Department of Health and Human Services
DEPARTMENTAL APPEALS BOARD
Appellate Division

Ridgecrest Healthcare Center
Docket No. A-12-132
Decision No. 2493
January 8, 2013

FINAL DECISION ON REVIEW OF ADMINISTRATIVE LAW JUDGE DECISION

Ridgecrest Healthcare Center (Ridgecrest or Petitioner) appeals the June 29, 2012 decision of Administrative Law Judge (ALJ) Carolyn Cozad Hughes upholding the determination by the Centers for Medicare & Medicaid Services (CMS), based on an annual recertification survey on June 18, 2010 and a revisit survey on September 30, 2010 conducted by the California Department of Public Health (CDPH), that Ridgecrest was not in substantial compliance with the requirements for Medicare participation at 42 C.F.R. § 483.25(h). *Ridgecrest Healthcare Ctr.*, DAB CR2561 (2012) (ALJ Decision). The ALJ concluded that Ridgecrest failed to establish that it had returned to substantial compliance before November 24, 2010, which is the date CDPH conducted a second revisit survey. The ALJ found that Ridgecrest failed to maintain a wheelchair belonging to one of the residents in working order and failed to have a system in place to ensure that wheelchairs remained in proper working order in violation of section 483.25(h). Finally, the ALJ concluded that the civil money penalties (CMPs) imposed by CMS — $1,000 per day from June 19 through September 29, 2010 and $150 per day from September 30 through November 23, 2010 — were reasonable.

For the reasons explained below, we affirm the ALJ Decision.

Background[1]

The Social Security Act (Act) sets forth requirements for nursing facility participation in the Medicare or Medicare programs, and authorizes the Secretary of Health and Human Services to promulgate regulations implementing those statutory provisions. Act § 1819.

[1] The statutory and regulatory background is set out in more detail on pages 2-5 of the ALJ Decision. The factual information in this section, unless otherwise indicated, is drawn from undisputed findings of fact in the ALJ Decision and undisputed facts in the record before her and is presented to provide a context for the discussion of the issues raised on appeal. Nothing in this section is intended to replace, modify, or supplement the ALJ's findings of fact or conclusions of law.

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.

The Secretary contracts with State survey agencies to conduct periodic surveys to determine whether skilled nursing facilities (SNF) 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. Survey findings are reported in a Statement of Deficiencies (SOD). A "deficiency" is a defined as a "failure to meet a participation requirement specified in the Act or [42 C.F.R. Part 483]." 42 C.F.R. § 488.301. Section 488.301 defines "substantial compliance" as "a level of compliance with the requirements of participation such that any identified deficiencies pose no greater risk to resident health or safety than the potential for causing minimal harm." *Id.* Any "deficiency that causes a facility to not be in substantial compliance" constitutes "noncompliance." *Id.*

CMS may impose various remedies on a facility that is found not to comply substantially with the participation requirements, including per-day civil money penalties (CMPs) for the number of days that the facility is not in substantial compliance, and a denial of payment for new Medicare admissions (DPNA) during the period of noncompliance. 42 C.F.R. §§ 488.406, 488.417, 488.430(a). CMS has the option to impose either a per-instance or per-day CMP whenever a facility is not in substantial compliance. 42 C.F.R. § 488.408(d)(3)(i). A per-day CMP may accrue from the date the facility was first out of compliance until the date it is determined to have achieved substantial compliance. 42 C.F.R. § 488.440(a)(1),(b). For noncompliance determined to pose immediate jeopardy, CMS may impose per-day CMPs in amounts ranging from $3,050-$10,000 per day. 42 C.F.R. § 488.408(e)(2)(i),(ii). For noncompliance at less than the immediate jeopardy level, CMS may impose per-day CMPs in amounts ranging from $50-3,000 per day. 42 C.F.R. § 488.408(d) (1) (iii). The regulations set out a number of factors that CMS considers in determining the amount of a CMP. 42 C.F.R. §§ 488.438(f), 488.404.

In general, when a facility has been found not to be in substantial compliance with the participation requirements, the facility must submit a plan of correction (PoC) that is acceptable to CMS or the state agency. 42 C.F.R. §§ 488.402(d), 488.408(f). If CMS accepts a noncompliant SNF's PoC, the facility must then timely implement all of the steps that it identified in the PoC as necessary to correct the cited problems. *Cal Turner Extended Care Pavilion*, DAB No. 2030, at 18-19 (2006); s*ee also Meridian Nursing Ctr.*, DAB No. 2265 (2009); *Lake Mary Health Care*, DAB No. 2081, at 29 (2007). A noncompliant facility "is not considered to be [back] in substantial compliance until a determination has been made, through a revisit survey or based on 'credible written evidence' that 'CMS or the State can verify without an on-site visit,' that the facility

returned to substantial compliance." *Omni Manor Nursing Home*, DAB No. 2431, at 6 (2011) (citing or quoting 42 C.F.R. § 488.454(a)(1) and *Oceanside Nursing & Rehab. Ctr.*, DAB No. 2382, at 20 (2011)). The Board has previously held that the noncompliance found during a survey is "presumed to continue until the facility demonstrates that it has achieved substantial compliance." *Taos Living Ctr.*, DAB No. 2293, at 20 (2009). The regulations and prior Board decisions also make clear that a facility's "noncompliance is deemed to be corrected or removed only when the incidents of noncompliance have ceased and the facility has implemented appropriate measures to ensure that similar incidents will not recur." *Florence Park Care Ctr.*, DAB No. 1931, at 30 (2004); *see also Oceanside* at 20. Moreover, the facility "bears the burden of showing that it returned to substantial compliance on a date earlier than that determined by CMS," and the Board "has rejected the idea that CMS must establish a lack of substantial compliance during each day in which a remedy remains in effect." *Owensboro Place & Rehab. Ctr.*, DAB No. 2397, at 12 (2011).

