Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Burlington House Nursing Home,
(CCN: 36-5892),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-13-518

Decision No. CR4599

Date: May 3, 2016

DECISION

Burlington House Nursing Home (Burlington or Petitioner) challenges the Centers for Medicare & Medicaid Services' (CMS) determination that it was not in substantial compliance with the Medicare program participation requirements that a skilled nursing facility (SNF) immediately report to its administrator and the state survey agency the mistreatment, neglect, or abuse of a resident. 42 C.F.R. § 483.13(c). Burlington also challenges CMS's imposition of a $55,200 civil money penalty (CMP). For the reasons discussed below, I affirm CMS's determination.

I. Background

The Social Security Act (Act) sets forth requirements for a SNF's participation in the Medicare program and authorizes the Secretary of Health and Human Services (the Secretary) to promulgate regulations implementing those statutory provisions. 42 U.S.C. § 1395i-3. The Secretary's regulations are found at 42 C.F.R. Parts 483 and 488. To participate in the Medicare program, a SNF must maintain substantial compliance with program participation requirements. To be in substantial compliance, a SNF's

deficiencies may "pose no greater risk to resident health or safety than the potential for causing minimal harm." 42 C.F.R. § 488.301. "Noncompliance" means "any deficiency that causes a facility to not be in substantial compliance." *Id*.

The Secretary contracts with state agencies to conduct periodic surveys to determine whether SNFs are in substantial compliance. 42 U.S.C. § 1395aa(a); 42 C.F.R. § 488.10. The Act also authorizes the Secretary to impose enforcement remedies against SNFs that are not in substantial compliance with the program participation requirements. 42 U.S.C. § 1395i-3(h)(2). The regulations specify the enforcement remedies that CMS may impose. 42 C.F.R. § 488.406. Among other enforcement remedies, CMS may impose a per-day CMP for the number of days a SNF is not in substantial compliance or a per-instance CMP for each instance of the SNF's noncompliance. 42 C.F.R. § 488.430(a). A per-day CMP may range from either $50 to $3,000 per day for less serious noncompliance, or $3,050 to $10,000 per day for more serious noncompliance that poses immediate jeopardy to the health and safety of residents. 42 C.F.R. § 488.438(a). "Immediate jeopardy" exists when "the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident." 42 C.F.R. § 488.301. The authorized range for a per-instance CMP is $1,000 to $10,000. 42 C.F.R. § 488.438(a)(2). If CMS imposes a CMP based on a noncompliance determination, then the facility may request a hearing before an Administrative Law Judge (ALJ) to challenge the noncompliance finding and enforcement remedy. 42 U.S.C. §§ 1320a-7a(c)(2), 1395i(h)(2)(B)(ii)); 42 C.F.R. §§ 488.408(g), 488.434(a)(2)(viii), 498.3(b)(13).

Burlington is a SNF located in Cincinnati, Ohio, that participates in the Medicare program. On August 19, 2012, while assisting Resident 98 with toileting, one of Burlington's State tested nurse aides (STNA) noticed that Resident 98 was bleeding from her vaginal area. Several licensed practical nurses (LPNs) assessed Resident 98 and contacted a physician who, based on the LPNs' observations, diagnosed boils and ordered treatment consistent with that diagnosis. On August 21, 2012, Burlington had a wound care physician examine Resident 98. The wound care physician determined that Resident 98's vaginal area appeared to have been subject to trauma and ordered Resident 98 transported to a hospital. CMS Exhibit (Ex.) 12 at 100. Later on August 21, 2012, Burlington reported this diagnosis to the Ohio Department of Health.

In response to Burlington's report, three registered nurses (RN) from the Ohio Department of Health (survey agency) conducted a complaint survey of the facility, which was completed on September 13, 2012. CMS Exs. 4, 19-21. The survey included reviewing records, interviewing staff, and observing residents at the facility. CMS Exs. 9-11, 19-21. The surveyors completed a Statement of Deficiencies (Form CMS-2567) in which they determined that Burlington did not meet the requirements in 42 C.F.R. § 483.13(c). CMS Exs. 4, 9-11.

