Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Springhill Senior Residence,
(CCN: 01-5435),

Petitioner,

v.

Centers for Medicare and Medicaid Services.

Docket No. C-11-765

Decision No. CR2653

Date: October 24, 2012

DECISION

Petitioner, Springhill Senior Residence (Petitioner or facility), is a long-term care facility located in Mobile, Alabama, that participates in the Medicare program. Based on a complaint investigation survey completed on June 24, 2011, the Centers for Medicare and Medicaid Services (CMS) determined that Petitioner was not in substantial compliance with Medicare participation requirements. CMS imposed against Petitioner a civil money penalty (CMP) of $5,550 per day effective May 2 through June 23, 2011, and a CMP of $100 per day effective June 24 through June 30, 2011. Petitioner also lost its approval to conduct a nurse-aide training program (NATCEP).

For the reasons set forth below, I sustain CMS's determinations. Petitioner was not in substantial compliance with the requirements for participation at 42 C.F.R. § 483.15(a) (Tag F241, Quality of Life, Dignity); 42 C.F.R. § 483.10(e) (Tag F164, Resident Rights, Privacy and Confidentiality); and 42 C.F.R. § 483.75(l)(4) (Tag F164, Administration,

Clinical Records). I also find that the CMP that CMS imposed is reasonable, and with this finding, the law requires Petitioner's loss of approval to conduct a NATCEP.[1]

I. Background

The Social Security Act (Act) sets forth requirements for skilled nursing facility and nursing facility participation in the Medicare program. The Act authorizes the Secretary of Health and Human Services (Secretary) to promulgate regulations implementing those statutory provisions. Act §1819 (42 U.S.C. § 1395i-3). The Secretary's regulations are found at 42 C.F.R. Part 483. To participate in the program, a 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 agencies to conduct periodic surveys to determine whether skilled nursing facilities are in substantial compliance. Act § 1864(a) (42 U.S.C. § 1395aa(a)); 42 C.F.R. §§ 488.10; 488.20. The Act and regulations require that facilities be surveyed on average every 12 months, and more often if necessary, to ensure that identified deficiencies are corrected. Act § 1819(g)(2)(A) (42 U.S.C. § 1395i-3(g)(2)(A)); 42 C.F.R. §§ 488.20(a), 488.308.

Surveyors from the Alabama Department of Public Health, State Survey Agency (state agency) conducted a survey of Petitioner from June 21 through 24, 2011. Based on their findings, CMS determined the facility was not in substantial compliance with the three participation requirements cited above. CMS notified Petitioner by letter dated July 15, 2011 (notice letter) that based on this noncompliance it was imposing a CMP of $5,550 per day from May 2 through June 23, 2011 (assessed due to CMS's determination that immediate jeopardy existed during this period), and a CMP of $100 per day from June 24, 2011, until Petitioner achieved substantial compliance or its provider agreement was terminated. In the notice letter, CMS also informed Petitioner that it was losing its approval to offer a NATCEP. CMS found Petitioner returned to substantial compliance as of July 1, 2011. The period of substantial noncompliance thus ran from May 2 through June 30, 2011.

On September 8, 2011, Petitioner timely requested a hearing contesting all findings of noncompliance and related remedies set forth in CMS's notice letter. The case was assigned to me for hearing and decision. On September 13, 2011, I issued an acknowledgment and initial prehearing order establishing a briefing schedule. In

[1] A state may not approve, and must withdraw any prior approval of, a SNF's NATCEP that has been, among other things, assessed a CMP of not less than $5,000. 42 C.F.R. § 483.151(b)(2).

accordance with the schedule, the parties filed prehearing exchanges, including prehearing briefs (CMS Br. and P. Br., respectively), exhibit and witness lists, and proposed exhibits.

I held a prehearing conference, by telephone, on February 15, 2012. During the conference, the parties declined the opportunity to request cross-examination of each other's witnesses and agreed that I should decide the case based on an exchange of written briefs and the documentary evidence of record. I documented this understanding in my February 15, 2012 Order following the prehearing conference (February 15 Order). During the conference I also admitted into the record the exhibits the parties exchanged (CMS exhibits (CMS Exs.) 1-28 and Petitioner's exhibits (P. Exs.) 1-10) and set a briefing schedule. Both parties submitted response briefs (CMS R. Br. and P. R. Br., respectively).

