Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

The Green House Cottages of Southern Hills
(CCN: 04-5377),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-14-730

Decision No. CR3437

Date: October 28, 2014

DECISION

I. Introduction

I enter summary judgment in favor of the Centers for Medicare & Medicaid Services (CMS) and sustain imposition of the following remedies against Petitioner, The Green House Cottages of Southern Hills:

- A per-instance civil money penalty of $2000;
- A per-diem civil money penalty of $5050 for each day of a period that began on October 9, 2013 and that ran through November 7, 2013; and
- A per-diem civil money penalty of $500 for each day of a period that began on November 8, 2013 and that ran through December 4, 2013.

I base my decision on undisputed material facts establishing that Petitioner, a skilled nursing facility doing business in the State of Arkansas, failed to comply with Medicare participation requirements. The findings of noncompliance were made at surveys of Petitioner's facility that were completed on September 13 and November 14, 2013.[1]

CMS offered exhibits that it identified as CMS Ex. 1 – CMS Ex. 3, CMS Ex. 6, CMS Ex. 15, CMS Ex. 19 – CMS Ex. 21, CMS Ex. 23 – CMS Ex. 27, CMS Ex. 30 – CMS Ex. 41, and CMS Ex. 47 – CMS Ex. 53. Petitioner offered exhibits that it identified as P. Ex. 1 – P. Ex. 30. I receive all of these exhibits for purposes of deciding CMS's motion for summary judgment.

II. Issues, Findings of Fact and Conclusions of Law

A. Issues

The issues in this case are whether undisputed material facts establish that: Petitioner failed to comply substantially with Medicare participation requirements; CMS's determination of immediate jeopardy noncompliance is clearly erroneous; and CMS's remedy determinations are reasonable.

B. Findings of Fact and Conclusions of Law

CMS alleges the following instances of noncompliance by Petitioner with Medicare participation requirements:

- *Failure to comply with the requirements of 42 C.F.R. § 483.25.* This regulation directs that each resident of a skilled nursing facility must receive and the facility must provide the necessary care and services so that the resident attains or maintains the highest practicable physical, mental, and psychosocial well-being, in accordance with the resident's comprehensive assessment and plan of care. CMS asserts that it determined at the survey ending September 13 that Petitioner failed to comply with the regulation in that it failed to administer pain medication to a resident who is identified as Resident # 9, in accordance with the resident's physician's orders. CMS bases the $2000 per-instance civil money penalty determination on this noncompliance assertion.

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[1] On November 21, 2013 there was a third survey of Petitioner's facility resulting in noncompliance findings. CMS, however, appears not to be basing any of its remedy determinations on the findings that were made at this survey and it has offered no evidence pertaining to it. Petitioner moved for summary judgment as to the November 21, 2013 survey findings and I grant Petitioner's motion.

- *Failure to comply with the requirements of 42 C.F.R. §§ 483.13(b) and (c)(1)(i).* These two subsections effectively prohibit a facility or any member of its staff from abusing a resident, either mentally or physically. CMS asserts that it determined at the November 14 survey that a member of Petitioner's staff, a certified nursing assisted who is identified as CNA # 5, engaged in unchecked abuse of several of Petitioner's residents. CMS asserts further that the noncompliance was so egregious as to cause immediate jeopardy for Petitioner's residents. CMS bases the $5050 and $500 per-diem civil money penalty determinations on this allegation of noncompliance and the ones that follow.

- *Failure to comply with the requirements of 42 C.F.R. §§ 483.13(c)(1)(ii) – (iii), (c)(2), (c)(3), and (c)(4).* These subsections, read together in relevant part, establish investigation and reporting requirements for a skilled nursing facility when confronted with allegations or suspicions of abuse.[2] Subsection (c)(2) requires all abuse allegations to be reported promptly to a facility's administrator and to State authorities in accordance with State law. Subsection (c)(3) requires a facility to investigate thoroughly all allegations of abuse and to protect its residents from abuse while investigations are ongoing. Subsection (c)(4) imposes reporting requirements on skilled nursing facilities of the results of abuse investigations. CMS alleges that it determined at the November 14 survey that Petitioner failed to comply with these requirements in that it failed to investigate thoroughly injuries sustained by a resident who is identified as Resident # 1. It alleges further that Petitioner failed timely to report incidents of resident abuse to Arkansas authorities in accordance with State law. CMS alleges that this noncompliance was so egregious as to put residents at immediate jeopardy.

