Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Twinbrook Nursing Home,
(CCN: 18-5456),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-14-234

Decision No. CR4762

Date: December 15, 2016

DECISION

In this case, we again consider a long-term care facility's obligation to investigate and report allegations of abuse made by someone whom facility staff consider unreliable.

Petitioner, Twinbrook Nursing Home, is a long-term care facility, located in Louisville, Kentucky, that participates in the Medicare program. Based on surveys completed August 13 (life safety code), August 22 (health), and November 5, 2013 (follow-up), the Centers for Medicare & Medicaid Services (CMS) determined that, from August 10 through September 20, 2013, the facility was not in substantial compliance with Medicare program requirements and that, from August 10 through 14, its deficiencies posed immediate jeopardy to resident health and safety. CMS imposed civil money penalties (CMPs) of $4,800 per day for five days of immediate jeopardy, followed by $200 per day for 37 days of substantial noncompliance that was not immediate jeopardy. Petitioner requests review but limits its appeal to the issues surrounding the finding of immediate jeopardy.

For the reasons discussed below, I find that, from August 10 through 14, 2013, the facility was not in substantial compliance with 42 C.F.R. § 483.13(c) and that its

deficiencies posed immediate jeopardy to resident health and safety. The penalty imposed is reasonable.

Background

The Social Security Act (Act) sets forth requirements for nursing facility participation in the Medicare program and authorizes the Secretary of Health and Human Services to promulgate regulations implementing those statutory provisions. Act § 1819. The Secretary's regulations are found at 42 C.F.R. Part 483. To participate in the Medicare program, a nursing facility must maintain substantial compliance with program requirements. To be in substantial compliance, a facility's deficiencies may pose no greater risk to resident health and safety than "the potential for causing minimal harm." 42 C.F.R. § 488.301.

The Secretary contracts with state survey agencies to conduct periodic surveys to determine whether skilled nursing facilities are in substantial compliance. Act § 1864(a); 42 C.F.R. § 488.20. Each facility must be surveyed annually, with no more than fifteen months elapsing between surveys. Facilities must be surveyed more often, if necessary, to ensure that identified deficiencies are corrected. Act § 1819(g)(2)(A); 42 C.F.R. §§ 488.20(a); 488.308. The state agency must also investigate all complaints. Act § 1819(g)(4).

In this case, surveyors from the Kentucky Cabinet for Health and Family Services (state agency) completed life safety code (LSC) and health surveys on August 13 and 22, 2013, respectively. CMS Exs. 4, 5. In addition to their LSC deficiencies (which apparently are not part of this appeal),[1] CMS determined that the facility was not in substantial compliance with the following program requirements:

- 42 C.F.R. §§ 483.13(c)(1)(ii)-(iii), (c)(2)-(4) (Tag F225) (staff treatment of residents: investigate/report allegations of abuse), at scope and severity level J (isolated instance of noncompliance that poses immediate jeopardy to resident health and safety);

- 42 C.F.R. § 483.13(c) (Tag F226 – policies to prohibit abuse and neglect) at scope and severity level J; and

[1] CMS's notice letter mentions the LSC survey deficiencies (which were not inconsequential) but is ambiguous as to whether CMS attributed any part of the penalty to them. CMS Ex. 2. Petitioner has not appealed the LSC findings, and neither party addressed them in its submissions, so I do not consider them here.

- 42 C.F.R. § 483.65 (Tag F441 – infection control) at scope and severity level D (isolated instance of noncompliance that causes no actual harm with the potential for more than minimal harm).

CMS Exs. 2, 4.

Surveyors returned to the facility and completed a follow-up survey on November 5, 2013. Based on these findings, CMS determined that the facility returned to substantial compliance on September 21. CMS Ex. 3.

CMS imposed against the facility CMPs of $4,800 per day for five days of immediate jeopardy (August 10-14) and $200 per day for 37 days of substantial noncompliance that was not immediate jeopardy (August 15 – September 20), for a total penalty of $31,400 ($24,000 + 7,400 = $31,400). CMS Ex. 2.

