Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

In the Case of:	)	
	)	
Guardian Care Nursing & Rehabilitation Center (CCN: 10-5797),	)	Date: October 31, 2008
	)	
Petitioner,	)	
	)	
- v. -	)	Docket No. C-07-607
	)	Decision No. CR1858
Centers for Medicare & Medicaid Services.	)	
	)	

DECISION

Guardian Care Nursing & Rehabilitation Center (Petitioner or facility) is a skilled nursing facility (SNF), located in Orlando, Florida, that participates in the Medicare program. Based on the results of a May 17, 2007 recertification survey completed by the Florida Agency for Health Care Administration (State Agency), the Centers for Medicare & Medicaid Services (CMS) determined that, from May 17 through June 25, 2007, the facility was not in substantial compliance with Medicare requirements. CMS imposes a civil money penalty (CMP) of $700 per day for each day of substantial noncompliance (total $28,000). Petitioner appeals.

For the reasons set forth below, I find that the facility was not in substantial compliance from May 17 through June 25, 2007. I find unreasonable the amount of the penalty, which I lower to $450 per day (total $17,000). I also find that the conduct of CMS counsel interfered with the speedy and orderly conduct of the hearing, and award to Petitioner certain attorneys' fees and costs incurred as a result of CMS counsel's actions.

I. 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 the statutory provisions. Act, section 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 SNFs are in substantial compliance with program participation requirements. Act, section 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, section 1819(g)(2)(A); 42 C.F.R. §§ 488.20(a), 488.308.

In this case, following a survey completed May 17, 2007, the State Agency concluded, and CMS agreed, that the facility was not in substantial compliance with federal requirements for nursing homes participating in the Medicare and Medicaid programs. Specifically, they determined that the facility did not meet the following federal requirements:

- 42 C.F.R. § 483.10(n) (Tag F176 – self-administration of drugs) at a "D" level of scope and severity (isolated instance of noncompliance that causes no actual harm with the potential for more than minimal harm);

- 42 C.F.R. § 483.15(a) (Tag F241 – dignity) at a "D" level of scope and severity;

- 42 C.F.R. § 483.15(f)(1) (Tag F248 – activities) at a "D" level of scope and severity;

- 42 C.F.R. § 483.15(h)(2) (Tag F253 – housekeeping/maintenance) at an "E" level of scope and severity (pattern of noncompliance that causes no actual harm with the potential for more than minimal harm);

- 42 C.F.R. § 483.20(g)-(j) (Tag F278 – resident assessment) at a "D" level of scope and severity;

- 42 C.F.R. §§ 483.20(d) and 483.20(k)(1) (Tag F279 – comprehensive care plans) at a "D" level of scope and severity;

- 42 C.F.R. § 483.20(k)(3)(i) (Tag F281 – comprehensive care plans) at a "D" level of scope and severity;

- 42 C.F.R. § 483.20(d) (Tag F286 – resident assessment) at a "D" level of scope and severity;

- 42 C.F.R. § 483.25 (Tag F309 – quality of care) at a "G" level of scope and severity (isolated instance of noncompliance that causes actual harm that is not immediate jeopardy);

- 42 C.F.R. § 483.25(a)(3) (Tag F312 – activities of daily living) at a "D" level of scope and severity;

- 42 C.F.R. § 483.25(c) (Tag F314 – pressure sores) at a "D" level of scope and severity;

- 42 C.F.R. § 483.25(d) (Tag F315 – urinary incontinence) at a "D" level of scope and severity;

- 42 C.F.R. § 483.25(e)(2) (Tag F318 – range of motion) at a "D" level of scope and severity;

- 42 C.F.R. § 483.25(g)(2) (Tag F322 – naso-gastric tubes) at a "D" level of scope and severity;

- 42 C.F.R. § 483.25(h)(2) (Tag F324 – accidents) at a "D" level of scope and severity;

- 42 C.F.R. § 483.25(k) (Tag F328 – special needs) at a "D" level of scope and severity;

- 42 C.F.R. § 483.25(m)(1) (Tag F332 – medication errors) at a "D" level of scope and severity;

- 42 C.F.R. § 483.65(a) (Tag F441 – infection control) at a "D" level of scope and severity;

- 42 C.F.R. § 483.70(h) (Tag F465 – other environmental conditions) at a "D" level of scope and severity;

- 42 C.F.R. § 483.75(h) (Tag F500 – use of outside resources) at a "D" level of scope and severity;

and

- 42 C.F.R. § 483.75(l)(1) (Tag F514 – clinical records) at a "D" level of scope and severity.

CMS Ex. 19. Following a June 26, 2007 survey, the State Agency determined that the facility corrected its deficiencies and achieved substantial compliance effective that date. CMS Ex. 3, at 1.

Among other remedies (denial of payment for new admissions, potential termination), the State Agency recommended that CMS impose a CMP of $150 per day for the period of substantial noncompliance. CMS Ex. 3, at 3. CMS agrees that the facility was not in substantial compliance from May 17 through June 25, 2007, but rejected the state's monetary penalty recommendation and has imposed a CMP of $700 per day.

There has been considerable confusion as to the duration and total amount of the penalty. In its pre-hearing brief, CMS, without citation to the record, says, inconsistently, that Petitioner returned to substantial compliance as of June 26, 2007, and that the penalty was assessed through June 27, 2007. CMS Pre-hearing Brief (Br.) at 1. In its response to Petitioner's Motion for Summary Judgment (MSJ), CMS repeats the larger dollar amount ($28,700), but, again inconsistently, sets the date of return to substantial compliance as June 26, 2007. CMS Response to P. MSJ at 2, 3, 4. Petitioner, however, did not comment on these discrepancies. So, based on what appeared to be the (at least tacit) agreement of the parties, my June 18, 2008 Order states the issue as "whether, from May 17 through June 27, 2007, the facility was in substantial compliance" and sets the amount in controversy at $28,700. Order at 2 (June 18, 2008); *see also* CMS Closing (Cl.) Br. at 3 (without citation, CMS asserts that the facility achieved substantial compliance on June 27, 2007, and that the amount of the CMP is $28,700).

