**Department of Health and Human Services**

**DEPARTMENTAL APPEALS BOARD**

**Civil Remedies Division**

Sorrento Care Center
(CCN: 23-5512),

Petitioner

v.

Centers for Medicare and Medicaid Services.

Docket No. C-11-418

Decision No. CR2511

Date: March 28, 2012

# AMENDED DECISION

Petitioner, Sorrento Care Center (Petitioner or facility) was a long-term care facility, located in Detroit, Michigan. It participated in the Medicare program until October 22, 2010, when it closed its doors. Starting in May 2010, multiple surveys showed that the facility was not in substantial compliance with Medicare regulations. Initially, Petitioner did not challenge any survey findings or the resulting penalties. However, based on a complaint investigation/survey completed October 8, 2010, the Centers for Medicare and Medicaid Services (CMS) determined that the facility continued to violate program requirements and that its deficiencies posed immediate jeopardy to resident health and safety. Based on these determinations, CMS imposed a civil money penalty (CMP) of $10,000 per day for 17 days of immediate jeopardy and $1,600 per day for 20 days of substantial noncompliance that was not immediate jeopardy, for a total penalty of $202,000.

Petitioner now challenges the October 8 survey findings and resulting penalties.

The parties agree that this case presents no dispute of material fact, and each asks for summary judgment. For the reasons set forth below, I grant CMS's motion. The

undisputed facts establish that the facility remained out of substantial compliance with Medicare requirements and that its deficiencies posed immediate jeopardy to resident health and safety. The penalty imposed is reasonable.

## I. Background

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

The Secretary contracts with state survey agencies to conduct periodic surveys to determine whether skilled nursing facilities are in substantial compliance. Act § 1864(a); 42 C.F.R. § 488.20. The regulations require that each facility be surveyed once every twelve months and more often, if necessary, to ensure that identified deficiencies are corrected. Act § 1819(g)(2)(A); 42 C.F.R. §§ 488.20(a), 488.308.

Early surveys. Beginning May 19, 2010, the facility underwent multiple surveys: on May 19, May 24, June 21, July 15, July 23, and September 10, 2010. Based on the survey findings, CMS determined that the facility was not in substantial compliance with Medicare requirements and that its deficiencies sometimes posed immediate jeopardy to resident health and safety. CMS imposed the following CMPs (among other remedies): 1) $950 per day for 62 days of substantial noncompliance that was not immediate jeopardy (May 19-July 19, 2010); 2) $10,000 per day for two days of immediate jeopardy (July 20-21, 2010); 3) $1,100 per day for 25 days of substantial noncompliance (July 22-August 15, 2010); 4) $10,000 per day for 25 days of immediate jeopardy (August 16 – September 9, 2010); and $100 per day for five days of substantial noncompliance (September 10-14, 2010). CMS Ex. 1; CMS Ex. 94 at 1-7; *see* P. Br. at 3.

The facility did not appeal any of these determinations, which are therefore final and binding and justify the penalties imposed. CMS Ex. 94 at 8; P. Br. at 3; 42 C.F.R. § 498.20(b).

October 2010 survey. Surveyors from the Michigan Department of Community Health (State Agency) returned to the facility and completed a complaint investigation/survey on October 8, 2010. Based on their findings, CMS determined that the facility's substantial noncompliance continued and that its deficiencies posed immediate jeopardy to resident health and safety. Specifically, CMS cited deficiencies under the following regulations:

- 42 C.F.R. § 483.10(b)(11) (Tag F157 – notification of changes) at scope and severity level F (widespread noncompliance that poses no actual harm with the potential for more than minimal harm);

- 42 C.F.R. § 483.12(a)(2) (Tag F201 – transfer and discharge requirements) at scope and severity level F;

- 42 C.F.R. § 483.12(a)(3) (Tag F202 – documentation for transfer/discharge) at scope and severity level F;

- 42 C.F.R. § 483.12(a)(4)-(6) (Tag F203 – notice requirements prior to transfer/discharge) at scope and severity level F;

- 42 C.F.R. § 483.12(a)(7) (Tag F204 – orientation for transfer/discharge) at scope and severity level F;

- 42 C.F.R. § 483.15(a) (Tag F241 – quality of life – dignity) at scope and severity level F;

- 42 C.F.R. § 483.25 (Tag F309 – quality of care) at scope and severity level L (widespread immediate jeopardy);

- 42 C.F.R. § 483.75 (Tag F490 – administration) at scope and severity level F; and

- 42 C.F.R. § 483.75(d)(1)-(2) (Tag F493 – governing body) at scope and severity level F.

CMS Ex. 4.

The facility voluntarily ceased operations on October 22, 2010. CMS Ex. 92 at 2; P. Br. at 2.[1]

CMS imposed against the facility an additional CMP of $10,000 per day for 17 days of immediate jeopardy (September 15 through October 1, 2010), and $1,600 per day for 20 days of substantial noncompliance that was not immediate jeopardy (October 2 through 21, 2010), for a total CMP of $202,000.

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[1] Had the facility not achieved substantial compliance on or before November 19, 2010 (6 months from the initial findings of substantial noncompliance), CMS was required to terminate its provider agreement. Act § 1819(h)(2)(C); 42 C.F.R. §§ 488.412(d), 488.456.

Petitioner timely requested a hearing, and CMS now moves for summary judgment. Petitioner agrees that no material facts are in dispute but argues that it is entitled to summary judgment because those undisputed facts establish that the facility was in substantial compliance as of September 17, 2010. P. Br. at 7.

CMS has submitted its motion and memorandum in support of summary judgment (CMS Br.), along with 94 exhibits (CMS Exs. 1-94). Petitioner has filed its own brief (P. Br.) and 10 exhibits (P. Exs. 1-10).

## II. Issues

I consider whether either party is entitled to summary judgment.

On the merits, the issues before me are:

> 1. From September 15 through October 21, 2010, was the facility in substantial compliance with Medicare program requirements?
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> 2. If the facility was not in substantial compliance from September 15 through October 1, 2010, did its deficiencies then pose immediate jeopardy to resident health and safety?
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> and
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> 3. If the facility was not in substantial compliance, is the penalty imposed – $10,000 per day for 17 days of immediate jeopardy and $1,600 per day for 20 days of substantial noncompliance that was not immediate jeopardy – reasonable?

## III. Discussion

<u>Summary judgment</u>. Summary judgment is appropriate when a case presents no issue of material fact, and its resolution turns on questions of law. *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 247-48 (1986); *Livingston Care Ctr. v. U.S. Dep't of Health & Human Servs.*, 388 F.3d 168, 173 (6th Cir. 2004); *see also Ill. Knights Templar Home*, DAB No. 2274 at 3-4 (2009) (*citing Kingsville Nursing Ctr.*, DAB No. 2234 at 3-4 (2009)). The moving party may show the absence of a genuine factual dispute by presenting evidence so one-sided that it must prevail as a matter of law, or by showing that the non-moving party has presented no evidence "sufficient to establish the existence of an element essential to [that party's] case, and on which [that party] will bear the burden of proof at trial." *Livingston Care Ctr.,* 388 F.3d 168, 173 (*quoting Celotex Corp. v. Catrett*, 477 U.S. 317, 323-24 (1986)). To avoid summary judgment, the non-moving party must then act affirmatively by tendering evidence of specific facts showing that a dispute exists. *Matsushita Elec. Indus. Co. v. Zenith Radio Corp.,* 475 U.S. 574, 586 n.11

(1986); *see also Vandalia Park,* DAB No. 1939 (2004); *Lebanon Nursing & Rehab. Ctr.,* DAB No. 1918 (2004).

> To defeat an adequately supported summary judgment motion, the non-moving party may not rely on the denials in its pleadings or briefs, but must furnish evidence of a dispute concerning a material fact . . . .

*Ill. Knights Templar,* DAB No. 2274 at 4; *Livingston Care Ctr.*, DAB No. 1871 at 5 (2003).

In examining the evidence for purposes of determining the appropriateness of summary judgment, I must draw all reasonable inferences in the light most favorable to the non-moving party. *Brightview Care Ctr.*, DAB No. 2132 at 2, 9 (2007); *Livingston Care Ctr.*, 388 F.3d at 172; *Guardian Health Care Ctr.,* DAB No. 1943 at 8 (2004); *but see Cedar Lake Nursing Home*, DAB No. 2344 at 7 (2010); *Brightview*, DAB No. 2132 at 10 (upholding entry of summary judgment where inferences and views of non-moving party are not reasonable). However, drawing factual inferences in the light most favorable to the non-moving party does not require that I accept the non-moving party's legal conclusions. *Cedar Lake,* DAB No. 2344 at *7; Guardian,* DAB No. 1943 at 11 ("A dispute over the conclusion to be drawn from applying relevant legal criteria to undisputed facts does not preclude summary judgment if the record is sufficiently developed and there is only one reasonable conclusion that can be drawn from those facts.").

