Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Oceanside Nursing and Rehabilitation Center
(CCN: 11-5459),

Petitioner

v.

Centers for Medicare and Medicaid Services.

Docket No. C-09-569

Decision No. CR2269

Date: October 15, 2010

DECISION

I sustain the determination of the Centers for Medicare and Medicaid Services (CMS) to impose remedies against Petitioner, Oceanside Nursing and Rehabilitation Center, consisting of the following:

- Civil money penalties of $5,200 per day for each day of a period that began on March 13, 2009 and that ran through May 3, 2009; and

- Civil money penalties of $350 per day for each day of a period that began on May 4, 2009 and that ran through June 24, 2009.

I. Background

Petitioner is a skilled nursing facility in the State of Georgia. It participates in the Medicare program. Its participation in Medicare is governed by sections 1819 and 1866 of the Social Security Act (Act) and by implementing regulations at 42 C.F.R. Parts 483 and 488. Its right to a hearing is governed by regulations at 42 C.F.R. Part 498.

CMS determined to impose the remedies that I describe in this decision's opening paragraph based on findings of noncompliance that were made at a survey of Petitioner's facility completed on April 25, 2009 (April Survey). Petitioner requested a hearing, and the case was assigned to me for a hearing and a decision. I held a hearing in Savannah, Georgia on July 6, 2010. At the hearing I received into evidence exhibits from CMS that are identified as: CMS Ex. 1; CMS Ex. 2; CMS Ex. 4 – CMS Ex. 6; CMS Ex. 8 – CMS Ex. 10; CMS Ex. 12; and CMS Ex. 15 – CMS Ex. 46. I received into evidence exhibits from Petitioner that are identified as P. Ex. 1 – P. Ex. 21.

II. Issues, Findings of Fact, and Conclusions of Law

A. Issues

The issues are whether:

1. Petitioner failed to comply substantially with Medicare participation requirements;

2. CMS's determination of immediate jeopardy noncompliance is clearly erroneous; and

3. CMS's remedy determinations are reasonable.

B. Findings of Fact and Conclusions of Law

The surveyors who conducted the April Survey found that Petitioner manifested five deficiencies that were so egregious as to pose immediate jeopardy for Petitioner's residents. I discuss each of these deficiencies in detail, and I sustain CMS's findings of noncompliance with respect to each of them. The surveyors also found several instances of non-immediate jeopardy level noncompliance. I do not address these in this decision inasmuch as the findings of immediate jeopardy level noncompliance are sufficient to justify the remedies that CMS determined to impose and that I sustain.

I make the following findings of fact and conclusions of law (Findings).

1. Petitioner failed to comply substantially with the requirements of 42 C.F.R. § 483.13(c).

A skilled nursing facility must "develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property." 42 C.F.R. § 483.13(c). The word "neglect" is defined to mean the "failure to provide [a resident with] goods and services necessary to avoid physical harm, mental anguish, or mental illness." 42 C.F.R. § 488.301.

The regulation is broadly worded, but its intent is unmistakable. Its purpose is to assure that residents receive necessary care and services and to assure also that skilled nursing facilities do not omit to provide that which is necessary.

CMS bases its allegations that Petitioner neglected to provide necessary care to its residents on Petitioner's treatment of four residents who are identified as Resident # 8, Resident T, Resident # 6, and Resident C. The weight of the evidence supports CMS's allegations concerning Residents #s 8 and 6 and Resident T. I do not find that there is credible evidence supporting allegations of neglect concerning Resident C. However, the evidence pertaining to the other three residents amply supports a finding of noncompliance with the anti-neglect regulation.

a. Resident # 8

At the time of the April Survey Resident # 8 was a relatively young individual, aged 51. CMS Ex. 42 at 6. He had been incapacitated by strokes, had lost the use of both of his legs, was unable to turn his lower body, and was unable to ambulate. *Id.* at 7. The resident was dependent on Petitioner's staff for transfers. *Id.*

The resident had used a wheelchair in the past. CMS Ex. 42 at 7. That had provided the resident with inadequate protection, because he was not able to be positioned appropriately in a wheelchair. *Id.* He was placed in a chair known as a "Broda chair" to provide him with additional protection. I take notice that a Broda chair is a device that maintains its occupant's body at an angle and is intended to be inherently more stable than a wheelchair that positions its occupant's upper body in an upright position. However, the staff knew that putting the resident in a Broda chair would not provide the resident complete protection from falling. Accordingly, the resident's care plan instructed the staff to monitor Resident 8 for appropriate positioning while he was in his Broda chair. *Id.* at 9.

Petitioner's staff was aware that the resident was at risk for falls and injury when he was not in his Broda chair. They were particularly aware that the resident would be at risk when he was transferred to and from a doctor's appointment in a regular wheelchair. The resident's care plan instructed the staff to:

> Make sure to place [the resident] back in Broda chair following doctors appointments where he is transferred via w/c.

CMS Ex. 42 at 10.