The surveyors concluded:

> Based on medical record review, review of the hospital records, interviews with facility staff, the wound care physician, and hospital sexual assault nurse examiner (SANE), and review of the facility's abuse policy, the facility failed to immediately identify an injury of unknown source located on the genitals of one resident (#98) with severe cognitive impairment. The facility also failed to immediately: report the injury of unknown source to the administrator and the State survey agency; initiate an investigation; and take action to protect the facility's residents during the investigation. This resulted in immediate jeopardy for one (#98) of nine cognitively impaired residents reviewed for injuries of unknown source/abuse. All 98 residents in the facility were placed in immediate jeopardy from the risk of abuse because immediate action was not taken when staff found injuries of unknown source to Resident #98's genitals.
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> . . . Immediate Jeopardy began on 08/19/12 at 10:00 P.M. when State Tested Nurse Aide (STNA) #10 observed blood and bruising on Resident #98's genitals during toileting. STNA # 10 reported the blood and bruising to Licensed Practical Nurse (LPN) # 16 at the time of discovery. LPN # 16 failed to recognize and immediately report the abrasion with bruising and bleeding as an injury of unknown source that was suspicious in nature. On 08/21/12 at 7:00 A.M., Wound Physician #99 assessed Resident #98 and suspected the identified areas were caused by blunt force trauma. At that time, Resident #98 was put on one-on-one supervision until she was transferred to the hospital at 9:35 A.M. accompanied by Wound Care Nurse # 17.
>
> The Immediate Jeopardy was removed on 08/30/2012 when all staff were re-educated on the abuse policy with testing, residents were assessed for signs of abuse and staff monitoring was in place. The deficiency remained at Severity Level 2 (no actual harm with potential for more than minimal harm that is not immediate jeopardy) until the deficiency was corrected on 09/11/12 . . . .

CMS Ex. 4 at 2-3. The surveyors identified the following as corrective actions taken between August 21, 2012, and September 11, 2012: 1) a "Wound Physician" examined

Resident #98; the facility notified Resident 98's physician and family of her injury; 2) the facility notified the police department and implemented its Abuse Policy and Procedure; 3) the facility started taking statements from all staff who worked from August 17-21, 2012; 4) the facility staff and the Wound Physician completed a "skin audit" of the facility's residents to ensure that none of the other residents had injuries; 5) the facility initiated management monitoring of staff without prior notice to staff and scheduled a member of management staff to be in the facility 24 hours a day; 6) the facility instructed all night shift STNAs and nurses to sit in the middle of hallways between rounds to increase observation of the resident population; 7) the facility's social worker completed questionnaires with all of the facility's cognitively aware residents about resident abuse and none of the residents reported abuse; 8) the facility commenced new criminal background checks on its employees; 9) the facility educated staff on the facility's abuse policy, which included competency testing; and 10) the Wound Physician conducted training for all nursing staff on assessing skin conditions. CMS Ex. 4 at 3-6.

In a January 8, 2013 initial determination, CMS stated that, based on the September 13, 2012 survey, it found Petitioner was not in substantial compliance with 42 C.F.R. § 483.13(c) (F225) (Resident Behavior and Facility Practices) at the scope and severity level of "L," (immediate jeopardy) from August 19, 2012, through August 29, 2012.[1] CMS also found that immediate jeopardy no longer existed on August 30, 2012; however, Petitioner did not fully return to substantial compliance until September 11, 2012. CMS imposed a $4,900 per-day CMP for 11 days from August 19, 2012, through August 29, 2012, and a $100 per-day CMP for 13 days from August 30, 2012, through September 11, 2012. Further, CMS prohibited Petitioner from conducting in-house Nurse Aid Training and/ or Competency Evaluations for two years. CMS Ex. 1 at 1-3.

[1] Scope and severity levels are used by CMS and state survey agencies when selecting remedies. The scope and severity level is designated by letters A through L, selected by CMS or the state agency from the scope and severity matrix published in the State Operations Manual, chap. 7, § 7400.5 (Sep. 10, 2010). A scope and severity level of A, B, or C indicates a deficiency that presents no actual harm but has the potential for minimal harm, which is an insufficient basis for imposing an enforcement remedy. Facilities with deficiencies of a level no greater than C remain in substantial compliance. 42 C.F.R. § 488.301. A scope and severity level of D, E, or F indicates a deficiency that presents no actual harm but has the potential for more than minimal harm that does not amount to immediate jeopardy. A scope and severity level of G, H, or I indicates a deficiency that involves actual harm that does not amount to immediate jeopardy. Scope and severity levels J, K, and L are deficiencies that constitute immediate jeopardy to resident health or safety. The matrix, which is based on 42 C.F.R. § 488.408, specifies which remedies are required and optional at each level based upon the frequency of the deficiency.

