "[a]dministrative actions that are not initial determinations (and therefore not subject to appeal under [Part 498])." 42 C.F.R. § 498.3(b), (d).

The initial determinations that may be appealed do not include a decision by CMS to conduct a validation survey or a decision by CMS that a complaint is a "substantial allegation of noncompliance." Indeed, when issuing the regulation on validation of accreditation surveys of hospitals, the Secretary declined to establish regulatory criteria to assess "substantial allegations" because, the Secretary noted, "each allegation is unique and requires individual attention." 45 Fed. Reg. 74,826, 74,828 (1980). The Secretary stated that "the Regional Offices can be expected to exercise sound judgment in distinguishing between allegations which are substantial, and those which are not," thus reserving judgment of what constitutes a substantial allegation to CMS's discretion. *Id.* Accordingly, under the governing regulations, CMS's decision to order the September and October 2012 surveys simply was not subject to appeal.

The scope of the ALJ's review, therefore, was limited to whether Apollo met all of the requirements necessary to qualify for participation as a psychiatric hospital based on the September and October 2012 survey evidence, evidence presented by Apollo rebutting the survey findings, and the applicable statutory and regulatory requirements. Thus, even if we were to agree with Apollo that the September and October 2012 complaints did not constitute substantial allegations of noncompliance (which we do not), we would lack the authority to declare the surveys and survey findings invalid, as Apollo appears to suggest we should. CMS Exs. 2, 4, 7.

Accordingly, we sustain the ALJ's conclusion that CMS's decision to perform the validation surveys was not subject to review.

2. The procedures at 42 C.F.R § 488.28 do not provide for the relief requested by Apollo.

Apollo argues that the ALJ erred in concluding that CMS's actions "upon receiving the allegation of non-compliance . . . did not constitute a 'termination' under 42 CFR 488.7(d)" and that the procedures at section 488.28 are inapplicable here. RR at 2. Section 488.7(d) provides that "[i]f a validation survey results in a finding that the provider . . . is out of compliance with" a Medicare condition, the provider "will no longer be deemed to meet any Medicare conditions" and "will be subject to the participation and enforcement requirements applicable to all providers" that are found out of compliance after a state agency survey. According to Apollo, CMS's decision in

September 2012 not to issue the acceptance letter after receiving the Joint Commission's recommendation to enroll Apollo in Medicare, but instead to order the validation survey, was "in fact, a 'termination' of its provider agreement without due process or notice" to Apollo "in violation of Medicare regulations." RR at 2.

Apollo argues that CMS's actions constituted a termination and that CMS was required to give Apollo an opportunity to correct its deficiencies before deciding to proceed with termination. In this regard, Apollo points to section 488.28, which states that if a provider "is found to be deficient with respect to one or more of the standards in the conditions of participation," it may participate in Medicare only if it "has submitted an acceptable plan of correction for achieving compliance within a reasonable period of time acceptable to the Secretary." Apollo argues that it was "never afforded these regulatory remedies to correct its deficiencies" and "was denied a reasonable time to achieve compliance, as well as the opportunity to submit a plan of correction . . . ." RR at 2. Apollo also states that it "was not notified of any deficiencies until November 5, 2012, and CMS did not ask [it] to submit an acceptable plan of correction." *Id.* at 3. Instead, Apollo asserts, the only correspondence it received was the November 5, 2012 notice denying its "initial Medicare certification." *Id.* Nevertheless, Apollo states that it did "submit[] corrective action plans for both survey deficiencies on November 28, 2012 to both CMS and [the state agency]." *Id.*

We find no merit in Apollo's contention that CMS's post-complaint actions constituted a termination of Apollo's participation in Medicare. A psychiatric hospital is not a Medicare participating provider until CMS has determined that the entity meets the requirements specified in the Act and regulations and enters into a provider agreement with the entity. Act §§ 1861(e)(3)-(9), 1861(f), 1866; 42 C.F.R. §§ 488.3, 489.10, 489.11. The regulations describe the steps that lead to approval and the execution of a provider agreement. After a prospective provider has been surveyed and the surveying agency finds that it is in compliance with the conditions of participation, the state agency "certifies" the provider – that is, makes a *recommendation* to CMS to approve the facility for participation in Medicare. *See* 42 C.F.R. 488.1 (definition of "certification").