II. Issues

The issues stated in my February 15 Order, as agreed to by the parties, are:

1) Whether Petitioner failed to comply substantially with the requirements of:

   a) 42 C.F.R. § 483.15(a) (Quality of Life, Dignity) (Tag F241) with regard to Residents 1 – 4;

   b) 42 C.F.R. § 483.10(e) (Resident Rights, Privacy and Confidentiality) (Tag F164) with regard to Residents 1 – 4;

   c) 42 C.F.R. § 483.75(l)(4) (Administration, Clinical Records) (Tag F164) with regard to Residents 1 – 4;

2) With regard to this alleged noncompliance, whether CMS's assessment of immediate jeopardy was clearly erroneous; and

3) Whether the CMP that CMS imposed is reasonable in amount and duration.

III. Discussion

My findings and conclusions are set forth in the bold italicized headings and supported by the discussions in the sections below.

A. Petitioner was not in substantial compliance with 42 C.F.R. § 483.15(a) (Quality of Life, Dignity) (Tag F241) with regard to Residents 1 – 4.

B. Petitioner was not in substantial compliance with 42 C.F.R. § 483.10(e) (Resident Rights, Privacy and Confidentiality) (Tag F164) with regard to Residents 1 – 4.

C. Petitioner was not in substantial compliance with 42 C.F.R. § 483.75(l)(4) (Administration, Clinical Records) (Tag F164) with regard to Residents 1 – 4.

I discuss the deficiencies together because I base my findings on the same set of facts. P. Br. at 1-12; CMS Br. at 1-10; *see* P. Ex. 10.

On June 20, 2011, the state agency received a CD from the Trussville Police Department, Trussville, Alabama, containing videos and other images of elderly nursing home residents of the facility. These images had been downloaded from a cell phone found in a bar in New Orleans, Louisiana. CMS Ex. 16, at 8-9; CMS Ex. 17, at 49, 50. The cell phone was traced to its owner, CNA B, a CNA employed by Petitioner. CMS Exs. 7, at 1; 17, at 4. Petitioner does not dispute CMS's and the state's description of the images contained in the cell phone, and therefore neither side moved to enter the CD containing the images into evidence. February 15 Order. Below, I reference the June 24, 2011 statement of deficiencies (SOD) and other documentary evidence created during the state agency investigation to describe the content of those images as they reference Residents 1, 2, 3, and 4. February 15 Order; CMS Ex. 1 (the SOD); CMS Ex. 16 (the state agency investigative summary).

Resident 1: Resident 1 is an individual with diagnoses including Alzheimer's dementia, malnutrition, dehydration, and adult failure to thrive. She needs extensive assistance from staff for activities of daily living, such as eating, for which she requires staff to feed her pureed foods. CMS Ex. 12, at 4-6, 49, 55, 133, 151; CMS Ex. 17, at 29. Two of the videos in question depict CNA B feeding Resident 1. The SOD describes one video, recorded on May 28, 2011, at 1:17 p.m., as showing Resident 1 lying in bed, with oxygen on per nasal cannula and CNA B feeding her. CNA B calls Resident 1 "tootie fruitie." When Resident 1 asks for more food, CNA B tells her "No" and makes Resident 1 say "goodie good good" before giving her more food. Once Resident 1 repeats "goodie good good," CNA B gives her more food and then laughs. CMS Ex. 1, at 9-10.

The SOD describes another video, recorded on May 29, 2011, at 12:58 p.m., as showing:

> RI #1 [Resident 1] . . . telling the staff that she couldn't eat anymore; however, the staff (EI #1) [CNA B] continued to feed RI #1. RI #1 can be heard on the video saying "You dog." EI #1 replied, "You're a dog." RI #1 asked "Why don't you wipe my mouth?" EI #1 answered, "No, cause you called me a dog." EI #1 instructed RI #1 to say that she was sorry. RI #1 responded," . . . You got me too quick. I'm sorry. You messed me up; you hate my guts." EI #1 replied, "Eat mines." As EI #1 continued to hurriedly feed RI #1 large spoonfuls of food, the