Resident # 8 is a smoker. Petitioner's staff knew that this resident was potentially at risk for injury when he smoked, due to his physical impairments and the difficulty keeping the resident positioned in a stable manner when he was not in bed. The resident's care plan instructed that the resident would be permitted to smoke only when under the staff's supervision. CMS Ex. 42 at 8.

On January 8, 2009, Resident # 8 fell, sustaining a fractured clavicle. CMS Ex. 42 at 6. The circumstances of his fall establish that Petitioner's staff neglected to comply with the directives in the resident's care plan concerning: his use of a Broda chair; monitoring the resident; and supervising him while he smoked. On January 8, the resident was transported to and from a doctor's appointment in a regular wheelchair. The resident was not transferred from the wheelchair to a Broda chair on his return to the facility. Rather, he remained in a regular wheelchair, unsupervised by Petitioner's staff. *Id.* at 5. The resident then was taken to Petitioner's patio, apparently by another resident, where he attempted to smoke unsupervised. While there and unsupervised, the resident fell from the wheelchair and was injured. *Id.*

This is unequivocal evidence of neglect. The staff had a protocol for dealing with Resident # 8's problems, which they ignored on January 8. The staff should have assured that the resident was transferred to his Broda chair immediately upon his return to the facility from his doctor's appointment. They should have monitored him while he was in his Broda chair to assure that he remained positioned correctly and was stable. And, they should not have permitted the resident to smoke unsupervised. They contravened the express instructions in the resident's care plan when they failed to assure his safe transfer to a Broda chair, failed to monitor the resident, and allowed him to smoke unsupervised.

Petitioner argues that the events of January 8, 2009, are only:

> an isolated event in which another resident was able to circumvent the Facility's policies and procedures. There is not even any evidence that the Facility should have been on notice of a practice or propensity for other residents to take Resident #8 outside for unsupervised smoking.

Petitioner's Post-Hearing Brief at 14-15. I disagree. I am not persuaded that the events of January 8 establish merely an isolated event or an aberration. Rather, they show a breakdown in the support and surveillance system that Petitioner's staff supposedly had implemented for Resident # 8. The staff was put on notice that the resident was to be transferred *immediately* to a Broda chair upon his return to the facility. That not only did not happen, but there was a whole sequence of events in which the resident remained in a regular wheelchair without staff intervention. He entered the facility in a regular wheelchair. He was taken *by Petitioner's staff*, while in a regular wheelchair, to Petitioner's dining room where he was served a meal. He was then transported to the patio by a resident, without intervention by the staff. There, he smoked while unsupervised, and he fell.

b. Resident T

Resident T was admitted to Petitioner's facility from a local jail on June 23, 2008. At that time, the resident was 60 years old. He had resided at Petitioner's facility previously but had been incarcerated for a probation violation. CMS Ex. 43 at 14. The resident had

diagnoses of angina pectoris and cerebrovascular disease and had sustained multiple gunshot wounds at some point in the past. *Id.* He had gait problems and sometimes walked with the aid of a walker. *Id.*

Petitioner's staff knew that Resident T had behavioral problems. He would consume alcohol while outside of Petitioner's premises. CMS Ex. 43 at 15. He was at times verbally abusive towards other residents. *Id.* He had altercations with his roommate.

On January 5, 2009, Resident T returned to Petitioner's facility, evidently from an unescorted off premises sojourn. CMS Ex. 43 at 10. He had been drinking. *Id.* at 15-16. Shortly after his arrival the resident began shouting, cursing, and demanding that Petitioner's staff attend to him. *Id.* at 10. He then threw an object (a can of cookies) at a nursing assistant and continued to curse and throw objects from his room into a hallway. *Id.* at 11. The resident refused to calm down, and Petitioner's staff called the police. The resident eventually was transferred to a local hospital for evaluation.

Resident T plainly was a violence prone, abusive individual. Indeed, on April 26, 2009, months after the January 5 incident, Petitioner's staff assessed the resident as follows:

> Resident has high potential for violence. This is brought on by alcohol consumption. Resident becomes surly and verbally aggressive towards others . . . Resident is ambulatory and goes outside facility and buys his own alcohol. He has friends and family who sign him out for the day and travel to Savannah. He is aware of the facility's policy prohibiting alcohol from being brought into the building.

CMS Ex. 43 at 5. During the period between the resident's June 23, 2008 admission to the facility and this April 26, 2009 note, Petitioner's staff never developed a plan of care that specifically addressed the resident's behavior and proclivities, notwithstanding his history and his clearly violent behavior and Petitioner's staff's insight into the resident's personality and propensities. The staff knew that the resident was a dangerous individual, that his personal problems were exacerbated by his access to alcohol, and that he occasionally engaged in outbursts that posed risks for other residents. Yet, at no time, did they plan systematically to address these issues. This failure to plan for, and to address, the resident's problems strongly supports a finding that the staff neglected not only the needs of Resident T but those of other residents who were potential victims of the resident's anger.

