Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

NMS Healthcare of Hagerstown,
(CCN: 21-5256),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-14-1566

Decision No. CR3772

Date: April 10, 2015

DECISION

I enter summary judgment in favor of the Centers for Medicare & Medicaid Services (CMS) and against Petitioner, NMS Healthcare of Hagerstown, LLC. I impose civil money penalties against Petitioner of $5650 for each day of a period that began on January 22, 2014 and that ran through March 27, 2014 and civil money penalties of $150 for each day of a period that began on March 28, 2014 and that ran through June 25, 2014.

I. Background

Petitioner is a skilled nursing facility that participates in the Medicare program. It requested a hearing to challenge the remedy determinations that I cite above.

The parties exchanged pre-hearing submissions that included proposed exhibits. CMS offered 87 proposed exhibits that are identified as CMS Ex. 1–CMS Ex. 87. Petitioner offered 38 proposed exhibits that are identified as P. Ex. 1–P. Ex. 38. CMS moved to exclude certain of Petitioner's exhibits. On February 4, 2015 I issued a ruling (February ruling) granting CMS's motion in substantial part. I

explained my rationale in detail in that ruling and it is unnecessary that I restate it in detail here other than to summarize it briefly. The exhibits that I excluded were proffered by Petitioner, as justification after the fact, for its decision to confine a resident against her will in a locked wing of Petitioner's facility. I ruled that those exhibits were irrelevant because Petitioner's duty to the resident was to assess her and make care decisions based on existing clinical evidence of which it had knowledge prior to Petitioner's decision to confine the resident against her will in a locked secure unit. Petitioner may not justify, *post facto*, a decision that it failed to make based on adequate clinical evidence or analysis.

I am receiving the parties' proposed exhibits into the record except for those exhibits that I excluded from consideration in my February ruling.

I scheduled an in-person hearing. Shortly prior to the hearing CMS moved for summary judgment. I postponed the hearing without date so that I could decide CMS's motion.

II. Issues, Findings of Fact and Conclusions of Law

A. Issues

The issues are whether: Petitioner failed to comply with Medicare participation requirements; Petitioner's noncompliance with certain requirements was so egregious as to constitute immediate jeopardy for Petitioner's residents; and, CMS's remedy determinations are reasonable.

Summary judgment should not be entered in a case unless all necessary issues are resolved by undisputed material facts. In resolving the issues of this case I rely only on material facts that are undisputed.

B. Findings of Fact and Conclusions of Law

1. Immediate jeopardy level noncompliance

At the center of this case is a determination by CMS that Petitioner contravened Medicare nursing facility regulations to the extent that it placed a resident or residents of its facility at immediate jeopardy. The term "immediate jeopardy" is defined at 42 C.F.R. § 488.301 to mean noncompliance that is so egregious as to cause, or to be likely to cause, serious injury, harm, impairment, or death to one or more facility residents. The allegations of immediate jeopardy level noncompliance relate to a resident who is identified as Resident # 4, and they consist of the following:

- **42 C.F.R. § 483.10(j)(1)(vii).** This regulation directs a skilled nursing facility to provide "immediate access" to members of the immediate family of any of its residents. CMS asserts that Petitioner violated this requirement in that it restricted an immediate family member (one of Resident # 4's daughters) from visiting Resident # 4 based solely on the request of another of Resident # 4's daughters who held a power of attorney (POA) from Resident # 4. CMS alleges that Petitioner restricted Resident # 4's access to other persons as well, including an attorney who sought to represent Resident # 4, again responding solely to the request of the resident's daughter who held a POA.

- **42 C.F.R. § 483.13.** Among other things this regulation prohibits a skilled nursing facility from involuntarily secluding a resident. CMS alleges that Petitioner violated this regulation by placing Resident # 4 in its locked wing against the resident's wishes and without making any determination that secluding the resident was justified by the resident's medical condition.

