Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

In the Case of:	)	
	)	
N & R Quality Care,	)	Date: November 4, 2009
(CCN: 49-7632)	)	
	)	
Petitioner,	)	
	)	
- v. -	)	Docket No. C-09-403
	)	Decision No. CR2025
Centers for Medicare & Medicaid	)	
Services.	)	
	)	

DECISION

I grant summary judgment to the Centers for Medicare & Medicaid Services (CMS) sustaining its determination to terminate Petitioner N & R Quality Care's provider agreement.

I. Background

Petitioner, located in Fredericksburg, Virginia, was certified by Medicare as a home health agency (HHA). On January 27, 2009, the Virginia Department of Public Health (VDPH) completed a complaint investigation of Petitioner. CMS determined that Petitioner failed to meet five conditions of participation. On March 10, 2009, the VDPH conducted a follow-up survey and determined that Petitioner had not fully implemented its plan of correction for the deficiencies cited in January 27, 2009, and that Petitioner remained out of compliance with the two conditions of participation previously cited in the January 27, 2009 survey ― 42 C.F.R. § 484.16 (Group of Professional Personnel) and 42 C.F.R. § 484.52 (Evaluation of Agency Programs). CMS further determined that those documented deficiencies seriously limited Petitioner's capacity to render adequate levels of care. Consequently, because Petitioner was not in compliance with all conditions of participation, CMS by notice dated April 14, 2009 determined to terminate Petitioner's provider agreement, effective May 5, 2009.

Petitioner timely requested review and this matter was assigned to me. Pursuant to my initial order, on May 15, 2009 CMS filed a "Motion To Dismiss Petitioner's Purported Hearing Request or, In the Alternative, Motion for an Order To Show Cause Why Its Purported Hearing Request Should Not Be Dismissed Pursuant to 42 C.F.R. § 498.40(b)(1),(2)." CMS's Motion asserted that Petitioner's hearing request did not comply with the content requirements of 42 C.F.R. § 498.40(b)(1) and (b)(2) because it failed to specify the bases for contending that whatever findings or conclusions Petitioner did challenge were incorrect. Mindful that Petitioner appeared, *pro se*, I caused a "by-direction letter" to be sent dated May 19, 2009, explaining the procedural situation and reminding Petitioner that CMS's Motion must be answered promptly.

Petitioner's first attempt to answer CMS's Motion was unsuccessful, because it took the form of a disorganized and incomplete submission of material transmitted by a letter dated "5/19/2009," but received by the Civil Remedies Division on June 1, 2009. This submission was returned to Petitioner on June 3, 2009, with a "by-direction letter" explaining its deficiencies and extending the time for Petitioner's response until June 10, 2009. Petitioner submitted its amended response in a letter dated June 5, 2009, which was accompanied by a substantial amount of documentary material marked as Petitioner's Exhibits 1 through 5 (P. Exs. 1-5). After reviewing Petitioner's submission, I determined that good cause existed to permit, indeed to solicit, CMS's reply, as 42 C.F.R. § 498.17(b)(2) authorizes.

CMS filed its reply on July 20, 2009, along with two exhibits, labeled CMS Exhibits 1 and 2 (CMS Exs. 1, 2). In that reply, CMS's position shifted somewhat: CMS no longer relied on Petitioner's asserted non-compliance with the content requirements of 42 C.F.R. § 498.40(b)(1) and (b)(2) to seek dismissal of Petitioner's hearing request, but instead asserted that Petitioner's June 5, 2009 pleading and its attached exhibits left no genuine issue of material fact before me, and thus sought summary disposition of this appeal in its favor, on the merits. By Order dated July 30, 2009, I gave Petitioner notice that its case may be subject to summary disposition in CMS's favor and I explained the summary disposition mechanism and offered Petitioner a final opportunity to plead its case by August 21, 2009. Petitioner filed its response by a letter dated August 14, 2009 accompanied by exhibits marked as P. Exs. 6-15. By Order dated August 27, 2009, I gave CMS an opportunity to reply to Petitioner's August 14, 2009 submission. CMS timely replied by submission dated September 11, 2009 accompanied by three exhibits labeled CMS Exs. 1-3.

The document proffered by CMS as CMS Ex. 2 in its July 20, 2009 submission is identical to the document proffered as CMS Ex. 2 in its September 11, 2009 proffer. The document proffered by CMS as CMS Ex. 1 in its September 11, 2009 submission has been remarked CMS Ex. 4 to avoid confusion with the similarly-numbered CMS exhibit

in the July 20, 2009 submission. Neither party objected to the other's exhibits, and P. Exs. 1-15 and CMS Exs. 1-4 are admitted.