Section 483.25(h) is part of the quality of care regulation at section 483.25, which states that "[e]ach 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." Section 483.25(h) imposes specific obligations upon a facility related to accident hazards and accidents, as follows:

> The facility must ensure that —
>
> (1) The resident environment remains as free of accident hazards as is possible; and
> (2) Each resident receives adequate supervision and assistance devices to prevent accidents.

The Board has held that section 483.25(h)(1) requires that a facility address foreseeable risks of harm from accidents "by identifying and removing hazards, where possible, or where the hazard is unavoidable because of other resident needs, managing the hazard by reducing the risk of accident to the extent possible." *Maine Veterans' Home - Scarborough*, DAB No. 1975, at 10 (2005). The Board has held that section 483.25(h)(2) requires that a facility take "all reasonable steps to ensure that a resident receives supervision and assistance devices that meet his or her assessed needs and mitigate foreseeable risks of harm from accidents." *Briarwood Nursing Ctr.*, DAB No. 2115, at 11 (2007), citing *Woodstock Care Ctr. v.*, DAB No. 1726 (2000) (facility must take "all reasonable precautions against residents' accidents"), aff'd, *Woodstock Care Ctr. v. Thompson*, 363 F.3d 583 (6th Cir. 2003).

Ridgecrest is a long-term care facility located in Ridgecrest, California, that participates in the Medicare program. Following its annual survey by the State survey agency, CDPH, that was completed June 18, 2010, CMS determined that the facility was not in

substantial compliance with several Medicare program requirements and that, for one day, its deficiencies posed immediate jeopardy to resident health and safety. P. Ex. 1. Most germane to this case is CMS's determination that Ridgecrest was not in substantial compliance with section 483.25(h) because the brakes on the wheelchair for Resident 6 were broken.[2] P. Ex. 2, at 46.

In response to the June survey findings, Ridgecrest submitted a PoC listing a "compliance date" of August 13, 2010, indicating that it had corrected the deficiencies as of that date, including having a system in place to ensure inspection and repair of malfunctioning wheelchairs. P. Ex. 2, at 46. CDPH conducted a revisit survey of Ridgecrest on September 30, 2010. Based on the survey findings, CMS determined that Ridgecrest remained out of substantial compliance with the Medicare requirements governing accident prevention at section 483.25(h) due to malfunctioning brakes on the wheelchair of R6/12. CMS Ex. 1. CMS also determined that Ridgecrest was also not in substantial compliance with section 483.25(h) based on the facility's use of Marissa slings on other residents. *Id.*

On November 24, 2010, CDPH conducted a second revisit survey of Ridgecrest. Based on the survey findings, CMS determined that the facility returned to substantial compliance as of November 24. P. Ex. 8, at 5.

Based upon the results of the June survey, CMS imposed a CMP of $10,000 for one day of immediate jeopardy (June 17, 2010) and $1,000 per day for 104 days of noncompliance that was not immediate jeopardy (June 18 through September 29, 2010). P. Ex. 3, at 2. Based upon the results of the September 30 revisit survey, CMS reduced the CMP to $150 per day for an additional 55 days (September 30 through November 23, 2010). P. Ex. 8, at 3. CMS also imposed a DPNA that was in effect from August 18 through November 23, 2010.

Ridgecrest did not appeal any of deficiencies based on the June survey findings and did not appeal the $10,000 CMP based on the immediate jeopardy finding. ALJ Decision at 3; P. Br. at 2-3; Pre-Hearing Conference Order at 2 (Sept. 15, 2011). However, Ridgecrest requested a hearing before an ALJ to challenge CMS's determination of the date it returned to substantial compliance, as well as the reasonableness of the CMPs imposed after the immediate jeopardy was abated. Before the ALJ, Ridgecrest contended that it returned to substantial compliance on August 13, the date on which the facility had submitted its PoC. ALJ Decision at 4.

[2] Resident 6 from the June survey was identified as Resident 12 in the SOD from the September 30 revisit survey. CMS Ex. 7, at 3. The ALJ refers to the resident as R6 throughout her decision. In contrast, Ridgecrest refers to the same resident as either Resident 12 or R12, and CMS refers to the resident as Resident 6/12 in its briefing. For the sake of clarity, we will refer to the resident as R6/12 herein unless the reference is part of a direct quote.

In compliance with a pre-hearing order, the parties submitted the direct testimony of their witnesses in writing in advance of the hearing. Ridgecrest submitted written direct testimony from the following individuals: Sharon Aleo (Director of Nursing), James Kapp (former maintenance supervisor), Letica Zubia (licensed LVN), Robin Becker (Director of Staff Development), Bertha Madarasz (certified nursing assistant), Vanessa Vertudes (nurse consultant), and Eugene Tito (licensed nurse and licensed nursing home administrator). P. Exs. 16-22. CMS submitted written direct testimony from CDPH surveyor Todd Elkins. CMS Ex. 7.

On November 7, 2011, the ALJ convened a video hearing from the offices of the Departmental Appeals Board in Washington, D.C. Counsel and witnesses convened in Bakersfield, California. Ridgecrest cross-examined surveyor Elkins, and CMS chose to cross-examine only Ms. Aleo, Ms. Becker, Ms. Madaraz, and Mr. Kapp. Tr. at 3.