> CNA (EI #1) stated, "Now, here, here some guts for you to eat; right here, guts, more guts . . . Hurry up." RI #1 screamed, "Quit!" EI #1 replied, "Dog that!" Although RI #1 yelled that she didn't want anymore, EI #1 continued feeding the resident and said, "Yea! You gon get some more." Again, RI #1 said that she didn't want anymore; but, EI #1 continued placing large spoonfuls of food into the residents mouth and said, "Yep (yes), gain five pounds." When RI #1 screamed to be left alone, EI #1 told RI #1 to, "Shut up! . . . drink up!" Also, EI #1 was seen holding a cup of liquid pressed against RI #1's chest while telling the resident to "shut up! . . . drink up!" Once the staff member removed the cup from RI #1's upper chest area, a circular indentation could be [seen] in the chest area, where the cup had been placed; but, the indentation quickly disappeared. EI #1 referred to RI #1 as "Tootie" and asked, "Was that good Tootie, Tootie?" RI #1 answered, "Fruitie my butt." EI #1 laughed and said, "Why Tootie?"

CMS Ex. 1, at 11; *see* CMS Ex. 1, at 3.

Resident 2: Resident 2 is an individual whose diagnoses include confusion and dementia. CMS Ex. 13, at 17. Her past medical history shows that in the past she underwent a right mastectomy. CMS Ex. 13, at 18. The SOD describes an image of Resident 2:

> (2) Image # 113, dated 05/02/11 at 8:56 AM, shows RI #2, a female resident who had undergone a mastectomy (the surgical removal of a breast), sitting in a shower room completely nude. RI #2's head was in a downward position and there was no indication that the resident knew she was having her picture taken.

CMS Ex. 1, at 3. During an interview with a surveyor, Resident 2 confirmed that she did not know her picture was being taken. CMS Ex. 16, at 5.

Resident 3: Resident 3 is a cognitively intact resident. CMS Ex. 16, at 5. The SOD describes a video of Resident 3:

> (3) Video #158, dated 05/19/11 at 10:40 AM, shows RI #3 lying in bed with no shirt on engaged in conversation with two facility staff members. A facility staff member (later identified as EI #3) could be seen in the video assisting RI #3 to put on a blue "muscle" shirt. Another staff member (later identified as EI #1) can be heard saying, "I don't know why he (RI #3) got a muscle shirt for, he ain't got no muscles." While assisting RI #3 into the blue "muscle" shirt, EI #3 asked the resident to use his arm muscles to lift himself (RI #3) up to assist with getting the shirt on. Then EI #1 can be heard saying, "He ain't got no muscles." Also, a facility staff member can be heard saying "Watch that thing." Then, the other facility staff member responded, "the camera." On 06/22/11, EI #3 denied

> knowing that she was being recorded. EI #3 identified EI #1 as the person who recorded the video.

CMS Ex. 1, at 3-4. CNA W is EI #3. CMS Ex. 16, at 6. When a surveyor informed Resident 3 that he had been videotaped without his consent, he expressed anger and humiliation, noting he was "mad as hell" because they could put something like that on [the internet]. CMS Ex. 16, at 6.

Resident 4: Resident 4 was admitted to the facility on February 10, 2011. CMS Ex. 15, at 21. Resident 4 had severe confusion caused by vascular dementia and major depression with psychotic features. CMS Ex. 15, at 17. Resident 4's May 17, 2011 minimum data set (MDS) showed she needed the extensive assistance of two or more staff for bed mobility, transfers and toilet use. CMS Ex. 15, at 33. The SOD describes a video of Resident 4:

> (4) Video #174, dated 06/04/11 at 8:51 AM, shows RI #4 lying in bed fully dressed with staff present. The video shows EI #2 in the resident's room and another staff member can be heard calling RI #4 by name and asking the resident to "look." EI #2 identified the other staff member as EI #1, the person doing the recording. EI #2 was laughing, holding her hand up to hide her face and saying, "Don't put that (referring to the camera) on me." EI #1 replied that she was "putting this on YouTube."

CMS Ex. 1, at 4. CNA K is EI #2. CMS Ex. 17, at 13-17.

After being apprised of the videos and images on the cell phone by the state agency, Petitioner terminated CNAs B and K, and staff counseled CNA W and provided her with mentoring, finding that CNA W apparently did not know that CNA B was recording on her cell phone. CMS Exs. 7; 8; 9; 17, at 45.