II. Issue, applicable law, and findings of fact and conclusions of law

A. Issue

I find it unnecessary to address CMS's motion to dismiss Petitioner's hearing request. In this decision I address CMS's alternative argument that summary disposition in its favor is appropriate.

B. Applicable law.

The Social Security Act (Act) sets forth requirements for HHAs participating in the Medicare and Medicaid programs, and authorizes the Secretary of Health and Human Services to promulgate regulations implementing the statutory provisions. Act, sections 1861(m) and (o), and 1891 (42 U.S.C. §§ 1395x(m) and (o); 1395bbb). The Secretary's regulations governing HHA participation in the Medicare program are found at 42 C.F.R. Part 484.

In order to participate in the Medicare program and obtain reimbursement for its services a HHA must be in compliance with all applicable "conditions" as specified in 42 C.F.R. Part 484. 42 C.F.R. § 488.3(a)(2). Periodic review of compliance with the conditions of participation is required and such reviews or surveys are generally conducted by the state agency. Based upon its survey, the state agency either certifies compliance or noncompliance of the surveyed provider. 42 C.F.R. §§ 488.20, 488.24, 488.26.

The state agency certifies that a HHA is not in compliance with the conditions of participation when "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 or not there is compliance with a 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); *CSM Home Health Services*, DAB No. 1622, at 6-7 (1997). Surveyors are required to "directly observe the actual provision of care and services to residents, and the effects of that care, to assess whether the care provided meets the needs of individual residents. . . ." 42 C.F.R. § 488.26(c)(2).

CMS is authorized to terminate a provider agreement when the provider no longer meets the requirements of the Act or fails to meet the conditions of participation, among other grounds listed in the regulation. 42 C.F.R. § 489.53.

C. Findings of fact and conclusions of law

I make findings of fact and conclusions of law (Findings) to support my decision in this case. I set forth each Finding below as a separate heading.

1. Summary judgment is appropriate where there are no disputed issues of material fact.

The regulations governing hearings at 42 C.F.R. Part 498 do not explicitly provide for summary judgment as a means of deciding cases. But these regulations have been interpreted consistently in this forum and by the Departmental Appeals Board (Board) to allow for summary judgment in circumstances that are analogous to those for which summary judgment is appropriate under FED. R. CIV. P. 56.

Rule 56 permits summary judgment where there is no dispute as to the material facts of a case. A fact is "material" where it is necessary to deciding a case's outcome. Summary judgment may be granted when a moving party alleges facts which, if not disputed, would be sufficient to establish a basis for that party to prevail on the merits.

Allegations of facts which, if undisputed, establish a basis for a judgment favorable to the moving party imposes a burden on the party opposing summary judgment to allege facts which create a genuine dispute. A party opposing a motion for summary judgment need not prove that the weight of the evidence in the case supports its position in order to prevail on the motion. But, at a minimum, it must allege facts and claim inferences which, if ultimately proven, would create a genuine controversy as to the facts of a case. I follow the Board's principles set out for the evaluation of facts and inferences in the context of summary disposition. *Brightview Care Center*, DAB No. 2132 (2007); *Kingsville Nursing and Rehabilitation Center*, DAB No. 2234 (2009); *Knights Templar Home, DAB No. 2274 (2009).*

2. The undisputed material facts alleged by CMS support a finding that Petitioner failed to comply with two conditions of participation.

CMS's allegations of condition-level noncompliance by Petitioner are based on a revisit survey. That survey determined that Petitioner failed to comply with two conditions of participation for a HHA as stated in the following regulations:

- 42 C.F.R. § 484.16 (Group of Professional Personnel);
- 42 C.F.R. § 484.52 (Evaluation of Agency Programs);

CMS Ex. 2; CMS Notice Letter dated April 14, 2009.

In its motion for summary disposition, CMS argues that Petitioner failed to adequately challenge the deficiencies that serve as a basis for the termination and failed to raise any material factual disputes. CMS further argues that Petitioner's exhibits fail to demonstrate that it was in substantial compliance, actually acknowledge the deficient practices, and raise no genuine dispute as to any material facts. In its response to the motion, Petitioner has failed to answer or contradict seriously many of CMS's arguments and failed to present credible evidence to establish the existence of any genuine issue of material fact.

