Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Appellate Division

In the Case of:	
Chicago Ridge Nursing Center	DATE: February 6, 2008
Petitioner,	Civil Remedies CR1498 App. Div. Docket No. A-07-10
- v. -	Decision No. 2151
Centers for Medicare & Medicaid Services.	

FINAL DECISION ON REVIEW OF
ADMINISTRATIVE LAW JUDGE DECISION

Chicago Ridge Nursing Center (Chicago Ridge), a Medicare-participating skilled nursing facility (SNF), appeals a September 7, 2006 decision by Administrative Law Judge (ALJ) Anne E. Blair, Chicago Ridge Nursing Center, DAB CR1498 (2006) (ALJ Decision). Based on cross-motions for summary judgment, the ALJ concluded that CMS had lawfully denied Medicare payment to Chicago Ridge for residents that it admitted between January 27, 2005 and February 24, 2005. CMS had taken this enforcement action pursuant to section 1819(h)(2)(D) of the Social Security Act (Act),[1] which requires the Secretary of Health and Human Services (HHS) to deny payment for new admissions when the SNF has failed to come back into substantial compliance with Medicare requirements within three months after the date it is found to be noncompliant.

In this appeal, Chicago Ridge does not contend that disputed issues of material fact precluded summary judgment. Chicago

[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.

Ridge does contend that, in view of the undisputed facts, the denial of payment was unlawfully imposed because it came back into substantial compliance with Medicare requirements within three months after an October 2007 survey found it noncompliant.

Although we disagree with some of the ALJ's legal analysis, we agree with her that the denial of payment was lawfully imposed in this case. Accordingly, we affirm the imposition of that remedy, with the clarification that the denial of payment may be enforced from January 27, 2005 through (and including) February 23, 2005.

I. Legal Background

To participate in the Medicare program, a SNF must comply with the requirements for participation found in 42 C.F.R. Part 483, subpart B. 42 C.F.R. §§ 483.1, 488.3. Compliance with these participation requirements is verified by surveys conducted by state health agencies. 42 C.F.R. Part 488, subpart E.

When a survey finds one or more "deficiencies" that cause the SNF to be out of "substantial compliance," CMS may impose enforcement remedies — such as a civil money penalty (CMP) or a denial of payment for new admissions (DPNA) — to encourage prompt corrective action. See 42 C.F.R. §§ 488.402(a) and (c), 488.406. A SNF is not in "substantial compliance" when it has a deficiency that creates the potential for more than "minimal harm" to one or more residents. See 42 C.F.R. § 488.301.[2] CMS's regulations (and we) use the term "noncompliance" to refer to any deficiency that causes a facility to be out of substantial compliance. Id. (definition of "noncompliance").

As noted, CMS is authorized to impose a DPNA, the remedy at issue here, whenever it finds the SNF not in substantial compliance.[3] Act §§ 1819(h)(2)(A)(ii), 1819(h)(2)(B); 42 C.F.R. § 488.417(a). In some circumstances, however, the Act and regulations *mandate*

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[2] The term "substantial compliance" is defined in the regulations to mean the "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.

[3] The authority to impose a DPNA for noncompliance with Medicare conditions of participation can be found in sections 1819(h)(2)(A)(ii) and 1819(h)(2)(B) of the Act, as well in regulations at 42 C.F.R. § 488.417(a).

imposition of a DPNA. Sections 1819(h)(2)(D) and 1819(h)(2)(E) of the Act provide:

> (D) ASSURING PROMPT COMPLIANCE. — If a skilled nursing facility has not complied with any of the requirements of subsections (b), (c), and (d) [which set forth Medicare conditions of participation], within 3 months after the date the facility is found to be out of compliance with such requirements, *the Secretary shall impose the remedy described in subparagraph (B)(i)* [i.e., denial of payment] for all individuals who are admitted to the facility after such date.
>
> (E) REPEATED NONCOMPLIANCE. — In the case of a skilled nursing facility which, on 3 consecutive standard surveys conducted under subsection (g)(2), has been found to have provided substandard quality of care, *the Secretary shall* (regardless of what other remedies are provided) *. . . impose the remedy described in subparagraph (B)(i)* . . . until the facility has demonstrated, to the satisfaction of the Secretary, that it is in compliance with the requirements of subsections (b), (c), and (d), and that it will remain in compliance with such requirements. [italics added)

CMS has implemented these statutory requirements in 42 C.F.R. § 488.417(b), which provides:

> *Required denial of payment.* CMS does or the State must deny payment for all new admissions when —
>
> (1) The facility is not in substantial compliance, as defined in § 488.301, 3 months after the last day of the survey identifying the noncompliance; or
>
> (2) The State survey agency has cited a facility with substandard quality of care on the last three consecutive standard surveys.

As discussed below, the DPNA at issue here was a mandatory DPNA imposed pursuant to section 1819(h)(2)(D) and section 488.417(b)(1).[4]

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[4] CMS did not argue that it would have imposed a permissive DPNA here even had a mandatory DPNA not been triggered.

II. Case Background

A. *Survey and Enforcement Actions*

On October 27, 2004, the Illinois Department of Public Health (IDPH) completed a complaint survey of Chicago Ridge. CMS Ex. 20, at 1, 30. That survey — which we call the October 27th complaint survey — found Chicago Ridge to be out of substantial compliance with 42 C.F.R. § 483.25(j), which requires a SNF to provide residents with "sufficient fluid intake to maintain proper hydration and health." Id. at 30. IDPH advised Chicago Ridge of two proposed remedies for this noncompliance (a CMP and inservice training) and further stated that the remedies would not be imposed if Chicago Ridge demonstrated substantial compliance with all participation requirements during a revisit survey. Id. at 2.

On December 14, 2004, IDPH conducted a revisit and complaint survey (December 14th survey). The surveyors found that Chicago Ridge had corrected the deficiency found in October. See Response Br. at 3 n.1; CMS Ex. 13; CMS Ex. 17, ¶ 4. The surveyors also found, however, that Chicago Ridge was not in substantial compliance as a result of a new deficiency finding under 42 C.F.R. § 483.12(a)(4)-(6). Id. That regulation provides that when a SNF plans to transfer or discharge a resident, it must give the resident and others advance written notice of that impending action. CMS Ex. 13. The December 14th survey found no other violations of Medicare participation requirements. Id.

In a letter dated December 27, 2004, IDPH notified Chicago Ridge of the December 14th survey's finding of noncompliance. CMS Ex. 20, at 6. That letter also notified Chicago Ridge of two "imposed" remedies for the "survey cycle" beginning on October 27, 2004. First, the letter stated that, with CMS's authorization, IDPH was imposing "directed inservice training" because of Chicago Ridge's failure to achieve or maintain substantial compliance with all participation requirements. Id. at 7. Second, the letter informed Chicago Ridge of CMS's imposition of a DPNA "effective January 27, 2005." Id. As subsequent correspondence from CMS makes clear, this DPNA was the denial of payment mandated by section 1819(h)(2)(D) of the Act for a SNF that has failed to attain substantial compliance within three months after being found noncompliant.