If CMS determines that the provider meets the requirements, it will send the provider written notice of that determination and two copies of the provider agreement. 42 C.F.R. 489.11(a). If the provider chooses to participate, it returns signed copies of the agreement. 42 C.F.R. 489.11(b). If CMS accepts the agreement, it returns one copy to the provider with a written notice indicating the date on which it was signed by the provider's representative and accepted by CMS and specifies the effective date of the agreement. 42 C.F.R. 489.11(c). Only after all of these steps are completed does the prospective provider become a participating provider in Medicare.

We accept for purposes of summary judgment that CMS initially planned to approve Apollo for participation based on the Joint Commission's recommendation, that CMS assigned Apollo a provider number, and that CMS had drafted an acceptance notice to Apollo in September 2012. We agree with the ALJ that these facts alone would not confer participating provider status on Apollo. CMS did not issue a final approval letter or execute a participation agreement with Apollo prior to ordering the September and October validation surveys, and CMS determined on the basis of those surveys that Apollo failed to meet the conditions of participation. Thus, CMS's actions after it received the complaints did not constitute a termination of Apollo's Medicare provider agreement because there was no such agreement; Apollo remained a prospective provider until February 8, 2013, the date of participation subsequently approved by CMS.

In any event, section 488.28 does not provide for the relief requested by Apollo, an effective date of participation of August 20, 2012 (the date the Joint Commission determined that the deficiencies found during the August 8-10, 2012 initial survey had been resolved). Section 488.28 states that if a provider "is found to be deficient with respect to one or more of *the standards* in the conditions of participation," it may participate in Medicare if the deficiencies identified neither "jeopardize the health and safety of patients nor are of such character as to seriously limit the provider's capacity to render adequate care" and it has submitted an acceptable plan of correction for achieving compliance "within a reasonable period of time acceptable to the Secretary." 42 C.F.R. § 488.28(a)-(b) (emphasis added). The regulation further states that the amount of "reasonable time" granted to achieve compliance depends on the "[n]ature of the deficiency" and the "[s]tate survey agency's judgment as to the capabilities of the facility to provide adequate and safe care." 42 C.F.R. § 488.28(c).

Thus, section 488.28 permits a provider found to have deficiencies to submit an acceptable plan of correction only where CMS has determined that the deficiencies are at *less than the condition level*. Contrary to what Apollo asserts, section 488.28 provides no opportunity to correct condition-level deficiencies. *See also* 42 C.F.R. § 488.24(c) ("If CMS determines that an institution or agency does not qualify for participation or coverage because it is not in compliance with the conditions of participation . . . the institution or agency has the right to request that the determination be reviewed ([under the] [a]ppeals procedures . . . set forth in Part 498 of this chapter."). Here, CMS determined based on the September and October survey findings that Apollo had multiple condition-level deficiencies, not simply standard-level deficiencies. Consequently, CMS was not obligated to afford Apollo an opportunity to submit an acceptable plan of correction.

Furthermore, under the regulation governing the effective date of a provider's participation in Medicare, if a provider meets all applicable conditions of participation but has lower-level deficiencies, its effective date for participation is the earlier of the date CMS or the state survey agency receives an acceptable plan of correction for the

lower-level deficiencies; or, if applicable, the date a CMS-approved accreditation organization issues a positive accreditation decision after it receives an acceptable plan of correction for the lower-level deficiencies; or the date CMS receives an approvable waiver request. 42 C.F.R. § 489.13(c)(2)(ii). Thus, submission of a plan of correction relating to the deficiencies found in the September and October surveys could not have resulted in Apollo obtaining an effective date of participation dating back to August 20, 2012, but instead at most the effective date would be determined based on the date CMS received the correction plan, if that plan were acceptable.