Petitioner appears here through its non-attorney Administrator. I have for that reason treated this matter as if Petitioner appears *pro se*, and have accordingly remained mindful of the Departmental Appeals Board's admonition that *pro se* litigants be afforded "some extra measure of consideration" in developing their cases. *Louis Mathews*, DAB No. 1574 (1996); *Edward J. Petrus, Jr., M.D., et al*., DAB No. 1264 (1991). My "by-direction letters" of May 19 and June 3, 2009, and my Order of July 30, 2009, demonstrate that extra measure of consideration. I have searched Petitioner's submissions for any arguments or contentions that might amount to a colorable defense to the termination. I have found nothing that could be so construed: Petitioner argues that it was in compliance at the time of the revisit survey but does not provide any evidence of compliance, but instead often provides irrelevant exhibits without any explanation or exhibits that were insufficient to establish compliance. In fact, Petitioner acknowledges the deficiencies by stating that it will "prevent this from happening in the future," that "PAC meetings will be documented correctly," and that "to prevent this from happening in the future PAC annual meeting, signature will be required." P. Ex. 4, at 2, 3. Further, during the surveys Petitioner failed to dispute the surveyor's findings, and instead repeatedly complained that it "did not understand the question." P. Ex. 4, at 4, 6, 8, 9, 11, 12, 13, 16.

As I discuss below, failure by Petitioner to comply with even one condition of participation gives CMS grounds to terminate its participation in Medicare. Thus, viewing the evidence in the light most favorable to Petitioner, and drawing every inference in Petitioner's favor that can reasonably be supported by that evidence, the undisputed facts establish that Petitioner was not in substantial compliance with all the conditions of participation and summary judgment is therefore appropriate.

3. CMS is authorized to terminate Petitioner's provider agreement when Petitioner no longer meets the requirements of the Act for participation as a HHA.

The regulations at 42 C.F.R. Part 484 establish the conditions of participation and standards by which HHA compliance with the Medicare program is determined. The standards set forth in the regulations are essentially the "yardsticks" by which surveyors measure the level of compliance of the HHA. If a HHA's performance does not measure up to the regulatory standard, a deficiency exists. If a deficiency exists, the question is whether that deficiency alone or considered in combination with another deficiency is "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). If the provider's capacity to furnish adequate care is substantially limited or if the health and safety of patients is adversely affected then a condition-level deficiency exists and termination may be appropriate. If no condition-level deficiency exists, CMS may still consider whether one or more standard-level deficiencies are repeated on survey and resurvey and, if no correction has occurred, CMS may declare the provider agreement terminated on that basis. If I determine that Petitioner failed to meet even one condition of participation, I may conclude that there is a basis for termination of Petitioner's provider agreement. 42 C.F.R. § 489.53(a) (CMS may terminate a HHA's provider agreement if it no longer meets the appropriate conditions of participation.).

4. Petitioner did not meet the condition of participation at 42 C.F.R. § 484.16 (Group of Professional Personnel).

Section 42 C.F.R. § 484.16 provides:

> Condition of participation: Group of professional personnel.
>
> A group of professional personnel, which includes at least one physician and one registered nurse (preferably a public health nurse), and appropriate representation from other professional disciplines, establishes and annually reviews the agency's policies governing scope of services offered, admission and discharge policies, medical supervision and plans of care, emergency care, clinical records, personnel qualifications, and program evaluation. At least one member of the group is neither an owner nor an employee of the agency.
>
> > (a) *Standard: Advisory and evaluation function.* The group of professional personnel meets frequently to advise the agency on professional issues, to participate in the evaluation of the agency's program, and to assist the agency in maintaining liaison with other health care providers in the

> community and in the agency's community information program. The meetings are documented by dated minutes.

42 C.F.R. § 484.16.

During both surveys on January 27, 2009 and March 10, 2009, the surveyors determined that the agency failed to have meetings of a committee of professional personnel or any documented minutes from any Professional Advisory Committee (PAC) meetings. CMS Ex. 4, 4-6, CMS Ex. 3, at 1-6. Although PAC meeting minutes were requested on each day of the survey, no program meeting minutes were ever presented for review by the surveyor. CMS Ex. 3, at 2, 3-4, 5, 6. At the survey, Petitioner failed to provide any documentation in the form of dated minutes from PAC meetings concerning an annual review of the agency's policies governing scope of services offered, admission and discharge policies, medical supervision and plans of care, emergency care, clinical records, personnel qualifications, and program evaluation. CMS Ex. 3, at 1-6. Petitioner failed to have any documentation in the form of dated minutes of PAC meetings that met to advise the agency on the evaluation of the agency's programs for the year 2008. CMS Ex. 3, at 4.