Petitioner timely requested a hearing before an ALJ to dispute CMS's findings. Following receipt of Petitioner's hearing request, I issued an Acknowledgment and Initial Prehearing Order. In that order, I directed the parties to file written direct testimony for all witnesses they wanted to present.

In compliance with my prehearing order, CMS filed a prehearing brief (CMS Br.) and 22 proposed exhibits (CMS Exs. 1-22). Three of the proposed exhibits were the written direct testimony for CMS's witnesses (CMS Exs. 19-21), all of whom were members of the state survey team who conducted the survey that ended on September 13, 2012. Petitioner then filed its prehearing brief (P. Br.) along with seven proposed exhibits (P. Exs. 1-7). Four of the proposed exhibits were the written direct testimony for Petitioner's witnesses (P. Exs. 1, 4-6). CMS requested to cross-examine one of Petitioner's witnesses and Petitioner requested to cross-examine all of CMS's witnesses.

On April 28, 2015, I held a video hearing at which I heard testimony on cross-examination from the facility's medical director, Dr. Moqeeth (P. Ex. 1), two Long-Term Care Surveyors from the Ohio Department of Health (CMS Exs. 20, 21), and a Field Manager from the Ohio Department of Health (CMS Ex. 19). At the hearing, I admitted all of the parties' proposed exhibits. Hearing Transcript (Tr.) at 10. After the hearing CMS and Petitioner filed post hearing briefs (CMS Post Hearing Br. and P. Post Hearing Br.) and reply briefs (CMS Reply Br. and P. Reply Br.)

II. Issues

The issues presented are:

1. Whether Petitioner was in substantial compliance with Medicare participation requirements at 42 C.F.R. § 483.13(c) from August 19, 2012, until September 11, 2012.

2. If Petitioner was not in substantial compliance with Medicare program requirements, did the deficiencies pose immediate jeopardy to resident health and safety from August 19, 2012, through August 29, 2012.

3. If Petitioner was not in substantial compliance with Medicare participation requirements, are the CMP amounts imposed on Petitioner reasonable.

III. Jurisdiction

I have jurisdiction to hear and decide this case. 42 U.S.C. §§ 1320a-7a(c)(2), 1395i(h)(2)(B)(ii)); 42 C.F.R. §§ 488.408(g), 488.434(a)(2)(viii), 498.3(b)(13).

IV. Findings of Fact

1. Resident 98 is female and was born on August 25, 1932. CMS Ex. 12 at 1, 5.

2. Resident 98 was admitted to Burlington on January 12, 2011, and had an admitting diagnosis that included Alzheimer's Disease. CMS Ex. 12 at 5.

3. By August 2012, Resident 98 had advanced dementia, was unable to communicate with Burlington's staff, and needed assistance with essentially all activities of daily living. CMS Ex. 12 at 3, 14, 21; P. Ex. 1 ¶ 4; Tr. 13.

4. On August 17, 2012, and August 18, 2012, Burlington staff who assisted Resident 98 did not notice any skin issues or bruising on Resident 98's body. CMS Ex. 12 at 121, 147, 151. On August 18, 2012, staff observed Resident 98 to exhibit behavior that they considered normal for her. CMS Ex. 12 at 127, 129.

5. On the night of August 19, 2012, STNA Amanda Snyder was assisting Resident 98 with using the toilet when STNA Snyder noticed blood coming from Resident 98's vaginal area. CMS Ex. 12 at 6, 144, 147; P. Ex. 6 ¶ 4.

6. STNA Snyder called LPN Heather Bates, who assessed Resident 98 and "noted both sides of her labia having a boil like appearance. The left was larger in size and had what appeared to be a small area of purpura. This is where the blood was coming from. No blood was present to vagina. Skin was natural in color besides the small area on [left] labia." CMS Ex. 12 at 144. STNA Snyder similarly observed that the "area was [a] little swollen and red, little blue like a small bruise . . . ." CMS Ex. 12 at 147.

7. Ms. Bates asked LPN Earle Brown and LPN Lisa Prentovik, to assess Resident 98 and provide their opinions. CMS Ex. 12 at 103, 144, 147; P. Ex. 5 ¶¶ 3-4.