The ALJ Decision

The two issues before the ALJ were: 1) Did Ridgecrest correct the deficiencies from the June 18 survey and achieve substantial compliance prior to November 24, 2010 and, if so, when?; and 2) if Ridgecrest's noncompliance continued beyond June 18, were the CMPs imposed — $1,000 per day from June 19 through September 29 and $150 per day from September 30 through November 23, 2010 — reasonable? ALJ Decision at 4.

The ALJ first concluded that Ridgecrest did not establish that it had corrected the deficiencies cited under section 483.25(h) and had returned to substantial compliance before November 24, 2010. ALJ Decision at 4, 12. The ALJ found that Ridgecrest did not implement all of the steps that had it identified in its PoC as necessary for it to achieve substantial compliance as of August 13, 2010. Specifically, contrary to assurances in the facility's PoC, Ridgecrest had not: 1) implemented effective procedures for ensuring that broken wheelchairs were promptly identified, reported to maintenance, and repaired; 2) inspected and repaired all of its wheelchairs; and 3) ensured that the brakes on R6/12's wheelchair functioned properly. ALJ Decision at 7. The ALJ observed that the "absence of effective procedures was especially problematic, because most of the facility's wheelchairs were old and had required multiple repairs." *Id*. (citation omitted).

Based on these findings, the ALJ concluded that Ridgecrest failed to ensure that each resident's environment remained as free of accident hazards as possible and, therefore, was not in substantial compliance with section 483.25(h).

The ALJ also concluded that the CMPs imposed were reasonable.

Standard of Review

The Board's standard of review on a disputed finding of fact is whether the decision is supported by substantial evidence on the record as a whole. *Guidelines for Appellate Review of Decisions of Administrative Law Judges Affecting a Provider's Participation in the Medicare and Medicaid Programs* (Board Guidelines), available at http://www.hhs.gov/dab/divisions/appellate/guidelines/prov.html. "Substantial evidence" is "more than a mere scintilla. It means such relevant evidence as a reasonable mind might accept as adequate to support a conclusion." *Richardson v. Perales*, 402 U.S. 389, 401 (1971), *quoting Consolidated Edison Co. v. NLRB*, 305 U.S. 197, 229 (1938). Under the substantial evidence standard, the reviewer must examine the record as a whole and take into account whatever in the record fairly detracts from the weight of the evidence relied on in the decision below. *Universal Camera Corp. v. NLRB*, 340 U.S. 474, 488 (1951). The Board's standard of review on a disputed conclusion of law is whether the ALJ's decision is erroneous. Board Guidelines.

Analysis[3]

A. The ALJ's conclusion that Ridgecrest did not establish that it corrected the deficiencies cited under 42 C.F.R. § 483.25(h) prior to November 24, 2010 is supported by substantial evidence in the record and is free from legal error.

Ridgecrest appeals the ALJ Decision sustaining CMS's determination that the facility was not in substantial compliance from June 18-November 23, 2010. Ridgecrest contends that a preponderance of the evidence demonstrates it returned to substantial compliance on August 13, 2010. The ALJ rejected this argument on the grounds that the facility did not complete the terms of its PoC by August 13.

Ridgecrest maintains that it returned to substantial compliance by August 13, 2010, which is the date of compliance stated in the PoC that Ridgecrest submitted to CDPH. P. Br. at 3, 15-18; P. Ex. 2, at 45-46. The PoC provided that, among other things, Ridgecrest's maintenance supervisor, Mr. Kapp, had fixed the wheelchair for R6/12 and would "monitor all wheelchairs during daily routine rounds to ensure that they are in good repair." P. Ex. 2, at 45-46. The facility's PoC also stated that Mr. Kapp had inspected "all other wheelchairs" to ensure that their brakes were "in good functioning." *Id.* at 46.

[3] Although we do not specifically discuss all of the evidence and arguments presented, we have fully considered all arguments raised on appeal and reviewed the entire record.

The ALJ disagreed, concluding that Ridgecrest did not establish that it had corrected the deficiencies under section 483.25(h) prior to November 24, 2010. ALJ Decision at 4, 12. In support of her conclusion, the ALJ found that "the facility did not implement all of the steps it identified as necessary for it to achieve substantial compliance." *Id*. at 10. The ALJ specifically found that Ridgecrest "did not maintain R6's wheelchair brakes in good working order and had no effective system in place to ensure that all other wheelchairs were kept in good repair."[4] *Id*.

The facility argues that, contrary to the ALJ's finding, it did have a system in place as indicated in the PoC to ensure that broken wheelchairs were promptly identified and reported to Mr. Kapp for repair. P. Br. at 13. In support of its argument, Ridgecrest argues that only one defective wheelchair was found during the June survey and the "one wheelchair found during the September 2010 [revisit] Survey was not a priority because the resident was not in the building." *Id*. Ridgecrest also points out that Mr. Kapp spent approximately two and a half hours a day repairing wheelchairs. *Id.*, citing Tr. at 168, 178. Ridgecrest also argues that no person was ever injured at the facility due to a non-functioning wheelchair. P. Br. at 13.

