Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Garden Crest Rehabilitation Center,
(CCN: 05-5161),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-15-384

Decision No. CR4768

Date: January 9, 2017

DECISION

Garden Crest Rehabilitation Center (Garden Crest or Petitioner), a skilled nursing facility (SNF) located in Los Angeles, California, challenges the Centers for Medicare & Medicaid Services' (CMS) determination that it was not in substantial compliance with the Medicare participation requirements at 42 C.F.R. § 483.65 relating to infection control. Petitioner also challenges CMS's imposition of a $10,000 per-instance civil money penalty (PICMP) for the noncompliance. For the reasons discussed below, I affirm CMS's determination.

I. Background

The Social Security Act (Act) sets forth requirements for SNFs to participate in the Medicare program and authorizes the Secretary of the Department of Health and Human Services (the Secretary) to promulgate regulations implementing those statutory provisions. Act § 1819 (42 U.S.C. § 1395i-3). The Secretary's regulations are found at 42 C.F.R. Parts 483 and 488. To participate in the Medicare program, an SNF must maintain substantial compliance with program requirements. To be in substantial compliance, an SNF's deficiencies may "pose no greater risk to resident health or safety

than the potential for causing minimal harm." 42 C.F.R. § 488.301. "Immediate jeopardy" exists when "the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident." 42 C.F.R. § 488.301.

The Secretary contracts with state agencies to conduct periodic surveys to determine whether SNFs are in substantial compliance. Act § 1864(a) (42 U.S.C. § 1395aa(a)); 42 C.F.R. § 488.10. The Act also authorizes the Secretary to impose enforcement remedies against SNFs that do not comply with the participation requirements. Act § 1819(h)(2) (42 U.S.C. § 1395i-3(h)(2)). The regulations specify the enforcement remedies that CMS may impose if a facility is not in substantial compliance. 42 C.F.R. § 488.406. Among other enforcement remedies, CMS may impose a per-day CMP for the number of days a facility is not in substantial compliance or a PICMP for each instance of the facility's noncompliance. 42 C.F.R. § 488.430(a). The regulations specify that if a PICMP is imposed against a facility, the PICMP will be in the range of $1,000 to $10,000 per instance, whether or not the noncompliance poses immediate jeopardy. 42 C.F.R. § 488.438(a)(2).

If CMS imposes a CMP based on a noncompliance determination, then the facility may request a hearing before an administrative law judge (ALJ) to determine whether there was a basis for the deficiency findings that led to the imposition of the remedy and whether the CMP imposed was reasonable. Act §§ 1128(c)(2) (42 U.S.C. § 1320a-7a(c)(2)), 1819(h)(2)(B)(ii) (42 U.S.C. § 1395i(h)(2)(B)(ii)); 42 C.F.R. §§ 488.408(g), 488.434(a)(2)(viii), 498.3(b)(13). However, the facility may not appeal CMS's choice of remedies. 42 C.F.R. § 488.408(g)(2).

CMS has the burden to come forward with evidence sufficient to make a *prima facie* showing of a basis for it to impose an enforcement remedy. If CMS makes this prima facie showing, Petitioner bears the burden of persuasion to show by a preponderance of the evidence that it was in substantial compliance with participation requirements or any affirmative defense. *Evergreene Nursing Care Ctr.*, DAB No. 2069 at 7 (2007); *Batavia Nursing & Convalescent Inn,* DAB No. 1911 (2004); *Batavia Nursing & Convalescent Ctr.,* DAB No. 1904 (2004), *aff'd, Batavia Nursing & Convalescent Ctr. v. Thompson,* 129 F. App'x 181 (6th Cir. 2005).

On July 19, 2014, the Los Angeles County Department of Public Health, the survey agency, completed an abbreviated survey of Petitioner in response to a complaint that it received on July 2, 2014. The complainant alleged that Resident 1, Family Member 1, and Family Member 1's partner contracted scabies due to their exposure to scabies at the facility; the complainant reported that Resident 1's roommate, "Resident 2," was the first person who had scabies. CMS Exhibit (Ex.) 1 at 4.

