Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

RehabCare Group East, Incorporated d/b/a RehabCare,
(CCN: 55-6531)

Petitioner

v.

Centers for Medicare & Medicaid Services.

Docket No. C-10-620

Decision No. CR2323

Date: February 15, 2011

DECISION

I sustain the determination made by the Centers for Medicare & Medicaid Services (CMS) to terminate Petitioner's participation as a provider of services in the Medicare program.

I. Background

Petitioner RehabCare Group East, Incorporated d/b/a RehabCare, operated a rehabilitation agency whose primary location was in Laguna Hills, California. Petitioner also provided services in other locations in California over a geographical area spanning several hundred miles. CMS Exhibits (CMS Exs.) 2, at 2; 3, at 2; 10. The services offered by Petitioner included physical therapy, speech pathology, and occupational therapy. CMS Ex. 1, at 1, 7; CMS Ex. 3, at 1. A recertification survey completed by the California Department of Public Health (state agency) on August 27, 2009 (August survey), found that Petitioner was not in compliance with six conditions of participation (CoPs) at 42 C.F.R. Part 485, Subpart H (specifically 42 C.F.R. §§ 485.709, 485.713, 485.715, 485.723, 485.725, and 485.727). Petitioner submitted a plan of correction and

the state agency resurveyed Petitioner on December 21, 2009 (December survey). The resurvey found that Petitioner continued to be out of compliance with three CoPs; 42 C.F.R. §§ 485.709 (administrative management), 485.715 (speech pathology services), and 485.727 (disaster preparedness). CMS notified Petitioner by letter dated March 4, 2010, that it was terminating Petitioner's provider agreement as of April 1, 2010, based on the findings of the December survey. CMS specifically notified Petitioner that the deficiencies, either individually or in combination, substantially limited Petitioner's capacity to render adequate care or adversely affected patient health and safety, establishing a basis for its conclusion that the CoPs were not met. CMS Ex. 1, at 1-4; 42 C.F.R. § 488.26(b).

Petitioner requested a hearing by letter dated April 5, 2010. The case was assigned to me for hearing and decision on April 19, 2010, and my Acknowledgment and Initial Docketing Order was issued on that date. In response to my Order, CMS filed a motion for summary disposition (CMS Br.), accompanied by 13 exhibits. Petitioner filed a response (P. Br.), accompanied by exhibits A and B. CMS filed a motion for leave to file a reply, with an attached reply (CMS Reply). In the absence of objection, I admit CMS Exs. 1-13 and Petitioner's exhibits (P. Exs.) A and B into evidence. I will also consider the arguments CMS advances in its Reply.

II. Legal Background

Facilities that participate in Medicare may be surveyed on behalf of CMS by state survey agencies in order to determine whether the facilities are complying with federal participation requirements. 42 C.F.R. Part 488, Subpart A. CMS may determine that an institution or agency does not qualify for participation in the Medicare and/or Medicaid programs if it is not in compliance with the CoPs. 42 C.F.R. § 488.24. The regulations provide that CMS may terminate a provider agreement if CMS finds that the provider no longer meets the CoPs. 42 C.F.R. § 489.53.

If a provider appeals CMS's action, then CMS must on appeal make a *prima facie* case that the provider has failed to comply substantially with participation requirements. Once CMS has established its *prima facie* case, a provider must overcome CMS's case by a preponderance of the evidence. *MediSource Corporation*, DAB No. 2011 (2006); *Batavia Nursing and Convalescent Center*, DAB No. 1904 (2004), *aff'd, Batavia Nursing and Convalescent Center v. Thompson*, No. 04-3325 (6th Cir. April 15, 2005); *Hillman Rehabilitation Center*, DAB No. 1611 (1997), *aff'd, Hillman Rehabilitation Center v. U.S. Department of Health and Human Services*, No. 98-3789 (GEB) (D.N.J. May 13, 1999).

The Social Security Act (Act) and regulations make a hearing before an Administrative Law Judge (ALJ) available to a provider in cases where CMS has terminated its provider agreement. The scope of the hearing is limited to whether the initial determination CMS

made is correct. 42 C.F.R. § 498.3(b)(8). The hearing is a *de novo* proceeding. *Anesthesiologists Affiliated, et al.*, DAB CR65 (1990), *aff'd*, 941 F.2d 678 (8th Cir. 1991).