Petitioner timely requested review, challenging the deficiencies cited at the immediate jeopardy level (42 C.F.R. § 483.13(c)), the finding of immediate jeopardy itself, and the penalty imposed for the period of immediate jeopardy.

The parties have filed pre-hearing briefs (CMS Br. and P. Br.) and closing briefs (CMS Cl. Br. and P. Cl. Br.). CMS has submitted 28 exhibits (CMS Exs. 1-28); Petitioner has submitted four exhibits (P. Exs. 1-4). In the absence of any objections, I admitted CMS Exs. 1-28 and P. Exs 1-4 into the record. Order Following Prehearing Conference at 3 (August 23, 2016). Petitioner also submitted a motion for summary judgment, and CMS filed a reply. I denied Petitioner's motion, finding that Petitioner has not established that it is entitled to judgment as a matter of law. *Id.* at 2-3. The parties provided the written direct testimony of their witnesses. Each party declined cross-examination of the other's witnesses, so an in-person hearing would serve no purpose, and the matter may be decided based on the written record. *Id.* at 3.

Issues

Based on the issues Petitioner did not appeal, I find that, from August 10 through September 20, 2013, the facility was not in substantial compliance with program requirements, and I sustain a CMP of at least $200 per day for that period.

The issues remaining are:

1. From August 10 through 14, 2013, was the facility in substantial compliance with 42 C.F.R. § 483.13(c) (Tags F225 and F226);

2. If, from August 10 through 14, the facility was not in substantial compliance with section 483.13(c), did its deficiencies then pose immediate jeopardy to resident health and safety; and

3. Is the penalty imposed ($4,800 per day) reasonable.

Discussion

1. The facility was not in substantial compliance with 42 C.F.R. § 483.13(c) because, contrary to that regulation's requirements and the facility's own policies for preventing resident mistreatment, neglect, and abuse, its staff did not immediately report or thoroughly investigate a resident's allegations of possible abuse; and they made no efforts to prevent potential abuse while an investigation was pending.[2]

Program requirements: "Abuse" means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. 42 C.F.R. § 488.301.

Facility residents have the right to be free from verbal, sexual, physical, and mental abuse. 42 C.F.R. § 483.413(b). To this end, a facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents. 42 C.F.R. § 483.13(c). It must ensure that all alleged violations are reported immediately to the facility administrator and appropriate state officials. The facility must have evidence that all alleged violations are thoroughly investigated, and it must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator (or designated representative) and to the appropriate state officials within 5 working days of the incident. If the violation is verified, the facility must take appropriate action. 42 C.F.R. § 483.13(c)(2), (3), and (4) (Tags F225, F226).

Facility policies. The facility had in place written policies for preventing, detecting, and reporting suspected abuse and neglect. CMS Exs, 13, 14. Consistent with the regulations, the policies define abuse as the willful infliction of injury, unreasonable confinement, intimidation, or punishment, with resulting physical harm, pain, or mental anguish. CMS Ex. 14 at 1. One of those policies mandates that facility staff immediately report to Adult Protective Services "all alleged violations and all substantiated incidents." Staff must then "initiate an investigation" and "take corrective action" as required. CMS Ex. 14 at 3; *see* CMS Ex. 13 at 9. That "corrective action" includes: 1) immediately take measures to protect the resident; 2) assess the resident for mental or physical harm; 3)

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[2] My findings of fact and conclusions of law are set forth, in bold and italics, as captions in the discussion section of this decision.

inform the facility administrator, director of nursing (DON), supervisor or charge nurse on duty, and the social worker of the incident; 4) call the incident in to the Department for Community Based Services; and 5) report alleged incidents to the Northern Enforcement Branch of the Office of the Inspector General. CMS Ex. 14 at 3.