Based on the findings of the survey, the survey agency concluded that the facility was not in substantial compliance with the Medicare requirements relating to infection control and that the noncompliance posed immediate jeopardy to facility residents. CMS Ex. 1 at 1. CMS concurred in the survey agency's determination and notified Petitioner that CMS was imposing a PICMP of $10,000 for noncompliance with Tag F441 – Infection Control, 42 C.F.R. § 483.65. CMS Exs. 1, 4. CMS further determined that Petitioner achieved substantial compliance with program requirements on August 27, 2014. CMS Ex. 4 at 2, 6.

Petitioner timely requested a hearing before an ALJ. The parties filed prehearing briefs (CMS PH Br. and P. PH Br.) and proposed exhibits, CMS Exs. 1-23, and Petitioner's exhibits (P. Exs.) 1-20. Because neither party indicated it wished to cross-examine the other party's witnesses, the ALJ originally assigned to this case scheduled final briefing in order to ultimately issue a decision based on the written record, overruled CMS's objections to Petitioner's exhibits, and admitted all of the parties' exhibits into the record. May 13, 2015 Order Scheduling Final Briefing; *see also* November 21, 2014 Acknowledgment and Pre-Hearing Order ¶¶ 8-10, 13; Civil Remedies Division Procedures §§ 16(b), 19(b), (d). The parties filed final briefs (CMS Br. and P. Br.). Because the ALJ originally assigned to this case transferred to a different division of the Department of Health and Human Services, this case was reassigned to me to render a decision. *See* 42 C.F.R. § 498.44(b).

II. Issues

1. Whether Petitioner was in substantial compliance with Medicare participation requirements at 42 C.F.R. § 483.65.[1]

2. If Petitioner was not in substantial compliance with Medicare participation requirements, is the PICMP of $10,000 reasonable.

---

[1] An ALJ may review the level of noncompliance (including a finding of immediate jeopardy) only if: (1) a successful challenge would affect the range of the CMP; or (2) 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). Here, the penalty imposed is a PICMP for which the regulations provide only one range ($1,000 to $10,000) so the level of noncompliance does not affect the range of the CMP. 42 C.F.R. § 488.438(a)(2). Furthermore, the deficiency here did not constitute "substandard quality of care," which is defined as one or more deficiencies related to participation requirements under 42 C.F.R. §§ 483.13, 483.15, or 483.25. 42 C.F.R. § 488.301. Accordingly, I will not review CMS's immediate jeopardy finding in this decision.

III. Jurisdiction

I have jurisdiction to hear and decide this case. 42 U.S.C. §§ 1320a-7a(c)(2), 1395i(h)(2)(B)(ii)); 42 C.F.R. §§ 488.408(g), 488.434(a)(2)(viii), 498.3(b)(13).

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

I set forth my findings of fact and conclusions of law in bold and italics font.

The Act requires every SNF that participates in the Medicare program to establish and maintain an infection control program "designed to provide a safe, sanitary, and comfortable environment" for its residents and designed "to help prevent the development and transmission of disease and infection." Act § 1819(d)(3)(A), (42 U.S.C. § 1395i(d)(3)(A)). The facility must be "designed, constructed, equipped, and maintained in a manner to protect the health and safety of residents, personnel, and the general public." Act § 1819(d)(3)(B), (42 U.S.C. § 1395i(d)(3)(B)). The regulations implementing the Act provide:

> The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of disease and infection.
>
> > (a) *Infection control program.* The facility must establish an infection control program under which it—
> >
> > > (1) Investigates, controls, and prevents infections in the facility;
> > > (2) Decides what procedures, such as isolation, should be applied to an individual resident; and
> > > (3) Maintains a record of incidents and corrective actions related to infections.
> >
> > (b) *Preventing spread of infection*.
> >
> > > (1) When the infection control program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.
> > > (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.

> (3) The facility must require staff to wash their hands after each direct resident contact for which handwashing is indicated by accepted professional practice.

