Department of Health and Human Services

# DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

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| In the Case of:<br><br>Sunnyview Nursing Home & Apartments,<br>(CCN: 26-5715),<br><br>Petitioner,<br><br>v.<br><br>Centers for Medicare & Medicaid Services. | Date: March 7, 2008<br><br>Docket No. C-06-132<br>Decision No. CR1745 |

## DECISION

Petitioner, Sunnyview Nursing Home & Apartments, violated 42 C.F.R. § 483.25.[1] A per-instance civil money penalty (PICMP) of $10,000 and the denial of payment for new admissions (DPNA) for the period from October 1, 2005 through October 16, 2005, are reasonable enforcement remedies.

### I. Background

Petitioner, located in Trenton, Missouri, is authorized to participate in Medicare as a skilled nursing facility (SNF) and in the Missouri Medicaid program as a nursing facility (NF). Petitioner was subject to a survey by the Missouri Department of Health & Senior Services (the state agency) that was completed on September 28, 2005. Surveyors concluded that Petitioner was not in substantial compliance with program participation requirements and that there was immediate jeopardy to resident health and safety.

[1] All references to the Code of Federal Regulations (C.F.R.) are to the revised C.F.R. in effect at the time of the survey, unless otherwise indicated.

The state agency notified Petitioner by letter dated September 29, 2005, that Petitioner was not in substantial compliance with participation requirements and that there was immediate jeopardy to the health, safety, and welfare of Petitioner's residents, specifically with regard to Petitioner's violation of 42 C.F.R. § 483.25 (Tag F309[2]). The state agency imposed a DPNA effective October 1, 2005. The state agency advised Petitioner that it would recommend to the Centers for Medicare & Medicaid Services (CMS) that it impose a civil money penalty (CMP) and terminate Petitioner's provider agreement. CMS Exhibit (CMS Ex.) 1, at 16-19. The state agency provided Petitioner a copy of the statement of deficiencies (CMS Form 2567 or SOD) as an enclosure to a letter dated October 14, 2005. CMS Ex. 1, at 10-12. Petitioner was subject to a revisit survey on October 17, 2005, that determined Petitioner returned to substantial compliance effective that date. CMS Ex. 1, at 8; CMS Ex. 3.

CMS notified Petitioner by letter dated October 20, 2005, that based upon the violation of 42 C.F.R. § 483.25 (Tag F309) found by the September 28, 2005 survey, CMS was imposing a PICMP of $10,000. CMS also advised Petitioner that its authority to conduct a Nurse Aide Training and Competency Evaluation Program (NATCEP)[3] would be withdrawn; the DPNA imposed by the state effective October 1, 2005, ended effective October 17, 2005; and that Petitioner's provider agreement would not be terminated. CMS Ex. 1, at 5-7.

Petitioner requested a hearing by letter dated November 18, 2005. The request for hearing was docketed as C-06-132 and assigned to me on December 23, 2005, for hearing and decision. A Notice of Case Assignment and Prehearing Case Development Order (Prehearing Order) was issued at my direction on December 23, 2005.

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[2] This is a "Tag" designation as used in the State Operations Manual (SOM), Appendix PP – Guidance to Surveyors for Long Term Care Facilities. The "Tag" refers to the specific regulatory provision allegedly violated and CMS's guidance to surveyors. Although the SOM does not have the force and effect of law, the provisions of the Social Security Act (Act) and regulations interpreting the Act clearly do have such force and effect. *State of Indiana by the Indiana Department of Public Welfare v. Sullivan*, 934 F.2d 853 (7th Cir. 1991); *Northwest Tissue Center v. Shalala*, 1 F.3d 522 (7th Cir. 1993). Thus, while the Secretary of Health and Human Services (Secretary) may not seek to enforce the provisions of the SOM, he may seek to enforce the provisions of the Act or regulations as interpreted by the SOM.

[3] Petitioner advised me at hearing that it had no NATCEP. Transcript (Tr.) 192-93.