On January 25, 2005, IDPH completed a third complaint survey. CMS Ex. 1; CMS Ex, 11, ¶ 4. During the January 25th complaint survey, IDPH determined that Chicago Ridge was not in substantial

compliance with the general quality of care requirement in 42 C.F.R. § 483.25.[5] CMS Ex. 1. This determination concerned the care of a female resident whose nephrostomy tube had fallen out of her body and needed to be reinserted. Id. (A nephrostomy tube is used to drain urine directly from the kidney. CMS Ex. 8.)

On January 26, 2005, IDPH completed a revisit survey in which it determined that Chicago Ridge had, as of January 14, 2005, abated the alleged noncompliance found during the December 14th survey. CMS Ex. 20, at 14, 35.

In a letter dated February 2, 2005, IDPH formally notified Chicago Ridge of the new deficiency finding of the January 25th complaint survey. IDPH further stated in this letter that, as a result of Chicago Ridge's failure to achieve or maintain substantial compliance, "all currently imposed remedies will remain in effect." CMS Ex. 20, at 12. The "currently imposed remedies" included the mandatory DPNA that became effective on January 27, 2005. On February 3, 2005, IDPH further informed Chicago Ridge that, although the January 26th revisit survey found that the December 14th survey deficiency had been corrected, the other deficiency found on January 25, 2005 remained outstanding.

On February 24, 2005, IDPH conducted a third revisit survey to determine whether Chicago Ridge had abated the noncompliance found during the January 25th complaint survey. CMS Ex. 20, at 23.

On March 24, 2005, CMS issued a letter stating that Chicago Ridge had come back into substantial compliance with all Medicare requirements on February 8, 2005, and that the mandatory DPNA had been discontinued on that date. CMS Ex. 20, at 19-20. On April 1, 2005, CMS amended its March 24th notice letter to state that Chicago Ridge had come back into substantial compliance on

[5] On the scale of seriousness, IDPH placed this alleged noncompliance at level G, which is for a deficiency that causes "actual harm" to one or more residents. CMS Ex. 1, at 1; see also Western Care Management Corp., DAB No. 1921, at 4 (2004). Following informal dispute resolution, IDPH withdrew its finding of actual harm and placed the noncompliance at level D, which is for a deficiency that causes no actual harm but creates the potential for more than minimal harm. CMS Ex. 20, at 17; Western Care Management Corp. at 4.

February 24, 2005, not February 8, 2005, and that the DPNA had been discontinued on February 24th. Id. at 22-23, 29.

Seeking to overturn the DPNA, Chicago Ridge appealed the findings of the December 14th and January 25th complaint surveys to the ALJ.

B. *ALJ Proceeding*

Before the ALJ, Chicago Ridge filed a motion for summary judgment, contending that the deficiency finding from the December 14th survey was erroneous and that the facility had, in fact, been in substantial compliance with section 483.12(a)(4)-(6) and all other Medicare participation requirements during that survey. Chicago Ridge further contended that because it was back in substantial compliance during the December 14th survey, within three months after first being found out of substantial compliance (during the October 27th survey), the statute and regulations did not mandate imposition of a DPNA effective January 27, 2005.

CMS responded with its own summary judgment motion, contending that the December 14th survey was irrelevant in deciding whether the mandatory DPNA had been lawfully imposed. CMS contended that it lawfully imposed the DPNA because Chicago Ridge was in a state of noncompliance on January 27, 2005, three months after being found out of substantial compliance during the October 27th complaint survey, regardless of whether the ALJ were to find that the new deficiency cited in December was unsupported.

C. *ALJ Decision*

Finding summary judgment appropriate, the ALJ sustained the DPNA imposed by CMS. ALJ Decision at 5, 14. In support of that result, the ALJ made findings of fact and conclusions of law (FFCLs) which we summarize here. First, the ALJ found that the state survey agency's finding of noncompliance from the October 27th complaint survey had not been appealed and was therefore final and binding on Chicago Ridge. Id. at 6. Second, regarding the deficiency citation from the December 14th survey, the ALJ concluded that Chicago Ridge was indeed out of compliance with 42 C.F.R. § 483.12(a) because it failed to give a resident's court-appointed guardian advance written notice of the resident's transfer to the hospital. Id. at 10-12. Third, regarding the deficiency citation from the January 25th complaint survey, the ALJ concluded that Chicago Ridge was in a state of noncompliance with section 483.25, noting that the facility had failed to rebut the evidence supporting the citation. Id. at 7-10. Fourth, the

ALJ found that Chicago Ridge did not attain substantial compliance with all participation requirements until February 24, 2005. Id. at 13-14.

Finally, the ALJ concluded that CMS could lawfully impose the mandatory DPNA in any case so long as Chicago Ridge was not in substantial compliance on January 27, 2005, the date three months after the survey in which noncompliance was initially found. ALJ Decision at 12-13. In reaching this conclusion, the ALJ agreed with CMS's contention that Chicago Ridge's compliance status during the December 14th survey was legally irrelevant:

> Even if CMS had revisited Petitioner's facility on December 14, 2004, and determined that Petitioner was in substantial compliance [with section 483.12 and all other requirements], CMS could have returned for the complaint survey on January 25, 2005, and determined that Petitioner was not in substantial compliance on that date and imposed the DPNA. Petitioner had been notified that a mandatory DPNA would be imposed on January 27, 2005 if it were not in substantial compliance on that date. CMS determined it was not. What happened between October 27, 2004 and January 27, 2005, is not relevant. The fact is that Petitioner was not in compliance on January 25, 2005, and the 90 day mandatory DPNA went into effect.

Id. at 12 (citation and footnote omitted).

III. Burdens of Proof and Standard of Review

In moving for summary judgment, CMS must present evidence sufficient to show, if uncontradicted, that CMS is entitled to judgment as a matter of law and must show that there are no genuine issues of material fact in dispute. St. Catherine's Care Center of Findlay, Inc., DAB No. 1964, at 6-7 (2005). If CMS makes this demonstration, the SNF can avoid an adverse summary judgment by: (1) proffering evidence that there is a genuine dispute regarding facts that are material to CMS's basis for claiming judgment in its favor; or (2) proffering evidence from which a trier of fact could conclude — if accepted as true — that the facility could carry the ultimate burden of persuasion (i.e., to prove that it was in substantial compliance). Id.; Vandalia Park, DAB No. 1939 (2004). In evaluating a SNF's response to a CMS motion for summary judgment, the ALJ is to view the evidence in the light most favorable to the SNF and is to draw all reasonable inferences therefrom in the SNF's favor. Id.

We review the ALJ's grant of summary judgment *de novo*, giving the evidence and inferences the construction most favorable to the party opposing summary judgment. Lebanon Nursing and Rehabilitation Center, DAB No. 1918, at 4 (2004).