An appellate panel of the Departmental Appeals Board (Board) recited the standard for summary judgment or disposition in *Senior Rehabilitation and Skilled Nursing Center*, DAB No. 2300, at 3 (2010), *aff'd, Senior Rehabilitation and Skilled Nursing Center v. Health & Human Services*, No. 10-60241 (5th Cir. Dec. 20, 2010). It stated that summary judgment is appropriate where the record shows that there is no genuine issue as to any material fact and the moving party is entitled to judgment as a matter of law. The party moving for summary judgment bears the initial burden of showing that there are no issues of material fact for trial and that it is entitled to judgment as a matter of law. To defeat an adequately supported motion, the non-moving party may not rely on the denials in its pleadings or briefs, but must furnish evidence of a dispute concerning a material fact – a fact that, if proven, would affect the outcome of the case under governing law. In determining whether there are genuine issues of material fact, the reviewer must view the evidence in the light most favorable to the non-moving party, drawing all reasonable inferences in that party's favor. In *Holy Cross Village at Notre Dame, Inc.*, DAB No. 2291, at 5 (2009), the Board stated that the role of an ALJ in deciding a summary judgment motion differs from the ALJ's role in resolving a case after hearing. An ALJ should not assess credibility or evaluate the weight of conflicting evidence.[1]

III. Findings and Discussion

My findings of fact and conclusions of law are noted below, in bold, and are followed by my discussion of each finding.

1. Petitioner was out of compliance with Medicare CoPs at the time of the December survey.

A rehabilitation agency such as Petitioner is defined by regulation as:

> *Rehabilitation agency.* An agency that –
> (1) Provides an integrated interdisciplinary rehabilitation program designed to upgrade the physical functioning of handicapped disabled individuals by bringing specialized rehabilitation staff together to perform as a team; and
> (2) Provides at least the following services:
> (i) Physical therapy or speech-language pathology services.

[1] Petitioner asserts that it should be allowed to cross-examine Lieutenant Commander Darren Orgel, who submitted an affidavit on CMS's behalf. P. Br. at 5. I do not rely on this affidavit in making my decision, and Petitioner's assertion is thus essentially moot.

(ii) Social or vocational adjustment services.

42 C.F.R. § 485.703.

Section 1861(p)(4) of the Act specifies that a rehabilitation agency must meet and maintain certain CoPs. 42 C.F.R. § 485.701. These CoPs are found in 42 C.F.R. Part 485, Subpart H. Each CoP is contained in a single regulation, which is divided into subparts called standards. Compliance with a CoP is determined by the manner and degree to which a provider satisfies the standards within the condition. 42 C.F.R. §§ 488.1, 488.26(b). Noncompliance with even one of the standards making up a CoP may constitute a violation of that CoP if the violation is significant enough. *Sonali Diagnostic Laboratory*, DAB No. 2008 (2006); 42 C.F.R. § 488.26(b).

A rehabilitation agency provides services at its primary site and it is that site that has an approved provider number. State Operations Manual (SOM), Ch. 2, § 2298 (CMS Ex. 4, at 2).[2] A rehabilitation agency may also provide services at locations other than its primary site, including freestanding offices, suites in an office or medical building, or in existing Medicare/non-Medicare participating providers (skilled nursing facility (SNF) or hospital). Such sites are termed "extension" locations. An extension location must meet the CoPs. It may not provide services the primary location does not provide (except aquatic therapy), but it does not have to provide all services provided at the primary site. SOM, Ch. 2, § 2298A (CMS Ex. 4, at 2-3). Services may also be provided in a patient's home or in a patient's room in a SNF. Because such locations are not considered extension locations, neither a patient's home nor a patient's room need satisfy the requirements of the SOM with which an extension location must comply. SOM, Ch. 2, § 2298B (CMS Ex. 4, at 4).