8. While examining Resident 98, LPN Brown observed that her labia was enlarged, with the left labium larger than the right and "[a] small abrasion was noted on the left labium, about the size of nickel – scant serosanguinous drainage noted – there was bruising around the area of abrasion." CMS Ex. 12 at 103.

9. While examining Resident 98, LPN Prentovik saw on the right side of the labia "a hard area . . . with a small purpura below it . . . no other bruising noted to pelvic area or buttocks." CMS Ex. 12 at 148. She also observed "small red raised areas and there was what looked like a ¼ cm tear in one spot." P. Ex. 5 ¶¶ 4-5.

10. The three LPNs believed that Resident 98's labia area probably had boils. CMS Ex. 12 at 103, 144, 147; P. Ex. 5 ¶ 6.

11. LPN Bates contacted the on call physician, who ordered administration of Bactrim and the application of warm compresses to the affected area. CMS Ex. 12 at 6, 144. Burlington's Director of Nursing was informed of this matter shortly after LPN Bates contacted the physician. CMS Ex. 12 at 144.

12. On August 20, 2012, Burlington's staff did not observe Resident 98 to behave abnormally. CMS Ex. 12 at 124, 126, 130, 133.

13. At about 11:00 a.m. on August 20, 2012, RN Tasha Rosenzweig assessed Resident 98, and noted that Resident 98's labia were "boil like . . . on both sides of the area, areas were reddened & inflamed no bruises noted." RN Rosenweig also noted that Resident 98 did not complain of pain or discomfort. CMS Ex. 12 at 136. However, at 3:16 p.m., RN Rosenzweig reported that the left side of Resident 98's labia did in fact have purpura. CMS Ex. 12 at 6.

14. On the night of August 20, 2012, STNA Gladys Veal noticed two purple spots on Resident 98's vagina and one on the left side of her buttocks. STNA Veal informed LPN Bates of this bruising. CMS Ex. 12 at 146; *see also* CMS Ex. 10 at 24; CMS Ex. 11 at 19.

15. On the night of August 20, 2012, LPN Bates assessed Resident 98 due to the previous diagnosis of boils and noted that boil like areas on the labia had decreased in size and were almost resolved. However, "[b]oth sides of her labia were bruised, deep purple in color. The bruising had covered the pubic region." CMS Ex. 12 at 145. At 1:04 a.m. on August 21, 2012, LPN Bates entered a clinical note that "[a]reas noted with increased bruising upon assessment this evening." CMS Ex. 12 at 6. LPN Bates informed Burlington's Director of Nursing. LPN Bates sent a text message at about 1 a.m. on August 21, 2012, to LPN Heather Beahan, the wound care nurse, that both she and the wound care physician should assess Resident 98 in the morning due to bruising on Resident 98. CMS Ex. 12 at 102, 145.

16. On the morning of August 21, 2012, STNA Kristine Huebener, while assisting Resident 98 to get up and change for breakfast, noticed that Resident 98 had bruises around the upper pubic region, labia, and buttock. Ms. Huebener did not observe those bruises when she had previously assisted Resident 98 on August 18, 2012. CMS Ex. 12 at 121.

17. Michael Dooley, an LPN and Assistant Director of Nursing, was called to Resident 98's room and noted bruising in Resident 98's "peri area." CMS Ex. 12 at 102, 134.

18. At some time after 7:15 a.m., LPN Beahan and Dr. Isaac Shaw assessed Resident 98 and "both agreed that she needed to be sent out [to] the ER for evaluation for possible trauma, infection or neoplasm." CMS Ex. 12 at 102; *see also* CMS Ex. 12 at 99-100. LPN Beahan informed Burlington's Director of Nursing of this. CMS Ex. 12 at 102.

19. At approximately 9:30 a.m., Burlington's Director of Nursing entered a clinical note that Resident 98 was being sent to the hospital for x-rays "due to increased bruising in her pelvic region." CMS Ex. 12 at 6.