Even assuming these facts are true, they would not suffice to show that the facility had implemented all of the measures contained in its PoC in order to return to substantial compliance as of August 13, 2010. Ridgecrest does not directly address the ALJ's finding that the facility "plainly had no such system in place" for ensuring that wheelchairs remain in good repair. ALJ Decision at 9. Ridgecrest does not dispute the ALJ's finding that it had no **written** policy in place to ensure that the resident's wheelchair would be repaired and safe for use when she returned to the facility from the acute care hospital. P. Br. at 22-23. The Director of Nursing, Ms. Aleo, confirmed during her redirect-examination that the facility did not have a written policy for monitoring and repairing wheelchairs used by its residents. Tr. at 108, 111. Indeed, Ms. Aleo testified that while the facility now has a written policy, it was only "becoming our standard" at the time of the September revisit survey. *Id.* at 111. Mr. Kapp testified that he was attempting to develop a system (which he referred to as an "inventory/log") for identifying the facility's wheelchairs, their location and repair history. However, he also acknowledged the system was "in the process of developing" and was "never completed." *Id.* at 183-84. Even more significantly, as the ALJ found, Mr. Kapp tried to develop the system on his own initiative and no one from the facility's management

[4] Petitioner concedes that the brakes to R6/12's wheelchair were broken at the time of the June 30 survey but maintains that, consistent with the assurance of its POC, it had fixed them immediately thereafter. P. Br. at 18-19. Maintenance Supervisor Kapp testified that he repaired R6/12's wheelchair brakes during the June survey, on the same day they were brought to his attention, and the ALJ found his testimony credible. ALJ Decision, at 7, citing P. Ex. 17 at 3; Tr. 167-168, 177. Neither party challenges the ALJ's finding.

required him to do so. *Id.* at 184 ("Nobody told me to do it. I just did it on my own."); *see* also *id*. at 191. Although Ms. Aleo testified that the facility had a "communication log" that was used to report problems with a resident's wheelchair, the ALJ noted that Ridgecrest did not submit the log as evidence during the hearing. *Id*. at 111; ALJ Decision at 9.

Despite these facts, Ridgecrest contends that "CMS at no time offered evidence to rebut, contradict, or address any contention by Ridgecrest that Ridgecrest returned to substantial compliance on August 13, 2010, when Ridgecrest submitted its PoC as set forth in the Declarations of Vanessa Vertudes [nurse consultant], Sharon Aleo [Director of Nursing], and Eugene Tito [Ridgecrest's administrator]." P. Br. at 16. Ridgecrest argues that Ms. Vertudes and Ms. Aleo both testified that all of the issues identified during the June 2010 survey had been corrected as of August 13, 2010 and that this testimony is unrebutted because CMS chose not to cross examine these witnesses. P. Br. at 16, 17. However, as discussed above, substantial evidence in the record demonstrates that the facility had not implemented all of the measures that were listed in its PoC. Moreover, the testimony from Ms. Vertudes, Ms. Aleo, and Mr. Tito is plainly insufficient to establish that Ridgecrest returned to substantial compliance on August 13. For example, Ms. Vertudes's testimony regarding substantial compliance consists of only a single conclusory sentence that does not identify what steps the facility took to correct the deficiencies from the June 2010 survey or explain why the facility returned to substantial compliance as of August 13. P. Ex. 21, at 3 ("I personally affirmed that each and every deficiency identified in the June 18, 2010 survey was corrected and that Ridgecrest was in substantial compliance with the Plan of Correction submitted on August 13, 2010."). [5] Neither Ms. Aleo nor Mr. Tito even testified that the facility had returned to substantial compliance on August 13. P. Exs. 16, 22. Indeed, Ms. Aleo did not identify any particular steps that the facility took to correct the deficiencies from the June survey, even though she testified that she participated in the preparation of the PoC. *See* P. Ex. 16, at 2.

[5] Ridgecrest contends that the ALJ's refusal to permit it to supplement the written declarations of its witnesses with oral testimony is unfair, biased and prejudicial to a small provider such as Ridgecrest because the "procedure provides an unfair advantage to CMS which has a panel of attorneys who either personally or through their office regularly appear before ALJ Hughes." P. Br. at 36. "[T]he Board has previously upheld the discretion of the ALJ to receive direct testimony in written form, so long as the right to effective cross examination is protected and no prejudice is alleged and shown." *Golden Living Ctr.-Frankfort*, DAB No. 2296, at 4 (2009) (internal quotation marks omitted), *aff'd, Golden Living Ctr.-Frankfort v. Sec. of Health & Human Svcs.,* No. 10-320 (6th Cir. Aug. 31, 2011), *available at http://www.ca6. uscourts.gov/opinionspdjlll a0249p-06.pdj*. Ridgecrest has not alleged or otherwise explained how it was prejudiced by the ALJ's refusal to permit its witnesses to supplement their written testimony. Thus, we see nothing in the record indicating that the ALJ improperly curtailed Ridgecrest's right of cross-examination or that Ridgecrest was unfairly prejudiced by the ALJ's requirement to submit direct testimony in writing.

Thus, we agree with the ALJ's statement that there is "virtually no evidence of any meaningful management involvement in ensuring that repairs were timely reported and made nor evidence that staff timely learned about malfunctioning equipment." ALJ Decision at 10. We further agree the ALJ's finding that Ridgecrest failed to have an effective system in place to ensure that all wheelchairs were kept in good repair is supported by substantial evidence in the record. These conclusions are further bolstered by the deficiency findings from the revisit survey which demonstrate that the same kinds of problems were still persisting at the facility in September 2010, as we discuss in the next section.

Thus, the ALJ's conclusion that Ridgecrest did not establish that it corrected the deficiencies cited under 42 C.F.R. § 483.25(h) prior to November 24, 2010 is supported by substantial evidence in the record and is free from legal error.

B. The ALJ's conclusion that Ridgecrest was not in substantial compliance with section 483.25(h) is supported by substantial evidence in the record and is free from legal error.