***A. CMS is entitled to summary judgment because the undisputed evidence establishes that, in its haste to rid itself of its residents and close its doors, the facility failed to insure that those residents received the care and services necessary for them to attain/maintain the highest practicable physical, mental, and psychosocial well-being; it failed to provide them with timely and adequate notice of discharge; and it neither prepared nor oriented them in a manner that would ensure their safe and orderly transfer.***[2]

Program requirements. As an overarching proposition, the Medicare statute (Title XVIII of the Act) and the "quality-of-care" regulation mandate that each resident receive, and the facility provide, the necessary care and services to allow a resident to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the resident's comprehensive assessment and plan of care. Act § 1819(b); 42 C.F.R. § 483.25; *see* 42 C.F.R. § 483.20(k) (requiring the facility to develop

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

a comprehensive care plan for each resident to meet the resident's needs as identified in his/her comprehensive assessment; the plan is developed by an interdisciplinary team that includes the attending physician, a registered nurse and other appropriate staff, based on the resident's needs). In that regard, the facility must *immediately* inform the resident, consult the resident's physician, and (if known) notify the resident's legal representative or interested family member when there is "a decision to transfer or discharge the resident from the facility. . . ." 42 C.F.R. § 483.10(b)(11)(i)(D).

The obligation to provide necessary care and services continues throughout the resident's stay at the facility, up to and including the time of discharge. With limited exceptions, the facility may not discharge its residents but must permit them to remain. Among the exceptions: a facility may discharge residents if it ceases to operate. 42 C.F.R. § 483.12(a)(2)(vi). However, before a facility transfers or discharges a resident, it must so notify the resident and, if known, a family member or legal representative "in writing and in a language and manner they understand." The written notice must include the following: 1) the reason for the transfer/discharge; 2) the effective date of transfer/discharge; 3) the location to which the resident is transferred/discharged; 4) a statement that the resident has the right to appeal the action to the state; 5) the name, address and telephone number of the state's long-term-care ombudsman; 6) for residents with developmental disabilities, the mailing address and telephone number of the state agency responsible for protecting the developmentally disabled; and 7) for mentally ill residents, the mailing address and telephone number of the state agency responsible for protection and advocacy of mentally ill individuals. 42 C.F.R. § 483.12(a)(4), (6). Unless the resident's health and safety dictate otherwise (or the resident has not resided in the facility for 30 days), the facility must provide the notice "at least 30 days before the resident is transferred or discharged." 42 C.F.R. § 483.12(a)(5).

The facility "must" also sufficiently prepare and orient residents "to ensure safe and orderly transfer or discharge from the facility." 42 C.F.R. § 483.12(a)(7).

Under the quality-of-life regulation, the facility must care for its 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." 42 C.F.R. § 483.15(a).

Finally, the 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 resident. 42 C.F.R. § 483.75. To this end, the facility must have a governing body, or designated persons functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the management and operation of the facility. 42 C.F.R. § 483.75(d)(1). The governing body appoints an administrator who is responsible for the facility's management. 42 C.F.R. § 483.75(d)(2)(ii).

<u>Undisputed facts – the transfers to Bennett Homes</u>. Petitioner concedes that, from May 19 through the time of the September 10, 2010 survey and beyond, the facility was not in substantial compliance with program requirements and its deficiencies sometimes posed immediate jeopardy to resident health and safety. P. Exs. 1, 2. As part of its plan to correct the deficiencies, the facility began discharging some of its residents. P. Ex. 3 at 3, 10; P. Br. at 1-2. On September 28, 2010, however, the facility advised the State Agency that, rather than correct its deficiencies, it intended to cease operations. P. Br. at 1-2. The facility closed its doors about three weeks later, on October 22, 2010. CMS Ex. 92 at 2; P. Br. at 3.

Obviously, the facility could not close its doors until it discharged all of its residents. In CMS's view, the facility did not ensure their "safe and orderly" transfer. CMS has come forward with evidence, which Petitioner does not challenge, that the facility sent four severely impaired residents to unlicensed, semi-independent homes, called Bennett Homes. The facility sent three residents (R102, R103, and R104) to a Bennett Home on Stansbury Street in Detroit, and it sent one resident (R101) to a Bennett Home on Hubbell Street. CMS Ex. 16 at 3-4; CMS Ex. 85 at 3-4 (Tanner Decl. ¶¶ 15, 16).

These "homes" kept no medical records and employed no licensed staff. P. Ex. 4 at 3 (Bennett Decl. ¶¶ 20, 21); P. Br. at 10; *see* CMS Ex. 16 at 3-4. CMS argues that the unlicensed homes could not – and did not – provide necessary care and services to the facility's discharged residents.

Petitioner responds that Bennett Homes' owner/manager agreed to accept these residents and to arrange for their care. In Petitioner's view, the facility met its obligations to these residents because it "appropriately planned the transfer of medications, home care services, mental health services (where necessary) and notified the receiving homes of needed medical procedures and laboratory work for the residents." P. Br. at 4-5. Petitioner argues that it should not be accountable for Bennett Homes' purported failures to live up to its agreements.

The uncontroverted evidence establishes that the residents in question, identified as R101, R102, R103, and R104, were severely impaired and, according to their most recent comprehensive assessments and care plans, required high levels of care:

<u>Resident 101</u>. R101 was a 55-year-old woman suffering from HIV, psychosis, schizophrenia, anxiety, depression, and dementia. CMS Ex. 16 at 18, 65. She was blind in one eye and had a visual deficit caused by cataracts in the other. CMS Ex. 16 at 17, 54, 62. She was occasionally incontinent of bowel and bladder because of her disease, decreased mobility, and an "inability to recognize urges." CMS Ex. 16 at 18, 62, 65. She was at high risk for falls. CMS Ex. 16 at 20, 54. Although she could walk, she generally used a wheelchair to get around. CMS Ex. 16 at 84, 104, 105. According to her August

4, 2010 assessment, for example, she had not walked at all for the preceding week. CMS Ex. 16 at 30.

R101 had a court-appointed legal guardian, an organization called Guardian Care, Inc. CMS Ex. 16 at 40.

On June 24, 2010, the State Agency's Office of Nursing Home/OBRA Program completed a comprehensive evaluation of R101 and concluded that, based on her physical, mental and psychosocial needs, she required the services of a nursing facility. CMS Ex. 16 at 51-89. According to her functional assessment, R101 required limited assistance with locomotion, dressing, eating and toilet use; but she required extensive assistance with bathing and personal hygiene. CMS Ex. 16 at 64, 125-26. The evaluators characterized as "unrealistic" R101's expectations regarding her ability to live independently. CMS Ex. 16 at 57.

The state assessment lists the nursing services that R101 needed that could not have been provided in an alternative setting: opthalmology follow-up, nutritional follow-up, weekly skin assessments, weekly blood pressure checks, pain management, assistance with activities of daily living, and 24-hour nursing care to address her HIV, hypertension, hypothyroidism, and diabetes. The assessment says "given her multiple physical problems, mental status and poor insight and judgment, it is doubtful if [she] can live healthy and safely in a less restrictive setting." CMS Ex 16 at 68.

R101's most recent care plan, prepared by an interdisciplinary team and dated August 22, 2010, accords with the state assessment. It says that R101 needs assistance with activities of daily living, including oral care and bathing. CMS Ex. 16 at 21. The plan instructs staff to assist the resident as needed with oral care, inspect her mouth for lesions, sores or excessive bleeding, inspect her oral cavity after meals, maintain adequate food and fluid intake, and remove the resident's dentures at night. CMS Ex. 16 at 111. The plan identifies R101's visual deficits and instructs staff to assist her in putting in and removing a contact lens from her left eye, and to teach her to do it herself. CMS Ex. 16 at 112.

The plan also notes that R101 is at risk for adverse drug reactions and instructs nursing staff to assess her for behavior and mood changes, blood pressure changes, and memory loss. CMS Ex. 16 at 22. Because of her drug regimen, she was also at high risk for falls. Among other interventions to prevent falls, nursing staff were required to monitor her at least every two hours and as needed for positioning and safety/security. CMS Ex. 16 at 20.

The plan describes occasional bowel and/or bladder incontinence. CMS Ex. 16 at 113. It says that she is at risk for skin breakdown because of her weakness and decreased mobility. CMS Ex. 16 at 23, 118.

Her hypothyroidism put her at risk for changes in her endocrine system, so nursing staff were instructed to assess for changes in mentation, restlessness, increased confusion, and anxiety. They were to assess for weight loss, tachycardia, chest pain, shortness of breath, elevated blood pressure, nervousness, and tremors. CMS Ex. 16 at 119. Because she was on multiple medications, nursing staff were required to monitor and report changes in consciousness, vital signs, lab results, and drug reactions. The facility's pharmacist was to monitor her drug regimen monthly and to recommend reductions. CMS Ex. 16 at 120.

