Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

In the Case of:	)	
	)	
Stone County Nursing and Rehabilitation Center, (CCN: 04-5146),	)	Date: March 9, 2009
	)	
Petitioner,	)	
	)	Docket No. C-07-532
- v -	)	Decision No. CR1918
	)	
Centers for Medicare & Medicaid Services	)	
	)	

DECISION

I sustain the determination of the Centers for Medicare & Medicaid Services (CMS) to impose a civil money penalty (CMP) and denial of payment for new admissions (DPNA) against Petitioner, Stone County Nursing and Rehabilitation Center (Petitioner or facility), for failure to comply substantially with federal requirements governing participation of long-term care facilities in Medicare and Medicaid programs. For the reasons that follow, I uphold the CMPs of $3050 per day from April 6 through April 7, 2007; $350 per day from April 8 through May 31, 2007; and $50 per day from June 1 through June 14, 2007. I also uphold a DPNA from May 19 through June 14, 2007. Additionally, I sustain the prohibition on Petitioner conducting a nurse aide training or competency evaluation program (NATCEP) for a two-year period.

I. Background

This case is before me pursuant to requests for hearing filed by Petitioner on June 22, 2007 and July 2, 2007. Petitioner is a long-term care provider located in Mountain View, Arkansas.

By letter dated May 4, 2007, CMS informed Petitioner that based on a survey completed on April 10, 2007, by the Arkansas Department of Health and Human Services (State survey agency), it was imposing selected remedies due to Petitioner's failure to be in

substantial compliance with the applicable federal requirements for long-term care facilities. The remedies were based on immediate jeopardy deficiencies as well as non-immediate jeopardy deficiencies. The letter informed Petitioner that CMS was imposing the following remedies:

- CMP of $3050 per day effective April 6, 2007, and continuing through April 7, 2007,
- CMP of $350 per day effective April 8, 2007, and continuing until the facility achieved substantial compliance;
- DPNA effective May 19, 2007; and
- termination of the provider agreement, effective July 10, 2007.

On a revisit survey conducted on June 1, 2007, it was determined that Petitioner was still out of substantial compliance with participation requirements. The results of that survey were communicated to Petitioner by letter dated June 19, 2007. It was noted that the CMP of $350 per day would run from April 8 through May 31, 2007. After that date, and commencing June 1st, a CMP of $50 per day would be imposed until substantial compliance was attained, and a DPNA was in effect beginning May 19, 2007. The proposed termination remedy was modified to become effective on September 10, 2007, if the facility failed to achieve substantial compliance prior to that date.[1] CMS Ex. 43. A subsequent revisit survey conducted on July 6, 2007, found that Petitioner had returned to substantial compliance as of June 15, 2007. CMS Ex. 66.

Petitioner filed a request for hearing on June 22, 2007, in response to the notice of remedies issued by the State survey agency on April 24, 2007. On July 2, 2007, Petitioner filed a second request for hearing in response to CMS's notice of remedies sent May 4, 2007, which basically adopted the State survey agency's recommendations. The request for hearing filed by Petitioner on June 22, 2007, made general references to the survey conducted by the State survey agency and the facility's appeal rights, but did not address any of the deficiency findings with specificity. In the July 2, 2007 request for hearing, Petitioner specifically took issue with the State survey agency's deficiency findings regarding Resident (R) 12 and R13, but did not address any of the other findings

[1] Petitioner came into substantial compliance prior to the effective date of termination of the provider agreement and, therefore, the termination was not effectuated.

which formed a basis for CMS's imposition of enforcement remedies.[2] Specifically, and as identified in the Statement of Deficiencies (SOD) dated April 10, 2007:

> • With respect to R13, the surveyors found that the facility failed to accurately assess and record skin condition, failed to consult with the physician, failed to obtain treatment appropriate for a stage IV pressure sore, and accepted no change in ordered treatment after the physician visit on April 5, 2007. The facts surrounding R13 gave rise to Tags F157, F314, F490, and F520. These were cited as immediate jeopardy violations.
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> • The deficiency as to R12 was cited under Tag F314 as actual harm, but less than immediate jeopardy.

CMS Ex. 2, at 2.

In view of the foregoing, I find that Petitioner has not appealed the non-immediate jeopardy findings identified during the survey completed April 10, 2007 (except for the deficiency as to R12, under Tag F314), nor has Petitioner appealed the deficiencies cited in the June 1, 2007 survey. Additionally, Petitioner has not appealed the DPNA.

A request for hearing must identify the specific issues with which the affected party disagrees. 42 C.F.R. § 498.40(b). In its request for hearing, Petitioner asserts that the facility was in substantial compliance with the immediate jeopardy deficiencies regarding R13. Petitioner also adequately addresses why it was in substantial compliance with Tag F314, cited at the less than immediate jeopardy level, with respect to R12.

As for the remaining non-immediate jeopardy level deficiencies cited during the April 10 and June 1, 2007 surveys (including the DPNA), those deficiencies were not properly

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[2] As a result of the April 10, 2007 survey, Petitioner was determined to be not in compliance with: 42 C.F.R. §§ 483.10(b)(11)(Tag F157); 483.25(a)(3)(Tag F312); 483.25(c)(Tag F314); 483.25(h)(1)(Tag F323); 483.25(k)(Tag F328); 483.25(l)(Tag F329); 483.25(m)(1)(Tag F332); 483.25(m)(2)(Tag F333); 483.75(Tag F490); 483.75(j)(1)(Tag F502); 483.75(o)(1)(Tag F520); and 483.70(a)(Tag K19). Additionally, Petitioner was determined to be not in compliance during the June 1, 2007 revisit survey with the following participation requirements: 42 C.F.R. §§ 483.25(k)(Tag F328); 483.25(m)(1)(Tag F332); and 483.25(m)(2)(Tag F333). *See* CMS Exs. 1, 2.

identified by Petitioner in its requests for hearing. Pursuant to 42 C.F.R. § 498.40(b), the request for hearing must:

> (1) [i]dentify the specific issues, and the findings of fact and conclusions of law with which the affected party disagrees; and
>
> (2) [s]pecify the basis for contending that the findings and conclusions are incorrect.

Petitioner did not mention or address any deficiency except to specifically single out the alleged erroneous findings made by the State survey agency as to R12 and R13. Therefore, I will only consider whether CMS's finding of immediate jeopardy was appropriate and whether the facility was not in substantial compliance regarding R12 under Tag F314 at the non-immediate jeopardy level.

Moreover, as a threshold matter, my review is limited to those issues that Petitioner has appealed and over which I have jurisdiction. Inasmuch as Petitioner does not challenge all the deficiencies cited during the April 10 and June 1, 2007 surveys, those findings and remedies remain uncontested and are therefore final and binding against Petitioner. 42 C.F.R. § 498.20(b).