In addition, it is well-settled under the appeals regulations that a decision by CMS not to accept a provider's plan of correction does not constitute an initial determination subject to review. *Elant at Fishkill*, DAB No. 2468 (2012) (the acceptance or rejection of Petitioner's plan of correction is not a matter subject to appeal or to ALJ review); *Foxwood Springs Living Ctr.*, DAB No. 2294, at 12 (2009) ("[t]he acceptance or rejection of a proposed [plan of correction] is not an appealable initial determination."); *Hermina Traeye Memorial Nursing Home*, DAB No. 1810, at 13 (2002) (noting that the ALJ "properly concluded that he lacked authority to adjudicate the question of whether [CMS] abused its discretion in deciding to reject the [plan of correction]"), *aff'd sub nom. Sea Island Comprehensive Healthcare Corp. v. U.S. Dep't of Health & Human Servs.*, 79 F. App'x 563 (4th Cir. 2003). Thus, even if the opportunity to correct in section 488.28 applied here (which it does not), CMS's decision not to accept Apollo's plan of correction is not subject to review by either the ALJ or the Board.

Accordingly, we conclude that there was no termination and that 42 C.F.R. § 488.28 does not provide for the relief requested by Apollo.

3. CMS is entitled to summary disposition.

In its motion for summary judgment, CMS asserted there was no dispute as to any material fact that at the time of the September and October 2012 surveys, Apollo had three condition-level deficiencies: 42 C.F.R. § 482.13 (Patient's Rights); 42 C.F.R. § 482.42 (Infection Control); and 42 C.F.R. § 482.62 (Special Staff Requirements for Psychiatric Hospitals). As the ALJ noted, Apollo conceded that it had deficiencies, but asserted that they were "standard level deficiencies that do not qualify as condition level deficiencies." P. Br. at 3; *see also* ALJ Decision at 6.

The ALJ concluded that "because Petitioner concedes that it had deficiencies at the time of the surveys," she did not need to decide whether Apollo met all of the conditions of participation. ALJ Decision at 6. Under the regulation governing the effective date of participation for prospective providers, the ALJ correctly observed (as we have discussed above) that if a prospective provider meets all applicable conditions of participation but has lower-level deficiencies, "its effective date for participation can be no earlier than the date CMS or the state agency 'receives an acceptable plan of correction for the lower-

level deficiencies.'" *Id. citing* 42 C.F.R. § 489.13(c)(2)(ii); *Comm. Hosp. of Long Beach*, DAB No. 1938 (2004). The ALJ further stated that "CMS's refusal to accept [Apollo's] plan of correction is not an initial determination and thus is not reviewable in this forum." *Id. citing* 42 C.F.R. 498.3(a); *Conchita Jackson, M.D.,* DAB No. 2495 (2013).

In its request for Board review, Apollo asserts that "the regulations require 'condition' level deficiencies in order to deny certification," that "the surveyors' reports . . . indicate the existence of only standard level deficiencies," and that "[i]f there are only standard level deficiencies, CMS should have accepted Apollo's Plan of Corrections." RR at 3. Apollo misrepresents the survey reports and mischaracterizes the regulation. With respect to the survey reports, contrary to what Apollo says, both the September and October surveys found not only standard-level deficiencies, but also condition-level deficiencies. CMS Ex. 6; CMS Ex. 16. With respect to section 488.28(a), the regulation does not state that CMS cannot deny certification absent condition-level deficiencies or that CMS must accept a plan of correction where there are only standard-level deficiencies. Rather, section 488.28(a) provides that a provider who "is found to be deficient with respect to one or more of the standards in the conditions of participation. . . may participate in Medicare *only* if it has submitted an *acceptable* plan of correction for achieving compliance" and the "existing deficiencies . . . neither jeopardize the health and safety of patients nor are of such character as to seriously limit the provider's capacity to render adequate care." Thus, the regulation not only does not provide that a provider may submit a plan of correction where CMS, as here, has found condition-level deficiencies; it makes clear that even where CMS finds only standard-level deficiencies, as is not the case here, CMS, at minimum, must not only receive a plan of correction but must determine the plan is acceptable to achieve compliance before the provider may participate. The opportunity for correction described in section 488.28 was not available to Apollo because CMS found condition-level deficiencies. But even if CMS had found standard-level deficiencies, Apollo would not have been able to participate by submitting a plan of correction absent a determination by CMS to accept the plan as sufficient to achieve compliance.