Petitioner argues that it provided its services at a primary site and in patients' homes or in rooms in a SNF, and that what it terms non-extension locations should not have been subject to survey as extension locations, citing the SOM, Ch. 2, § 2298B. Thus, any results of compliance surveys conducted at those locations should not be considered in determining whether Petitioner complied with the CoPs here at issue. Petitioner asserts, moreover, that this is a question of fact, not law, and argues among other things that: the surveyors required Petitioner's administrator to list Petitioner's non-extension locations as extension locations on the Form CMS-381 (CMS Ex. 10); the distance from the primary site to the non-extension locations should not be considered to support

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[2] While the SOM does not have the force and effect of law, the provisions of the Act and regulations, interpreted clearly, do have such force and effect. *State of Indiana by the Indiana Dep't of Public Welfare v. Sullivan*, 934 F.2d 853 (7th Cir. 1991); *Northwest Tissue Center v. Shalala*, 1 F.3d 522 (7th Cir. 1993). While the Secretary may not seek to enforce provisions of the SOM, the Secretary may seek to enforce the provisions of the Act or regulations as interpreted by the SOM.

noncompliance, as nowhere are there stated geographic limits between a primary site and other locations in a single state; and Petitioner has numerous employees who travel throughout California to oversee the actions and compliance of its services. P. Br. at 1-6, 18-20. CMS asserts that Petitioner's argument is contradicted by the Act, regulations, and CMS guidance.

Petitioner's argument that the CoPs should not apply to its non-extension locations is unavailing. The question is one of law. Regardless of where services are provided, a rehabilitation agency is responsible for complying with the CoPs. The law makes no distinction between a primary, extension, or other site or location for that purpose. Act, section 1861(p)(4); 42 C.F.R. §§ 485.701-.729.[3] The law contains no exception for services provided in a patient's home or room in a SNF and reaffirms the requirement that rehabilitation agencies must be in compliance with applicable CoPs. To allow otherwise would mean an agency might bill Medicare for providing services in a patient's home or room in a SNF without being subject to Medicare participation requirements. Allowing agencies to bypass rules designed to safeguard patient health and safety because such services are not provided in a primary or extension site or location would be in direct contradiction to Medicare participation requirements, which, as CMS notes, are designed with the patient in mind, not the location where services are provided. CMS Br. at 20-21; CMS Reply at 2; Act, sections 1861(p)(4), 1866; 42 C.F.R. §§ 489.1, 489.10(a), 489.53(a)(3).

CMS argues that Petitioner is out of compliance with three CoPs. CMS asserts that Petitioner's hearing request contains admissions (and omissions) that support CMS's findings of condition-level noncompliance.

The admissions referenced by CMS are found at page 6 of Petitioner's hearing request. CMS Ex. 2, at 6. Petitioner states that even if deficiencies were present in some circumstances they did not rise to a level constituting a violation of a CoP, and did not justify termination of its provider agreement, but instead were mere standard-level deficiencies. Here is the language Petitioner uses in its April 5, 2010 Request for Hearing (in quoting it, I have removed the bold-face print from Petitioner's original underlined heading to avoid confusion with my own bold-face headings, and I further note that Petitioner refers to itself in this quoted passage as "Agency," and should not be confused with the state agency involved here):

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[3] As noted by CMS, the SOM provision entitled "Exceptions to CoPs," at SOM, Ch. 2, § 2294 (CMS Ex. 4, at 2), notes that for clinics, rehabilitation agencies, and public health agencies to participate as providers they must be in compliance with all applicable CoPs, except that administrative management (42 C.F.R. § 485.709) is not applicable to public health agencies and rehabilitation program (42 C.F.R. § 485.717) is not applicable to clinics or public health agencies.

Erroneous Findings on Level of Deficiency Severity

Agency disputes that any Condition Out level deficiencies existed. Even if minor deficiencies existed at the time of the survey, any such deficiencies did not raise to the level of Condition Out status. Examples of minor deficiencies which should not have resulted in Condition Out status include, but are not limited to, the following:

485.709

- ° A number of the oversight issues cited in the survey were related to contract details which did not contribute to deficits in patient care.
- ° While patient care was started prior to insurance verification on 2 patients, this initiation of care would not be prohibited by the COPs provided that Agency did not bill for those services if the patient did not have coverage for said services even if Agency failed to advise the patient that their care would not be covered.
- ° While social and vocational services are no longer required under the COPs, the COPs do not preclude such screening.
- ° Agency Staff were educated on assorted infection control and emergency management policies. However, some staff failed to answer Surveyor's questions correctly. These erroneous answers resulted in part due to the confusing nature of the questions and manner of questioning as presented by the CDPH surveyor.