> (c) *Linens*. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

42 C.F.R. § 483.65.

This regulation requires "that a facility must not only 'establish' but 'maintain' an infection control program, and that this program must be 'designed' to achieve certain outcomes—namely a 'safe, sanitary, and comfortable environment' and the prevention of disease and infection." *Park Manor Nursing Home*, DAB No. 2005 at 60 (2005). Further, "[t]he regulation can only reasonably be interpreted as requiring not just that an infection control policy exist, but also that the policy be followed." *Heritage House of Marshall Health & Rehab. Ctr.*, DAB No. 2556 at 12 (2014). The purpose of the infection control program requirement is to assure that a facility develop, implement and maintain an infection prevention and control program in order to prevent, recognize, and control, to the extent possible, the onset and spread of infection within the facility. State Operations Manual (SOM), App. PP at F Tag 441.

1. ***Scabies is a parasitic infestation of the skin by mites that causes intense itching and, when an individual has crusted scabies, the individual has large numbers of mites and is very contagious.***

Scabies is a parasitic infestation of the skin by the human itch mite. CMS Ex. 8 at 1; CMS Ex. 17 at 1. The microscopic mite burrows into the upper layer of the skin where it lives and lays its eggs. CMS Ex. 17 at 1. Crusted scabies is a "severe form of scabies that can occur in some persons who are immunocompromised (have a weak immune system), elderly, disabled, or debilitated." CMS Ex. 17 at 1. "Persons with crusted scabies have thick crusts of skin that contain large numbers of scabies mites and eggs" and are "very contagious to other persons and can spread the infestation easily both by direct skin-to-skin contact and by contamination of items such as their clothing, bedding, and furniture." CMS Ex. 17 at 1. Crusted scabies "occurs when treatment for infestation has been delayed for many months and is characterized by thick, crusted lesions. Imbedded within these crusts are thousands to millions of live mites." CMS Ex. 8 at 4. The most common symptom of scabies is intense itching. CMS Ex. 17 at 1.

Although scabies is typically transmitted through skin to skin contact, "if the infestation is atypical or has progressed to the crusted stage, the environment may also harbor mites and contribute to transmission." CMS Ex. 8 at 4. Exposure to contaminated bedding

such as sheets or blankets, pillows, clothing, lotions, creams, walking belts, or upholstered furniture in close proximity to a patient with atypical or crusted scabies may also be a source of transmission. CMS Ex. 9 at 4. It may take as long as 2-6 weeks following exposure before symptoms of scabies infestation are apparent. CMS Ex. 9 at 4. Because nursing homes often are sites of scabies outbreaks, implementation of a facility's infection control program becomes particularly important to prevent and manage such a contagious infection. Effective treatment of scabies requires the application of a safe, effective scabicide, such as Elimite. CMS Ex. 8 at 10; CMS Ex. 17 at 3. Two applications or more may be required and are recommended to assure complete eradication of atypical scabies. CMS Ex. 8 at 8, 10; CMS Ex. 9 at 10. Multiple treatments may be required for the treatment of crusted scabies. CMS Ex. 8 at 15.

2. ***From at least February 8, 2014 until April 4, 2014, Petitioner failed to timely identify Resident 2's severe case of scabies and provide treatment for that condition.***

Resident 2 is a female who, in February 2014, was 100 years old. CMS Ex. 6 at 1. Petitioner's records show that on February 8, 2014, Resident 2 had been "scratching her arms and chest hard off and on," stating, "Do something. I am so miserable with this itching all over me." CMS Ex. 6 at 3. Staff called Resident 2's physician, who ordered, by telephone, Claritin and "Chlobetazole 0.05% Cream." CMS Ex. 6 at 3.

Petitioner's nursing notes for Resident 2 documented that on February 12, 2014, Resident 2 had crusty dry skin on both hands and that Resident 2's physician was notified of this. CMS Ex. 6 at 3. The nursing notes also show that on February 13, 2014, Resident 2's daughter expressed concern about her mother's hands because they had "whitish crusting formations" between her fingers on both hands, and Resident 2 continued to have itching on her arms and back. CMS Ex. 6 at 3.