But the State Agency's July 11 notice letter says that "all deficiencies were found to be corrected" at the time of the revisit survey "completed on June 26, 2007." CMS Ex. 3, at 1. I therefore find 40 (not 41) days of substantial noncompliance and a $28,000 CMP (40 days at $700 per day = $28,000). P. Ex. 1, at 6-8.

Petitioner timely filed its hearing request, specifically challenging the "G" level deficiency (42 C.F.R. § 488.438(f)), and CMS's determination to increase the penalty imposed from the state-recommended $150 per day to $700 per day.[1] The matter was

[1] As discussed below, Petitioner was apparently under the misapprehension that, but for the "G" level deficiency, CMS could not impose a penalty without first affording the facility an opportunity to correct. Unfortunately, CMS's submissions did little to disabuse it of that notion.

assigned to me. The parties have agreed that an in-person hearing is not necessary, and that this case may be decided based on their written submissions. Order (June 18, 2008).

The parties filed pre-hearing briefs (CMS Br.; P. Br.) and proposed exhibits. Petitioner filed its MSJ to which CMS filed a response. I denied Petitioner's MSJ. Order (June 18, 2008). The parties filed closing briefs and Petitioner filed a reply brief. I admit into evidence CMS Exs. 1-47, and P. Exs. 1-48.

II. Issues

The issues before me are:

- Whether, from May 17 through June 25, 2007, the facility was in substantial compliance with Medicare participation requirements, specifically, 42 C.F.R. §§ 483.10(n) (self-administration of drugs); 483.15(a) (dignity); 483.15(f)(1) (activities); 483.15(h)(2) (housekeeping/maintenance); 483.20(g) (resident assesssment); 483.25 (quality of care); 483.25(c) (pressure sores); 483.25(h)(2) (failure to prevent accidents); and 483.65(a) (infection control);

and

- If the facility was not in substantial compliance, was the penalty imposed, $700 per day, reasonable?

I recognize that the above-listed deficiencies represent fewer than half of the deficiencies cited by the state surveyors. CMS argues that I should nevertheless consider those citations that it has declined to address, suggesting that the administrative law judge (ALJ) is responsible for reviewing the record and developing CMS's arguments when CMS counsel declines to do so. I recognize that the ALJ has broad authority to consider issues and arguments not raised or developed by the parties (so long as fair notice is given). *See, e.g.*, 42 C.F.R. §§ 498.56, 498.60. However, the ALJ is also charged with fairly and expeditiously resolving the issues in dispute, and, to this end, has broad authority to require that a party set forth the issues, evidence, witnesses, and arguments it relies upon to make its case. *See* 42 C.F.R. §§ 498.47, 498.49, 498.50.

Here, my pre-hearing order directed the parties to set forth in their pre-hearing briefs: a) a statement of each of the facts the party intends to prove; b) a discussion of the relevant law and how it relates to the facts; and c) an explanation of how the proposed evidence proves the facts alleged. The order warns that the pre-hearing brief "must contain any argument that a party intends to make" and that "I may exclude an argument" if the party fails to address it in its pre-hearing brief. Initial Pre-hearing Order ¶ 7 (August 3, 2007). As discussed below, CMS submitted a pre-hearing brief containing few facts, and which

was virtually devoid of argument. In my first pre-hearing conference, I reminded CMS counsel of the agency's responsibilities and directed that it submit with its response to Petitioner's MSJ, a written statement setting forth any argument it intends to make, including "*a discussion of each deficiency it relies on to justify the penalty imposed . . . .*" Order, at 2-3 (March 31, 2008) (emphasis added). In its response, CMS discussed only the deficiencies set forth above. Having given CMS ample opportunity, time, and notice to put forward all of its arguments or to waive them, I consider that it has waived any argument not included in its pre-hearing brief or its response to Petitioner's MSJ.

III. Discussion

A. Because Petitioner's deficiencies posed the potential for more than minimal harm, the facility was not in substantial compliance with program requirements, and I have no authority to review CMS's decision to impose a remedy.[2]

Petitioner complains that CMS imposed a penalty rather than first allowing it to correct its deficiencies. In Petitioner's view, unless a deficiency is "sufficiently serious" – level "G" (actual harm that is not immediate jeopardy) or above – the facility should be afforded the opportunity to correct before a CMP is imposed. P. Cl. Br. at 4-5. In support of its position, Petitioner points to the State Agency's notice letter which lists circumstances under which Medicare regulations preclude allowing facilities the opportunity to correct before remedies are imposed. On that list is the SNF with a deficiency of actual harm at "G" level or above, that had a comparable-level deficiency at its previous standard survey or at any intervening survey. CMS Ex. 3, at 3.

From this notice letter, Petitioner argues that no remedies should have been imposed before the facility had the opportunity to correct because 1) the sole "G" level deficiency (Tag F309) from the May 17 survey was erroneously cited; and 2) the "G" level deficiencies from an earlier (March 2007) survey were also erroneously cited (although Petitioner had no opportunity to contest those findings because no remedies were then imposed).[3]

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[2] I make findings of fact and conclusions of law to support my decision. I set forth each finding, in italics, as a separate heading.

[3] CMS has not responded to Petitioner's argument in any intelligible way. Its response to Petitioner's MSJ might arguably have touched upon the issue because it says that "CMS has the right to impose any of the remedies set out in 42 C.F.R. § 488.406" (although it does not mention the circumstances under which CMS may do so, i.e., upon a finding of substantial noncompliance). CMS Response to P. MSJ at 2. Nevertheless, because this issue is jurisdictional, CMS's failure to offer a coherent argument does not

(continued...)

First, Petitioner's logic is flawed. That the regulations *require* imposition of a penalty when the State Agency and/or CMS finds consecutive, exceptionally serious deficiencies does not mean that they *preclude* imposition of a penalty in the absence of consecutive, exceptionally serious deficiencies.

Second, Petitioner's argument ignores the plain language of the statute and regulations, which give CMS the authority to impose one or more enforcement remedies – including a CMP – whenever a facility is not in "substantial compliance," i.e., its deficiencies pose no actual harm but have the potential for causing more than minimal harm. Act, section 1819(h); 42 C.F.R. §§ 488.301, 488.402, 488.406.

