DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
CMS Kansas City – Survey & Operations Group
601 E. 12th Street, Room 355
Kansas City, Missouri 64106

NOTICE OF MANDATORY TERMINATION OF MEDICARE PROVIDER AGREEMENT – PLEASE READ CAREFULLY

December 29, 2020
AMENDED

Sarah Wheeler, Administrator
Belle Terrace
1133 North Third St.
Tecumseh, NE 68450

CMS Certification Number: 285237

Dear Ms. Wheeler:

The Secretary of the U.S. Department of Health and Human Services (DHHS) has the duty and responsibility to protect the health, safety, welfare and rights of Medicare/Medicaid beneficiaries. The Secretary has delegated authority to administer and provide oversight of the Medicare program to Centers for Medicare & Medicaid Services (CMS).

After a careful review of the facts, we have determined that Belle Terrace does not meet the requirements for participation as a skilled nursing facility in the Medicare program under Title XVIII of the Social Security Act. Any skilled nursing facility receiving payment under Title XVIII must satisfy all the requirements contained in Section 1819 of the Act, 42 U.S.C. §1395i-3(h), and be in compliance with the standards contained in regulations at 42 CFR Part 483.

On June 24, 2020, the Nebraska Department of Health and Human Services (NE DHHS) completed a survey of your facility and found it to be out of substantial compliance with the regulatory requirements. Revisits conducted by the NE DHHS on September 14, 2020, October 22, 2020, December 3, 2020, and December 16, 2020, established that the facility has not obtained substantial compliance with regulatory requirements. The NE DHHS has provided you with the deficiencies noted at the time of the survey and each revisit.

TERMINATION

Under §§1819(h) and 1919(h) of the Social Security Act, the Secretary of Health and Human Services must terminate a skilled nursing facility's participation in the Medicare/Medicaid programs when a provider fails to meet the basic program requirements within six months of the initial findings.

Our termination notice, dated December 21, 2020, indicated that, "because of the deficiencies noted above, **your Medicare agreement will be terminated effective at the close of January 5, 2021**. We will also notify the State Medicaid Agency to terminate your Medicaid agreement." We are adjusting the termination date to be effective at the close of **January 19, 2021**.

The Medicare program will not make payment for covered services furnished to patients who were

admitted to your facility on or after August 14, 2020. For Medicare patients who remained in your facility prior to August 14, 2020, payment for covered services may be made after the date of termination for up to 30 days to ensure residents are successfully relocated per 42 C.F.R. §489.55(b) and 42 C.F.R. §441.11.

CMS is also sending a copy of this letter to your Medicare Administrative Contractor (MAC), Wisconsin Physicians Service. Please contact your MAC to make arrangements for filing a final cost report.

PUBLIC NOTICE OF TERMINATION

In accordance with 42 CFR 489.53(d) CMS will publish a legal notice prior to the termination and it will remain on the following website for six months:

https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Termination-Notices.html

WITHDRAWAL OF APPROVAL FOR NURSE AIDE TRAINING PROGRAM

Please note that Federal law, as specified in the Social Security Act at §1819(f)(2)(B) and §1919(f)(2)(B), prohibits approval of nurse aide training and competency evaluation programs (NATCEP) and nurse aide competency evaluation programs (NACEP) offered by, or in, a facility in which, within the previous two years, one or more of the following exists:

- Operated under a §1819(b)(4)(C)(ii)(II) or §1919(b)(4)(C)(ii) waiver (i.e., waiver of full-time registered professional nurse);
- Has been subject to an extended or partial extended survey as a result of a finding of substandard quality of care;
- Has been assessed a total civil money penalty of not less than $11,160;
- Has been subject to a denial of payment;
- Appointment of a temporary manager;
- Terminated from participation, and/or
- In the case of an emergency, has been closed and/or had its residents transferred to other facilities.

Your facility will receive further information regarding this from the State Agency.

APPEAL RIGHTS

The following remedy is being imposed:

- Termination

If you disagree with this action imposed on your facility, you or your legal representative **are required**

to file your appeal electronically at the Departmental Appeals Board Electronic Filing System Web site (DAB E-File) at https://dab.efile.hhs.gov/. To file a new appeal using DAB E-File, you first need to register a new account by: (1) clicking Register on the DAB E-File home page; (2) entering the information requested on the "Register New Account" form; and (3) clicking Register Account at the bottom of the form. If you have more than one representative, each representative must register separately to use DAB E-File on your behalf.

The e-mail address and password provided during registration must be entered on the login screen at https://dab.efile.hhs.gov/user_sessions/new to access DAB E-File. A registered user's access to DAB E-File is restricted to the appeals for which he is a party or authorized representative. Once registered, you may file your appeal by:

Clicking the **File New Appeal** link on the Manage Existing Appeals screen, then clicking **Civil Remedies Division** on the File New Appeal screen. Entering and uploading the requested information and documents on the "File New Appeal- Civil Remedies Division" form.