In its defense, Petitioner focuses almost exclusively on the January 5, 2009 incident involving Resident T. Petitioner's Post-Hearing Brief at 11-13. Petitioner argues that the resident's anger on that occasion was directed at Petitioner's staff and not at other residents. Therefore, according to Petitioner, the incident did not evidence any potential risk to the welfare of other residents. Moreover, according to Petitioner, the resident was not manifesting any psychiatric signs or symptoms after he was transported to the hospital on that date. From this, Petitioner argues that the resident's outburst was not

significant evidence of truly dangerous behavior. It contends also that the resident had calmed down by the time he returned to Petitioner's facility and, therefore, posed no threat. *Id.*

Petitioner's argument misses the point. Petitioner did not neglect to provide care for Resident and T and other residents affected by Resident T's anger solely as a consequence of the January 5, 2009 incident. That incident is evidence of the resident's propensity for violent behavior and, Petitioner's contentions to the contrary, evidences a danger that the resident could direct violence at anyone, not just a member of the staff. But, the neglect runs far deeper than the failure by Petitioner's staff to prevent that unique incident from occurring. The problem that is graphically illustrated by the evidence is a lack of planning by Petitioner's staff to address the obviously violent proclivities of Resident T.

c. Resident # 6

Resident # 6 was, as of the April Survey, an individual who was highly prone to sustaining injuries from falls. He had fallen on numerous occasions prior to March 13, 2009. On that date, the resident sustained a fall in his room, while he was getting up to use the bathroom. CMS Ex. 28 at 19, 28.

On March 14, the day following the fall, the resident began complaining of pain to his right leg and quadriceps area. CMS Ex. 28 at 28. The pain was evident on palpation of the resident's leg and also on rotation. However, Petitioner's staff gave the resident no pain medication on that date nor did they report the resident's complaints and their associated findings to the resident's physician.

The following day, March 15, 2009, the resident continued to complain of pain in his right leg with movement of that limb. *Id*. Again, the staff did not give the resident pain medication nor did they consult with the resident's treating physician. On the morning of March 16, the resident again complained of pain upon movement. Once more, the staff did not give the resident pain medication. The resident's physician did order an x-ray of the resident's right hip. CMS Ex. 28 at 25, 28-29. Petitioner's staff gave the resident a single dose of a non-prescription pain medication on the evening of March 16. CMS Ex. 28 at 29. The resident again complained of pain on March 17, 2009 and was given Tylenol as a pain relieving medication. *Id.* at 29. However, the staff continued not to consult with the resident's physician concerning his complaint of pain.

On March 18, 2009, the resident was examined by his physician, who ordered that the resident be given a CT scan of his right hip at a local hospital. CMS Ex. 28 at 30. The scan revealed a fractured femur and dislocation of the resident's right hip.

The resident returned to the facility on the evening of March 18 with a prescription for Lortab, a pain medication, to be administered every six hours as needed for pain ranging from mild to severe (the dosage varied depending on the amount of pain the resident was

experiencing). *Id.* at 27, 30. The staff assessed the resident's pain on March 19, 2009 as being of moderate severity with the pain being assessed as worse when the resident moved. CMS Ex. 38 at 31. Petitioner's staff administered Lortab to the resident on the 18th but did not administer another dose to the resident until March 26. CMS Ex. 28 at 9.

There is no evidence that Petitioner's staff ever met to address systematically this resident's persistent complaints of pain, and there is no evidence that they ever developed a plan to deal with his complaints. On March 18, 2009, the staff had a meeting to address some of the resident's problems. CMS Ex. 28 at 30. They discussed the resident's tube feedings, his continued chemotherapy and radiation therapy for esophageal cancer, and the weakness that the resident experienced as a result of his cancer and associated treatment. *Id.* However, there was no discussion of the resident's complaints of pain nor was any planning done to address those complaints.

The evidence that I have just discussed is strong proof that Petitioner neglected the needs of Resident # 6 by failing to plan for, and to take actions to address, the resident's complaints of pain. This resident was in at least intermittent pain beginning on March 14, 2009, and, yet, Petitioner's staff never systematically addressed that pain. No planning was done to address the resident's complaints, and no discussions about managing the resident's pain were held with the resident's physician. Furthermore, the staff was to say the least unsystematic in actually providing care to address the resident's complaints of pain. The staff gave the resident non-prescription pain medication only twice during the five day period before the resident was hospitalized for diagnosis of his fractured femur and dislocated hip. After his hospitalization, they gave the resident Lortab only once, notwithstanding their assessment of the resident's pain as being of moderate severity.

