Department of Health and Human Services
DEPARTMENTAL APPEALS BOARD
Appellate Division

Springhill Senior Residence
Docket No. A-13-25
Decision No. 2513
May 14, 2013

FINAL DECISION ON REVIEW OF ADMINISTRATIVE LAW JUDGE DECISION

Springhill Senior Residence (Springhill), a skilled nursing facility (SNF) located in Mobile, Alabama that participates in Medicare, appeals the October 24, 2012 decision of an Administrative Law Judge in *Springhill Senior Residence*, DAB CR2653 (2012) (ALJ Decision). The ALJ upheld the determination by the Centers for Medicare & Medicaid Services (CMS), based on a June 24, 2011 survey, that Springhill was not in substantial compliance with Medicare requirements relating to resident dignity, privacy, confidentiality and administration at 42 C.F.R. §§ 483.15(a), 483.10(e) and 483.75(l)(4). The ALJ also concluded that CMS did not clearly err in determining that Springhill's noncompliance posed immediate jeopardy to facility residents. In addition, the ALJ determined that the civil money penalty (CMP) imposed on Springhill, $5,550 per day effective May 2 through June 23, 2011, and $100 per day effective June 24 through June 30, 2011, was reasonable in duration and amount and that the loss of Springhill's approval to conduct a nurse-aide training and competency evaluation program (NATCEP) was required by law.

For the reasons discussed below, we affirm the ALJ Decision.

Legal Background

The Federal Nursing Home Reform Act, part of the Omnibus Budget Reconciliation Act of 1987, established minimum standards of care that long-term care facilities, including SNFs, must meet to participate in Medicare and Medicaid. Pub. L. No. 100-203, §§ 4201-4218 (1987). The central focus of the law is to ensure that residents of nursing homes receive quality care that will result in their achieving or maintaining their "highest practicable" physical, mental, and psychosocial well-being. Social Security Act (Act)

§§ 1819(b)(2), 1919(b)(2).[1] The law also establishes "residents' rights" that the facility "must promote and protect." Act §§ 1819(c)(1)(A), 1919(c)(1)(A). Those rights include the "right to be free from physical or mental abuse," the "right to privacy," the "right to confidentiality" and "any other right established by the Secretary." *Id.*

Implementing the Act, the regulations at 42 C.F.R. Part 483, subpart B, delineate the quality of care requirements and the resident rights that SNFs must promote and protect. 42 C.F.R. § 483.1. State agencies under contract with CMS perform onsite surveys to assess compliance with these requirements. Act §§ 1819(g) and1864; 42 C.F.R. Part 488, subpart E.

Adverse survey findings are reported on a form called a "Statement of Deficiencies" (SOD). A "deficiency" is defined as a "failure to meet a participation requirement specified in the Act or [42 C.F.R. Part 483]." 42 C.F.R. § 488.301. For organizational purposes, the SOD identifies deficiencies using "tag" numbers that CMS has assigned to the regulatory requirements. In an appendix to its State Operations Manual (SOM), CMS publishes "interpretive guidelines" that help surveyors understand and apply the regulations. CMS Pub. 100-07, § 7203 & App. PP (Guidance to Surveyors for Long Term Care Facilities), available at http://cms.hhs.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf. [2]

Section 488.301 defines "substantial compliance" as "a level of compliance with the requirements of participation such that any identified deficiencies pose no greater risk to resident health or safety than the potential for causing minimal harm." "Noncompliance" means "any deficiency that causes a facility to not be in substantial compliance." *Id.* CMS may impose enforcement remedies, including CMPs, on the basis of noncompliance found during a survey. 42 C.F.R. § 488.402(b).