- *Failure to comply with the requirements of 42 C.F.R. § 483.13(c).* This allegation also arises from the November 14 survey and CMS contends that Petitioner's noncompliance was at the immediate jeopardy level. The regulation requires a skilled nursing facility to develop and implement policies that protect residents against abuse, mistreatment, and neglect. CMS asserts that Petitioner failed to comply with this regulation in that it failed to implement its own abuse policy.

[2] In fact, 42 C.F.R. §§ 483.13(c)(1)(ii) and (iii) have no relevance here. These subsections prohibit a facility from employing any individual who has been convicted of abusing, neglecting, or mistreating residents and they impose reporting requirements on a facility when it becomes aware of an adverse finding relating to abuse, neglect, or mistreatment by a court of law. CMS makes no allegations that CNA # 5 had a record of a conviction for abuse or that Petitioner was aware of such a record and failed to report it.

Specifically, CMS contends that Petitioner failed to implement its policy because its staff failed to report to Petitioner's administrator suspected resident abuse. CMS alleges that Petitioner also violated its anti-abuse policy by failing to interview Resident # 1 and other individuals with potential knowledge when it investigated allegations of abuse of that resident.

- *Failure to comply with the requirements of 42 C.F.R. § 483.75.* This is another noncompliance allegation, at the immediate jeopardy level, arising from the November 14 survey. The regulation at issue requires a skilled nursing facility to 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. CMS alleges that Petitioner's management failed repeatedly to ensure that its staff carried out policies that protected residents against abuse.

The undisputed material facts strongly substantiate CMS's noncompliance allegations and I sustain them. Additionally, these facts support CMS's assertions of immediate jeopardy and I sustain them as well. Finally, the undisputed material facts support CMS's remedy determinations.

The undisputed facts relating to Petitioner's noncompliance with the requirements of 42 C.F.R. § 483.25 are that Petitioner's staff failed to administer a pain relieving medication to Resident # 9 that had been prescribed to the resident by his physician. On the morning of September 10, 2013, the physician ordered the staff to discontinue administering hydrocodone 7.5/500 milligrams (mg) to the resident and to give him 650mg of Lorcet-10 every four hours as needed. CMS Ex. 14 at 6. This medication change represented an increased dosage of narcotics for pain management. CMS Ex. 52 at 13. The facility's Medication Administration Record shows that its staff did not provide any pain medication to Resident # 9 during the day after 8:15 a.m. on September 10. CMS Ex. 14 at 6. Petitioner argues that its staff checked on Resident #9 during the day and he denied pain that needed control with the prescribed pain medication. I accept that as true for the purpose of summary judgment. However, in the evening of September 10 an Arkansas State agency surveyor observed the resident complaining of pain during and immediately after the staff's attempt to move him. CMS Ex. 52 at 10. After approximately one hour, Petitioner's staff gave the resident a dosage and medication (Lortab) that was not part of the resident's current prescription and not the Lorcet-10 that had been prescribed by the resident's physician. CMS Ex. 14 at 10. The resident's treatment records do not show that the staff ever offered the appropriate medication to the resident on September 10. *Id.* As a result, Petitioner's staff provided a lower dosage of pain medication than what the physician had ordered to control Resident #9's pain.

Petitioner does not deny these facts. Rather, Petitioner responds by asserting that its staff regularly administered pain medication to Resident # 9 as needed and appropriately on September 10, 2013. That assertion begs the question, however. That the staff may have given pain medication to the resident at certain times is clear. But, the staff did not give the resident the medication for over an hour when the resident complained of pain on September 10, and when they eventually did, it was not the proper amount of pain medication that the physician had prescribed. Staff did not document any justification for its failure to do so. Obviously, there was a reason for the physician changing the resident's pain medication to Lorcet-10. The physician's order allowed no room for the staff to substitute their judgment for that of the physician and to give the resident something other than precisely what had been ordered. The staff's failures to provide the prescribed dose of pain medication to the resident when he complained of pain and to carry out the physician's order are inconsistent with providing him the care and services necessary to maintain his highest level of well-being and are patent regulatory violations.