IV. Discussion

Chicago Ridge disagrees with four of the FFCLs upon which the ALJ based her decision. First, Chicago Ridge contends that it did not violate section 483.12(a)'s notice requirement and therefore was in substantial compliance during the December 14th survey. App. Br. at 7-16. Second, Chicago Ridge contends that the ALJ erred in concluding that its compliance status during the December 14th survey was irrelevant in determining whether the mandatory DPNA had been lawfully imposed. Id. at 16-28. According to Chicago Ridge, a mandatory DPNA cannot be imposed if the SNF comes back into substantial compliance within three months after the initial survey of a SNF's "survey cycle." Id. at 22. Chicago Ridge asserts that the challenged DPNA is unlawful because it was back in substantial compliance during the December 14th survey, within three months after the October 27th complaint survey, which initiated the relevant survey cycle. Id. at 22. Third, Chicago Ridge contends that the ALJ erroneously concluded that it was not in substantial compliance with section 483.25 as of January 25, 2007 (when the third complaint survey was completed). Id. at 28-30. Finally, assuming we determine that a mandatory DPNA took effect on January 27, 2005, Chicago Ridge contends that the DPNA should have been discontinued on February 8, not February 24, 2005. Id. at 30-32. Chicago Ridge does not contend that there are disputes of material fact that preclude summary judgment.

Although we vacate one of the ALJ's FFCLs below, we conclude, for the reasons explained below, that CMS may enforce a mandatory DPNA for the period January 27, 2005 through February 23, 2005.

A. *Chicago Ridge was not in substantial compliance during the October 27th complaint survey.*

There is no dispute that Chicago Ridge failed to appeal the finding of noncompliance from the October 27th complaint survey. We thus conclude (as the ALJ did) that Chicago Ridge was not in substantial compliance during the October 27th complaint survey.

B. *Chicago Ridge was not in substantial compliance with 42 C.F.R. § 483.12(a) during the December 14th survey.*

The December 14th survey found that Chicago Ridge had corrected the problems found in October 2004, but also found that Chicago Ridge was now out of substantial compliance with the notice requirement in 42 C.F.R. § 483.12(a)(4). That provision implements section 1819(c)(2)(B) of the Act and states as follows:

> (4) *Notice before transfer.* Before a facility transfers or discharges a resident, the facility must —
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> (i) Notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand.
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> (ii) Record the reasons in the resident's clinical record; and
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> (iii) Include in the notice the items described in paragraph (a)(6) of this section

42 C.F.R. § 483.12(a)(4) (emphasis added). The required notice must be provided at least 30 days before the resident is transferred or discharged, unless one of the exceptions listed in section 483.12(a)(5)(ii) applies. 42 C.F.R. § 483.12(a)(5)(i). These exceptions include a situation in which "[a]n immediate transfer or discharge is required by the resident's urgent medical needs[.]" Id., § 483.12(a)(5)(ii)(D). In this situation, the required notice must be made "as soon as practicable before transfer or discharge. Id., § 483.12(a)(5)(ii). Section 483.12(a)(6) states that written notice must contain, among other things, the reason for the transfer or discharge, the location to which the resident is transferred or discharged, and a statement that the resident has the right to appeal the action to the State." Id., § 483.12(a)(6).

The following facts are undisputed.[6] Sometime in the early afternoon of October 29, 2004, Resident 3, a 42 year-old male

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[6] These facts are reflected in the following portions of the record: Affidavit of Martha Ryles (attached to Petitioner's Motion for Summary Judgment), ¶ 8; CMS Ex. 15, at 2, 8, 14-18 (record of surveyor interview of Martha Ryles, R.N.; nursing notes of October 29, 2004; "admission and discharge form" for Resident 3; patient transfer form dated October 29, 2004; and other records); CMS Ex. 17, ¶¶ 8-12 (Declaration of Wanda Higgenbotham, R.N.); and CMS Ex. 18 (Declaration of Lisa Williams Stepney).

paraplegic with bipolar disorder and manic depression, complained about numbness and loss of sensation in his left hand and right leg. The nursing staff quickly notified his physician, who ordered his immediate transfer to the hospital. At approximately 1:50 p.m. on October 29th, Resident 3 was transferred from Chicago Ridge to the hospital by ambulance.

Resident 3 was first admitted to Chicago Ridge on May 9, 2003. From that date through the period at issue here, Lisa Williams Stepney was Resident 3's state-appointed guardian. In that capacity, she was responsible for ensuring that Resident 3 received the care necessary to meet his medical, housing, and nursing needs. Chicago Ridge's "Admission and Discharge Summary" sheet for Resident 3 identifies Stepney as his "State Guardian" and "responsible party." The same sheet lists Michael Papadopoles, also a State Guardian, and Resident 3's father as "emergency contacts." Under Illinois law, the probate division of the state circuit court may appoint a guardian for a "disabled person" who, because of his disability, "lacks sufficient understanding or capacity to make or communicate responsible decisions concerning the care of his person." 755 Ill. Comp. Stat. 5/11a-3(a) (West 1998).

When Resident 3 was taken to the hospital on October 29, 2004, Chicago Ridge failed to notify Stepney about the transfer, either before or after it occurred. Stepney learned about the transfer from Resident 3's sister, who had called Stepney to ask why Stepney had not told her (the sister) about her brother's hospitalization.

The only notification made by Chicago Ridge concerning Resident 3's transfer was given to Resident 3's father. The notice was given to him verbally on October 29, 2004, but the precise manner and timing of this verbal notice is unclear.[7]

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[7] Marva Ryles, a registered nurse employed by Chicago Ridge, was on duty in the facility when Resident 3 was transferred to the hospital on October 29, 2004 and was involved in Resident 3's care that day. In an affidavit attached to Chicago Ridge's summary judgment motion, Nurse Ryles stated that, at approximately 3:30 p.m., almost two hours after Resident 3 had been taken to the hospital, she notified Resident 3's father by telephone of his son's transfer. However, according to the declaration of surveyor Wanda Higgenbotham, R.N., Nurse Ryles stated in a survey interview that she did not telephone Resident 3's family when he was transferred, and that Resident 3's father

(continued...)

CMS contends that Chicago Ridge's failure to notify Resident 3's court-appointed guardian of the resident's transfer constituted noncompliance with the notice requirement in section 483.12(a)(4). In response, Chicago Ridge asserts that section 483.12(a)(4)'s command — to notify a "family member <u>or</u> legal representative" — is in the disjunctive, and thus it complied with the regulation by notifying a family member (Resident 3's father) of the transfer. Chicago Ridge asserts that "[i]t is a basic rule of statutory construction that use of the word 'or' indicates that alternatives were intended." App. Br. at 11. Applying this canon, Chicago Ridge asserts that section 483.12(a) is not ambiguous and clearly gives facilities a choice about whom to notify when a resident is transferred: a legal representative or a family member. <u>Id.</u> at 13.

The applicable notice requirement is part of a regulation that identifies a SNF resident's rights with respect to "admission, transfer, and discharge." 42 C.F.R. § 483.12. Chief among these rights is the right not to be moved from the facility without legally sufficient cause. Section 483.12(a)(2) states that the SNF "must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility" unless one of six conditions is met, one of them being that the transfer or discharge "is necessary for the resident's welfare and the resident's needs cannot be met in the facility."