On February 22, 2014, Petitioner's staff reported by telephone to Resident 2's doctor "that the crustings in between [Resident 2's] fingers were not responding to current" treatment and Resident 2's doctor ordered Benadryl for the itching. CMS Ex. 6 at 4. On February 26, 2014, Resident 2's physician ordered her transferred to a hospital for suspected hyperkalemia, pneumonia, and anemia. CMS Ex. 6 at 5. Resident 2 returned to Petitioner's facility a few days later on March 1, 2014. CMS Ex. 6 at 5. Resident 2's care plan dated March 1, 2014, indicated that she had a problem with "pruritus all over her skin" that was related to "rashes" and manifested by "extreme itching." CMS Ex. 6 at 10. The goal of her care plan was relief from her itching, and the care plan approach called for the following: using the medicated cream prescribed earlier by Resident 2's doctor; shower and bath as scheduled; monitor skin; advise Resident 2 not to scratch vigorously using her brush or wood scratcher; assist to reposition Resident 2 on her side off her back; the certified nurse aide (CNA) would keep her fingernails trimmed; and encourage Resident 2 to take fluids if not contraindicated. CMS Ex. 6 at 10.

Despite Resident 2's ongoing discomfort and the ineffectiveness of prescribed treatments, it was not until April 4, 2014, that Petitioner arranged for a dermatologist to evaluate Resident 2. On that date a dermatologist diagnosed Resident 2 with crusted scabies after performing skin scrapings. P. Ex. 2 at 2. The doctor prescribed treatment with Permethrin. P. Ex. 2 at 2. Resident 2's care plan called for keeping the doctor informed, using contact isolation during the course of her treatment, following up with employees' treatment to prevent the scabies from spreading, and following up with the dermatologist in a few weeks. P. Ex. 2 at 5. Resident 2 was moved to another room for isolation purposes and appears to have been successfully treated. CMS Ex. 6 at 8, 9; CMS Ex. 19 at 10. However, at the time of her infection, Resident 2 had several roommates, including Resident 1.

3. ***Despite Resident 2's diagnosis in April 2014 of crusted scabies and Resident 1's diagnoses of scabies in June 2014, Petitioner did not fully follow its infection control policy.***

Resident 1, who was 78 at the times relevant to this case, was admitted to Petitioner's facility on March 7, 2014, with diagnoses of rheumatoid arthritis, muscle weakness, hypertension, and type II diabetes. CMS Ex. 5 at 1. During an assessment on March 14, 2014, Petitioner's staff noted that Resident 1 did not have any skin conditions. CMS Ex. 5 at 9. On April 4, 2014, the day that Resident 2 was diagnosed with scabies, Petitioner's staff, with the consent of Resident 1's physician, prophylactically treated Resident 1 with Elimite. CMS Ex. 5 at 14, 16, 26, 56, 61. Neither Petitioner's nursing notes nor any documentation in the record indicates that Petitioner placed Resident 1 in contact isolation for 24 hours, that Residents 1 and 2's linens, undergarments and clothing were separated and cleaned, or that the room Residents 1 and 2 shared was deep cleaned.[2] *See* CMS Ex. 5 at 26-27; CMS Ex. 13 at 5 (a housekeeping employee from Petitioner's facility stating to the state surveyor there had not been deep cleaning for Resident 2's room); CMS Ex. 19 at 7, 9.

On June 11, 2014, Resident 1 was observed to have skin rashes that caused itching. CMS Ex. 5 at 41; *see also* CMS Ex. 5 at 13, 37. Resident 1's physician again ordered "prophylactic" treatment with Elimite on June 11, 2014, which Petitioner's staff provided. P. Ex. 7 at 17-18; CMS Ex. 5 at 15, 17, 18, 33, 34, 57, 61, 67. On June 12,

---

[2] Regina Quimpo, LVN (Licensed Vocational Nurse), Petitioner's Director of Infection Control, stated in her declaration that Resident 1 was in contact isolation following the April 4, 2014 treatment with Elimite. P. Ex. 8 at 1. Without documentation, I do not credit Ms. Quimpo's brief statement on this subject. Further, Ms. Quimpo, as Director of Infection Control, would have known if Petitioner deep cleaned Resident 1's room following the April 4 diagnosis that Resident 2 had scabies; however, no such assertion appears in the declaration.