CMS assesses the seriousness of each deficiency in order to select the appropriate remedies, if any, to impose on the facility. *See* 42 C.F.R. § 488.404. The level of seriousness is based on an assessment of the scope of the problem within the facility (whether the deficiency is isolated, a pattern, or widespread) and the severity (the degree of actual, or potential, harm to resident health and safety posed by the deficiency). *Id.* The most serious type of noncompliance is one that places residents in "immediate jeopardy," defined as "a situation in which 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, 488.404(b).

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[1] The current version of the Act can be found at http://www.socialsecurity.gov/OP_Home/ssact/ssact.htm. Each section of the Act on that website contains a reference to the corresponding United States Code chapter and section. A cross-reference table for the Act and the United States Code can be found at 42 U.S.C.A. Ch. 7, Disp Table.

[2] As reflected in its briefs, Springhill was familiar with the SOM guidelines. *See, e.g.,* P. Br. at 16.

Case Background

On June 20, 2011 the Alabama Department of Public Health (State agency) received a compact disk (CD) from the Trussville, Alabama Police Department containing an image and videos of four Springhill residents, referred to in the ALJ Decision and herein as Residents 1, 2, 3, and 4. CMS Ex. 1, at 5-6. The recordings and image had been downloaded onto the CD from a cell phone found in a bar in New Orleans, Louisiana. CMS Exs. 16, at 8-9; 17, at 49-50. The police traced the cell phone to its owner, a Springhill certified nurse aide (CNA), referred to in the ALJ Decision and herein as CNA B. CMS Exs. 7, at 1; 17, at 4.[3]

From June 21 through June 24, 2011, state agency surveyors conducted an abbreviated and partial extended survey of Springhill. The survey identified deficiencies relating to privacy, confidentiality and facility administration under sections 483.10(e) and 483.75(l)(4) (Tag 164), and deficiencies relating to resident dignity and respect of individuality at section 483.15(a) (Tag 241). CMS Ex. 1.

Based on the survey findings, CMS determined that from May 2, 2011 through June 23, 2011, conditions at Springhill posed immediate jeopardy to residents' health and safety. CMS Ex. 2, at 1. CMS determined that as of June 24, 2011, the scope and severity of the noncompliance was reduced to "D" level (no actual harm with potential for more than minimal harm that is not immediate jeopardy). *Id.* CMS imposed a CMP in the amount of $5,500 per day effective May 2, 2011 through June 23, 2011, and $100 per day effective June 24, 2011 and continuing until the facility returned to substantial compliance, on July 1, 2011. *Id.* at 2; CMS Ex. 1, at 1-3. CMS also determined that Springhill lost its approval to run a NATCEP for two years under section 1819(f)(2)(B) Act as a result of the survey findings. CMS Ex. 2, at 3.

Proceedings before the ALJ

Springhill timely requested an ALJ hearing to contest CMS's determination. The parties submitted briefs, documentary evidence and written, direct testimony. Springhill did not dispute that the state agency accurately described the content of the CD videos and image in the SOD (CMS Ex. 1) and in the state agency's investigative summary (CMS Ex. 16). ALJ Decision at 4. Consequently, the parties did not move to enter the CD into the record. *Id.* We therefore rely on the SOD and the State agency investigative summary,

[3] The survey documents identify residents and employees by numbered "Resident Identifiers" (RI) and "Employee Identifiers" (EI). Residents 1 through 4 are RI#1 through RI#4; CNA B is EI#1; CNA K is EI#2; and CNA W is EI#3. CMS Exs. 16, at 6; 17; ALJ Decision at 4-6.

as the ALJ did, to describe the content of the videos and image. In addition, the parties declined the opportunity to cross-examine each other's witnesses. With the parties' consent, the ALJ decided the case based on the briefs and documentary evidence of record, including witness declarations. ALJ Decision at 3.