The policy includes a checklist form, which directs that the "supervisor on duty at the time of the incident" follow its directions and fill it out. CMS Ex. 14 at 4.

A separate policy lists criteria to help staff identify victims of abuse. "*Resident reports abuse*" is among those criteria. CMS Ex. 13 at 1 (emphasis added). The policy includes additional procedures staff should follow when abuse is suspected: 1) notify the supervisor who ensures the resident's safety and immediately notifies the administrator or DON; 2) the supervisor immediately completes an incident report and begins an investigation, documenting his/her findings "because key evidence may be lost in first few hours"; 3) the supervisor must follow incident reporting procedures; 4) the documentation is safeguarded and held in the administrator's office; 5) staff must notify the resident's family and physician that an investigation is taking place; 6) the administrator or DON notifies the abuse agency as required by regulations; and 7) the corporate vice president of quality management and clinical services educates the facility administrators and regional staff on this policy "and ensure[s] an environment free from abuse . . . ." CMS Ex. 13 at 1-2.

Elsewhere, the policy reinforces the notion that potential abuse is identified through (among other items) allegations of abuse, which must be immediately reported to the supervisor, DON, and administrator. The policy requires the facility to investigate thoroughly all allegations and to take "appropriate actions." Investigations must be "prompt, comprehensive, and responsive to the situation." CMS Ex. 13 at 6. Staff must: 1) notify the attending physician and family; 2) protect the resident and immediately suspend the alleged abuser; 3) identify the resident, assess him or her for injury or harm, and summarize the allegation; 4) identify the accused and review that individual's personnel file; 5) indicate where and when the incident occurred; 6) identify witnesses and others who know about the incident; 7) interview and obtain written statements from individuals who may have first-hand knowledge of the incident; and 8) assess the affected resident and intervene appropriately. CMS Ex. 13 at 6.

The policy repeats that any employee aware of an allegation of abuse must immediately report the incident to his supervisor, the facility administrator, or DON. If reported to the supervisor, the supervisor must immediately report the allegation to the administrator or DON. "Failure to do so will result in disciplinary action, up to and including termination." The facility will report the allegations to the state agency and to local authorities, as appropriate. It may also notify the local ombudsman, as appropriate. CMS Ex. 13 at 7.

<u>The incident</u>. Resident 20 (R20) was an 83-year old woman, who had previously broken her hip. She suffered from cellulitis, venous insufficiency, diabetes, and other disorders. CMS Ex. 11 at 5, 7. She was totally dependent on staff for most of her activities of daily living and, because she was unable to walk, she used a wheelchair for mobility. CMS Ex. 11 at 17-18; CMS Ex. 21. Nevertheless, her cognitive skills were intact. CMS Ex. 11 at 11-13.

According to her most recent (July 2013) assessment, R20 occasionally experienced severe pain. CMS Ex. 11 at 22; see CMS Ex. 11 at 101.

On the first day of the survey, August 13, the state ombudsman told Surveyor Connie Williams that R20 had asked to speak to her in private. R20 told Surveyor Williams that, during her shower, a nurse aide had deliberately pulled her leg and hurt her. R20 also told Surveyor Williams that, when the incident occurred, she reported it to staff and asked that the aide no longer care for her. CMS Ex. 25 at 1 (Williams Decl. ¶¶ 6, 8); *see* CMS Ex. 24 at 2 (reporting that the nurse aide "took my leg and picked it up – jerked it a little, a bit. I yelled, hurt").