Petitioner's response to this evidence is to argue that the resident's complaints of pain were infrequent and were addressed by Petitioner's staff when he voiced them. Petitioner argues also that its staff engaged in "repeated consultation" with the resident's physician about the resident's complaints. Petitioner's Post-Hearing Brief at 10. I do not find these arguments to be persuasive. First, the resident's complaints of pain were not minimal. He voiced complaints of pain with movement of his leg. There is nothing to suggest that the resident lay perfectly still for hours on end with only sporadic movement of his leg. Moreover, he voiced these complaints consistently, for a period of several days, whenever he was asked by Petitioner's staff. Yet, these complaints did not prompt the staff to do a systematic assessment of the resident's pain nor did they prompt the staff to develop a plan to deal with that pain. It is true that Petitioner's staff consulted with the resident's physician, eventually. But, that consultation did not take place until several days had elapsed after the resident sustained his fall. In the interim, the resident complained of pain, and those complaints did not prompt consultation.

d. Resident C

CMS also cited the care that Petitioner's staff allegedly gave to Resident C as support for its contention that Petitioner's staff neglected residents' needs. As I have stated, the evidence of neglect respecting Residents #s 6 and 8 and Resident T is ample support for a finding that Petitioner neglected its residents' needs. I sustain the finding of noncompliance with the requirements of 42 C.F.R. § 483.13(c) based on that evidence. The allegations concerning Resident C are not necessary to my finding of neglect. And, in fact, these allegations are not supported by the evidence.

The allegations rest on the assertions that Resident C made to a surveyor during the April survey. She complained to the surveyor that, on March 13, 2009, she asked a member of the staff to assist her while she took a shower. According to the resident, the staff member – a nursing assistant – initially agreed to help the resident but then failed to assist her. The resident complained that the nursing assistant was eating, when the resident presented herself to the nursing assistant as being ready for her shower. The resident then averred that she went to take a shower on her own, fell in the shower, and was injured.

It is true that the resident fell in the shower while attempting to shower alone and that she was injured. It is also true that the staff had assessed the resident as needing assistance to bathe. Furthermore, it is true that the resident was attempting to shower without supervision or assistance when she fell. But, there is no persuasive evidence that shows that Petitioner's staff neglected the resident's needs on the day she sustained her fall. In particular, there is no credible evidence that the staff refused the resident's request that she be assisted.

The resident's complaint about the nursing assistant's refusal to help her is hearsay evidence and was made without corroboration. CMS has offered no evidence that would enhance the probative value of the resident's hearsay complaint. I find Resident C's complaint to be unreliable, because there is nothing that supports it. I find it to be suspect, because the resident delayed making her complaint for several weeks. The resident did not complain about the care she received until the April Survey, more than a month after she had sustained her fall.

2. Petitioner failed to comply substantially with the requirements of 42 C.F.R. § 483.20(k)(3)(ii)

A skilled nursing facility must provide services to each of its residents by qualified persons in accordance with that resident's written plan of care. 42 C.F.R. § 483.20(k)(3)(ii). CMS alleges, and I find, that Petitioner failed to provide services to several of its residents in accord with these residents' plans of care. The allegations made by CMS address the care that Petitioner gave to residents who are identified as Residents #s 8, 4, and 5, and Resident C. I sustain CMS's allegations as respects Residents #s 8, 4, and 5. I do not sustain them as respects resident C, for the reasons I have explained at Finding 1 of this decision. I find, however, that the proof of noncompliance as respects

the other three residents is sufficient to sustain an overall finding of noncompliance by Petitioner.

a. Resident # 8

As I discuss at Finding 1, Petitioner's staff was instructed to keep Resident # 8 in a Broda chair, with special emphasis on assuring that he would be transferred immediately to this chair upon return from a visit to his doctor, and he was supposed to be supervised while smoking. Petitioner plainly failed to provide these services to the resident.

Petitioner has provided no argument to respond to this evidence except to contend that what happened to the resident was an isolated incident. I explain at Finding 1 why I find this argument to be unpersuasive.

b. Resident # 4.

Resident # 4 was very susceptible to falling. Petitioner's staff assessed him as being a high risk for falling. CMS Ex. 26 at 16. Between June 20, 2008 and October 7, 2008, the resident fell on four occasions while he was in his room. *Id.* at 11. He fell again on January 22, February 7, and March 27, 2009.

Petitioner's staff developed, and the resident's physician ordered, interventions to protect the resident against falling, including: 1) on February 4, 2009 the resident's physician ordered that the resident be supplied with a bed alarm (CMS Ex. 26 at 10); and 2) Petitioner's staff planned to check the bed alarm every two hours. CMS Ex. 26 at 9.

In fact, Petitioner's staff failed to implement these measures, either consistently or at all. After the February 7, 2009 fall by Resident # 4, the staff discovered that his bed alarm was not working. CMS Ex. 26 at 7, 9. Although the staff was instructed to check the alarm for functioning at two hour intervals, facility documents show that the alarm was being checked only once every eight-hour shift. *Id.* at 25. When nurses were interviewed by a surveyor during the April Survey, two of the three nurses who were interviewed were unable to say which residents were supposed to have their alarms monitored, and they admitted that there was no system in place at Petitioner's facility for checking alarms. CMS Ex. 18 at 1, 3.

CMS now alleges additionally that the resident was observed by surveyors not wearing a seatbelt that had been prescribed by the resident's physician. However, no reference is made to this allegation in the statement of deficiencies for the April survey nor did CMS make the allegation in its pre-hearing brief. Consequently, I do not consider it here.