The ALJ Decision

The ALJ made the following findings of fact and conclusions of law:

> A. Petitioner was not in substantial compliance with 42 C.F.R. § 483.15(a) (Quality of Life, Dignity) (Tag F241) with regard to Residents 1 – 4.
>
> B. Petitioner was not in substantial compliance with 42 C.F.R. § 483.10(e) (Resident Rights, Privacy and Confidentiality) (Tag F164) with regard to Residents 1 – 4.
>
> C. Petitioner was not in substantial compliance with 42 C.F.R. § 483.75(l)(4). (Administration, Clinical Records) (Tag F164) with regard to Residents 1 – 4.
>
> D. CMS's determination of immediate jeopardy is not clearly erroneous.
>
> E. The CMP that CMS imposed is reasonable in duration and amount.

ALJ Decision at 3-13. The ALJ also concluded that Springhill's loss of approval to conduct a NATCEP was required by law. *Id.* at 13.

Proceedings before the Board

Springhill timely appealed the ALJ Decision to the Board. Following submission of the parties' briefs, the Board held an oral argument on March 25, 2013, at Springhill's request and without objection by CMS. The transcript of the oral argument is included in the administrative record.

Standard of Review

We review a disputed finding of fact to determine whether the finding is supported by substantial evidence in the record as a whole, and a disputed conclusion of law to determine whether it is erroneous. *Departmental Appeals Board, Guidelines -- Appellate Review of Decisions of Administrative Law Judges Affecting a Provider's Participation in the Medicare and Medicaid Programs*, http://www.hhs.gov/dab/divisions/appellate/guidelines/prov.html.

Analysis

Below, we first set out the undisputed facts underlying CMS's determination. We next discuss why we conclude that the ALJ's findings of Springhill's noncompliance are supported by substantial evidence on the record as a whole and free from legal error. We then explain why we sustain the ALJ's determination that CMS's immediate jeopardy determination was not clearly erroneous. Finally, we describe why we uphold the ALJ's conclusion that the CMP imposed is reasonable in duration and amount and that the loss of Springhill's NATCEP was required by statute.

Undisputed facts

Medical history, videos, and survey interviews relating to Resident 1

Resident 1 was a 97 year-old woman with diagnoses of vascular dementia with depression, mood disorder, psychosis, chest wall carcinoma, failure to thrive, dehydration, malnutrition, chronic constipation, urinary tract infection, anemia, organic brain syndrome and dysphagia ("swallowing difficulty . . . when tolerating regular thin liquids. Wet vocal quality, nasal emissions, watery eyes, and coughing."). CMS Ex. 12, at 4-5, 23, 36. Resident 1 required extensive assistance to eat and to perform other activities of daily living. *Id.* at 55. She was totally dependent on staff for physical transfers. *Id.* To address the Resident's dysphagia/swallow function and risk of aspiration, physician orders for Resident 1 included a diet of pureed solids and nectar thick liquids. *Id.* at 12, 18, 32-33. Springhill's Speech Pathologist "educated the direct care staff on safe swallowing precautions and compensatory swallowing strategies to be used with [Resident 1]." CMS Ex. 1, at 35.

Resident 1's sponsor filled out a "Springhill Senior Resident Standard Authorization Form" on February 9, 2011. CMS Ex. 12, at 3. The word "NO!" is handwritten in the space to authorize release of "graphic images" of the resident, including "photographs and video," for publication in Springhill's advertising and promotional materials or for use by the media. *Id.*

The CD provided by the Trussville, Alabama Police Department includes six videos of Resident 1 that were recorded on CNA B's cell phone over a ten-day period in May 2011. Video 159, recorded May 19, 2011 at 1:16 p.m., "shows an elderly white female [Resident 1] lying in bed being fed by staff." CMS Ex. 1, at 9. Video 163, recorded May 25, 2011 at 1:18 p.m., shows Resident 1 "lying in bed with oxygen on per nasal cannula." *Id.* Midway through the 47-second recording, "the camera is placed on a staff member (later identified as [CNA B])." *Id.* CNA B is shown "mouthing some words, with the television on in the background." *Id.* "When [Resident 1] begins to ramble in speech, … a voice in the recording … tells [Resident 1] 'shh' (be quiet)." *Id.*