2014, Resident 1 was examined outside Petitioner's facility by a physician assistant who diagnosed Resident 1 with scabies. The physician assistant prescribed Elimite for seven days and advised Petitioner's facility that it should "make sure linens/clothes are washed [with] hot water/soap [and Resident 1] has appropriate care." CMS Ex. 5 at 19-20. Petitioner received the physician assistant's orders regarding the scabies diagnosis. CMS Ex. 5 at 30. On June 13, 2014, Resident 1's physician told Petitioner's staff to disregard the physician assistant's order to treat with Elimite for more than the one day the physician had already ordered. CMS Ex. 5 at 31; P. Ex. 17 at 22.

Petitioner did not place Resident 1 in isolation on or after June 11, 2014. CMS Ex. 19 at 9. Following the Elimite treatment, Petitioner did not perform scrapings of Resident 1's skin to determine whether the treatment was effective. CMS Ex. 5 at 42; *see also* CMS Ex. 19 at 7.

It was not until June 27, 2014, that Resident 1's daughter was given two prophylactic treatments with Elimite. Resident 1's daughter claimed to the state surveyor that Petitioner had not warned her that there was a risk of contracting scabies because she frequently visited Resident 1.[3] CMS Ex. 13 at 1; CMS Ex. 19 at 5. On June 30, 2014, Resident 1's daughter called Petitioner's facility, upset because she had read on the internet that she could have transmitted the scabies to her partner and housemates. CMS Ex. 5 at 31. Later, it was confirmed that Resident 1's daughter and her partner contracted scabies. CMS Ex. 5 at 42, 53; CMS Ex. 7. Because Resident 1's daughter stayed at a hotel for four nights, Petitioner's Administrator was concerned that she may have caused the further spread of scabies. CMS Ex. 18.

On July 19, 2014, an "IM Note" indicated that the facility should implement its infection control protocol. CMS Ex. 5 at 42. Also on July 19, 2014, Resident 1 was examined at the hospital and, while there was evidence of "areas of excoriations to back" and "[p]ossible fungal-type skin lesions to the left front chest," the hospital did not conclude that there was clear evidence of scabies. CMS Ex. 5 at 49.

---

[3] Petitioner contends that it notified Resident 1's other daughter verbally on April 4, 2014, although admittedly no documentation of this exists. Petitioner claims the communication was not documented because it was part of its standard practice. P. Br. at 19. But if such communication was standard practice, Petitioner should have informed both daughters. And, it is odd that the daughter whom Petitioner's staff failed to inform happens to be Resident 1's primary contact for all purposes—emergency, health care, and financial. CMS Ex. 5 at 1.

4. Petitioner was not in substantial compliance with 42 C.F.R. § 483.65 because its Administrator and staff failed to maintain an infection control program to help prevent the transmission of disease and infection.

Petitioner adopted as part of its own scabies infection control program the policies and procedures set forth in the "Prevention and Control of Scabies in California Long-Term Care Facilities," published by the California Department of Public Health, Division of Communicable Disease Control. Hearing Request, attached August 14, 2014 at 1; CMS Ex. 1 at 1, CMS Ex. 8;[4] CMS Ex. 19 at 9. The policy states that "[c]ontrolling the transmission of scabies once a case has been identified requires immediate action. Contacts must be identified, isolation precautions must be implemented and a determination of who should be treated must be made." CMS Ex. 8 at 25. Under the policy, the facility's infection control program coordinator must develop a contact identification list that identifies every resident, health care worker, visitor, and volunteer who may have had direct, physical contact with the resident within the previous month. CMS Ex. 8 at 6. If more than one symptomatic case is identified, the facility must develop a separate contact list for each case. CMS Ex. 8 at 6. The facility must also, among other things, "[n]otify visitors (spouse, family members or friends) who may have visited the case within the past month." CMS Ex. 8 at 7.