The ALJ also found that Ridgecrest was not in substantial compliance as of the date of the first revisit survey, September 30, 2010.[6] ALJ Decision at 4, 12. The ALJ correctly noted that the facility had to demonstrate not only that it returned to substantial compliance but also that it was capable of remaining in substantial compliance. *Id*. at 7, citing 42 C.F.R. § 488.454(e); *Hermina Traeye Mem'l Nursing Home*, DAB No. 1810, at 12 (citing 42 C.F.R. § 488.454(a) and (e)); *Cross Creek Care Ctr.*, DAB No. 1665 (1998). She also sustained CMS's determination based on the September 30, 2010 revisit survey that Ridgecrest was noncompliant with section 483.25(h). Ridgecrest contends that the "preponderance of the evidence shows that the wheelchair of Resident 12 was repaired, an ongoing system was in place to ensure all wheelchairs were inspected and repaired as necessary, and there was not a potential of more than minimal harm for any resident." P. Br. at 18. However, as previously explained, our standard of review of the ALJ Decision is whether her factual findings are supported by substantial evidence in the record as a whole and whether her legal conclusions based on that evidence are erroneous. As explained below, we conclude that Ridgecrest has not pointed to any evidence that the ALJ failed to address in her analysis that detracts from her factual findings or demonstrated that the findings otherwise lack substantial evidence.

[6] The ALJ did not address the second noncompliance finding from the September 30 revisit survey involving the placement of the Marissa slings based on her conclusion that Ridgecrest's deficiencies regarding identification and repair of wheelchair brakes justify the CMPs imposed following the September survey. ALJ Decision, at 10 n.6. Before us, Ridgecrest addressed this deficiency in order "to avoid any implication that Ridgecrest has evidenced or conceded any indication of non-compliance." P. Br. at 29-33. CMS did not offer any response to Ridgecrest's arguments on this issue. For the reasons previously expressed by the ALJ, we will not consider Ridgecrest's arguments involving the Marissa slings in this decision.

During the September 30 revisit survey, Surveyor Elkins sought to learn whether Ridgecrest had completed the actions identified on its PoC. CMS Ex. 7, at 2. He examined R6/12's wheelchair because it had been identified as needing repair during the June survey and "observed that the two front brakes did not secure the wheelchair when engaged, and that the wheelchair moved forward easily when pushed with a slight force." CMS Ex. 7, at 3; Tr. at 75. Surveyor Elkins subsequently spoke to Licensed Vocational Nurse Letticia Zubia, who confirmed that the brakes did not work properly. CMS Ex. 7, at 3-4; P. Ex. 18, at 1; Tr. at 60. Before the ALJ, Ridgecrest conceded that the brakes on R6/12's wheelchair were broken at the time of the September 30 survey but argued that it was the back brakes that were nonfunctional.[7] ALJ Decision at 7. The ALJ noted that the "parties argue about whether Surveyor Elkins observed and discussed broken front brakes, broken back brakes, or both." *Id*. at 6. The ALJ found "this dispute of little consequence" because "Surveyor Elkins testified, credibly, that the wheelchair moved even when the brakes were engaged" and that Ridgecrest "has not refuted this testimony." *Id*. Although Ridgecrest contends that the ALJ did not mention the inconsistency in Surveyor Elkins testimony, P. Br. at 21, we defer to the ALJ's credibility determination, especially in light of her conclusion that the inconsistency is not relevant given that the parties agree the brakes were not working and the wheelchair moved forward even with the slightest push.[8] ALJ Decision at 6.

Although the wheelchair being used by R6/12 undisputedly had malfunctioning brakes, it had not been inspected or scheduled for repair as of the September 30 resurvey.[9] The ALJ also found that the facility had not established how long the brakes had been broken prior to R6/12's admission to an acute care hospital three days earlier and that the wheelchair had been left in her room with no indication it was broken and no plan for repair. ALJ Decision at 8. Ridgecrest argues that there is no regulation requiring the facility to place a note on the wheelchair to indicate it was broken and that there is no

[7] During cross-examination, Mr. Kapp testified that the wheelchair Surveyor Elkins examined during the September 30 revisit survey was a different wheelchair from the one at issue in June survey. Tr. at 172-74. However, the ALJ found that facility records show the same wheelchair in the same room with the same resident and with the same serial number. ALJ Decision at 8; *see also* P. Ex. 13, at 2, 3. The ALJ went on to "find it ultimately irrelevant whether the broken wheelchair Surveyor Elkins examined in September was the same one that the surveyors inspected in June. Replacing R6's broken wheelchair with another broken wheelchair would not have corrected the deficiency." ALJ Decision at 8. We agree.

[8] We defer to credibility findings unless there is a "compelling" reason not to do so, and Ridgecrest has not proffered any such reason here. *Woodland Oaks Healthcare Facility*, DAB No. 2355, at 7 (2010); *Koester Pavilion*, DAB No. 1750, at 15, 21 (2000).

[9] Although Ms. Aleo testified that R6/12's wheelchair "was on the maintenance schedule to be fixed" at the time of the September 30 revisit survey, T. at 98, P. Ex. 16 at 2-3, the ALJ found that her testimony was not credible in light of Mr. Kapp's testimony that he did not learn the brakes were broken until *after* Surveyor Elkins observed the wheelchair in R6/12's room. ALJ Decision at 9; Tr. at 187. Similarly, Ms. Aleo also testified that staff reported such problems on a "maintenance log" and on a "communication log." Tr. at 96, 97, 111-12. However, the ALJ observed that the facility had not produced any log entries showing that the broken brakes were reported anytime between June and September. ALJ Decision at 9.

evidence that Ridgecrest knew or should have known the wheelchair was broken. P. Br. at 22. However, this argument is undercut by its statement that, "The uncontroverted evidence is that Ridgecrest was aware that the wheelchair in question needed repairs and that Ridgecrest intended to have the repairs done before R12 returned to Ridgecrest." P. Br. at 23-24. Moreover, given that the wheelchair for the same resident had previously been broken and was the focal point of the deficiency for the June survey, the facility was on notice that this wheelchair was problematic, especially given that the chair was "old" and had been "repaired multiple times" before September 2010. CMS Ex. 1, at 2; Tr. at 168.