The regulations also limit my authority to review CMS's selection of remedies for a substantially non-compliant facility. I may not review CMS's exercise of its discretion to impose the CMP. 42 C.F.R. §§ 488.408(g)(2) ("A facility may not appeal the choice of remedy, including the factors considered by CMS or the State in selecting the remedy . . . ."); 488.438(e) (If an ALJ finds a basis for imposing a CMP, he/she *may not* review CMS's exercise of its discretion to do so.). So long as CMS establishes one "D" level deficiency – defined as no actual harm with the potential for more than minimal harm – it may impose a penalty. If the penalty CMS selects is a per day CMP, the amount must be at least $50 per day. 42 C.F.R. § 488.438.

B. From May 17 through June 25, 2007, the facility was not in substantial compliance with Medicare requirements.

1. The facility was not in substantial compliance with 42 C.F.R. § 483.25 (quality of care).

Under the statute and the "quality of care" regulation, each resident must receive, and the facility must provide, the necessary care and services to allow a resident to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the resident's comprehensive assessment and plan of care. Act, section 1819(b); 42 C.F.R. § 483.25.

In this case, Resident 3 (R3) was a 90-year old non-ambulatory blind woman suffering from a multitude of impairments including uncontrolled diabetes, dementia, congestive heart failure, peripheral vascular disease, anemia, renal failure, and multiple, chronic, non-healing pressure sores (stages III and IV) on both her heels and her coccyx.[4] P. Ex.

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[3](...continued)
mean that Petitioner prevails by default.

[4] Pressure sores (also referred to as pressure ulcers or decubitus ulcers) are
(continued...)

43, at 1, 2, 5; P. Ex. 45. By the time of the May survey, she also had a gastrostomy tube in place, and was receiving hospice care. P. Ex. 43, at 2, 5.

Surveyor Fema Changcoco testified that, on May 15, 2007, she observed facility staff providing wound care to R3's pressure sores. R3 was "moaning and groaning in pain." As the nurse removed the soiled dressings from R3's heels, according to Surveyor Changcoco, "the resident groaned in pain and attempted to pull away." CMS Ex. 46, at 3 (Changcoco Decl. ¶ 16a). The wound care nurse ignored the resident's moans, telling Surveyor Changcoco that she "always does that." CMS Ex. 46, at 3 (Changcoco Decl. ¶ 16b). At no time did staff even consider providing R3 any pain relief medication. Indeed, Surveyor Changcoco reviewed the resident's Medication Administration Record and found no orders for pain medication. CMS Ex. 46, at 3 (Changcoco Decl. ¶¶ 16b, 16c).

Petitioner admits that the facility did not provide any pain medication to R3, but argues, without much support, that R3 did not experience pain because her wounds had progressed beyond her nerve endings. P. Cl. Br. at 10; P. Ex. 41, at 3 (Clark Decl. ¶ 12). According to Petitioner, Surveyor Changcoco observed behaviors related to R3's dementia, not to any pain. Petitioner maintains that medical professionals regularly noted the behaviors that Surveyor Changcoco observed, but no one ever suggested that these behaviors were related to pain. P. Cl. Br. at 8. The medical records submitted contradict Petitioner's position.[5] They include multiple instances in which medical professionals

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[4](...continued)
classified into stages, based on the extent of the damage to skin and underlying tissue. At stage I, the ulcer appears as a defined area of persistent redness in lightly pigmented skin, or may appear with persistent red, blue, or purple hues in darker skin. The color change may be accompanied by changes in skin temperature, tissue consistency, and/or sensation (pain, itching). Stage II is characterized by partial thickness skin loss, and presents as an abrasion, blister, or shallow crater. Stage III involves full thickness skin loss with damage or necrosis. It presents as a deep crater with or without undermining of adjacent tissue. By stage IV, the skin loss is full thickness skin loss with extensive destruction, tissue necrosis, or damage to muscle, bone or supporting structures. Undermining and sinus tracts may also be associated with stage IV pressure ulcers. *See Sunbridge Care and Rehabilitation*, DAB CR1102, at 8 n.2 (2003).

[5] Petitioner has submitted limited medical records. They have not included the Medication Administration Record referred to by Surveyor Changcoco, for example. Petitioner claims that no pain medications were administered by hospital staff when R3 underwent debridement of her pressure sores, but does not provide reports of those procedures.

describe R3 as a woman in pain. In March 2007, she was admitted to the hospital with respiratory problems and bacteremia related to her pressure sores. Among her problems, her treating physician, Dr. Muqeet Siddiqui, M.D., noted that she suffers from "chronic right knee pain." P. Ex. 45, at 1.

A consulting physician, Dr. Kurt Wiese, examined R3 on March 22, 2007, for bacteremia. He described her as "an uncomfortable woman crying out in pain lying in bed on her side." P. Ex. 45, at 8. He noted that she had a stage III coccygeal decubitus with bloody drainage, measuring about 1.5 cm. She had stage IV decubiti on both heels, the left heel much more necrotic, measuring 7 cm across, which was foul-smelling with purulence. *"This is tender*." He also described a 7-8 cm area over the right knee of irregular fascia that seemed to be healing but was "*tender to the touch*." (emphasis added). He also noted that she "does not voluntarily move the legs very much." P. Ex. 45, at 8.

In addition to these physician reports from R3's March hospitalization, Petitioner has submitted nurses notes from March 23 through May 15, 2007. P. Ex. 44. They describe a woman in need of total care, who is occasionally "vocal" and "profane" during treatment, particularly when receiving respiratory therapy. (She seems to have objected to wearing a face mask). P. Ex. 44, at 15, 17, 35. There are few notes from the wound care nurse, and they generally describe R3's deteriorating pressure sores without reference to her behavior during wound care. P. Ex. 44, at 30, 32, 37-38. However, an April 12 note by the wound care nurse describes her right heel ulcer (8.2 cm X 5.0 cm) with heavy drainage and odor, left heel ulcer (6.5 cm X 5.5 cm) with odor and heavy drainage *and pain*, as well as her coccyx wound (2.8 cm X 3.0 cm X.0.2 cm) with heavy drainage and odor. P. Ex. 44, at 18.

A nursing note, dated May 14, describes the wound on R3's coccyx (grey-green purulent drainage; malodorous) and her foot drop,[6] stating that the patient "yells in pain to touch plantar surface of feet." P. Ex. 44, at 41.

Plainly, R3 was capable of suffering pain, and suffered pain while at the facility.