485.715

- ° This condition out level deficiency was isolated to one sole patient at a "non-extension" site. There was no evidence of an established pattern or practice deficient (sic) with regard to the provision of speech therapy.
- ° No Speech Therapy services were delivered at the primary site since October 22, 2009. Furthermore, there had been no referrals for speech therapy and the COPs do not specify how frequently speech services must be provided at the primary site.

Below, I find Petitioner out of compliance with participation requirements at 42 C.F.R. §§ 485.709 and 485.715 at the condition level. Moreover, if even one CoP is out of compliance, CMS is justified in terminating Petitioner's provider agreement. Here, I sustain CMS's determination of a deficiency at 42 C.F.R. § 485.715, and find that condition-level deficiency alone justifies CMS's decision to terminate. However, I also discuss 42 C.F.R. § 485.709, as providing another CoP out of compliance. I do not address the participation requirement at 42 C.F.R. § 485.727, because it is not necessary that I do so to sustain CMS's decision to terminate Petitioner's provider agreement. *Golden Living Center – Frankfort*, DAB No. 2296, at 3 n.2 (2009); *Community Skilled Nursing Centre*, DAB No. 1987 (2005); *Batavia Nursing and Convalescent Center*, DAB No. 1904.

a. Petitioner was out of compliance with the CoP at 42 C.F.R. § 485.715 (speech pathology services).

CMS argues that Petitioner's admissions show that there are no material facts in dispute regarding Petitioner's violation of this CoP. The CoP requires that if speech pathology services are offered, an organization provide an adequate program of speech pathology services and have an adequate number of qualified personnel and equipment necessary to carry out its program and fulfill its objectives.[4] The standard at 42 C.F.R. § 485.715(a) includes that an adequate program must provide diagnostic and treatment services to effectively treat speech disorders. CMS notes that in its hearing request Petitioner admitted that at the time of the survey it had not provided speech services at its primary site since October 22, 2009, a period of about two months. Since Petitioner was not providing speech pathology services at its primary site, it was not authorized to offer such services elsewhere, because the state agency surveyor was precluded from assessing the adequacy of Petitioner's services *at its primary site* and even from determining whether Petitioner was in compliance with the CoPs at that primary site.

CMS argues also that Petitioner failed to have the equipment and facilities required under 42 C.F.R. § 483.715(b) for speech pathology services, having no speech pathology equipment at its primary site or at non-extension locations. CMS notes that Petitioner did not deny that it had no speech pathologist for the primary site at the time of the survey, that it had no space set aside at its primary site for providing speech pathology services, and it had virtually no speech pathology equipment. CMS notes that Petitioner's speech-language pathology services policy requires that it provide an array of services that require the use of instrumentation and adaptive devices in at least some circumstances, and that its scope of practice and clinical interventions follow American Speech-Language Hearing Association (ASHA) guidelines, which state that the practice of speech-language pathology involves using instrumentation and selecting, fitting, and establishing effective prosthetic/adaptive devices for communicating, swallowing or other upper aerodigestive functions. CMS Ex. 5, at 7, 12-13. The surveyor did not observe or discover, and was not shown, any such equipment at the primary site, except for a book titled "Picture Communicator, Intermediate Size for Everyday Communication Situations." CMS Ex. 1, at 47. Moreover, CMS asserts that Petitioner's receptionist/physical therapy aide admitted to the surveyor that Petitioner had no speech pathology area, and a tour of the facility confirmed that there was no space and no

[4] Rehabilitation agencies cannot provide services at extension locations not provided at the primary site. SOM, Ch. 2, § 2298A (CMS Ex. 4, at 3).

equipment in operation to deliver speech pathology services.[5] CMS Ex. 1, at 46-47. Petitioner's plan of correction after the August survey states that Petitioner would provide speech services in a leased private treatment room and that speech language pathologists would be oriented to the practice by its administrator on December 1, 2009. CMS Ex. 1, at 48.