Ridgecrest also argues that the ALJ failed to consider evidence indicating that there was no potential for more than minimal harm to any resident. P. Br. at 18, 36. In support of this argument, Ridgecrest states, "It is uncontroverted that R12 could not possibly get hurt by using a wheelchair when she is completely outside of the building and not using the chair at all." *Id*. at 24. This argument is without merit. The ALJ specifically considered the danger to **any** facility resident who used the broken wheelchair and found that, "Whatever the underlying cause [of the broken brakes], the evidence establishes that R6's wheelchair brakes did not prevent the chair from moving, which, everyone agrees, endangers **any** resident who uses the broken chair." ALJ Decision at 6 (emphasis added). The ALJ thus implied that the potential for the broken wheelchair to be used in R 6/12's absence presented a risk of more than minimal harm because the brakes were not functional and the wheelchair could be pushed forward with only a "slight force." Such uncontrolled movement, the ALJ reasonably inferred, could endanger the occupant of the wheelchair and nearby residents or staff. This conclusion is consistent with the unrebutted testimony of Surveyor Elkins who stated, "The failure of the brakes on Resident 12's wheelchair, or any other wheelchair in the facility, could cause serious injury or death to the resident." CMS Ex. 7, at 4. Surveyor Elkins further testified, "if a resident attempted to lean on or stand up using a wheelchair with faulty brakes and the wheelchair moved suddenly, the resident could suffer a potentially catastrophic fall." *Id*. at 4-5. Here, the ALJ could reasonably infer that a resident might be at risk not only while sitting in the wheelchair but even by using it for support, unaware of its instability.

For these reasons, the ALJ's conclusion that Ridgecrest did not ensure that each resident's environment remained as free of accident hazards as possible and was not in substantial compliance with section 483.25(h) is supported by substantial evidence in the record and is free from legal error.

C. The ALJ did not err in concluding that the CMP amounts were reasonable.

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). To determine the amount of

a CMP, CMS considers the following factors: The facility's history of noncompliance (including repeated deficiencies), its financial condition, its degree of culpability for the cited deficiencies, the seriousness of the noncompliance, and the relationship of one deficiency to the other deficiencies resulting in noncompliance. *Id.* §§ 488.404, 488.438(f).

If a facility challenges the amount of a CMP imposed by CMS, the role of an ALJ on appeal is to determine whether the amount of the CMP imposed is reasonable. *Brian Ctr. Health & Rehab./Goldsboro*, DAB No. 2336, at 12 (2010). The ALJ's determination of whether a CMP amount is reasonable is conducted de novo based on the facts of the case contained in the appeal record, and "the only relevant evidence that the ALJ can consider is that which falls within the scope of the regulatory factors." *Jewish Home of E. Pa.*, DAB No. 2451, at 13 (2012) (citations omitted); *Cedar Lake Nursing Home*, DAB No. 2288, at 14 (2009) ("[W]hether the CMP amount is reasonable is a legal conclusion to be drawn from the application of regulatory criteria to the facts of the case."). "A facility bears the burden of introducing evidence or argument challenging specific regulatory factors at 42 C.F.R. § 488.438(f) for determining the reasonableness of the CMP amount." *Windsor House*, DAB No. 1942, at 62 (2004).

Here, CMS imposed a CMP in the amount of $10,000 for one day (June 17, 2010), which the facility did not appeal. *See* Pre-Hearing Conference Order at 2. CMS also imposed a CMP in the amount of $1,000 per day from June 18 through September 29, 2010 (104 days for a total of $104,000) based upon the results of the June survey. CMS subsequently imposed a reduced CMP in the amount of $150 per day from September 30 through November 23, 2010 (55 days for a total of $82,500) based upon the results of the September survey. The total amount of the CMPs imposed was $122,500.

In evaluating the regulatory factors, the ALJ stated, "CMS does not argue that the facility's history [of noncompliance] justifies a higher CMP." ALJ Decision at 11. The ALJ also stated that Ridgecrest had not claimed that its financial condition affected its ability to pay the CMP, *id.*, and Ridgecrest does not challenge her statement before us. The record also does not contain any indication that Ridgecrest had submitted any evidence to either CMS or the ALJ regarding its overall financial condition.

Regarding the other regulatory factors, the ALJ determined that the $1,000 per-day CMP was based on the findings of the June survey, and the "sheer number of deficiencies cited" justifies a "significant penalty." *Id.* at 11. The ALJ then recited the facts surrounding some of the deficiencies involved in the June survey that the facility did not appeal, and she concluded that even after the immediate jeopardy was abated, these deficiencies still "caused actual harm to facility residents." *Id.* The ALJ noted that the

per-day CMP range for deficiencies that did not constitute immediate jeopardy is $50 to $3,000, as provided for under 42 C.F.R. §§ 488.408(d)(1)(iii) and 488.438(a)(1)(ii). *Id.* The ALJ concluded that the $1,000 per-day CMP imposed by CMS, which she observed is at the lower end of the applicable penalty range, was reasonable in light of the seriousness of the deficiencies.

Ridgecrest does not challenge the ALJ's evaluation of these regulatory factors, but nevertheless asserts that the $1,000 per-day CMP is unreasonable.[10] P. Br. at 2. Ridgecrest specifically contends that the ALJ failed to consider the financial impact of the CMPs and DPNA in evaluating the reasonableness of the penalty imposed. P. Br. at 2. We note that this argument is untimely because the facility could have raised this issue before the ALJ but chose not to do so.[11] In any case, Ridgecrest has provided little evidence to support this claim even were we to countenance it at this late stage.

