Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Appellate Division

In the Case of:	DATE: January 29, 2010
Senior Rehabilitation and Skilled Nursing Center,	
Petitioner,	Civil Remedies CR1953 App. Div. Docket No. A-09-107
	Decision No. 2300
- v. -	
Centers for Medicare & Medicaid Services.	

FINAL DECISION ON REVIEW OF ADMINISTRATIVE LAW JUDGE DECISION

Senior Rehabilitation and Skilled Nursing Center (Senior Rehab) appeals the decision of Administrative Law Judge (ALJ) Carolyn Cozad Hughes in Senior Rehabilitation and Skilled Nursing Center, DAB CR1953 (2009) (ALJ Decision). The ALJ granted summary judgment in favor of the Centers for Medicare & Medicaid Services (CMS), sustaining a CMS determination that Senior Rehab was not in substantial compliance with Medicare participation requirements from June 2 through July 15, 2008. The ALJ affirmed as reasonable the civil money penalty (CMP) of $800 per day, resulting in a total penalty of $35,200.

For the reasons discussed below, we uphold the ALJ Decision granting summary judgment in favor of CMS.

Applicable Legal Authority

To participate in Medicare, a skilled nursing facility (SNF) must comply with the requirements in 42 C.F.R. Part 483, subpart B. A facility's compliance with the participation requirements is assessed through surveys performed by state health agencies. Section 1819 of the Social Security Act[1] (Act); 42 C.F.R. Parts 483, 488, and 498.

"Substantial compliance" means a level of compliance with the participation requirements "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. "Noncompliance" is defined as "any deficiency that causes a facility to not be in substantial compliance." Id.

CMS may impose remedies against a facility that is not in substantial compliance with the participation requirements. 42 C.F.R. §§ 488.408, 488.440(a). CMS determines the seriousness of each deficiency found during a survey in order to select the appropriate remedies, if any, to impose on the facility. See 42 C.F.R. § 488.404. The level of seriousness is based on an assessment of scope (whether the deficiency is isolated, a pattern, or widespread) and severity (the degree of harm, or potential harm, to resident health and safety posed by the deficiency). Id. The highest level of severity is "immediate jeopardy," defined at section 488.301 of the regulations as "a situation in which the provider's noncompliance . . . has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident."

CMS may impose a CMP for "either the number of days a facility is not in substantial compliance" (a per-day CMP), or "for each instance that a facility is not in substantial compliance" (a per-instance CMP). 42 C.F.R. § 488.430(a). If a per-day CMP is imposed for noncompliance at less than the immediate jeopardy level, the CMP must be set within the range of $50 to $3,000 per-day. 42 C.F.R. § 488.438(a)(1)(ii).

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

Standards for Summary Judgment

Summary judgment is appropriate when 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. Kingsville Nursing and Rehabilitation Center, DAB No. 2234, at 3 (2009), citing Celotex Corp. v. Catrett, 477 U.S. 317, 322-25 (1986). While the Federal Rules of Civil Procedure (FRCP) are not binding in this administrative appeal, we are guided by those rules and by judicial decisions on summary judgment in determining whether the ALJ properly granted summary judgment. See Thelma Walley, DAB No. 1367 (1992). The ALJ told the parties that she would decide motions for summary judgment relying on the principles of FRCP 56. Acknowledgment and Initial Pre-Hearing Order at 4-5.

The party moving for summary judgment bears the initial burden of showing that there are no genuine issues of material fact for trial and that it is entitled to judgment as a matter of law. Kingsville at 3, citing Celotex, 477 U.S. at 323. If the moving party carries its initial burden, the non-moving party must "come forward with 'specific facts showing that there is a genuine issue for trial.'" Matsushita Elec. Industrial Co. v. Zenith Radio, 475 U.S. 574,587 (1986) (quoting FRCP 56(e)). To defeat an adequately supported summary judgment 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. Id. at 586, n.11; Celotex, 477 U.S. at 322. In determining whether there are genuine issues of material fact for trial, 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. U.S. v. Diebold, Inc., 369 U.S. 654, 655 (1962).

Standard of Board Review

Whether summary judgment is appropriate is a legal issue that we address de novo. Lebanon Nursing and Rehabilitation Center, DAB No. 1918 (2004). In reviewing whether there is a genuine dispute of material fact, we view the proffered evidence in the light most favorable to the non-moving party. Kingsville at 4, and cases cited therein. The standard of review on a disputed conclusion of law is whether the ALJ decision is erroneous. Departmental Appeals Board, Guidelines--Appellate Review of Decisions of Administrative Law Judges Affecting a Provider's Participation in the Medicare and Medicaid Programs, http://www.hhs.gov/dab/divisions/appellate/guidelines/prov.html.

Background

The following background information is drawn from the ALJ Decision and the record and is not intended to substitute for or modify any of the ALJ's findings.

Senior Rehab is a SNF located in Port Arthur, Texas that participates in the Medicare program. On June 12, 2008, the Texas Department of Aging and Disability Services (State agency) completed a complaint/investigation survey of Senior Rehab. Based on the survey findings, CMS determined that Senior Rehab was not in substantial compliance with the following participation requirements:

- 42 C.F.R. § 483.10(b)(11) (Resident Rights: Notification of Changes);
- 42 C.F.R. § 483.25(a)(3) (Quality of Care: Activities of Daily Living); and
- 42 C.F.R. § 483.25(c) (Quality of Care: Pressure Sores).[2]

P. Ex. 5; CMS Ex. 1. In its July 30, 2008 determination notice, CMS advised Senior Rehab that it was imposing a CMP of $800 per day against the facility, beginning June 2, 2008. CMS Ex. 1.

CMS subsequently determined that Senior Rehab returned to substantial compliance on July 16, 2008. CMS Exs. 1, 3; P. Exs. 1, 2, 5. In a September 10, 2008 notice, CMS advised Senior Rehab that the CMP was effective from June 2, 2008 through July 15, 2008, resulting in a total penalty of $35,200. P. Ex. 1.