The regulation at 42 C.F.R. § 483.15 covers a resident's quality of life and provides that a "facility must care for its residents in a manner and in an environment that promotes maintenance or enhancement of each resident's quality of life." The subsection at 483.15(a) references:

> (a) *Dignity*. The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.

CMS argues that the facility was not in substantial compliance with this regulation when it failed to ensure that Resident 1 was fed in a dignified manner; failed to prevent a nude picture of Resident 2 being taken without her knowing the picture was being taken; failed to ensure that Resident 3 was not ridiculed and humiliated by comments about his

physical appearance and the videotaping of that incident; and failed to prevent Resident 4's "dehumanization" when facility staff asked him to look at the camera in order to post his face on the internet. CMS Br. at 8-9.

The regulation at 42 C.F.R. § 483.10 discusses resident rights, and the subsection at 483.10(e) states:

> (e) *Privacy and confidentiality.* The resident has the right to personal privacy and confidentiality of his or her personal and clinical records . . .
>
> (1) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups . . . .
>
> (2) . . . the resident may approve or refuse the release of personal and clinical records to any individual outside the facility . . . .

The regulation at 42 C.F.R. § 483.75 discusses facility administration, and the subsection at 42 C.F.R. § 483.75(l) discusses clinical records, with the subsection at 483.75(l)(4) stating:

> (4) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is required . . . .

CMS argues Petitioner was not in substantial compliance with these regulatory requirements when its staff violated facility policies and showed no respect or concern for the four residents' right to privacy by videotaping images of residents that were private and personal and failing to safeguard the images from public disclosure. CMS Br. at 7. CMS asserts that at the time they were hired, Petitioner's employees were required to execute confidentiality agreements stating that they would not copy or in any manner disclose resident medical records or any other information concerning a resident. CMS Exs. 20, 21, 22. These agreements required staff to agree to access confidential information only when necessary to perform their job-related duties and to obtain resident consent or a properly executed release of medical information to disclose private information and clinical records to individuals outside the facility. CMS Ex. 20, at 3. Here, facility staff did not obtain the residents' consent to be photographed or videotaped and the images taken were not necessary for the staff to perform their job-related duties. CMS Exs. 7, 8, 9.

Petitioner concedes that its staff took inappropriate images of these four residents and does not contest that the CNAs' conduct was noncompliant with any of the three regulatory requirements at issue. Petitioner admits that CNAs B and K were involved in the inappropriate imaging of residents and that CNA B inappropriately spoke to residents. P. Br. at 1, 11-12. For the reasons advanced by CMS noted above, I find that their

conduct was noncompliant with the specified regulations [with regard to dignity, by Petitioner's failure to feed Resident 1 in a dignified manner, failure to prevent a nude photo of Resident 2 being taken without her knowledge, failure to protect Resident 3 from being ridiculed and humiliated by comments about his physical appearance and videotaping the incident, and failure to prevent Resident 4's dehumanization by staff having him look at the camera so that they could purportedly post his image on the internet; with regard to resident rights and clinical records by Petitioner's failure to not only protect residents by preventing the videotaping of them but also to fail to discover and intercept these videos before that were disclosed and discovered in a public establishment].

Although conceding that staff's actions were not compliant, Petitioner argues the real issue in the case is whether CNAs B and K's failure to follow Petitioner's policies and expectations with respect to resident privacy and dignity should be imputed to Petitioner. Petitioner asserts that it should be insulated from deficiency findings because it took all reasonable and necessary steps to protect its residents from known or reasonably foreseeable inappropriate actions by its staff with respect to dignity and personal privacy. Petitioner asserts that the CNAs' actions are separate from the actions of the facility. Petitioner asserts that both CNAs B and K were appropriately screened, trained in-depth both in a classroom and via an intensive preceptorship program, and were then appropriately supervised. Moreover, Petitioner asserts it has strong policies and procedures regarding residents' rights to privacy and dignity. Because of this vigorous training and supervision, Petitioner argues that no reasonable person could reach the conclusion that the CNAs involved were untrained regarding resident privacy and resident care.