Although the total amount of the CMP imposed combined with the alleged loss of revenue associated with the DPNA in this case may indeed be significant, Ridgecrest has not submitted any evidence of its overall financial condition, as required by sections 488.404 and 444.438(f) to put that amount in the context of its ability to pay. Nor has the facility demonstrated that the amount of the CMP imposed would pose such a financial hardship that the CMP should be reduced. Because Ridgecrest did not proffer any relevant evidence that falls within the scope of the regulatory factors, we have no basis to conclude that the per-day amount of the CMP should be revised. *See Coquina Center*, DAB No. 1860, at 32 (2002) ("[T]here is a presumption that CMS has considered the regulatory factors in setting the amount of the CMP and that those factors support the CMP amount imposed by CMS. Unless a facility contends that a particular regulatory factor does not support that CMP amount, the ALJ must sustain it.").

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[10] Ridgecrest does not appear to contest the ALJ's finding that the $150 per-day CMP imposed from September 30 through November 23, 2010 is reasonable. *See* P. Br. at 1-2, 4-5, 34-36. However, to the extent Ridgecrest's overarching argument is that the ALJ failed to consider the financial impact of the entire amount of the CMP (i.e., $122,500), we find the $150 per-day CMP reasonable for the same reasons expressed by the ALJ. *See* ALJ Decision at 11 (finding the $150 per-day CMP reasonable given that the remaining deficiency from the September 30 survey "was serious, threatening resident health and safety").

[11] *See* Board Guidelines ("The Board will not consider issues . . . which could have been presented to the ALJ but were not."); *see also Columbus Park Nursing & Rehab. Ctr.*, DAB No. 2316, at 11 (2010) ("Columbus Park, however, waived its opportunity to make this argument since it failed to raise it below."). The Board has previously held that "if a facility contends that its financial condition or some other factor makes a CMP unreasonable, then the facility must raise that contention on a timely basis before any question would arise as to CMS's responsibility for producing evidence as to that factor." *Clermont Nursing & Convalescent Ctr.*, DAB No. 1923, at 31 (2004) (citations omitted); *see also* P. Ex. 3, at 2 n.1 (August 3, 2010 letter from CMS notifying Ridgecrest about the findings of the June 2010 survey and the imposition of a CMP states, "If you are of the opinion that there is information concerning your financial status that [CMS] should consider, you have the opportunity to submit such information within five (5) days of receipt of this notice."). There is nothing in the record indicating that Ridgecrest provided CMS or CDPH with any information about its financial condition.

Accordingly, we sustain the ALJ's conclusion that the amount of the CMPs imposed is reasonable.

D. The ALJ's determination of the duration of CMPs and DPNA is supported by substantial evidence and free from legal error.

The amount of the total CMP and the losses which Ridgecrest attributed to the DPNA is largely a factor of the length of time which passed before Ridgecrest regained substantial compliance. According to Ridgecrest, the combined financial impact of the CMP ($122,500) and the loss of revenues from new patients admitted during the period the DPNA was in effect is $865,904, if all the noncompliance findings, penalties, and compliance dates determined by CMS are sustained. P. Br. at 6, 35. The key question regarding duration of the $1,000 per-day CMP and the DPNA, is when Ridgecrest corrected the noncompliance from the June 2010 survey and returned to substantial compliance. *See, e.g., Plott Nursing Home*, DAB No. 2426 (2011). The approved PoC for each of the noncompliance findings from the June survey (including the two we have upheld above) identified specific corrective actions for affected residents and alleged that they would be completed on August 13, 2010. P. Ex. 1, at 46.

The Board has held that CMS does not need to establish noncompliance on each day for which it imposes a CMP. *See, e.g., Regency Gardens Nursing Center*, DAB No. 1858, at 7-11 (2002) and cases cited therein. As the Board pointed out in *Regency*, the congressional purpose in providing in 1987 for alternative remedies short of termination was to allow CMS to apply pressure to motivate facilities to solve problems quickly and so protect residents without disrupting placements unnecessarily. *See, e.g.*, H.R. Rep. No. 100-391(1), at 470-77 (1987); 59 Fed. Reg. 56,116-17, 56,177-78 (Nov. 10, 1994). Thus, the Board stated that, consistent with that purpose, "a non-compliant facility is required to promptly file for CMS's approval a plan stating when and how the facility will correct the conditions violating participation requirements and is not entitled to have the remedies lifted unless and until the facility **demonstrates** that substantial compliance has been achieved." *Regency* at 11, citing 42 C.F.R. §§ 488.401, 488.402(d)(emphasis added).

As previously discussed, we sustained the ALJ's finding that Ridgecrest did not return to substantial compliance by August 13, 2010. Ridgecrest argues that it nevertheless "reasonably believed" that it had returned to substantial compliance on that date. P. Br. at 35, citing P. Ex. 22, at 6. Ridgecrest further adds that it was "confused, misled, and prejudiced by mixed actions, mixed representations, and non-action by CMS and its agent CDPH as to the effectiveness and dates of the concurrent [DPNA] and the CMPs." *Id*. at 34. All of this, Ridgecrest argues, led to a "perfect storm" including its designation as a Special Focus Facility and CDPH's inability "to timely and adequately perform its duties" due to its severe financial crisis and understaffing. P. Br. at 3-4. As a consequence, according to Ridgecrest, CDPH "unreasonably extend[ed] the non-compliance period" thereby causing Ridgecrest to admit and provide care for new

Medicare patients while the DPNA was in effect, thinking it would be found in compliance. *Id*. at 4. Under these alleged circumstances, Ridgecrest contends that "[i]t would be inequitable for CMS to take advantage of unreasonable delays and procedural ambiguities to benefit from this situation (free care for Medicare beneficiaries[,])" and that ultimately — "The punishment does not fit the crime." *Id*. at 34-35.