CMS argues that in its hearing request Petitioner admitted the speech pathology services it provided to one patient at a non-extension location were deficient. CMS states that the patient referred to is Patient 5, who began receiving speech pathology services on December 1, 2009. Patient 5 resided on the "memory unit" of one of the facilities where Petitioner provided services. Patient 5 was referred to Petitioner by the facility because of a decreased ability to swallow a regular diet. The speech pathologist, however, provided no documentation of working with facility staff regarding Patient 5's ability to tolerate "chewing and swallowing the least restrictive diet." CMS Ex. 1, at 43-44. CMS asserts treatment notes dated December 2, 8, and 9 were inadequate, because they only documented "follow safety precautions" and decreased "cognition ongoing." CMS Ex. 7, at 11-12; CMS Ex. 1, at 44. The treatment notes had no additional documentation to indicate Patient 5's safety precautions, the level and impairment of the patient's decreased cognition, and what type, if any, caregiver training had been done. Petitioner's administrator had no information about what speech pathology services Patient 5 was receiving. CMS Ex. 1, at 44-45. CMS argues that the administrator should have known what services Patient 5 was receiving because patient records are to be kept at the primary site and an administrator is responsible for communicating with the clinician if problems or questions arise concerning a patient's chart.

Petitioner argues that its admission that no speech pathology services were provided at its primary site after October 22, 2009, is not an admission that such services were not available, but instead suggests only that during that period no requests were made for Petitioner to provide such services. Petitioner argues that it "cannot force or solicit patients off the street solely to be able to demonstrate that it provides speech pathology services at its primary site. These services are scheduled and provided based on appropriate requests for the speech pathology services." P. Br. at 9-10. Had Petitioner received such a request between October and December, 2009, Petitioner asserts that it would have provided the services. P. Br. at 10.

Petitioner also asserts that the regulations do not specify the length of time between when various types of services are offered by a rehabilitation agency. Here, although Petitioner admits it did not provide speech pathology at the primary site for two months, it maintains that such services were offered and could have been referred to a contract

[5] CMS asserts that a speech pathologist who had not treated patients at Petitioner's facility since October 22, 2009, revealed that she preferred to treat patients in their homes because the homes were quiet and there were fewer distractions. CMS Ex. 1, at 45, 47.

agency if needed. Petitioner asserts that it had a written procedure in place to provide such services and it provided a copy of the procedure to the surveyor. Furthermore, Petitioner stated that if a patient needed speech pathology Petitioner would retain a contract agency or pathologist to provide such services until a speech pathologist was hired. Petitioner asserts that although it did not have a full-time speech pathologist at its primary site, it employs many speech pathologists who are available to provide such services at the primary site if so requested. Petitioner notes that while the SOM provides for surveyors to directly observe the actual provision of care and services, the SOM does not require that an agency have a full-time therapist for every discipline or have discipline-appropriate patients on the caseload to treat. And, although the SOM provides that speech pathology services could not be provided at extension locations if not provided at the primary location, Petitioner did not provide such care to Patient 5 at an extension location, but instead provided it at a non-extension location. Petitioner also asserts it did not admit in its hearing request that it provided deficient services to a patient.

As noted by CMS in its reply, Petitioner did not directly address the deficiency alleged by CMS with regard to Patient 5, except to generally deny the allegation by stating "[n]o such admission ever was made that conceded RehabCare provided deficient services." P. Br. at 10. Merely denying an allegation is insufficient to overcome summary judgment. *Senior Rehabilitation and Skilled Nursing Center*, DAB No. 2300. Petitioner's failure to offer more than a general denial regarding the allegation supports a finding that there is no issue of disputed material fact regarding the deficient speech pathology services provided by Petitioner to Patient 5.