Petitioner maintains that it was in compliance with this regulation. In its June 5, 2009 submission Petitioner states:

> We have a Medical Director and a Registered Nurse with [sic] Professional Advisory Committee and met 01/05/2009 and 4/20/2009 with the group of Professional Personnel. I have had meetings with my Medical Director, Registered Nurse and Professional Advisory one on one since 2007; they have expertise in community affairs, federal, state and local government, accounting, health administration, health profession, business, finance, banking, and personnel management as well as social services such as religion, education, and welfare.

P. June 5, 2009 submission at 2.

Further, Petitioner complains that she did not understand the questions the surveyor was asking about PAC meetings and states: "The committee was established formally in 2009; however, I meet with each member on a one-on-one basis since 2007. I misunderstood the requirement for signatures for my Professional Advisory Committee." *Id*. at 1. Petitioner thus actually admits this violation while trying to explain the violation away.

Along with Petitioner's June 5, 2009 submission, Petitioner attached five exhibits. Many of Petitioner's exhibits are irrelevant. P. Ex. 1 is a CMS letter to Petitioner dated January 31, 2008, more than a year before the revisit survey, notifying Petitioner that it has been

accepted to participate as a HHA, and is irrelevant. P. Ex. 3 is text from the Virginia State Board of Health and is irrelevant. P. Ex. 4 is the statement of deficiencies along with Petitioner's Plan of Correction (POC). A POC does not demonstrate that corrections, even if acceptable to CMS, were ever implemented. Also, the POC, is dated "6/5/09," *after* the termination, and is therefore irrelevant to demonstrate compliance. P. Ex. 5 is a marketing brochure for the HHA and is also irrelevant.

P. Ex. 2 contains an agenda for a meeting on January 5, 2009. The meeting is not characterized on the face of the document as a Professional Advisory Committee meeting, and the document is captioned only "N & R Quality Care/Minutes of Meeting/January 5, 2009." The one-page document is signed only by Ruthette Fannin, Petitioner's Administrator. P. Ex. 2, at 1. The "Agenda" and "Action Items" sections of the document state only — and in the vaguest and most general terms — that there was a discussion of policies and procedures for plan of care, emergency care, clinical records and evaluation, a discussion of a corporate tax return and a resolution of accounts between accountants in preparing a final return. *Id.* The agenda, even if it were sufficient to show that a PAC meeting took place, is silent on the important elements required of it by 42 C.F.R. § 484.16, such as the scope of services offered, admission and discharge policies, medical supervision, and personnel qualifications. This document was not provided to surveyors during either the January 27 or the March 10 surveys, even though the meeting purportedly took place only three weeks earlier on January 5 and the surveyor specifically requested minutes of meetings. Most importantly, a document setting out prospective topics of discussion and noting "action items discussed" is hardly the same as dated minutes of a meeting describing what actually took place at the meeting, as is required by the regulation. In essence, the basis of the noncompliance for which Petitioner was in this instance cited is the failure to have PAC meetings to evaluate agency programs during 2008 and Petitioner admits that the PAC was not formally established until 2009. P. June 5, 2009 submission. P. Ex. 2 also includes an agenda of a meeting on April 20, 2009, which date is of course after both surveys at issue and therefore is not relevant to the issue before me.

P. Ex. 2, at 6 is entitled Medical Director, Clinical Director, and Professional Advisory Committee. This document states that there were discussions at a meeting concerning financial matters and taxes and "staying in compliance with CMS" without any further elaboration. This document is undated and has a number of signatures on it. Dr. Richard Ameen, allegedly Petitioner's Medical Director, signed this document under a handwritten statement that, "I received the Nursing Assessment packet" even though there is no indication that the meeting involved a nursing assessment packet or that such a packet was discussed. Another signature, under the handwritten word, "Received," is that of E. Thomas Blalock, an individual purportedly involved in Petitioner's financial affairs. Again, there is no indication what was received by Mr. Blalock. This undated document, indicating receipt of some item still unidentified, is not sufficient evidence that a PAC

meeting took place, when it took place, or what was discussed during any such meeting, and it falls short of what would be required to demonstrate compliance with 42 C.F.R. § 484.16.