Senior Rehab timely requested an ALJ hearing to contest CMS's determination. CMS thereafter moved for summary judgment. Senior Rehab opposed CMS's motion. On May 18, 2009 the ALJ granted summary judgment in favor of CMS and upheld the CMP based on conclusions that the facility failed to comply substantially with sections 483.10(b)(11) and 483.25(c). Senior Rehab timely appealed the ALJ Decision to the Board.[3]

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[2] CMS also determined that the facility failed to comply substantially with 42 C.F.R. §§ 483.20, 483.20(b) (Resident Assessment), but this finding was removed during the informal dispute resolution process. CMS Ex. 12, at 7.

[3] The record on appeal includes Senior Rehab's Notice of Appeal (P. Br.) and CMS's Response. The Board denied Senior

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Analysis

Senior Rehab argues that the ALJ failed to follow the summary judgment standards by granting CMS's motion "based exclusively upon evidence provided by the three [State agency] surveyors in the face of contravening and undisputed medical records and affidavits." P. Br. at 1. The ALJ Decision, Senior Rehab contends, "completely dismisses . . . contemporaneous and unchallenged medical evidence and testimony." Id. at 1-2. Senior Rehab also alleges that the ALJ Decision "represents a breach of fundamental fairness by depriving Senior Rehab of a hearing" and the right to cross-examine the surveyors. Id. at 2, 16.

According to Senior Rehab, this case is similar to Madison Health Care, Inc., DAB No. 1927 (2004). The Board remanded the Madison case on appeal from an ALJ decision granting summary judgment in favor of CMS after concluding that "the ALJ appeared to treat as uncontested assertions by CMS about which the record contained at least some conflicting evidence." P. Br. at 3, quoting DAB No. 1927, at 10. Senior Rehab contends that here, likewise, "the ALJ found each of CMS's assertions to be 'undisputed' facts in spite of evidence to the contrary . . . ." P. Br. at 4. Senior Rehab argues that we should remand this matter "because the ALJ, in a conclusory fashion, acted in the same manner and with the same inappropriate rationale, observations and inferences he made in Madison."[4] Id.

This case is distinguishable from Madison, however. Contrary to Senior Rehab's characterization, the ALJ here addressed the evidence submitted by the facility to contest CMS's allegations of noncompliance, construing it in the light most favorable to the facility. While resolving all genuine factual disputes in favor of the facility for purposes of her analysis, the ALJ nevertheless concluded that summary judgment was warranted based on material facts that Senior Rehab had not disputed which, in themselves, were adequate to support the determination that the facility was not in substantial compliance.

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Rehab's motion for leave to file its reply brief out of time.

[4] Senior Rehab incorrectly attributes the ALJ Decision in this case to ALJ Steven T. Kessel, the ALJ in Madison. P. Br. at 1, 4. As noted above, the ALJ in this case was ALJ Carolyn Cozad Hughes.

As we further explain below, Senior Rehab mistakes the conclusory opinions of its affiants for evidence of material fact. Senior Rehab itself observes that the "affiants for each side state that they reviewed the same survey findings, but reached opposite opinions." P. Br. at 7 (emphasis in original). This apt description in itself demonstrates why the case was suited for summary judgment -- there was no genuine dispute of material fact, but opposing conclusions as to whether, applying the regulatory requirements to the undisputed facts, the facility was or was not in substantial compliance. Here, the ALJ properly undertook such an analysis and, as discussed below, correctly concluded that Senior Rehab was not in substantial compliance with the requirements at 42 C.F.R. §§ 483.10(b)(11) and 483.25(c).

Below, we first address Senior Rehab's arguments and the evidence regarding the facility's compliance with the physician consultation requirement at section 483.10(b)(11). We next address the evidence and arguments concerning the facility's compliance with the quality of care requirements on pressure sores at section 483.25(c).[5] We then discuss the penalty imposed

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[5] Senior Rehab's brief also contests CMS's determination that the facility did not comply substantially with section 483.25(a)(3) (at scope and severity level "E") based on the failure to provide timely incontinent care to three residents. P. Br. at 11-12; P. Ex. 5, at 39. The ALJ did not address whether Senior Rehab was in substantial compliance with section 483.25(a)(3), noting that it was within her discretion to limit her decision to findings necessary to support the remedies imposed. ALJ Decision at 8, n.8, citing Batavia Nursing and Convalescent Center, DAB No. 1904, at 23 (2004); Beechwood Sanitarium, DAB No. 1824, at 19 (2002). On appeal, Senior Rehab does not argue that the ALJ was required to affirm this lower-level noncompliance finding in order to uphold the remedies imposed, or that it was prejudiced because the ALJ did not address this deficiency. Nor does Senior Rehab argue that a finding of compliance with that section would have affected the outcome of the decision. Accordingly, we see no need to revisit the issue here. We note, however, that Senior Rehab's discussion of its compliance with section 483.25(a)(3) refers to the sworn statement of Nurse Dana Banks about the incontinent care provided to R26 and R131. P. Br. at 11-12. Since Nurse Banks' statement also is relevant to whether the facility complied substantially with section 483.25(c), we discuss it under section two of our analysis below.

for the facility's noncompliance. Finally, we address the facility's argument that it is entitled to a hearing in order to cross-examine the state surveyors and challenge the survey findings.

1. The ALJ did not err in concluding that undisputed facts establish that Senior Rehab was not in substantial compliance with 42 C.F.R. § 483.10(b)(11).

Among the standards that a facility must meet to participate in Medicare is the physician consultation requirement at section 483.10(b)(11), which provides in part:

> Notification of changes. (i) A facility must immediately . . . consult with the resident's physician . . . when there is--
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> . . .
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> (B) A significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); [or]
> (C) A need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment) . . . .

CMS's interpretation of the regulation, set forth in Appendix PP of the CMS State Operations Manual (SOM), states that "[c]linical complications are such things as development of a stage II pressure sore, onset or recurrent periods of delirium, recurrent urinary tract infection, or onset of depression." [6] The Board has previously stated that the physician consultation requirement "is not a mere formality;" it ensures a resident's right to timely receive the treating physician's input as to the care required under the circumstances. Britthaven of Goldsboro, DAB No. 1960, at 11 (2005).