- **42 C.F.R. § 483.20(k)(3)(i).** This regulation mandates a skilled nursing facility to provide care that meets professional standards of quality. CMS asserts that this regulation prohibits a facility from confining a resident – as Petitioner allegedly did with Resident # 4 – without making a determination of clinical necessity. Any action taken by a facility pursuant to its determination, according to CMS, must utilize the least restrictive means possible. CMS contends that Petitioner contravened the regulatory requirements in that it confined Resident # 4 without making a clinical determination that confinement was necessary and without making any judgment that the means that it resorted to were the least restrictive means necessary to protect the resident's health and safety.

The undisputed material facts unequivocally sustain CMS's assertions. Petitioner has raised no facts that create a genuine fact dispute in this case nor has it offered arguments that justify its actions in light of the undisputed material facts.

The undisputed material facts are as follows. Resident # 4, a woman in her 70s, resided at Petitioner's facility beginning in December 2011. The resident has a number of health problems that include a bipolar mood disorder, chronic obstructive pulmonary disease, hypothyroidism, and hypertension. CMS Ex. 9 at 39. From December 2011 until January 2014 the resident resided continuously in the non-restricted part of Petitioner's facility. She was free to come and go within the facility's premises. Her movements were unrestricted.

Resident # 4 was hospitalized briefly between January 17 and 22, 2014. She was admitted complaining of chest pain. CMS Ex. 9 at 30. Tests were performed that did not reveal cardiac disease and at the end of her stay the resident was discharged without complaints of chest pain. *Id.* During her hospital stay the resident evidenced some confusion and expressed some resistance about being returned to Petitioner's facility. *Id.* at 37. However, she eventually cooperated and returned. *Id.*

The resident was moved to the locked unit of Petitioner's facility upon her return on January 22, 2014. From that date and thereafter, the resident was confined behind a locked door that denied her egress from the wing on which she was confined and from the facility itself. Petitioner not only confined Resident # 4, it restricted her access to members of her immediate family and to other individuals, including an attorney who sought to provide her with legal counsel. Many of these restrictions predated the resident's confinement. In November and December of 2013 members of Petitioner's staff confronted an attorney with whom Resident # 4 was consulting and ordered him to leave Petitioner's premises. CMS Ex. 67 at 2–3, 38–39. After being confined Resident # 4 complained that she wanted to speak with an attorney but that Petitioner would not allow her to. *Id.* at 9. Beginning in at least 2012 Petitioner's staff restricted one of the resident's daughters from visiting the resident. CMS Ex. 9 at 17, 23, 115.

When interviewed, Resident # 4 expressed a desire to leave the facility and complained about the restrictions on her freedom of movement. CMS Ex. 67 at 40. The resident's desire to leave was known to Petitioner's staff. *Id.* at 13.

The only reference in the resident's treatment record to the decision to confine her is a social services note dated January 22 that says, laconically: "Resident moved to room 418B." CMS Ex. 9 at 132. The clinical record suggests no basis for confining Resident # 4 against her will or for restricting her access to family members and an attorney. Nothing whatsoever in the record suggests a change in the resident's medical or psychiatric condition prior to or on January 22, 2014 that would support confining her. To the contrary, the record of the resident's mental status shows her to be calm and cooperative and not to be deteriorating in the nearly three years prior to her being confined. CMS. Ex. 9 at 52–110. There is no physician's report supporting confining the resident or restricting her access to visitors. There is no comprehensive assessment suggesting a need to change her status. Nor is there anything in the resident's care plan that either records the change in status or addresses how it is to be managed.

Similarly, there is no explanation in the resident's treatment records as to why the *particular* restrictions employed by the facility were clinically necessary. Why, for example, were certain individuals excluded from the facility? Petitioner has no assessments or explanations of the medical or clinical reasons for this decision.

There is, however, a reason for Petitioner's actions and it stands without rebuttal. Petitioner confined Resident # 4 and restricted her access to visitors at least in part because Petitioner's daughter, ("JF"), who held a power of attorney (POA), wanted her mother to be confined and the restrictions to be imposed. Petitioner took the actions it took in part because JF requested that it take them. The only reasonable conclusion that I can draw from the undisputed facts of this case is that Petitioner acted on JF's desire that her mother be confined without making any determination as to whether confinement and visitor restrictions were clinically justified or whether seclusion and restrictions were the least restrictive and most reasonable means of protecting Resident # 4. CMS Ex. 9 at 17, 23, 115; CMS Ex. 82.