I convened a hearing in Kansas City, Missouri, on June 15, 2006. CMS offered CMS exhibits 1 through 5, 9, 10, and 11. I admitted CMS exhibits 1 through 5 (pages 5 through 12), 9, 10 (pages 1 through 3, 7 through 8, 19, 29 through 52, 54 through 57, 59 through 61, and 69 through 72), and 11. Tr. 22-27. Petitioner offered, and I admitted, Petitioner's exhibits (P. Exs.) 1, 2, 2A, 3, 4, 4A, and 5 through 35. Tr. 19-21. Post-hearing, Petitioner submitted P. Ex. 36 for admission to the record. P. Ex. 36 is Petitioner's plan of correction and it was discussed at hearing. Tr. 13-16, 18. CMS did not object to admission and consideration of P. Ex. 36 and it is admitted.[4] Petitioner also requested post-hearing that I take administrative notice of the version of the SOM in effect at the time of the survey; CMS did not object; and the motion is granted. CMS called as a witness surveyor Barbara J. Barnes. Petitioner called as witnesses licensed practical nurse Lindsay N. Porter; Director of Nurses Abigail E. Neff; and Jeanne Rutledge, an independent consultant to long-term care facilities and agencies providing elderly-care services. The parties submitted post-hearing briefs and post-hearing reply briefs.

## II. Discussion

### A. Findings of Fact

The following findings of fact are based upon the exhibits admitted and the parties' stipulations. Citations to exhibit numbers related to the findings of fact are in the analysis section of this decision if not found here.

1. Resident 1 was a female, 83 years-old at the time of her death, with diagnoses including end-stage Parkinson's disease, a history of coronary artery disease, hypothyroidism, hypertension, depression, arthritis, peripheral neuropathy, diverticulosis, and urge urinary incontinence. CMS Ex. 11, at 11-12; P. Exs. 2A, 3, 5, 6, 17, 32.

2. Resident 1 complained of difficulty initiating urination despite urgency, burning with urination, and low back pain, on August 26, 2005. CMS Ex. 11, at 17; P. Ex. 11, at 2.

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[4] Petitioner requested that all exhibits from which residents' names and other identifying information have not been redacted be treated as sealed. CMS did not oppose the motion and it is granted. Tr. 29-30.

3. On August 26, 2005, Petitioner's staff requested that Dr. H. Borhani, Resident 1's treating physician, order a urinalysis, and an order for urinalysis was issued during the morning on August 26, 2005. CMS Ex. 11, at 17; P. Ex. 11, at 2.

4. On August 27, 2005, Resident 1 continued to have diarrhea and complained of shaking and feeling cold with a temperature of 99 degrees Fahrenheit, which had increased from a temperature of 96.9 degrees as recorded on August 26, 2005. CMS Ex. 11, at 17; P. Ex. 11, at 2.

5. Resident 1's temperature was recorded as 99.7 degrees at 6:30 p.m. on August 27, 2005, and she continued to have diarrhea. CMS Ex. 11, at 17; P. Ex. 11, at 2.

6. Resident 1 continued to have diarrhea and elevated temperature on August 28, 2005. CMS Ex. 11, at 17; P. Ex. 11, at 2.

7. Petitioner's staff did not obtain a urine sample for urinalysis until 7:35 a.m. on August 29, 2005, when it was obtained with "minimal difficulty" by catheter and it was tea-colored. CMS Ex. 11, at 17; P. Ex. 11, at 2.

8. Resident 1 continued to feel badly at 9:25 a.m. on August 29, 2005, and her doctor was called. CMS Ex. 11, at 17; P. Ex. 11, at 2.

9. A laboratory report dated August 29, 2005, shows that it was verified at 10:58 a.m. on August 29, that Resident 1 had a large amount of bacteria in her urine; the report was sent by facsimile to both Petitioner and Resident 1's doctor; and an antibiotic was ordered for administration to Resident 1. CMS Ex. 11, at 21; P. Ex. 16, at 2; P. Ex. 32.