On June 5, 2008, Petitioner submitted a petition to waive oral hearing. By Order dated June 6, 2008, I canceled all previously established deadlines and instructed the parties to simultaneously submit briefs, witness declarations and proposed exhibits by July 18, 2008. CMS filed its brief (CMS Br.) on July 17, 2008. CMS offered 71 exhibits (Exs.), identified as CMS Exs. 1-71. I receive CMS Exs.1-71 into evidence without objection. Petitioner filed its brief (P. Br.) on July 18, 2008. Petitioner offered 12 exhibits, identified as P. Exs. 1-12. I receive P. Exs. 1-12 into evidence without objection. I established August 11, 2008 as the date for filing simultaneous reply briefs. In accordance with that directive, Petitioner submitted a reply brief on August 11, 2008. CMS chose not to file a reply brief.

Based on the documentary evidence, the arguments of the parties, and the applicable law and regulations, I find that Petitioner was not in substantial compliance, at the immediate jeopardy level, on the dates determined by the State survey agency and CMS. For the reasons discussed in this decision, I further find that CMS was authorized to impose against Petitioner the proposed enforcement remedies including a CMP, a DPNA, and a prohibition on Petitioner conducting a NATCEP for a two-year period.

II. Applicable Law and Regulations

Petitioner is considered a long-term care facility under the Social Security Act (Act) and regulations promulgated by the Secretary of Health and Human Services (Secretary). The statutory requirements for participation by a long-term care facility are found at sections 1819 and 1919 of the Act, and at 42 C.F.R. Parts 483 and 488.

Sections 1819 and 1919 of the Act invest in the Secretary authority to impose CMPs and DPNAs against a long-term care facility for failure to comply substantially with participation requirements.

Facilities that participate in Medicare may be surveyed on behalf of CMS by state survey agencies in order to determine whether the facilities are complying with federal participation requirements. 42 C.F.R. §§ 488.10; 488.28; 488.300; 488.335. Pursuant to 42 C.F.R. Part 488, CMS may impose either a per day CMP or a per instance CMP against a long-term care facility when a state survey agency concludes that the facility is not complying substantially with federal participation requirements. 42 C.F.R. §§ 488.406; 488.408; 488.430. The penalty may start accruing as early as the date that the facility was first out of compliance until the date substantial compliance is achieved or the provider agreement is terminated. 42 C.F.R. § 488.440.

The regulations specify that a per day CMP that is imposed against a facility will fall into one of two broad ranges of penalties. 42 C.F.R. §§ 488.408, 488.438. The upper range of CMPs, from $3050 per day to $10,000 per day, is reserved for deficiencies that constitute immediate jeopardy to a facility's residents, and in some circumstances, for repeated deficiencies. 42 C.F.R. §§ 488.438(a)(1), (d)(2). The lower range of CMPs, from $50 per day to $3000 per day, is reserved for deficiencies that do not constitute immediate jeopardy, but either cause actual harm to residents, or cause no actual harm, but have the potential for causing more than minimal harm. 42 C.F.R. § 488.438(a)(1)(ii).

The regulations define the term "substantial compliance" to mean:

> [A] level of compliance with the requirements of participation such that any identified deficiencies pose no greater risk to resident health or safety than the potential for causing minimal harm.

42 C.F.R. § 488.301.

"Immediate jeopardy" is defined to mean:

> [A] situation in which 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.

In determining the amount of the CMP, the following factors, specified at 42 C.F.R. § 488.438(f), must be considered:

1. the facility's history of noncompliance, including repeated deficiencies;
2. the facility's financial condition;
3. the seriousness of the deficiencies as set forth at 42 C.F.R. § 488.404; and
4. the facility's degree of culpability.

The Act and regulations make a hearing before an administrative law judge (ALJ) available to a long-term care facility against whom CMS has determined to impose a CMP. But the scope of such hearings is limited to whether an *initial determination* made by CMS is correct. Act § 1128A(c)(2); 42 C.F.R. §§ 488.408(g), 498.3(b)(13). A facility may challenge the scope and severity level of noncompliance found by CMS only if a successful challenge would affect the range of CMP amounts that could be collected by CMS or impact upon the facility's nurse aide training program. 42 C.F.R. § 498.3(b)(14) and (d)(10)(I). Pursuant to 42 C.F.R. §§ 483.151(b)(2) and (e)(1), a state may not approve and must withdraw any prior approval of a NATCEP offered by a long-term care facility that: (1) has been subject to an extended or partial extended survey under sections 1819(g)(2)(B)(i) or 1919(g)(2)(B)(ii) of the Act; (2) has been assessed a CMP of not less than $5000; or (3) has been subject to termination of its participation agreement, denial of payment, or the appointment of temporary management. CMS's determination as to the level of noncompliance must be upheld unless it is clearly erroneous. 42 C.F.R. § 498.60(c)(2). This includes CMS's finding of immediate jeopardy. *Woodstock Care Center*, DAB No. 1726, at 9 (2000), *aff'd, Woodstock Care Center v. U.S. Dep't of Health and Human Services*, 363 F.3d 583 (6th Cir. 2003). In a case involving a CMP, CMS must make a *prima facie* case that the facility has failed to comply substantially with participation requirements. To prevail, a long-term care facility must overcome CMS's showing by a preponderance of the evidence. *Hillman Rehabilitation Center*, DAB No. 1611 (1997), *aff'd, Hillman Rehabilitation Center v. U.S. Dep't of Health and Human Servs.*, No. 98-3789 (GEB), slip op. at 25 (D.N.J. May 13, 1999).

III. Issues

A. Whether the facility was complying substantially with federal participation requirements on the dates CMS determined to impose a CMP.

B. Whether CMS's determination of immediate jeopardy was clearly erroneous.

C. Whether the penalty imposed by CMS is reasonable, if noncompliance is established.

IV. Findings and Discussion

The findings of fact and conclusions of law noted below, in *italics*, are followed by a discussion of each finding.

A. Petitioner was not in substantial compliance with federal participation requirements from April 6 through June 14, 2007.

1. CMS has established that Petitioner was not in substantial compliance with the requirements of 42 C.F.R. §§ 483.10(b)(11)(Tag F157) and 483.25(c)(Tag F314).

The regulation at 42 C.F.R. § 483.25(c) requires the facility to ensure that a resident who enters that facility without pressure sores does not develop them unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. Further, the facility is required to immediately consult with the resident's physician when there is a significant change in the resident's status in either life-threatening conditions or clinical complications. 42 C.F.R. 483.10(b)(11).

CMS alleges that the facility failed to ensure that: (1) resident skin condition was monitored; (2) the physician was consulted regarding the development or deterioration of pressure sores so that treatment orders could be obtained or changed as necessary; (3) increased caloric and protein needs were assessed upon development of pressure sores with interventions developed to promote healing; and (4) pressure relieving devices, incontinent care, or repositioning provided for residents with pressure sores. CMS also alleges that this failure related to services for six residents (R2, R6, R12, R13, R21, and R23) under Tag F157, and six residents under Tag F314 (R2, R6, R12, R13, R21, and R23). Additionally, CMS determined that Petitioner's deficient practices resulted in actual harm to R12, R13, and R2. CMS found the failure regarding R13 to be at the

immediate jeopardy level. This resident suffered or was likely to suffer serious injury, harm, impairment, or death.