The third video, numbered 165 and recorded May 28, 2011 at 1:17 p.m., shows Resident 1 "lying in bed with oxygen on per nasal cannula being fed by staff." *Id.* CNA B "is heard in the recording calling [Resident 1] 'tootie fruitie.'" *Id.* at 10. When Resident 1 asks for more food, CNA B tells the resident "no," and makes the resident say "goodie good good," before giving the resident more food. Once [Resident 1] repeats "goodie good good," the employee gives Resident 1 more food and laughs. *Id.*

The fourth video, numbered 166, recorded May 28, 2011 at 1:21 p.m., shows Resident 1 lying in bed and "asking the staff member for some more [food], but the staff [CNA B] is heard saying there isn't any more, it's all gone." *Id.*

The last two videos of Resident 1, numbered 167 and 168, were recorded on the afternoon of May 29, 2011. Video 167 shows Resident 1 "in bed being fed by staff." *Id.* The video shows Resident 1 telling the employee "that's too much" after the employee "placed a large food portion in her mouth." *Id.* Video 168, taken five minutes after video 167, shows Resident 1--

> in bed being fed by staff. [Resident 1] is seen and heard in this video telling the staff that she couldn't eat anymore; however, [CNA B] continued to feed [the resident]. [Resident 1] can be heard on the video saying "You dog." [CNA B] replied, "You're a dog." [Resident 1] asked "Why don't you wipe my mouth?" [CNA B] answered, "No, cause you called me a dog." [CNA B] instructed Resident 1 to say that she was sorry. [Resident 1] responded, ". . . you got me too quick. I'm sorry. You messed me up; you hate my guts." [CNA B] replied, "Eat mines." As [CNA B] continued to hurriedly feed [Resident 1] large spoonfuls of food, [CNA B] stated, "Now, here, here some guts for you to eat; right here, guts, more guts . . . . Hurry up." [Resident 1] screamed, "Quit!" [CNA B] replied, "Dog that!" Although [Resident 1] yelled that she didn't want any more, [CNA B] continued feeding the resident and said, "Yea! You gon get some more." Again, [Resident 1] said that she didn't want anymore; but, [CNA B] continued placing large spoonfuls of food into the resident[']s mouth and said, "Yep (yes), gain five pounds." When [Resident 1] screamed to be left alone, CNA B told [Resident 1] to, "Shut up! . . drink up!" Also, [CNA B] was seen holding a cup of liquid pressed against [Resident 1's] chest while telling the resident to "shut up! . . . drink up!" Once the staff member removed the cup from [the resident's] upper chest area, a circular indentation could be [seen] in the chest area, where the cup had been placed; but, the indentation quickly disappeared. [CNA B] referred to [Resident 1] as "Tootie" and asked, "Was that good Tootie, Tootie?" [Resident 1] answered, "Fruitie my butt." [CNA B] laughed and said, "Why Tootie?"

Id. at 10-11.

In a survey interview on June 21, 2011, CNA B initially denied that she or any coworker had ever taken any pictures or videos of residents. CMS Ex. 1, at 7. CNA B also stated that she did not know how her cell phone got to New Orleans. *Id.* at 8. The surveyor showed CNA B the picture and videos taken from her cell phone and asked her if she could explain the recordings. *Id.* She replied, "I can't offer any explanation for [Resident 2] but there is a video of [Resident 1]." *Id.* When asked what was said in a video of Resident 1, CNA B answered that it was a video of the resident being called "tootie frutie." *Id.* When the surveyor asked CNA B the identity of the person who had filmed the video, CNA B replied, "I did. I don't want to get anybody else in trouble." *Id.*

In a follow-up interview on June 22, 2011, CNA B was asked if anyone else was present during the filming of Resident 1. *Id.* at 12. CNA B said, "Can't remember just me." *Id.* When asked how she could feed the resident and record the video at the same time, CNA B said, "I did it." *Id.*