10. At 11:00 a.m. on August 29, 2005, Resident 1's temperature continued at 101.3 degrees, but decreased to 100 degrees by 1:30 p.m. CMS Ex. 11, at 17; P. Ex. 11, at 2.

11. Resident 1 was noted to have a temperature of 99.8 degrees and diarrhea, and to have been drinking a lot of Maalox from a bedside bottle; the Maalox was removed by the evening shift on August 29, 2005. CMS Ex. 11, at 17; P. Ex. 11, at 2.

12. Resident 1's temperature was 99.6 degrees at 3:15 a.m., but had increased to 101.1 degrees at 6:00 a.m. on August 30, 2005; Resident 1 was noted to be complaining of aching all over and she had difficulty swallowing medication. CMS Ex. 11, at 17; P. Ex. 11, at 2.

13. At 8:00 a.m. on August 30, 2005, Resident 1's breathing was labored; her oxygen saturation was only 89 percent and she was put on oxygen; her skin was dusky in color; she was wheezing bilaterally; her heart rate was fast; the nurses were unable to get an accurate blood pressure; Resident 1 was noted to have received a dose of antibiotic for a urinary tract infection (UTI); she had blood in her stool; and she had lower extremity swelling or edema; her doctor was notified; and she was transported to the hospital by ambulance. CMS Ex. 11, at 17-18; P. Ex. 11, at 2-3.

14. Resident 1 was unresponsive when she arrived at the hospital on August 30, 2005; she was described as comatose and in severe distress with a temperature of 102.7 degrees, respiration of 36, oxygen saturation of 89 percent, pulse of 109, and blood pressure reading of 64/36; and urine extracted by Foley catheter was dark and creamy. CMS Ex. 11, at 1-3; P. Ex. 17.

15. At the hospital on August 30, 2005, Resident 1 was assessed with septic shock with coma, "most probably" due to UTI and urosepsis, or intra-abdominal infection, mental status change and coma secondary to sepsis, renal failure, advanced end-stage Parkinson's disease, hypertension, a history of coronary artery disease, hypothyroidism, gastroesophageal reflux disease, osteoarthritis, and peripheral neuropathy. CMS Ex. 11, at 1-3; P. Ex. 17, at 2-3.

16. Resident 1 died at the hospital August 31, 2005, at 9:58 a.m. P. Exs. 11, at 3; 19.

17. The cause of Resident 1's death is listed on her discharge summary as septicemia with multi-organ failure, probably due to urosepsis rather than peritonitis; renal failure and anuria (kidney failure); and advanced Parkinson's disease, among other causes. CMS Exs. 11, at 4, 6; P. Exs. 19 and 32.

18. The death certificate lists as the underlying cause of death "possible septicemia – few days" and advanced end-stage Parkinson's disease is listed as a significant condition. CMS Ex. 11, at 81; P. Ex. 32.

**B. Conclusions of Law**

1. Petitioner timely requested a hearing and I have jurisdiction.

2. Petitioner violated 42 C.F.R. § 483.25.

3. There is a basis for the imposition of remedies.

4. A DPNA from October 1, 2005 through October 16, 2005, and a PICMP of $10,000, are reasonable enforcement remedies.

**C. Issues**

The issues in this case are:

(1) Whether there is a basis for the imposition of an enforcement remedy; and

(2) Whether the remedies, including a DPNA from October 1, 2005 through October 16, 2005, and a PICMP of $10,000, are reasonable.

**D. Applicable Law**

Petitioner is a long-term care facility participating in the federal Medicare program as a SNF and in the state Medicaid program as a NF. The statutory and regulatory 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. Part 483 of the regulations. Sections 1819 and 1919 of the Act vest the Secretary with authority to impose a CMP against a long-term care facility for failure to comply substantially with federal participation requirements.

Facilities that participate in Medicare are subject to surveys by state agencies on behalf of CMS 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 various sanctions for failure to substantially comply with Medicare program requirements, including a PICMP or per-day CMP against a long-term care facility. 42 C.F.R. §§ 488.406; 488.408; 488.430.