We disagree. First, Ridgecrest has not explained how it "was confused, misled, and prejudiced by mixed actions, mixed representations, and non-action by CMS and its agent CDPH." P. Br. at 34. The only evidence that Ridgecrest points to is a letter from CDPH dated October 19, 2010. P. Br. at 3, citing P. Ex. 4. However, the October 19 letter does not state that Ridgecrest returned to substantial compliance on August 13, 2010. Instead, the letter states, "On September 30, 2010, we conducted a first revisit to verify that your facility had achieved and maintained compliance. We *had presumed*, based upon your allegation of compliance that your facility was in substantial compliance as of August 13, 2010." P. Ex. 4, at 1 (emphasis added). Ridgecrest contends that CMS did not offer any evidence to explain why CDPH would state in its letter that it "presumed" Ridgecrest had returned to substantial compliance when it submitted its PoC. P. Br. at 16. This argument is without merit because CMS and/or CDPH obviously determined that a revisit was necessary to verify that the facility had implemented all of the measures contained in its PoC. On its face, the letter merely conveys that CDPH had "presumed" the facility had done what it alleged in its PoC that it would do before finding through a revisit that its presumption was disappointed. The letter can not reasonably be read to mean that CDPH had determined the facility had actually returned to substantial compliance prior to conducting the revisit survey. The facility's attempted misreading of the word "presumed" is inconsistent with the well-settled rule that the period of noncompliance continues until the facility affirmatively demonstrates a return to substantial compliance. *Premier Living & Rehab. Ctr.*, DAB No. 2146, at 23 (2008); *Lake City Extended Care*, DAB No. 1658, at 12-15 (1998).

CMS had previously notified the facility in a letter dated August 3, 2010 that CMS concurred with the June survey findings listed in the SOD, and that a $1,000 per-day CMP and a DPNA would be imposed effective August 18, 2010. P. Ex. 3, at 2-3. In that letter, CMS clearly notified Ridgecrest that the remedies would continue until the facility demonstrated that it could "attain and maintain substantial compliance with all applicable participation requirements at 42 C.F.R. Part 483." *Id*. Ridgecrest could not reasonably have believed that merely submitting a PoC alleging compliance was sufficient to make that demonstration. As the Board has recognized, a PoC indicating a specific date of implementation is not sufficient evidence by itself to establish that the measures in the PoC had been satisfactorily implemented. *See Rosewood Care Ctr. of Rockford*, DAB No. 2466, at 10-11 (2012).

We find both these letters clear and unambiguous and nothing in either letter justified Ridgecrest in assuming it would be paid for Medicare patients admitted after the date that it was notified that a DPNA would be in effect. Ridgecrest does not explain who, when, or how CMS or CDPH otherwise "misled" the facility in any other way, or made "mixed actions" and "mixed representations." Similarly, Ridgecrest points to no evidence to support any of its broad allegations. Thus, we see no factual basis that the facility could reasonably have relied upon to support its belief it would be found to have returned to substantial compliance on August 13th.

Second, to the extent the facility is suggesting that agency "inaction" unreasonably extended the period of noncompliance because the revisit surveys were not conducted sooner than in September and November, this argument is without merit. As noted above, the duration of a per-day CMP is controlled by the regulations, which provide that remedies, such as a CMP and a DPNA, are computed for the number of days of noncompliance (or until the facility is terminated) and accrue until the date of correction determined by an on-site revisit or by "written credible evidence" which CMS or the State agency receives and accepts, which here is November 23, 2010. *Jennifer Matthew Nursing & Rehab. Ctr.*, DAB No. 2192, at 42 (2008), citing *Cross Creek Health Care Ctr.*, DAB No. 1665, at 3 and 42 C.F.R. §§ 488.440, 488.454. The Board has specifically held that "the regulations tie the cessation of remedies and the resumption of payments to the actual date the facility achieves substantial compliance - not necessarily the date of the revisit itself." *Foxwood Springs Living Ctr.*, DAB No. 2294 (2009) (emphasis in original). The date of the revisit survey is thus not decisive in determining when the facility actually returned to substantial compliance, and Ridgecrest has not shown how it was prejudiced by any delay in the revisit surveys given its failure to timely implement its PoC.

Finally, Ridgecrest's argument that it would be inequitable for CMS not to pay for medical care of its Medicare residents during the period of noncompliance is without merit. Ridgecrest acknowledges that it did not have to admit the new residents, thereby taking the financial risk that CMS would not find that the facility had returned to substantial compliance on the date claimed in its PoC. P. Br. at 4, 34. Moreover, the Board is bound by applicable laws and regulations and does not have the authority to provide equitable relief. *Jewish Home of E. Pa.*, DAB No. 2451, at 13 (citations omitted); *Oaks of Mid City Nursing & Rehab. Ctr*, DAB No. 2375, at 30 (2011) (citations omitted).

Thus, the ALJ's determination of the duration of CMPs and DPNA is supported by substantial evidence and free from legal error.

IV. Conclusion

For all of the foregoing reasons, we affirm the ALJ Decision.

/s/
Leslie A. Sussan

/s/
Constance B. Tobias

/s/
Stephen M. Godek
Presiding Board Member