Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Bella Vista Healthcare Center
(CCN: 05-5693),

Petitioner

v.

Centers for Medicare and Medicaid Services.

Docket No. C-10-62

Decision No. CR2451

Date: October 12, 2011

DECISION

Petitioner, Bella Vista Healthcare Center, violated 42 C.F.R. § 483.12(b)(2);[1] however, the violation did not pose a risk for more than minimal harm, and Petitioner remained in substantial compliance with program participation requirements. There is no basis for imposing an enforcement remedy, and no remedy is reasonable.

I. Background

Petitioner is located in Ontario, California, and participates in Medicare as a skilled nursing facility (SNF) and the state Medicaid program as a nursing facility (NF). On July 8, 2009, the California Department of Public Health (state agency) completed a complaint

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[1] References are to the revision of the Code of Federal Regulations (C.F.R.) in effect at the time of survey, unless otherwise indicated.

investigation and abbreviated survey of Petitioner, finding that Petitioner was not in substantial compliance with program participation requirements. The Centers for Medicare and Medicaid Services (CMS) notified Petitioner by letter, dated August 17, 2009, that it was imposing the following enforcement remedies: a per-instance civil money penalty (PICMP) in the amount of $2,500 for an alleged violation of 42 C.F.R. § 483.12(b)(2) (Tag F205); a denial of payment for new admissions (DPNA) effective September 1, 2009; and termination of Petitioner's provider agreement and participation in Medicare, if Petitioner did not return to substantial compliance before January 8, 2010. CMS Exhibit (CMS Ex.) 4. CMS notified Petitioner by letter, dated October 5, 2009, that a revisit survey concluded that Petitioner returned to substantial compliance effective August 24, 2009, and that the DPNA and termination would not be effectuated. CMS Ex. 5.

Petitioner requested a hearing before an administrative law judge (ALJ) on October 15, 2009. The case was assigned to me for hearing and decision on October 26, 2009, and an Acknowledgement and Prehearing Order was issued at my direction. On June 29, 2010, a hearing was convened in San Bernardino, California, and a transcript (Tr.) of the proceedings was prepared. CMS offered CMS exhibits 1 through 17 that were admitted as evidence. Tr. at 29. Petitioner offered Petitioner exhibits (P. Exs.) 1 through 19, and they were admitted as evidence. Tr. at 32. Petitioner subsequently requested leave to withdraw P. Ex. 15, the curriculum vitae of a witness, and that motion was granted. Tr. at 49-50. CMS called one witness, Surveyor Janine Nichols, RN (Registered Nurse). Petitioner called the following witnesses: Lucieanne Hawley, Licensed Vocational Nurse (LVN); Ivan Gonzalez; Gloria Miranda, RN; Nathan Ure, Director of Operations for California Healthcare Management Services; and Tyrus Lefler, Petitioner's Administrator. The parties filed post-hearing briefs (CMS Br. and P. Br., respectively). Petitioner filed a post-hearing reply brief (P. Reply), but CMS waived filing a reply.

II. Discussion

A. Issues

Whether there is a basis for the imposition of an enforcement remedy; and

Whether the remedy imposed is reasonable.

B. Applicable Law

The statutory and regulatory requirements for participation of a SNF in Medicare are found at section 1819 of the Social Security Act (Act) and at 42 C.F.R. Part 483. Section 1819(h)(2) of the Act authorizes the Secretary of Health and Human Services (Secretary) to impose enforcement remedies against a SNF for failure to comply substantially with

the federal participation requirements established by sections 1819(b), (c), and (d) of the Act.[2] The Act requires that the Secretary terminate the Medicare participation of any SNF that does not return to substantial compliance with participation requirements within six months of being found not to be in substantial compliance. Act § 1819(h)(2)(C). The Act also requires that the Secretary deny payment of Medicare benefits for any beneficiary admitted to a SNF, if the SNF fails to return to substantial compliance with program participation requirements within three months of being found not to be in substantial compliance – commonly referred to as the mandatory or statutory DPNA. Act § 1819(h)(2)(D). The Act grants the Secretary discretionary authority to terminate a noncompliant SNF's participation in Medicare, even if there has been less than 180 days of noncompliance. The Act also grants the Secretary authority to impose other enforcement remedies, including a discretionary DPNA, civil money penalties (CMPs), appointment of temporary management, and other remedies, such as a directed plan of correction. Act § 1819(h)(2)(B).