Per-day CMPs fall into one of two broad ranges of penalties. 42 C.F.R. §§ 488.408, 488.438. The upper range of CMP, 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)(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)(1)(ii). As for PICMPs, the regulations provide for a single range from $1000 to $10,000, which could be imposed whether or not immediate jeopardy is found. 42 C.F.R. §§ 488.408(d)(1)(iv); 488.438(a)(2).

A long-term care facility against which CMS has determined to impose an enforcement remedy is entitled to a hearing before an administrative law judge (ALJ). Act, § 1128A(c)(2); 42 C.F.R. §§ 488.408(g); 498.3(b)(13). A hearing before an ALJ is a *de novo* proceeding. *Anesthesiologists Affiliated, et al.*, DAB CR65 (1990), *aff'd*, *Anesthesiologists Affiliated, et al. v. Sullivan*, 941 F.2d 678 (8th Cir. 1991); *Emerald Oaks*, DAB No. 1800, at 11 (2001); *Beechwood Sanitarium*, DAB No. 1906 (2004); *Cal Turner Extended Care Pavilion*, DAB No. 2030 (2006)*; The Residence at Salem Woods*, DAB No. 2052 (2006). A facility has a right to appeal a "certification of noncompliance leading to an enforcement remedy." 42 C.F.R. § 488.408(g)(1); *see also* 42 C.F.R. §§ 488.330(e) and 498.3. However, the choice of remedies by CMS or the factors CMS considered when choosing remedies are not subject to review. 42 C.F.R. § 488.408(g)(2). A facility may only challenge the scope and severity level of noncompliance found by CMS if a successful challenge would affect the amount of the CMP that could be collected by CMS or impact upon the facility's NATCEP. 42 C.F.R. §§ 498.3(b)(14) and (d)(10)(i). 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, 38 (2000), *aff'd, Woodstock Care Center v. Thompson*, 363 F.3d 583 (6th Cir. 2003). The Departmental Appeals Board has long held that the net effect of the regulations is that a provider has no right to challenge the scope and severity level assigned to a noncompliance finding, except in the situation where that finding was the basis for an immediate jeopardy determination. *See, e.g.*, *Ridge Terrace*, DAB No. 1834 (2002); *Koester Pavilion*, DAB No. 1750 (2000). Review of a CMP by an ALJ is governed by 42 C.F.R. § 488.438(e).

When a penalty is proposed and appealed, CMS must make a *prima facie* case that the facility has failed to comply substantially with federal participation requirements. "*Prima facie*" means that the evidence is "[s]ufficient to establish a fact or raise a presumption unless disproved or rebutted." *Black's Law Dictionary* 1228 (8th ed. 2004); *see also*, *Hillman Rehabilitation Center*, DAB No. 1611, at 8 (1997), *aff'd, Hillman Rehabilitation Center v. U.S. Dept. of Health and Human Services*, No. 98-3789 (D.N.J. May 13, 1999). To prevail, a long-term care facility must overcome CMS's showing by a preponderance of the evidence. *Batavia Nursing and Convalescent Center*, DAB No. 1904 (2004); *Batavia Nursing and Convalescent Inn*, DAB No. 1911 (2004); *Emerald Oaks*, DAB No. 1800 (2001); *Cross Creek Health Care Center*, DAB No. 1665 (1998); *Evergreene Nursing Care Center*, DAB No. 2069, at 7-8 (2007).