Petitioner contends that it implemented the interventions that I have described "but that on a few isolated occasions they were discovered not to be working or to have been removed by the resident." Petitioner's post-hearing brief at 16. However, the evidence that I have described shows more than a "few isolated occasions" of noncompliance.

There was a clear failure by Petitioner's staff to follow instructions to check the resident's bed alarm at two-hour intervals. There was also confusion by Petitioner's staff concerning which residents were to be monitored and whether there was a system for assuring that monitoring would take place.

c. Resident # 5

This resident was a greatly debilitated individual. The resident suffered from flexion contractures of her hands. Her plan of care directed that she be supplied with hand rolls and palm protectors for both hands. *Id.* at 8.

There is persuasive evidence showing that Petitioner's staff failed to comply with these instructions in providing care to Resident # 5. A surveyor observing Resident # 5 on several occasions on April 23 and 24, 2009, found that the resident was not wearing palm protectors or hand rolls. CMS Ex. 27 at 16. Deborah Herring, one of the surveyors who participated in the April survey, testified persuasively that hand rolls, while they cannot reverse contractures, can prevent further contractures. Tr. at 59-61. Preventing contractures from worsening is important, because such protection can protect the skin from breaking down and protect against the development of pressure sores. *Id.*

Petitioner argues essentially that hand rolls and palm protectors would not have been effective had they been supplied to the resident. Petitioner's Post-Hearing Brief at 18-19. However, the issue is not whether the hand rolls and palm protectors would have prevented the development of skin breakdown or pressure sores. Rather, the issue is whether Petitioner implemented the care plan it had developed for Resident # 5. Plainly, it did not. Arguing now that there would have been no benefit in following the plan that Petitioner's own staff developed begs the question of compliance. Petitioner's staff developed a plan for the resident. They were obligated to follow that plan. If they determined that the plan was not effective – and there is no evidence in the record of this case to show that the staff made that determination with respect to Resident # 5's use of hand rolls and palm protectors – then the staff could have modified the plan to reflect their new assessment. But, absent such an assessment and modification, the staff had no license to ignore their own care plan.

CMS now alleges additionally that Petitioner failed to follow a physician's instructions for tube feeding Resident 5. However, these allegations were not made in the statement of deficiencies for the April survey at an immediate jeopardy level of noncompliance. CMS Ex. 5 at 30-32. Nor did CMS seek to amend its allegations in either its pre-hearing brief or at any time prior to hearing. For that reason, I do not consider the allegations now.

3. *Petitioner failed to comply substantially with the requirements of 42 C.F.R. § 483.25(h).*

A skilled nursing facility must ensure that its resident environment must remain as free of accident hazards as is possible, and it must also ensure that each of its residents receives adequate supervision and assistance devices to prevent accidents. 42 C.F.R. § 483.25(h)(1), (2). The regulation does not make a facility strictly liable for accidents that its residents may sustain, but it does require that a facility take all reasonable measures to protect residents against accidents.

CMS asserts that Petitioner failed to comply with this regulation in providing care to Residents #s 8 and 4 and Resident C. I do not find noncompliance in providing care to Resident C for the reasons that I explain at Finding 1. But, there is ample evidence to establish noncompliance in providing care to Residents #s 8 and 4, and this evidence is sufficient to establish noncompliance by Petitioner with the regulation's requirements.

a. *Resident # 8*

As I discuss at Finding 1, Petitioner failed to provide Resident # 8 with the care he needed to protect him from falling. Specifically, Petitioner's staff failed to: assure that the resident was immediately transferred from a wheelchair to a Broda chair upon his return to the facility from a doctor's appointment; monitor him while he was on the premises; and supervise him while he smoked. These failures plainly establish noncompliance with the requirements of 42 C.F.R. § 483.25, because they are failures to supervise and to provide the resident with an assistance device, a Broda chair.

b. *Resident # 4*

As I discuss at Finding 2, Petitioner failed to provide Resident # 4 with the care he needed to protect him against falling by its staff's failure to assure that the resident's bed alarm was checked as often as directed. Additionally, Petitioner failed to have in place a system that would tell its staff which of its residents needed to have his or her alarm checked.

Petitioner has provided no defenses to CMS's allegations of noncompliance with 42 C.F.R. § 483.25 other than those which it raised in response to other allegations of noncompliance. I discussed those defenses at Findings 1 and 2, and I do not need to re-address them here.

4. *Petitioner failed to comply substantially with the requirements of 42 C.F.R. § 483.75.*

A skilled nursing 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 of its residents. 42 C.F.R. § 483.75. The

evidence of Petitioner's noncompliance with this regulation lies in the noncompliance that I have discussed at Findings 1 – 3 of this decision. The failures of care that I discuss in those Findings are, ultimately, a failure of Petitioner's management to implement policies and procedures that protect residents against staff misfeasance. For example, Petitioner should have had a system in place to assure that its residents who wore, or were supplied with, alarms had those devices checked regularly. A non-functioning alarm is worse than no alarm at all, because the staff assume that an alarm that is supplied to a resident will work as intended. But, Petitioner – although being cognizant of the need to check its residents' alarms – failed to create or implement a system that would assure that the alarms were checked.