The ALJ agreed with CMS that the regulation should be interpreted as requiring notification of a legal guardian when the guardian is someone other than a family member:

> . . . I agree with CMS that the regulation makes no sense if the regulation actually allowed notification to a family member when a resident had a legal guardian other than that family member. Such an interpretation could raise privacy issues in addition to the concerns expressed by CMS [about ensuring notification to persons having legal capacity to make medical decisions on the resident's behalf]. The whole purpose of the Act and regulations is the protection of Medicare and Medicaid beneficiaries. There is no reason for the

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[7](...continued)
was told of the transfer in person on October 29, 2004 when he happened to come by the facility to visit his son that day. CMS Ex. 17, ¶ 11. It is unclear whether this in-person notification, assuming it occurred, was made before or after Resident 3's transfer.

> transfer notification provisions in the regulations if the notified person cannot provide protection and advocacy for the resident. If a resident actually has a legal representative, that is the person who should be notified.

ALJ Decision at 11-12.

We agree with the general thrust of the ALJ's analysis. The ALJ's reasoning does not undercut the disjunctive sense of "or." Neither the ALJ nor CMS suggests that the facility had to notify both the guardian and a family member. Chicago Ridge points to the general expectation that terms connected by a disjunctive are construed to be "separate and distinct alternatives." App. Br. at 12; see also In re Espy, 80 F.3d 501, 505 (D.C. Cir. 1996) (where Independent Counsel may receive referral from court or Attorney General, the Attorney General's consent to referral is not always required). Chicago Ridge concludes that the regulation must be read to permit the facility to notify either any member or the guardian, as it chooses. Chicago Ridge did not point to any authority holding that the use of "or" always means that two listed alternatives must be considered equally available in all circumstances. Here, imposing such a restricted reading would frustrate the evident purpose of the relevant notice provision to ensure that the resident's rights may be protected by the legal representative if one has been appointed, or, if not, by a family member.

The requirement that notice of transfer or discharge be given to a "family member or legal representative" is clearly imposed because the resident may be unable, due to physical or mental impairment, to make responsible decisions regarding his personal care, including a decision regarding transfer or discharge. In these situations, either a family member or a legal representative, if one exists, may have the authority or obligation to exercise the resident's rights. Indeed, the preceding regulation, section 483.10, provides that when a resident has been adjudged incompetent under the laws of a State by a court of competent jurisdiction, the rights of the resident are exercised by the person appointed under State law to act on the resident's behalf." 42 C.F.R. § 483.10(a)(3). If the resident has not been adjudged incompetent, "any legal-surrogate designated in accordance with State law may exercise the resident's rights to the extent provided by State law." 42 C.F.R. § 483.10(a)(4). The notice requirement in section 483.12(a)(4) ensures that the person with the authority or obligation to exercise, or help protect, the rights of an incapacitated resident is aware of an event (transfer or

discharge) that may impinge on those rights. We conclude that CMS's reading of section 483.12(a)(4) to require a facility to notify the guardian, if one has been appointed, and, if not, a family member, is both reasonable and, in fact, the only reading consistent with the purpose of the requirement and the context of the surrounding provisions ensuring a resident's right to have any state-appointed guardian enabled to protect his rights.

In this case, it is undisputed that Resident 3 had a state court-appointed guardian who was empowered to protect his health and assert his rights regarding medical care. It is also undisputed that the facility knew that Resident 3 had a legal guardian and knew how to contact that guardian by phone and mail. Furthermore, the facility's own Admission and Discharge summary for Resident 3 identified the guardian (Lisa Stepney) as his "responsible party." CMS Ex. 15, at 15. Surveyor Higgenbotham stated, and Chicago Ridge did not dispute, that Resident 3's father was "not [Resident 3's] legal guardian and could not have made a medical decision on [his] behalf." CMS Ex. 17, ¶ 12. There is also no evidence — and no claim by Chicago Ridge — that any other member of Resident 3's family was authorized to make decisions, medical or otherwise, on his behalf.[8] In short, the record clearly establishes that legal responsibility for Resident 3's care rested not with Resident 3's family, but with his long-time guardian.

As noted, an obvious goal of section 483.12(a)'s notice requirement is to ensure that the resident, or someone acting on his behalf, has a timely and adequate opportunity to assert or protect the resident's rights regarding transfer or discharge. A secondary goal of notice is to ensure that the resident's health and well-being are protected in the location to which he has been transferred. Those goals would be defeated entirely if the facility could, in the circumstances here, be deemed compliant with section 483.12(a) by giving notice to a family member who lacked authority under state law to act on the resident's behalf. When the resident has a legal representative who (through judicial appointment or non-judicial instrument) is authorized, obligated, or responsible under state law to assert or protect

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[8] The existence of the guardian's authority and responsibility is illustrated by evidence that the family *expected* to get notification of significant events, including a nursing home transfer, *from the guardian*. After learning of Resident 3's October 29th transfer, Resident 3's sister called the guardian to complain that the *guardian* had not notified her of the transfer. CMS Ex. 17, ¶ 12.

the resident's rights regarding his care, section 483.12(a)(4) obligates the facility to notify the legal representative.[9] Chicago Ridge failed to comply with its obligation by failing to notify Resident 3's guardian of his transfer to the hospital on October 29, 2004.

Chicago Ridge suggests that its interpretation of the regulation does not undercut the notice provision's purposes because a family member, once notified, would be in the position to notify the guardian or other legal representative. App. Br. at 13, n.4. Chicago Ridge cites nothing in support of the purported expectation that family members will notify a guardian where one has been appointed. In some instances, moreover, the guardian is appointed precisely because family members have shown an unwillingness or inability to act responsibly or in an incapacitated resident's best interests. We find it highly improbable that Congress or CMS would have designed the notification requirement based on an assumption of secondary notification by the family member to the resident's legal representative. Moreover, it is clear that this assumption did not hold in this case. The record shows that Resident 3's father, whom the facility notified of the transfer, did not in turn notify the guardian. The guardian was notified of the transfer only when called by a different family member, Resident 2's sister, who herself had not received notice of the transfer from the facility. The sister's complaint that the guardian had not notified her of this transfer plainly shows that the family assumed the guardian would have already been notified by the facility and that they expected the guardian to provide notice to the family, not the other way around.