20. On August 21, 2012, Resident 98 was admitted to the hospital with an admission diagnosis of labia bruising of the vagina. CMS Ex. 12 at 42. A sexual assault nurse examiner conducted a pelvic examination in which the nurse noted intravaginal mucosal tears and diagnosed a sexual assault. CMS Ex. 12 at 39. Resident 98 had to be sedated for the pelvic examination. CMS Ex. 12 at 41, 102. The Emergency Room Physician Report stated that a pelvic examination of Resident 98 "revealed significant vaginal trauma consistent with penile or foreign object penetration as well as anal trauma . . . it is not possible that [Resident 98] sustained these injuries accidently." CMS Ex. 12 at 41. Resident 98 received a discharge diagnosis of "sexual assault." CMS Ex. 12 at 41-42.

21. On August 21, 2012, Burlington completed an Ohio Department of Health "Self Report Incident Form," on which Burlington indicated that staff identified an injury of unknown source and that abuse, neglect, or misappropriation is suspected. CMS Ex. 12 at 154-55; *see also* P. Ex. 4 ¶ 10.

22. On August 21, 2012, Burlington: initiated an investigation; conducted a "skin audit" of all of the residents at Burlington; initiated training to STNAs and nurses on Burlington's abuse policy and abuse scenarios; instructed STNAs and nurses to sit in hallways between rounds to increase observation at Burlington's facility; and initiated a procedure where a Burlington management team members enters the facility without warning to staff. CMS Ex. 7 at 4-5; CMS Ex. 12 at 101-149; CMS Ex. 13 at 1-2; CMS Ex. 15; CMS Ex. 17; Tr. 35.

23. On August 23, 2012, Burlington staff interviewed cognitively aware residents and none of them alleged they were subject to abuse. CMS Ex. 7 at 5; CMS Ex. 16; CMS Ex. 13 at 2.

24. On August 30, 2012, Burlington completed retraining staff on abuse policy and with competency testing, commenced criminal background checks for Burlington staff; and Burlington management members were in the facility 24 hours a day actively checking the halls. CMS Ex. 7 at 5-6; CMS Ex. 13 at 2; CMS Ex. 18.

25. On September 11, 2012, Burlington provided training by Dr. Shaw, the wound care physician, on assessing skin conditions. CMS Ex. 7 at 6; CMS Ex. 18 at 2.

26. There is no evidence in the record that the police found the perpetrator of the sexual assault on Resident 98. Tr. 44.

V. Conclusions of Law and Analysis

My conclusions of law are in italics and bold.

1. Burlington was not in substantial compliance with 42 C.F.R. § 483.13(c) because Burlington's staff failed to immediately inform Burlington's Administrator and the Ohio Department of Health that Resident 98 had an injury from an unknown source and/or was subject to abuse.

Residents of a SNF have "the right to be free from . . . sexual . . . abuse." 42 C.F.R. § 483.13(b). As a result, SNFs

> Must ensure that all alleged violations involving mistreatment, neglect, or abuse, **including injuries of an unknown source** . . . are reported **immediately** to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).

42 C.F.R. § 483.13(c)(2) (emphasis added). The regulations do not define the phrase "injuries of unknown source" or the word "immediately." However, CMS issued an interpretive guideline for section 483.13(c)(2) in the State Operations Manual. The State Operations Manual provides the following test for determining whether an injury is from an unknown source:

> The source of the injury was not observed by any person **or** the source of the injury could not be explained by the resident; **and**
>
> The injury is suspicious because of the extent of the injury **or** the location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma) **or** the number of injuries observed at one particular point in time **or** the incidence of injuries over time.

State Operations Manual, Appendix PP (emphasis in original). Further, "immediately" means as soon as possible, but not more than 24 hours since the discovery of a reportable

incident. *Id*. Although the State Operations Manual is not binding on me, I will apply the interpretations above in this case because they are reasonable and Petitioner had notice of them, as can be seen by Petitioner's adoption of these interpretations into its Polices and Standard Procedures related to resident abuse (CMS Ex. 14 at 1-2, 5). *Baylor Cnty. Hosp. Dist. d/b/a Seymour Hosp.*, DAB No. 2617, at 4 (2015).