Medical history and image of Resident 2

Resident 2 was a 78 year-old woman with diagnoses of dementia, diarrhea, anorexia, acute pyelonephritis, a lung mass consistent with metastatic cancer, cardiomyopathy, diabetes and atrial fibrillation. CMS Ex. 13, at 17, 23. Resident 2 had a surgical history of cholecystectomy and right mastectomy. *Id.* at 18. *Id.*

An image on the CD dated May 2, 2011 at 8:56 a.m., shows Resident 2 "sitting in a shower room completely nude." CMS Ex. 1, at 3, 20. Resident 2's "head was in a downward position and there was no indication that the resident knew she was having her picture taken." *Id.*

Medical history, video, and survey interviews relating to Resident 3

Resident 3 was an 83 year-old man with diagnoses including respiratory abnormality, obstructive chronic bronchitis with exacerbation, congestive heart failure, hypertension, and history of prostatic malignancy. CMS Ex. 14, at 3, 7-8. A May 2011 assessment identified Resident 3 as "cognitively intact" and "requiring extensive assistance of one person for dressing and personal hygiene tasks." CMS Ex. 1, at 22. A June 6, 2011 social services note states that Resident 3 "continue[d] to be alert and oriented x3 with confusion evident by need for [f]requent reas[s]urance" and that his diagnoses included vascular dementia and depression. CMS Ex. 14, at 16.

Video 158, recorded May 19, 2011 at 10:40 a.m., shows Resident 3 "lying in bed with no shirt on engaged in conversation with two facility staff members." CMS Ex. 1, at 3. CNA W is shown assisting Resident 3 to put on a blue "muscle" shirt. *Id.* at 3-4. A second employee, later identified as CNA B, can be heard saying, "I don't know why [Resident 3] got a muscle shirt for; he ain't got no muscles." *Id.* at 4. Assisting Resident

1 with the shirt, CNA W asks the resident to use his arm muscles to lift himself up. CNA B can be heard saying, "He ain't got no muscles." *Id.* An employee can be heard saying "Watch that thing," and the other employee responds, "the camera." *Id.*

In a survey interview on June 22, 2011, CNA W stated that she did not know who recorded the video and "commented that there was only one other person in the room," later identified as CNA B. *Id.* at 23. The surveyor asked CNA W if Resident 3 knew he was being filmed, and the CNA answered, "I don't think so." *Id.* When asked if it is okay to videotape a resident, CNA W said, "No it's not at all because that's somebody's privacy." *Id.* The surveyor then asked what the CNA would do if she observed a staff member videotaping a resident. CNA W said that she "would first confront the staff and then report it to the charge nurse." *Id.* She added, "If I would have know[n] I would have told somebody but I didn't know [. . .] that's an invasion of privacy." *Id.*

On June 23, 2011, the surveyor interviewed Resident 3 and allowed him to review the video. *Id.* at 24. Resident 3 said that he was "mad as hell" that the recording had been made without his knowledge or permission and that "if he owned the company, he would fire all of them [the CNAs using their cell phones in his room]." *Id.* Resident 3 added that he was "mad as hell because they could put something like that on Ebay (Internet)." *Id.* Resident 3 also "stated that he was humiliated and asked could he sue the staff for this." *Id.*

Medical history, video, and survey interviews relating to Resident 4

Resident 4 was a 72 year-old woman with diagnoses that included cerebrovascular accident with right hemiparesis, hypertension, diabetes mellitus, vascular dementia, and major depression with psychotic features. CMS Ex. 15, at 3-4, 17, 36-37. Resident 4 had "multiple behavioral problems," suffered from "disabling anxiety," required extensive assistance to perform activities of daily living, and was totally dependent on staff for some activities, such as dressing. *Id.* at 3, 33.