I find that the failure to provide adequate speech pathology services to Resident 5 alone is sufficient to find Petitioner out of compliance with this CoP. The failure by the speech pathologist to document working with facility staff and to provide adequate treatment notes was serious. The failure of Petitioner's administrator to know about the speech pathology services Resident 5 was receiving is even more serious, as it points out the complete absence of supervision by Petitioner in general and its administrator in particular over the speech pathologist working at Petitioner's self described non-extension site. In the absence of adequate oversight, supervision, and documentation there is no way for Petitioner to know whether a patient is being correctly treated.

However, Petitioner's deficient treatment of Resident 5 alone is not the only example of Petitioner's failure to comply with this CoP. Petitioner has not shown that speech pathology services were actually being offered at the primary site at the time of the survey. While Petitioner asserts it had a procedure in place to provide speech pathology services and that it would do so through a contract agency, it admits that it had no speech pathologist on staff at the primary site. Its only response to CMS's assertions that it did not have an adequate array of instrumentation and adaptive devices at its primary site is to state that it had the one "Picture Communicator" book available, and that it would rent

any other equipment it needed to treat a patient, justifying the situation through the assertion that it had no patients requiring other instrumentation at the primary site. P. Br. at 12-13. In referring to the surveyor's finding that there was no space to provide speech pathology services, Petitioner asserts its "Corrective Action Plan" ("CAP") responding to the August 27, 2009 survey stated speech patients would be treated in a private meeting room if requested. This private meeting room was available at the time of the resurvey . . . ." P. Br. at 13-14. However, the survey in question is not the August survey, but the December survey, and an allegation of compliance made in a corrective action plan is not evidence of compliance.

Even accepting all Petitioner's arguments and assertions as true — that it had one device available, that it would rent equipment necessary to treat a patient, and that it would make space available to treat a patient — this does not show that Petitioner was providing speech services at its primary site and it certainly does not show that Petitioner was capable of providing speech pathology services at its non-extension locations. In fact, Petitioner's own arguments show that it did not have the capacity to supervise and oversee speech pathology services, as exemplified by its failure to adequately treat or supervise the treatment of Patient 5.

b. Petitioner was out of compliance with the CoP at 42 C.F.R. § 485.709 (administrative management).

The CoP requires that a rehabilitation agency must have an effective governing body that is legally responsible for the conduct of the agency, and that the governing body designate an administrator and establish administrative policies. CMS argues that there were deficiencies under three of the four standards under this CoP. Those three specific standards are entitled "Governing body," "Administrator," and "Patient care policies." 42 C.F.R. § 485.709(a), (b) and (d); CMS Ex. 1, at 1, 3, 12, 27.

CMS notes that Petitioner had therapy locations in assisted living facilities. CMS Ex. 1, at 54; CMS Ex. 3. One location was over 441 miles from Petitioner's primary site; another was over 179 miles from Petitioner's primary site; and two others were more than 40 miles from the primary site. While CMS admits that the SOM does not set a limit for how far an extension location may be from a primary site, the SOM provides some guidance in stating:

> An extension location cannot be denied based solely on geographical distance. If there is considerable geographical distance between the primary site and the extension location(s), it is important to determine whether the primary site can adequately supervise the staff at the extension location(s) as well as manage and oversee all operations of the extension location. Supervision should be available by telephone and be able to drive to the extension location in a reasonable amount of time, provide ongoing staff training, etc.

CMS Ex. 4, at 6; SOM, Ch. 2, § 2302. CMS notes that Petitioner disagrees that the distances between its primary site and other locations is a problem, but argues that Petitioner has failed to explain the basis of the disagreement and how, despite these distances, it maintained oversight and control over the non-extension locations.

CMS points out that in its hearing request Petitioner admitted there were "oversight issues" but that they did not contribute to deficits in patient care. CMS Ex. 2, at 6. CMS asserts that this claim ignores the underlying reality that according to Petitioner's administrator and Petitioner's policy, Petitioner was responsible for ensuring that each therapy had the equipment it needed, but that staff at Facility 5 used the SNF's equipment. Moreover, Petitioner had no procedures regarding how staff was to obtain equipment and supplies. CMS Ex. 1, at 15-16; CMS Ex. 5, at 2.