Petitioner asserts that it made the *clinical* determination that the confinement and restrictions it imposed on Resident # 4 were in the resident's best interest. It argues that its decisions to confine Resident # 4 and impose restrictions on her access to visitors were made based on professional assessments of the resident's condition and reflected the judgment and professional expertise of Petitioner's staff. Petitioner concedes that it has nothing whatsoever in writing to support these contentions. It asserts that written assessments were unnecessary in this case and it relies, rather, on the after the fact declarations of several medical professionals. It contends that, at the very least, these declarations raise issues of fact that preclude the entry of summary judgment against it.

I disagree with Petitioner's contention that there was no need to record evaluations or assessments of Resident # 4 showing that her confinement and the restrictions imposed on her access to visitors were clinically necessary. An absolutely essential element of a skilled nursing facility's obligation to a resident is that it document the care that it provides to its residents. Failure to do so is grounds to conclude that the care was not provided. *River City Care Ctr.*, DAB No. 2627, at 9 (2015); *Evergreene Nursing Care Ctr.*, DAB No. 2069, at 25 (2007), citing *Western Care Mgmt. Corp. d/b/a Rehab Specialties Inn*, DAB No. 1921, at 48 (2004). Furthermore, a skilled nursing facility is required by law to prepare a comprehensive plan of care that lays out in precise detail the problems that the resident is experiencing and explains how the facility intends to address those problems. 42 C.F.R. § 483.20. That plan of care must be based on a

comprehensive and detailed assessment. *Id.* The regulation may not state explicitly that the assessment and care plan must be in writing but it is inconceivable that a facility would develop an oral plan that is not memorialized in writing. That simply defies common sense.

Moreover, in this case, Petitioner had a written plan of care for Resident # 4. CMS Ex. 9 at 38–50. That plan is devoid of any mention of Petitioner's decision to confine Resident # 4 and restrict her access to visitors.

But, even if there is no legal requirement that a facility memorialize its assessments in writing, Petitioner has offered no facts showing that it actually assessed Resident # 4 and concluded that confinement and restrictions on access to visitors were necessary based on actual clinical findings. Petitioner has offered the written testimony of five individuals: Stephanie Comer-Concordia, NP; Barbara Sweeney, RN; M. Khalid Waseem, M.D.; Charles A. Crecelius, MD, PhD, FACP, CMD; and Daniel Haimowitz, M.D., CMD, to support its assertions that it made its decisions based on clinical evidence. I have examined these statements closely. None of them identify any clinical facts that, if true, would show that Petitioner actually assessed Resident # 4 as needing to be confined and having her access to visitors restricted.

Ms. Concordia avers that:

> I participated in the Interdisciplinary Team that made the decision that it was in Resident # 4's best interest after her acute hospitalization to readmit to our facility on that [secure] unit. This was done in concert with the assessment done by our medical director and was agreed to enthusiastically by the Resident's POA. We all believed that this placement was clinically beneficial to the Resident's best interest. This conversation occurred on the date of her readmission to the facility, which is why Resident # 4 was placed on the secure unit.

P. Ex. 28 at 1−2. However, Ms. Concordia points to zero clinical evidence that supports her conclusion. She merely avers that there was an assessment without saying what facts were adduced, how they were evaluated, or why the facility's staff came to the conclusions that she avers they came to. Simply saying that the staff thought that they were acting in the resident's best interest or that the POA enthusiastically agreed to the staff's actions raises no material facts at all. The actions taken by Petitioner were unjustified absent clinical evidence to support them and proof that judgments were based on that evidence.

Ms. Sweeney adds nothing to Ms. Concordia's testimony. She avers that Petitioner's Interdisciplinary Team "informally" decided in January 2014 that it would be in the resident's best interest to confine her. P. Ex. 17 at 4. This merely reiterates Ms. Concordia's unfounded conclusion.