According to Surveyor Changcoco, the facility's wound care policy required staff to assess the resident for pain related to pressure sores and/or pressure sore treatment, and allowed for administering an analgesic prior to a dressing change. CMS Ex. 46, at 3 (Changcoco Decl. ¶ 16d). The facility did not submit a copy of this document, but has not disputed its existence or contents. But nothing in this record suggests that facility staff followed the policy. Nurses notes reflect only one instance in which the wound care

[6] "Foot drop" describes a person's inability to raise the front part of the foot due to weakness or paralysis of the muscles.

nurse assessed for pain – on April 12, when she determined that the pressure sore on R3's left heel caused her pain. P. Ex. 44, at 18. But no analgesics had been ordered and none were administered. Apparently no one even contacted R3's physician to suggest such an order.

The remaining wound care nurse entries contain no evidence of any pain assessment. P. Ex. 44, at 30, 32, 37-38.

Nor did R3's situation improve when she began receiving hospice care. Her hospice care plan called for pain assessment and management, with the expected outcome that the "[p]atient will demonstrate/verbalize an acceptable level of pain control and symptom management." P. Ex. 43, at 4.

But hospice staff did not assess R3 for pain. Her hospice assessment, dated April 23, 2007, describes stage III and stage IV pressure sores. It describes R3 as "anxious," "combative," and "agitated," but, with respect to pain, says "unable to assess due to altered mental state." P. Ex. 43, at 5, 18. Inexplicably, the nurse writes "no [signs or symptoms] of pain noted," even though she has just described what many (including the facility's own policies, discussed below), would consider symptoms of pain: anxiety, combativeness, and agitation. P. Ex. 43, at 22.

Hospice nursing notes, dated May 1 and May 4, 2007, repeat "unable to assess [pain] due to [altered] mental status. P. Ex. 43, at 35.

A document dated May 2, 2007, titled "Hospice Plan of Care and Initial Certification," includes an order signed by R3's attending physician and calls for staff to "assess and manage pain and symptom control." P. Ex. 43, at 10. No evidence suggests that this order was followed.

The failure of staff to assess R3 for pain is even more puzzling because the facility had in place a policy for pain assessment in the cognitively impaired. The policy notes that the "elderly and cognitively impaired should be considered at risk for under-treatment of pain as a result of misinformation about pain sensitivity, pain tolerance, and ability to use opioids," and calls upon the clinician to evaluate "both subjective and objective signs and symptoms of pain." P. Ex. 37. The evaluator is instructed to 1) review nursing, social service, and clinical assessments; 2) obtain and document resident history regarding the resident's response to pain, successful interventions, and fears regarding pain management; 3) observe for objective signs and symptoms of pain, such as decreased physical function, decreased participation in activities, and noisy or strenuous breathing; and 4) observe for negative vocalizations, sad facial expressions, fright, tense body language, fidgeting/restlessness, changes in sleep patterns, decreased cognition, vital signs, agitation, and aggression. The policy then offers specific instructions for evaluating pain in the cognitively impaired – employing a face scale, color scales, visual

analog scales, and/or number scale, as appropriate. P. Ex. 37. The record here contains no evidence that anyone, from either the facility or the hospice staff, evaluated R3's pain as directed by this policy.

Thus, facility staff did not appropriately assess R3's pain; even when staff recognized that she was in pain, they took no action to alleviate it. I therefore conclude that the facility was not providing her the necessary care and services to allow her to attain/maintain the highest practicable physical, mental, and psychosocial well-being, and was not in substantial compliance with 42 C.F.R. § 483.25.

Petitioner's complaints as to the level of noncompliance cited (level "G") are not reviewable here because a successful challenge would not affect the range of CMP. 42 C.F.R. § 498.3(b)(14)(i). Whether deficiencies cause actual harm *or* they cause no actual harm, but have the potential for more than minimal harm, the penalty range is the same – the lower range ($50 – $3000).

2. The facility was not in substantial compliance with 42 C.F.R. § 483.25(c) (pressure sores).

Under the quality of care regulation, the facility must also ensure, based on the resident's comprehensive assessment, that the resident who enters the facility without pressure sores does not develop them unless his/her clinical condition shows that they were unavoidable. 42 C.F.R. § 483.25(c)(1). If a resident has pressure sores, the facility must ensure that he/she receives the treatment and services necessary to promote healing, prevent infection, and prevent new sores from developing. 42 C.F.R. § 483.25(c)(2). In assessing the facility's compliance with this requirement, the relevant question is: did the facility "take all necessary precautions" to prevent new sores from developing, and, if they nevertheless develop, to promote healing and prevent infection. If the facility has done so, and the resident develops sores anyway, I could find no deficiency. But, if the evidence establishes that the facility fell short of taking all necessary precautions, then the regulation is violated. *Koester Pavilion*, DAB No. 1750, at 32 (2000).

Here, citing surveyor observations of two residents (including R3), CMS alleges that the facility did not take all necessary precautions to promote healing, prevent infection, and prevent new pressure sores from developing. Surveyor Changcoco testified that, on May 15, she observed a certified nurse assistant performing urinary catheter care on R3. The stage IV pressure sore on R3's coccyx was exposed. R3 had a bowel movement and Surveyor Changcoco observed feces inside the open pressure sore. The wound had a "foul odor with a pus like discharge." CMS Ex. 46, at 4 (Changcoco Decl. ¶¶ 22a, 22b). When surveyor Changcoco inquired, the wound care nurse admitted that she had not provided any wound care that day, but explained that she was waiting for a new physician order to address the deteriorating sore. This does not excuse the staff's exposing R3's open and already-infected wound to an additional contaminant. Moreover, according to

the facility's pressure sore management policy, the wound should have been cleaned and dressed, even when awaiting new physician orders. CMS Ex. 46, at 4 (Changcoco Decl. ¶¶ 22c, 22d, 22e).

Surveyor Changcoco also noted that R3's last skin check had been performed on May 2.