As stated earlier, inasmuch as Petitioner only appealed the deficiencies as to R12 and R13, my analysis will be limited to these two residents.[3]

(a) Petitioner's violation as to 42 C.F.R. §§ 483.10(b)(11)(Tag F157) and 483.25(c)(Tag F314) relative to services to R12.

The following is a summary of the deficiency as to R12 as recited in the SOD:

> R12 had diagnoses of congestive heart failure and insulin dependent diabetes mellitus. He was admitted to the facility on February 21, 2007. The resident assessment conducted on admission documented, under skin condition, notes that R12 had multiple bruising of the arms – antecubital [front of the elbow] sites and hands, bilaterally, were noted. No documentation of heel breakdown was noted. On February 24, 2007, R12 was sent to the hospital with complaints of chest pain. He was readmitted to the facility the following day, with no evidence of pressure sores. However, he was on a turning/repositioning program. CMS Ex. 2, at 22.
>
> Nurses Notes, dated February 28, 2007, reveal that R12 complained of pain in the left heel, and he was fitted with a heel protector. Although, at that time, no skin breakdown was reported, a blister was observed in the left heel measuring 4 cm x 4 cm. There was also no documentation that the physician was consulted regarding this pressure sore. CMS Ex. 2, at 22.
>
> It was not until March 10, 2007, 10 days after the pressure sore was first identified, that a physician's order was obtained for antibiotic treatment and wound dressing. CMS Ex. 2, at 22.
>
> On March 20, 2007 the pressure sore showed deterioration in that it had red drainage and skin detaching. However, the physician was not consulted regarding the worsening of the pressure sore. Although the physician was called that same day, it was to inform him that R12 had difficulty swallowing and felt bad all over. He did not see the resident, but ordered that he be taken to the hospital emergency room. CMS Ex. 19, at 80-88.

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[3] CMS cited Petitioner for violations under Tag F314 for R2, R6, R12, R13, R21, and R23. However, as previously noted, Petitioner only appealed the deficiencies as to R12 and R13.

> When R12 returned to the facility from the hospital, he had no new pressure sores, but the left heel sore was still present with no improvement. CMS Ex. 19, at 84.
>
> On April 5, 2007, the surveyor observed a Licensed Practical Nurse (LPN) change R12's dressing. The back of the heel was stage II, with calloused skin and a small oval area that was open and indented in the center of the heel. There were curling edges of skin that had been the blistered area, and the bed of the blister was pink. As of April 5, 2007, there was no documentation on the Pressure Sore Form, the Nurses Notes, the Medicare Nurse Assessment, Physician Orders, or Treatment Procedures, that the physician was consulted regarding the status of the wound or for further orders when the wound showed no improvement. CMS Ex. 2, at 23.
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> The Assistant Director of Nursing (ADON), Jane Humphrey, was asked on April 5, 2007, how R12 acquired the pressure sore, and she responded that it was caused after he returned from the hospital from wearing hard leather shoes during physical therapy.[4] After the resident complained of heel pain, soft leather shoes were procured. Additionally, the facility applied heel protectors and monitored the blister until it ruptured. It was at that time that the physician was called (on March 10, 2007), and a treatment order obtained. When asked why the physician was not consulted when the blister first appeared (on February 28, 2007), the ADON stated that it was because they had to wait until it was open. CMS Ex. 2, at 23-24.

See also CMS Ex. 69 (Surveyor Melva Snellenberger Declaration).

Petitioner was cited as violating these participation requirements based on the surveyor's determination that Petitioner failed to consult with the residents physician when a new pressure sore was identified, and when the pressure sore failed to improve or showed signs of deterioration.[5] CMS Ex. 2, at 2.

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[4] Though not specifically mentioned in the SOD, I infer that this statement refers to the time when the resident was discharged from the hospital on February 25, 2007. R12 re-entered the hospital on March 20, 2007, and was discharged with the same pressure sore that he had when admitted. CMS Ex. 19, at 53, 84.

[5] Petitioner was cited under Tag F157 for R2, R6, R12, and R13; however, the discussion will only address services provided to R12 and R13 as Petitioner did not appeal the findings for R2 and R6 under this tag. *See* CMS Ex. 2, at 2; June 22, 2007 Request for Hearing.

CMS's official interpretation of 42 C.F.R. § 483.10(b)(11)(i)(B), set forth in the State Operations Manual (SOM), and discussed similarly in the preamble to the regulation, for purposes of notification to the treating physician, reads as follows:

> For purposes of § 483.10(b)(11)(i)(B), life-threatening conditions are such things as a heart attack or stroke. *Clinical complications are such things as development of a stage II pressure sore* (emphasis added), onset or recurrent period of delirium, recurrent urinary tract infection, or onset of depression. A need to alter treatment significantly means a need to stop a form of treatment because of adverse consequences (e.g. an adverse drug reaction), or commence a new form of treatment to deal with a problem (e.g., the use of any medical procedure, or therapy that has not been used on that resident before).

See SOM, Appendix PP, *Guidance to Surveyors for Long Term Care Facilities*, Tag F157;[6] *see also*, 56 Fed. Reg. at 48,833 (Sept. 24, 1991).

Contrary to Petitioner's assertions, there is no indication in the SOM that a pressure sore blister has to rupture before the physician is notified.

With respect to the treatment of R12's pressure sore, Petitioner raises the following contentions:

- It was erroneous for CMS to conclude that after the treating physician was consulted on March 10, 2007, no further orders were obtained when the wound failed to show improvement, because the course of treatment for R12 was appropriately changed. In support of this argument, Petitioner makes reference to the SOM, Appendix PP, *Guidance to Surveyors for Long Term Care Facilities,* that states that if a pressure sore fails to show some evidence of progress toward healing within 2-4 weeks, the pressure sore (including potential complications) and the resident's overall clinical condition should be assessed. Petitioner adds that R12 was admitted to the hospital on March 20, 2007, that is, within the 2-4 week time frame allowed to determine the progress of healing the pressure sore. P. Br. at 22-23.

[6] The SOM is available on CMS's public website at http://www.cms.hhs.gov/Manuals/IOM/list.asp.

- The survey findings in reference to R12 stating that as of April 5, 2007 there was no documentation on the Pressure Sore Form, the Nurses Notes, the Medicare Nurse Assessment, Physician Orders, or Treatment Procedures that the physician was consulted, is erroneous. A Nurse's Note dated March 10, 2007, shows that R12's physician was consulted, and on March 20, 2007, his physician ordered his transfer to the hospital when he was feeling bad all over. Additionally, on March 27, 2007, the physician ordered specific treatment for the pressure sore. P. Br. at 22-23.