The plan identifies behavior problems that include going into the rooms of others and taking food and personal items from them. CMS Ex. 16 at 13.

Most significant, the facility's own interdisciplinary team wrote that R101 *needs continued long-term-care placement* because of her schizoaffective disorder, history of noncompliance with medications, history of alcohol and polysubstance abuse, history of homelessness/multiple residences, and not caring for herself. The plan calls for her to remain in long-term-care for at least 90 days. The plan also recommends a follow-up psychiatric evaluation.[3] CMS Ex. 16 at 12.

At the same time, an August 22, 2010 "discharge plan review," signed by Jackie Gordon, BSW (Bachelor of Social Work), says that the resident is "voicing desire to be considered for alternative placement," but that her legal guardian requests "psych input" regarding the appropriateness of a lesser level of care. CMS Ex. 16 at 139.

As late as September 14, 2010, an amendment to R101's plan addresses the resident's potential for infection and calls for regular nursing assessments. Among other interventions, nursing was to monitor for and report any adverse reactions to medications. They were to observe for signs of infection and document all observations and lab results. They were to assess the skin for lesions, ulcerations, bruising, and bleeding and report to the physician. They were to monitor for diarrhea, profuse sweating, nausea, vomiting, fever, lethargy, fatigue, and changes in mental status. They were to monitor for signs of dehydration, note any coughing, congestion, shortness of breath, observe for signs of depression, and monitor for pain. CMS Ex. 16 at 106.

A physician's progress note, dated September 17, 2010, says that R101 uses a wheelchair. CMS Ex. 16 at 104-05.

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[3] The most recent psychiatric progress note, dated August 17, 2010, cites no new behaviors and recommends that she continue her psychotropic medications (Risperdal and Ativan), that she continue to be followed by the state's "Older Adult Services," and that her weight, fasting blood sugars, lipid and triglyceride profiles be monitored. The note does not mention changing her level of care. CMS Ex. 16 at 48.

Yet, less than 30 days after her care plan declared that she needed long-term-care, the facility transferred R101 to one of the Bennett Homes. A discharge note, dated September 20, 2010, at 4:00 p.m., says that R101 left the facility with Leenetta Ingraham, "licensed professional nurse," from the Bennett Homes. CMS Ex. 16 at 37. In fact, Leenetta Ingraham is not a licensed nurse; she is a certified nursing assistant, who says that she "trained" as a nurse but does not claim any degrees or licenses. P. Ex. 5 at 1 (Ingraham Decl. ¶ 2). The note says that the home would provide medication/medical management, a visiting nurse would visit the resident twice weekly, and that a Dr. Harris (mobile physician) would be following with physical therapy, as needed. Bennett Homes' owner would escort the resident to her appointments with the infectious disease physician. CMS Ex 16 at 37.

A telephone order, dated September 20, 2010, and signed by the physician on September 22, discharges R101 to Bennett Home with unspecified home care services. CMS Ex. 16 at 43.

Notwithstanding her most recent assessments and care plan, a "resident transfer form" dated September 20, 2010 describes the resident as continent, although she wears briefs. It does not check the blocks for mental or vision impairments. It says that she is independent in personal hygiene, dressing, feeding, transfer, and locomotion. It says that she does not use a wheelchair. It says that she is "aware" of the transfer and that her meds would be sent along with her. CMS Ex. 16 at 6-7.

A "post-discharge plan of care," [4] which was completed and signed by BSW Gordon, describes R101 as "independent for bathing, grooming and dressing," but says that she requires "medication assistance." With respect to services she would need – transportation, meals, housekeeping, physician service, home health care – the plan says only that Bennett Home would be responsible or would arrange. CMS Ex. 16 at 35. The plan says that the resident has no social support and no financial needs.

A social service progress note dated September 20, 2010 says that the resident is "OK'd" to go to Bennett Residential Care Home, which she had an opportunity to visit a week earlier. According to the note, the resident was distressed at the prospect of a transfer to another nursing home and said that she agreed to follow the new home's rules regarding alcohol and limited visits. CMS Ex. 16 at 43-44.

On September 30, 2010 – ten days after the resident's discharge – facility staff called Guardian Care and confirmed that, contrary to an August 30 note written by BSW

[4] The regulations require a "post-discharge plan of care" that is developed with the participation of the resident and her family in order to "assist the resident to adjust to . . . her new living environment." 42 C.F.R. § 483.20(l)(3).

Gordon, the agency was still R101's legal guardian.[5] According to the note, staff saw "no evidence" of a redetermination that the resident no longer required skilled nursing services and could be placed in adult foster care. CMS Ex. 16 at 94.

Resident 102. R102 was a 56-year-old man with diagnoses of mental retardation, developmental disabilities, cerebral palsy and diabetes. He had difficulty walking. CMS Ex. 17 at 12, 16, 26, 35, 37.

In a letter dated January 11, 2010, R102's physician wrote that the resident's health was deteriorating and that he needed an emergency guardianship to make his medical and financial decisions. CMS Ex. 17 at 35. In a court order, dated January 20, 2010, R102's cousin was named his temporary guardian, the appointment to expire on April 20, 2010. CMS Ex. 17 at 32.

According to his August 2010 assessment, R102 required supervision in order to reposition himself in bed. He required limited assistance for transfers, dressing, toileting and personal hygiene, and extensive assistance in bathing. CMS Ex. 17 at 9-10.

An entry to his care plan, dated August 19, 2010, says that the resident wants to reside with his cousin and voices distress about nursing home placement. Nevertheless, the plan calls for him to remain in long-term care for 90 days, with his placement to be reviewed at that time. CMS Ex. 17 at 13. As of August 19, his discharge plan says that he wants "to go to his cousin's house," but that his cousin, described as his "formal legal guardian," had not been interviewed. The plan calls for a reassessment and says "no immediate" discharge plans. CMS Ex. 17 at 26.

In a notice dated September 8, 2010, the State Agency advised the facility that, based on his recent comprehensive evaluation, R102's physical, mental, and psychosocial needs could adequately be met in a nursing facility and that he qualified for the level of services provided there. *See* 42 C.F.R. § 483.100 *et seq*. The notice says that R102 also requires specialized mental health/developmental disabilities services. This determination would be effective until R102's next evaluation was completed, which should have been about a year later (or sooner, if the resident's condition changed). CMS Ex. 17 at 40; *but see* CMS Ex. 17 at 39 (checking the box next to "no nursing facility").

In a letter dated September 9, 2010, the State Agency reiterated that it had determined that R102 "**does** require nursing facility placement and may need specialized or other mental health services." CMS Ex. 17 at 36 (emphasis in original).

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[5] In an August 30 social service progress note, BSW Gordon wrote that, at the resident's request, guardianship was changed to herself. CMS Ex. 16 at 43. The facility's subsequent "clarification" establishes that this note was inaccurate, and Petitioner does not now claim otherwise. At the time of her discharge, R101 had a legal guardian.

On September 15, 2010, the day before R102's discharge, BSW Gordon wrote a progress note saying that she notified the resident's cousin that he would be transferred to Bennett Homes the following day. The cousin did not object, according to the note, saying "wherever he wants to go is ok with me." CMS Ex. 17 at 23.

An entry dated September 16, 2010, signed by BSW Gordon, says that R102 requests alternative placement, declines a nursing home, and will be discharged to Bennett Homes that day. CMS Ex. 17 at 13. A nurse's note, also dated September 16, 2010, says that he is discharged to Bennett Residential Home, that he and his guardian are aware of the discharge and agree. His physician and "all disciplines notified and in agreement." CMS Ex. 17 at 22.

According to his "discharge plan," Bennett Homes would arrange for a visiting nurse, therapy services, and home physician. CMS Ex. 17 at 19.

A physician's order dated September 16, 2010 says "discharge to Bennett Residential Home." CMS Ex. 17 at 6, 7.

The "resident transfer form," also dated September 16, says that R102 is in a wheelchair, that he requires weekly blood pressure checks and blood sugar testing. According to the document, staff should administer his diabetes medications (insulin and Glucagon) based on a sliding scale, the dosages determined by his blood sugar levels. The form also says that R102 needs assistance and supervision with personal hygiene and dressing and that someone should "stand by" when he transfers or moves. CMS Ex. 17 at 24, 25. The form does not mention any need for assistance in bathing. *See* CMS Ex. 17 at 10.

A document titled "interdisciplinary discharge summary," dated September 16, 2010, is signed by BSW Gordon. It says that the resident is "excited" and wants to leave before his discharge date. It says that he is alert and oriented, able to make decisions, has no legal guardian, and that his discharge potential is good. The form's sections on nursing services and dietary services are left blank. CMS Ex. 17 at 28.