In this case, the evidence shows, and Senior Rehab does not contest, that Resident 26 (R26) was a 72-year-old female diagnosed with organic brain syndrome, dysphagia, hypertension, convulsions and a history of stroke. CMS Ex. 6, at 5, 10, 14-18. R26 was unable to speak and completely dependent on staff for all activities of daily living. Id. at 16, 19. By

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[6] The SOM is available at http://www.cms.hhs.gov/manuals.

physician order, she received medications, nutrition and hydration via a gastric tube in her stomach. Id. at 10-11, 17, 19. Senior Rehab documented that R26 was at "high risk" for pressure sores. Id. at 21. R26 had pressure sores on her coccyx and left inner knee when she was re-admitted to the facility in January 2008 following a hospital stay for the treatment of a urinary tract infection. Id. at 31-32. On re-admission, R26 was prescribed an "indwelling catheter to promote wound healing" of the coccyx sore. Id. at 31. Her care plan goal relating to the catheter was that she would not experience a urinary tract infection. Id. Over time, the coccyx wound did not heal and R26 developed stage II pressure sores in other areas. Id. at 43-45, 58. Senior Rehab's policy, "Prevention of Pressure Ulcers," states that pressure sores "are often made worse by [numerous factors,] including decline in nutrition and hydration status." CMS Ex. 9, at 1.

The evidence also shows, and Senior Rehab does not dispute, that between March and April 2008, R26 experienced a weight loss of nine pounds (from 93.6 pounds to 84.6 pounds), or 9.6 percent of her body weight. Id. at 8-9. Senior Rehab's consultant dietician was apprised of the weight loss and addressed it in an April 17, 2008 dietary progress note. Noting the amount of the weight loss, R26's ideal body weight and her body mass index, the dietician described R26 to be "at risk." Id. The dietician's note pointed out that R26 had a pressure sore on her right back and a stage IV coccyx wound. Id. In response to these factors, the dietician recommended an increase in R26's nutritional intake, that staff be reminded to turn on R26's feeding tube "in a timely manner," and that R26 be weighed weekly. The record further reflects, and Senior Rehab acknowledges, that staff did not notify R26's physician of her weight loss or of the dietician's recommendations until May 7, 2008, more than three weeks after the weight loss was documented and the dietician made recommendations responding to it. Id. at 8; P. Ex. 28.

Applying the physician consultation requirement at section 483.10(b)(11)(i) to the foregoing facts, the ALJ concluded that Senior Rehab was not in substantial compliance with the participation standard because "undisputed facts . . . . establish that the facility did not immediately consult the resident's attending physician following a significant change in her condition." ALJ Decision at 7. The ALJ stated that, as a consequence of the facility's failure to meet the regulatory requirement, "R26's care plan was not amended to address the weight loss problem until May 6, and the new care plan [which directed staff to 'obtain dietary consult if needed' and 'assess

for need to change dietary consistency'] was obviously developed without regard to the dietician's recommendations and without attending physician input (since the physician had not yet been notified of the problem)." Id. at 5, citing CMS Ex. 6, at 36.

In reaching the conclusion that summary judgment was appropriate, the ALJ stated that Senior Rehab "tender[ed] no evidence showing that a factual dispute exist[ed] with respect to its fulfilling its obligation to consult R26's attending physician about her weight loss and the dietician's recommendations." ALJ Decision at 5. The ALJ noted that the Board has read the term "immediately" in the regulation to mean "as soon as the change . . . is detected, without any intervening interval of time." Id., citing Magnolia Estates Skilled Care, DAB No. 2228, at 8 (2009); The Laurels at Forest Glenn, DAB No. 2182, at 13 (2008). Here, the ALJ observed, the affidavit of R26's treating physician confirmed that he was not "apprised" of R26's weight loss or of the dietician's April 17 report and recommendation until May 7, 2008. ALJ Decision at 5, quoting P. Ex. 28. Moreover, the ALJ stated, Senior Rehab did "not allege that it did anything other than 'communicate' or 'inform'" the physician on May 7. Id. The physician consultation regulation, however, "requires a dialogue with a responsive directive from the resident's physician as to what actions are needed; it is not enough to merely notify the physician of the resident's change in condition." ALJ Decision at 5, quoting Magnolia at 9.

On appeal, Senior Rehab argues that summary judgment was not appropriate because the affidavits of William George, M.D. (R26's treating physician), and Dana Banks, R.N. (the Director of Nursing), create a factual dispute as to whether the facility complied substantially with the physician consultation requirement. Specifically, Senior Rehab cites Dr. George's sworn statement that the "facility, in [his] opinion, provided adequate care" to R26 and "kept [him] reasonably and timely informed about her care needs and changes in health condition." P. Br. at 8, quoting P. Ex. 28. Senior Rehab also cites Dr. George's statement that R26's "skin wounds . . . were medically unavoidable due to her compromised circulation and other underlying diseases." Id. Similarly, Senior Rehab relies on Nurse Banks' statement that the "fact that Resident #26's physician, Dr. George, declined to increase her tube feedings . . . as recommended by the dietician did not cause or contribute to this resident's weight loss and/or skin breakdown" and that R26 "was already receiving adequate nutrition . . . ." P. Ex. 29, at 2.