The record, as concerns R12, shows that when he entered the facility on February 21, 2007, he exhibited no pressure sores on his heels. He was transferred to the hospital on February 24, 2007, for a one-day stay due to complaints of chest pain, and was readmitted to the facility on February 25, 2007. Upon readmission, it was documented that he had no pressure sores, and was on a turning/repositioning program. On February 28, 2007, at 11:30 a.m., it was discovered that R12 had a 1 cm bruised area on the left heel. A heel protector was applied. CMS Ex. 19, at 42. However, at 2:30 p.m., on that same day, it was noted that the left heel exhibited a 4 cm x 4 cm fluid-filled blister. CMS Ex. 19, at 44. In spite of the rapid worsening of the pressure sore, the treating physician was not consulted. It was not until March 10, 2007, that the physician was consulted since the pressure sore first surfaced, at which time he provided a telephone order for Triple Antibiotic Ointment and 4 x 4 border gauze to be applied daily.

As previously noted in this decision, on April 5, 2007, the ADON was asked why the physician was not consulted when the blister first appeared, and she responded that at that time the blister was not open. There was no need, she said, to call the doctor until the blister was open. CMS Ex. 2, at 24. I find nothing in the regulation that lends support to that theory. The regulation at 42 C.F.R. § 483.25(c)(2) mandates that the facility must ensure that a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection, and prevent new sores from developing. The record in this case is silent as to the measures taken by the facility to promote healing and prevent infection since February 28, 2007, when R12 was first noted to exhibit a pressure sore until the physician was consulted on March 10, 2007. It was the facility's duty to immediately inform the treating physician of any significant change in the resident's physical status. The facility failed to do so.

Further, there is nothing in the record that shows that the physician was consulted between March 10, 2007 and March 27, 2007, or that the treatment was appropriately changed. The implication that the physician was consulted on March 20, 2007, regarding R12's pressure sore is misplaced. P. Br. at 22. Rather, the record before me clearly supports that the treating physician was called on March 20, 2007, because the resident complained of feeling bad all over. The call had nothing to do with R12's pressure

wound nor is there any reference in the record to any change in treatment for the left heel sore. There is merely a factual description of the pressure sore, but no indication that the physician was consulted on the matter or that he gave new treatment instructions. P. Ex. 2, at 52-53. From March 10, 2007 to March 20, 2007, the pressure sore showed no improvement, and the physician was not notified of the deterioration in the resident's condition as required by the regulations at 42 C.F.R. §§ 483.25(c)(2) and 483.10(b)(11)(B). CMS Ex. 19, at 6. Petitioner argues that Dr. Scott Dibrell's March 27, 2007 order was within the SOM guidelines allowing for a 2-4 week time frame to determine the progress of healing the pressure sore (SOM, Appendix PP, *Guidance to Surveyors for Long Term Care Facilities*). However, those guidelines do not relieve the facility of the duty to provide residents with pressure sores the necessary treatment and services to promote healing and notify the treating physician of a significant change or deterioration in a resident's physical or mental condition.

In view of the foregoing, I find that CMS has established a *prima facie* case that Petitioner was in violation of Tags F157 and F314 regarding R12 at the less than immediate jeopardy level. Petitioner has not overcome that showing by a preponderance of the evidence.

(b) Petitioner's violation as to 42 C.F.R. §§ 483.10(b)(11)(Tag F157) and 483.25(c)(Tag F314) relative to services to R13.

The following is a summary of the deficiency as to R13 as recited in the SOD:

> R13 had a diagnosis of cerebral vascular accident (CVA) and was totally dependent on staff for bed mobility. The admission Minimum Data Set (MDS) dated February 1, 2007, revealed no pressure sores and no history of resolved pressure sores. CMS Ex. 20, at 169. However, the resident was noted to be at risk for skin breakdown due to status post CVA.
>
> On February 1, 2007, R13 was transferred to the hospital and readmitted to the facility on February 11, 2007. No pressure sore or skin problems were noted.
>
> A Pressure Sore Form for the right heel first documented a 1 cm x 1 cm pressure sore (stage II) on February 12, 2007.
>
> Facility assessments of the pressure sore on the right heel documented continuous decline of the pressure sore and the development of additional pressure sores. CMS Ex. 2, at 17, 18.

The facility documented on March 12, 2007, that the pressure sore on the right heel had declined to a stage IV and measured 4 cm x 3 cm. CMS Ex. 2, at 18. On March 26, 2007, the facility also documented the observation of a stage IV pressure sore above the resident's right heel, and on March 27, 2007, a stage II pressure sore on the resident's right outer ankle.

There was no documentation on the Pressure Sore Form regarding consultation with the physician concerning the deterioration in the pressure sore on R13's right heel. There was no documentation in the Medicare Nurse Assessment dated February 25, 2007, March 12, 2007, March 18, 2007, March 26, 2007, or March 27, 2007 regarding consultation with the physician concerning the deterioration in the pressure sore on the right heel or the development of additional pressure sores. CMS Ex. 2, at 18, 19.

On April 5, 2007, the ADON admitted that the physician had not been notified, and that an order would have been obtained had the pressure sore opened.

The weekly skin audit report which was signed April 6, 2007, documented a 1 cm x .5 cm black area at the top of the resident's right foot; a .3 cm x .4 cm black area on the resident's right ankle; a stage IV 8 cm x 7 cm black area on R13's right inner heel; and a stage IV 3 cm x 3 cm black area on the resident's back right foot/leg.

A call to the treating physician on April 7, 2007, resulted in an order for Exuderm Satin to be applied to the resident's right ankle after cleaning with Dermal wound cleaner every three days, and as needed.

On April 6, 2007, a Medical Nutrition Therapy Screening and Assessment Summary Plan, signed by the Dietary Manager, referred the resident to the Registered Dietician due to the pressure sores. An entry signed by the Registered Dietician Consultant on April 6, 2007, recommended a protein increase to aid in decubitus healing.

On April 7, 2007 at 3:25 p.m., a LPN was unable to feel a pulse in either of R13's feet, and the right foot was cold to the touch. At 3:30 p.m., the Administrator spoke by phone with the physician and expressed her concern regarding the resident's right foot. After speaking with the Nurse

Supervisor, the physician ordered transfer of R13 to the hospital for evaluation.

CMS Ex. 2, at 16-21.

Petitioner maintains that the attending physician was aware of R13's pressure sore inasmuch as he had seen the resident one day prior to the declaration of immediate jeopardy. P. Br. at 11. Furthermore, Petitioner contends that according to Dr. Dibrell, the treating physician, R13's right heel pressure sore had been stable since he first noted its existence back in October 2006. P. Br. at 10. In a written declaration, Lisa Rhoades, the Director of Nursing (DON) states that Dr. Dibrell made rounds, was aware of the resident's condition, and asserts that there was no lack of notification. P. Ex. 9, at 1. Additionally, the DON also states that the SOD misconstrues the ADON's statement that physician had not been notified because the pressure sore had not opened. Ms. Rhoades explains the intent of the ADON's statement by averring that such utterance was not made in reference to R13. P. Br. at 11.