Moreover, Petitioner asserts that its administration and other staff were not aware of the situations involving these two CNAs, and the images taken of Residents 1 – 4, until state agency surveyors apprised them of the videos on June 21, 2011. Petitioner asserts that as soon as it learned of the conduct, it took all appropriate and necessary measures to ensure resident safety and that there was thus no "action or failure of action" on its part. Petitioner argues that, despite its rigorous screening and extensive training, these two CNAs purposely chose to engage in actions in direct opposition to Petitioner's policy and practice and their extensive training. Petitioner argues that CMS did not identify any other measures Petitioner could have taken to protect these residents, nor did CMS dispute that Petitioner did not know about their actions until the state agency apprised them of the CD containing their staff's actions. P. Br. at 1-11; P. R. Br. at 1-12.

Petitioner argues further that if I uphold the remedies CMS imposed it will be based on an inappropriate application of a strict liability standard. In support, Petitioner references regulations regarding staff treatment of residents prohibiting abuse and neglect at 42 C.F.R. § 483.13(c) and infers that the general intent of the regulations is to ensure that a facility is doing all that is within its control to prevent occurrences of abuse and neglect,

not that a facility should be found strictly liable for any instance of abuse or neglect attributable to its staff alone. P. Br. at 12-13. Petitioner also cites an administrative law judge's (ALJ) decision in the case of *Oakwood Manor Nursing Center*, DAB CR818 (2001), for the proposition that an isolated instance of abuse should not render a facility deficient automatically with respect to participation requirements. Petitioner also references the Departmental Appeals Board's (Board) decision in *Mary & Martha Lutheran Services*, DAB No. 2147, at 6 (2008), requiring that pursuant to 42 C.F.R. § 483.25(h)(2), a facility is to "implement 'all reasonable efforts to protect residents against adverse events that are reasonably foreseeable.'" Although the regulatory sections cited by Petitioner are not directly applicable here, Petitioner references them to argue that the actions of its staff members were not reasonably foreseeable, and it should not be found liable for them. Petitioner argues that it screens its employees (including CNAs B and K) before hiring, teaches them about its policies and procedures regarding privacy and dignity, tests their understanding of these concepts, and requires clinical preceptorship training for new direct care staff.

I accept that Petitioner took some immediate steps to protect its residents once it was made aware of the videos and images, including placing CNAs B and K on administrative leave pending an investigation of the images on CNA B's phone and terminating their employment at the completion of the investigation. P. Br. at 12. I would expect no less of any facility faced with such evidence. However, the public discovery of these abhorrent videos, involving three of Petitioner's staff members, clearly suggests Petitioner had not taken all reasonable steps to prevent abuse in its facility at the time.

Despite Petitioner's assertions regarding the vigilance of its screening, training, and supervision, the Act and regulations hold a facility accountable for the actions of its staff. The Board has consistently held that a facility cannot disavow responsibility for the actions of its employees as Petitioner attempts to do here. A "facility acts through its staff, and is correspondingly responsible for their actions as employees." *Royal Manor*, DAB No. 1990, at 12 (2005). Employees are the agents of their employers, "empowered to make and carry out daily care decisions." *Emerald Oaks*, DAB No. 1800, at 7 n.3 (2001). The fact that Petitioner investigated and then terminated the offending employees[2] does not insulate it from a finding of noncompliance. *Sunshine Haven Lordsburg*, DAB No. 2456, at 16-17 (2012); *Franklin Care Center*, DAB No. 1900, at 8 n.4 (2003). What a facility's employees do or do not do comprises a facility's compliance or noncompliance with the regulations. When an employee errs, that error

[2] Petitioner did not terminate the employment of CNA W because it found she was not aware of the videotaping of the incident involving Resident 3. CMS Ex. 17, at 45-46. However, despite a "zero tolerance" policy for any type of abuse (P. Ex. 10, at 4, 6), it is not clear why Petitioner did not terminate her employment for not reporting the mistreatment of Resident 3.

must be evaluated as if committed by the facility itself. *See Life Care Center of Gwinnett*, DAB No. 2240, at 13 n.9 (2009).

Petitioner argues that a reasonable person could not disagree that its CNAs were appropriately trained. Petitioner's argument, however, does not completely comport with the facts. Here the images on CNA B's cell phone show a chilling pattern of resident mistreatment, involving several residents and CNAs B, K, and W, lasting over a period of almost two months. Despite what Petitioner regards as its rigorous employee training and supervision, at the very minimum, Petitioner cannot explain how its vaunted training program failed in application based on the conduct of the CNAs, particularly CNA B, and in the failure of the other two CNAs to report CNA B's misconduct. P. Br. at 1-11. It was sheer serendipity that her cell phone was found, the CNAs' misconduct discovered, and Petitioner's residents finally protected from further abuse.