CMS next asserts that a second resident with pressure sores, R8, was not given increased nutritional supplements recommended by the facility's dietician to aid in healing pressure sores. No one from the facility notified R8's physician of the dietician's recommendation, and it was not documented in the resident's medical record. CMS Cl. Br. at 10. The deficiency is cited in the survey report form (CMS Ex. 19, at 20-21), but I could not find any other evidence supporting it. The surveyor declarations say nothing about it.[7] Nevertheless, inasmuch as Petitioner concedes the deficiency, asserting that the issue was "quickly corrected," I accept that the facility failed to address the dietician's recommendations. P. Cl. Br. at 25. *Community Nursing Home*, DAB No. 1807, at 18 (2002) (surveyor observations, as recorded in the survey report form, found credible in the absence of any evidence from Petitioner that refuted the findings).

Because facility staff allowed contaminants to invade R3's open pressure sore, and because it ignored R8's identified nutritional needs, the facility fell short of taking all necessary precautions to promote healing and prevent infection of pressure sores, and was not in substantial compliance with 42 C.F.R. § 483.25(c).[8]

3. The facility was not in substantial compliance with 42 C.F.R. § 483.25(h)(2) (failure to prevent accidents).

The quality of care regulation also specifically requires the facility to "take reasonable steps to ensure that a resident receives supervision and assistance devices designed to meet his or her assessed needs and to mitigate foreseeable risks of harm from accidents."

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[7] The record may contain other evidence to support the deficiency, but I could not find it. I note that CMS provided very few citations to the record. Those citations were often unhelpful. In its closing brief, CMS rarely provided a specific page number, instead citing generally to either the survey report form or the surveyor declaration, apparently considering it the ALJ responsibility to parse through the documents and locate the specific support.

[8] Petitioner also points out that the survey report form erroneously cites problems with "*3* of 21 sampled residents," when, in fact, the surveyors found problems with *two* residents. P. Cl. Br. at 25 (emphasis added). Petitioner argues that this error "should draw [the citation's] credibility into question." *Id.* I consider the obvious typographical error of little consequence. It certainly does not call into question deficiencies that Petitioner has not disputed.

Windsor Health Care Center, DAB No. 1902, at 5 (2003); *Asbury Center at Johnson City*, DAB No. 1815, at 12 (2002); *Koester Pavilion,* DAB No. 1750, at 25-26 (2000); *Woodstock Care Center,* DAB No. 1726, at 25 (2000), *aff'd Woodstock Care Center v. Thompson*, 363 F.3d 583 (2003). The regulation directs the facility to anticipate what accidents might befall a resident and to take steps – increased supervision or the use of assistance devices – to prevent them. *Guardian Health Care Center*, DAB No. 1943, at 18 (2004); 42 C.F.R. § 483.25(h)(2).

> A facility is permitted the flexibility to choose the methods it uses to prevent accidents, but the chosen methods must constitute an "adequate" level of supervision under all the circumstances.

Windsor Health Care Center, DAB No. 1902, at 5.

Surveyor Donna Barton testified that R8 had poor safety awareness, and was assessed as a fall risk. Her care plan, updated on March 8, 2007, called for a personal body alarm at all times. Yet, on May 14 and 15, Surveyor Barton observed R8 sitting in a wheelchair without the alarm. On May 17, the alarm was attached to R8's wheelchair, but the pull string that is supposed to be worn by the resident was missing, which rendered the alarm useless. CMS Ex. 45, at 4-5 (Barton Decl. ¶ 22).

As evidenced by her care plan, the facility recognized that a properly attached and functioning body alarm was necessary to keep R8 safe from falls. The facility's failure to follow that plan created the potential for more than minimal harm. The facility was therefore not in substantial compliance with 42 C.F.R. § 483.25(h)(2).

Again, Petitioner does not dispute the surveyor observation, but points out that the deficiency caused no actual harm, and was immediately corrected. But assertions that a facility subsequently corrected its deficiencies do not defeat allegations of noncompliance. *See Community Nursing Home*, DAB No. 1807, at 18. Moreover, substantial compliance means not only that the specific cited instances of substandard care were corrected, and that no other instances have occurred, but also that the facility has implemented a plan of correction designed to assure that no such incidents occur in the future. The burden is on the *facility* to prove that it has resumed complying with program requirements, not on CMS to prove that deficiencies continued to exist after they were discovered. *Asbury Center at Johnson City*, DAB No. 1815, at 19-20. A facility's return to substantial compliance usually must be established through a resurvey. *Cross Creek Care Center*, DAB No. 1665 (1998). Here, Petitioner provides no reliable evidence that it achieved substantial compliance any earlier than the June 26 survey.

4. The facility was not in substantial compliance with 42 C.F.R. § 483.10(n) (self-administration of drugs).

Under the resident rights regulation are provisions for allowing certain residents to self-administer their medications. An individual resident may self-administer drugs if his/her "interdisciplinary team . . . has determined that this practice is safe."[9]

CMS charges that staff allowed R11 to self-administer drugs without having any assessment that she could do so safely. Surveyor Changcoco testified that, at 9:30 a.m. on May 14, she observed on R11's bedside table, a medication cup containing a 20 mg Prilosec tablet. R11 told her that the pill "was usually" left on her table for her to take when she awakened. CMS Ex. 46, at 2 (Changcoco Decl. ¶ 10).

Petitioner admits that a nurse, on her own, without review by the interdisciplinary team, agreed to leave R11's medication, Prilosec, on the resident's bedside table so that the resident could take it whenever she awakened. P. Cl. Br. at 18. Petitioner characterizes this as an isolated incident, quickly remedied.

This incident demonstrates that at least one of the facility's professional staff did not understand the requirements for self-administration of drugs. Moreover, the nurse's willingness to leave the medication was plainly visible, yet no other staff questioned the practice. I find this situation sufficiently troubling to present the potential for more than minimal harm. The facility was therefore not in substantial compliance with 42 C.F.R. § 483.10(n).

5. The facility was not in substantial compliance with 42 C.F.R. § 483.15(h)(2) (housekeeping/maintenance).

The quality of life regulation requires that the facility provide for its residents an environment that "promotes maintenance or enhancement of each resident's quality of life." 42 C.F.R. § 483.15. To this end, the facility must provide the "housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior." 42 C.F.R. § 483.15(h)(2). Surveyor Barton describes the following:

- In room 247 she observed two chairs, two over-bed tables, two wheelchairs, one walker, an uncovered, soiled foam cushion, and a hamper full of dirty laundry, which obstructed the room's resident's ability to get to his bathroom;

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[9] The interdisciplinary team is composed of the attending physician, responsible registered nurse, "and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative." 42 C.F.R. § 483.20(k)(2)(ii).