The undisputed facts establish that CNA # 5 carried out something akin to a reign of terror against Petitioner's residents, a reign that went unchecked until Arkansas State agency surveyors uncovered it. There is a mass of evidence – which was not rebutted in the least by Petitioner – that establish several instances in which CNA # 5 brutalized residents of the facility. The CNA's conduct was abusive in every sense of the word, and it falls squarely within the regulatory definition of "abuse," the willful infliction of harm or injury. 42 C.F.R. § 488.301. Such abuse is a plain violation of the requirements of 42 C.F.R. §§ 483.13(b) and (c)(1)(i).

- CNA # 5 verbally and physically abused Resident # 4, an individual who was cognitively impaired, at risk for malnutrition, and who expressed extreme anxiety, especially at mealtimes. CMS Ex. 31 at 1, 6, 43.
  - The resident's daughter reported that CNA # 5 made derogatory statements to her about her mother. CMS Ex 51 at 3; P. Ex. 8 at 5.
  - Petitioner's certified dietary manager reported that the CNA made insulting comments to the resident as the resident attempted to eat. CMS Ex. 51 at 3.
  - Another CNA, CNA # 7, reported that she had witnessed CNA # 5 slap Resident # 4 on the side of her head. *Id.*; P. Ex. 11 at 2.
- CNA # 5 verbally abused Resident # 13, an individual who suffered from anxiety and depression along with severe physical impairments.

  - Two other CNAs, CNA # 6 and CNA # 7, observed CNA # 5 threatening the resident, telling the resident that she would not provide assistance to the resident if the resident used the call light to request assistance in going to the bathroom. CMS Ex. 51 at 3; P. Ex. 12 at 3.

- CNA # 5 physically abused Resident # 14, a totally dependent individual who suffered from, among other things, cerebral palsy that caused the resident to experience severe physical and cognitive impairments. CMS Ex. 34 at 1.

  - CNA # 6 and CNA # 7 observed CNA # 5 on several occasions physically forcing Resident # 14 to eat by holding down the resident's arms, forcing food into her, and refusing to let her drink until she ate. CMS Ex. 34 at 5-6.

- CNA # 5 verbally abused Resident # 15, an individual who suffered from dementia that produced behavioral disturbances. CMS Ex. 35 at 1.

  - CNA # 6 and CNA # 7 reported seeing CNA # 5, as she was providing care to the resident, tell the resident to "shut up" and to lie down. *Id.* at 5-6.

Petitioner has offered no specific facts that rebut the foregoing. It has offered three notices from the Arkansas Office of Long Term Care to CNA # 5 – after she had been fired from Petitioner's facility – stating that three abuse allegations against her were "unfounded." P. Ex. 1. But the notices do not explain what standard the agency used to reach that result, the evidence it had before it, or which three out of the several abuse allegations were unfounded. Nor does it offer any determinations about the remaining allegations. In addition, Petitioner asserts that it disputes the assertions of CNAs # 6 and # 7. But, it offers no facts of its own that would show or even suggest that these statements are inaccurate. It also asserts that its director of nursing will offer testimony that refutes the CNAs' statements. But, the written direct testimony of Petitioner's director of nursing contains nothing of the sort. P. Ex. 28. I directed the parties to file *all* of their witnesses' proposed testimony in writing. The failure of Petitioner's director of nursing to respond to the CNAs' assertions in her written direct testimony cannot now be cured by promised testimony because that testimony is inadmissible.[3]

In deciding a motion for summary judgment I am required to draw all possible inferences from the facts before me that are favorable to the opposing party even if it is unlikely that I would draw those inferences after an on the record hearing. But, I am not required to draw inferences from bald assertions that are not backed up by admissible evidence. A