The Secretary has delegated to CMS and the states the authority to impose remedies against a long-term care facility that is not complying substantially with federal participation requirements. "*Substantial compliance* means a level of compliance with the requirements of participation such that any identified deficiencies pose no greater risk to resident health or safety than the potential for causing minimal harm." 42 C.F.R. § 488.301 (emphasis in original). A deficiency is a violation of a participation requirement established by sections 1819(b), (c), and (d) of the Act or the Secretary's regulations at 42 C.F.R. Part 483, subpart B. Noncompliance refers to any deficiency that causes a facility not to be in substantial compliance. 42 C.F.R. § 488.301. State survey agencies survey facilities that participate in Medicare on behalf of CMS to determine whether the facilities are complying with federal participation requirements. 42 C.F.R. §§ 488.10-.28, 488.300-.335. The regulations specify the enforcement remedies that CMS may impose if a facility is not in substantial compliance with Medicare requirements. 42 C.F.R. § 488.406. CMS is authorized to impose a PICMP from $1,000 to $10,000. 42 C.F.R. § 488.438(a)(2).

The Act and regulations make a hearing before an ALJ available to a long-term care facility against which CMS has determined to impose an enforcement remedy. Act §§ 1128A(c)(2), 1866(h); 42 C.F.R. §§ 488.408(g), 498.3(b)(13). The hearing before an ALJ is a *de novo* proceeding. *The Residence at Salem Woods*, DAB No. 2052 (2006);

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[2] Participation of a NF in Medicaid is governed by section 1919 of the Act. Section 1919(h)(2) of the Act gives enforcement authority to the states to ensure that NFs comply with their participation requirements established by sections 1919(b), (c), and (d) of the Act.

Cal Turner Extended Care, DAB No. 2030 (2006); *Beechwood Sanitarium*, DAB No. 1906 (2004); *Emerald Oaks*, DAB No. 1800, at 11 (2001); *Anesthesiologists Affiliated*, DAB CR65 (1990), *aff'd*, 941 F.2d 678 (8th Cir. 1991). A facility has a right to appeal a "certification of noncompliance leading to an enforcement remedy." 42 C.F.R. § 488.408(g)(1); 42 C.F.R. §§ 488.330(e), 498.3. However, the choice of remedies, or the factors CMS considered when choosing remedies, are not subject to review. 42 C.F.R. § 488.408(g)(2). A facility may only challenge the scope and severity level of noncompliance determined by CMS, if a successful challenge would affect the range of the CMP that may be imposed or impact the facility's authority to conduct a nurse aide training and competency evaluation program. 42 C.F.R. § 498.3(b)(14), (d)(10)(i). The CMS determination as to the level of noncompliance, including the finding of immediate jeopardy, "must be upheld unless it is clearly erroneous." 42 C.F.R. § 498.60(c)(2). *Woodstock Care Ctr.*, DAB No. 1726, at 9, 38 (2000), *aff'd*, 363 F.3d 583 (6th Cir. 2003). The Departmental Appeals Board (the Board) has long held that the net effect of the regulations is that a provider has no right to challenge the scope and severity level assigned to a noncompliance finding, except in the situation where that finding was the basis for an immediate jeopardy determination. *See, e.g.*, *Ridge Terrace*, DAB No. 1834 (2002); *Koester Pavilion*, DAB No. 1750 (2000). ALJ review of a CMP is subject to 42 C.F.R. § 488.438(e).

The standard of proof, or quantum of evidence required, is a preponderance of the evidence. CMS has the burden of coming forward with the evidence and making a *prima facie* showing of a basis for imposition of an enforcement remedy. Petitioner bears the burden of persuasion to show by a preponderance of the evidence that it was in substantial compliance with participation requirements or any affirmative defense. *Batavia Nursing & Convalescent Inn*, DAB No. 1911 (2004); *Batavia Nursing & Convalescent Ctr.*, DAB No. 1904 (2004), *aff'd, Batavia Nursing & Convalescent Ctr. v. Thompson*, 129 F. App'x 181 (6th Cir. 2005); *Emerald Oaks*, DAB No. 1800; *Cross Creek Health Care Ctr.*, DAB No. 1665 (1998); *see Hillman Rehab. Ctr.*, DAB No. 1611 (1997), *aff'd, Hillman Rehab. Ctr. v. U.S.*, No. 98-3789 (GEB), 1999 WL 34813783 (D.N.J. May 13, 1999).