- The louver door in the bathroom of room 250 was off its track and leaning against a wall;

- A leaking faucet in a whirlpool tub caused a large rust stain in the tub;

- Room 253 was occupied by three residents, including an ambulatory resident suffering from dementia. Surveyor Barton observed an unlabeled plastic bottle and an open can of shaving cream left on a window sill; a dusty piece of PVC pipe was left on top of a paper towel dispenser;

- Screens were not on the bathroom windows in rooms 207 and 221. The windows were open; insects were "flying around" in room 207, and Surveyor Barton saw "several dead insects" in the toilet bowl;

- The temperature in a laboratory refrigerator, which should range between 38 to 41 degrees, measured 44 degrees.

CMS Ex. 45, at 2-3 (Barton Decl. ¶ 13). The survey report form lists multiple additional observations, although neither CMS nor its witnesses discuss them. CMS Ex. 19, at 4-8; *but see Community Nursing Home*, DAB No. 1807, at 18 (surveyor observations, as recorded in the survey report form, found credible in the absence of any evidence from Petitioner that refuted the findings).[10]

In any event, I find that the above observations, by themselves, are sufficient to establish substantial noncompliance in this area. And Petitioner does not dispute the findings, but asserts that they were corrected "shortly after the survey" and that the facility instituted "an ongoing system of maintenance monitoring and repairs" as well as a program of staff education. Again, such assertions do not constitute a meaningful defense to allegations of noncompliance, and substantial compliance means not only that the specific cited instances of substandard care were corrected, and that no other instances have occurred, but also that the facility has implemented a plan of correction designed to assure that no such incidents occur in the future. *See* discussion above at III.B.3.

Petitioner provides no reliable evidence that it achieved substantial compliance with respect to housekeeping and maintenance any earlier than the June 26 survey.

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[10] So, CMS could have relied solely on the survey report form to support these additional observations. However, as discussed above, I repeatedly directed CMS to discuss every deficiency it relied on to justify the penalty imposed. Since it did not even mention these observations, I consider that CMS has waived any reliance on them.

6. Petitioner was not in substantial compliance with 42 C.F.R. § 483.15(f)(1) (activities).

The facility must provide an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident. 42 C.F.R. § 483.15(f)(1). Surveyor Jane Woodson testified that for one hour on the morning of May 14, 2007, for two hours during the afternoon of May 14, 2007, and for an hour and a half on the morning of May 15, 2007, she observed four residents sitting near the nurses station, "disengaged and without any meaningful activity." She saw no staff interaction with the residents. No one encouraged them to participate in any activities. CMS Ex. 47, at 2 (Woodson Decl. ¶ 10a).

Surveyor Woodson then reviewed the care plans for these inactive residents, and noted that each had been prescribed daily participation in activities, but that each also required staff encouragement to participate in activities. CMS Ex. 47, at 2 (Woodson Decl. ¶ 10b).

Petitioner does not dispute the surveyor observations, but characterizes the observations as "isolated" and "not sufficient to support extrapolated generalizations being drawn from them." P. Cl. Br. at 22. Petitioner misunderstands its responsibilities here. Its failure to provide appropriate activities to *any one* of its residents would violate the regulation. Moreover, the surveyor observation (four residents sitting idle for long periods of time) establishes a *prima facie* case that the facility was not providing activities as required. If, in fact, the facility had in place an activities program meeting the interests and well-being of every resident, Petitioner needed to come forward with evidence of such program. It has failed to do so. *See Hillman Rehabilitation Center*, DAB No. 1611 (1997), *aff'd, Hillman Rehabilitation Center v. HHS*, No. 98-3789 (D.N.J. May 13, 1999) (discussing relative burdens of proof in nursing home cases).

Petitioner also asserts that the deficiency was "immediately resolved and no longer existed prior to the resurvey on June 27, 2007." P. Cl. Br. at 21. As discussed above, such assertions do not constitute a meaningful defense to allegations of noncompliance (*Community Nursing Home*, DAB No. 1807, at 18), and the facility's return to substantial compliance usually must be established through a resurvey. *Cross Creek Care Center*, DAB No. 1665. Petitioner again provides no reliable evidence that it corrected this deficiency and maintained substantial compliance any earlier than the June survey.

7. Petitioner was not in substantial compliance with 42 C.F.R. § 483.65(a) (infection control).

The facility is required to 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. Specifically, the facility must: 1)

investigate, control and prevent infections in the facility; 2) decide what procedures, such as isolation, should be applied to an individual resident; and 3) maintain a record of incidents and corrective actions related to infections. 42 C.F.R. § 483.65(a).

R1 had a stage IV pressure sore on her coccyx, and open, stage II wounds on the front and back of her right knee. Surveyor Barton observed the wound care nurse wash her hands, put on gloves, and care for the stage IV wound. The nurse then removed the gloves and put on another pair without first washing her hands, after which she cared for the stage II wounds. She treated both wounds without washing her hands or changing her gloves. CMS Ex. 45, at 5-6 (Barton Decl. ¶ 28). According to the survey report form, the facility's handwashing policy dictated that hands be washed "before and after each procedure," "before touching wounds, changing dressings, obtaining specimen collections, and providing catheter care." CMS Ex. 19, at 35. Petitioner concedes that the nurse violated the facility's hand-washing policy. P. Cl. Br. at 28.

The survey report form also describes a second incident in which a nurse put on gloves, then administered eye medication to both of R26's eyes. She then removed the gloves. She did not wash her hands, but put on new gloves and administered a second medication into both of the resident's eyes. She used the same tissue to wipe and pat the inner corner of each eye. This, according to the survey report form, violated the facility policy regarding eye ointment/drops, which required use of a separate tissue for each eye. CMS Ex. 19, at 35. I did not see any other evidence or testimony regarding this incident (Surveyor Barton's declaration does not mention it). However, Petitioner does not challenge that the nurse "improperly administered eye drops to a resident," and agrees that the nurse violated facility policy. P. Cl. Br. at 28.

The nurses in question were not following facility policies and procedures designed to protect residents from infection. Such deficient practice creates the potential for more than minimal harm, and puts the facility out of substantial compliance with 42 C.F.R. § 483.65(a).