D. CMS's determination of immediate jeopardy is not clearly erroneous.

CMS asserts that Petitioner was out of substantial compliance with participation requirements at a level of 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. The regulation does not require that a resident actually be harmed. *Lakeport Skilled Nursing Center*, DAB No. 2435, at 8 (2012). I must uphold CMS's determination as to the level of a facility's substantial noncompliance (which includes an immediate jeopardy finding) unless it is "clearly erroneous." 42 C.F.R. § 498.60(c). The Board directs 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." *See, e.g.*, *Barbourville Nursing Home*, DAB No. 1962, at 11 (2005); *Florence Park Care Center*, DAB No. 1931, at 27-28 (2004), *citing Koester Pavilion*, DAB No. 1750 (2000).

Here, CMS has shown that the forcible manner in which CNA B fed Resident 1 placed Resident 1's physical health in serious danger because Resident 1 was at risk for aspiration. CMS Ex. 12, at 33. Her care plan required that staff feed her pureed food in accordance with facility guidelines. CMS Ex. 6; CMS Ex. 16, at 3. However, CNA B fed Resident 1 in a manner inconsistent with facility guidelines. *Id.;* CMS Ex. 12, at 133; CMS Ex. 17, at 51. This left Resident 1 at risk of inhaling food into her lungs, which could have led to aspiration pneumonia or death. CMS Ex. 16, at 3-4. I may sustain CMS's finding of immediate jeopardy based only on CNA B's treatment of Resident 1 during feeding.

CMS has also further shown, though, that each of the four residents' dignity and self-respect was compromised by their treatment at the CNAs' hands, as well as by the exposure of the videos to public view (which lasted until CNA B's cell phone was turned

over to the police). The videotaping of the residents, and the potential exposure of these videotapes to public view, was likely to harm the residents' psychosocial well-being. CMS Exs. 26, 27, 28. Resident 3, who was cognitively intact, sustained actual psychosocial harm, in that he told the surveyors he was humiliated and angry that he had been videotaped without his consent. CMS Ex. 16, at 6. Although Residents 1, 2, and 4 had little discernable response to the breach of their privacy due to their cognitive deficits, a facility's obligation is to protect the health and safety of every resident, including those that are incapable of perception or are unable to express themselves. This presumes that instances of abuse of any resident, whether the resident is cognizant or not, causes physical harm, pain, or mental anguish. 59 Fed. Reg. 56,116, 56,130 (Nov. 10, 1994).

Petitioner does not directly contest that the CNAs actions did not constitute immediate jeopardy. Petitioner instead asserts that it took all necessary, reasonable and appropriate measures to ensure resident safety and privacy and that no action or failure on its part constituted immediate jeopardy. P. Br. at 11. It reiterates that CNAs B and K purposely chose to engage in actions in opposition to their training and facility policy, other staff were not aware of their actions, and that, after finding out about their actions, Petitioner took immediate action to protect its residents. This argument, as noted above, is unavailing. Petitioner bears the burden of proving that CMS's determination of immediate jeopardy is clearly erroneous, and I find it has not done so.

E. The CMP that CMS imposed is reasonable in duration and amount.

The regulations provide that remedies continue until "[t]he 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 [CMS or the State] can verify without an on-site visit; or . . . CMS or the State terminates the provider agreement." 42 C.F.R. § 488.454(a). The facility has the burden of proving that it achieved substantial compliance on a date earlier than that determined by CMS. *Kenton Healthcare, LLC*, DAB No. 2186, at 24-25 (2008).

CMS assessed the immediate jeopardy level CMP beginning the day the first video was taken, May 2, 2011, and ended that period on June 23, 2011, when Petitioner interviewed all residents and found no additional violations, conducted staff training, and began randomly monitoring staff while they gave care to residents. CMS asserts Petitioner remained out of substantial compliance at a non-immediate jeopardy level from June 24 through 30, 2011, and that it fully came into substantial compliance only after CMS found Petitioner had time to monitor and revise its corrective actions. CMS Ex. 1, at 39; P. Ex. 1, at 1; CMS Br. at 2, 13-14.