CMS also argues that Petitioner's primary site was not in control of the services being rendered at other locations. It is Petitioner's responsibility to ensure that its patients receive the necessary treatment and care. Here, Petitioner's primary site did not receive patient treatment records until one or two weeks after care had been provided. CMS Ex. 1, at 11-12. Thus, Petitioner was not providing on-going oversight of direct patient care.

CMS argues that Petitioner's administrator's failings also demonstrate its lack of oversight and control. An administrator is responsible for completing data entry of all patient documentation onto tracking logs for each provider site, coordinating, monitoring and managing missing or incomplete documentation for each site, and for communicating with clinicians regarding questions or problems with patient charts. CMS Ex. 1, at 25. Yet, the statement of deficiencies notes that, among other things, the administrator admitted he had not reviewed Patient 6's record (CMS Ex. 1, at 21-22); a discharge summary for speech pathology services last provided to Patient 2 on October 22, 2009, was missing; the administrator had not followed-up on that missing discharge summary or documented actions to obtain it (CMS Exs. 1, at 22; 6); and there were no weekly progress notes for occupational therapy sessions provided between October 22-28, 2009, for Patient 8, no discharge summary for occupational therapy for Patient 8 (who was discharged on November 2, 2009), and no documentation that the administrator had followed up on missing documentation regarding Patient 8.[6] CMS Ex. 8; CMS Ex. 1, at 22-23.

[6] CMS argues also that agency staff did their own performance evaluations and asserts that because they were self reporting Petitioner had no meaningful information about their performance. I accept Petitioner's assertions that employee self-evaluation is just one step in Petitioner's review process, which apparently also includes meetings with supervisory staff to discuss their performance and performance goals. P. Br. at 16.

Petitioner responds to CMS by arguing that its CAP following the August 2009 survey explained how it maintains oversight and control of its non-extension locations and how its staff obtained equipment and supplies. Petitioner references the affidavit of Laurie Thomas (P. Ex. B), the senior vice president of RehabCare Group, Inc., in which she states that Petitioner utilizes "trackers" (a term she does not define or explain in any useful detail), including the "Agency Extension Site Personnel File Monitoring Tool" as one of two "trackers" to monitor services to patients.[7] Petitioner also utilizes the "Agency Non-Extension Site Personnel File Monitoring Tool," but states that document is not as comprehensive as the extension site tool and the extension site tool was "chosen to be used to proactively increase compliance and oversight of agency personnel. . . ." P. Ex. B, at 4. Petitioner notes that because the surveyors found this process insufficient during the August survey, Petitioner implemented what it terms "Assistant Agency Administrators" at each non-extension site in November 2009, and asserts that these entities provided ongoing oversight and/or direct patient care at those locations. P. Ex. B, at 4. Petitioner asserts that these assistant agency administrators were in place at the time of the December resurvey. Petitioner asserts the surveyor overlooked or disregarded this process during the survey and that there is thus a factual dispute as to whether or not the process was in place at the time of the resurvey.

Petitioner argues that if there are deficiencies under this section of the regulations they do not support a finding of condition-level noncompliance. Petitioner argues that CMS cannot demonstrate any patient harm it can link to Petitioner's furnishing inadequate care. Petitioner reiterates its argument that the therapy services provided are located in patient's rooms in SNFs or their homes and that these non-extension locations are not subject to survey or to the requirements set forth for extension locations.

Petitioner also argues that CMS's allegation that it did not have a written plan with procedures to be followed when staff treated patients in their homes or in a SNF is incorrect. It asserts that CMS Ex. 5 contains all written plans and procedures for staff to follow both at the primary site and in a patient's home or room. Petitioner asserts these policies were available on site during the December 2009 resurvey.