Surveyor Williams confirmed that R20 had earlier reported the incident to staff. Several staff members were aware of it, but, for two or three days, they did not investigate or even report it to the facility administrator or DON. CMS Ex. 25 at 1-2 (Williams Decl. ¶ 9). Review of staff interviews and notes confirms that R20 complained about the nurse aide's behavior but that staff did not take her complaints seriously:

- In notes dated August 12, 2013, the facility social worker, Judy Stone, wrote that "yesterday" (Sunday, August 11), R20 complained that, on Saturday, "her leg hurt" when a nurse aide lifted it from the bed. According to the note, R20 reported that, at the time of the incident, she told the nurse, "Justin," who talked to the nurse aide. The nurse aide said that she didn't know she'd hurt the resident and would be more careful, according to the social worker's note. The social worker also reported that R20 told her that "[she] [was] happy." CMS Ex. 21 at 5.

  Neither the nurse aide involved, Amanda Tower, nor the nurse, Licensed Practical Nurse (LPN) Justin Thomas, confirm this rendition of facts. They maintain that R20 "never mentioned anything about being hurt by Amanda Tower or any other [facility] staff member." P. Ex. 2 (Thomas Decl. ¶ 7); *see* CMS Ex. 24 at 16; P. Ex. 3 (Tower Decl. ¶ 8, 9); *see* CMS Ex. 24 at 16.

- Hours later on August 12, Social Worker Stone wrote a second note. In it, she described a call from "LPN Ellen," who reported that R20 "was saying that some [nurse aide] had hurt her." Social Worker Stone spoke to R20, who (according to the social worker's note) repeated her story except "this time she was in her [wheel chair] instead of her bed." Social Worker Stone reported the complaint to

"[DON] Kelly [Weihe]," according to the note. She told the DON that she considered R20's complaint an attention-seeking event attributable to her husband's not visiting that week. CMS Ex. 21 at 5. As noted below, DON Weihe claims that no one told her about the allegation until August 13.

- The following day (which would have been August 13, the same day R20 complained to Surveyor Williams), Social Worker Stone wrote another note, repeating that R20 told her that she'd reported to "Justin" that her leg hurt when the nurse aide was working with her in bed and that he spoke to the aide and "took care of it." According to the note, R20 said that "I am just fine." CMS Ex. 21 at 6.

- On August 13, 2013, someone from the facility interviewed LPN Justin Thomas. According to the interview notes, LPN Thomas reported that, on "Saturday" morning, he administered Tylenol in response to R20's complaints of knee pain. The Tylenol was not effective, so he gave her Lortab, which was effective. He confirmed that the resident was showered and that she told him "I don't like Amanda," but when he asked why, R20 allegedly said "never mind." LPN Thomas also reported that R20 "say[s] 'oh-oh-oh,' when you do anything with her and that 'we handle her with kid gloves.'" According to LPN Thomas, he "never suspected anything that needed reporting." CMS Ex. 21 at 12. On August 14, LPN Thomas provided similar information to the surveyors. CMS Ex. 24 at 16; *see* P. Ex. 1; P. Ex. 2 (Thomas Decl.).

- On August 13, DON Kelly Weihe filled out the facility's checklist form, which, according to facility policies, should have been filled out at the time of the incident. CMS Ex. 14 at 4. She wrote that the incident occurred on August 10 but was reported *by the state surveyor* on August 13. The accused staff member was removed from the schedule pending investigation, and DON Weihe reported the accusation to the appropriate state agencies. CMS Ex. 8 at 1. The facility administrator also suspended Social Worker Stone. CMS Ex. 27 at 1. This is the first suggestion that anyone reported the allegation to the administrator. *See* CMS Ex. 27 at 1. A copy of DON Weihe's report confirms that, at *9:36 p.m. on August 13*, the facility finally reported the allegations to the state agency. The report says very little except that the resident told surveyors that, over the week end, a staff member was rough with her and hurt her leg during a shower. The resident had no marks or bruises. CMS Ex. 7 at 1.

- A short paragraph indicates that another social worker, Lou Wilson, interviewed R20 on August 14, as part of a facility-wide plan to interview all capable residents. The resident did not respond verbally to any question, but nodded when asked if she felt safe, if she gets good care, if her concerns are addressed timely, and if she feels treated kindly. CMS Ex. 21 at 17.