R102's "post-discharge plan of care," dated September 16, identifies as needs: medication assistance, assistance and supervision for bathing, grooming, and dressing, and says that Bennett Home will provide transportation, meals, and housekeeping and will arrange for a visiting nurse and home physician. The plan also says "meds provided for take home." CMS Ex. 17 at 30-31.

Resident 103. R103 was a 62-year-old man who had resided in the facility for about three years. Among other ailments, he suffered from schizoaffective disorder, bipolar, epilepsy, chronic obstructive pulmonary disease (COPD), asthma, and cerebral-vascular

disease. CMS Ex. 18 at 5.[6] He had had a stroke and was confined to a wheelchair. CMS Ex. 18 at 65. He had a court-appointed guardian, an agency called Adult Well-Being Services. CMS Ex. 18 at 12, 18.

On March 8, 2010, the State Agency completed a comprehensive evaluation of R103 and recommended that he remain in a nursing home with ongoing psychiatric consultation and follow-up for medication reviews and supportive therapy. CMS Ex. 18 at 57, 59, 61, 68. The assessment noted that R103 required moderate to extensive assistance with activities of daily living due to the effects of a stroke and for his own safety. CMS Ex. 18 at 58, 67. The report specifically noted that prior placements in adult foster case "did not provide enough structure to prevent his [alcohol] use." CMS Ex. 18 at 59.

In a letter dated March 15, 2010, the State Agency advised R103's guardian that, after reviewing the resident's comprehensive evaluation, it determined that he "requires the services of a nursing facility and does not require specialized mental health/developmental disabilities services, but he may need other mental health or developmental disabilities services." The determination would remain in effect until a new evaluation was completed, in one year (or sooner, if his condition changed). CMS Ex. 18 at 55.

On May 5, 2010, R103 unsuccessfully petitioned the court to terminate the guardianship. CMS Ex. 18 at 26-28.

A discharge plan, dated August 11, 2010, says "no immediate plans to [discharge] at this time" and that "per" the resident's legal guardian, "[long-term care] to [continue at] this time." CMS Ex. 18 at 25.

An August 17, 2010 psychiatric progress note says that the resident has been compliant with his medications, which include Risperdal, Depakote, Ativan and Celaxa, and "has been getting along fairly good [sic] with other residents and staff members but does get upset with the staff at times." The psychiatrist concluded that R103 should continue his medications, be followed by "Older Adult Services," and be monitored for any significant weight gain. His fasting blood sugars, lipid profile and triglyceride profile should be monitored regularly. The note does not mention changing his level of care. CMS Ex. 18 at 29.

According to the facility's August 2010 assessment, R103's cognitive skills for daily decision-making were moderately impaired. He had been verbally abusive. He required extensive assistance in moving between locations in his room and in bathing. He

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[6] His March 2010 state assessment diagnosed schizophrenia, paranoid type, rather than schizoaffective disorder. *See* CMS Ex. 18 at 57; *see also* CMS Ex. 18 at 73 (12/14/09 psychiatric diagnosis of schizophrenia, chronic paranoid type).

required supervision with transfers and bed mobility, and limited assistance with dressing, toileting and personal hygiene. According to the assessment, he was taking 13 medications, including antipsychotics, antianxiety medications, and antidepressants. CMS Ex. 18 at 21-22.

R103's care plan, updated on August 25, 2010, reflects his complicated combination of impairments, requiring a multitude of interventions from all of the facility disciplines. Among the many problems identified are the potential for injury related to his seizure disorder. Staff were to administer his anti-seizure medication, remain with him if he had a seizure, monitor his lab values as needed, and follow the facility's seizure precautions. CMS Ex. 18 at 35. The plan also identifies the resident's need for "extensive to limited" assistance with activities of daily living related to his multiple impairments, his occasional episodes of bladder incontinence, and occasional inappropriate behavior. Among other interventions, the plan instructs staff to assess for skin breakdown, assist with and provide oral care twice a day, provide showers/baths twice a week, and supervise and provide limited assistance with activities of daily living (dressing, hygiene, shower/bath, toileting). CMS Ex. 18 at 36.

To address his shortness of breath caused by asthma, the plan instructs staff to monitor for signs and symptoms of oxygen loss, cyanosis, shortness of breath, lethargy and decreased mental status, and to monitor for potential side effects from his medications (palpatations, tachycardia, headaches, nervousness). CMS Ex. 18 at 37. Similarly, to address his risk of altered cardiac output related to his hypertension and use of antihypertensive medications, staff were to monitor for complaints of headache, dizziness, flushed appearance, blurred vision, and increased blood pressure. They were to monitor his blood pressure and to monitor for edema in ankles/feet and wrists/hands. CMS Ex. 18 at 38.

The plan identifies R103 as at high risk for falls related to his multiple impairments and medications. Among the interventions, nursing staff were to assess for signs and symptoms of adverse reactions to his medications, assess for orthostatic hypotension, make sure he was positioned safely, and encourage the resident not to attempt independent transfers or ambulation. They were instructed to monitor him at least every two hours and as needed for positioning and safety/security. CMS Ex. 18 at 39.

The plan identifies R103 as at risk for skin breakdowns related to his prior stroke and occasional episodes of bladder incontinence. Staff were to assist and teach him to reposition himself, and audit his skin twice weekly when bathing and daily while providing care. They were to explain that he should reposition himself every two hours, keep his linens dry and wrinkle free, and make sure he had adequate fluids and food. CMS Ex. 18 at 41.

The plan says that R103 is at risk for an adverse drug reaction. To maintain his stable behavior and prevent an adverse reaction, the plan instructs staff to (among other interventions): administer the medications as ordered; assess and report to his physician any behavioral or mood changes; assess for blood pressure changes when a drug is taken; assess memory loss; obtain a physician evaluation to set a time period for drug reduction. Nursing staff were also instructed to monitor lab values and vital signs as ordered. A licensed pharmacist would review the drug regimen monthly to recommend reductions. CMS Ex. 18 at 42-43.

To ensure a safe environment, the resident's smoking had to be monitored. His care plan precluded him from keeping any of his smoking paraphernalia with his personal belongings. He was required to return his smoking materials to facility staff. Staff would light his cigarettes, conduct random "smoke checks" to make sure he did not have smoking materials, and monitor him when he went out to smoke on facility property. CMS Ex. 18 at 46.

An August 11, 2010 entry to his behavior plan describes R103 as verbally abusive to his peers and staff, using profanity and racial slurs. He reportedly refused baths, showers and shaving at times. To address these issues, the plan instructs nursing and social services staff to encourage him to maintain personal hygiene, offer him opportunities to shave daily, encourage him not to use profanity or racial slurs, talk to him about his feelings, and refer him for mental health services as warranted. CMS Ex. 18 at 47.

A social service progress note, dated September 15, 2010, says that the resident "was informed he would need discharge to [an] alternative [nursing home] or [group home]." According to the note, he cursed and said he would not go to another nursing home. He declined the opportunity to see Bennett Home/Stansbury. CMS Ex. 18 at 15. An addendum to the note says that the "new provider" came to the facility on September 13, 2010, and the resident was informed that he would be discharged on September 16. "Adult Well-Being notified on 9/15/10 [and] 9/16/10." The note identifies the Adult Well-Being case manager as Mary Cain. CMS Ex. 18 at 91.

A nurse's note, dated September 16, 2010, says (incorrectly) that R103 is transferred to another nursing home, his physician and his guardian were notified, and his medications and belongings were transferred with him. CMS Ex. 18 at 16.

A physician's telephone order, dated September 16, 2010, says "transfer to the Bennett Home – facility." The order is signed by a facility nurse but was never counter-signed by the physician. CMS Ex. 18 at 24.

R103's transfer form lists some of his diagnoses and indicates that he is unable to walk and uses a wheelchair. It notes that he needs assistance turning and sitting in bed and with most aspects of personal hygiene, dressing, and transfers. He is described as

disruptive at times, and needing mental health services. CMS Ex. 18 at 7. His post-discharge plan of care says that he needs medication assistance, as well as assistance with bathing, grooming and dressing. It says that the nursing home wheelchair van will transport him to the home and that Bennett Home will provide meals, housekeeping, and will arrange for home care, physician, pharmacy, mental health and other services. The plan also says "medication provided for take home." CMS Ex. 18 at 8-9.

In the document titled "interdisciplinary discharge summary," BSW Gordon describes the resident's attitude as "good," his cognitive status as "alert and oriented," and his discharge potential as "good – [with] supportive services." A nurse writes that he needs assistance with activities of daily living, uses a wheelchair, and has his own teeth. CMS Ex. 18 at 17.