8. CMS failed to establish that the facility was not in substantial compliance with 42 C.F.R. §§ 483.15(a) (dignity) and 483.20(g)-(j) (resident assessment) because the problems cited do not present the potential for more than minimal harm.

CMS also charges that the facility was not in substantial compliance with 42 C.F.R. § 483.15(a) because, following wound care, a nurse neglected to put socks on R8's feet. 42 C.F.R. § 483.15(a) requires that the facility promote care for residents in a manner and an environment "that maintains or enhances each resident's dignity and respect in full

recognition of his or her individuality." While I agree that staff should have put the socks back on following wound care, CMS has not shown that this single error presented the potential for more than minimal harm.

CMS also charges that the facility was not in substantial compliance with 42 C.F.R. § 483.20(g)-(j) which sets forth certain requirements for resident assessments. Assessments must be accurate and complete. A registered nurse must conduct or coordinate each assessment with the appropriate health professionals. CMS points to two alleged discrepancies among the resident records. First, Surveyor Barton testified that R8's quarterly Minimum Data Set (MDS) "indicated that the resident received Buspar, an anti-anxiety medication [for] 1 day." CMS Ex. 45, at 3 (Barton Decl. ¶ 16a). In fact, in accordance with the physician order, R8 received the medication twice daily. CMS Ex. 19, at 9; CMS Ex. 45, at 3 (Barton Decl. ¶ 16a). First, I find CMS's assertion ambiguous. Is CMS charging that the MDS said that R8 was administered the drug once daily, when he was in fact administered the drug twice daily? Or is CMS complaining that the MDS indicates that he only took the drug for one day, when, in fact, he took it over time? Obviously, the MDS should reflect the appropriate drug orders and administration. However, neither CMS nor any witness explains how the apparent discrepancy in this instance created the potential for more than minimal harm.

Second, according to the survey report form, R10's quarterly MDS did not reflect that the resident was receiving hospice care. CMS Ex. 19, at 10. CMS offers no testimony as to this assertion, and again does not explain how this discrepancy created the potential for more than minimal harm.

CMS has therefore not established that the facility was not in substantial compliance with 42 C.F.R. §§ 483.15(a) and 483.20(g)-(j).

C. The amount of the CMP – $700 per day for the period of noncompliance – is not reasonable and should be lowered to $450 per day.

Having found a basis for imposing a CMP, I now consider whether the amount imposed is reasonable, applying 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.

Remarkably, CMS mis-states the standard of review here, suggesting that, so long as CMS considered the relevant factors in reaching its determination, the penalty amount should be upheld. CMS Response to P. MSJ at 4. But it is well-settled that, in reaching a decision on the reasonableness of the CMP, I may not look into CMS's internal decision-making processes. Instead, I consider whether the evidence presented on the record concerning the relevant regulatory factors 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 other factors involved (financial condition, facility history, culpability). 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 Center*, DAB No. 1848, at 21 (2002); *Community Nursing Home*, DAB No. 1807, at 22 *et seq.*; *Emerald Oaks*, DAB No. 1800, at 9 (2001); *CarePlex of Silver Spring*, DAB No. 1683, at 8 (1999).

CMS has imposed a penalty of $700 per day. Although higher than the state's recommendation of $150 per day, it is still at the lower end of the penalty range ($50 – $3000). 42 C.F.R. § 488.438(a)(1).

With respect to history, CMS points to a March 19, 2007 survey that cited two "G" level deficiencies. Petitioner, however, challenges any reliance on these survey findings, arguing that the findings were erroneous. The facility was not allowed to challenge the survey results because CMS imposed no penalty. It is well-settled that facilities may not appeal deficiency findings where CMS has imposed no remedy. *Schowalter Villa*, DAB No. 1688 (1999). Because of this, the facility is disadvantaged, perhaps unfairly, where, as here, CMS later relies on unappealable deficiencies to justify a higher CMP. At least one other judge has suggested that a facility might appropriately challenge the earlier findings of noncompliance if CMS later relies on them to justify a higher CMP. *See Walker Methodist Health Center*, DAB CR1316, at 8 n.4 (2005).

In this case, Petitioner has a legitimate grievance about CMS's reliance on the March 2007 survey results. According to CMS, the facility then had "G" level deficiencies under 42 C.F.R. § 483.13(b) (abuse) and 42 C.F.R. § 483.13(c) (staff treatment of residents). That CMS declined to impose any penalty for alleged abuse that caused actual resident harm seems baffling (and disturbing). However, review of the underlying circumstances suggests that CMS would not have sustained its determination had Petitioner been allowed to appeal (which arguably explains its declination to impose a penalty). The facility has presented compelling evidence that the facility's so-called "abuse" was, in fact, staff's innocent, joking remark to one of the residents, who, by all appearances (and her own declaration), did not take offense. P. Exs. 6, 7, 10, 12, 14, 17. I therefore decline to include the March 2007 survey findings in my consideration of the facility's history.

But that does not mean that the facility history is not a factor in determining the reasonableness of the penalty. CMS has also provided the facility's OSCAR reports, showing the results of prior annual surveys. Housekeeping and maintenance appear to be persistent problems, having been cited at level "E" in 2005 and 2004, and level "D" in 2006. Problems with resident assessments were cited at level "D" in 2005 and 2006; quality of care was a problem in 2003 and 2004; and failure to prevent accidents was cited in 2004. CMS Ex. 35, at 1. In addition, in 2005 and 2006, the facility was cited at levels "E" and "F," respectively, for sanitation problems related to food storage, preparation, and distribution. CMS Ex. 35, at 2. Thus, the facility history is sufficiently problematic to justify a CMP above the minimal amounts.

With respect to the facility's financial condition, Petitioner argues that it is an independent, not-for-profit, charity facility, supported by donations and grants. Its directors serve without pay. The facility itself is located in an economically-challenged area. P. Exs. 46-47. Petitioner has provided evidence that the facility maintains an almost 90 percent Medicaid census, and experiences an annual short-fall of $250,000 each year, that must be made up through charitable contributions. P. Ex. 48, at 11.