## E. Analysis

### 1. Petitioner violated 42 C.F.R. § 483.25 (Tag F309).

Pursuant to 42 C.F.R. § 483.25, Petitioner is required to provide each of its residents necessary care and services to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, in accordance with the resident's comprehensive assessment and plan of care. The surveyors allege in the SOD that Petitioner violated the regulation because Petitioner's "staff failed to obtain a physician ordered urinalysis in a timely manner and provide prompt medical attention for one resident (Resident #1)." P. Ex. 36, at 1. The facts pertinent to this decision are set forth in my Findings of Fact and need not be repeated in detail here. The key facts are: on August 26, 2005, staff recognized Resident 1's signs and symptoms as indicating a possible UTI; staff asked Resident 1's primary care physician, Dr. Borhani, for an order for a urinalysis for a suspected UTI; Dr. Borhani gave the order for a urinalysis on August 26, 2005, but Petitioner's staff failed to obtain a urine specimen until August 29; and the laboratory results confirmed that Resident 1 was suffering from a UTI on August 29, 2005. From the time the order for a urinalysis was requested during the morning of August 26, 2005, to the time a urine sample was obtained and sent to the laboratory during the morning of August 29, 2005, Petitioner's clinical records show that Resident 1's condition worsened, which I infer was due to her worsening infection. The issue in this case is not whether Resident 1 died from a UTI. The issue is whether or not Petitioner acted reasonably to ensure that Resident 1 received necessary care and services as required by the regulation. I conclude that Petitioner did not act reasonably to ensure that Resident 1 received necessary care and services and, specifically, the urinalysis and treatment for the UTI. Thus, Petitioner violated the regulation.

Petitioner argues that "CMS relies on the testimony of Barbara Barnes, a surveyor employed part-time by the state agency, to establish its *prima facie* case," but that Ms. Barnes's testimony was objectionable because she had limited involvement in the survey process and her testimony lacked "proper foundation to support CMS' prima facie case." Petitioner's Opening Post Hearing Brief (P. Brief) at 5-6. I disagree with Petitioner that there was no proper foundation for Ms. Barnes's testimony. Ms. Barnes was involved in the survey process and had knowledge of the basis for the citation of deficiency at issue. Tr. 37-38. I note that this decision does not turn on the testimony of Ms. Barnes. Rather, my decision is based largely upon Petitioner's own records.

Petitioner does not deny that its staff failed to obtain a urine sample for three days after a urinalysis was ordered by Resident 1's physician. The doctor's order raises the presumption that the urinalysis was reasonable and necessary.[5] Petitioner's failure to obtain the urine specimen and submit it for laboratory testing in accordance with Dr. Borhani's order is *prima facie* evidence of a violation of 42 C.F.R. § 483.25 (Tag F309), i.e., the resident's doctor determined that the urinalysis was a necessary service that Petitioner then failed to deliver. Petitioner is mistaken in its arguments that CMS failed to make a *prima facie* showing of a violation. Petitioner argues that CMS did not show Resident 1 had an elevated temperature, or that the failure to obtain the urinalysis when ordered led to septic shock and death. P. Brief at 5. Petitioner's clinical records for Resident 1 obtained by the surveyors and admitted as evidence clearly show that Resident 1 had an elevated temperature. Findings of Fact 4 through 6. Further, while the cause of death could reflect the seriousness of the harm in this case, the cause of death is not important to the conclusion that the regulation was violated. It is sufficient to find a violation based on evidence in this case that a doctor's order was issued and that the order was not promptly fulfilled.

The issues remaining are whether or not Petitioner was in substantial compliance despite the delay in obtaining the urinalysis and beginning treatment for the UTI; whether Petitioner has an affirmative defense that might excuse its failure to act; and whether or not Resident 1 suffered any harm due to the delay in receiving antibiotics. If these issues are resolved against Petitioner, the final question is whether or not the remedy proposed by CMS is reasonable.

Petitioner argues that Resident 1's treating physician, Dr. Borhani (P. Ex. 32), and its experts Dr. Boulware (P. Exs. 23 and 33) and Jeanne Rutledge (Tr. 194-231), provided evidence that there is no established connection between the failure to obtain the urinalysis and suspected septic shock and death of the resident. P. Brief at 5. Petitioner argues that Dr. Boulware opined that a delay in obtaining a urine specimen had no effect or impact on Resident 1; that any delay in obtaining the urinalysis was not the proximate cause of the resident's deterioration; that Resident 1 was appropriately monitored, assessed, and treated from August 25, 2005 to August 30, 2005; that Petitioner was in substantial compliance with the regulation; that any identified deficiency posed no greater