Chicago Ridge suggests that the ALJ's interpretation of the notice requirement rests on the flawed premise that the person notified must be able to "provide 'protection and advocacy for the resident.'" App. Br. at 13 (quoting ALJ Decision at 4)). For residents without a legal guardian, Chicago Ridge asserts that "there is nothing in the regulation that requires that the family member to be notified be legally authorized to act for the resident (or to provide any such 'protection and advocacy' services)." Id. at 13-14. We disagree that the ALJ acted on a flawed premise. It is true, of course, that a resident may have no legal guardian and may have also failed to designate another legal representative to act on his behalf in the event of incapacity. In that case, it would be proper for the facility to

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[9] The facility may, but need not, also notify a family member in cases where a guardian has been appointed.

notify a family member who shows he has assumed responsibility for the resident's care. The point of our discussion here is that when a guardian has been judicially appointed to safeguard the resident's health, then the guardian must be notified to ensure that the resident's rights and interests are protected.[10]

Finally, Chicago Ridge contends that the notice requirement in section 483.12(a) does not apply to Resident 3's hospitalization. It asserts that section 483.12(a) applies to "involuntary transfers or discharges (as distinguished from hospitalizations)," and that the only regulation containing a notice requirement for "hospitalizations" is section 483.25(b), which requires the SNF to give prior written notice of its "bed-hold" policies. This contention is entirely meritless. The notice provision in section 483.12(a)(4) applies to any "transfer" or "discharge." These terms are defined to include any "movement" of the resident "outside the certified facility," including movement to another institutional setting, such as a hospital. 42 C.F.R. § 483.12(a)(1); see also 42 C.F.R. § 483.202."[11] The notice of bed-hold policies required by section 483.12(b) does not in any way limit a facility's notice obligations under section 483.12(a). Section 483.12(b) merely

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[10] We note that it is undisputed that Chicago Ridge never provided written notice to anyone of the transfer. Chicago Ridge suggests that it would only have delayed the necessary hospitalization to have tried to mail a letter to the resident's guardian. Nothing in the regulation precludes giving immediate verbal notice prior to a transfer required to meet a resident's emergent needs and following up with a written notice (which, of course, could be transmitted electronically rather than mailed). Chicago Ridge did not deny that it had available to it the necessary information to promptly contact the guardian.

[11] The terms "transfer" and "discharge" are defined separately in 42 C.F.R. § 483.202. In that regulation, "transfer" is defined, in relevant part, to mean the "movement from an entity that participates in Medicare as a skilled nursing facility . . . to another institutional setting when the legal responsibility for the care of the resident changes from the transferring facility to the receiving facility." "Discharge" is defined, in relevant part, to mean the "movement from an entity that participates in Medicare as a skilled nursing facility . . . to a noninstitutional setting when the discharging facility ceases to be legally responsible for the care of the resident." Section 483.202 states that these definitions are applicable to 42 C.F.R. Part 483, subpart B, which includes section 483.12.

imposes an additional notice requirement when the resident is transferred to a hospital or is allowed to go on "therapeutic leave."[12]

Surveyor Higgenbotham stated that the lack of notification had the potential for more than minimal harm to Resident 3:

> At the hospital, [Resident 3] was diagnosed with bilateral acute DVT [deep vein thrombosis]. This is a serious condition because a blood clot can potentially break off and travel to the heart and clog the flow of blood to the heart. If a serious medical complication had arisen, and a competent person was needed to make a decision on Resident 3's behalf, then the lack of proper notification of the transfer could have resulted in serious harm to Resident 3 because no one with the authority to decide for [Resident 3] would have even known where he was.

CMS Ex. 17, ¶ 12. In addition, Surveyor Higgenbotham stated that, at the time of the survey, Chicago Ridge "did not have a policy that it followed on notifications for transferring and/or discharging that was specific to residents who have a state guardian." Id., ¶ 13. The absence of such a policy posed a risk that the rights and well-being of other residents with legal guardians might be compromised because of failure to notify the guardian in appropriate circumstances. Based on the statements of Surveyor Higgenbotham, which Chicago Ridge did not dispute, we find that its violation of section 483.12(a)(4)-(6) created a potential for more than minimal harm not only to Resident 3, but to other residents in the facility with guardians or other legal representatives. We thus conclude that Chicago Ridge was not in

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[12] Section 483.12(b)(1) provides that "before" a nursing facility transfers a resident or allows the resident to go on therapeutic leave, the nursing facility must provide written information to both the resident and a family member or legal representative about (1) the "duration of the bed-hold policy under the [Medicaid] State plan, if any, during which the resident is permitted to return and resume residence in the nursing facility"; and (2) the nursing facility's policies regarding "bed-hold periods." In addition, section 483.12(b)(2) provides that, "[a]t the time of transfer . . . for hospitalization or therapeutic leave," the nursing facility must give the resident and a family member or legal representative written notice specifying the duration of the bed hold policy described in section 483.12(b)(1).

substantial compliance with section 483.12(a)(4)-(6) during the December 14th survey.[13]

D. *Chicago Ridge was not in substantial compliance with 42 C.F.R. § 483.25 during the January 25, 2005 complaint survey.*

Title 42 C.F.R. § 483.25 sets out the following general quality of care requirement: "Each resident must receive and the facility must provide 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." As a result of the January 25th complaint survey, CMS determined that Chicago Ridge was not in substantial compliance with this requirement because it "failed to obtain timely medical treatment" for a resident who needed to have a nephrostomy tube reinserted, and because it failed to care for that resident in a manner that would have prevented "multiple episodes" of the nephrostomy tube being pulled out and reinserted. CMS Ex. 1, at 1-2; CMS Ex. 11, ¶ 7.

In support of its motion for summary judgment on this deficiency finding, CMS submitted, among other things, the declaration of Joella Daniels, R.N., the state survey agency employee who conducted the January 25th complaint survey. CMS Ex. 11. Based on her interviews, observations, and review of treatment records and other documents, Surveyor Daniels asserted the following facts and opinions.

Resident 2 was, at the time of the survey, 75 years old. CMS Ex. 11, ¶ 8. She had been a resident of Chicago Ridge for 19 years and was totally dependent on the nursing staff for "activities of daily living," such as bathing, dressing, grooming, and repositioning in bed ("bed mobility"). Id., ¶¶ 8, 14. For at least the previous five years, Resident 2 had a nephrostomy tube that drained urine directly from her right kidney. Id., ¶ 10. She also had a Foley catheter that drained urine from her left

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[13] The ALJ's reasoning for her conclusion that it was irrelevant whether Chicago Ridge was in substantial compliance at the time of the December 14, 2004 survey, so long as Chicago Ridge was not in substantial compliance on January 27, 2005, is obscure. In any case, the ALJ did not need to reach this issue, nor do we in light of our disposition of the issue of the December 14th survey finding above. We therefore vacate the ALJ's conclusion of law on this question as unnecessary to the proper resolution of this case.

kidney. Id. Resident 2's plan of care states that she was at "high risk for urosepsis due to repeated need for nephrostomy [tube] reinsertions." Id., ¶ 11. Urosepsis is septic poisoning from the absorption and decomposition of urinary substances in the tissues. Id.

During a survey interview, Resident 2's sister asserted that, in the previous year, the nephrostomy tube had been pulled out approximately 18 times while Resident 2 was being cared for by the facility's staff. CMS Ex. 11, ¶ 12. Doreen Hickman, Chicago Ridge's administrator, confirmed that the tube had come out multiple times over the years, and that when this happened, the facility usually sent Resident 2 to the hospital to have the tube reinserted. Id.

Nursing notes from 2004 indicate that the nephrostomy tube came out of Resident 2's kidney on June 30, July 17, and November 3, 2004 and needed to be reinserted.[14] CMS Ex. 11, ¶ 13. Nursing notes also indicate that Resident 2 was admitted to Christ Hospital on July 17, 2004 due to "nephrostomy complications." Id.