Petitioner argues finally that there is no basis for a deficiency finding based solely on the distance between various locations where therapy services are provided. Petitioner asserts that as a national company engaged in providing post-acute care services, Petitioner has a large team of trained professionals to oversee the services it provides, wherever they are provided. P. Ex. B, at 1-2. Although California is a large state — the third largest in area of all the 50 states — and some of the distances noted earlier in this Decision are far more than modest, geography itself is not a *prima facie* indicator of a facility's inability to manage its far-flung components. Given the lack of evidence to

[7] Petitioner states that by naming this an "extension" tool it is not admitting that the tool is limited to use at "extension" locations. P. Ex. B, at 4.

demonstrate that distance between the primary site and other locations is in and of itself a basis for a deficiency, Petitioner has demonstrated that CMS is not entitled to summary judgment on that point.

CMS's motion for summary disposition referenced specific instances of "oversight issues" and administrative failures that Petitioner did not specifically rebut. Thus, there are no genuine questions as to several critical and material facts. Those points include Petitioner's staff's established use of SNF equipment instead of their own; the established failure of Petitioner's primary site to receive patient treatment records until one or two weeks after care had been provided; the established failure of Petitioner's administrator to review Patient 6's record; and the established facts that a discharge summary was missing and not followed-up on by the administrator for Patient 2, that there were no weekly progress notes for occupational therapy sessions or a discharge summary, and that no documentation exists to show that the administrator followed-up on the missing documentation for Patient 8. P. Br. at 15-17; P. Ex. A (the affidavit of Petitioner's administrator). Thus, there is no dispute of material fact regarding these deficiencies. I find these failures alone show that Petitioner failed to provide adequate administrative services.

Petitioner argues that its corrective action plan to the August survey shows that it was able to maintain oversight and control over the locations where it provided therapy services. Putting aside whether Petitioner's corrective action plan to a prior survey is even relevant, an allegation of compliance made in such a plan is not a substitute for a finding of actual compliance. The December survey found Petitioner remained out of compliance with this CoP. Moreover, while Ms. Thomas' affidavit asserts that placing assistant agency administrators at each non-extension site in November 2009 provided the necessary oversight of patient care, her assertions do not create a genuine dispute of material fact. As noted by CMS, Petitioner does not say what the responsibilities of the assistant agency administrators were or are, what their qualifications were or are, how they provided oversight or direct patient care, or whether they were actually providing such oversight and care. Moreover, since Petitioner had no designated office or clinical space at its non-extension sites, Petitioner did not even make clear where these individuals were located.

I agree with CMS that Petitioner's deficiencies constitute condition-level noncompliance. The deficiencies substantially limit Petitioner's capacity to furnish adequate care and may adversely affect the health and safety of patients. Petitioner's administrative failures show that Petitioner lacked the necessary control and oversight of the care its staff were providing at multiple and geographically-distinct locations. Without such oversight and control Petitioner could not ensure that its own policies were being followed, or ensure the quality of the care its staff provided, to determine whether the care provided was appropriate.

2. CMS is authorized to terminate Petitioner's participation as a provider of services in the Medicare program.

Pursuant to 42 C.F.R. § 489.53(a), CMS may terminate a provider agreement with any provider if CMS finds the provider no longer meets the appropriate CoPs. As I have found Petitioner in violation of two conditions of participation, CMS is authorized to terminate its provider agreement.

3. I am without authority to consider Petitioner's due process arguments.

Petitioner argued in its hearing request that the state agency and CMS failed to provide Petitioner with due process during the survey process by failing to ask questions of its staff in a "manner that could be easily understood" and by failing to adhere to a timely process of communication. CMS Ex. 2, at 4-5. I do not have the authority to consider whether procedures utilized by CMS or a state survey agency in determining compliance with the conditions of participation violate a petitioner's constitutional right to due process. 42 C.F.R. § 498.3; *Beverly Health & Rehabilitation – Spring Hill*, DAB No. 1696 (1999), *aff'd Beverly Health & Rehabilitation Services, Inc.*, 223 F. Supp. 2d 73 (D.C. Dist. 2002); *Carehouse Convalescent Hospital*, DAB No. 1799 (2001); *Lake Park Nursing and Rehabilitation Center*, DAB CR1341, n.2 (2005).

IV. Conclusion

For the reasons set forth above, CMS's motion for summary disposition must be, and it is, GRANTED. CMS was authorized to terminate Petitioner's participation as a provider of services in the Medicare program.

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/s/
Richard J. Smith
Administrative Law Judge