C. Findings of Fact, Conclusions of Law, and Analysis

My conclusions of law are set forth in bold text followed by my findings of fact and analysis. CMS alleges, based upon the survey that ended July 8, 2009, that Petitioner was not in substantial compliance with program participation requirements due to an alleged violation of 42 C.F.R. § 483.12(b)(2) (Tag F205) that caused actual harm to a resident. CMS Ex. 1; CMS Br. at 1. CMS proposes to impose a $2,500 PICMP based upon the alleged violation.

I have carefully considered all the evidence and the arguments of both parties, though not all may be specifically discussed in this decision. I discuss in this decision the credible

evidence given the greatest weight in my decision-making.[3] The fact that evidence is not specifically discussed should not be considered sufficient to rebut the presumption that I considered all the evidence and assigned such weight or probative value to the credible evidence that I determined appropriate within my discretion as an ALJ. There is no requirement for me to discuss the weight given every piece of evidence considered in this case, nor would it be consistent with notions of judicial economy to do so.

1. Petitioner violated 42 C.F.R. § 483.12(b)(2).

2. CMS has not made a *prima facie* showing of noncompliance under Tag F205, because CMS did not show there is a risk for more than minimal harm due to the regulatory violation.

3. Even if CMS made a *prima facie* showing of noncompliance, the CMS showing has been rebutted by Petitioner by a preponderance of the evidence.

4. There is no basis for the imposition of an enforcement remedy because Petitioner remained in substantial compliance.

The Secretary has established admission, discharge, and transfer rights for residents of long-term care facilities with which facilities participating in Medicare agree to comply. 42 C.F.R. § 483.13. The regulation requires that a long-term care facility give its residents two written notices regarding bed-hold policy. The first notice must be given in writing sometime before a resident is transferring to a hospital or going on therapeutic leave. The first notice is given to the resident, the resident's family member, or the resident's legal representative. The first notice must advise the resident or representative of the duration of the bed-hold policy under the state plan, if any. The bed-hold policy specifies the period during which a resident is permitted to return to the facility following hospitalization or therapeutic leave. The first notice must also advise the resident or representative of the facility's policy regarding bed-hold periods. 42 C.F.R. § 483.12(b)(1). The second notice is given to the resident or representative at the time of transfer to the hospital or for therapeutic leave. The regulation specifies that the second notice must also be in writing. The second notice specifies the duration of the bed-hold policy, *i.e.*, the period during which the facility will ensure it has a bed to which the resident may return and resume residence at the facility. 42 C.F.R. § 483.12(b)(2). The

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[3] "Credible evidence" is evidence that is worthy of belief. *Black's Law Dictionary* 596 (18th ed. 2004). The "weight of evidence" is the persuasiveness of some evidence compared to other evidence. *Id*. at 1625.

parties agreed at hearing that the regulation applied to Residents 1, 2, 3, and 4, the residents who were the focus of the July 8, 2009 survey. Tr. at 69.

The duration of the bed hold in California is seven days. If a resident of a SNF in California transfers to an acute care hospital, the SNF is required to hold a bed open for the resident for seven days, if requested by the resident or the resident's representative within 24 hours of being informed of the right to have a bed held. Like the federal regulation at issue before me, the California regulation requires that residents of a SNF, or their representatives, be notified of the right to exercise a bed hold in writing when admitted to the SNF and at the time of transfer to an acute hospital. CAL. CODE REGS. tit. 22, § 72520(a) (2009); CMS Ex. 16.

Petitioner's Bed Hold Notification policy, dated January 2004, specifies that a resident or representative is to be given written notice of the right to exercise a bed hold at the time of admission and at the time of transfer for hospitalization or for therapeutic leave. The policy specifies that: the resident or representative must be advised of the right to exercise a seven-day bed hold; a non-Medicaid eligible resident will be liable for the cost of the bed-hold days up to the resident's daily rate and that insurance may not cover the cost; that the resident or representative must notify Petitioner if the right to a bed hold is being exercised within 24 hours of being advised of the right; and Petitioner need not maintain the bed hold if the resident's physician advises Petitioner that the resident's acute care hospital stay is expected to be more than seven days. CMS Ex. 11.

The federal regulation, the California regulation, and Petitioner's bed-hold policy each requires that the second bed-hold notice be given at the time of transfer for hospitalization or for therapeutic leave and that the notice be in writing.