Petitioner relies on the following statement by Dr. Waseem, as support for its contentions that Resident # 4 was assessed as being suitable for confinement and that there are disputed issues of fact:

> Anytime a resident has been deemed incapable, we always reconfirm that finding at each visit, when we look for changes in condition . . . The decision for [placement in a secure unit] was made by Resident # 4's Interdisciplinary Team and in consultation with Resident # 4's POA who was responsible for making healthcare decisions, including where to receive care.

P. Ex. 32 at 2. But, this assertion raises no facts and in particular it raises no clinical facts justifying the resident's confinement. Dr. Waseem does not recite any specific reason for confining the resident. Nor does he recite clinical findings about the resident's condition. He suggests nothing that shows that the resident's condition changed after her hospitalization in a way that necessitated confinement.

Dr. Waseem never assessed Resident # 4 as being suitable for confinement prior to Petitioner's deciding to confine her. He concedes that in his testimony. Dr. Waseem states:

> Although Resident # 4 did not need the secure unit prior to her January 2014 hospital admission, it was and remains my considered determination that placement after that hospitalization in a secure unit was both beneficial and necessary for the Resident's welfare. *Shortly after the placement and since that time, I concurred with the facility's assessment of the placement on the secure unit and believe it was in the patient's best interest.*

Id. (emphasis added). As Dr. Waseem admits, his evaluation – whatever he might have done – was made after the fact. That provides no support for Petitioner's assertion that it assessed the resident *before* it confined her.

Neither Dr. Crecelius nor Dr. Haimowitz had anything to do with caring for Resident # 4 prior to Petitioner's decision to confine her. They provided no care to the resident and were not consulted about her care. In my February 4, 2015 ruling I found Dr. Haimowitz' testimony to be largely irrelevant. Petitioner has not shown how his testimony is relevant here. His testimony consists solely of his

opinion as to whether Petitioner, viewed from the vantage point of hindsight, acted appropriately. That adds nothing to the facts of this case. Moreover, Dr. Haimowitz hasn't added a single fact to this case that is material or that raises a fact dispute. He suggests that it was appropriate to confine Resident # 4 because she was an "elopement risk." P. Ex. 30. But, he has cited to nothing in the record to show that the resident was assessed by Petitioner's staff as being at risk for eloping as of January 22, 2014. Obviously, the possibility that the resident might elope hadn't bothered the staff prior to the resident's January 2014 hospitalization sufficiently for the staff to modify the resident's care. What changed during or as a consequence of the hospitalization? Dr. Haimowitz cites to nothing. Moreover, neither does Petitioner's staff.

Petitioner cites Dr. Crecelius for the proposition that there is no standard of care for determining precisely how to evaluate a resident for placement in a secure unit. P. Ex. 26 at 3. I will accept that assertion as true for the purposes of this decision. It changes nothing. The absence of a precise standard of care did not mean that Petitioner had license to act arbitrarily. Whether or not there was a precise standard of care, Petitioner still was required to assess the resident for the suitability of confinement, to plan her care, and to use the least restrictive means necessary to protect her.

Petitioner also quotes Dr. Crecelius as saying this:

> It is unrealistic and not within the standard of care to require frequent or arbitrary redeterminations of capacity when there is no substantial change in condition in a disease process which has no realistic expectation of sustained improvement.

P. Ex. 26 at 3. But, CMS is not arguing that Petitioner was required to make "frequent" or "arbitrary" redeterminations of Resident # 4's capacity. Implicit in Petitioner's decision to confine the resident was that the Resident's condition had changed in some way as to make confinement necessary. Absent that, there would be no reason whatsoever to confine her inasmuch as she had lived perfectly well without confinement at Petitioner's facility for three years prior to January 2014. But, if her condition changed, Petitioner had to document it and assess it. And, if it hadn't, then the decision to confine her was unjustified. Either way, Petitioner was obligated to explain why it confined the resident. It failed utterly to do that.