These sworn statements do not provide a basis for reversing the ALJ Decision. As the ALJ accurately explained in addressing Dr. George's affidavit, the physician's statements that the facility provided "adequate" care and kept him "reasonably and timely informed" are conclusions reflecting the doctor's individual opinion, not evidence of material facts under the governing regulation. ALJ Decision at 5, citing P. Br. at 7, P. Ex. 28; Guardian Health Care Center, DAB No. 1943, at 11 (2004) (holding that statements that a facility provided "effective," "appropriate," or "aggressive" interventions were "conclusory in nature," not tied to evidence of specific facts, and "insufficient to create a genuine factual dispute"). Indeed, whether a facility substantially complied with section 483.10(b)(11)(i) is not a question of whether, in the opinion of a particular treating physician, the physician was "reasonably and timely informed" about the resident's status or whether the care provided was "adequate." Rather, under the language of the regulation, the relevant issue here is whether there was a "significant change in the resident's physical, mental, or psychosocial status" - that is, "a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications," and if so, whether the facility "consulted" with the attending physician "immediately" about the change. See, e.g., Magnolia at 8; The Laurels at Forest Glenn at 11-13. Dr. George's statement simply does not address whether R26's unplanned and substantial weight loss under the particular circumstances here evidenced a significant change in R26's health status under the regulation, nor does it explain how a delay of three weeks in even notifying him could be considered to comply with a standard requiring immediate consultation.

Indeed, Senior Rehab does not argue, or proffer evidence to dispute, that R26's unplanned loss of nearly ten percent in body weight between March and April 2008, considered in the context of her clinical complications and in light of the dietician's evaluation, was not a "significant change" in physical status within the meaning of the regulation.[7] Nor does Senior Rehab

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[7] In addition to the uncontested facts in the record supporting the ALJ's finding that R26 experienced a significant change in physical status, we note that Appendix PP of the SOM states that an unplanned weight loss of five percent in a single month is "significant," and that a loss of more than five percent in a single month is "severe." Cf. Claiborne-Hughes Health Center, DAB No. 2179 (2008) (upholding an ALJ determination that a resident had suffered a significant change

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claim that notifying Dr. George more than three weeks after the facility detected R26's weight loss qualifies as "immediate" consultation. Accordingly, we conclude, the ALJ did not err in determining that she "need not accept" Dr. George's conclusory opinions about the adequacy of Senior Rehab's care of R26 and notifications to him about her condition "for purposes of summary judgment" under the applicable regulatory standard. ALJ Decision at 5.

The ALJ also addressed Nurse Banks' statement that R26 "was already receiving more than adequate nutrition" and Dr. George's opinion that R26 "was receiving adequate nutrition and fluids without the increase recommended." ALJ Decision at 6-7; P. Ex. 29, at 2; P. Ex. 28. Applying the governing legal standard, the ALJ "accept[ed] these assertions as true for purposes of summary judgment." ALJ Decision at 6. The ALJ explained, however, that the statements were immaterial since they would not impact the outcome of the case. Even if R26's physician "might well have had sound reasons for rejecting the dietician's recommendations," the ALJ stated, "failing to consult R26's attending physician about her dramatic weight loss risked her health and safety and presented the potential for more than minimal harm." ALJ Decision at 6. Further, the ALJ concluded, "while fortuitous that Dr. George ultimately concurred (at least temporarily)[[8]] with the actions (or inaction) taken by facility staff without his knowledge or approval, . . . reject[ing] an expert's recommendation without input from the attending physician . . . poses a risk to resident health and safety and presents the potential for more than minimal harm." Id. at 6-7.

We agree that Dr. George's affidavit did not raise a genuine dispute of material fact. Since the question of whether summary judgment is appropriate is a legal issue that we address de novo, we accept as true that R26's nutritional intake was more than adequate without the recommended increase in nutrition and fluids. We further accept as true for purposes of summary

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in physical condition under section 483.10(b)(11) when the resident's food intake declined and weight dropped from 135 to 116.5 pounds over a five-week period).

[8] The ALJ noted that on June 2, 2008 the physician ordered an increase in R26's nutritional intake to "62 cc/hr per dietary recommendation." ALJ Decision at 6, n.7, citing CMS Ex. 6, at 62.

judgment Dr. George's assertion that R26 "did not suffer any actual harm and was not in jeopardy of potential harm *due to not receiving the increase in feedings recommended*" by the dietician. P. Ex. 28 (emphasis added). Even accepting these assertions as true, however, they are not probative. That is, the issue of substantial compliance here is not whether Senior Rehab's *failure to increase R26's feedings* posed the potential for more than minimal harm, but whether the facility's *failure to immediately consult with the physician*, as required, had that potential given the resident's medical history and identified clinical risks. As reflected in the facility records and Dr. George's affidavit itself, R26 had a "complex underlying medical condition," was cognitively and physically severely impaired, was at "high risk" for pressure sores, and at the time of her admission weighed only 92 pounds. P. Ex. 28; CMS Ex. 6, at 5, 9-11, 15-27. At "92% of IBW [ideal body weight]" and with a "BMI [body mass index] of 19," the dietician noted, R26 was "[at] risk." CMS Ex. 6, at 6. These uncontested facts provide ample support for the ALJ's finding that the facility's failure to obtain immediately the physician's assessment and evaluation of the resident's sudden and severe unplanned weight loss placed an already compromised and vulnerable resident at risk of more than minimal harm, even if the response might not have been to increase feedings immediately. Moreover, Dr. George's post hoc assertion that he did "not attribute the lack of [the] recommended additional feedings to [R26's] weight loss," begs the question of whether the doctor, had he been timely consulted, might have determined the factors at issue in R26's significant change in status and immediately ordered other interventions or changes in R26's treatment.

Finally, in concluding that Senior Rehab failed to substantially comply with the physician consultation requirement at section 483.10(b)(11), we recognize that such consultation might not have ensured a positive outcome for R26. As the preamble to the 1989 final rule states, "a facility cannot ensure that the treatment and services will result in a positive outcome since outcomes can depend on many factors, including . . . disease processes." 54 Fed. Reg. 5316, 5332 (1989). Nevertheless, as a participant in the Medicare program, Senior Rehab had an affirmative duty to consult R26's physician immediately, and R26 had a right to have her physician directly involved in her medical care, under the undisputed circumstances here.

2. The ALJ did not err in concluding that uncontested evidence establishes that Senior Rehabilitation was not in substantial compliance with 42 C.F.R. § 483.25(c).