- The surveyors interviewed Nurse Aide Amanda Tower on August 14. The nurse aide reported that, when she rolled R20 out of bed prior to her Saturday morning shower, the resident complained of right leg pain. According to Nurse Aide Tower, R20 "does yell out when you roll her sometime." The nurse aide also acknowledged that the resident complained of pain when, in preparing the resident for her shower, she moved R20's right leg and that the resident said, "ouch that hurt me," when the nurse aide rolled her over the "hump" in the shower room. R20 did not yell out for Justin (according to Nurse Aide Tower), although she has done so in the past. Nurse Aide Tower denied grabbing the resident's leg or telling her to shut up. CMS Ex. 24 at 16; *see* P. Ex. 3 (Tower Decl.).

- In an August 15 interview, LPN Ellen Linker described hearing R20 allege that staff mistreated her. LPN Linker was in R20's room, and the resident complained that "the other day" a nurse aide touched her leg and hurt her. R20 said that she wanted to smack the nurse aide and that, when she yelled, the nurse aide told her to shut up. Nurse Aide "Tressa," who had been caring for R20 that day, told LPN Linker that "she had been talking about this all day." LPN Linker called Social Worker Stone who said that R20 had "changed her story." She asked LPNs Linker and Nancy Murray to listen at the door while she spoke to R20, but the nurses had a hard time hearing what was said. CMS Ex. 21 at 13. Although the interview notes do not specify the date of this encounter, based on the social worker's note, it probably occurred on August 12 at 3:00 p.m. *See* CMS Ex. 21 at 5.

- In an August 15 telephone interview, Social Worker Stone described R20's complaints: her leg hurt when the nurse aide lifted it off the bed; she complained to Justin, who then talked to the nurse aide; the nurse aide apologized, telling R20 that she didn't realize that she hurt her. According to Social Worker Stone, R20 then reported that everything was fine. She insisted that R20 never used the word "rough." CMS Ex. 21 at 15.

- In a note dated August 21, 2013, LPN Linker again described hearing R20's allegations: she was in R20's room with Nurse Aide "Tressa" when R20 told her that the nurse aide who cared for her "the other day" hurt her leg; R20 said that she'd yelled and wanted to hit the nurse aide but the aide told her to shut up. LPN Linker called Social Worker Stone and reported R20's complaint. LPN Linker said that she would report the complaint to the DON, but Social Worker Stone told her not to do so, that R20 was changing her story "again." Social Worker Stone asked LPNs Linker and Murray to stand outside the resident's room to witness Social Worker Stone's conversation with R20 (presumably so that R20 would not know they were listening in). But the nurses could not hear, so they left. CMS Ex. 21 at 8-9. As she left work that day, LPN Linker spoke to Social Worker

Stone, who told her that she had spoken to the DON and would "take care of everything." CMS Ex. 21 at 9-10. Again, the note does not mention the date of these events, but the facts align with Social Worker Stone's August 12 note.

- In her own note, LPN Murray confirmed much of LPN Linker's August 21 report: Social Worker Stone asked them to listen at the door to R20's room; they could not hear a lot of what was said "but I did hear [Social Worker] Stone ask [R20] if she felt that [the nurse aide] hurt her" and that R20 replied "No, she was just being rough." CMS Ex. 21 at 11.

- Finally, the first record of anyone speaking to R20's husband about his wife's allegation is dated September 11, 2013. The entry claims that he was aware of the report because staff notified him on August 13, although no contemporaneous note supports this. According to the report, R20's husband was satisfied with her care and said that his wife has a long history of exaggerating things. CMS Ex. 21 at 18.

