Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Jewish Home of Eastern Pennsylvania
(CCN: 39-5103),

Petitioner

v.

Centers for Medicare and Medicaid Services.

Docket No. C-10-654

Decision No. CR2421

Date: August 30, 2011

DECISION

Petitioner, Jewish Home of Eastern Pennsylvania (Petitioner or facility), is a long-term care facility, located in Scranton, Pennsylvania, that participates in the Medicare program. Based on a survey completed January 14, 2010, the Centers for Medicare and Medicaid Services (CMS) determined that the facility was not in substantial compliance with Medicare program requirements and imposed a penalty. Petitioner appealed.

CMS now moves for summary judgment, pointing out that Petitioner does not challenge any of the survey's deficiency findings, but instead argues survey bias and related claims. Petitioner raised identical arguments in earlier appeals to the Departmental Appeals Board (Board) and the Third Circuit Court of Appeals – with no success.

For the reasons set forth below, I grant CMS's motion for summary judgment.

Background

The Social Security Act (Act) sets forth requirements for nursing facility participation in the Medicare program and authorizes the Secretary of Health and Human Services to

promulgate regulations implementing those statutory provisions. Act §1819. The Secretary's regulations are found at 42 C.F.R. Part 483. To participate in the Medicare program, a nursing facility must maintain substantial compliance with program requirements. To be in substantial compliance, a facility's deficiencies may pose no greater risk to resident health and safety than "the potential for causing minimal harm." 42 C.F.R. § 488.301.

The Secretary contracts with state survey agencies to conduct periodic surveys to determine whether skilled nursing facilities are in substantial compliance. Act § 1864(a); 42 C.F.R.§ 488.20. The regulations require that each facility be surveyed once every twelve months and more often, if necessary, to ensure that identified deficiencies are corrected. Act § 1819(g)(2)(A); 42 C.F.R. §§ 488.20(a), 488.308.

Here, following a survey completed on January 14, 2010, CMS determined that the facility was not in substantial compliance with the following Medicare participation requirements:

- 42 C.F.R. § 483.10(b)(11) (Tag F157 -- notification of changes);
- 42 C.F.R. § 483.15(f)(1) (Tag F248 -- activities);
- 42 C.F.R. § 483.25(c) (Tag F314 -- pressure sores);
- 42 C.F.R. § 483.25(f)(1) and (f)(2) (Tags F319 and F320 -- mental and psychosocial functioning);
- 42 C.F.R. § 483.35(i) (Tag F371 -- sanitary conditions);
- 42 C.F.R. § 483.60(c) (Tag F428 -- drug regimen review);
- 42 C.F.R. § 483.60(b), (d), and (e) (Tag F 431 -- pharmacy services);
- 42 C.F.R. § 483.65(a) (Tag F441 -- infection control); and
- 42 C.F.R. § 483.75(l)(1) (Tag F514 -- clinical records).

CMS Exhibit (Ex.) 1. CMS subsequently determined that the facility returned to substantial compliance on February 12, 2010. CMS imposed against the facility a civil money penalty of $600 per day for 29 days of substantial noncompliance, from January 14 through February 11, 2010 ($17,400 total). CMS Ex. 2.

Petitioner appealed.

The parties have filed their pre-hearing briefs (CMS Br.; P. Br.) and proposed exhibits (CMS Exs. 1-34; P. Exs. 1-9).

While this matter was pending, decisions were issued by the Court of Appeals for the Third Circuit and the Board in Petitioner's appeals of earlier survey findings: *Jewish Home of E. Pa. v. CMS*, 2011 WL 477818 (3rd Cir. 2011) and *Jewish Home of E. Pa.*, DAB No. 2380 (2011). In those cases, the Court and the Board addressed the issues Petitioner raised in this appeal. Therefore, in an order dated June 3, 2011, I directed the parties to submit status reports that: 1) addressed the impact, if any, of the Court and Board decisions on this matter; 2) identified the material facts in dispute, if any; and 3) specified the issues remaining before me.