Petitioner's August 14, 2009 submission argues that it had both a Medical Director who is a physician and a registered nurse. Petitioner states, "In 2008 Dr. Ameen served as medical director and Nurse Heieck as the registered nurse which is the minimum requirement for professional personnel." P. August 14, 2009 submission, at 1. Even if this is true, Petitioner does not further state that PAC meetings took place that established and annually reviewed the agency's policies governing scope of services offered, admission and discharge policies, medical supervision and plans of care, emergency care, clinical records, personnel qualifications, and program evaluation Neither does Petitioner state that meetings took place that advised the agency on professional issues, participated in the evaluation of the agency's program, or assisted the agency in maintaining liaison with other health care providers in the community and in the agency's community information program.

Along with its August 14, 2009 submission, Petitioner attached ten exhibits labeled P. Exs. 6-15, of which P. Exs. 6-9 allegedly support Petitioner's contention that it was in compliance with 42 C.F.R. § 484.16. But again, Petitioner's exhibits are often irrelevant. P. Ex. 6 concerns Medical Directors in nursing homes, not in a HHA. P. Ex. 8 is a letter showing that M. Heieck, R.N., was on staff since September 29, 2008 but does not show that she was involved in establishing and annually reviewing the agency's policies governing scope of services offered, admission and discharge policies, medical supervision and plans of care, emergency care, clinical records, personnel qualifications, and program evaluation. P. Ex. 8 also includes a self-serving statement from the Administrator that Petitioner was in compliance at the time of the surveys but does not provide any specific evidence, examples, or details of compliance. P. Ex. 9 includes unsigned letters concerning insurance and payroll and is irrelevant.

P. Ex. 7 includes some correspondence to or from Dr. Ameen. Nowhere in this exhibit is Dr. Ameen titled as Petitioner's Medical Director. Nothing in this exhibit demonstrates that Dr. Ameen functions for Petitioner as a physician who establishes and annually reviews the agency's policies governing scope of services offered, admission and discharge policies, medical supervision and plans of care, emergency care, clinical records, personnel qualifications, and program evaluation. The letter from Dr. Ameen at page 3 of P. Ex. 7 does not even mention Petitioner's HHA. The letter at page four of this exhibit is dated November 6, 2006, before the period at issue, and is irrelevant. P. Ex. 7 also includes other irrelevant pages such as a facsimile cover sheet (page 2) and a billing statement (page 5). P. Ex. 7, at 6 was already discussed since it was previously submitted as page 6 of P. Ex. 2. Nothing in this exhibit indicates that Dr. Ameen fulfills the role or responsibilities of Medical Director at the facility.

After reviewing all of Petitioner's submissions, I conclude that the undisputed evidence is that Petitioner failed to have documentation that demonstrated that a group of professional personnel established and annually reviewed the agency's policies governing scope of services offered, admission and discharge policies, medical supervision and plans of care, emergency care, clinical records, personnel qualifications, and program evaluation. Accordingly, I find that Petitioner failed to meet the condition at 42 C.F.R. § 484.16.

5. Petitioner did not meet the condition of participation at 42 C.F.R. § 484.52 (Evaluation of the Agency's Program).

Section 42 C.F.R. § 484.52 provides:

> Condition of participation: Evaluation of the agency's program.
>
> The HHA has written policies requiring an overall evaluation of the agency's total program at least once a year by a group of professional personnel (or a committee of this group), HHA staff, and consumers, or by professional people outside the agency working in conjunction with consumers. The evaluation consists of an overall policy and administrative review and a clinical record review. The evaluation assesses the extent to which the agency's program is appropriate, adequate, effective, and efficient. Results of the evaluation are reported to and acted upon by those responsible for the operation of the agency and are maintained separately as administrative records.
>
> (a) *Standard: Policy and administrative review.* As part of the evaluation process the policies and administrative practices of the agency are reviewed to determine the extent to which they promote patient care that is appropriate, adequate, effective, and efficient. Mechanisms are established in writing for the collection of pertinent data to assist in evaluation.
>
> (b) *Standard: Clinical record review.* At least quarterly, appropriate health professionals, representing at least the scope of the program, review a sample of both active and closed clinical records to determine whether established policies are followed in furnishing services directly or under arrangement. There is a continuing review of clinical records for each 60-day period that a patient received home health services to determine adequacy of the plan of care and appropriateness of continuation of care.