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[3] Petitioner had a full month's notice of CMS's evidence and had plenty of opportunity to produce a statement from its director of nursing addressing the allegations of CNA # 6 and CNA # 7.

party cannot refute facts offered by the moving party simply by denying them. Looking at Petitioner's response to the allegations concerning abuse, I see nothing other than bald denials. Given that, there are no inferences that I can draw that are favorable to Petitioner.[4]

The undisputed facts also establish that Petitioner failed to comply with the abuse investigation/reporting requirements of 42 C.F.R. §§ 483.13(c)(2), (c)(3), and (c)(4). They establish that Petitioner failed to: conduct a complete and thorough investigation into injuries sustained by Resident # 1; and report timely to appropriate State authorities the results of investigations into abuse sustained by other residents at the hands of CNA # 5.

Resident # 1 was a dependent individual, beset with numerous medical problems that included the residuals of a fractured hip, anemia, and dementia. CMS Ex. 30 at 1. On October 9, 2013 the resident complained of leg pain. She revealed a grapefruit-size swelling on her lower right leg that was determined subsequently to be a broken tibia. *Id.* at 18-19.

Petitioner launched an investigation into the possible cause of the resident's injuries. During that investigation Petitioner's management interviewed members of the staff, all of whom denied knowing the cause or source of the resident's injury. CMS Ex. 30 at 33-34. The management eventually concluded that the resident's injury was a consequence of osteoporosis or some unknown event.

What Petitioner's management did *not* do was significant because there were key individuals who Petitioner never interviewed. Petitioner failed to interview: Resident # 1; the driver of the van who transported the resident to the hospital on October 19; or the resident's physician.

Regulations require that any investigation into suspected abuse be "thoroughly investigated." 42 C.F.R. § 483.13(c)(3). The term is not susceptible to widely disparate interpretations. A thorough investigation necessitates in depth interviews of every individual who might have knowledge of the cause of a resident's injury.

Here, key individuals plainly were not interviewed. The resident – albeit demented – might have been able to provide critical information about the cause of her injury. In fact, three weeks after her fractured leg, Resident # 1 told CNA #6 and CNA #7 that CNA #5 had pushed her into the toilet, which caused her to hurt her leg. P. Ex. 28 at 5. There is no record of anyone asking her before then about how she injured her leg, so it

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[4] Even if I inferred based on the vague notices that that three instances of abuse by CNA # 5 were not true, that leaves other instances of abuse (outlined above) that these notices do not address at all and for which there is no other contradictory evidence.

became nearly impossible, three weeks later, to determine the truth of her claim that a staff member violently assaulted her. Similarly, the resident's treating physician, a person with intimate knowledge of the injury, might have been in a position to opine whether the resident's fracture was caused by the kind of blunt force that is associated with abuse. The van driver might have talked to the resident during her drive to the hospital and might have learned something from the resident during that trip. Indeed, the van driver, apparently in transferring the resident, had told a licensed practical nurse at Petitioner's facility that Resident # 1 said she fell in the shower. CMS Ex. 30 at 35. But there were no further inquiries about how the van driver knew that or what other information he or she might have had. *Id*.

Petitioner's oversight was not trivial. The very real possibility existed that Resident # 1 – frail and helpless – was the victim of an assault by someone in Petitioner's facility. At a minimum, Petitioner owed a duty to Resident # 1 to do everything possible to ascertain the cause of the resident's injury. Moreover, the possibility existed, as evidenced by the injury sustained by the resident, that there was an extremely abusive individual on the loose on Petitioner's premises. Petitioner owed a duty, not just to Resident # 1, but to all other residents as well to determine the cause of the resident's injury by conducting a thorough investigation and not presumptively dismissing potential and critical witnesses.