Petitioner argues that if any period of immediate jeopardy noncompliance can be said to exist, that period of noncompliance should run only from June 21, 2011, when the facility

first became aware of CNAs B and K's actions, and run through June 23, 2011, when the parties agree that the immediate jeopardy was abated (the "D" level deficiencies ending on June 30, 2011). P. Br. at 14. I disagree. May 2, 2011, is when the period of noncompliance first occurred (the day Resident 2 was photographed in the shower) and it is not unreasonable, and within CMS's discretion, to begin the period of noncompliance from that date. Moreover, it is reasonable to require a period of time for Petitioner to monitor and revise their corrective actions before finding Petitioner back in substantial compliance. Thus, concluding the period of noncompliance on June 30, 2011, is also reasonable considering the facility needed to complete retraining of its staff on the facility's abuse protocol and the use of cell phones in the facility.

With regard to the amount of the CMP, I examine whether a CMP is reasonable by applying 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) the 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 listed 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.

The regulations specify that a CMP that is imposed against a facility on a per day basis will fall into one of two ranges of penalties. 42 C.F.R. §§ 488.408; 488.438. The upper arrange of a CMP, $3,050 per day to $10,000 per day, is reserved for deficiencies that pose immediate jeopardy to a facility's residents and, in some circumstances for repeated deficiencies. 42 C.F.R. § 488.438(a)(1)(i); 488.438(d)(2). The lower range of CMP, $50 per day to $3,000 per day, is reserved for deficiencies that do not pose 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).

With regard to the amount of the CMP here, CMS has imposed a $5,550 per day CMP for the period of immediate jeopardy noncompliance and a $100 per day CMP for the period of non-immediate jeopardy noncompliance. Petitioner believes the total CMP imposed is not reasonable and is "extraordinarily high." P. Br. at 14. Petitioner notes that the state agency recommended only a $1,000 per instance CMP and argues that CMS unreasonably failed to adopt the state's recommendation.

As Petitioner recognizes, the state agency's suggestion of a per instance CMP is only a recommendation. However, I must consider whether the evidence presented supports a finding that the CMP amount 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 other factors involved. The state agency's recommendation is surprisingly low and would hardly yield corrective action.

The regulations leave the decision regarding the choice of remedy to CMS, and the amount of the remedy to CMS and the ALJ, requiring only that the regulatory factors at 42 C.F.R. §§ 488.438(f) and 488.404 be considered when determining the amount of a CMP within a particular range. 42 C.F.R. §§ 488.408; 488.408(g)(2); 498.3(d)(11); *see also* 42 C.F.R. § 488.438(e)(2); *Alexandria Place*, DAB No. 2245, at 27 (2009); *Kenton Healthcare, LLC*, DAB No. 2186, at 28-29. Under this standard, CMS has generously imposed a CMP for the period of immediate jeopardy in the lower half of the range of immediate jeopardy and in the very low part of the range for the period of non-immediate jeopardy.

Unless a facility contends that a particular regulatory factor does not support the CMP amount, the ALJ must sustain it. *Coquina Center*, DAB No. 1860 (2002). With respect to its financial condition, it is Petitioner's responsibility to show if it cannot pay the CMP. Petitioner was free to call any witnesses to testify to its financial condition or to submit any documentary evidence regarding its financial condition. However, Petitioner provided no evidence to show that its financial condition hinders it from paying the proposed CMP. Petitioner has also not contested CMS's assertion that it has past non-compliance from a 2010 survey, also relating to quality of care for residents. CMS Br. at 13.

I do find the amount of the CMP especially reasonable given the scope and severity of the noncompliance. As CMS showed, Petitioner failed to protect the health, dignity, and privacy of four residents when members of its staff ridiculed and videotaped them without their consent and forcibly fed one resident. The exposure of these vulnerable residents to staff who could subject them to abuse with such impunity is highly concerning. Although I base my decision on the videotaped abuse, I do fear for what occurred to the facility's residents once staff turned the camera off.

For the reasons set forth above, I find the CMP to be reasonable and Petitioner's loss of approval to conduct a NATCEP to be required by law.

/s/
Joseph Grow
Administrative Law Judge