CMS responded with a motion for summary judgment (CMS MSJ) with three attachments, marked CMS Exs. A-C. Petitioner filed a status report (P. Status Rep.) and a brief in opposition to summary judgment (P. Opp.) with two attachments (P. Attachs. 1-2).

Discussion

1. CMS is entitled to summary judgment because Petitioner has not challenged its determinations that the facility was not in substantial compliance with specific Medicare program requirements. Those determinations are therefore final and binding and provide a sufficient basis for imposing a penalty.[1]

Summary judgment. Summary judgment is appropriate here because this case presents no issue of material fact, and its resolution turns on questions of law. *See Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 247-48 (1986); *Livingston Care Ctr. v. United States Dep't of Health and Human Servs.*, 388 F.3d 168, 173 (6th Cir. 2004). *See also Illinois Knights Templar Home*, DAB No. 2274 at 3-4 (2009) (*citing Kingsville Nursing Ctr.*, DAB No. 2234 at 3-4 (2009)). Although Petitioner opposes summary judgment, none of the issues it preserved turns on a question of fact. Instead, Petitioner raises constitutional and other legal arguments, most of which I have no authority to review.

[1] My findings of fact/conclusions of law are set forth, in italics and bold, in the discussion captions of this decision.

Petitioner's Appeal. In a submission dated May 17, 2010, Petitioner appealed, raising what it characterizes as constitutional and statutory issues.[2] Specifically, it complained that: 1) in setting the CMP, CMS considered the facility's history of noncompliance, which, in Petitioner's view, is impermissible until the facility has exhausted all appeals of earlier survey findings; 2) the CMP impermissibly takes into account alleged non-compliance based on the facility's Quality Assurance privilege found at 42 C.F.R. § 483.75(o)(3) and (4);[3] 3) a provision of the federal regulation governing the amount of the CMP (42 C.F.R. § 488.438(f)(4)) violates the Act; 4) CMS imposed a CMP greatly in excess of the state agency's recommendation; and 5) the CMP "is based on violations of Equal Protection princip[les]." Hearing Request at 3-5. Included among its "constitutional and statutory" claims, Petitioner also asserted generally that CMS "lacks substantial evidence to support the citations" of noncompliance or the "level of noncompliance upon which the CMP is based." Hearing Request at 5.

With respect to the specific citations of noncompliance, Petitioner did not "identify the specific issues, and the findings of fact and conclusions of law" with which it disagreed, nor did it "specify the basis for contending that those findings and conclusions [were] incorrect," as required by the 42 C.F.R. § 498.40(b). Instead, for each of the deficiencies cited, except one, it argued, generally, that the survey report form "does not contain substantial evidence of a violation of the regulation," promises to introduce evidence to establish its compliance and "decrease its culpability," and/or claims that it satisfied the cited requirement. Hearing Request at 5-9. Petitioner did not mention at all the deficiencies cited under 42 C.F.R. § 483.10(b)(11) (Tag F157 – notification of changes).

The Board has determined that an inadequate hearing request does not compel an appeal's dismissal *Carlton at the Lake*, DAB No. 1829 (2002); *Alden Nursing Ctr. – Morrow*, DAB No. 1825 (2002). But a petitioner must eventually articulate the bases for its appeal. In these proceedings, my pre-hearing order directed Petitioner to do so with its pre-hearing exchange. See discussion below.

Petitioner's pre-hearing submissions. In an order dated May 24, 2010, I directed the parties to file pre-hearing exchanges, which would include proposed exhibits, declarations of proposed witnesses, and pre-hearing briefs. My order specified that a pre-hearing brief "must contain any argument that a party intends to make" and warned that I

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[2] Petitioner earlier sought a stay of the appeal period or an extension of time in which to file. In an order dated April 29, 2010, I found no good cause for extending or staying the matter but granted Petitioner an additional ten days in which to appeal. Order, April 29, 2010.

[3] Petitioner only lists the argument concerning a Quality Assurance privilege in its submission of May 17, 2010 and does not discuss this argument in its pre-hearing brief or its brief in opposition to CMS's motion for summary judgment.