Esther Jacobs, R.N., a facility employee, told Surveyor Daniels in an interview that Resident 2's nephrostomy tube fell out if she was repositioned in bed with the tube's drainage bag hanging from the bedframe. CMS Ex. 11, ¶ 14. If the drainage bag was not removed from the bedframe during repositioning, the tube became taut and dislodged from Resident 2's back. Id. Nurse Jacobs also told Surveyor Daniels that, at the time of the interview, the nursing staff had begun laying the drainage bag on the bed when repositioning Resident 2 in order to prevent the tube from being pulled out again. Id.

On Saturday, December 11, 2004, Nurse Jacobs went to change Resident 2's nephrostomy tube dressing and found that the tube had fallen out. CMS Ex. 11, ¶ 17. She called Resident 2's physician and the Christ Hospital emergency room. The hospital informed Nurse Jacobs that the situation was not an emergency and told her to call its Interventional Radiology unit (IRU). Id.

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[14] Administrator Hickman reported that, on November 3, 2004, Christ Hospital told the facility that it would not reinsert Resident 2's nephrostomy tube in its emergency room. CMS Ex. 11, § 27. According to a November 3, 2004 nursing note, the hospital instructed Chicago Ridge to have Resident 2's physician arrange for hospital admission or to make an appointment for a tube reinsertion procedure. Id.

Nurse Jacobs called the IRU but got no answer and had to leave a voicemail message. Id. Nurse Jacobs then phoned Resident 2's physician, who instructed her to call the IRU back on Monday, December 13th to make an appointment for tube reinsertion. Id. On December 13th, Nurse Jacobs called the IRU and was told to call back the following morning. Id., ¶ 18. Because she worked a double shift on December 13th, Nurse Jacobs phoned the IRU a second time that day (during the evening shift), left a voicemail message, and waited for the IRU to call back. Id. In the end, Nurse Jacobs was unable to make an appointment for Resident 2 on December 13th or 14th. However, she did not contact the physician that day to tell him that an appointment had not been made. Id. Resident 2's nephrostomy tube was not reinserted until approximately 10:00 a.m. on Wednesday, December 15, 2004. Id., ¶ 19. The reinsertion procedure was performed by Dr. David Warner. Id.

Immediately after this procedure, Dr. Warner wrote the following letter to Chicago Ridge:

> [Resident 2] was presented to us for a nephrostomy tube reinsertion, which fell out several days earlier. Fortunately, we were able to replace the tube despite the fact that the track had already almost completely closed. Please be advised that the inadvertent withdrawal of this nephrostomy tube is an urgent medical situation that can result in pyonephrosis[15] (which she had) followed by sepsis and potentially death. If and when the catheter falls out again, please refer her to an appropriate physician for reinsertion ASAP or at least within 24 hours.

CMS Ex. 7, at 29 (footnote added). Administrator Hickman shared the information in Dr. Warner's letter with Chicago Ridge's nursing staff. CMS Ex. 11, ¶ 24.

In an interview with Surveyor Daniels, Dr. Warner stated that a nephrostomy tube should be reinserted as soon as possible for two reasons. CMS Ex. 11, ¶ 22. First, the sooner the tube is reinserted, the easier it is to use the same opening in which to place the tube. Id. If the delay is too long, then another incision must be made, which is potentially dangerous. Id. Second, without the tube, urine backs up in the kidney, making

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[15] In a declaration, Dr. Warner explained that pyonephrosis "literally means pus in the kidney" and is a "dangerous condition." CMS Ex. 12, ¶ 5.

the patient susceptible to infection at the site of the opening. Id. Dr. Warner further stated that, during Resident 2's procedure on December 15th, he found pus in Resident 2's urine and that this condition was potentially dangerous or lethal. Id., ¶ 21.

Based on the foregoing information and statements, Surveyor Daniels stated that, in her professional opinion, Chicago Ridge's nursing staff should have informed Resident 2's physician on Monday, December 13th that Resident 2's nephrostomy tube would not be reinserted that day as the physician had instructed. CMS Ex. 11, ¶ 18. According to Nurse Jacobs, "[t]he physician should have been able to decide whether [Resident 2] could afford to wait additional time to have her tube reinserted." Id. Surveyor Daniels further stated:

> [T]he facility nurses should have questioned [Resident 2's] physician's order to wait so long, at least 3 days, before the tube was reinserted. This waiting period allowed [Resident 2's] kidney to build up urine without having her condition relieved by reinserting her nephrostomy tube as soon as possible. The nursing staff should have questioned the physician's orders to wait and staff should have sought to have [Resident 2's] tube reinserted in the days before December 15, 2004 when it was reinserted.

Id. In addition, Surveyor Daniels stated, on the basis of interviews with nursing staff, that "the nursing care itself was partially responsible for the nephrostomy tube continually falling out":

> As Dr. Warner indicated, a gravity drip into a drainage bag hanging from the bedframe would have been the best approach. By simply holding up the tube and drainage bag when repositioning [Resident 2], the nursing staff could have ensured that the nephrostomy tube would not have fallen out with the same frequency that it did when staff repositioned [Resident 2] and left the tube and drainage bag alone.

Id., ¶ 28. Surveyor Daniels, who had almost 16 years of experience as a surveyor, further stated that Resident 2 "was exposed to more than minimal harm because in her vulnerable condition she was unable to safely eliminate all urine if her nephrostomy tube was not inserted and functioning at all times." Id. Finally, Surveyor Daniels stated that the "delay in getting Resident 2's nephrostomy tube reinserted [led], directly or

indirectly, to her becoming infected, and infection in someone as vulnerable as [Resident 2] could prove to be fatal." Id.

It is clear from the evidence submitted by CMS, and Chicago Ridge does not dispute, that Resident 2 was at risk for serious medical complications if her nephrostomy tube fell out of her kidney and was not reinserted promptly. Thus, when Resident 2's nephrostomy tube fell out on December 11, 2004, it was incumbent on Chicago Ridge to take reasonable steps to ensure that reinsertion occurred promptly. Upon learning that the tube had fallen out on December 11, 2004, Nurse Jacobs immediately contacted Resident 2's physician and followed his instructions to call the hospital to have the tube reinserted. When the hospital advised her that it would not see Resident 2 in the emergency room on December 11th, Nurse Jacobs advised the physician and followed his instructions by seeking to make the necessary hospital appointment on Monday, December 13th. CMS did not cite these actions by Nurse Jacobs as a basis for its deficiency finding. CMS did cite, however, the nursing staff's failure to contact Resident 2's physician again on December 13th after Nurse Jacobs failed to arrange for tube reinsertion that day. Such contact might have prompted the physician to arrange for Resident 2's immediate admission to the hospital for tube reinsertion. As it turned out, Resident 2 had to wait for another 36 to 48 hours for the procedure, a delay that Dr. Warner called unacceptable. CMS also found, on the basis of Surveyor Daniels' opinion, that the nursing staff's practices were "partially responsible for the nephrostomy tube continually falling out," and that certain steps could have been taken earlier to lessen the risk of that occurrence and associated medical complications. CMS Ex. 6, at 5. The risk of complication was not remote or speculative because, as CMS's evidence showed, Resident 2 was found to have pyonephrosis, a condition that Dr. Warner called dangerous, during the December 15th reinsertion procedure. CMS Ex. 12, ¶ 5.