The participation requirement on pressure sores is part of the quality of care standards at 42 C.F.R. § 483.25. Under the regulation, a facility must provide to each resident "the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care." 42 C.F.R. § 483.25; see also Act § 1819(b). Thus, the plain language of the regulation requires a facility to provide all of the services set forth in each resident's care plan, which reflects the facility's own determination of the care necessary to attain or maintain that resident's highest practicable well-being. See, e.g., Sheridan Health Care Center, DAB No. 2178, at 15 (2008). The Board also has held that it is reasonable to "rely on a facility policy as evidence of the provider's own judgment as to what must be done to attain or maintain its residents' highest practicable physical, mental and psychosocial well-being, as required by section 483.25." Id.

The subsection on pressure sores states:

> (c) Pressure sores. Based on the comprehensive assessment of a resident, the facility must ensure that--
> (1) A resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and
> (2) A resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.

This section, the Board has held, imposes a duty on facilities to "go beyond merely what seems reasonable, to, instead, *always furnish what is necessary* to prevent new sores unless clinically unavoidable, and to treat existing ones as needed." Koester Pavilion, DAB No. 1750, at 32 (2000)(emphasis added). Explaining the regulation's requirements, the SOM states that each facility should have a system in place to ensure that pressure sores are timely and appropriately assessed in order to evaluate the efficacy of existing treatment and prevention measures, especially when the resident develops new sores in the course of treatment. SOM App. PP, Tag 157.

According to Senior Rehab's pressure sore prevention policy statement, pressure sores "are often made worse by continual pressure, heat, moisture, irritating substances on the resident's skin (i.e. perspiration, feces, urine, wound

discharge, soap residue, etc.), decline in nutritional and hydration status, acute illness and/or decline in the resident's physical and/or mental condition." CMS Ex. 9, at 1. Thus, the policy states with respect to incontinence that skin should be cleaned "as soon as soiled" and that urine leaks must be assessed and treated. Id. at 2; see also CMS Ex. 12, at 4 (Surveyor McElroy statement that the "prevention or healing of pressure ulcers requires scrupulous and continuous attention to . . . avoiding maceration from continuous moisture and contact with the skin-erosive contents of urine, feces and bacteria").

As noted above and acknowledged by Senior Rehab, R26 was at "high risk" for pressure sores, and she had pressure sores on her coccyx and left inner knee when she was re-admitted to the facility in January 2008.[9] R26's coccyx pressure wound did not heal, and she developed additional pressure sores over time. In April, R26 was documented as having developed a nonstageable pressure sore on her right lower back. CMS Ex. 6, at 48, 49, 52. By May, she also had developed a pressure sore on her right hip. P. Ex. 15, at 9. At the time of the June survey, Surveyor Gill found R26's coccyx wound "tunneling (a narrow channel or passageway extending into healthy tissue)." CMS Ex. 13, at 2. R26 also had a pressure sore on her lower back, stage II pressure sores on her left and right hips, a stage II pressure sore on her left elbow, and a stage I pressure sore on her left lateral foot. CMS Ex. 6, at 43, 44, 45, 48, 57, 58; CMS Ex. 13, at 2.

The ALJ Decision describes in detail the facility's assessments of, and care plans for, R26's pressure sores between January and

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[9] Senior Rehab's brief on appeal also addresses the pressure sore care provided to R92 and R100. The ALJ did not address the care provided to those two residents because, she concluded, "the deficiencies in the care provided to R26, by themselves, justify the penalties imposed." ALJ Decision at 8, citing Batavia at 23; Beechwood at 19. As explained more fully below, we agree with the ALJ that the deficiencies in the care provided to R26 were sufficient to support the penalty imposed. We note, however, that Senior Rehab has not denied that at the time of the survey: R100 had a pressure wound and dressing on his right hip; he was observed lying in bed on his right side; there was a sign on the wall above his bed that said "do not position on R [right] side," and the facility's policy on the treatment of pressure sores explicitly states, "[a]void positioning the resident on a pressure ulcer." CMS Ex. 3, at 16; CMS Ex. 8, at 4, ; CMS Ex. 9, at 5.

June 2008. ALJ Decision at 9-12. While we do not repeat all of that information here, we note in particular that R26's general care plan, originally dated January 24, 2008, and updated monthly thereafter, stated that R26 had an indwelling catheter "to promote wound healing [due to] unstageable decub[itus ulcer] to coccyx." CMS Ex. 6, at 31; P. Ex. 13, at 3. That care plan also directed staff to provide incontinent care every two hours *and as needed*, "washing and drying skin thoroughly and applying moisture barrier ointment;" conduct "ongoing assessment of skin for [signs and symptoms of] redness or breakdown;" and "frequently assess skin for signs/symptoms of breakdown or injury . . . ." CMS Ex. 6, at 31-32, 35 (emphasis added). In addition, the care plan addressed R26's bowel incontinence by establishing the goal that R26 would "remain clean and odor free." CMS Ex. 6, at 35. It directed staff to meet this goal by, among other things, "check[ing the] resident frequently for incontinence" and "provid[ing] incontinent care every two hours and as needed." CMS Ex. 6, at 35.

Also important to note, an April 4, 2008 "skin - acute care plan," which identified a pressure ulcer on R26's "r[igh]t lower back," directed staff to "*assess [that] wound daily.*" Id. at 40 (emphasis added). An April 11, 2008 acute skin care plan addressing the ulcer on R26's coccyx directed staff to assess that wound daily as well. Id. at 39. The facility records, however, include assessments of these wounds on only two other days in April and six days in May. CMS Ex. 6, at 46-55; P. Ex. 15, at 1-10. (A log titled "Weekly Focused Assessments for Skin Integrity" indicates the wounds were treated on May 12, 19 and 26, but provides no actual assessments. CMS Ex. 6, at 61.)