A complaint was filed against Petitioner by Resident 1, which triggered the complaint investigation and abbreviated survey by the state agency that was completed on July 8, 2009. Surveyor Janine Nichols conducted the investigation and abbreviated survey. Tr. at 52-55, 104-05. The Statement of Deficiencies (SOD) for the survey alleges that Petitioner violated 42 C.F.R. § 483.12(b)(1) and (2), related to Petitioner's giving of notice of the bed-hold policy to Residents 1, 2, 3, and 4. However, Surveyor Nichols testified at hearing that she did not conclude that Petitioner violated 42 C.F.R. § 483.12(b)(1) and that the citation is included in the SOD only because she could not alter the computer-generated text to remove the reference to 42 C.F.R. § 483.12(b)(1). Tr. at 110-11. The parties stipulated prior to hearing that all four residents received the first written notice of bed-hold policy required by 42 C.F.R. § 483.12(b)(1). Joint Stipulation of Facts (Jt. Stip.) ¶ 1. Surveyor Nichols also testified that the evidence shows that all four residents received the first notice. Tr. at 57, 110. The stipulation is consistent with, and supported by, the allegations of the surveyor in the SOD and her testimony that all four residents did receive the first notice. CMS Ex. 1, at 4, 7, 8, 9. Accordingly, the evidence shows that there was no violation of 42 C.F.R. § 483.12(b)(1)

in the case of the four residents cited in the survey. Furthermore, CMS does not allege before me that there was a violation of 42 C.F.R. § 483.12(b)(1). CMS Br. at 1-3, 25-26. I conclude that there was no violation of 42 C.F.R. § 483.12(b)(1).

Surveyor Nichols concluded that: there was a violation of 42 C.F.R. § 483.12(b)(2) based on the examples of Residents 1, 2, 3, and 4; the violation resulted in actual harm to Resident 1; and, as a result, Petitioner was not in substantial compliance and subject to an enforcement remedy. CMS Ex. 1, at 1-2. Surveyor Nichols did not specifically allege in the SOD that Residents 2, 3, and 4 suffered harm or that they were at risk for any harm. CMS Ex. 1, at 7-10.

The parties stipulated prior to hearing that, when Residents 1, 2, 3, and 4 were transferred to an acute care hospital, they were orally advised of the seven-day bed hold but they were not given a writing at that time. Jt. Stip. ¶ 2; Tr. at 38-41. The evidence shows that Resident 1 received his second bed-hold notice in person on June 26, 2009. CMS Ex. 6, at 5, 13, 19, 20. A physician's order on June 26, 2009, directed that Resident 1 be discharged from Petitioner to the hospital for surgery and that his bed be held by Petitioner for seven days. CMS Ex. 6, at 6. Resident 2's representative was given the second bed-hold notice on July 5, 2009, by telephone. CMS Ex. 7, at 9, 11. A physician's order on July 5, 2009, directed that Resident 2 be transferred to the hospital by emergency services and that his bed at Petitioner was to be held for seven days. CMS Ex. 7, at 10. Resident 3's representative was given a second bed-hold notice on June 30, 2009, by telephone. CMS Ex. 8, at 6, 7. A physician's order directed her admission to the hospital on June 30, 2009 and ordered a seven-day hold on her bed at Petitioner. CMS Ex. 8, at 8. Resident 4's representative was given the second notice of bed hold on May 13, 2009, by telephone. CMS Ex. 9, at 6, 18-19. A physician's order on May 14, 2009, directed that the resident be transferred to the emergency room and that her bed be held by Petitioner for seven days. CMS Ex. 9, at 8. There is no dispute that none of the residents or their representatives received a writing specifying the duration of the bed hold at the time of their transfers to the hospital. Accordingly, I conclude that Petitioner violated the requirement of 42 C.F.R. § 483.12(b)(2) that the second notice be given to the resident, or his or her representative, in writing.

Although I conclude that Petitioner violated 42 C.F.R. § 483.12(b)(2), I conclude that the violation did not amount to noncompliance. Noncompliance is any deficiency that causes a facility not to be in substantial compliance. 42 C.F.R. § 488.301. A facility remains in substantial compliance so long as no identified deficiency poses a "greater risk to resident health or safety than the potential for causing minimal harm." 42 C.F.R. § 488.301. Therefore, a violation of a condition for participation in Medicare does not amount to noncompliance unless it poses "a greater risk to resident health or safety than the potential for causing minimal harm." 42 C.F.R. § 488.301. An enforcement remedy is authorized only for noncompliance. 42 C.F.R. § 488.402(b). CMS must show as part of its *prima facie* case not only a violation of a statutory or regulatory condition of