Most of the facts in this case are not in dispute; however, CMS and Petitioner disagree as to when Petitioner's staff observed an injury of unknown origin. P. Post Hearing Br. at 12 ("The primary issue in this case centers around whether or not Resident #98 had an injury of unknown origin on August 19 and 20, 2012. There is no dispute that she had an injury of unknown origin on August 21, 2012."). If it was on August 19, 2012, when STNA Snyder first noticed that Resident 98 was bleeding, as CMS urges, then Petitioner's staff failed to immediately report (i.e., within 24 hours) the injury of unknown origin to Petitioner's Administrator and the Ohio Department of Health in violation of 42 C.F.R. § 483.13(c)(2). If it was not until the morning of August 21, 2012, as Petitioner asserts, then Petitioner complied with the notice requirements in 42 C.F.R. § 483.13(c)(2). Based on the facts in this case, I conclude that CMS is correct.

Petitioner argues that on the evening of August 19, 2012, after STNA Snyder informed LPN Bates that Resident 98 was bleeding from her vaginal area, the facility reasonably believed that Resident 98 was merely suffering from boils because: three LPNs immediately assessed Resident 98 as having boils; LPN Bates phoned the on-call physician, who ordered that Resident 98 receive care for boils; and Petitioner's Director of Nursing, who is an RN, assessed Resident 98 on the morning of August 20, 2012, and continued to believe Resident 98 had boils. P. Post Hearing Br. at 12-13; P. Reply Br. at 2. Petitioner asserts that its staff did not discover an injury of unknown origin until the early morning hours of August 21, 2012, when bruising appeared on Resident 98. P. Post Hearing Br. at 14; P. Reply Br. at 2. Petitioner points out that bruising goes through stages and often only becomes visible between 24 to 48 hours following an injury and that only bruising was sufficient to cause Petitioner's staff to believe that Resident 98 had received an injury of unknown origin. P. Post Hearing Brief at 14; P. Reply Br. 2; P. Ex. 1 ¶ 9; P. Ex. 2 at 1; Tr. at 23, 40-41.

Based on the record in this case, I do not agree that it was reasonable for Petitioner's staff to fail to notify the Administrator within 24 hours of the evening of August 19, 2012, that Resident 98 appeared to have an injury of unknown origin. STNA Snyder noticed that Resident 98 was bleeding from her vaginal area. The three LPNs who examined Resident 98 each noticed purpura or bruising, one noted a ¼ centimeter tear, and another a nickel-sized abrasion. The LPNs thought Resident 98 had boils and LPN Bates informed the on-call physician of this, which led to an order to provide Resident 98 with care for boils. Although Petitioner asserts that a diagnosis for boils was not unwarranted (P. Reply at 3), Petitioner provides no argument as to why Petitioner's staff did not inform its Administrator immediately of the bruising that its staff found. Indeed,

Petitioner's policy and procedures concerning resident abuse directed Petitioner's staff to immediately report "[e]ach occurrence of resident incident, bruise, abrasion, or injury of unknown etiology" in writing so it can be ultimately be reported to the Director of Nursing and the Administrator. CMS Ex. 14 at 5. Treating Resident 98 for boils did not preclude further action on the part of Petitioner's staff from reporting a possible injury to Resident 98.

I am also unpersuaded by Petitioner's argument that because bruising generally occurs 24 to 48 hours after an injury, it was not possible for Petitioner's staff to realize, on August 19, 2012, that Resident 98 had an injury of unknown origin. Although Petitioner's Medical Director testified that bruising only becomes visible 24-48 hours after an injury, he could not categorically state that bruising could appear earlier. P. Ex. 1 ¶ 9 ("It is extremely rare for bruising to appear immediately."). Based on Dr. Shaw's examination of Resident 98 shortly after 7:00 a.m. on August 21, 2012, Dr. Shaw estimated that Resident 98's injury occurred two days earlier. CMS Ex. 11 at 18; *see also* CMS Ex. 21 ¶ 5 (stating that CMS Ex. 11 at 18 misidentifies Dr. Shaw as Dr. Swan). That means that Resident 98 was sexually assaulted in the morning of August 19, thus leaving at least 12 hours for some bruising to become apparent. Given that all three LPNs who examined Resident 98 on August 19 noted bruising, it seems more likely than not that Resident 98 showed bruising earlier than the average individual.

Finally, although Petitioner asserts that its Director of Nursing examined Resident 98 on the morning of August 20, 2012, and that the Director of Nursing concurred with the diagnosis of boils, there is no contemporaneous or testimonial evidence in the record to corroborate these assertions.