According to the SOD and Surveyor Gill's sworn statement, when the survey began on June 2, 2008, the surveyor also observed pressure sores on R26's left hip, both feet and left elbow that the facility had not yet assessed. CMS Ex. 3, at 10; CMS Ex. 13, at 2. The SOD states that on the morning of June 2, the surveyor observed R26 -

> . . . lying in bed in a fetal position on her right side. The resident had a Foley catheter and had dressings on the coccyx, right mid back and both hips. The resident's incontinent pad was wet with brown drying edges that almost covered the entire pad. At this time, the LVN staff A was asked if the ring and odor was from draining pressure sores or urine. She stated it smelled like urine.

CMS Ex. 3, at 8; see also CMS Ex. 13, at 3 (statement of Surveyor Gill that R26 was lying "on an incontinent pad that had a drying brown ring and with a foul urine odor").

Based on the proffered exhibits, sworn statements, and the parties' arguments, the ALJ determined that uncontested evidence established that Senior Rehab failed to comply substantially with section 483.25(c). ALJ Decision at 7. Specifically, the ALJ determined, "uncontroverted evidence establishes that staff did not consistently follow care plan instructions and . . . allowed a vulnerable resident [R26] to lie for up to two hours on a urine and feces contaminated incontinent pad." Id. Thus, the ALJ concluded, Senior Rehab was "not taking all necessary precautions to promote healing, prevent infection, and prevent new pressure sores from developing, as required by [the regulation], and CMS is entitled to summary judgment on that issue." Id.

On appeal, Senior Rehab argues that the ALJ's summary judgment determination should be reversed because the facility's evidence demonstrates that it "took measures, adequate and reasonable under the circumstances, to provide the necessary treatment and services [under the regulation]." P. Br. at 11. Specifically, Senior Rehab cites Dr. George's statement that, in his "opinion, the development of [R26's] skin wounds located on her feet, left elbow, hips and coccyx were medically unavoidable due to her compromised circulation and other underlying diseases." P. Br. at 10-11, citing P. Ex. 28. Senior Rehab also relies on Nurse Banks' statements that: the facility evaluated the resident "to be at high risk for pressure ulcers;" "[c]are related goals and approaches were care planned" for R26; actual pressure sores and R26's risk for skin breakdown "were care planned initially and regularly updated based upon changes in care needs;" and "weekly skin assessments were conducted and acted upon." P. Br. at 9, citing P. Ex. 29, ¶7.

Senior Rehab further cites the affidavit of Registered Nurse Lisa Jackson. Nurse Jackson's statements in part respond to the survey finding that "there were no weekly skin assessments in the resident's clinical record or treatment book regarding the pressure sores on the elbow, bilateral hips, and feet." P. Br. at 10, citing P. Ex. 27, at ¶4. According to Nurse Jackson, "there would have not been weekly skin assessments for the elbow, the left hip and the feet since these areas were new." Id. Senior Rehab further quotes from Nurse Jackson's sworn statement that the "facility took reasonable measures to prevent" the development of pressure sores and "mitigate deterioration of existing wounds" by assessing, care planning,

monitoring, and implementing necessary interventions, as reflected in the care and services relating to R26's "right inner leg ulcer." P. Br. at 10, citing P. Ex. 27, at ¶5, ¶7.

These sworn statements were addressed by the ALJ and do not warrant reversal of her determination. With respect to Dr. George's statement, the ALJ accepted as true for purposes of summary judgment that the pressure sores that R26 developed were clinically unavoidable. ALJ Decision at 8. Nevertheless, the ALJ correctly stated, such a factual finding would not relieve Senior Rehab of its responsibility under section 483.25(c) to furnish all of the care and services necessary to promote healing, prevent infection, and prevent other pressure sores from developing, consistent with the resident's own care plan.

With respect to the nurses' sworn statements, the ALJ noted that CMS did "not dispute the existence of some assessments and care plans." Id. at 8. While R26's general care plan directed staff to conduct ongoing and frequent skin checks, the ALJ accurately observed, the directions were "ambiguous about how frequently staff were supposed to perform skin checks." Id. at 12, citing CMS Ex. 6, at 31, 35. Thus, for purposes of summary judgment, the ALJ also "allow[ed] that a weekly skin assessment could be consistent with R26's [general] care plan for skin assessments." Id. In addition, the ALJ accepted as true Nurse Jackson's implication that "not one of the four additional wounds [she described] was detectable on or before May 23, the date of the last weekly skin assessment prior to the surveyor observations of June 2." Id. Even accepting these assertions, however, the ALJ concluded that "undisputed evidence establishes that the facility was not in substantial compliance because its staff did not consistently follow the instructions" in all of R26's care plans. Id. at 9.

We agree. Nurse Jackson's affidavit does not address R26's right hip wound, which was first documented May 5. P. Ex. 15, at 9. There is no evidence that that wound was assessed weekly since it was next documented May 29. Id. at 10. Furthermore, the June 6 weekly skin report indicates that a "right hip abrasion" was found on April 28. CMS Ex. 11, at 14. Yet it was not mentioned in the weekly reports of May 2, May 9, May 16, or May 23, suggesting, as the ALJ concluded, that "staff were not adequately conducting weekly skin assessments in accordance with R26's care plan." ALJ Decision at 12, citing CMS Ex. 11, at 3, 6, 9, 12.

Moreover, Senior Rehab does not take exception to the ALJ's conclusion that it was undisputed that R26's April 4 and 11

acute care plans explicitly directed staff to conduct *daily* assessments of the pressure sores on R26's coccyx and back. CMS Ex. 6, at 39, 40. Yet, the ALJ accurately stated, the facility "present[ed] no evidence - indeed does not claim - that staff followed the care plans in this regard." ALJ Decision at 12. Thus, undisputed material facts support the ALJ's conclusion that the facility failed to provide all of the skin care checks and pressure ulcer assessments called for under R26's care plans, as required under the quality of care regulation.