The failure of Petitioner's staff to assure that Resident # 8 was in a Broda chair at all times when he was on Petitioner's premises and awake is a failure by Petitioner's management to assure that staff was properly trained to assure that the resident received the care that had been ordered for him. On January 8, 2009, the resident had to have been seen by numerous members of Petitioner's staff while in a wheelchair and not in a Broda chair. He was brought into the facility from outside the premises in a regular wheelchair. He was wheeled into the facility's dining room by one of Petitioner's staff to receive a meal along with other residents. And, yet, none of the staff reacted to an obvious deviation from the care plan that had been written for the resident.

Petitioner offers no evidence to address specifically the allegations of noncompliance with 42 C.F.R. § 483.75. Rather, it reasserts the defenses it raised previously and which I have discussed at Findings 1, 2, and 3 of this decision. I do not need to re-address those defenses here.

5. Petitioner failed to comply substantially with the requirements of 42 C.F.R. § 483.75(o)(1).

A skilled nursing facility must have a quality assessment and assurance committee that meets at least quarterly to identify issues concerning quality assessment and assurance and that develops and implements appropriate plans of action to correct identified quality assurance issues. 42 C.F.R. § 483.75(o)(1). CMS asserts that Petitioner did not have a meaningful quality assurance committee, in that its committee failed to identify and address certain quality of care issues.

As support for this argument, CMS refers to an interview that a surveyor conducted with Petitioner's quality assurance coordinator. This individual acknowledged to the surveyor that Petitioner's quality assurance committee had not discussed who would assure that restraints and safety devices would be monitored appropriately. She acknowledged that Petitioner did not have any program in place to identify residents who are at risk for falling. She admitted that the quality assurance committee had not identified any resident who had a problem with pain. Nor had the committee discussed problems associated with resident behavior. Finally, the quality assurance coordinator was unable to say

whether Petitioner had conducted previously planned in-service training of its staff to implement a pain assessment protocol. CMS Ex. 30 at 13-14.

This evidence supports a finding that Petitioner did not have an effective quality assurance committee. As I have discussed at Findings 1 – 4, there were obvious quality of care problems at Petitioner's facility. These included a failure by Petitioner to implement a system for monitoring alarms. They also included a failure to assure that falls prone residents were systematically and adequately protected. And, they included a failure to address residents' pain in a systematic and thorough manner. The failure of the quality assurance committee to identify and address these problems shows that this committee was ineffective.

Petitioner has offered no defense to the evidence of inadequate quality assurance other than to cite evidence that I have addressed previously. I find it unnecessary to re-visit Petitioner's arguments here.

6. Petitioner did not prove CMS's findings of immediate jeopardy level noncompliance to be clearly erroneous.

The term "immediate jeopardy" means noncompliance that is so egregious that it causes, or is likely to cause, serious injury, harm, impairment, or death to a resident. 42 C.F.R. § 488.301. CMS determined that Petitioner's noncompliance with each of the regulations that I discuss at Findings 1 – 5 of this decision was so egregious as to comprise immediate jeopardy.

The evidence strongly supports CMS's determinations of immediate jeopardy level noncompliance. Residents #s 4, 6, and 8 were all at risk of serious harm as a consequence of Petitioner's failure to provide them with care that complied with regulatory requirements. Petitioner's failure to address systematically and comprehensively the violent outbursts of Resident T put other residents, at least, at a risk for serious harm. Petitioner offered no evidence to rebut CMS's immediate jeopardy determination except to argue that, in fact, it was complying with participation requirements. I have addressed these arguments at Findings 1 – 5.

Petitioner argues that CMS found that immediate jeopardy level noncompliance commenced on March 13, 2009, citing to the report of the April Survey. *See* CMS Ex. 5 at 1. From this Petitioner asserts that much of the evidence concerning the care that Petitioner gave to its residents, including Residents #s 4 and 8, and Resident T, is irrelevant, because it pertains to incidents that took place prior to March 13.

I disagree. It is true that CMS determined that, for purposes of imposing remedies, immediate jeopardy commenced on March 13, 2009. But, that does not mean that evidence that predates March 13 is irrelevant to whether immediate jeopardy existed on that date. Noncompliance is not bounded by the duration of an incident or care that fails to comply with regulatory requirements. For example, in the case of Resident # 8,

Petitioner's staff plainly failed to comprehend their duties to supervise and protect the resident and to monitor his activities. The fact that this failure was exposed in January 2009 does not mean that Petitioner's staff corrected their noncompliance immediately after the incident. Indeed, as of March 13, 2009, Petitioner and its staff had done nothing to address the problems that were revealed by the January incident concerning Resident # 8.

Petitioner also argues that, even if there was immediate jeopardy level noncompliance, the *duration* of its noncompliance was less than was determined by CMS. It asserts that, on April 27, 2009, it conducted in-service training for its staff on all issues that were identified by the surveyors at the April Survey. Thus, according to Petitioner, all staff were trained to avoid the problems cited by the surveyors by no later than April 27.