Petitioner's records present inconsistent accounts of R13's pressure sore history. Whereas the admission assessment made on February 1, 2007, one day after admission, reflects neither a history nor the presence of pressure sores (CMS Ex. 20, at 166, 169), a Pressure Sore Form dated February 12, 2007, refers to a non-facility acquired, pre-existing stage II pressure sore. The Pressure Sore Form employed by the facility describes the stage II pressure sore as a "partial thickness loss of skin layers that presents clinically as an abrasion, blister, or shallow crater."[7] P. Ex. 3, at 11. Inasmuch as Dr. Dibrell stated that he had observed the resident with a pressure sore in October 2006, the indication on the MDS as to the absence of a history of pressure sores appears to be an oversight.

The aforementioned Pressure Sore Form defines the four stages of a pressure sore and classifies a pressure sore as stage IV when a full thickness of skin and subcutaneous tissue is lost, exposing muscle and/or bone. P. Ex. 3, at 11. I infer that the nursing staff identified the resident's right heel pressure sore as having progressed from a 1 cm x 1 cm stage II sore to a 4 cm x 3 cm stage IV sore, based on the previously stated definition. Petitioner contends that the sore in question was labeled as stage IV, in accordance with clinical guidelines in the SOM, only because of the presence of eschar and its unstageable quality, and is therefore not indicative of the severity of the sore. P. Br. at 5. However, Petitioner provides no support in the record for the reasoning employed in designating the resident's sore on March 12, 2007, as stage IV. Specifically, there is an absence of facility rationale in the documentation that reflects a basis for labeling the sore as stage

[7] The MDS assessment form describes a stage II pressure sore as a "partial thickness loss of skin layers that presents clinically as an abrasion, blister, or shallow crater." CMS Ex. 20, at 169.

IV for a reason other than the definition found in the Pressure Sore Form. Thus, Petitioner's position regarding this issue is presented as mere argument in the aftermath without any reference in the record of a failed attempt to "stage" the sore in question.

However, as argued by Petitioner, even if the pressure sore was properly designated as stage IV, based on the SOM instructions to facilities, to code the pressure sore as stage IV if eschar and necrotic tissue are covering and preventing adequate staging of the pressure sore regardless of degree of severity, it is also true that R13's sore evolved from a 1 cm x 1 cm wound on February 12, 2007 to a 4 cm x 3 cm by March 12, 2007. P. Reply Br. at 9. That is certainly not evidence of a wound that remained stable, as asserted by Dr. Dibrell. More importantly, at no time during the deteriorating progression of the sore was the treating physician notified of the change. On February 25, 2007, March 12, 2007, March 18, 2007, March 26, 2007, and March 27, 2007 (the dates of the Medicare Nurse Assessments), there was not only an indication that R13's right heel pressure sore had deteriorated, but also that new sores had developed. CMS Ex. 2, at 17, 18. One of the new sores was labeled stage IV, and measured 8 cm x 7 cm. In addition to this stage IV sore, others had also developed, but there is no record that the treating physician was notified. Petitioner argues that Dr. Dibrell saw the resident one day prior to the declaration of immediate jeopardy, and was thus aware of her pressure sores. However, the surveyor found no documentation of any change in the treatment order for the right heel wound nor was there any documentation of treatment orders for the additional sores to the right outer ankle and above the right heel. CMS Ex. 2, at 19. In fact, it was on the same day that immediate jeopardy was declared that the treating physician was notified of the deteriorating condition of R13's right foot. Additionally, it was not until the surveyor inquired about the resident's pedal pulse on April 7, 2007, that it was determined that she had no pulse in either foot. This prompted another call to the physician, who ordered a transfer to the hospital for evaluation, at which time R13 was admitted to Stone County Medical Center. CMS Ex. 2, at 20, 21.

It should also be noted that it was not until April 6, 2007, that a Medical Nutrition Therapy Screening and Assessment Summary Plan signed by the Dietary Manager documented a referral to the Registered Dietician because of the pressure sores. That same day, the Registered Dietician Consultant documented a recommendation to increase the protein nutrients to aid in healing decubitus. CMS Ex. 2, at 20.

Petitioner's additional argument that the SOD misconstrues a statement by the ADON that the physician had not been notified because the pressure sore had not opened, is without merit. Moreover, the DON's explanation that the ADON's statement was not made in reference to R13, but in regard to another resident, is also unavailing. P. Br. at 11; P. Ex 9, at 2, ¶ 6.

At 5:45 p.m. on April 5, 2007, surveyor Melva Snellenberger interviewed the ADON. The surveyor questioned Ms. Humphrey as to how R12 acquired the pressure sore on his heel. In response, the ADON provided the following explanation:

> When he came back from the hospital, he was on PT [physical therapy] and was wearing hard leather shoes and PT [staff] walked him in those shoes and he wore them all day. When he complained of pain we put those shoes away. His wife brought in soft shoes. We put heel protectors on and monitored the blister until it ruptured. Then we called the doctor and got a treatment order. It was not open. No need to call the MD until it opened.

CMS Ex. 19, at 4.

At 7:30 p.m. on April 5, 2007, another surveyor, Dennis Adams interviewed the ADON regarding R13's pressure sore. The ADON stated that she had not notified the physician about R13's pressure sore because it had not opened. She thought that the physician was aware of the heel sore, and that he had signed an order for application of medication. Upon record review, the surveyor found that the physician did not issue a treatment order until April 6, 2007. CMS Ex. 20, at 4.

The surveyor interview notes show that ADON Humphrey made similar statements to two different surveyors regarding R12 and R13. In both instances, she maintained that the practice was to notify the physician of the existence of a pressure sore only when it had opened and not before.

As has been stated earlier, CMS's official interpretation of 42 C.F.R. § 483.10(b)(11), set forth in the SOM and discussed similarly in the preamble to the regulation, reads, where pertinent:

> For purposes of § 483.10(b)(11)(i)(B), . . . Clinical complications are such things as development of a stage II pressure sore . . . .

See SOM, Appendix PP, *Guidance to Surveyors for Long Term Care Facilities*, Tag F157; *see also*, 56 Fed. Reg. at 48,833 (Sept. 24, 1991).

Additionally, the MDS defines a blister on the skin as a stage II pressure sore. Thus, with respect to pressure sores designated by the facility as stage II or blisters[8] (whether open or not), staff were required to notify the physician and treat them according to regulatory requirements. In this regard, 42 C.F.R. § 483.25(c) provides as follows:

> (c) *Pressure sores*. Based on the comprehensive assessment of a resident, the facility must ensure that (1) A resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and (2) A resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.