Moreover, as stated above and by the ALJ, and not contested by Apollo, a decision by CMS not to accept a provider's plan of correction may not be appealed. Thus, even if Apollo had only standard-level deficiencies, CMS's decision not to accept Apollo's proposed plan of correction would not be subject to review by the ALJ or the Board and, therefore, would not provide an opportunity for Apollo to receive an earlier effective date of participation.[3]

[3] Apollo argues that the ALJ "erred by not considering CMS' failure to accept Apollo's Plan of Corrections in accordance with State Operations Manual 5100." RR at 3. We do not read section 5100 of the State Operations Manual (SOM) to require CMS to have accepted Apollo's plan of correction. In any event, "while ALJs and the Board may find the SOM instructive, they are bound by [the regulations], not by the SOM." *Mississippi Care Ctr. of Greenville*, DAB No. 2450, at 12 (2012) (citations omitted).

In any event, we agree with the ALJ that the uncontested facts and "significant" deficiencies that Apollo conceded relating to the infection control requirements in section 482.42 and the patient's rights requirements in section 482.13 "warranted CMS's insisting that they be corrected before the facility could be certified." ALJ Decision at 6-10.

With respect to infection control, section 482.42 provides that the "hospital must provide a sanitary environment to avoid sources and transmission of infections and communicable diseases," and must have "an active program for the prevention, control, and investigation of infections and communicable diseases." The ALJ noted that Apollo conceded that its infection control officer failed to conduct a hand hygiene survey in September 2012, as required by the facility's own policy. *Id.* at 7, *citing* P. Br. at 4; CMS Ex. 49, at 3. This lapse, the ALJ concluded, was significant because it showed "staff failed to meet its obligation one out of four times" since the policy had gone into effect in June 2012. *Id.*

The failure "becomes even more significant," the ALJ determined, in light of the surveyors' observations that in numerous instances facility staff failed to demonstrate good hand hygiene. *Id.* at 7-8, *citing* CMS Ex. 6, at 19-23 (September 27, 2012 Survey Statement of Deficiencies). For example, the surveyors observed two mental health technicians wipe drool from a patient and perform other actions without taking adequate infection control precautions. CMS Ex. 6, at 19-20. The surveyors also observed the hospital phlebotomist failing to perform hand hygiene in the course of entering a patient's room, drawing the patient's blood, and returning to the nurses' station. *Id.* at 22-23.

The ALJ stated that Apollo did "not challenge the surveyors' observations, nor deny that they constituted infection control deficiencies," but characterized them as "a few isolated incidents [that] should not rise to the level of a condition level deficiency." *Id.* at 8, *citing* P. Br. at 6, P. Ex. 13, at 2; P. Ex. 14, at 2, CMS Ex. 49, at 3. "Whether they rose to condition-level (which I find highly likely)," the ALJ stated, "such deficiencies are significant enough to warrant CMS's insisting that they be corrected before the hospital could be certified." *Id.* at 8.

The ALJ further explained that section 482.13 provides that a "hospital must protect and promote each patient's rights." ALJ Decision at 8. The hospital must, among other things, inform each patient of the patient's rights prior to furnishing or discontinuing patient care; must ensure that each patient has the right to participate in the development and implementation of his or her care plan; and must ensure that each patient has the right to personal privacy and to receive care in a safe setting. 42 C.F.R. § 482.13(a)-(c).