The policy provides additional precautions to prevent any further transmission of scabies in the facility. For example, a symptomatic resident must be placed on isolation precautions in the resident's assigned room for the duration of the first treatment period, 8 to 12 hours. Staff must use appropriate gowns and gloves covering the wrists of the gowns when applying the scabicide, and visitors also must wear gowns and gloves until the scabicide has been washed off of the resident. CMS Ex. 8 at 7. In addition, all of the resident's personal washable clothes must be sealed in plastic, washed in hot water and detergent, and dried in a hot dryer; non-washable personal clothes must be dry cleaned, placed in a hot dryer for 20 minutes or sealed in a plastic bag for 5-7 days. All bed linens must be placed in a plastic bag and sent for processing. The facility must disinfect the mattress, pillow covers, bedside equipment and floors, as well as multiple use equipment, such as blood pressure cuffs, after the scabicide has been washed off the resident. CMS Ex. 8 at 8.

At the outset, Petitioner admits it failed to timely diagnose and treat Resident 2 for crusted scabies. P. Br. at 18. As reflected in Resident 2's medical records, scabies causes intense, unrelenting, and unbearable itching. Here, Resident 2 had noticeable crusty furrows between her fingers as early as February 13, 2014; crusty furrows between

---

[4] Petitioner also submitted a five-page, undated document on its letterhead titled "Infection Control For Scabies," which it describes in its prehearing brief as its "Infection Control for Scabies Policy." P. Ex. 5; P. PH Br. at 9.

fingers is a telling symptom of crusted scabies. Yet, it was not until April 4, 2014, that Resident 2 was evaluated by a dermatologist, who confirmed the crusted scabies by skin scrapings. Petitioner's failure to identify and investigate the condition causing Resident 2's intense discomfort not only prolonged her suffering, but also left Resident 2's roommates, staff, visitors, and others who may have come into close, personal contact with these people, at significant risk for infection. Although Resident 2 was aged, in February 2014, nursing notes indicate that she was mobile in her wheelchair, went to the dining room to eat, and went to group activities. CMS Ex. 6 at 4, 5.

In a similar case, the Departmental Appeals Board (DAB) upheld a violation of 42 C.F.R. § 483.65:

> Grand Oaks did not take timely steps to rule out an infectious condition such as scabies as the cause of R3's rash and to initiate effective treatment where (1) for weeks the attending physician was re-prescribing treatments that had previously failed, and (2) the facility knew that R3, who was "scratching his brains out", was constantly wandering about his unit and was frequently lying down in other residents' beds. By failing to expeditiously determine the cause of R3's skin condition, Grand Oaks allowed other residents and staff to be exposed to an infectious condition for almost a two-month period and thereby failed to "help prevent the . . . transmission of disease and infection" as required by section 483.65.

Grand Oaks Care Ctr., DAB No. 2372 at 9-10 (2011). The situation in the present case is sufficiently analogous to compel me to conclude that Petitioner's actions in relation to Resident 2 resulted in a deficiency under section 483.65.

Once Resident 2 was finally diagnosed, Resident 1 received prophylactic treatment for scabies. Petitioner states that "although not documented in the nursing notes," Petitioner observed contact precautions with Resident 1 until the treatment was removed by bathing on April 5, 2014. P. Br. at 14. Petitioner's only support is the Director of Infection Control's basic statement of this in her declaration. P. Ex. 8 at 1. Similarly, Petitioner claims, admittedly without any contemporaneous documentation in support, that Resident 1's linens, undergarments, and clothing were separated and cleaned and then, on April 5, 2014, while Resident 1 attended activities, her room was deep cleaned. P. Br at 14. However, there is also no evidence that Petitioner deep cleaned the room Residents 1 and 2 shared, even though Resident 2 had been in there for a prolonged amount of time with scabies. The surveyor testified by written declaration that her investigation revealed the lack of documentation to support actions that Petitioner allegedly took in response to Resident 2's scabies diagnosis. CMS Ex. 19 at 9-11.