Inasmuch as Petitioner maintains that ADON Humphrey was referring to another resident and not R13 when she stated that the physician would not be notified until the pressure sore had opened, I infer that Petitioner is arguing that the "other resident" intended in the ADON's remark was R12. However, the implication that the facility practice which was to not notify the physician of the existence of a pressure sore until it ruptures, is something facility staff would apply in the case of R12, but not in the case of R13, is unconvincing. In fact, the argument is unpersuasive whether the ADON was referring to R12 or any other resident.

In view of the foregoing, I find that the delay in physician involvement in the treatment of R13's pressure sores prevented the resident from receiving the necessary treatment and services to promote healing. I further find that CMS has established a *prima facie* case that Petitioner failed to ensure: (1) that skin condition was monitored; (2) that the physician was consulted regarding the development or deterioration of pressure sores so that treatment orders could be obtained or changed as necessary; and (3) that increased caloric and protein needs were assessed upon development of pressure sores with interventions developed to promote healing. Moreover, I find that the deficiencies under Tags F157 and F314 constitute violations at the immediate jeopardy level.

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[8] One of the new sores was labeled stage IV, and the physician had not been notified of its existence. CMS Ex. 2, at 19.

2. CMS has established that Petitioner was not in substantial compliance with the requirements of 42 C.F.R. § 483.75(Tag F490).

The April 10, 2007 survey found that Petitioner was not in substantial compliance, at an immediate jeopardy level (K scope and severity level), with the regulation at 42 C.F.R. § 483.75.

The regulation at 42 C.F.R. § 483.75 provides that:

> A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.

CMS alleges that Petitioner failed to meet this participation requirement by not ensuring that, as to Residents 2, 6, 12, 13, 21, and 23, "skin assessments were done timely, the physician was consulted and treatment orders obtained and changed, provide pressure relieving devices, provide incontinent care, and provide turning and repositioning of residents with pressure sores." CMS Br. at 24. CMS concluded that Petitioner's failure resulted in immediate jeopardy to R13, actual harm to R2, R12, and R13, and the potential for more than minimal harm to R6, R21 and R23. *Id.* As Petitioner limited its appeal under this tag only to the findings related to R12, and R13, I will only address the facts relative to those two residents. However, as previously noted, inasmuch as Petitioner does not challenge all the deficiencies cited during the April 10 and June 1, 2007 surveys, those findings and remedies remain uncontested and are therefore final and binding against Petitioner. 42 C.F.R. § 498.20(b).

In support of the allegations associated with Tag F490, CMS relies on the same set of facts which form the basis for the deficiencies cited at Tags F157 and F314 (42 C.F.R. §§ 483.10(b)(11) and 483.25(c)).

The Administration deficiency is a derivative deficiency based on findings of other deficiencies. *See Cross Creek Health Care Center*, DAB No. 1665, at 19 (1998); *Asbury Center at Johnson City*, DAB No. 1815 (2002); *Eastwood Convalescent Center*, DAB No. 2088 (2007). The regulation requires a facility's management to both assure that its staff identify and address resident needs and that staff follow established procedures and protocols.

In neither its opening brief nor its reply brief does Petitioner address the deficiency cited at Tag F490. Instead, Petitioner focuses its argument and assertions on Tag F520 which I address in the next section of this decision.

As discussed above, I have determined that Petitioner was not in substantial compliance with participation requirements at 42 C.F.R. §§ 483.10(b)(11) and 483.25(c). I have no difficulty finding the nexus between the deficiency findings I have addressed and the allegation that those deficiencies establish that Petitioner was not being administered effectively and efficiently. As such, I find that Petitioner was not in compliance with the requirements at section 483.75. Despite the facility's policy in place for addressing the issue of prevention and treatment of pressure sores (*see* CMS Attachment D, at 2 – Pat Casey affidavit), R13 developed a substantial pressure sore on her right heel, which ultimately progressed to a stage IV pressure sore that was not addressed and not treated properly. Petitioner's systems, even if in place, were not effective to prevent the violations I have discussed above. To reiterate, Petitioner failed to ensure that R13's skin condition was sufficiently monitored; that the resident's physician was consulted regarding the development/deterioration of pressure sores in order for treatment orders to be timely obtained or changed as needed; and to assess R13's increased caloric and protein needs upon the development of pressure sores with development of interventions to promote healing. I therefore conclude that Petitioner's facility was not administered in a manner so that its resources were used effectively to help R13 attain the highest practicable physical, mental, and psychosocial well-being. Accordingly, I find that Petitioner was in violation of 42 C.F.R. § 483.75, and that the deficiency cited is at the immediate jeopardy level of noncompliance.

3. CMS did not establish a prima facie case that Petitioner failed to comply substantially with the requirements of 42 C.F.R. § 483.75(o)(1)(Tag F520).

In the SOD, the surveyors specifically allege Petitioner's failure to comply with the provisions at 42 C.F.R. § 483.75(o)(1). CMS Ex. 2, at 74-98. The regulation at section 483.75(o)(1) provides that:

> A facility must maintain a quality assessment and assurance committee consisting of:
>
> (i) The director of nursing services;
> (ii) A physician designated by the facility; and
> (iii) At least 3 other members of the facility's staff.

The SOD further alleges that Petitioner's substantial noncompliance was at a K scope and severity level. CMS Ex. 2, at 74-98.

CMS contends that Petitioner failed to comply with this requirement in that it:

> . . . failed to have an "effective Quality Assessment and Assurance Committee [QA&A Committee] that identified and evaluated systems or lack thereof that affected the quality of services provided to residents by failure to ensure that skin assessments were done timely, the physician consulted and treatment orders were obtained or changed, provide pressure relieving devices, provide incontinent care, and turn and reposition residents with pressure sores."

CMS Br. at 25.

In the April 10, 2007 SOD, the surveyors alleged that Petitioner failed to meet the regulatory standards under Tag F520 in that the QA&A Committee did not ensure that:

> issues were identified and corrective actions were implemented to ensure staff promptly identified new pressure sores and declines in pressure sores, staff promptly consulted the physician to obtain or revise treatment, to ensure pressure relieving devices were used, to ensure incontinent care and turning/repositioning were provided at least every two hours and more frequently if needed for 6 of 10 [residents] with pressure sores.

CMS Ex. 2, at 74-75.