In short, CMS presented evidence of facts establishing that Chicago Ridge failed, in certain respects, to ensure that Resident 2 received timely and appropriate care relating to her nephrostomy tube, and that this failure increased the risk of serious health complications or deterioration. This evidence, if unrebutted, would warrant summary judgement for CMS on its allegation that Chicago Ridge did not, as required by section 483.25, provide Resident 2 with care and services she needed to attain or maintain her highest practicable well-being in accordance with her assessment and plan of care. Chicago Ridge, as we discuss below, did not proffer evidence of any disputed fact that would, if credited and viewed in the most favorable light, serve to rebut that showing.

During the ALJ proceeding, Chicago Ridge introduced no evidence to rebut the facts or opinions asserted by Surveyor Daniels and Dr. Warner. In addition, it proffered no evidence from which a reasonable trier of fact could conclude that the nursing staff's services adequately ensured that Resident 2 attained and maintained her highest practicable well-being. Indeed, its briefs to the ALJ did not discuss at all the merits of the deficiency finding from the January 25th complaint survey, identify a genuine dispute of material fact, or otherwise contend that CMS had failed to satisfy the requirements for summary judgment regarding this aspect of the case.

Likewise, in this appeal, Chicago Ridge does not claim that CMS failed to produce evidence which, if unrebutted, would warrant finding the facility out of substantial compliance, nor does Chicago Ridge allege that the opinions expressed by Surveyor Daniels and Dr. Warner are erroneous. See App. Br. at 28-30. While Chicago Ridge does allege that certain facts are material and in dispute, we find that these factual allegations are either immaterial or unsupported by any evidence proffered by Chicago Ridge.[16]

First, Chicago Ridge asserts that Resident 2's physician "was advised" that "an appointment could not be obtained at the out-patient radiology department until the morning of December 15[.]" Id. at 29 (citing CMS Ex. 7, at 1, 6, 7, 28, and 30). If Chicago Ridge is claiming here that its nursing staff promptly notified Resident 2's physician of its unsuccessful attempt to schedule the tube reinsertion procedure on December 13th, the facility's record citations fail to support that claim. There is no evidence that Chicago Ridge notified or attempted to notify Resident 2's physician on December 13th about its failure to secure an appointment on that date. The record does show that, sometime around 10:00 a.m. on December 14th, the nursing staff notified Resident 2's physician that tube reinsertion had been scheduled for December 15th. CMS Ex. 7, at 7 (12/14/04 entry). However, this contact is immaterial because, in Surveyor Daniels'

[16] Since it disregarded the summary judgment context, Chicago Ridge framed its appeal as asserting that the ALJ's conclusion with respect to this alleged noncompliance "is not supported by substantial evidence and is contrary to the evidence in the record." App. Br. at 28. However, Chicago Ridge fails to identify any specific part of the ALJ's analysis with which it takes issue. We have reviewed the ALJ Decision using the proper summary judgment standard, which is more favorable to Chicago Ridge.

uncontroverted opinion, and consistent with the other evidence of record, the nursing staff should have notified the physician *on December 13th* of its inability to arrange for tube reinsertion on that day. Furthermore, the nursing staff's December 14th phone call does not undercut Surveyor Daniels' opinion that the nursing staff was partly responsible for multiple instances of the nephrostomy tube falling out, an occurrence that, according to Dr. Warner and Surveyor Daniels, posed a risk of more than minimal harm.

Second, Chicago Ridge asserts that the "time elapsed between the tube falling out and hospital reinsertion was approximately 2-5/6 days, not 5 days as alleged in the statement of deficiencies." App. Br. at 29. According to Chicago Ridge, the nephrostomy tube fell out at noon on December 12th (not on December 11th), tube reinsertion occurred at about 10:00 a.m. on December 15th, and thus the gap between these two events was slightly less than three days. Id.

Chicago Ridge asserts that nursing notes on page six of CMS Exhibit 7 confirm that the tube fell out on December 12th. Chicago Ridge does not identify the author of these notes, and the initials next to them are practically illegible, but they describe actions that Nurse Jacobs reportedly took after discovering that Resident 2's nephrostomy tube had fallen out. The first note, a 12 p.m. entry, states that Resident 2's nephrostomy tube was out and that its author had received instructions from Resident 2's physician to call the Christ Hospital IRU to make an appointment for tube reinsertion. There is a handwritten date next to this note, but the month and day is obscured. A second note, a 12:15 p.m. entry, states that its author called the hospital's IRU, learned that it was closed, and then told Resident 2's physician, who ordered that an appointment be made on Monday morning (December 13th). The date next to the 12:15 p.m. entry is partially obscured, but the day appears to be the 11th rather than the 12th, although again the entry is not easy to decipher. Whatever the case, these two entries hardly support Chicago Ridge's assertion that the nephrostomy tube fell out on December 12th. In fact, Chicago Ridge did not deny that Nurse Jacobs herself reported to surveyors that the tube was already dislodged when she attempted to change the tube's dressing on December 11th. CMS Ex. 11, ¶ 17. Other than the inconclusive nursing notes in CMS Exhibit 7, Chicago Ridge produced no evidence disputing Nurse Jacobs' account. In addition, Chicago Ridge has not shown or explained how or why the fact that the nephrostomy tube may have come out on December 12th should cause a reasonable trier of fact to discount Surveyor Daniels' opinion that the nursing staff should have alerted

Resident 2's physician on December 13th about its failure to make the appointment for tube reinsertion on that day.

Finally, contending that the facts show "no deficiency," Chicago Ridge asserts:

> When most dialysis patients in this country are on a three times/week schedule (because that is all medicare will pay for) and, thus, go 72 hours without dialysis at least once every week, it is hard to conceive how the government can contend that 68-70 hours without urinary drainage (with the full knowledge of the resident's physician and under his treatment directions) violated the standard of care. This is particularly true here because [Resident 2] also had a Foley catheter in place and, therefore, the nephrostomy tube was not the sole method of urinary/kidney drainage for this resident.

App. Br. at 30. Chicago Ridge's suggestion that there was no violation of section 483.25 because Resident 2 received the care that "most dialysis patients in the country" would have received is unavailing for several reasons. First, there is no evidence that "most dialysis patients" go 72 hours without dialysis at least once per week. Second, and more important, there is no evidence that Resident 2's condition is or was similar to that of "most dialysis patients." Section 483.25 required Chicago Ridge to provide Resident 2 with more than just standard treatment regimen suitable for "average," "typical," or "most" residents. It required the types or level of individualized care necessary to ensure that Resident 2 maintained her highest practicable well-being, as described or defined in her comprehensive assessment and plan of care. As noted, Chicago Ridge proffered no evidence that it satisfied the relevant quality of care requirement. Third, the frequency of dialysis for average patients has no relevance to the risk here that the opening for the tube might close up or become infected, making reinsertion more problematic. Finally, the record contradicts Chicago Ridge's suggestion that Resident 2's use of a Foley catheter mitigated or eliminated the risk of harm stemming from the delay in getting her nephrostomy tube reinserted. In her declaration, Surveyor Daniels explained that the Foley catheter drained urine only from Resident 2's left kidney and that Resident 2 could not safely eliminate all urine if her nephrostomy tube, which ran into her right kidney, was not inserted and functioning at all times. CMS Ex. 11, ¶ 28.