Video 174, dated June 4, 2011 at 8:51 a.m., shows Resident 4 "lying in bed fully dressed with staff present." CMS Ex. 1, at 4. CNA K is shown in the resident's room, and CNA B can be heard calling Resident 4 by name and asking the resident to "look." *Id.* CNA K is shown "laughing, holding her hand up to hide her face and saying, 'Don't put that (referring to the camera) on me.'" *Id.* at 4, 14-15. CNA B replies that she is "putting this on YouTube." *Id.* CNA B is heard laughing, calling Resident 4 by name and repeatedly asking, "Who did this to you?" *Id.* at 15. An employee is shown placing her hand on the resident and "has the resident … roll over so that the resident's face becomes visible." *Id.* CNA asks again, "[Resident 4], who did this to you." *Id.* An employee gives the resident a red doll and says, "Here you go honey"; while another staff members says 'you gone need him Jesus.'" *Id.* The two CNAs then have a discussion, while laughing, about repositioning the resident. *Id.*

In a survey interview on June 22, CNA K identified herself and CNA B in the video of Resident 4, and she reported that CNA B filmed the video. *Id* at 15-16. CNA K stated that she was the employee in the video who gave the doll to Resident 4 and that the resident usually has the doll sitting on the armrest of her chair. *Id.* CNA K said that she did not know why CNA B made the recording and that she had not reported CNA B's actions to anyone. *Id.* When asked whether it was "okay to film a resident," she answered, "I would think not it's against their rights." *Id.* at 16. When asked why she did not report CNA B, CNA K stated, "Because I don't get into other people' business. . . I don't get involved with stuff like that; it didn't have anything to do with me." *Id.*

In a survey interview on June 22, 2011, CNA B was asked what staff knew she was recording. *Id.* at 17. CNA B said, "Just one other person, [CNA K] and you (state surveyor) already spoke with her." *Id.* When asked during which recordings CNA K was present, CNA B answered that CNA K was present when she recorded Resident 4. *Id.*

Once apprised of the CD recordings, Springhill terminated CNAs B and K and reported CNA B to the state agency and local law enforcement authorities. *Id.* CMS Ex. 1, at 2. Springhill determined that CNA W was not aware that CNA B was taking videos on her cell phone. CMS Ex. 9. CNA W "was counseled and mentored by [the] DON and Risk Manager/Social Worker." CMS Ex. 1, at 2. The Risk Manager "checked YouTube, Twitter, and Facebook for possible resident images and none were found on 6-23-11." *Id.*

The ALJ's determination that Springhill failed to comply substantially with 42 C.F.R. § 483.15(a) is supported by substantial evidence and free from legal error.

Section 483.15 of the participation requirements addresses resident quality of life. Paragraph 483.15(a), "Dignity," requires the facility to "promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality." The SOM explains that "'[d]ignity' means that in … interactions with residents, staff carries out activities that assist the resident to maintain and enhance his/her self-esteem and self-worth." SOM, App. PP, F241. Examples in the SOM include:

> • Respecting residents by speaking respectfully, addressing the resident with a name of the resident's choice, avoiding use of labels for residents such as "feeders," not excluding residents from conversations or discussing residents in community settings in which others can overhear private information;
>
> • Focusing on residents as individuals when they talk to them and addressing residents as individuals when providing care and services; and

> • Maintaining resident privacy of body including keeping residents sufficiently covered, such as with a robe, while being taken to areas outside their room, such as the bathing area . . . .