I find that this particular allegation fails to establish a *prima facie* case that Petitioner did not substantially comply with the participation requirements at 42 C.F.R. § 483.75(o)(1). CMS has presented no evidence to show that Petitioner was not compliant with section 483.75(o)(1). The facts relied upon by both the surveyors and CMS with regard to this specific deficiency may possibly support an allegation of substantial noncompliance under section 483.75(o)(2)[9]; but the facts do not support a deficiency citation pursuant to section 483.75(o)(1). There is nothing in the record to demonstrate that Petitioner failed to establish a QA&A Committee which consisted of the Director of Nursing Services, a facility physician, and, at least, three other staff members. To the contrary, as noted in

[9] The regulation at section 483.75(o)(2) requires that the QA&A Committee meet at least quarterly to identify issues relative to quality assessment and assurance activities, and develop and implement plans of action to correct identified quality care deficiencies.

the SOD, a surveyor stated that, when questioned on this point, the facility Administrator advised the surveyor that the QA&A Committee consisted of the facility Medical Director, Administrator, DON, Dietary Manager, Continuous Quality Improvement Coordinator, and Maintenance Director. CMS Ex. 2, at 75; *see also*, P. Ex. 8, at 3; P. Ex. 9, at 2; P. Ex. 12, at 1. The primary focus of CMS's arguments go to the effectiveness of the QA&A Committee at identifying and evaluating systems which provide sufficient quality of services to ensure proper assessment and treatment of pressure sores. CMS Br. at 25-26. Clearly the regulatory provision cited at Tag F520 does not go to the effectiveness of the QA&A Committee, although there may be other provisions within Part 483 which specifically address this issue. If it is CMS's position that section 483.75(o)(1) in fact governs the question of the effectiveness of the QA&A Committee, it did not present an argument in support of this specific assertion in its brief. *See* CMS Br. at 25-26.

B. CMS's finding of immediate jeopardy was not clearly erroneous.

Immediate jeopardy exists where a 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. For a finding of immediate jeopardy, it is not necessary to show that the noncompliance caused serious injury, harm, impairment, or death. It is sufficient to show that the noncompliance was *likely* to cause serious injury, harm, impairment, or death. *Fairfax Nursing Home, Inc.*, DAB No. 1794, at 14 (2001).

It is Petitioner's burden to prove clearly erroneous a finding by CMS that a deficiency puts residents at immediate jeopardy. 42 C.F.R. § 498.60(c)(2). Here, CMS established strong *prima facie* evidence of immediate jeopardy level deficiencies under Tags F157, F314, and F490. Petitioner contends in its brief that there were no immediate jeopardy level deficiencies with respect to R13. Petitioner argues that the survey team erred in finding immediate jeopardy on the assumption that no pressure sore was present on February 12, 2007, and then a stage II pressure sore suddenly developed on February 12, 2007. P. Br. at 12. Petitioner's assertions are unavailing. That is not why a finding of immediate jeopardy is justified as to R13. Immediate jeopardy is based on the facility's failure to consult the treating physician regarding R13's pressure sores from February 17, 2007, until after the ADON was interviewed on April 5, 2007. It was not until then that a treatment order was obtained from the physician for antibiotic therapy and a change in treatment. Additionally, it was not until the surveyor's inquiry that the Consultant Dietician addressed R13's nutritional needs due to pressure sores on April 6, 2007, when an increase in feeding pump rate and the administration of Beneprotein were recommended to "aid in healing decubitus." CMS Ex. 68, at 3. Petitioner knew, or should have known, that if the resident's development of pressure sores was not timely

made known to the treating physician, the condition could deteriorate and could, or would, be likely to cause serious injury, harm, impairment, or death to the resident.

C. Petitioner is properly subject to a two-year prohibition on conducting a NATCEP.

In addition to the CMP, I conclude that the State survey agency was required to prohibit Petitioner from conducting a NATCEP for a period of two years.

Pursuant to 42 C.F.R. § 483.151(b)(2) and (e)(1), a state may not approve and must withdraw any prior approval of a NATCEP offered by a skilled nursing facility or nursing facility that: 1) has been subject to an extended or partial extended survey under sections 1819(g)(2)(B)(i) or 1919(g)(2)(B)(i) of the Act; 2) has been assessed a CMP of not less than $5000; or 3) has been subject to termination of its participation agreement, denial of payment, or the appointment of temporary management. Extended and partial extended surveys are triggered by a finding of "substandard quality of care" during a standard or abbreviated standard survey and involve evaluating additional participation requirements. 42 C.F.R. § 488.301. "Substandard quality of care" is identified in instances where surveyors identify one or more deficiencies related to participation requirements established by 42 C.F.R. § 483.13 (Resident Behavior and Facility Practices), 42 C.F.R. § 483.15 (Quality of Life), or 42 C.F.R. § 483.25 (Quality of Care), that are found to constitute either immediate jeopardy, a pattern of or widespread actual harm that does not amount to immediate jeopardy, or a widespread potential for more than minimal harm that does not amount to immediate jeopardy and there is no actual harm. *Id.*

As I have found Petitioner to be noncompliant at the immediate jeopardy level with a participation requirement under 42 C.F.R. § 483.25 (Quality of Care), and that a total CMP of more than $5000 is reasonable, a two-year prohibition of Petitioner conducting a NATCEP is required by law.

D. I do not have authority to address and resolve the issue regarding the alleged inappropriate conduct of one of the surveyors.

In its opening brief, Petitioner alleges that Surveyor Pat Casey "displayed inappropriate and questionable behavior during the Survey which calls into question the motivation for and appropriateness of the finding of [i]mmediate [j]eopardy." P. Br. at 13-14. In support of these allegations, Petitioner offers the sworn affidavits of Tammy Romero, Facility Administrator (P. Ex. 8); Lisa Rhoades, DON (P. Ex. 9); and David Jarvis, Assistant Administrator and Chief Operating Officer for White River Health Systems (P. Ex. 11). Among other things, the affiants commented on: the surveyor's negative demeanor toward the facility's primary physician, Dr. Scott Dribell; her references to

certain facility staff members as a "problem;" and in some instances, her yelling at the staff members. *See, e.g.*, P. Ex. 11, at 1-2; P. Ex. 8, at 1. As part of her affidavit, Administrator Romero included statements obtained from four staff members who either witnessed or were subjected to the surveyor's adverse behavior. P. Ex. 8A, at 1-8. Ms. Romero further noted that she was contacted by the Director of the Office of Long Term Care on the last day of the April 2007 survey regarding survey activities. Ms. Romero states that she advised the Director of the concerns of various members of the facility's staff regarding Ms. Casey's behavior and noted the receipt of written statements from staff. P. Ex. 8, at 2. Ms. Romero also states that the Director apologized for the surveyor's behavior, requested that the written staff statements be forwarded to her, and subsequently, the survey team was instructed to remove themselves from the facility and report to the Office of Long Term Care on the following business day. *Id.* at 2-3.

Petitioner did not request any specific relief regarding the aforementioned; however, I have assumed that the issue was raised for the purpose of demonstrating the surveyor's alleged negative attitude which gives pause as to whether the immediate jeopardy citation is a legitimate and credible citation.