Again, the present case is similar to *Grand Oaks Care Center* where the DAB concluded that the SNF had violated 42 C.F.R. § 483.65 in part because it did not comply with its policy regarding isolation and laundering/cleaning resident living space. DAB No. 2372 at 9-10 (2011). Similar to this case, the DAB found that the SNF's "nonspecific testimony is not persuasive in light of the surveyors' contrary findings" and contrary indications in the nursing notes. *Id.* at 11. As a result, Petitioner's failure to follow its policy, as indicated above, further supports a violation of section 483.65.

Given Petitioner's failure to properly deal with Resident 1's room, it is unsurprising that Resident 1's physician again needed to order "prophylactic" treatment with Elimite on June 11, 2014. P. Ex. 7 at 17-18. At no time from April 4, 2014 through June 2014 was a dermatological consult ordered for Resident 1, nor were skin scrapings performed to definitively rule out scabies. Petitioner argues that Resident 1 did not have a diagnosis of scabies in June 2014; therefore, infection containment procedures were unnecessary. Petitioner also asserts that Resident 1 did not have scabies and that no other persons were infected with scabies after April 2014. Finally, Petitioner insists that because Resident 1's physician did not agree with the physician assistant who diagnosed scabies on June 12, 2014, Petitioner could take no action because it would violate the treating physician's contrary diagnosis.

However, contrary to Petitioner's assertions, the fact that Resident 1's physician disagreed with the scabies diagnosis does not relieve it of implementing its policy regarding scabies. It has already been noted that Resident 1 had a rash in June 2014 that was not responding to other treatments and a physician assistant officially diagnosed scabies on June 12, 2014; the physician assistant transmitted the diagnosis and suggested containment actions to Petitioner. Even Resident 1's physician took action in case she had scabies and ordered treatment on June 11, 2014. All of this information should have caused Petitioner to act under its policy. *See* CMS Ex. 19 at 11.

Petitioner's policy indicates that "[w]hen scabies is *suspected*, an immediate search for additional cases should be initiated." CMS Ex. 8 at 6. Further, "[a]s soon as a *possible* case of scabies is identified, the infection control practitioner should develop a contact identification list." CMS Ex. 8 at 6 (emphasis added). However, despite its own policy and the regulatory requirement that an SNF maintain a record of incidents and corrective actions related to infections (42 C.F.R. § 483.65(a)(3)), Petitioner has not offered documentation showing that at the time of and after the June 2014 treatment, Petitioner followed its infection control policy, including whether it followed contact precautions, changed all bed linens, removed used towels and bed clothes, placed clothing in plastic bags to send to the laundry to be washed separately, or cleaned the residential environment. As the DAB stated in *Grand Oaks Care Center*, "the alleged fact that no other residents contracted scabies would not require the ALJ to infer that [Petitioner] was in compliance with section 483.65. Further, given the evidence in the record indicating that [Petitioner] failed to implement its scabies policy and the absence of required

documentation about implementation, inferring that [Petitioner] fully implemented its scabies policy would be unreasonable even if there had been no additional cases of scabies." DAB No. 2372 at 12.

Petitioner's argument that CMS erroneously concluded it was not in substantial compliance with section 483.65 is difficult to understand. Petitioner admits there were errors with its infection control program through April 2014, but argues that by the time of the survey in July it had corrected these errors. P. Br. at 4, 17 ("There were no serious infectious [sic] control oversights at [Petitioner] after April 2014, which would have created a crisis situation."). Petitioner admits: (1) Resident 2 did not receive a timely diagnosis and treatment for scabies; (2) Petitioner did not timely report Resident 2's crusted scabies to the Department of Public Health;[5] and (3) Petitioner failed to inform the daughter of Resident 2's roommate of Resident 2's scabies. Essentially, Petitioner contends that its admitted errors did not result in further scabies infections and, therefore, did not present a serious risk of harm to anyone at the time of the survey in July 2014. Thus, it claims that CMS erred in finding that it was not in substantial compliance after April 2014 because CMS has no evidence of poor infection control procedures at the facility after April 2014 with respect to Resident 1, one of Resident 2's other roommates, or any other resident. P. Br. at 21.