participation, but must also show that the violation posed a risk for more than minimal harm to one or more residents. The Board has been consistent in its view that CMS has the burden of coming forward with evidence to establish a *prima facie* case that Petitioner was not in substantial compliance with federal participation requirements to justify the imposition of an enforcement remedy. The Board has stated that CMS must come forward with "evidence related to disputed findings that is sufficient (together with any undisputed findings and relevant legal authority) to establish a *prima facie* case of noncompliance with a regulatory requirement." *Evergreene Nursing Care Ctr.*, DAB No. 2069, at 4 (2007); *Batavia Nursing and Convalescent Ctr.*, DAB No 1904. Only when CMS makes a *prima facie*[4] showing of noncompliance, is the facility burdened to show, by a preponderance of the evidence on the record as a whole, that it was in substantial compliance or had an affirmative defense. *Evergreene Nursing Care Ctr.*, DAB No. 2069, at 4. The fact that the residents were not given the second bed-hold notice in writing is not disputed, and the CMS burden to show a deficiency, *i.e.*, a violation of a participation requirement, is satisfied. The dispute in this case is whether or not the facts show that the violation posed a risk for more than minimal harm to any resident. I conclude that the CMS evidence is not sufficient to establish as fact, to trigger a presumption, or to support an inference that there was a risk for more than minimal harm.[5] I conclude that CMS has not met its burden to show that there was a potential for more than minimal harm resulting from Petitioner's failure to give residents written notice of the duration of the bed hold at the time of transfer. Accordingly, Petitioner remained in substantial compliance, and there is no basis for the imposition of an enforcement remedy.

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[4] *Prima facie*" means generally that the evidence is "[s]ufficient to establish a fact or raise a presumption unless disproved or rebutted." *Black's Law Dictionary* 1228 (8th ed. 2004).

[5] One of CMS's arguments could be understood to be that the mere violation of a regulation that is a condition for participation permits an inference or triggers a presumption that there is a risk for more than minimal harm. CMS Br. at 6, 7 n.1. CMS cites no decision of the Board that has gone so far. The interpretation suggested by CMS would also be inconsistent with, and render meaningless, the regulatory scheme that recognizes the distinction between deficiencies that do not pose a risk for more than minimal harm and do not amount to noncompliance and deficiencies that do pose a risk for more than minimal harm and are noncompliance for which CMS is authorized to impose an enforcement remedy. 42 C.F.R. Part 488, subpts E & F. If a mere violation triggered a presumption of more than minimal harm, CMS and the state agencies could impose a remedy for every deficiency without the need to consider whether the deficiency posed a risk for more than minimal harm, placing the burden on facilities to rebut the presumption in every case.

The evidence that CMS presented shows that each resident, or the resident's representative, was orally advised about the right to have his or her bed held during his or her hospitalization. The CMS evidence also demonstrates that each resident or representative exercised the right to have a bed held, and there is a physician's order to hold each bed for seven days. Therefore, when the residents were transferred, there was no longer any need for them to exercise the right to have their bed held, and there is no evidence they had any cause for concern that Petitioner would not honor the obligation to hold a bed for them. CMS has not presented any evidence to support a finding that any of the residents were at risk for suffering any harm, physical or psychological, due to the process Petitioner followed for giving the second bed-hold notice and obtaining the resident's election.

Surveyor Nichols testified that she concluded that there was a potential for more than minimal harm from providing only oral advice with no writing because a resident may not be able to understand or recall the oral advice, and the resident could suffer psychological harm if they lost their bed as a result. Tr. at 78-80. CMS argues that residents who miss the opportunity to exercise their right to a bed hold are potentially at risk for more than minimal "psychosocial harm." CMS Br. at 1, 3-6. The concern of CMS and Surveyor Nichols is not supported by the evidence that the surveyor collected during her investigation and that was presented in support of the CMS *prima facie* case, as that evidence shows that all four of the residents or their representatives were orally advised and exercised the right to have a bed held at the time of transfer.[6] CMS has presented no evidence of: a resident transferred without receiving oral notice of the right to a bed hold; oral notice being given to a resident or representative unable to comprehend the notice or to knowingly exercise the right; or a resident or representative who failed to exercise the right after receiving oral notice – evidence from which one might reasonably infer that there was a risk for potential harm.