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[5] I do not find credible or persuasive Petitioner's argument, based upon the testimony of Jeanne Rutledge, that the urinalysis was unnecessary based upon her interpretation of CMS or Centers for Disease Control (CDC) policy statements. P. Brief at 5. I find more persuasive that Petitioner's staff identified Resident 1's signs and symptoms; that Resident 1's treating physician ordered a urinalysis based upon staff's request; and that the delayed urinalysis confirmed the resident had been suffering the effects of a UTI for at least three days.

risk to Resident 1 than the potential for minimal harm; that the cited deficient practice did not pose immediate jeopardy; that Resident 1 received nursing care consistent with acceptable nursing practice; and that the delay in obtaining a urinalysis did not contribute to the resident's decline or death. P. Brief at 8-9. Petitioner argues that Jeanne Rutledge testified that Resident 1's signs and symptoms did not meet the criteria established by CMS or the CDC for when a facility should suspect and treat a UTI. P. Brief at 5. Petitioner argues that Dr. Borhani opined that it was not possible to determine to a reasonable degree of medical certainty that Resident 1's decline and death were due to septic shock rather than another cause. P. Brief at 8. Petitioner's briefing evinces the hope that I will find a defense among the hodgepodge of opinions provided.

The problem for Petitioner is that its arguments and the testimony of its experts do not address objective medical evidence that Resident 1's urine was finally tested on August 29, 2005, and it was confirmed that Resident 1 had a UTI. CMS Ex. 11, at 26; P. Ex. 32, at 2. The laboratory test result is unrebutted. There is no dispute that on August 29, 2005, Dr. Borhani ordered an antibiotic "covering both pathogens isolated from her (Resident 1's) bladder . . . ." P. Ex. 32, at 2. According to Dr. Borhani, the urinalysis done at the hospital showed that the amount of bacteria in Resident 1's urine was less than that found as a result of a prior test. P. Ex. 32, at 2. However, Dr. Borhani stated in his affidavit that the resident still had an infection when she arrived at the emergency room and that she was administered Vancomycin and Levaquin, both of which are antibiotics. P. Ex. 32, at 2. Thus, there is no question that Petitioner's staff was correct on August 26, 2005, when it requested an order for a urinalysis to confirm whether or not Resident 1 had a UTI. There is no question that Dr. Borhani correctly determined laboratory testing of the resident's urine was reasonable and necessary and that ordering the urinalysis was a correct medical judgment.

Petitioner fails to adequately address the delay in obtaining the urine sample for testing once ordered by Dr. Borhani, or to show the delay in obtaining the urine and urinalysis and the resulting delay in treatment for the UTI, was reasonable or excusable. The opinion of Jeanne Rutledge that CMS or CDC criteria for identifying a UTI were not met in this case, even if her opinion is correct, offers no defense in this case. Petitioner's staff correctly identified signs and symptoms of a UTI. Contrary to Petitioner's position, Ms. Rutledge testified that no more than 24 hours should have passed without a clean catch of urine before staff contacted Dr. Borhani to request an order to obtain a urine sample by catheter. Tr. 227. Dr. Borhani does not suggest in his affidavit that the delay in obtaining

the urine specimen was acceptable to him or consistent with standard practice. P. Ex. 32. Nowhere in his lengthy affidavit does Dr. Boulware opine that the three-day delay in obtaining the urinalysis was acceptable. P. Ex. 33.[6]