It is also evident that Petitioner failed to report the findings of other investigations as is required by Arkansas law, and that failure is a violation of the requirements of 42 C.F.R. § 483.13(c)(2) and (c)(4). *See* Ark. Code § 12-12-1708. Petitioner failed to identify allegations of CNA #5 verbally intimidating or humiliating residents as possible verbal abuse. *See* P. Exs. 8, 9, 12. Petitioner also failed to report timely and accurately the results of investigations into abuse perpetrated against residents by CNA # 5 and offered no excuse for its failure to do so. CMS Ex. 51 at 5.

Petitioner has offered no meaningful response to this evidence. Its essential response to CMS's motion for summary judgment is to attack the credibility of CNA # 6 and # 7. I have discussed above why denying the truth of witnesses' assertions is not a defense to a motion for summary judgment absent any evidence that establishes the witnesses not to be credible. As I have explained, a bald denial is never sufficient to rebut admissible evidence when that evidence establishes material facts that are the basis for the motion. Furthermore, CMS's assertions about Petitioner's failure to comply with investigation and reporting requirements have nothing to do with the statements of the two CNAs. Their statements are not the basis for the allegations.

The uncontroverted facts offered by CMS additionally show a failure by Petitioner to comply with the requirements of 42 C.F.R. § 483.13(c). Petitioner failed to follow its own policies respecting investigating and reporting of incidents of possible abuse.

Petitioner's policy governing possible abuse of residents essentially tracks the requirements of 42 C.F.R. § 483.13(c)(2), (c)(3), and (c)(4). The facility pledges that its administrator or an employee designated as its compliance officer will immediately investigate any allegation of abuse. The policy explicitly directs the person conducting an investigation to interview and document in detail an affected resident's account of an allegedly abusive episode. CMS Ex. 48 at 4.

Petitioner plainly failed to comply with its own policy in investigating the possible abuse of Resident # 1 because it never interviewed that resident. True, the resident was demented and her dementia might have called into question the reliability of her statements. But, the resident was able to communicate. At a minimum, Petitioner owed it to the resident to get her side of the story as best as it could. Statements given by the resident might have proved valuable. But, Petitioner never made the effort.

Petitioner's policy also requires its staff to report immediately to the facility administrator all incidents that might comprise abuse. CMS Ex. 48 at 1. Petitioner's staff failed to discharge this responsibility by not immediately reporting episodes of abuse, at least in the case of abuse perpetrated by CNA # 5 against Resident # 13. CNA # 7 admitted that, although she had witnessed abuse, she'd never reported it. CMS Ex. 21 at 18.

I find no controverted facts from which I can draw inferences favorable to Petitioner. It failed to offer any affirmative proof that it complied with its abuse policies. In particular, Petitioner has not denied that its management failed to interview Resident # 1.

Finally, the facts offered by CMS strongly support a finding that Petitioner was not efficiently and effectively administered as is required by 42 C.F.R. § 483.75. That is evident in Petitioner's failure to protect its residents against the depredations of CNA # 5, its failure to investigate thoroughly the cause of the injury sustained by Resident # 1, its failure to report to the State all abuse allegations and investigations timely and accurately, and its failure to comply with its own abuse policy. All of these areas are areas that are or should be subject to direction and guidance by Petitioner's management and such direction and guidance clearly was lacking.

CMS determined the deficiencies established at the November 14 survey posed immediate jeopardy for Petitioner's residents. "Immediate jeopardy" is defined at 42 C.F.R. § 488.301 to be noncompliance that has caused or is likely to cause serious injury, harm, impairment, or death to a facility resident. I find that the uncontroverted material facts of this case establish that all of the November 14 deficiencies were at the immediate jeopardy level. Consider the situation that prevailed at Petitioner's facility: a highly abusive individual was employed by Petitioner and that individual was acting, essentially unchecked, to perpetrate abuse against frail and dependent residents. Her abuses included physical abuse in which she struck at least one resident and verbal abuse. The repeated episodes of abuse that this employee committed put residents at risk, not only

for bodily harm, but for psychological harm as well. This is not simply a case where there was a likelihood of serious harm. There was *actual serious harm* being perpetrated by CNA # 5. And, despite that, Petitioner's management did little to protect the facility's residents. Compounding the problem was the failure by management to investigate incidents of abuse thoroughly and to report to State authorities the abusive acts in the facility.