Surveyor Nichols testified that Petitioner violated Resident 1's right to a bed hold because Petitioner did not hold a bed for him for the entire seven-day bed-hold period when the hospital advised Petitioner that Resident 1 was being discharged to a different SNF. She testified that Resident 1 suffered actual psychological harm based upon his statements to a social worker reflected in the evidence. Tr. at 83-84, 122-26, 139, 141. She also alleged in the SOD that Petitioner's failure to allow Resident 1 to return to Petitioner caused actual harm in the form of depression with suicidal thoughts that

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[6] The parties stipulated that, when Residents 2, 3, and 4 were at the acute care hospital, they requested that a bed be held, and they subsequently returned to Petitioner. Jt. Stip. ¶ 3. Petitioner advised me at hearing that Resident 4 actually returned home from the hospital rather than returning to Petitioner. Tr. at 98; P. Br. at 5, ¶ 7.

required admission to a psychiatric hospital. CMS does not advance this argument in its post-hearing brief or address it in its proposed findings of fact and conclusions of law for good reasons. The charge in the SOD and the charge that CMS has pursued in the case before me is that Petitioner violated 42 C.F.R. § 483.12(b)(2) by failing to give the second bed-hold notice in writing. There is no alleged violation of a regulatory or statutory provision based on a violation of Resident 1's right to a bed hold. The CMS evidence shows that, on June 26, 2009, Resident 1 was orally advised of the right to a seven-day bed hold, he exercised the right to a bed hold, and a physician's order was obtained. On June 29, 2009, while at the hospital, Resident 1 decided to go to Upland Rehabilitation, consistent with his physician's preference. On June 30, 2009, Resident 1 was accepted as a resident by Heritage Park, and he agreed to go there. On June 30, 2009, the fourth day of the bed hold at Petitioner, Petitioner was notified by the hospital that Resident 1 was going to a different long-term care facility and would not be returning to Petitioner. Resident 1 was discharged from the hospital to Heritage Park on June 30, 2009. The CMS evidence shows that, on July 1, 2009, Resident 1 was returned to the hospital for pain management, and his physician was contacted and approved transfer to any SNF that could administer narcotics intravenously during the day and by mouth at night. Resident 1 refused to go to any facility until he was assured he could receive his pain medication. On July 2, 2009, Heritage Park denied that Resident 1 was ever admitted to that facility. On July 2, 2009, which would have been the sixth day of the bed hold at Petitioner, Resident 1's hospital case manager called Petitioner but was told that there was no bed available for Resident 1 because the resident's bed was taken off hold when Petitioner was notified that Resident 1 was going to a different facility. CMS Ex. 6, at 5-6, 13, 19, 20, 26-27, 32-34; Jt. Stip. ¶¶ 4-10. Surveyor Nichols agreed at hearing that there is no federal regulation that required Petitioner to hold a bed for Resident 1 after Petitioner was advised by the hospital on June 30, 2009, that Resident 1 was being discharged to another facility. Tr. at 136-37. Accordingly, Petitioner's release of the bed hold did not violate a condition of participation, and any distress Resident 1 suffered as a result of that action is not properly before me.

Surveyor Nichols also agreed on cross-examination that Resident 1's complaints of mental distress were inconsistent. Tr. at 129-30. The CMS evidence shows that, on July 7, 2009, five days after Resident 1 learned that Petitioner had no bed for him, Resident 1 met with a social worker for discharge planning. Resident 1 advised the social worker that he had called the state to investigate Petitioner because he was denied a bed. The social worker opined that Resident 1 was manipulative with paranoid tendencies. Resident 1 told the social worker he saw a psychiatrist for anxiety and admitted to depression. Resident 1 told the social worker that he needed a facility where he could have physical therapy but did not mention his prior concern about going somewhere that could administer his narcotics. Resident 1 denied any suicidal ideation, stating that he would not hurt himself but joked he might hurt someone else. The social worker noted that Resident 1 was alert and oriented at the time and does not report that the resident was currently suffering any signs or symptoms of either depression or anxiety. CMS Ex. 6, at

39-40. Two days later on July 9, 2009, the CMS evidence shows that Resident 1 saw another social worker and complained he was feeling very depressed due to his medical issues and problems with the SNF. He was tearful and stated he felt suicidal for about two weeks. He felt he should shoot himself in the head with a gun. The social worker requested suicide precautions and referred Resident 1 for a psychiatric evaluation. CMS Ex. 6, at 42. Without assessing Resident 1's credibility or weighing this evidence, it is clear that it is inconsistent. Given the inconsistencies of Resident 1's reports to social workers, those reports standing alone are insufficient to show that the resident suffered any harm, either on account of Petitioner's failure to give him the second bed-hold notice in writing or releasing the bed hold prior to the expiration of seven days.