The evidence relied on by Petitioner as proof that it corrected all of its deficiencies by April 27 consists of records of the in-service training that was conducted after the April Survey. P. Ex. 5 – P. Ex. 13. Each of these records addresses a specific subject. For example, P. Ex. 7 is a record of in-service training conducted to address the risks associated with residents falling. The exhibit contains a synopsis of the material that was covered during the training plus the initials of the staff members who attended it. *Id.*

I find these exhibits to be unpersuasive evidence that Petitioner corrected its deficiencies by April 27, for two reasons. First, the exhibits do not prove that Petitioner's staff actually was thoroughly trained to address the problems identified by the surveyors. They are merely lists of the course material that ostensibly was taught to the staff. They do not prove how thoroughly this material was taught, how well the staff absorbed the subject matter that was taught to them, or whether the staff then put into practice the information that they received from the in-service training.

Furthermore, the documentary evidence that Petitioner offered is, as a matter of law, insufficient to establish that Petitioner corrected its deficiencies. The undisputed facts establish that these deficiencies share a feature in that each deficiency involved errors by Petitioner's staff in determining how, and in what way, to provide care.

Where CMS imposes a remedy to address a deficiency or deficiencies that remedy will continue in effect until:

> The facility has achieved substantial compliance, as determined by CMS or the State based upon a revisit or after an examination of credible written evidence that it can verify without an on-site visit . . . .

42 C.F.R. § 488.454(a)(1). The regulation does not specify the circumstances where a revisit is necessary or where CMS might be able to verify written evidence of compliance without revisiting a facility. That issue was addressed in the Secretary's comments in the

preamble to the Part 488 regulations:

> There are other cases in which documentation cannot confirm the correction of noncompliance, and in these cases an on-site revisit is necessary. For example, one of the requirements for Infection Control is that personnel must handle, store, process and transport linens so as to prevent the spread of infection as specified in § 483.65. If a deficiency is cited for a violation of this requirement and a civil monetary penalty is imposed, submitting written documentation would not confirm the correction of the violation. An on-site revisit to observe personnel behavior is necessary in this case to confirm that the facility is, in fact, back in substantial compliance with this regulatory provision.

59 Fed. Reg. 56,207 (Nov. 10, 1994). The preamble clarifies the regulation by defining the circumstances in which documentation alone will not serve to establish compliance. Deficiencies that involve staff members' providing care to residents are not deficiencies that normally can be certified as corrected based solely on a review of documents, because documents alone cannot prove that staff are actually providing care according to professionally recognized standards of care. For such deficiencies, observation of performance is a critical element of certifying compliance.
Deficiencies that involve the providing of care by staff are distinguishable from those that involve mechanical issues or equipment. This latter type of deficiency is one in which correction can be certified based on documents. For example, a Life Safety Code deficiency might be based on the failure of a specific piece of equipment at a facility. In that circumstance, a facility might be able to prove compliance by offering written proof that the faulty piece of equipment had been repaired or replaced.

The deficiencies that I have found at Findings 1 – 5 all fall into the category of deficiencies that cannot be certified as having been corrected based solely on documents. Each of these deficiencies is, at bottom, a failure by Petitioner's staff to provide care to residents in accord with professionally recognized standards of care. For example, Petitioner's staff failed to address appropriately a resident's pain. Retraining the staff in identifying complaints of pain and addressing them certainly is a critical part of correcting this deficiency. But, retraining alone is not sufficient. There must be proof that the staff absorbed the information provided by the retraining and that they applied it in practice. That aspect of compliance cannot be established simply by documents but requires observation.

Thus, and as a matter of law, Petitioner could not establish compliance with the deficiencies that I describe in Findings 1 – 5 based solely on documents representing that its staff had been retrained. What was minimally necessary to establishing compliance was that the staff be observed actually providing the care implicated in the deficiencies. Certification of that required a revisit to the facility. That revisit occurred on May 4, 2009, and that was the date on which CMS determined that immediate jeopardy had been

abated. As a matter of law, May 4 was the earliest date when immediate jeopardy could have been abated due to the nature of Petitioner's noncompliance.

7. CMS's remedy determinations are reasonable.

The civil money penalties that CMS determined to impose fall into two ranges, that which is reserved for immediate jeopardy level deficiencies and that which applies to those deficiencies that are substantial but which are not at the immediate jeopardy level of scope and severity. The permissible range of immediate jeopardy level penalties is from $3,050 to $10,000 per day. 42 C.F.R. § 488.438(a)(1)(i). The permissible range of non-immediate jeopardy level penalties is from $50 to $3,000 per day. 42 C.F.R. § 488.438(a)(1)(ii).

There are regulatory criteria that must be used for deciding what is a reasonable penalty amount for a penalty that falls within either of the two penalty ranges. These criteria include: the seriousness of a facility's noncompliance; its culpability; its compliance history; and its financial condition. 42 C.F.R. §§ 488.438(f)(1) – (4) (incorporating 42 C.F.R. § 488.404 by reference into 42 C.F.R. § 488.438(f)(3)).