Petitioner argues that there is no basis to find immediate jeopardy level noncompliance. Its premise is that the whole case for immediate jeopardy rests on the unbelievable assertions of CNA # 7. I disagree with that characterization of CMS's case. The evidence of noncompliance pertaining to Petitioner's failure to investigate abuse has nothing whatsoever to do with CNA # 7's assertions about what she witnessed. Furthermore, and as I have discussed, denying CNA # 7's assertions does not create a fact controversy in the absence of any facts that show that CNA # 7's reports are not credible. Petitioner, as I have noted, now says that its director of nursing is prepared to testify that CNA # 7 is not credible. But, the written direct testimony of the director of nursing says nothing of the kind and the time has long since passed when Petitioner can offer new evidence in this case.

I find the remedies in this case to be reasonable. Petitioner has not challenged the duration of its noncompliance. It has not asserted that it corrected deficiencies earlier than was found to be the case by CMS. Consequently, the duration of remedies is not an issue in this case. What remains at issue is the penalty amounts – that is to say, whether the per-instance and per-diem civil money penalty amounts are reasonable.

Penalty amounts are governed by regulation. Per-instance civil money penalties are assessed at amounts that fall within a range of from $1000 to $10,000 per instance of noncompliance. 42 C.F.R. § 488.438(a)(2). Per-diem civil money penalties for immediate jeopardy level noncompliance are assessed at amounts that fall within a range of from $3050 to $10,000 for each day of noncompliance. 42 C.F.R. § 488.438(a)(1)(i). Per-diem civil money penalties for non-immediate jeopardy level noncompliance are assessed at amounts that fall within a range of from $50 to $3000 for each day of noncompliance. 42 C.F.R. § 488.438(a)(1)(ii).

There are regulatory factors that may be used to decide where within the foregoing ranges a penalty amount should fall. These factors may include: the seriousness of the noncompliance; a facility's noncompliance history; its culpability; and its financial condition. 42 C.F.R. §§ 488.438(f)(1) – (4); 488.404 (incorporated by reference into 42 C.F.R. § 488.438(f)(3)).

The seriousness of Petitioner's noncompliance more than justifies the amounts of the penalties that were imposed here. The immediate jeopardy level noncompliance manifested at the November 14 survey was egregious. Residents of Petitioner's facility

were harmed, seriously, by the depredations of CNA # 5 and Petitioner allowed this abusive conduct to go unchecked. As I have discussed, Petitioner allowed the CNA to perpetrate a reign of terror against several frail and grievously ill residents. A penalty amount of $5050 per day is actually very modest in light of the fact that the harm was so egregious; it is only about one-half of the maximum allowable civil money penalty amount for immediate jeopardy level noncompliance. I find also that the $2000 per-instance civil money penalty that was imposed for the noncompliance found at the September 13 survey is reasonable. Petitioner's staff disregarded an explicit physician's order by failing to give a resident medication that the physician had prescribed and by giving a non-prescribed medication to that resident. The potential for harm from such misfeasance is evident. Finally, I find that the $500 per-diem penalty amount for the period after November 7, 2013 is reasonable. As I have stated, Petitioner has not alleged that it cured its deficiencies on or before November 7. Those deficiencies were serious even if they were not at the immediate jeopardy level of noncompliance. The post-November 7 penalty amount of $500 per day is not only reasonable but extremely modest, constituting only one-sixth of the maximum that CMS could have imposed.

Petitioner argues that the penalty amounts are unreasonable. But, it has not offered evidence showing why the penalty amounts are unreasonable. It contends that it has a relatively good compliance history. However, CMS has offered evidence showing that Petitioner was cited for a medication-related deficiency as recently as May 2013. CMS Ex. 50 at 1-2. Even if I considered this a "good" compliance history, which I don't, Petitioner's past history does not offset the egregiousness of the noncompliance that I have found here. Petitioner argues also that the penalty amounts will have a severe financial impact on it. But, it has offered no evidence proving that to be the case.

/s/

Steven T. Kessel
Administrative Law Judge