Furthermore, Senior Rehab does not deny that on June 2, 2008, R26 was observed lying on a wet incontinent pad with a drying brown ring and a foul urine odor.[10] In response to the observation, the facility cites Nurse Banks' sworn statement that staff was required to provide incontinent care every two hours and that the circumstances in which R26 was observed "do not necessarily indicate the facility failed to provide incontinent care within a two hour period." P. Br. at 11-12, citing P. Ex. 29, ¶6. "The words 'drying' and 'wet' used to describe the urine, feces and brown ring [in the descriptions of R26 and R131]" Nurse Banks stated, "indicates [sic] the . . . urine could have just as easily been a recent occurrence (i.e. less than two hours old)." Id.

Even assuming that facility staff had provided incontinent care to R26 within two hours of the surveyor's observation of R26, this would not absolve the facility of its responsibilities under the quality of care regulation. The record shows, and Senior Rehab does not dispute, that R26's care plan required not only that she be provided incontinent care every two hours but also *as needed.* Moreover, R26 was prescribed an indwelling catheter to prevent her skin from coming into contact with "the skin-erosive contents of urine" altogether. CMS Ex. 12, at 4. Indeed, the facility's own policy required staff to "[m]ake sure that there is no disconnection or leaking of urine from the [catheter] system (except into the drainage bag)." CMS Ex. 9, at 7. Thus, the fact that R26 was lying on a urine-soaked incontinent pad for any duration of time was evidence, in itself, that the facility was not providing incontinent care as needed and was not ensuring that the catheter was functioning as called for under R26's care plan and the facility's own policy.

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[10] The ALJ's description of R26's incontinent pad as contaminated by feces (in addition to urine) appears to have been based only on Surveyor Gill's observation of Resident 131. See CMS Ex. 13, at 3. We find uncontested, however, the evidence that R26's incontinent pad was contaminated by urine.

Accordingly, we sustain the ALJ's determination on CMS's motion for summary judgment that Senior Rehab failed to substantially comply with section 483.25(c) because undisputed material facts establish that it did not take all necessary precautions to promote healing, prevent infection, and prevent new sores from developing as called for under R26's care plans and facility policies.[11]

3. The ALJ did not err in concluding that the CMP imposed is reasonable in amount.

When a per-day CMP is imposed based on a finding of noncompliance at less than the immediate jeopardy level, the CMP must be set within the range of $50 to $3,000 per day. 42 C.F.R. § 488.438(a)(1)(ii). To determine the amount of a CMP, CMS and the ALJ consider the factors listed at section 488.438(f), which are: (1) the facility's history of noncompliance; (2) the facility's financial condition; (3)

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[11] Senior Rehab also argues that a genuine dispute of material fact as to whether it was in "substantial compliance" was raised by Nurse Jackson's sworn statement that Senior Rehab "properly cared for and met the needs of [the residents]" and "took reasonable measures" to treat and prevent pressure sores. P. Ex. 27, at ¶7. Nurse Jackson also stated that, "[w]hile the facility did not provide perfect care, any shortcomings in this regard resulted in no more than the potential for minimal harm to the residents." Id. These generalized and conclusory opinions do not create a genuine dispute of material fact as to the risks posed by Senior Rehab's noncompliance with section 483.25(c). Nurse Jackson did not address the undisputed facts that the facility failed to fully implement R26's care plans or carry out the facility's own pressure sore and catheter care policies, as required by the quality of care regulation. Nurse Jackson also did not address the potential for harm posed by the facility's noncompliance with the physician consultation regulation. Finally, to the extent that Senior Rehab also seeks to challenge CMS's finding that the facility's noncompliance constituted substandard quality of care under section 498.3(b)(16) (substandard quality of care finding reviewable only if it leads to facility's loss of approval of its nurse aide training program), the ALJ properly declined to review that issue. ALJ Decision at 15, n.13. As the ALJ correctly stated, where, as in this case, the penalty imposed is greater than $5,000, the Act precludes approval of the training program regardless of the substandard quality of care finding. Act § 1819(f)(2)(B).

factors specified in 42 C.F.R. § 488.404; and (4) the facility's degree of culpability, which includes neglect, indifference, or disregard for resident care, comfort or safety. The factors specified in section 488.404 include the seriousness of the deficiency, the relationship among the deficiencies resulting in the noncompliance, and the facility's history of noncompliance in general and specifically with respect to the cited deficiencies.

The ALJ determined that the $800 per-day CMP, beginning June 2 and continuing through July 15, 2008, was reasonable based on the facility's history of noncompliance and its culpability. The ALJ assessed the facility's culpability based on the same undisputed facts relating to R26 that supported the findings of noncompliance under sections 483.10(b)(11) and 483.25(c) of the regulations. She also stated that the amount was "at the low end of the penalty range" and that the facility had not argued that its financial condition affected its ability to pay the penalty. ALJ Decision at 14.

Senior Rehab argues on appeal that the "Board has held [that] where '. . . the reasonableness of the amount' of a civil money penalty is 'at issue, an ALJ may not dispose of the case entirely on a summary judgment motion.'" P. Br. at 6, n.4, 13. (quoting Madison at 13). Further, the facility claims, "there is no evidence CMS considered" many of the factors it was required to take into account in assessing the penalty. Id. at 12-13.

These arguments have no merit. First, Senior Rehab's quotation from the Madison decision is incomplete and, as a result, inaccurate. In Madison, the Board stated that "where the duration of a per-day CMP or the reasonableness of the amount of the CMP are at issue, an ALJ may not dispose of the case entirely on a summary judgment motion *without considering whether there is a genuine dispute of fact material to resolving those issues.*" Madison at 21, quoting Lebanon at 5 (emphasis added). The Board has never held that under no circumstances may an ALJ resolve a case on summary judgment when the reasonableness of the CMP amount is contested. Here the ALJ did consider whether there was a genuine dispute of material fact as to any of the factors to be considered in determining whether the $800 per-day CMP was reasonable. The ALJ properly analyzed the issue under the summary judgment standard and concluded that the undisputed evidence as to the facility's history of noncompliance and culpability together supported the amount. ALJ Decision at 14-15.