Using the State Operational Manuals two-part test to determine an injury of unknown origin, it is clear that Resident 98 had such an injury on the night of August 19, 2012. CMS established the first prong of the test by showing that LPNs noted that Resident 98 had bruising, an abrasion, and a tear in her vaginal area, but none of Petitioner's staff had observed the source of the injury and Resident 98, in an advanced state of dementia, was unable to communicate what had happened. CMS also established the second prong of the test because the location of the injury, Resident 98's vaginal area, is one that is not generally vulnerable to trauma. Therefore, I conclude that Petitioner's staff became aware that Resident 98 had an injury of unknown origin on the evening of August 19, 2012, but staff failed to notify Petitioner's Administrator and the Ohio Department of Health immediately in violation of 42 C.F.R. § 483.13(c)(2).

2. CMS's determination that Petitioner's deficiencies posed immediate jeopardy was not clearly erroneous.

Immediate jeopardy exists when 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.

An ALJ must affirm an "immediate jeopardy" determination unless Petitioner shows that it is clearly erroneous. 42 C.F.R. § 498.60(c)(2). The "clearly erroneous" standard imposes a heavy burden on SNFs and CMS may prevail where CMS presented evidence "from which '[o]ne could reasonably conclude' that immediate jeopardy exists." *See Barbourville Nursing Home*, DAB No. 1962, at 11 (2005) (citing *Florence Park Care Ctr.*, DAB No. 1931, at 27-28 (2004). The regulation does not require that a resident actually be harmed. *See Lakeport Skilled Nursing Ctr.*, DAB No. 2435, at 8 (2012).

Petitioner asserts that while Resident 98 suffered actual harm due to the sexual assault that occurred, CMS has made no allegation that Burlington failed to prevent the sexual assault or contributed to the likelihood of the sexual assault. Petitioner argues in the alternative that even if there was immediate jeopardy, Burlington's extensive corrective actions on August 21, 2012, means that the immediate jeopardy finding should not last beyond that day. P. Post Hearing Br. at 15.

CMS contends that its immediate jeopardy finding is appropriate because Petitioner's staff failed to follow Petitioner's abuse policy, resulting in the loss of time to investigate Resident 98's injury and implement changes to ensure the safety of all residents. CMS Post Hearing Br. at 21. CMS argues that it was proper to extend immediate jeopardy through August 29, 2012, because it was not until then that the facility re-educated all staff on Petitioner's abuse policy with testing. CMS Post Hearing Br. at 22.

There is no doubt that Petitioner placed Resident 98 and other residents in immediate jeopardy. Although CMS did not hold Petitioner responsible for the actual sexual assault on Resident 98, Petitioner's staff was unprepared to respond when a cognitively impaired resident was sexually assaulted. Despite observing bleeding, bruising, an abrasion, and a tear in the vaginal area, the three LPNs who assessed Resident 98 on August 19, 2012, did not consider the possibility of abuse. As testified to by one of the nurse surveyors:

> Q Were other residents besides R-98 in immediate danger of serious injury or harm?
>
> A Yes.
>
> Q How so?
>
> A By failing to identify the injury of unknown origin it put the other residents at risk had any other resident shown a sign. There were three nurses that did not identify the fact that there was any injury of unknown origin, and they were caring for the other residents.

Tr. at 26-27.

In fact, despite Petitioner's abuse procedures, facility staff did not notify the Administrator that Resident 98 had an injury of unknown origin. Such a lack of familiarity with the procedures caused Resident 98 to receive delayed care at the hospital for an assault that ultimately caused massive bruising throughout her pelvic area. It also likely contributed to the police's inability to determine who committed this heinous crime. Finally, it delayed changes Petitioner ultimately instituted to make Petitioner's facility more secure (i.e., nurses and STNAs to sit in hallways when not on rounds, management team members present 24 hours a day to walk around the hall).

The evidence in the record shows that Petitioner's conduct commencing August 19, 2012, had caused, or was likely to cause, serious injury, harm, impairment, or death to a resident. 42 C.F.R. § 488.301. Therefore, CMS's immediate jeopardy determination is not clearly erroneous. Further, the evidence shows that Petitioner's staff was not re-trained and tested on Petitioner's abuse policy until at least August 30, 2012 (CMS Ex. 18); therefore, CMS's determination that immediate jeopardy lasted through August 29, 2012, is not clearly erroneous.