While the issue of the alleged inappropriate behavior of a member of a survey team during the course of official business is of major concern, unfortunately, it is not an issue which I have authority to entertain. My review as to the alleged deficiencies is a *de novo* review. A *de novo* review requires that the ALJ make an independent decision, based solely on the evidence which is introduced by the parties either at hearing or through the agreed-upon briefing process. Therefore, I am required to make my decision in this case based on the record independent from the determination of the State survey agency whose action is being challenged.

E. The CMPs CMS proposed to impose against Petitioner of $3050 per day from April 6 through April 7, 2007; $350 per day from April 8 through May 31, 2007; and $50 per day from June 1 through June 14, 2007 are reasonable.

If a facility is not in substantial compliance with program requirements, CMS has the authority to impose one or more of the enforcement remedies listed in 42 C.F.R. § 488.406, including a CMP. CMS may impose a CMP for the number of days that the facility is not in compliance or for each instance that a facility is not in substantial compliance. 42 C.F.R. § 488.430(a). There are two ranges for per day CMPs. 42 C.F.R. §§ 488.408; 488.438. The upper range of CMP, of from $3050 per day to $10,000 per day, is reserved for deficiencies that constitute immediate jeopardy to a facility's residents, and, in some circumstances, for repeated deficiencies. 42 C.F.R. § 488.438(a)(l)(i), (d)(2). The lower range of CMP, from $50 per day to $3000 per day, is reserved for deficiencies that do not constitute immediate jeopardy, but either cause

actual harm to residents, or cause no actual harm, but have the potential for causing more than minimal harm. 42 C.F.R. § 488.438(a)(l)(ii). In this case, CMS chose to impose a CMP of $3050 per day from April 6 through April 7, 2007; $350 per day from April 8 through May 31, 2007; and $50 per day from June 1 through June 14, 2007.

My responsibility in deciding what penalty amounts are reasonable is to make a *de novo* analysis of the evidence as it relates to the regulatory criteria governing penalty amounts. In determining whether the amount of the CMP is reasonable, the following factors as specified at 42 C.F.R. § 488.438(f) must be considered: (1) the facility's history of noncompliance, including repeated deficiencies; (2) the facility's financial condition; (3) the seriousness of the deficiencies as set forth at 42 C.F.R. § 488.404; and (4) the facility's degree of culpability.

I have received no evidence of prior noncompliance and Petitioner has not submitted information related to its financial condition nor has it claimed an inability to pay the amount of the proposed penalty. Where Petitioner has failed to take advantage of its opportunity to submit evidence of its financial condition, that opportunity is waived. *Community Nursing Home*, DAB No. 1807, at 15-16 (2002); *Emerald Oaks*, DAB No. 1800 (2001). Consequently, I base my decision as to penalty amounts solely on the seriousness of the deficiencies based on the violations Petitioner did not challenge[10] and which are now binding on Petitioner, as well as the violations of 42 C.F.R. §§ 483.10(b)(11); 483.25(c); and 483.75, and Petitioner's relative culpability for them.

As already discussed, the evidence did not substantiate that Petitioner was in violation of 42 C.F.R. § 483.75(o)(1)(Tag F520), and, therefore, I take that into consideration in my review.

Petitioner did not challenge all the deficiencies cited during the April 10 and June 1, 2007 surveys. Specifically, Petitioner did not appeal the non-immediate jeopardy findings identified during the survey completed April 10, 2007 (except for the deficiency as to R12, under Tag F314), which were cited at a scope and severity level of "D" and "E," nor did it appeal any of the deficiencies cited in the June 1, 2007 resurvey. As previously noted, those findings and remedies remain uncontested and are therefore final and binding against Petitioner. 42 C.F.R. § 498.20(b). As such, CMS has established a finding of

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[10] Petitioner did not challenge the following citations: 42 C.F.R. §§ 483.10(b)(11)(Tag F157 for R2 and R6); 483.25(a)(3)(Tag F312); 483.25(c)(Tag F314 for R2, R6, R21, and R23); 483.25(h)(1)(Tag F323); 483.25(k)(Tag F328); 483.25)(l)(Tag F329); 483.25(m)(1)(Tag F332); 483.25(m)(2)(Tag F333); 483.75 (Tag F490); 483.75(j)(1)(Tag F502); and 483.70(a)(Tag K19). *See* CMS Exs. 1, 2; June 22, 2007 Request for Hearing.

noncompliance which provides a basis for its imposition of a CMP at the lower range of $50 to $3000 per day for deficiencies that do not constitute immediate jeopardy, but either cause actual harm or caused no actual harm, but have the potential for more than minimal harm. *See* 42 C.F.R. § 488.438(a)(ii).

As for the deficiencies related to R12 which Petitioner did challenge, I find that Petitioner's violation of Tags F157 and F314 at the less than immediate jeopardy level, specifically, the facility staff's failure to provide R12 the necessary services and treatment to be a serious failure on the part of Petitioner which further justifies CMS's imposition of a CMP against Petitioner at the lower range of $50 to $3000 per day. A central reason for housing a resident in a long-term care facility is to provide the resident with care, including supervision, which the resident is unable to provide for himself or herself, or that the resident's family is unable to provide at home. The evidence before me shows that facility staff were not diligent in meeting their fundamental responsibility to residents in ensuring that a resident with pressure sores received necessary treatment and services and communicating with a resident's physician to facilitate the provision of appropriate treatment.

Moreover, for the reasons described earlier, I find that Petitioner's violation at the immediate jeopardy level of participation requirements at 42 C.F.R. §§ 483.10(b)(11)(Tag F157); 483.25(c)(Tag F314); and 483.75(Tag F490) related to R13 justify the imposition of a CMP in the amount of $3050 from April 6 through April 7, 2007. I note that $3050 is the minimum daily penalty amount for deficiencies that constitute immediate jeopardy to a facility's residents. 42 C.F.R. § 488.438(a)(1)(I).

I further note that for both R12 and R13, I find that Petitioner's staff manifested a high degree of culpability.

Petitioner has not appealed the DPNA and, as such, that penalty is binding against Petitioner. Although, had Petitioner challenged the DPNA, I find sufficient evidence before me to justify the imposition of a DPNA against Petitioner from May 19 through June 14, 2007. As Petitioner is subject to denial of payment, section 1819(f)(2)(B) of the Act prohibits approval of Petitioner from conducting a NATCEP for a two-year period.

V. Conclusion

Based on the documentary evidence, the arguments of the parties, and the applicable law and regulations, I find that Petitioner was not in substantial compliance at the immediate jeopardy level from April 6 through April 7, 2007, and that the imposition of a CMP of $3050 per day during that period is reasonable. I find that a CMP of $350 per day from April 8 through May 31, 2007, and a CMP of $50 per day from June 1 through June 14, 2007, is also reasonable. CMS was also justified in the imposition of a DPNA from May 19 through June 14, 2007. Additionally, the two-year prohibition on conducting a NATCEP is consistent with the law and regulations.

/s/
José A. Anglada
Administrative Law Judge