Petitioner argues that Resident # 4 received a prescription for the medication Haldol during her hospital stay and suggests that this is clinical evidence that justifies her confinement upon her readmission to the facility. However, there is nothing in the facility's records suggesting that the resident's prescription was considered as a reason for confining her. Indeed, none of Petitioner's staff now assert that they decided to confine her for that reason.

Petitioner also suggests that it confined Resident # 4 in order to protect her against the possibility that a family member other than JF might attempt to abduct the resident from the facility. As support for this assertion Petitioner relies on an incident that occurred on January 15, 2012, in which one of the resident's daughters was found assisting the resident to pack her belongings in an apparent attempt to leave the facility. CMS Ex. 9 at 23. Petitioner characterizes that episode as proof of "abuse" and asserts that it was trying to protect the resident from such episodes in the future by confining her.

The episode in question occurred *more than two years prior* to January 22, 2014. There is no evidence at all that anything of that nature happened during the intervening period and there is zero proof that this ancient episode had anything at all to do with Petitioner's decision to confine the resident in January 2014. The resident resided peacefully and undisturbed at Petitioner's facility during the two years between the January 15, 2012 incident and January 2014 and, based on facility records, no thought was given to confining her during that entire time.

Furthermore, Petitioner has provided no explanation as to why it was necessary to confine the resident in order to protect her from family members other than JF. It leaps to the conclusion that shutting the resident away behind a locked door is the least restrictive approach that one could reasonably employ without providing an iota of analysis as to why this is so.

Petitioner asserts that its restrictions on visitors' access to Resident # 4 were "reasonable." It doesn't explain why they were reasonable. It has offered no facts to support its assertion that these restrictions were necessary or reasonable. It makes a series of characterizations concerning the individuals whose visits were restricted or prohibited without any factual support for them. For example, it asserts that the resident's daughter who assisted the resident in packing her belongings in 2012 was attempting to "kidnap" the resident. That characterization contains no support in the record. Petitioner did not investigate the incident, did not prepare a report, and apparently, interviewed no one about it. Whether the daughter was attempting to carry out her mother's wishes or had some other motive is simply unknown. If Petitioner wanted to restrict that individual's visitation rights it was required to explain why it was doing so and to document its explanation. It did not.

Similarly, Petitioner contends that an attorney "surreptitiously" attempted to have Petitioner revoke her POA and it suggests that banning him from visiting the facility was an appropriate response. There are no facts suggesting that the lawyer did something surreptitiously. Petitioner asserts that the attorney failed to contact its administrator, its director of nursing, its general counsel, the resident's physician, its medical director, or the facility social worker before speaking with Resident # 4. But, Petitioner has offered nothing to show that the attorney had a duty to speak to any of these individuals before speaking to the resident. At the time there was no legal impediment prohibiting the resident from consulting with counsel. She was absolutely entitled to speak with the attorney *in private* and without the interference of any of the individuals whose titles are cited by Petitioner.

Finally, Petitioner argues that JF's assent to confining Resident # 4 was a "health care" decision and within the scope of the POA given to JF. I disagree. The record is devoid of any evidence to suggest that JF made a health care decision. In fact, there is nothing in the record that explains JF's reasoning at the time that she assented to her mother's confinement.

One can speculate as to JF's reasons. She may have wanted her mother confined for reasons of personal convenience, or to further limit contact between her mother and other family members. Or, she may have genuinely believed that her mother's medical condition required confinement. But, there is nothing in the record – nothing at all – that explains her reasoning at the time that the decision was made to confine Resident # 4. On its face, the decision to confine the resident was arbitrary, and the arbitrariness of that decision is not mitigated in any way by the fact that JF held a POA on her mother's behalf.

A skilled nursing facility is not excused of its obligations to provide care by the fact that a resident or someone on the resident's behalf demands that the facility provide a certain type or level of care. The regulations governing skilled nursing facilities do not allow facilities to abdicate their responsibilities to residents in order to cater to the whims of residents' family members, whether or not they have POAs. Otherwise, nursing facilities could be turned into prisons in which family members lock their relatives away purely for the sake of convenience. When a family member – even one holding a POA – requests a facility to confine a resident that facility continues to have the duty to ascertain that what is asked for is clinically necessary and that whatever is decided upon is the least restrictive approach that is reasonable to protect the resident and assure his or her health and safety. Doing anything less than could be consent to imprisonment.