42 C.F.R. § 484.52.

During the January 27 and March 10, 2009 surveys, the surveyors determined that Petitioner failed to conduct or maintain any documentation such as meeting minutes for an annual overall evaluation of the HHA's program for the year 2008 that included an overall review of policies, an administrative review or a clinical record review. CMS Ex. 3, at 6-7. Petitioner's PAC policy included a requirement that the PAC "[p]articipate in the annual evaluation of the agency's policies." *Id.* at 7. As mentioned above, no meeting minutes were presented to the surveyor even though the minutes were requested on March 9 and 10, 2009. *Id.* at 7. Further, Petitioner failed to conduct or maintain any documentation such as meeting minutes that an evaluation took place to assess the extent to which the agency's program were appropriate, adequate, effective, and efficient. *Id.* at 8. Even though Petitioner's "Annual Evaluation" policy required such an evaluation and the surveyor requested meeting minutes where such evaluations took place, no meeting minutes documenting any such evaluation were provided by Petitioner. *Id.* at 8-9. Also, Petitioner failed to have the results of any such evaluation reported to and acted upon by those responsible for the operation of the agency. *Id.* at 9. The evaluation results were not maintained separately as administrative documents for the year 2008. *Id.* at 10. The policies and administrative practices were not reviewed to determine that extent to which they promote patient care that is appropriate, adequate, effective, and efficient. The agency also failed to provide documented evidence of a mechanism in place to collect pertinent data to assist in the evaluation of the agency's program. *Id.* at 13. No meeting minutes or documents were presented to the surveyor even though the minutes and documents were requested on March 9 and 10, 2009 to demonstrate any of the elements of 42 C.F.R. § 484.52.

Petitioner submitted five exhibits, P. Exs. 10-14, to support its claim that it was in compliance with 42 C.F.R. § 484.52. Once again, some of Petitioner's exhibits are irrelevant: P. Ex. 11 consists of three pages entitled "Assessment Roster" and is not relevant to this deficiency; P. Ex. 12, at 3-5 are entitled "Employee Roster" and are not relevant; P. Ex. 13, at 1 is a one-page marketing document that describes Petitioner's services and P. Ex. 13 at 2-3 are entitled "Statements of Income" and are irrelevant; P. Ex. 14, at 2 is a Plan of Treatment for an unidentified patient and is irrelevant; P. Ex. 15 is CMS's termination notice dated April 14, 2009 and obviously does nothing to establish Petitioner's compliance with federal regulations. Petitioner fails to explain how any of these irrelevant exhibits supports its claim that it was in compliance with 42 C.F.R. § 484.52.

P. Ex. 10 is a one-page policy and procedure for Annual Evaluations. P. Ex. 10 is undated and unsigned. The survey alleges that Petitioner failed to maintain any documented evidence that an evaluation took place to assess the extent to which the agency's program is appropriate, adequate, effective and efficient for the 2008. A policy entitled Annual Evaluation is not evidence that an appropriate evaluation was performed

including the required elements of 42 C.F.R. § 484.52 during the time period at issue before me.

P. Ex. 12, at 1 is a "Skills Core Competency" form for one nurse or aide dated October 1, 2008. This form purports to illustrate that this nurse or aide was evaluated in certain skills and scored either "Good", "Fair" or "Not performed" in certain skill areas. P. Ex. 12, at 2 is a "Home Health Aide Competency Checklist" which does not mention the name of the individual being evaluated but only the name of the person doing the evaluation and is dated November 14, 2008. It does not establish the competency of any person and was not provided at the time of the survey to the surveyors. CMS Reply to Petitioner's August 14, 2009 submission, at 12. P. Ex. 14, at 1 is a Chart Audit Checklist, which standing alone does not establish compliance and was not provided to the surveyor at the time of the survey. CMS Reply to Petitioner's August 14, 2009 submission, at 13.

In sum, Petitioner's exhibits are largely irrelevant, were not supplied to the surveyor at the time of the survey, and taken either alone or together, utterly fail to establish compliance with either of the conditions of participation at issue. Petitioner failed to provide me with minutes of PAC meetings and failed to provide me with documentation that an annual overall evaluation with results reported to and acted upon by those responsible for the HHA was ever undertaken as required by 42 C.F.R. § 484.52.

6. Petitioner's violation of even one condition of participation is sufficient to sustain CMS's termination.

The undisputed facts support a determination that Petitioner did not meet at least two conditions of participation. A finding of a violation of even one condition is sufficient to sustain the termination. Here, I find and conclude that Petitioner violated at least two conditions of participation and these violations were sufficient to sustain CMS's termination of Petitioner.

III. Conclusion

Based on the above findings and analysis, I sustain CMS's determination that there were condition-level violations of the Medicare conditions of participation, and I find and conclude that a basis exists for termination of Petitioner's provider agreement and participation in Medicare, effective May 5, 2009.

/s/
Richard J. Smith
Administrative Law Judge