For all the reasons above, we affirm the ALJ's conclusion that Chicago Ridge was not in substantial compliance with section 483.25 during the January 25th complaint survey.

E. *CMS lawfully imposed the mandatory DPNA effective January 27, 2005.*

For purposes of determining whether the mandatory DPNA was lawfully imposed, Chicago Ridge's certification cycle began on October 27, 2004. We have found that the facility was not in substantial compliance at the December 14th survey. The certification cycle therefore continued until Chicago Ridge was determined to have achieved substantial compliance as discussed in the next section. CMS was required to impose the mandatory DPNA unless Chicago Ridge came back into substantial compliance within three months of the start of the certification cycle, that is, by January 27, 2005.

The state survey agency determined on January 26, 2005 that the noncompliance found during the December 14th survey was corrected by January 14, 2005. The surveyors also found based on their complaint survey the preceding day, however, that Chicago Ridge had not achieved substantial compliance because of the new finding of noncompliance with 42 C.F.R. § 483.25 discussed in the previous section. The record shows that the noncompliance discovered during the January 25th complaint survey was not corrected until February 2005. See CMS Ex. 20, at 20-26.

In short, Chicago Ridge was not in substantial compliance as of October 27, 2004 and did not come back into substantial compliance at any point during the ensuing three-month certification cycle. Thus, pursuant to section 1819(h)(2)(D) of the Act, CMS lawfully imposed the mandatory DPNA effective January 27, 2005.

F. *Chicago Ridge did not come back into substantial compliance until February 24, 2005.*

On March 24, 2005, CMS issued a written notice stating that Chicago Ridge had come back into substantial compliance as of February 8, 2005 and that previously imposed enforcement remedies (including the mandatory DPNA) would be lifted on that date. CMS Ex. 20, at 20. On March 25, 2005, IDPH, the state survey agency, issued a letter whose stated purpose was to notify Chicago Ridge of the "correct" compliance date. Id. at 25. This letter stated that IDPH would recommend to CMS that remedies be discontinued on February 24, 2005 (the date of the last revisit survey). Id. On April 1, 2005, CMS sent Chicago Ridge an amended notice letter

stating that substantial compliance had been attained on February 24, 2005, not February 8, 2005. Id. at 23, 29.

The ALJ found that there was "nothing in the record to suggest" that CMS's initial designation of February 8th as the compliance date was anything more than a "policy error." ALJ Decision at 13. The ALJ also found that Chicago Ridge had proffered no evidence that it had, in fact, come back into substantial compliance on February 8, 2005. Id. In addition, the ALJ stated that CMS was under no obligation to prove noncompliance between January 27, 2005 (the effective date of the DPNA) and February 24, 2005; rather, said the ALJ, Chicago Ridge had the "burden of showing compliance during that time period." Id. Accordingly, the ALJ determined that Chicago Ridge's compliance date was February 24, 2005. Id.

Chicago Ridge now asserts that it offered evidence that IDPH had actually found the facility in substantial compliance as of February 8, 2005, and thus CMS should have proffered a declaration or affidavit verifying that February 8th was in fact the wrong compliance date. App. Br. at 32. Chicago Ridge claims that the ALJ's finding regarding the compliance date is not supported by substantial evidence. Id. at 30.

We find no merit to this argument. The only evidence that Chicago Ridge cites to support its assertion that IDPH had found the facility in substantial compliance as of February 8, 2005 is the initial version of CMS's March 24, 2005 notice letter, which CMS amended on April 1, 2005. In the interim, IDPH clarified its position regarding the compliance date by stating in its March 25, 2005 letter that it would recommend to CMS that remedies be discontinued as of February 24, 2005. Because remedies are discontinued on the date that a facility achieves substantial compliance, this clarification supports the ALJ's finding that CMS's initial designation of February 8th as the compliance date was a mere error or misstatement made as a consequence of the error in the initial IDPH letter.

In any event, CMS was under no obligation to prove lack of substantial compliance on or after February 8, 2005. If a survey finds a SNF out of substantial compliance, CMS may impose one of several alternative, non-termination remedies (such as civil money penalties) beginning as early as the date that the facility was first out of substantial compliance and continuing in effect until the facility establishes that it has achieved substantial compliance or is terminated from the program. 42 C.F.R. §§ 488.440(a), 488.454(a); see also Cal Turner Extended Care Pavilion, DAB No. 2030, at 18-19 (2006); Regency Gardens, DAB No.

1858 (2006). We have consistently rejected the contention, as being contrary to the structure and purposes of the nursing home enforcement scheme, that CMS must affirmatively prove that noncompliance exists on each day that a remedy is in effect after the first day of noncompliance. Cal Turner Extended Care Pavilion.

Thus, Chicago Ridge had the burden to prove that it came back into substantial compliance sooner than February 24, 2005 (the day CMS lifted the DPNA), a burden it made no attempt to carry. See Lake Mary Health Care, DAB No. 2081, 29 (2007) ("The burden is on the facility to show that it timely completed the implementation of [a plan of correction] and in fact . . . achieved substantial compliance (to end the application of remedies)); Barn Hill Care Center, DAB No. 1848 (2002) (rejecting contention that CMS must assert and prove that the facility was noncompliant on the days for which it actually imposed a CMP); Spring Meadows Health Care Center, DAB No. 1966 (2005) (holding that once CMS established noncompliance on April 24th, the facility had the burden to show abatement of the immediate jeopardy and any residual noncompliance in order to forestall application of remedies that continued after April 24th); cf. Petitioner's Motion for Summary Judgment (R. 10); Petitioner's Response Brief (R. 13).

G. *The DPNA was in effect from January 27, 2005 through February 23, 2005.*

The ALJ Decision states that CMS was authorized to impose a DPNA "from January 27, 2005 *until* February 24, 2005."[17] ALJ Decision at 1 (italics added). We modify this statement to make it clear that because Chicago Ridge was found to be back in substantial compliance on February 24, 2005, no DPNA may be imposed for that date. CMS may impose a DPNA from January 27, 2005 *through* (and including) February 23, 2004.

[17] The concluding paragraph of the ALJ Decision states that CMS was authorized to impose a DPNA starting on January 27, 2004. The "2004" is an obvious typographical error. The starting point is January 27, 2005.

Conclusion

For the reasons discussed, we affirm the DPNA imposed on Chicago Ridge for the period January 27, 2005 through February 23, 2005.

/s/
Sheila Ann Hegy

/s/
Constance B. Tobias

/s/
Leslie A. Sussan
Presiding Board Member