Although the weight of the expert testimony is that it is not possible to decide with certainty the cause of death, there is no question that Resident 1 suffered harm by the delay in complying with Dr. Borhani's order and the resulting delay in treatment. My Findings of Fact 2 through 6, and 8, show that Resident 1 was in discomfort between August 26 and 29, 2005. Findings of Fact 10 through 14 show that Resident 1 continued to suffer discomfort until her death. Petitioner has not shown that Resident 1's discomfort was not attributable, at least in part, to the UTI, or that the UTI was not more severe due to the delayed diagnosis and treatment with antibiotics. Dr. Boulware's opinions that might be construed to the contrary are simply not credible. Accordingly, I conclude that Resident 1 suffered actual harm due to Petitioner's failure to deliver necessary care and services. Furthermore, Petitioner has not presented credible evidence that an untreated UTI in a resident in a SNF or NF is unlikely to cause serious injury, harm, impairment, or death of a resident. Thus, CMS's conclusion that the deficiency posed immediate jeopardy has not been shown to be clearly erroneous.[7]

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[6] Dr. Boulware's affidavit demonstrates the danger of offering an expert opinion without the opportunity for cross-examination or examination by the ALJ, to establish the foundation for the opinions or to test their validity. Dr. Boulware opines favorably to Petitioner that the delay in obtaining the urinalysis probably did not harm Resident 1. However, several of his opinions could be read to support a conclusion that Resident 1 was deprived of necessary care and services because Petitioner's staff failed to identify signs and symptoms of a gastrointestinal infection, e.g., P. Ex. 33, at 9, para. 41, 42; at 10, para. 43, 45; at 11, para. 48, which include Dr. Boulware's opinion that sepsis was due to, or indicated by, Resident 1's continuing diarrhea, but Dr. Borhani was not aware of the diarrhea present prior to August 26, because staff had not consulted with him regarding the diarrhea. CMS did not give Petitioner prior notice of such a basis for finding a regulatory violation. I conclude that the delay in obtaining the urinalysis and the resulting delay in treatment of confirmed UTI constitute a deprivation of necessary care and services and a violation of 42 C.F.R. § 483.25. Therefore, I conclude it unnecessary to reopen the record to further develop the record to establish more grounds for finding regulatory violations. 42 C.F.R. § 498.56.

[7] Petitioner had no NATCEP and the proposed remedy is a PICMP and DPNA. Therefore, whether or not the deficiency posed immediate jeopardy is not at issue.

Petitioner also argues that it would be denied due process if I found it responsible for CMS's allegations first raised at hearing and which were not included in the SOD. If not clear from the foregoing analysis, my decision is limited to the allegations originally made by the surveyors as set forth in the SOD, at P. Ex. 36, at 1. Accordingly, Petitioner's due process concern is unfounded.

**2. The DPNA and PICMP imposed in this case are reasonable.**

I have concluded that Petitioner violated 42 C.F.R. § 483.25. Hence, there is a basis for the imposition of an enforcement remedy and I must consider the reasonableness of the remedies imposed by CMS.

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 DPNA and 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). In this case CMS chose to impose a PICMP. CMS is authorized to impose a PICMP from $1000 to $10,000. Unlike a per-day CMP, a finding of immediate jeopardy is not required to impose the maximum PICMP.

In determining whether the amount of the CMP is reasonable, the following factors specified at 42 C.F.R. § 488.438(f) must be considered: (1) the facility's history of non-compliance, 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 offered any evidence showing an inability to pay. The key considerations in this case are the seriousness of the deficiency and Petitioner's culpability. The evidence shows, and I have found, that Resident 1 suffered actual harm. Although the evidence is not conclusive that Resident 1's decline and death was due to sepsis from an untreated UTI, the untreated UTI was clearly a contributing factor. Dr. Boulware's and Dr. Borhani's affidavits, evidence offered by Petitioner, show that Resident 1 suffered from multiple problems, all of which potentially contributed to her death, but none of which Petitioner's staff specifically addressed with Dr. Borhani. Petitioner is culpable in the resident's suffering, if not her death. Petitioner offers no credible explanation for why three days passed without obtaining a urine specimen so that Resident 1 could be administered antibiotics.

**III. Conclusions**

For the foregoing reasons, I conclude that Petitioner violated 42 C.F.R. § 483.25. I further conclude that the remedies of a DPNA from October 1, 2005 through October 16, 2005, and a PICMP of $10,000, are reasonable.

/s/

Keith W. Sickendick
Administrative Law Judge