"may exclude an argument and evidence that relates to such argument if a party fails to address it in its pre-hearing brief." Acknowledgment and Initial Pre-Hearing Order at 4, ¶ 7) (May 24, 2010).

CMS's pre-hearing exchange included comprehensive discussions of five of the deficiencies cited (42 C.F.R. §§ 483.10(b)(11), 483.25(c), 483.35(i)(2), 483.60(b)(d) and (e), and 483.65). Its submission included detailed factual allegations and legal arguments, supported by facility documents, surveyor notes and testimony, as well as the written testimony of two expert witnesses and publications setting forth generally accepted standards of care.

In light of CMS's submissions, to avoid summary judgment, Petitioner would have to furnish evidence of specific facts showing that a dispute exists. *See Matsushita Elec. Indus. Co. v. Zenith Radio Corp.*, 475 U.S. 574, 586 n.11 (1986); *see also Vandalia Park*, DAB No. 1939 (2004); *Lebanon Nursing and Rehab. Ctr.*, DAB No. 1918 (2004). Petitioner, however, did not respond to CMS's specific arguments or evidence relating to the facility's noncompliance. Indeed, I see no indication that Petitioner intended to challenge any specific deficiency finding. Instead, it proffered four arguments: 1) the CMP should be stricken, and CMS's exhibits and testimony should be excluded because "they are all the product of selective enforcement that violates equal protection principles"; 2) CMS cited one of the deficiencies (42 C.F.R. § 483.25(c) – Tag F314) at a scope and severity level greater than recommended by the state agency; 3) CMS erred in calculating the CMP; and 4) CMS may not impose and I may not review a CMP, until the facility has exhausted all appeals of past allegations of noncompliance, apparently up to – and including – Supreme Court review.

CMS is entitled to summary judgment because, as a matter of law, Petitioner cannot prevail in this forum on any of the issues it preserved in this appeal.

Selective enforcement/equal protection. First, Petitioner argues that CMS has imposed a CMP that is "the result of selective enforcement in violation of Equal Protection Principles," so I must exercise discretion afforded me by 42 C.F.R. § 498.61 to "exclude or suppress such evidence." P. Br. at 4. Petitioner does not specify any particular exhibits or testimony that should be excluded, but it presumably refers to any evidence that supports the imposition of a CMP.

As a threshold matter, inasmuch as Petitioner did not appeal any of the deficiencies cited, CMS's determination that it was not in substantial compliance with Medicare program requirements is final and binding, without regard to any of CMS's proffered evidence. 42 C.F.R. § 498.20(b). So, the question of whether I should "exclude or suppress such evidence" is simply irrelevant to the case before me.

In any event, Petitioner made the same argument -- even relying on the same evidence -- in two prior appeals. The Board and the Court of Appeals for the Third Circuit have rejected its claims. *Jewish Home of E. Pa.*, DAB No. 2380, at 6-8 (2011); *Jewish Home of E. Pa.*, DAB No. 2254 at 13-15 (2009) *aff'd*, *Jewish Home of E. Pa. v. CMS*, 2011 WL 477818 at 8-9 (3rd Cir. 2011). In those appeals, Petitioner relied on evidence from 2005 and 2006, and said that it was "in the process" of comparing the data from the January 2010 survey, but, because so many deficiencies were cited in January 2010, it would take "approximately 60 days to complete the queries." P. Br. at 5-9. Petitioner submitted this argument and its evidence more than nine months after the date of the survey and five months after I issued my pre-hearing order. Petitioner thus had ample time in which to gather its evidence. In any event, Petitioner did not submit the promised data.

Petitioner also relied on allegations that a state surveyor made biased remarks during an *October 2004* survey. P. Ex. 2; P. Br. at 9-10. Petitioner made the same claims in its earlier appeals to the Board and the Third Circuit. The Court of Appeals characterized Petitioner's reliance on the surveyor's remarks as "misplaced." It found the remarks "clearly taken out-of-context," as well as "not relevant or facially discriminatory." 2011 *Jewish Home of E. Pa.,* WL 477818 at 9. The Court's decision resolves the issue.