Petitioner appears to consider the surveyor's identification of immediate jeopardy on July 18, 2014, as a determination that Petitioner's noncompliance was somehow limited to that singular period of time. That is not the case. CMS's determination was largely based on Petitioner's failures with its infection control program with respect to its care and treatment of Resident 2, dating back to February 2014. In fact, Petitioner's conceded errors alone support CMS's determination that Petitioner was not in substantial compliance with the requirements for establishing and maintaining an infection control program pursuant to 42 C.F.R. § 483.65, and more than support CMS's imposition of a per instance CMP. The issue here is whether Petitioner established and maintained an infection control program that prevents transmission and development of infection. Petitioner's questionable argument that there were no further cases of scabies after April 2014 is irrelevant to the issue of whether Petitioner established and implemented its infection control policies and procedures for prevention and control of scabies in its facility. Whether other residents contracted scabies after Resident 2 is not material; what is material is that Petitioner's admitted lapses in implementing its infection control program put its residents at serious risk for infection. Moreover, Petitioner also failed to provide documentation to support actions that it allegedly took in conformance with its policy to contain scabies.

---

[5] The record does not reflect that Petitioner ever reported Resident 2's case of crusted scabies to the Los Angeles County Department of Public Health.

5. The $10,000 PICMP is reasonable.

CMS must consider several factors when determining the amount of a CMP (factors an ALJ considers de novo when evaluating the reasonableness of the CMP that CMS imposed): (1) the facility's history of noncompliance; (2) the facility's financial condition, i.e., its ability to pay the CMP; (3) the severity and scope of the noncompliance, the "relationship of the one deficiency to other deficiencies resulting in noncompliance," and the facility's prior history of noncompliance; and (4) the facility's degree of culpability. 42 C.F.R. §§ 488.438(f), 488.404(b), (c).

The DAB has repeatedly held that "an ALJ or the Board properly presumes that CMS considered the regulatory factors and that those factors support the amount imposed." *See, e.g.*, *Pinecrest Nursing & Rehab. Ctr.*, DAB No. 2446 at 23 (2012). Thus, CMS did not need to present evidence regarding each regulatory factor. Instead, the burden was on Petitioner "'to demonstrate, through argument and the submission of evidence addressing the regulatory factors, that a reduction is necessary to make the CMP amount reasonable.'" *Id.* (quoting *Oaks of Mid City Nursing & Rehab. Ctr.*, DAB No. 2375, at 26-27 (2011)).

Petitioner did not challenge the reasonableness of the $10,000 PICMP imposed in its appeal and did not contest any of the factors set forth in the regulation that would affect my consideration of the amount of the penalty. 42 C.F.R. § 488.438(f). There is no evidence or argument that Petitioner does not have the financial resources to pay the CMP. Although Petitioner does not have a past history of a deficiency at the immediate jeopardy level, it is worth noting that Petitioner was previously found to have had four "D" and "E" level deficiencies for Tag F441 (i.e., the one at issue in this case) in 2010, 2011, 2012, and 2013. This evidences a consistent failure to comply with 42 C.F.R. § 483.65. Petitioner is also culpable in this case because it should have reacted more quickly to Resident 2's situation, both for Resident 2's sake and to ensure that other individuals in the facility were not placed at risk.

For the reasons stated above, I find the PICMP imposed is reasonable given the admitted noncompliance and Petitioner's culpability, especially considering its delay in treating and diagnosing Resident 2's crusted scabies.

V. Conclusion

I conclude Petitioner was not in substantial compliance with 42 C.F.R. § 483.65 and the PICMP imposed is reasonable.

/s/

Scott Anderson
Administrative Law Judge