I am frankly skeptical of Social Worker Stone's first August 12 note, which seriously understates R20's August 11 allegations. CMS Ex. 21 at 5. LPN Linker subsequently described R20's far more serious allegations and, in her second note, Social Worker Stone conceded that R20 "repeated" the story she had told earlier (with some changes not related to the seriousness of the allegations). CMS Ex. 21 at 5, 13. Ultimately, the staff notes and interviews confirm that R20 unambiguously and repeatedly complained that a nurse aide hurt her. CMS Ex. 21 at 13 ("she had been talking about this all day," which should have triggered the facility's obligation to report and investigate).

Petitioner nevertheless claims that R20 did not accuse anyone of injuring her deliberately; rather, she complained of pain stemming from her chronic medical condition. In Petitioner's view, there was no allegation of abuse for facility staff to report or investigate.

Both section 483.13(c) and the facility's policies broadly define the types of allegations that must be reported and investigated. *All* alleged violations must be reported immediately to the facility administrator and appropriate state officials. 42 C.F.R. § 483.13(c); CMS Ex. 13 at 1, 6, 7, 9; CMS Ex. 14 at 3. The pertinent question is not whether any abuse occurred or whether the facility had reasonable cause to believe that any abuse occurred, but whether there is an allegation that facility staff abused a resident. *Britthaven, Inc.*, DAB No. 2018 at 15 (2006), citing *Cedar View Good Samaritan*, DAB No. 1897 at 11 (2003).

Here, on August 12, and probably as early as August 11, R20 alleged that a nurse aide hurt her, she yelled, and the nurse aide told her to shut up. CMS Ex. 21 at 5, 8. By any definition, this is an allegation of abuse. But until the end of the day on August 13 – after R20 repeated her allegations to the state surveyor – facility staff did not investigate; they

took no steps to assure resident safety while they investigated; and they did not report the allegation to the appropriate state agency. This puts them out of substantial compliance with 42 C.F.R. § 483.13(c). That, when confronted by obviously skeptical staff, R20 subsequently downplayed her complaints does not relieve the facility of its obligations to report and investigate.

Among the staff members who heard R20's allegation, only LPN Linker recognized her responsibilities and immediately reported the allegations to Social Worker Stone. CMS Ex. 14 at 3. Social Worker Stone, however, was already aware of them and had apparently determined, on her own, that the allegations were without merit. Individual staff members are not given the option of deciding whether to report allegations. As Judge Kessel pointed out in *Somerset Place*, DAB CR2164 at 3 (2010), there is an "obvious reason" for the regulation's categorical requirement. It assures that the allegation will be reviewed by an unbiased fact finder rather than an employee whose self-interest dictates that she not report.

Social Worker Stone assured LPN Linker that she would convey R20's complaints to DON Weihe and, in her notes and interviews, she documented that she did so. CMS Ex. 21 at 5, 9-10. DON Weihe, however, effectively denies that Social Worker Stone reported to her. In DON Weihe's report to the state agency, she claimed that she first learned of the allegation from the state surveyor on August 13. CMS Ex. 8 at 1. In her written declaration, she does not mention that Social Worker Stone or any other staff member reported the complaints to her; she repeats that she learned of the allegations after they were reported by the state surveyor on August 13. P. Ex. 4 at 1 (Weihe Decl. ¶¶ 8, 9).

Obviously, only one of these claims can be true. But I need not make credibility findings because, in either case, the individual or individuals charged with enforcing the facility's anti-abuse policies failed to do so, which put the facility out of substantial compliance with section 483.13(c).

I recognize that the obligation to take seriously all allegations of potential abuse, no matter the source, may seem excessively burdensome to facility staff. But even the least trustworthy of residents can be abused; in fact, given their challenging personalities and problematic behaviors, they may be more susceptible to abuse than most. That those charged with protecting them will dismiss their allegations out-of-hand makes them even more vulnerable.

2. CMS's determination that, from August 10 through 14, 2013, the facility's deficiencies posed immediate jeopardy to resident health and safety is not clearly erroneous.