I discuss the two penalty amounts that CMS determined to impose as follows.

a. $5,200 per day for immediate jeopardy level noncompliance

A civil money penalty of $5,200 per day for immediate jeopardy level noncompliance falls at the middle of the permissible immediate jeopardy penalty range. I find that amount to be reasonable because of the seriousness of Petitioner's noncompliance. That is measured by the seriousness of individual immediate jeopardy level deficiencies but also by the fact that Petitioner manifested five of them. Each of these deficiencies was serious in its own right. Petitioner put several of its residents at great risk of injury or harm by virtue of its failure to provide care for them that met professional standards of care and regulatory requirements. Thus, for example, Petitioner allowed a resident (Resident T) to reside on its premises for an extended period, knowing that this resident was prone to alcohol abuse and violence, yet failing to develop a comprehensive plan to deal with the resident's proclivities. Petitioner identified another resident (Resident # 4) as being at great risk for falls and, yet, failed to implement the basic protections that the staff had determined to be necessary for the resident. As another example, Petitioner's staff knew that Resident # 8 was highly vulnerable to falling if not placed in a protective Broda chair, and, despite that knowledge, the staff allowed the resident to be in the facility in an ordinary wheelchair and to smoke unsupervised.

The seriousness of the individual deficiencies is magnified by the fact that Petitioner was noncompliant at an immediate jeopardy level of noncompliance across a whole range of regulatory requirements.

Petitioner asserts that immediate jeopardy level penalties of $5,200 would be unfair given its financial condition. Petitioner asserts that its long term financial condition is such that it would not be able to survive the impact of the penalties that CMS determined to impose. Petitioner's Post-Hearing Brief at 22-24.

In assessing Petitioner's arguments, I note first that, under no circumstance, may I reduce an immediate jeopardy level penalty to a daily sum that is less than $3,050. That amount is the *minimum* immediate jeopardy penalty amount, and I have no authority to waive it. That having been said, I am not persuaded by Petitioner's contention that it merits a reduction of penalties, if only to an amount of $3,050 per day.

The thrust of Petitioner's argument is that the entity that is Petitioner is losing money with a net income loss during the first five months of more than $282,000 and an operating loss for the last two years. Tr. at 89, 95. But, that assertion does not tell the entire story of Petitioner's financial condition. Petitioner is one of several interrelated entities with common ownership. Tr. at 85. The gross revenue of all of these companies, including Petitioner, is about $75 million per year. Tr. at 93.

I cannot adjudicate Petitioner's arguments about its financial condition while wearing blinders. That Petitioner exists as an entity that is legally separate from other, similar entities with common ownership likely means that the other entities do not share in the legal responsibility to pay Petitioner's debts and liabilities. But, that does not mean that Petitioner is without access to very significant resources that could be used to pay the civil money penalties that are at issue here. Indeed, considering Petitioner's status in isolation is in my opinion an artificial way of addressing its financial status, given that it is owned in common with other facilities which, obviously, have enormous resources and large assets at their disposal and under their control. Moreover, considering Petitioner as an isolated entity without looking at the broader picture would simply encourage skilled nursing facilities that are held in common with other similar facilities to contend that they must be treated as isolated facilities regardless of the financial wherewithal of the entity or individual that owns them along with other similar facilities. That would be an open invitation for skilled nursing facilities to avoid paying civil money penalties.

Furthermore, even if Petitioner is considered as an isolated entity, the evidence does not establish that it would be unable to pay the penalties that are at issue here. Petitioner's owner contended that it would contemplate bankruptcy if forced to pay the penalties. Tr. at 97. But, he did not contend that the facility would be forced to close its doors. Rather, he acknowledged that a prospective bankruptcy would be under Chapter 11, a form of bankruptcy that would enable Petitioner to continue to operate even if insolvent. *Id.*

Petitioner also characterizes the total penalty amount that CMS determined to impose – more than $283,000 – as an "incredible amount of money." Petitioner's post-hearing brief at 24. I take that characterization to mean that Petitioner is contending that the total penalty amount is unreasonably large. I do not agree. The amount reasonably takes into consideration the presence of five immediate jeopardy level deficiencies that persisted for

weeks at Petitioner's facility. As I have stated, it constitutes only very slightly more than one half the maximum penalty amount for deficiencies of this type.

b. $350 per day for non-immediate jeopardy level noncompliance

This penalty amount covers the period between May 4, 2009, when immediate jeopardy was abated, and June 24, 2009, when CMS determined that Petitioner finally attained compliance with all participation requirements. The daily penalty amount is modest. $350 per day is less than 12 percent of the maximum non-immediate jeopardy level amount. Petitioner did not contend that this amount is unreasonable nor did it offer any evidence to show that it is unreasonable aside from its argument that Petitioner lacks the wherewithal to pay civil money penalties. Consequently, I sustain it.

/s/

Steven T. Kessel
Administrative Law Judge