At minimum, the Civil Remedies Division (CRD) requires a party to file a signed request for hearing and the underlying notice letter from CMS that sets forth the action taken and the party's appeal rights. A request for a hearing should identify the specific issues and the findings of fact and conclusions of law with which you disagree, including a finding of substandard quality of care, if applicable. It should also specify the basis for contending that the findings and conclusions are incorrect. The DAB will set the location for the hearing. Counsel may represent you at a hearing at your own expense.

All documents must be submitted in Portable Document Format ("PDF"). Any document, including a request for hearing, will be deemed to have been filed on a given day, if it is uploaded to DAB E-File on or before 11:59 p.m. ET of that day. A party that files a request for hearing via DAB E-File will be deemed to have consented to accept electronic service of appeal-related documents that CMS files, or CRD issues on behalf of the Administrative Law Judge, via DAB E-File. Correspondingly, CMS will also be deemed to have consented to electronic service. More detailed instructions for using DAB E-File in cases before the DAB's Civil Remedies Division can be found by clicking the button marked **E-Filing Instructions** after logging-in to DAB E-File.

For questions regarding the E-Filing system, please contact E-File System Support at OSDABImmediateOffice@hhs.gov.

Please note that **all** hearing requests must be filed electronically unless you have no access to the internet or a computer. In those circumstances, you will need to provide an explanation as to why you are unable to file electronically and request a waiver from e-filing with your written request. Such a request should be made to:

Department of Health and Human Services
Departmental Appeals Board, MS 6132
Civil Remedies Division
330 Independence Avenue, SW
Cohen Building, Room G-644
Washington, D.C. 20201

A request for a hearing must be filed no later than 60 days from the date of receipt of this notice.

A copy of the hearing request shall be submitted electronically to:

kevin.wright@cms.hhs.gov

DENIAL OF PAYMENT FOR NEW ADMISSIONS

The NE DHHS notified you in a letter dated July 15 2020, a denial of payment for new admissions was imposed effective **August 14, 2020**. The denial of payment will remain in effect until your provider agreement is terminated effective **January 19, 2021**.

TEMPORARY MANAGER

The temporary manager imposed effective **August 29, 2020** will continue until the termination date of **January 19, 2021**, and for up to 30 days beyond the termination date while residents are being relocated.

REINSTATEMENT AFTER TERMINATION

As a result of the serious nature and circumstances of the involuntary termination, should Belle Terrace desire to re-enter the Medicare Program as a provider of Long Term Care services, Belle Terrace must provide CMS with reasonable assurance of its capacity to maintain compliance with the Medicare requirements for Long Term Care (LTC) certification, as provided in Section 1866 (c) (1) of the Social Security Act and with 42 C.F.R §489.57. The provider will not be accepted unless CMS determines (1) the institution submits with its request for readmission sufficient justification to indicate that the reasons for termination no longer exist; (2) all of the applicable statutory and regulatory requirements are met; (3) there is reasonable assurance for Medicare entities that the deficiencies that caused the termination will not recur.

Please feel free to contact Kevin Wright (816)426-6327, Health Insurance Specialist, in our Kansas City Office at (816) 426-2011 if you have additional comments or concerns.

.

Sincerely,

Dianna Wardlow-Dotter

Digitally signed by Dianna Wardlow-Dotter
Date: 2020.12.29 09:53:23 -07'00'

CDR Dianna Wardlow-Dotter
Division Director, CMS Kansas City & Denver
Survey & Operations Group
Center for Clinical Standards & Quality

cc:
NE DHHS
Wisconsin Physicians Service
OGC

Amended Medicare and Medicaid Notice to the Public

Notice is hereby given that on January 19, 2021 the Centers for Medicare & Medicaid Services (CMS) will terminate the agreement between the Secretary of Health and Human Services and Belle Terrace, Tecumseh, Nebraska as a skilled nursing facility in the Medicare program. In addition, as authorized by the Nebraska State Medicaid Agency, notice is given that the provider's agreement as a nursing facility in the Medicaid program will also be terminated effective January 19, 2021.

CMS has determined that Belle Terrace has failed to attain substantial compliance with the Medicare and Medicaid participation requirements.

Based on the Denial of Payment for New Admissions imposed by the Nebraska Department of Health and Human Services in a letter dated July 15, 2020, the Medicare program will not make payments for skilled nursing facility services furnished to residents admitted to the facility on or after August 14, 2020. For residents admitted prior to August 14, 2020, payment may continue for up to 30 days of services on or after January 19, 2021, the date of termination.

In addition, Federal Financial Participation will not be available to the State for any Medicaid residents admitted to the facility on or after August 14, 2020. For Medicaid residents admitted prior to August 14, 2020, Federal Financial Participation may continue to be made to the State for up to 30 days of covered services to qualified residents furnished on or after January 19, 2021, the date of termination.