We also reject Senior Rehab's contention that the ALJ's action should be reversed absent evidence that CMS took into account all of the regulatory factors in determining the penalty amount. The Board has held that, in evaluating whether a CMP amount is reasonable, the ALJ should not look into CMS's internal decision-making process. Rather, the ALJ must make a de novo determination as to whether the amount is reasonable applying the regulatory criteria to the record developed before the ALJ. See, e.g., Kingsville at 14-15. Thus, even without evidence as to how CMS took into account the regulatory factors to derive the penalty amount, the ALJ and the Board may evaluate whether the penalty is reasonable under the relevant factors.

Senior Rehab further argues that "there is no evidence to suggest the alleged deficiencies . . . were the result of indifference or disregard for resident care . . . or that Senior Rehab had a history of similar or repeated regulatory violations." P. Br. at 14. Senior Rehab also challenges CMS's determination of the June 2, 2008-July 15, 2008 noncompliance period, stating that any deficiency with the physician consultation requirement "had to occur prior to June 2" because Dr. George "had notice of the dietary issues by May 7." P. Br. at 14. Thus, Senior Rehab argues, "there is a fact issue as to whether the penalty can be supported by" the evidence relating to the physician consultation requirement. Id.

Senior Rehab's sweeping assertion that there is no evidence regarding the facility's noncompliance history or culpability is simply wrong. As discussed by the ALJ, Surveyor McElroy's sworn statements address the facility's history of noncompliance, including a prior finding of noncompliance with the physician consultation requirement. The surveyor pointed out that the facility was in its "sixth noncompliance cycle;" that this matter was the first enforcement action since April 2005; and that, in April 2008, surveyors "found a pattern of noncompliance with 42 C.F.R. § 483.10(b)(11) that caused no actual harm, but with the potential for more than minimal harm." ALJ Decision at 14, citing CMS Ex. 12, at 7; CMS Ex. 1. Senior Rehab does not deny the facts asserted by the surveyor.

Further, the undisputed facts establishing the facility's failure to comply substantially with the physician consultation and quality of care regulations, discussed in detail above and in the ALJ Decision, amply support the ALJ's culpability findings. We concur in the ALJ's determination that the facility showed disregard for R26's care, comfort, and safety. The facility failed to keep R26 clean and dry, failed to conduct all of the assessments called for in her various care plans, and

waited more than three weeks to notify her attending physician of her weight loss, despite the resident's severely compromised status, completely dependent status, and the risk of harm posed by the facility's inactions.

Accordingly, we see no error in the ALJ's determination that Senior Rehab's history of noncompliance and degree of culpability alone are sufficient to justify the $800 per-day CMP, which is in the lower third of the CMP range.

Finally, we reject Senior Rehab's challenge to the duration of the penalty period and the relationship of the penalty to that period. Section 488.440(a)(1) of the regulations provides that a per-day CMP may begin to accrue "as early as the date that the facility was first out of compliance, as determined by CMS or the State." Under section 488.454(a), "alternative remedies," including per-day CMPs, continue to accrue until "[t]he facility has achieved substantial compliance, as determined by CMS or the State based upon a revisit or after an examination of credible written evidence that it can verify without an on-site visit." Section 488.454(e) states that an alternative remedy may terminate on a date prior to a revisit survey if the facility "can supply documentation acceptable to CMS or the State survey agency that it was in substantial compliance" on that earlier date and was capable of remaining in substantial compliance.

In this case, while the undisputed evidence shows that the facility's noncompliance with the physician notification and pressure sores requirements began prior to the June 2008 survey, it was within CMS's discretion to elect the date on which the survey began as the starting date of the CMP period. Further, while Dr. George may have been given notice on May 7 of R26's significant weight loss, that fact alone does not establish that the facility returned to substantial compliance at that time. Based on the governing regulations, the Board has held that "a facility's noncompliance is deemed to be corrected or removed only when the incidents of noncompliance have ceased <u>and</u> the facility has implemented appropriate measures to ensure that similar incidents will not recur." <u>Florence Park Care Ctr.</u>, DAB No. 1931, at 30 (2004), citing <u>Lake City Extended Care Center</u>, DAB No. 1658, at 14 (1998). Here, Senior Rehab has not presented evidence to establish that, prior to July 16, 2008, it implemented all of the measures necessary to ensure that similar violations of the participation requirements would not recur.

Accordingly, we uphold the ALJ's determination that the $800 per-day CMP, imposed from June 2 through July 15, 2008 (total $35,200) was reasonable.

4. Senior Rehabilitation is not entitled to a hearing.

Finally, Senior Rehab argues that whether it "did or did not comply with these federal regulations, it is entitled to 'cross examine' the credibility of the State surveyors and the strength of their survey findings." P. Br. at 16. "Without this ability," the facility contends, it is deprived "of its property without procedural due process by stripping its right to notice, its right to be heard and its right to confront adverse witnesses." Id.

As the Board has previously explained, where there are no material factual disputes, an ALJ's consideration of undisputed facts alleged in surveyor affidavits to support a decision granting summary judgment in favor of CMS does not deprive the facility of any right to cross-examine surveyor-witnesses. Carrier Mills Nursing Home, DAB No. 1883, at 8-9 (2003). Furthermore, under FRCP 56, to which we look for guidance in determining whether an ALJ's use of summary procedures was proper, a party moving for summary judgment may submit an affidavit in support of its motion, and the adverse party may submit opposing affidavits. Id. In ruling on the motion, the judge must consider whether the pleadings, together with the affidavits and evidence, show that there is no genuine issue as to any material fact and that the moving party is entitled to judgment as a matter of law. Id.

In this case, Senior Rehab had the opportunity to dispute facts alleged in the surveyors' declarations when the facility filed its opposition to CMS's motion for summary judgment. Since Senior Rehab did not raise a genuine dispute as to the facts on which the ALJ relied in ruling on the motion, there was no reason to conduct an in-person hearing or permit cross-examination.

Conclusion

Based on the foregoing analysis, we affirm the ALJ Decision granting summary judgment for CMS and upholding the CMP.

/s/
Judith A. Ballard

/s/
Constance B. Tobias

/s/
Leslie A. Sussan
Presiding Board Member