A "discharge plan review" consists of a short note signed by BSW Gordon: "Resident discharged to Bennett Home per his choice today. [Legal Guardian – Adult Well-Being] aware. Home will provide [assistance with activities of daily living], toileting, [illegible], meds." CMS Ex. 18 at 104.

The surveyors spoke to BSW Gordon on September 29, 2010. She admitted that she had not provided a 30-day notice of discharge to R103 or his guardian. Instead, she told R103 that the facility was "down-sizing" and that his unit would be closed, and that he would have to relocate to another nursing home or to adult foster care (AFC). She told the surveyors that her "friend," Ms. Bennett, owned an AFC and met with R103, after which he agreed to placement in her home. R103's legal guardian did not participate in the placement decision, although the agency was notified of the new arrangement. CMS Ex. 18 at 77.

The surveyors also contacted Adult Well-Being Services. R103's caseworker, Vivenne Shaw, told them that the facility notified her of the transfer after it had taken place. She did not participate in the decision, did not tour the home in advance (her "standard practice"), and had not signed any admission documents. The facility had not given her any contact information for the new placement. She questioned the appropriateness of the placement, pointing out that R103's assessments concluded that he needed a skilled level of care. CMS Ex. 18 at 78. Facility documents confirm that Vivienne Shaw was R103's emergency contact. CMS Ex. 18 at 157.

The surveyors saw no evidence of a "redetermination" as to the level of care R103 required. CMS Ex. 18 at 78.

On October 1, 2010, the state surveyors spoke to Douglas Lewis at R103's new residence, who, they understood, was the "house manager." He told them that R103 had not had a shower or bath since the date of his arrival (September 16) because "this is 'assisted living'[;] the residents give themselves showers and/or baths." He also said that

R103 had not asked for any bathing help, so he had not received any. The surveyors described R103 as "disheveled." The resident and Mr. Lewis confirmed that Mr. Lewis gave him his medications twice a day (8:00 a.m. and 8:00 p.m.), although Mr. Lewis did not know what medications the resident received, only that "he gets a lot of stuff." CMS Ex. 18 at 10-11.

According to Petitioner, Mr. Lewis was not the house manager. He is a Bennett family member who lived in the house on Stansbury. When the surveyors visited the house, its manager, Kimberly Bennett, was on vacation, and Leeneta Ingraham was managing the house in her absence, although she was obviously not present at the time, and, apparently, Mr. Lewis did not think to summon her. P. Br. at 10l; P. Ex. 4 at 3 (Bennett Decl. ¶¶ 22-24). For purposes of summary judgment, I accept Petitioner's representation but find it not material. Petitioner has not come forward with any evidence suggesting that it disputes CMS's underlying allegation: that R103 had not bathed since admitted to Bennett House.[7]

Resident 104. R104 was a 61-year-old man suffering from congestive heart failure, myocardial infarct, hypertension, diabetes, cerebrovascular disease, and renal failure. CMS Ex. 19 at 3. He was taking the blood thinner, Coumadin, and required periodic blood testing (PT/INR).[8] CMS Ex. 19 at 6, 7, 8. He was admitted to the facility on May 18, 2010, and readmitted on July 13, 2010, just two months before it decided to close its doors. CMS Ex. 19 at 14, 52.

A discharge plan, dated July 16, 2010, signed by N. LeJeune, LCSW (Licensed Clinical Social Worker), quotes R104 as saying that he would like to stay in the facility. CMS Ex. 19 at 38.

According to his September 1, 2010 assessment, R104's short-term and long-term memory were impaired. His "cognitive skills for daily decision-making" were described as "modified independence" (some difficulty in new situations only). He required limited assistance with bed mobility, transfer, walking between locations in his room, dressing,

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[7] Of course, accepting Petitioner's assertion raises an additional troubling question, which I decline to address in this decision on summary judgment: why was no responsible person present in the home when the surveyors visited?

[8] Specific tests, referred to as PT/INR (prothrombin time/international normalized ratio) evaluate the ability of blood to clot properly. The INR is the ratio of an individual's prothrombin time to a control (i.e., normal) sample – the higher the INR, the greater the chance of bleeding. Normal INR ranges for a health person are 0.9 to 1.3, although for people on Coumadin the desirable range may be 2.0 to 3.0. According to the drug's manufacturer an INR greater than 4.0 increases the risk for major (even fatal) bleeding, without providing additional therapeutic benefits. *See* www.coumadin.com.

eating, and with personal hygiene. He did not walk outside his room, and required supervision when he moved about in his wheelchair. He needed extensive assistance with bathing. CMS Ex. 19 at 14-15.

According to his care plan, completed August 19, 2010, R104 was an elopement risk because he had packed his belongings and was found in the elevator with them. Staff were instructed to observe him for attempts to leave the facility and to involve him in activities. CMS Ex. 19 at 22; *see* CMS Ex. 19 at 36 (indicating that, when the resident was found at the elevator with his coat and hat, he told staff he was going to visit his sick aunt).

His care plan notes that he requires supervision and cueing-to-limited assistance with activities of daily living and care needs. Among a long list of interventions, the plan calls for a 1-person assist with transfers, assistance with activities, combing hair, dressing, hygiene, grooming, shaving, and bathing. The plan instructs staff to assist R104 with turning and repositioning every two hours and as needed. CMS Ex. 19 at 23.

According to the plan, R104 needed a therapeutic diet and was at risk for weight fluctuations. Staff were to monitor and assess his intake and weigh him monthly. CMS Ex. 19 at 25.

He was at risk for falls because of his weakness, decreased muscle strength, and unsteady gait, so staff were to assist with transfers, monitor his whereabouts, document signs and symptoms of medication side effects, monitor every two hours and as needed for positioning and safety/security. He was to be up in his wheelchair as tolerated. CMS Ex. 19 at 26-27.

His plan also indicates that he was at risk for adverse drug reactions related to his use of anticoagulants, so staff were to monitor his dietary intake, specifically for foods high in vitamin K. They were to monitor for bleeding every shift and for bruising, and to monitor his lab values, including PT/INR results. CMS Ex. 19 at 28.

A social services note dated September 13, 2010 says that the resident and his sister "were informed" that the facility was no longer able to provide his care. He said that he did not want to go to another nursing home, but, after visiting the Bennett Home, he said that he wanted to go there, and "is agreeable to discharge on 9/16/10." His sister also agreed, according to the note. CMS Ex. 19 at 37.

Nurses' notes dated September 15, 2010, indicate abnormally high PT/INR levels (66.2/6.4). Staff notified his physician who put a hold on his Coumadin and ordered staff to hold R104's Coumadin and recheck his PT/INR the following day. A note, written at 7:00 p.m. on September 16, says that the resident has transferred to another facility, his doctor and sister (who was his responsible party) were notified, and his medications were

sent with him. Staff wrote his PT/INR levels on the transfer sheet and indicated that his Coumadin was on hold until his next blood draw. CMS Ex. 19 at 7, 8, 35.[9]

A social service note dated September 16 says that R104 was discharged to Bennett Home that evening by means of the facility's wheelchair van. CMS Ex. 19 at 37.

The "interdisciplinary discharge summary" is dated September 16, 2010, and says that the resident was "sent to another facility." LCSW Le Jeune signed the social services section of the form. She checked that R104 was unable to make his needs known but described him as "oriented X3" and described his attitude toward the transfer as "acceptance." With respect to nursing services, the form indicates that R104 is ambulatory but uses a wheelchair and needs assistance with activities of daily living. CMS Ex. 19 at 40.

R104's "resident transfer form" says to "hold Coumadin pending results of PT & INR which needs to be drawn on 9/17/10." It lists his PT as 6.4 and INR as 66.2.[10] The document also includes a sliding scale for administration of his insulin (Novoli R), with dosages determined by his blood sugar levels. In contrast to his September 1 assessment, the September 16 document describes the resident as independent in bed mobility and transfers (except in the tub, where the form indicates he needs assistance). It says that he requires assistance/supervision with personal hygiene and "some" assistance and supervision with dressing. The form also says to "assess for elopement." CMS Ex. 19 at 45; *but see* CMS Ex. 19 at 14-15, 23, 26-27.

A telephone order dated September 16, 2010, which was not signed by the physician, says "transfer to the Bennett Home." CMS Ex. 19 at 9.

R104's "post-discharge plan of care" notes that the resident needs medication assistance, set up and some assistance and supervision for bathing, grooming and dressing. It says that the facility's wheelchair van would transport him. Bennett Home was to provide meals and housekeeping services and to arrange for physician, pharmacy and other services. The form says "meds provided for take home." CMS Ex. 19 at 42-43. Leneeta Ingraham concedes that, notwithstanding the Post-Discharge Plan of Care, R104's insulin was not sent with him to Bennett Home. P. Ex. 5 at 1 (Ingraham Decl. ¶ 6).