The ALJ described uncontested evidence showing that in two instances, staff responded to different patients who became aggressive and violent by calling the sheriff's office and asking deputies to remove the patients from the facility with no physician orders

authorizing such transfers. ALJ Decision at 8-10, *citing* CMS Exs. 30, 36, 42, 43, 45. In one case, Apollo staff asked the deputies to take the patient to jail. As the ALJ noted, the deputies recognized that "sending to jail a mentally-ill patient in an acute psychotic state is hardly an appropriate intervention, particularly for a psychiatric hospital whose staff are supposed to be trained to handle such events." *Id.* at 8-9, *citing* CMS Ex. 36. The deputies took the patient to another hospital. In a second incident, the psychiatrist of a patient diagnosed with paranoid schizophrenia ordered that Thorazine be administered to the patient immediately to control her violent behaviors. CMS Ex. 30, at 3, 12-13. The hospital had no Thorazine in stock, and instead of attempting to contact the doctor for further instructions, called the police, "who escorted [the patient], in hand cuffs, to [another hospital]." ALJ Decision at 9, *citing* CMS Ex. 30, at 1, 24-25; CMS Ex. 42, at 2.

As the ALJ noted, Apollo conceded all of these facts but denied that its policy was to call police if a patient becomes violent and asserted that "this unfortunate episode" was "an isolated situation" and did not constitute a condition-level deficiency under section 482.13. ALJ Decision at 10, *citing* P. Br. at 7; P. Ex. 13, at 2. CMS asserted that neither of the patient's care plans described appropriate responses to aggressive behavior, the ALJ explained, and Apollo did not identify in the care plans any directives addressing appropriate responses to such behavior. In light of these undisputed facts, the ALJ concluded, Apollo had significant deficiencies under the patient rights requirements "that warranted CMS's insisting that they be corrected before the facility could be certified." ALJ Decision at 10.

Apollo asserts on appeal that the "ALJ erred in her findings with regards to the actual survey results." RR at 3. Apollo does not identify which of the facts it contests, however, nor does it point to any portions of the record that counter the ALJ's findings. Instead, Apollo merely summarily states that it "disputes the factual findings of the Honorable ALJ with regards to the specific areas of alleged deficiencies from the surveys, and which are detailed in the numerous documents submitted by the parties in this matter and which are detailed in Apollo's Exchange and Opposition to Motion for Summary Judgment." RR at 4.

The regulations governing Board review provide that a request for review of an ALJ decision "must specify the issues, the findings of fact or conclusions of law with which the party disagrees, and the basis for contending that the findings and conclusions are incorrect." 42 C.F.R. § 498.82(b). In addition, the Board's guidelines for appeals of ALJ decisions involving Medicare provider participation expressly prohibit incorporation by reference of briefs submitted during the ALJ proceedings.

The guidelines, the Board previously has stated, "make it clear that the Board may decline to consider an issue that is . . . unaccompanied by argument, record citations, or statements that articulate the factual or legal basis for the party's objection to the ALJ's findings." *Wisteria Care Ctr.*, DAB No. 1892 (2003).

On review of the record, we concur in the ALJ's identification and characterization of the undisputed facts relating to Apollo's deficiencies under the infection control and patient's rights requirements. In light of our determination that the ALJ's legal analysis relating to summary judgment is free from error, our review of the record evidence, and the absence of specificity in Apollo's contention that the ALJ erred in her findings relating to the survey results, we affirm the ALJ's conclusion that CMS was entitled to summary disposition.

VI. Conclusion

For the reasons discussed above, we sustain the ALJ Decision.

/s/
Sheila Ann Hegy

/s/
Leslie A. Sussan

/s/
Stephen M. Godek
Presiding Board Member