Immediate jeopardy. Immediate jeopardy exists if a facility's noncompliance has caused or is likely to cause "serious injury, harm, impairment, or death to a resident." 42 C.F.R. § 488.301. CMS's determination as to the level of a facility's noncompliance (which would include an immediate jeopardy finding) must be upheld unless it is "clearly erroneous." 42 C.F.R. § 498.60(c). The Board has observed repeatedly that the "clearly erroneous" standard imposes on facilities a "heavy burden" to show no immediate jeopardy, and has sustained determinations of immediate jeopardy where CMS presented evidence "from which '[o]ne could reasonably conclude' that immediate jeopardy exists." *Barbourville Nursing Home*, DAB No. 1962 at 11 (2005) (citing *Florence Park Care Ctr.*, DAB No. 1931 at 27-28 (2004), citing *Koester Pavilion*, DAB No. 1750 (2000)); *aff'd*, *Barbourville Nursing Home v. U.S. Dep't of Health & Human Servs.*, 174 F. App'x 932 (6th Cir. 2006); *Daughters of Miriam Ctr.*, DAB No. 2067 at 7, 9 (2007).

Here, several facility employees – including one or two of the employees specifically charged with implementing the facility's anti-abuse policies – repeatedly disregarded those policies in critical respects: reporting, protecting the resident, and investigating. Such disregard of the measures in place to protect residents from abuse puts residents at risk, and the situation is likely to cause serious harm. CMS's determination that the deficiencies posed immediate jeopardy to resident health and safety is therefore not clearly erroneous.

3. The penalty imposed –$4,800 per day for the days of immediate jeopardy – is reasonable.

To determine whether the CMPs are reasonable, I apply the factors listed in 42 C.F.R. § 488.438(f): 1) the facility's history of noncompliance; 2) the facility's financial condition; 3) factors specified in 42 C.F.R. § 488.404; and 4) the facility's degree of culpability, which includes neglect, indifference, or disregard for resident care, comfort or safety. The absence of culpability is not a mitigating factor. The factors in 42 C.F.R. § 488.404 include: 1) the scope and severity of the deficiency; 2) the relationship of the deficiency to other deficiencies resulting in noncompliance; and 3) the facility's prior history of noncompliance in general and specifically with reference to the cited deficiencies.

I consider whether the evidence supports a finding that the amount of the CMP is at a level reasonably related to an effort to produce corrective action by a provider with the kind of deficiencies found, and in light of the above factors. I am neither bound to defer to CMS's factual assertions, nor free to make a wholly independent choice of remedies

without regard for CMS's discretion. *Barn Hill Care Ctr.*, DAB No. 1848 at 21 (2002); *Cmty. Nursing Home*, DAB No. 1807 at 22 *et seq*. (2002); *Emerald Oaks*, DAB No. 1800 at 9 (2001); *CarePlex of Silver Spring*, DAB No. 1638 at 8 (1999).

Here, CMS imposed a penalty of $4,800 per day for the period of immediate jeopardy, which is at the lower end of the per-day penalty range for situations of immediate jeopardy ($3,050-$10,000). 42 C.F.R. §§ 488.408(e)(1)(iii); 488.438(a)(1)(i).

Except to argue that it was in substantial compliance and is therefore not subject to any penalty, Petitioner has not specifically challenged the amount of the CMP.

CMS does not argue that the facility's history justifies a higher CMP. Petitioner does not claim that its financial condition affects its ability to pay.

Applying the remaining factors, at least one, and possibly two, of the individuals charged with administering the facility's anti-abuse policies disregarded them. They declined to investigate, report, and protect the resident. The facility is culpable for these failings, which justify the CMP.

Conclusion

For these reasons, I find that, from August 10 through 14, 2013, the facility was not in substantial compliance with 42 C.F.R. § 483.13(c); that its deficiencies posed immediate jeopardy to resident health and safety; and that the $4,800 per day penalty is reasonable.

__________/s/____________________
Carolyn Cozad Hughes
Administrative Law Judge