<u>Application of law to undisputed facts</u>. The problems with the facility's efforts to discharge its residents are almost too numerous to list. Among them are the following

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[9] It appears, however, that the writer reversed the PT and INR values, writing "PT=6.4 and INR=66.2."

[10] Again, the writer reverses the actual values. *See* CMS Ex. 19 at 35 (listing PT as 66.2 and INR as 6.4).

deficiencies, any one of which puts the facility out of substantial compliance with Medicare program requirements:

Inadequate notice. First, the uncontroverted evidence establishes that the facility made little to no effort to meet Medicare's notice requirements for the residents it discharged. The facility has produced no evidence that it provided *written* notice to any of multiple residents cited, nor to any of their responsible parties. Indeed, Petitioner does not claim that it did so. With respect to the verbal notices, it is sometimes difficult to determine exactly when facility staff told a resident or his/her guardian about an impending discharge, but the undisputed evidence establishes that the facility never came close to meeting the 30-day notice requirement. CMS has come forward with evidence – the facility's own records – establishing that the facility repeatedly provided no more than a few days' notice. Petitioner has not challenged this evidence. Drawing every inference in the light most favorable to Petitioner, I find that the facility provided its residents no more than a few days verbal notice prior to discharge, and sometimes not even that much. Specifically:

- Staff contacted **R101's** legal guardian ten days *after* her transfer.[11]

- Just one day prior to his discharge, facility staff called **R102's** cousin/guardian to tell her of the move.

- Staff told **R103** on September 13 that he would be discharged on September 16. CMS Ex. 18 at 15. The evidence as to when they told his guardian is ambiguous. One note says that Adult Well-Being was notified on September 15 and 16, but the resident's caseworker told the surveyors that she learned of the transfer after the fact. CMS Ex. 18 at 78. For summary judgment purposes, I accept that the facility contacted R103's guardian one day prior to his discharge.

- **R104** and his sister were informed on September 13 that he could not remain at the facility; he was discharged on September 16. CMS Ex. 19 at 37.

- Finally, CMS provides evidence that numerous other residents were discharged without adequate notice or preparation. CMS Br. at 17-19; CMS Ex. 51 at 38; CMS Ex. 87 at 2, 5-6 (Kaelin Decl. ¶¶ 5, 6, 19); CMS Ex. 88 at 4-5 (Wright Decl. ¶¶ 15, 17); CMS Ex. 89 at 2 (Sieg-Cox Decl. ¶ 5). For example, staff notified one resident less than two hours prior to his transfer. CMS Ex. 52 at 41. They told a second resident on the day of his transfer that he had to leave that day. CMS Ex.

[11] The record does not disclose when the facility first told R101 of her impending transfer.

> 36 at 23. Petitioner has not come forward with any evidence suggesting that it disputes these allegations.

Thus, by its own admission, the facility did not provide its residents, their family members and/or legal representatives with at least 30-days written notice of their discharges, which puts it out of substantial compliance with 42 C.F.R. § 483.12.

Disregard for resident assessments and care plans. CMS charges that, for the four residents transferred to Bennett Homes (R101, R102, R103, and R104), the facility did not provide necessary care and services, in accordance with their assessments and care plans. In response, Petitioner argues that these residents were not "randomly chosen" for discharge to Bennett Homes, because Kim Bennett, the homes' owner/manager, visited the facility "approximately four times," spoke to residents, and reviewed their charts "to ensure the residents who chose the Bennett Homes were appropriate for the Bennett Homes." P. Br. at 9; P. Ex. 4 at 1 (Bennett Decl. ¶¶ 6-8).

Petitioner also relies on the "post-discharge plans of care" to justify its actions, suggesting that those documents provided Bennett Homes the information it needed. P. Br. at 9. In Petitioner's view, the facility should not be penalized if Bennett Homes did not then provide necessary care and services.

Petitioner's justifications fail for two reasons. First, according to their most recent assessments, prepared by interdisciplinary teams of health care professionals, all of these residents required skilled care. By her own admission, Kim Bennett is not a medical professional; she claims no degrees, no licenses or certification in any discipline, only that she "trained as a Certified Nursing Assistant, a Phlebotomist, and a Direct Care Worker." P. Ex. 4 at 1 (Bennett Decl. ¶ 2). She is simply not qualified to nullify the assessments of the facility's own interdisciplinary teams.

Second, the facility's "post-discharge plans of care" and other transfer documents inadequately conveyed the care and services these residents required. Comparing those documents to the residents' most recent assessments and care plans – some completed less than a month prior to the discharge – underscores how inadequate they were. In every case, the plan failed to reflect all of the resident's needs; and, in some cases, the plan actually misrepresented the resident's needs.

For example, on August 22, 2010, **R101's** legal guardian told BSW Gordon that, before the resident could be considered for alternative placement, she needed psychiatric input as to whether a lower level of care would be appropriate. CMS Ex. 16 at 139. The facility obtained no such input. Instead, within 30 days of the conversation, the facility discharged the resident to adult foster care without even notifying R101's guardian. The facility did not reassess R101 regarding the level of care she required. CMS Ex. 16 at 5 (admitting that the facility sent R101 to an adult foster care home without determining

whether the change in her level of care was appropriate); *see also* CMS Ex. 18 at 4 (confirming that the facility did not ask the state to redetermine the appropriate levels of care for R101 and R103).

Comparing R101's most recent assessments and care plan to her "post-discharge plan of care" and related documents shows that the Bennett Home placement was not appropriate and underscores the inadequacies of the transfer documents. For example:

- The State Agency in June 2010 and the facility in August 2010 concluded that R101 required long-term-care placement. CMS Ex. 16 at 12, 51-89. Those evaluators doubted that she could be healthy and safe in a less restrictive setting. CMS Ex. 16 at 68. In contrast, her discharge documents say almost nothing about the appropriateness of her new placement, only that she is "OK'd to go to Bennett Residential Care Home." CMS Ex. 16 at 43;

- The state assessment says that R101 needs 24-hour nursing care, and the facility's care plan says that she requires significant nursing interventions. CMS Ex. 16 at 22, 68, 106, 111, 119, 120. In contrast, a discharge note says that a nurse would visit her at Bennett Homes twice weekly. CMS Ex. 16 at 37;

- Her most recent assessment and care plan say the she is occasionally incontinent of bowel and bladder (CMS Ex. 16 at 18, 62, 65, 113), but her resident transfer form says that she is continent. CMS Ex. 16 at 6-7;

- The State Agency and the facility's interdisciplinary team agreed that R101 required assistance with locomotion, dressing, eating, bathing, personal hygiene, and toilet use. CMS Ex. 16 at 21, 64, 124-26. Her transfer form and post-discharge plan of care say that she is independent in personal hygiene, bathing, dressing, feeding, transfer and locomotion. CMS Ex. 16 at 35, 67;

- Even though R101 regularly used a wheelchair to get around (CMS Ex. 16 at 30, 104, 105), her transfer form says that she does not use a wheelchair. CMS Ex.16 at 6-7;

- R101's care plan also describes her risk for falls, adverse drug reactions (CMS Ex. 16 at 20, 22, 120), skin breakdown (CMS Ex. 16 at 23, 118), and infection (CMS Ex. 16 at 106). Her transfer documents do not mention any of these problems.

Petitioner challenges CMS's assertion that the State Agency determined that **R102** required a skilled level of care. As noted above, the state's September 9, 2010 notice letter says that R102 "**does** require nursing facility placement and may need specialized or other mental health services." CMS Ex. 17 at 36 (emphasis in original). According to

Petitioner, this was simply a form letter, sent for a different purpose (to admonish the facility because it failed to comply with federal requirements for preadmission screening and annual review). Petitioner implies, but does not say, that the letter's placement language was in error. Petitioner points out that, in the report itself, the evaluators checked a box that says "No Nursing Facility/Specialized Mental Health Services." CMS Ex. 17 at 39; P. Br. at 11-12. I agree that the state's documents seem to contain a discrepant checked box describing the appropriate level of care.[12] On the other hand, both the September 9 cover letter and the narrative portion of the state's report say that the resident "qualifies for the level of services provided by a nursing facility." CMS Ex. 17 at 36, 40. Nevertheless, because I am deciding this case on summary judgment, I accept Petitioner's claim that the state assessment does not mandate nursing home placement.

But this finding is not material. The regulation says that the facility must provide care and services *in accordance with the resident's care plan*. 42 C.F.R. § 483.25. R102's August 19, 2010 care plan says that the resident should remain in long term care for at least 90 days (or until November 17), and that his placement should be reviewed at that time. CMS Ex. 17 at 13. The facility ignored the care plan and discharged the resident after less than a month, without reassessing his level of care.