Moreover, a facility is not inherently a neutral arbiter. There can be a conflict of interest between a facility and its resident. Here, for example, Resident # 4 had repeatedly expressed an interest in leaving Petitioner's facility. Had Resident # 4 left, the financial consequences to Petitioner would have been substantial. Resident # 4 generated a steady stream of revenue to Petitioner, no doubt amounting to several thousand dollars a month. The line of least resistance for Petitioner to follow in dealing with the resident would have been to do everything in its power to retain her, even to the extent of confining her, if that was necessary to keep her on its rolls. Given that potential conflict of interest it was incumbent on Petitioner to be scrupulously neutral in dealing with the resident. Simply going along with JF's wishes in this case – without independently assessing the resident to determine whether confining her and restricting her access to visitors was appropriate – was anything but neutral.

CMS's findings of immediate jeopardy are not clearly erroneous. Whether or not Resident # 4 was actually harmed seriously by Petitioner's actions is not determinative of the issue of immediate jeopardy. There was a very high likelihood that residents – including Resident # 4 – would be harmed by Petitioner's cavalier approach to confinement. As I have stated, nursing facilities are not intended to be prisons for older or incapacitated individuals. Residents of nursing facilities have rights and those rights include the right to freedom of movement. A facility may not confine or seclude any of its residents for reasons that are not medically necessary and that are not documented. Nor may it unreasonably restrict a resident's access to the outside world, including visitors.

Any time a facility confines a resident unreasonably it is imprisoning that resident and doing so in a particularly cruel way. Elderly and frail individuals may not be capable of exercising their rights vigorously. Those who are confined against their will or without medical reason may be too feeble to protect themselves. The result is that they suffer the psychological trauma that goes with imprisonment and the hopelessness that comes with the knowledge that there may be no way out.

Petitioner offered no facts to challenge the duration of its noncompliance. It did not allege that it abated its immediate jeopardy level deficiencies prior to March 28, 2014. Indeed, Resident # 4 was confined at Petitioner's facility throughout the period that began on January 22, 2014 and that ran through March 28, 2014. Given that Petitioner was noncompliant at the immediate jeopardy level throughout this period the only issue that potentially is in dispute is the daily penalty amount of $5650 that CMS determined to impose against Petitioner.

I find no material fact dispute as to whether this penalty amount is reasonable. It falls within the middle of the range of penalties (between $3050 and $10,000 per day) that CMS may impose for immediate jeopardy level deficiencies. 42 C.F.R. § 488.438(a)(1)(i). I find that the undisputed material facts establish that the penalty amount is entirely consistent with the seriousness of Petitioner's noncompliance.

Petitioner asserts that Resident # 4 was not actually harmed by her confinement. That assertion is belied by the undisputed facts of this case. The resident was forced to live for months and to interact on a daily basis with individuals whose cognitive functioning was lower than hers. CMS Ex. 9 at 140, 142, 143. The resident was deprived of interactions with people whose cognitive levels were higher and she was deprived of access to individuals with whom she had lived and interacted with for years. Moreover, housing her in the locked unit subjected the resident to the trauma and the stigma of being forced to live with individuals who suffered from behavioral problems that rendered them unmanageable in the unsecured part of Petitioner's facility. CMS Ex. 67 at 41, 42.

Finally, the resident was imprisoned against her will. Petitioner's staff kept her behind a locked door despite the resident's frequently expressed desire to leave and they did so without clinical evidence supporting the resident's imprisonment. Asserting that the resident was unharmed by such imprisonment defies reality.

The seriousness of Petitioner's noncompliance also is illustrated by the likelihood of harm to other residents besides Resident # 4. The cavalier way in which Petitioner confined Resident # 4 potentially put other residents at risk for similar treatment. It is evident that Petitioner had no safeguards in place to assure that residents' rights were respected in circumstances where family members – even if they meant well – insisted that residents be confined against their will.