If it is concluded on further review that CMS made a *prima facie* showing based either upon a presumption of more than minimal harm triggered by the violation of 42 C.F.R. § 483.12(b) or the inconsistent evidence of Resident 1's condition, I conclude that Petitioner rebutted CMS's *prima facie* showing with evidence that there was no risk for more than minimal harm. My conclusion is supported by the unrebutted testimony of Petitioner's witnesses and Petitioner's documents.

Lucieanne Hawley, LVN, Petitioner's Minimum Data Set (MDS) coordinator, testified that, when Resident 1 transferred to the acute care hospital on June 30, 2009, he did so for an elective surgery. He indicated that he was considering other options to coming back to Petitioner, and he was in the care planning process for a lower level of care. Tr. at 151-54. She explained that the procedure followed at Petitioner at the time was to discuss the bed hold with the resident, and, if they requested that their bed be held, Petitioner obtained a physician's order. Tr. at 157-58. LVN Hawley's credible testimony is consistent with Resident 1 having been advised of, and understanding his right to, a bed hold while in the hospital for surgery.

Ivan Gonzalez, who was Petitioner's admissions coordinator in June 2009, testified that residents, including the four in question, were given the written bed-hold notice at the time of admission. He testified that, when residents transferred to an acute care facility, it was explained to them, or their representative, that they could have their bed held for seven days. He testified that he met with Resident 1 frequently, and Resident 1 was considering transfer to a lower level of care. Mr. Gonzalez testified that he took Resident 1 to visit a couple places. On June 26, 2009, he discussed with Resident 1 his right to a bed hold, and Resident 1 was considering transferring to another facility or level of care after his hospitalization. Mr. Gonzalez opined that Resident 1 understood his right to a bed hold. Mr. Gonzalez testified he received a telephone call from the case manager at San Antonio Community Hospital who advised him that Resident 1 was to be discharged to another facility. Resident 1's bed was being held, but, when the case worker advised he was being discharged to another facility, his bed hold was terminated. Mr. Gonzalez explained that, if Resident 1 was being admitted to another facility, Petitioner could no longer bill for the held bed. He testified that the bed was committed to a new resident the

same day he was advised that Resident 1 was not returning. Tr. at 161-70. Mr. Gonzalez testified that a couple days later he received word that Resident 1 wanted to return to Petitioner, but there was no bed available. Tr. at 170-71. Mr. Gonzalez's testimony is credible.

Gloria Miranda, RN, testified that she was employed by California Healthcare Management Services, which provided clinical services at Petitioner's facility. Tr. at 176. She was assigned to Petitioner in June 2009 and knew all four residents mentioned in the SOD. Tr. at 177-78. RN Miranda testified that, when residents transferred, their bed-hold right was explained until the resident or representative understood, and, if they exercised the right, a physician's order was obtained and sent to the hospital with them to ensure discharge planners at the hospital knew that a bed was being held for the resident. The transferring residents were not just given a piece of paper. Tr. at 181, 184, 191, 196. She opined that residents did not suffer harm by not receiving a piece of paper because it was assured that they knew about the bed hold and could exercise the right immediately. Tr. at 182. She opined that Resident 1's suicidal ideations were not caused by failure to receive a piece of paper but were due to a long history of depression with a history of suicidal ideations. Tr. at 184-87. RN Miranda's testimony is credible, and her opinion regarding Resident 1's suicidal ideations is entitled to weight based on her knowledge of the resident.

Nathan Ure, Director of Operations for California Healthcare Management Services, which provided support services for Petitioner, testified credibly that each of the four residents knew about and exercised their bed-hold rights, which shows that Petitioner substantially complied with the regulation. He testified that advising the resident or representative of the right to a bed hold, having them execute that right, and obtaining a physician's order avoids the need for the resident or representative to do so within 24 hours after transfer and ensures that the hospital knows a bed is being held for the resident. Tr. at 202, 204-12. He opined that there was no risk for more than minimal harm because the right to a bed hold was explained carefully, and it was ensured the resident or representative could exercise the right. Tr. at 213. He also testified credibly that the state agency had previously considered Petitioner's procedure and opined it met the regulatory requirement. Tr. at 214-19. Petitioner does not urge an estoppel defense but, rather, argues that the state agency's opinion is consistent with and evidence in support of Petitioner's position that its procedure posed no risk for more than minimal harm. P. Reply at 11.