I recognize the laudable goal of placing individuals in the least restrictive environment, as pointed out by Petitioner's witness, Erica Holman, LCSW. P. Ex. 6 at 1-2 (Holman Decl. ¶¶ 4, 5). However, that placement must always be to an appropriate setting, capable of providing necessary care and services, as determined by the resident's assessment and care plan. Here no assessment or care plan suggested that R102's needs could be met in adult foster care. This was particularly important for someone like R102, who was mentally retarded, severely physically impaired, and diabetic, and whose physician questioned his ability to make medical decisions.[13]

**R103's** most recent state assessment concluded that he required nursing facility services, and specifically noted that an adult foster care placement would not provide sufficient structure. CMS Ex. 18 at 55, 59. On August 11, 2010, his guardian directed that his placement in long-term care continue. CMS Ex. 18 at 25. Yet, a month later, the facility transferred him to Bennett Home/Stansbury. Moreover, R103's transfer documents do

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[12] Of course a facility is obligated to clarify such a discrepancy, and Petitioner has not explained its failure to do so.

[13] In her deeply troubling declaration, Bennett Homes' owner/manager Kim Bennett says that R102 "is doing very well," except that he "*does refuse his blood sugar and insulin*." P. Ex. 4 at 2 (Bennett Decl. ¶ 16) (emphasis added). Owner/manager Bennett does not acknowledge that such refusal puts R102's health and safety in jeopardy; nor does she suggest that the home plans any interventions to address the problem.

not accurately reflect his assessed needs in that many of his significant problems are not mentioned: his potential for injury related to his seizure disorder (CMS Ex. 18 at 35); his occasional bladder incontinence (CMS Ex. 18 at 36); his shortness of breath caused by asthma (CMS Ex. 18 at 37); his risk of altered cardiac output (CMS Ex. 18 at 38); his high risk for falls (CMS Ex. 18 at 39); his risk for skin breakdown (CMS Ex. 18 at 41); his risk for an adverse drug reaction (CMS Ex. 18 at 42); and the need to monitor his smoking to ensure a safe environment. CMS Ex. 18 at 46.

Similarly, **R104's** transfer documents do not mention his need for monitoring every two hours to keep him safe from falls. CMS Ex. 19 at 26-27. They say that he is independent in bed mobility and transfers (other than while in the bath), even though his assessment says that he requires assistance. CMS Ex. 19 at 14-15, 45. Moreover, the facility understood that Bennett Homes kept no medical records. Yet, I see no evidence that it considered how that home would monitor dietary intake, bleeding/bruising, and lab values, notably his PT/INR values, if it kept no such records.

The undisputed evidence establishes that the facility discharged these residents without regard for their assessments and care plans. Rather than following the instructions of the facility's own interdisciplinary teams – not to mention state office charged with approving placement for those with mental impairments – the facility relied on the opinion of an unlicensed, unqualified individual regarding whether the placement would be appropriate. Petitioner offers no evidence that it even considered whether Bennett Homes had in place the staff and systems needed to provide the care called for in the transferred residents' assessments and care plans. The facility is not penalized because Bennett Homes failed to provide necessary care and services; it is penalized because it sent vulnerable residents to places that, as any reasonable observer could see, were not capable of providing them the care and services they needed.

Thus, in transferring its residents, the facility did not assure that they would receive necessary care and services to allow them to attain or maintain the highest practicable physical, mental, and psychosocial well-being, as required by 42 C.F.R. § 483.25.

<u>Errors in transfer process</u>. CMS claims that, even though her transfer form says that "meds will be sent with [resident], the facility did not send **R101's** anti-viral medications with her to the Bennett Home. CMS Ex. 16 at 7; *but see* CMS Ex. 16 at 37 (indicating in the nurse's discharge note that the new provider would furnish R101's medication). Nor did the facility respond to her repeated calls asking about the medication. In fact, she was without that medication, necessary to treat her HIV, for eight days. CMS Ex. 85 at 4 (Tanner Decl. ¶ 16). Eventually, according to CMS, the facility sent her a bottle of Norvir (an antiretroviral drug used to treat HIV), with someone else's name on it. CMS Ex. 85 at 4 (Tanner Decl. ¶ 18).

Petitioner's witness, Leeneta Ingraham, denies that R101 did not have her HIV medications. She says that the resident came from the facility with her medication, although Bennett Homes had to call the facility to get "the refill bottle for one of her medications" and the bottle the facility sent had someone else's name on it, "but she had enough medication until we got that straightened out as there was more than one bottle of that medication." P. Ex. 5 at 1-2 (Ingraham Decl. ¶ 6).

CMS also charges that, in discharging **R104**, the facility did not provide him with a glucometer, with which to check his blood sugar levels, and did not send his Novolin (insulin) with him. Petitioner does not challenge CMS's charge regarding the glucometer and concedes that R104 had no insulin at the time of his arrival, but dismisses this as insignificant because "he got his insulin within a day or two." P. Ex. 5 at 1 (Ingraham Decl. ¶¶ 4, 5).

Again, for purposes of summary judgment, I accept as true Petitioner's claims, which means that: (1) the facility sent R101 a bottle of medication that had someone else's name on it; (2) the facility discharged R104 without the equipment needed to test his blood sugar; and (3) the facility discharged R104 without his insulin. Thus, contrary to Petitioner's claim, the facility did not consistently transfer the residents' medications to their new placements.

I do not agree that these errors were insignificant. Sending a resident a prescription medication with someone else's name on it is a dangerous practice. It means that either R101 received medications meant for someone else, or someone mislabeled her own medications. In either case, the facility violated professional standards of quality for administering medications and placed the resident at risk. That R104 had no immediate need for insulin was fortuitous, but sending a diabetic away without the means for testing his blood and without critical medications puts him in jeopardy.

Finally, the parties agree that the facility sent R104 to foster care despite his elevated PT/INR levels. His physician ordered new blood testing on September 17 and discontinued his Coumadin pending the outcome of those tests. According to CMS, Bennett Homes continued to administer Coumadin and did not test the resident's PT/INR levels as ordered. CMS Ex. 85 at 5 (Tanner Decl. ¶¶ 22, 23); CMS Br. at 11. Petitioner points out that its transfer form says to hold the Coumadin pending the results of PT/INR "which needs to be drawn on 9/17/10." CMS Ex. 19 at 45. In Petitioner's view, so long as the facility told Bennett Homes to hold the Coumadin and schedule the blood draw, it fulfilled its responsibilities. P. Br. at 16. I disagree.

Petitioner recognizes that the physician's order should have been followed and does not dispute CMS's assertion that the administration of Coumadin requires "constant and meticulous" attention to keep the resident safe from either bleeding out or forming a clot. *See* CMS Br. at 11. Here, in light of his elevated PT/INR levels, the resident was

especially susceptible to uncontrolled bleeding. The facility discharged him to Bennett Homes on the evening of September 16; his blood should have been tested the following day, literally within hours of his departure from the facility. CMS Ex. 19 at 35. At a minimum, the facility had a duty to ensure that arrangements were already in place to do so. Petitioner comes forward with no evidence suggesting that the facility did more than jot an instruction on the transfer sheet; it did not verify that Bennett staff (who were not medical professionals) would immediately review the transfer documents or were otherwise aware of the physician orders and had made arrangements for the blood draw.

Thus, the undisputed evidence establishes that the facility did not ensure that its residents received the care and services necessary for them to attain/maintain the highest practicable physical, mental and psychosocial well-being, in accordance with their assessments and plans of care; and it did not provide timely and adequate notice of discharge to its residents. It did not prepare them or orient them in a manner that would ensure their safe and orderly transfer. The facility was therefore not in substantial compliance with 42 C.F.R. §§ 483.12 and 483.25.

Finally, as the Departmental Appeals Board (Board) has observed, a finding of substantial noncompliance in the facility's administration may derive from findings of substantial noncompliance in other areas.

> [W]here a facility has been shown to be so out of compliance with program requirements that its residents have been placed in immediate jeopardy, the facility was not administered in a manner that used its resources effectively to attain the highest practicable physical, mental, and psychosocial well-being of each resident.