Change in scope and severity. Next, Petitioner complains that CMS did not follow the state agency's recommendation that the deficiency cited under 42 C.F.R. § 483.25(c) (Tag F314 – pressure sores) be cited at scope and severity level D (an isolated instance of noncompliance that caused no actual harm, but with the potential for more than minimal harm) and instead cited it at level G (an isolated instance of noncompliance that caused actual harm). First, CMS plainly has the authority to determine the scope and severity of deficiencies, and, where its opinion conflicts with that of the state agency, CMS prevails. *See* 42 C.F.R. § 488.452. In any event, I have no authority to review that determination. An Administrative Law Judge (ALJ) may review CMS's scope and severity findings only if a successful challenge would affect the range of the CMP or if CMS has made a finding of substandard quality of care that results in the loss of approval of a facility's nurse aide training program. 42 C.F.R. § 498.3(b)(14); 42 C.F.R. § 498.3(d)(10); *Cedar Lake Nursing Home*, DAB No. 2344, at 9 (2010); *Evergreen Commons*, DAB No. 2175 (2008); *Aase Haugen Homes*, DAB No. 2013 (2006). Here, the per-day penalty is in the same lower range whether the deficiencies are cited at a D or a G level of scope and severity. (42 C.F.R. § 488.438(a)(ii)). Petitioner does not allege, nor does it appear that CMS found substandard quality of care resulting in the loss of approval of the facility's nurse aide training program. CMS Ex. 2. Petitioner is therefore not entitled to review of the scope and severity finding.

CMS's procedures for calculating the CMP. Petitioner faults the method by which CMS determined the CMP, arguing that the agency arrived at the amount without considering the facility's culpability. I note first that a facility's culpability can only increase the penalty; absence of culpability is not a mitigating factor. 42 C.F.R. § 488.438(f)(4).

Thus, CMS's purported failure to consider the facility's culpability could only have benefited Petitioner. Moreover, I have no authority to review CMS's internal decision-making processes. The Board has consistently rejected the notion that an ALJ should consider whether CMS followed the correct procedures in setting the amount of the CMP.

> The ALJ resolves [the question of whether the amount of the CMP is reasonable] de novo in the sense that the determination is based on the evidence as it is developed before the ALJ and not on how CMS evaluated the evidence as it stood at whatever point CMS made its assessment.

Emerald Oaks, DAB No. 1800 at 13(2001), *accord Woodland Oaks Healthcare Facility*; DAB No. 2355 at 21 (2010); *CarePlex of Silver Spring*, DAB No. 1683 (1999).

Delays in reviewing the reasonableness of a CMP. Facility history is a factor I consider in deciding whether a CMP is reasonable. 42 C.F.R. § 488.438(f). In Petitioner's view, the facility history cannot be assessed until all avenues of appeal have been exhausted. Thus, in its pre-hearing brief, Petitioner argued that I could not decide the reasonableness of the CMP until the Third Circuit decided its appeals of 2005 and 2006 survey findings, and the Board decided its appeal of 2007 and 2008 survey findings. P. Br. at 24-25. Now that the Third Circuit and the Board have resolved those cases in favor of CMS, and the Third Circuit has denied its motion for rehearing *en banc* (CMS Ex. A), Petitioner says that it plans to appeal its losses to the United States Supreme Court and the Third Circuit respectively, and that, until those appeals are resolved, presumably by the Supreme Court, I may not review the reasonableness of the CMP. P. Opp. at 3-4.

Petitioner does not support its position with any persuasive authority or rational argument. Moreover, its position is wholly impracticable and would defeat the underlying purposes of imposing CMPs. The CMP should be at a level that might reasonably be expected to induce the facility to correct its deficiencies and maintain substantial compliance. *CarePlex of Silver Spring*, DAB No. 1638, at 8. To that end, CMS (and the ALJ) consider the factors set forth in 42 C.F.R. § 488.438(f), which include the facility's history of noncompliance. Under Petitioner's theory, CMS (and the ALJ) would be faced with two unpalatable choices: 1) ignore the regulation and disregard facility history in determining the amount of the CMP; or 2) for any facility with a history of deficiencies, wait until all appeals have been exhausted before determining the amount of the CMP. So, inasmuch as Petitioner here is still appealing deficiencies found in 2005, CMS could not have imposed on Petitioner any CMPs for the last six years. Not only would this encourage delay and meritless appeals, it would make unworkable a regulatory scheme that relies on the imposition of CMPs to compel facilities to correct their deficiencies and maintain substantial compliance.