Tyrus Lefler, Petitioner's Administrator, testified that the facility gave written notice of the bed-hold policy at the time of admission and that Residents 1, 2, 3, and 4 all received the written notice. He testified that, upon transfer, a resident had to exercise the right to a bed hold within 24 hours of the notice. He testified that he personally spent an hour and a half discussing the bed-hold right with Resident 1 on June 30, 2009, and the resident requested that his bed be held even though he was not certain he was coming back to

Petitioner. He testified that Residents 2, 3, and 4 also requested that their beds be held at the time of transfer. Administrator Lefler testified that Resident 1's bed hold was terminated because Petitioner was advised Resident 1 was being discharged to another facility, and the bed was committed to a new resident the same day. He testified that, even if Resident 1 had been given a written second bed-hold notice, once he decided to go to another facility, the bed hold would have been released. He testified that, when Resident 1 went to another facility, Petitioner could no longer bill for a held bed. He also testified that it is not permissible to commit a single bed to two residents or more residents than the number for which Petitioner is licensed. Tr. at 224-47, 261. He opined that the residents exercised their bed holds, and the outcome would not have been different if they had received a piece of paper. Therefore, he did not see any potential for more than minimal harm. Tr. at 253-54. Mr. Lefler's testimony was not rebutted, and it is credible.

Resident 1's physician, Michael Chai, MD, provided Petitioner a statement in which he states he recommended that Resident 1 choose another facility due to his expressed dissatisfaction with Petitioner. Dr. Chai states that Resident 1 was able to make his own decisions about health care, and he did so when he decided to go to Heritage Park. P. Ex. 8; Tr. at 241-42. CMS did not object to my consideration of this statement or request cross-examination. I find the statement credible and entitled to weight as Dr. Chai was Resident 1's treating physician. Petitioner's documents also show that Resident 1 elected to go to a different facility after exercising his right to a bed hold at Petitioner. P. Ex. 12, at 12-14 (physician ordered discharge to Heritage Park not Petitioner); Tr. at 198. Further, Resident 1's complaints of depression and suicidal ideation on July 9, 2009 are simply not credible as they are inconsistent with his denial of suicidal thoughts on July 7, 2009 (CMS Exs. 39-40, 42), and no such complaints are reflected in other records from his hospitalization between July 1 and 7, 2009 (P. Ex. 12, at 15-19).

Petitioner takes the position that, although it was not in literal compliance with 42 C.F.R. § 483.12(b)(2), it fulfilled the intent of the regulation and "went above and beyond" to ensure that its residents were aware of, and understood, the bed-hold policy and duration.[7] In Petitioner's view, its procedure of orally going over the bed-hold policy with residents at the time of transfer, and having residents actually exercise their right to the seven-day bed hold before they left the facility, benefitted the residents because it eliminated the risk that they would forget to exercise their right to a bed hold within the

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[7] Petitioner's position is that its practice exceeds the requirements of CMS' policy that it is sufficient to simply put a copy of a written notice in the packet of paperwork that accompanies a resident to the hospital with no requirement for an oral explanation of the bed-hold policy or duration to the resident or representative at the time of transfer. State Operations Manual, app. PP, Tag F205.

24-hour period that the California regulation required. Petitioner contends that its system protected its residents' rights and eliminated any potential for harm that could result from the failure to exercise the right to a bed hold since the residents had already exercised such right. I conclude this argument has merit. Petitioner contends further that, since Residents 1, 2, 3, and 4 had already exercised their bed-hold rights prior to transfer, it would have been redundant to give them a written notice explaining their right to exercise the bed hold. While I agree that it is redundant to give a written notice after exercise of the right, written notice is what the law required. Petitioner could have avoided the cost of this enforcement action had it simply complied strictly with the regulation. Finally, with respect to Resident 1, Petitioner argues that CMS has failed to establish a nexus or connection between Petitioner's failure to give him a written notice at the time of transfer and any alleged harm suffered by Resident 1. I agree for the reasons already discussed.

Petitioner's violation of 42 C.F.R. § 483.12(b)(2) did not pose a risk for more than minimal harm and, therefore, did not amount to noncompliance. Accordingly, I conclude that Petitioner remained in substantial compliance, and no enforcement remedy is authorized or reasonable in this case.

III. Conclusion

For the foregoing reasons, I conclude that Petitioner remained in substantial compliance, and there is no basis for the imposition of an enforcement remedy.

/s/
Keith W. Sickendick
Administrative Law Judge