*Asbury Ctr. at Johnson City*, DAB No. 1815 at 11 (2002); *Odd Fellow and Rebekah Health Care Facility*, DAB No. 1839 at 7 (2002); *Stone County Nursing and Rehab. Ctr*., DAB No. 2276 at 15-16 (2009). As discussed below, I find that the facility's deficiencies posed immediate jeopardy to resident health and safety, which, by itself, justifies the finding that the facility was not in substantial compliance with 42 C.F.R. § 483.75. Moreover, the failures here were not attributable to any one individual or even group of individuals, but derived from an ill-advised facility-wide practice, geared toward discharging all residents. The facility was therefore not administered in a manner that used its resources effectively to attain or maintain the highest practicable physical, mental and psychosocial well-being of its residents and was therefore not in substantial

compliance with 42 C.F.R. § 483.75.[14]

### *B. CMS's determination that, from September 15 through October 1, 2010, the facility's deficiencies posed immediate jeopardy to resident health and safety is not clearly erroneous.*

Immediate jeopardy exists if a facility's noncompliance has caused or is likely to cause "serious injury, harm, impairment, or death to a resident." 42 C.F.R. § 488.301. CMS's determination as to the level of a facility's noncompliance (which would include an immediate jeopardy finding) must be upheld unless it is "clearly erroneous." 42 C.F.R. § 498.60(c). The Board has observed repeatedly that the "clearly erroneous" standard imposes on facilities a "heavy burden" to show no immediate jeopardy, and has sustained determinations of immediate jeopardy where CMS presented evidence "from which '[o]ne could reasonably conclude' that immediate jeopardy exists." *Barbourville Nursing Home*, DAB No. 1931 at 27-28 (2004) (*citing Koester Pavilion*, DAB No. 1750 (2000)); *Daughters of Miriam Ctr.*, DAB No. 2067 at 7, 9 (2007).

Here, medical professionals assessed and developed care plans for seriously impaired residents. Based on the judgments of these professionals, the residents required services available only in a skilled nursing facility. Even a cursory review of their care plans shows the high level of care they needed to remain safe. Yet, after providing minimal notice to the residents, their guardians and their families, the facility transferred them to unlicensed homes. Petitioner does not claim to have independently assessed whether the foster care homes were capable of meeting the residents' extensive needs. Rather, it relied on the judgment of the homes' owner/manager – a woman who claims no degrees, licenses, or certifications in any discipline – to override the residents' assessments and care plans. P. Br. at 9; P. Ex. 4 at 1 (Bennett Decl. ¶¶ 2, 6-8).

Such total disregard for a resident's assessment and care plan is likely to cause serious injury or harm, and CMS's immediate jeopardy determination is therefore not clearly erroneous.

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[14] I have not here considered all of the deficiencies cited, because the findings I make more than justify the penalty imposed. *Senior Rehab. & Skilled Nursing. Ctr.*, DAB No. 2300 at 6, n.5 (2010), *aff'd, Senior Rehab. & Skilled Nursing Ctr.*, 405 F. App'x 820 (5th Cir. 2010).

***C. CMS's determination as to the duration of the periods of noncompliance and immediate jeopardy are consistent with statutory and regulatory requirements.***

Petitioner concedes that the facility was not in substantial compliance with program requirements at the time of the September 10, 2010 survey and that its deficiencies then posed immediate jeopardy to resident health and safety. Petitioner argues, however, that it corrected those deficiencies as of September 17, 2010. P. Br. at 2, 5-7. Pointing to a September 27, 2010 letter, Petitioner claims that the State Agency found that it was in substantial compliance with program requirements on September 17, 2010. P. Br. at 5-7.

Petitioner misinterprets the letter and the law. Based on a partial survey (investigating multiple complaints), completed September 10, 2010, the State Agency determined that the facility was not in substantial compliance with program requirements and that its deficiencies posed immediate jeopardy to resident health and safety. P. Ex. 1. The facility removed the immediate jeopardy on the date of the survey, but its substantial non-compliance continued, because it had not corrected deficiencies cited during earlier surveys. On September 17, the surveyors revisited the facility and determined that those specific deficiencies had been corrected, but they did not find that the facility had achieved substantial compliance. To the contrary, as the State Agency's September 27, 2010 notice letter points out, correcting the cited deficiencies, by itself, does not mean that the facility has achieved substantial compliance; facilities must remain in substantial compliance. The "regulations emphasize the need for continued compliance, rather than cyclical compliance." The facility must not only remedy deficient practices, but must "also ensure that correction is permanent." P. Ex. 2 at 3; 42 C.F.R. § 488.454(e); *Hermina Traeye Mem'l Nursing Home*, DAB No. 1810 at 12 (*citing* 42 C.F.R. §488.456(a), (e)); *Cross Creek Care Ctr.*, DAB No. 1665 (1998).

Further, the State Agency recommended that the penalties imposed, including a $1,150 per day CMP, continue until the date of the facility's termination and said that the "imposed enforcement remedies remain in effect until [the State Agency] makes a determination that your facility has achieved and maintained substantial compliance with all Federal and State regulatory requirements for Long Term Care facilities." P. Ex. 2 at 2, 3. Such penalties are imposed only if a facility is not in substantial compliance with program requirements. 42 C.F.R. §§ 488.400, 488.402, 488.406.

I note also that the September 17 revisit had a limited purpose. The surveyors were not conducting a full survey; they looked specifically at the previously-cited deficiencies. As the above-discussion establishes, the facility's practices in discharging R101, R102, R103, and R104 were riddled with errors, posing immediate jeopardy to the discharged residents. These deficient practices were taking place on and after September 17, 2010.

Finally, even if I agreed that the state found the facility in substantial compliance as of September 17 (which I do not), CMS ultimately determines whether a facility has achieved substantial compliance. If the CMS and the state disagree, CMS's findings of noncompliance take precedence. 42 C.F.R. § 488.452(a)(2).

Thus, as a matter of law, the facility did not achieve substantial compliance as of September 17, 2010, nor at any other time.

***D. The penalties imposed are reasonable.***

To determine whether a CMP is reasonable, I apply the factors listed in 42 C.F.R. § 488.438(f): 1) the facility's history of noncompliance; 2) the facility's financial condition; 3) factors specified in 42 C.F.R. § 488.404; and 4) the facility's degree of culpability, which includes neglect, indifference, or disregard for resident care, comfort or safety. The absence of culpability is not a mitigating factor. The factors in 42 C.F.R. § 488.404 include: 1) the scope and severity of the deficiency; 2) the relationship of the deficiency to other deficiencies resulting in noncompliance; and 3) the facility's prior history of noncompliance in general and specifically with reference to the cited deficiencies. I am neither bound to defer to CMS's factual assertions, nor free to make a wholly independent choice of remedies without regard for CMS's discretion. *Barn Hill Care Ctr.*, DAB No. 1848 at 21 (2002); *Cmty. Nursing Home*, DAB No. 1807 at 22 *et seq*. (2002); *Emerald Oaks*, DAB No. 1800 at 9 (2001); *CarePlex of Silver Spring*, DAB No. 1638 at 8 (1999).

Here, from the time the facility decided to close rather than correct its deficiencies, its financial interests dictated that it discharge its residents as quickly as possible, so that the daily penalty would no longer accrue. This gives a facility a powerful incentive to disregard the regulations in the interest of speed. The penalty imposed under these circumstances must therefore be substantial enough to deter facilities from hasty and ill-advised discharges.

CMS has imposed a penalty of $10,000 per day, the maximum per-day penalty for the period of immediate jeopardy ($3,050 – $10,000). I recognize that the maximum penalty is reserved for the most egregious cases. The remaining penalty – $1,600 per day for the period of substantial noncompliance that was not immediate jeopardy – is in the middle of the penalty range ($50-$3,000). 42 C.F.R. §§ 488.408(d), 488.438(a)(1).

The facility's dismal compliance history would justify almost any penalty. From May 19, the facility was continuously out of substantial compliance, and its deficiencies twice posed immediate jeopardy to resident health and safety. One period of immediate jeopardy lasted 25 days. CMS Ex. 1; CMS Ex. 94 at 1-7. In July 2010, the facility's quality-of-care deficiencies (42 C.F.R. § 483.25, Tag F309) posed immediate jeopardy to resident health and safety. CMS Ex. 3. Even though CMS imposed penalties of up to

$10,000 per day, the amounts were nevertheless insufficient to produce necessary corrections. CMS Ex. 1. Thus, the facility's history alone justifies a significant penalty.

Petitioner does not claim that its financial condition affects its ability to pay the CMP.

I need not even consider the remaining factors to sustain the penalties imposed. But I consider the deficiencies very serious. The facility simply ignored assessments and care plans, thus disregarding the care, comfort and safety of its residents. It sent residents to foster care, without considering whether those unlicensed homes were capable of providing adequate care. For this the facility is highly culpable.

## IV. Conclusion

I grant CMS's motion for summary judgment because the undisputed evidence establishes that, from September 15 through October 21, 2010, the facility remained out of substantial compliance with program requirements; from September 15 through October 1, 2010, its deficiencies posed immediate jeopardy to resident health and safety, and the penalties imposed ($10,000 per day for 17 days of immediate jeopardy and $1,600 a day for substantial noncompliance that was not immediate jeopardy) are reasonable.

/s/
Carolyn Cozad Hughes
Administrative Law Judge