Petitioner contends that there are disputed facts that necessitate a hearing as to penalty amount. It has identified none.

2. Non-immediate jeopardy level noncompliance

CMS asserts that the undisputed material facts establish that Petitioner manifested four non-immediate jeopardy level deficiencies that continued unabated through June 25, 2014. It argues that the presence of these deficiencies supports imposition of $150 daily civil money penalties for each day of the period that ran from March 28 through June 25, 2014.

CMS alleges that during the period the undisputed material facts establish that Petitioner failed to comply substantially with the following regulations.

- **42 C.F.R. § 483.10(b)(4).** This section, among other things, affords a skilled nursing facility resident the right to participate in the formulation of any advanced directive (an "advanced directive" is a statement in which a resident provides written instruction to a facility or other health care provider concerning the care he or she is to receive under certain conditions. An advanced directive is frequently used to instruct a provider about end of life care when the author of the directive is incapacitated). CMS asserts that Petitioner failed to comply with this section because it, in conjunction with JF, Resident # 4's POA, made an amendment to the resident's advanced directive without consulting her.

- **42 C.F.R. § 483.10(k).** The regulation states that a resident shall have reasonable right to use a telephone where his or her calls cannot be overheard. CMS alleges that Petitioner contravened this regulation by restricting Resident # 4's access to a telephone. First, according to CMS, it allowed only individuals who provided a special code to facility staff to talk to the resident. Second, CMS alleges that the resident was restricted to the use of a specific phone and that the facility required that a staff member place all calls made by the resident.

- **42 C.F.R. § 483.13(c).** In relevant part this regulation requires a skilled nursing facility to develop and implement policies that protect against misappropriation of residents' property. CMS contends that Petitioner failed to comply with this requirement in that it did not report to law enforcement authorities allegations from Resident # 4's complaint that certain property belonging to her (a cellphone) had been misappropriated.

- **42 C.F.R. § 483.75(l)(1).** This section requires a facility to maintain complete and accurate clinical records, among other things. CMS asserts that Petitioner failed to comply with this requirement because it maintained records for a resident, identified as Resident # 60, that were internally inconsistent on a critical issue, that being whether cardio-pulmonary resuscitation should be administered to the resident in the event of a life-threatening emergency.

The civil penalty amount that is at issue here, $150 a day, is minimal, comprising only five percent of the maximum allowable penalty amount for non-immediate jeopardy level violations. 42 C.F.R. § 488.438(a)(1)(ii). The penalty amount is so low that establishing even one of the four alleged deficiencies would be sufficient to sustain the penalties that CMS determined to impose.

I find it unnecessary to resolve whether Petitioner failed to comply with the requirements of 42 C.F.R. § 483.10(b)(4) and 42 C.F.R. § 483.13(c). Petitioner has raised arguments concerning its alleged noncompliance with these requirements that, in my judgment, preclude summary judgment. But, there is no dispute of fact as to Petitioner's compliance with the other two regulations and I find that the undisputed material facts plainly establish noncompliance and justify the minimal civil money penalties that CMS imposed.

Petitioner asserts that it "vehemently" denies that it restricted Resident # 4's access to the telephone. However, it defines "access" in limited and self-serving terms. It argues that Resident # 4 never was prohibited from making outgoing calls. For purposes of this decision I will accept that assertion as true. But, that begs the question of whether the resident's use of the phone was restricted. CMS alleges that Petitioner limited *incoming* calls to the resident to individuals who had a special access code. Petitioner hasn't denied that allegation. That is an obvious restriction on the resident's use of the telephone because it means that certain individuals weren't allowed to speak to the resident over the phone when they attempted to contact her. Likewise, Petitioner hasn't denied that the facility required the resident's calls to be placed for her. There is no evidence that the resident was unable to make calls on her own and so, this limitation was an unreasonable restriction of the resident's right to make calls in private.

Petitioner has offered no facts challenging CMS's assertions concerning its noncompliance with the requirements of 42 C.F.R. § 483.75(l)(1). Consequently, CMS's allegations stand unrebutted.

/s/
Steven T. Kessel
Administrative Law Judge