Although the Departmental Appeals Board has not definitively addressed the issue, many judges (including myself) have noted that even severe financial losses may not be sufficient to establish a provider's inability to pay. *Kenton Healthcare, LLC*, DAB CR1666, at 43 (2007); *Ridge Terrace,* DAB CR938 (2002); *Wellington Specialty Care & Rehabilitation Center*, DAB CR548 (1998). A facility's profits or losses may rise and fall over short periods of time depending on a host of other factors, but short-term profits and/or losses may not accurately describe the facility's overall financial health. Profits and losses must be considered in the context of other factors, including the facility's financial reserves, its credit-worthiness, and other long-term indicia of its survivability. *Ridge Terrace*, DAB No. CR938, at 4-5. But such factors seem scarcely relevant to an institution, like Petitioner, that experiences consistent losses, and survives only through substantial charitable contributions.

I am therefore satisfied that Petitioner's financial condition is sufficiently precarious to justify its serious consideration in assessing a penalty.

Regarding the other factors, I am particularly troubled by the facility staff's apparent disregard for the pain R3 suffered, which they took no steps to alleviate, even when that pain was recognized and documented.

Considering all of these factors – particularly the facility's financial condition – I am not satisfied that the $700 per day penalty is reasonable. On the other hand, I consider the state's recommendation of $150 per day too low to induce the level of permanent corrective action necessary. I therefore lower the penalty to $450 per day (total $17,000).

D. CMS's disregard of my pre-hearing order interfered with the speedy, orderly, and fair conduct of these proceedings and justifies my ordering CMS to pay to Petitioner $5000 in attorneys' fees.

Section 1128A(c)(4) of the Act authorizes me to sanction "a person, including any party or attorney, for failing to comply with an order or procedure, failing to defend an action, or other misconduct as would interfere with the speedy, orderly, or fair conduct of the hearing." Sanctions must "reasonably relate to the severity and nature of the failure or misconduct." They include, among other actions, prohibiting the party from introducing evidence or otherwise supporting a particular claim or defense, dismissal of the action, entering a default judgment, and ordering the party to pay attorneys' fees and costs.

On August 3, 2007, I issued a pre-hearing order in this case directing the parties to submit, in turn, their pre-hearing exchanges. CMS's exchange was due first – on December 5, 2007. My order explicitly ordered CMS to submit: 1) a pre-hearing brief containing "a statement of each of the facts [CMS intended] to prove;" 2) "a discussion of the relevant law and how it relates to the facts;" and 3) "an explanation of how the evidence that the party proposes to offer proves the facts that the party alleges." The order also said that the brief "must contain any argument that [CMS] intends to make," and warned that "I may exclude an argument and evidence that relates to such argument if a party fails to address it in its pre-hearing brief." Initial Pre-hearing Order ¶ 7. The order also warned that "I may impose sanctions pursuant to section 1128A(c)(4) of the [Act] for a party's failure to comply with any order including this order." Initial Pre-hearing Order ¶ 11.

In response to my order, CMS filed a pre-hearing brief of less than three pages. The brief erroneously states that the facility's deficiencies posed immediate jeopardy to resident health and safety. CMS Br. at 1. It states inconsistently that the facility returned to compliance on June 26 but that it was assessed a penalty for June 26. The brief cites no regulations, contains no citations to the record, and discusses only one deficiency citation, Tag F309. It does not cite the relevant regulation (42 C.F.R. § 483.25) or explain what that regulation requires. With respect to the other deficiency findings, the brief is silent except to say that "documentary evidence and oral testimony" related to them "will be presented to substantiate the findings of noncompliance which form the basis of this action." CMS Br. at 3. Although Petitioner's hearing request complains in some detail about the CMP imposed, CMS's brief says nothing to justify the penalties. Nor does it address Petitioner's implication that a deficiency below "G" level does not justify the imposition of a penalty.

Based on CMS's pre-hearing brief, I could reasonably have concluded that its case was limited to the quality of care deficiency.

But, at the pre-hearing conference in this case, when I suggested that, based on its brief, CMS appeared to have limited the issues in this case to the one deficiency, CMS counsel denied vehemently any intent to limit its case in that fashion.[11] Pointing to CMS witness declarations and proposed exhibits, she claimed that the relevant issues were contained in all of those documents. *See* Order (March 31, 2008).[12]

I find that CMS's initial submissions were wholly inadequate. They provided neither this tribunal nor Petitioner with an adequate picture of the issues CMS intended to pursue. Although the statute and my pre-hearing order would have authorized my ruling that CMS had waived all issues other than facility compliance with 42 C.F.R. § 483.25, I determined that doing so might undermine the Act's legitimate purpose of protecting resident health and safety.

I do not impose this sanction lightly. However, because CMS failed to follow my order, Petitioner unquestionably expended unnecessary resources (which it can ill-afford) attempting to defend what it anticipated CMS's case might be.[13] Therefore, pursuant to my authority under section 1128A(c)(4) of the Act, I direct CMS to pay Petitioner the sum of $5000 for attorneys' fees and costs attributable to the actions (or inaction) of CMS counsel in this case.

IV. Conclusion

For all of the reasons discussed above, I find that, from May 17 through June 25, 2007, the facility was not in compliance with Medicare program requirements, specifically, 42 C.F.R. §§ 483.10(n) (self-administration of drugs); 483.15(f)(1) (activities); 483.15(h)(2) (housekeeping/maintenance); 483.25 (quality of care); 483.25(c) (pressure sores); 483.25(h)(2) (failure to prevent accidents); and 483.65(a) (infection control).

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[11] In fact, although I specifically instructed her not to go, CMS counsel walked out in the middle of the call. She eventually returned with her supervisor and complained that her work had been unfairly criticized.

[12] But CMS submitted 47 proposed exhibits – more than 600 pages – including documents relating to the March 2007 survey, which had resulted in no penalties. CMS's brief did not explain the relevance of those documents.

[13] Petitioner submitted an accounting of its attorney time and expenses. Counsel claims fees and expenses in excess of $20,000 attributable to CMS counsel's interference with the "speedy, orderly" and "fair" conduct of these proceedings. I consider this amount excessive, and lower it to a more reasonable $5000.

I find the $700 per day penalty unreasonable, and decrease the CMP to $450 per day for the period of noncompliance (total $17,000).

I award Petitioner an additional $5000 in attorneys' fees and costs.

/s/
Carolyn Cozad Hughes
Administrative Law Judge