2. The penalty imposed -- $600 per day -- is not unreasonably high.

To determine whether a CMP is reasonable, I apply the factors listed in 42 C.F.R. § 488.438(f): 1) the facility's history of noncompliance; 2) the facility's financial condition; 3) 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 absence of culpability is not a mitigating factor. The factors in 42 C.F.R. § 488.404 include: 1) the scope and severity of the deficiency; 2) the relationship of the deficiency to other deficiencies resulting in noncompliance; and 3) the facility's prior history of noncompliance in general and specifically with reference to the cited deficiencies.

As noted above, I consider whether the evidence supports a finding that the amount of the CMP is at a level reasonably related to an effort to produce corrective action by a provider with the kind of deficiencies found, and in light of the section 488.438(f) factors. I am neither bound to defer to CMS's factual assertions, nor free to make a wholly independent choice of remedies without regard for CMS's discretion. *Barn Hill Care Ctr.*, DAB No. 1848, at 21 (2002); *Cmty. Nursing Home*, DAB No. 1807, at 22 *et seq*. (2002); *Emerald Oaks*, DAB No. 1800, at 9 (2001); *CarePlex of Silver Spring*, DAB No. 1638, at 8.

In light of the facility's dismal history, CMS has imposed a remarkably modest penalty – $600 per day – which is at the low end of the penalty range for per-day CMPs ($50-$3,000). 42 C.F.R. §§ 488.408(d), 488.438(a)(1).

In every annual survey since 2005, the facility has been out of substantial compliance with program requirements. CMS Ex. 30 at 4 (Van Wieren Decl. ¶ 9); CMS Ex. 30 at 6-9. Many of the deficiencies cited during the January 2010 survey are recurring problems, including:

- 42 C.F.R. § 483.10(b)(11) (Tag F157 – notification of changes), cited in October 2006;
- 42 C.F.R. § 483.25(c) (Tag F314 – pressure sores), cited in February 2009 and November 2007;
- 42 C.F.R. § 483.35(i) (Tag F371 – sanitary conditions), cited in February 2009, November 2007, and October 2006);
- 42 C.F.R. § 483.60 (Tag F431 – pharmacy services), cited in February 2009

- 42 C.F.R. § 483.65(a) (Tag F441 – infection control), cited in October 2006; and

- 42 C.F.R. § 483.75(l)(1) (Tag F514 – clinical records), cited in October 2006.

CMS Ex. 30 at 6-9.

CMS has, over the years, imposed penalties ranging from $350 per day (2005) to $600 per day (2007-2008). *Jewish Home of E. PA*, DAB No. 2254 at 1 (2009). Yet, none of these penalties were sufficient to produce ongoing corrective action. In its efforts to compel ongoing compliance, CMS could therefore justifiably impose significantly higher penalties.

By itself, the facility history more than justifies the penalty imposed.

With respect to the remaining factors, Petitioner does not claim that its financial condition affects its ability to pay this relatively small CMP. The sheer number of deficiencies cited at scope and severity levels D, E (pattern of substantial noncompliance that caused no actual harm, with the potential for more than minimal harm), F (widespread substantial noncompliance that caused no actual harm, with the potential for more than minimal harm), and G also independently justifies the penalty imposed.

Conclusion

Petitioner has not challenged CMS's determination that, from January 14 through February 11, 2010, it was not in substantial compliance with Medicare program requirements. Nor has it challenged any material facts underlying the amount of the penalty imposed. CMS is therefore entitled to summary judgment. I sustain its determination that the facility was not in substantial compliance with Medicare program requirements and affirm the $600 per-day penalty.

/s/
Carolyn Cozad Hughes
Administrative Law Judge