3. CMS's determination of the amount of CMP is reasonable.

In determining whether the per-instance CMP amounts imposed against Petitioner are reasonable, I apply the factors listed in 42 C.F.R. § 488.438(f). 42 C.F.R. § 488.438(e)(3). These factors include: (1) the facility's history of compliance; (2) the facility's financial condition; (3) the factors specified at 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 at 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. Unless a facility contends that a particular regulatory factor does not support the CMP amount, the ALJ must sustain it. *Coquina Ctr.*, DAB No. 1860, at 32 (2002).

In the present case, CMS imposed a CMP of $4,900 per day from August 19, 2012, through August 29, 2012, and a $100 per-day CMP from August 30, 2012, through September 11, 2012. CMS Ex. 1 at 1. The total CMP amount imposed was $55,200. Despite imposing the CMP, CMS provided Petitioner with 15 days to submit evidence related to the regulatory factors for calculating the CMP. In particular, CMS provided detailed instructions for Petitioner if Petitioner wanted to assert it could not pay the CMP due to its financial circumstances. CMS Ex. 1 at 2.

Petitioner argues that CMS failed to consider the regulatory factors when determining the CMP amount. In particular, Petitioner avers that CMS did not meet its burden to consider the facility's financial condition. P. Post Hearing Br. at 16-17; P. Reply Br. at 3.

Petitioner also disputes CMS's consideration, as part of Petitioner's history of compliance, of a 2010 "D" level deficiency for which no CMP was imposed and, thus, no appeal by Petitioner was possible. P. Br. at 7; P. Post Hearing Br. at 16.

After considering the factors in the regulations, I conclude that the CMP amounts imposed in this case are reasonable. Petitioner does have a history of noncompliance as can be seen by the deficiency cited in 2010, and it did involve a failure to report to the Ohio Department of Health and investigate a resident's claim of theft, resulting in a deficiency cited for the same regulations at issue in this case, 42 C.F.R. § 483.13(c). However, the deficiency was at a "D" level, i.e., the lowest level of noncompliance; therefore, it provides only modest support for the CMP.

In regard to consideration of Petitioner's financial condition, I cannot conclude that this is a reason to reduce the penalty amount in this case. The record contains no information about Petitioner's financial condition, despite the fact that CMS, in its initial determination, provided Petitioner with extensive instructions on the documentation to file. Further, Petitioner was free to file evidence of its financial condition with its prehearing exchange in this case. However, Petitioner did not do so.

I consider Petitioner to have a fairly high degree of culpability in this case. As indicated above, Petitioner's staff did not appear to consider the possibility that Resident 98 was sexually assaulted, despite the nature and location of Resident 98's injury. Had Resident 98 not exhibited significant bruising by August 21, 2012, she would likely not have received any care for her traumatic injuries. Further, Petitioner would not have instituted greater security measures and training. Resident 98 was completely dependent on Petitioner to keep her safe and, barring that, to care for her injuries. She could not communicate the horrible wrong done to her. Petitioner's staff needed to be especially careful to respond to any potential injury with such a resident.

In regard to the scope and severity of the deficiency, as indicated above, I agree that CMS properly determined that Petitioner's deficiency was at the immediate jeopardy level. I also believe that CMS properly continued to penalize Petitioner at a non-immediate jeopardy level from August 30, 2012, until September 11, 2012, because it was not until September 11, 2012, that Petitioner trained its staff on assessing skin conditions. CMS Ex. 18 at 2. Such training was clearly necessary due to the failure by Petitioner's staff to identify Resident 98's injury.

Based on the factors above, I conclude that $4,900 per-day CMP during the immediate jeopardy period is reasonable and a $100 per-day CMP is reasonable for the period below the immediate jeopardy level. The $4,900 is in the lower range for immediate jeopardy matters (i.e., per-day CMPs for immediate jeopardy can be from $3,050 to $10,000). 42 C.F.R. § 488.438(a)(1)(i). The $100 per-day amount is only $50 more than minimum amount that the regulations require to be imposed. 42 C.F.R. § 488.438(a)(1)(ii).

VI. Conclusion

I conclude that Petitioner was not in substantial compliance with 42 C.F.R. § 483.13(c). Further, I conclude that a $4,900 per-day CMP from August 19, 2012, through August 29, 2012, and a $100 per-day CMP from August 30, 2012, through September 11, 2012, is reasonable.

/s/
Scott Anderson
Administrative Law Judge