Id. The SOM also directs surveyors to "[d]etermine if staff members respond in a dignified manner to residents with cognitive impairments, such as not contradicting what residents are saying, and addressing what residents are trying to express (the agenda) behind their behavior." *Id.*

Applying the resident dignity requirement to the facts in this case, we conclude that the ALJ's determination that Springhill was not in substantial compliance with section 483.15(a) is supported by substantial evidence and free from legal error. The videos and image described in the SOD show that Springhill CNAs, whose job was to assist residents with activities of daily living such as eating, dressing and bathing, failed to provide care in an environment and manner that recognized their dignity. The most egregious behavior is evidenced in the videos of Resident 1, who was cognitively and physically impaired, which show CNA B repeatedly mistreating, taunting and humiliating the resident. The videos document CNA B addressing Resident 1 with the demeaning name, "tuttie-fruitie," coercing the resident to say "goodie good good" to be fed, laughing at the resident, referring to the resident's food as "guts," and pressing a cup of liquid against the resident's chest while telling her to "shut up!" and "drink up!" At times, the videos show, CNA B denied the resident food when the resident asked for it, while at other times CNA B force-fed the resident against her expressed will. This behavior was not only psychologically harmful, but as discussed in greater detail below, posed a risk of serious physical harm to the resident who suffered from both malnourishment and dysphagia.

Staff treatment of Residents 2, 3 and 4 also violated the facility's obligation to provide care to residents in a manner and in an environment that maintained or enhanced their dignity and right to respect. The very act of taking a picture of Resident 2 while naked and bathing showed no respect or concern for the resident's dignity. Moreover, the videos of Residents 3 and 4 show that staff interactions with these residents were disrespectful and demeaning. While CNA W was helping Resident 3 change his shirt, CNA B made degrading comments about the resident's physique and referred to him in the third person as if he were not present ("I don't know why [he] got a muscle shirt for; he ain't got no muscles. . . . He ain't got no muscles."). CMS Ex. 1, at 4. The record also evidences mistreatment by CNAs B and K of Resident 4, who was physically and cognitively impaired. The video of Resident 4 shows CNAs B and K belittling the resident and treating her as an object for their amusement, laughing while repeatedly asking, "who did this to you," and "asking the resident to 'look.'" *Id.* at 14-15. CNA K

"can be seen and heard laughing, holding her hand up to hide her face and saying, "Don't put that (referring to the camera) on me.'" *Id.* In response, CNA B states she is "putting this on YouTube." *Id.* These actions show a disturbing disregard for the residents' dignity and right to respect.

> *The ALJ's determination that Springhill failed to comply substantially with the requirements of 42 C.F.R. §§ 483.10(e) and 483.75(l)(4) is supported by substantial evidence and free from legal error.*

Consistent with the SOM, the survey SOD grouped together the allegations of noncompliance under sections 483.10(e) and 483.75(l)(4). Section 483.10 imposes on facilities the duty to protect and promote resident rights. It provides in pertinent part:

> (e) Privacy and confidentiality. The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.
>
> > (1) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.
> >
> > (2) Except as provided in paragraph (e)(3) of this section, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility;
> >
> > (3) The resident's right to refuse release of personal and clinical records does not apply when—
> > (i) The resident is transferred to another health care institution; or
> > (ii) Record release is required by law.

CMS's guidelines interpreting section 483.10(e) state that "staff must examine and treat residents in a manner that maintains the privacy of their bodies." SOM, App. PP, F164. The SOM further states that if "an individual requires assistance, authorized staff should respect the individual's need for privacy." *Id.*

Section 483.75 addresses facility administration, requiring each entity 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." Under subsection 483.75(l)(4), the "facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is required by" law, the resident, a third-party contract or transfer to another health care institution. CMS's guidelines interpreting 483.75(l)(4) define "keep confidential" to mean "safeguarding the content of information

including video, audio, or other computer stored information from unauthorized disclosure without the consent of the individual and/or the individual's surrogate or representative." SOM, App. PP, F164.

Applying the privacy and confidentiality requirements to the uncontested facts here, we conclude that the ALJ's determination that Springhill was not in substantial compliance with sections 483.10(e) and 483.75(l)(2) is supported by substantial evidence and free from legal error. The existence of the six videos of Resident 1, the image of Resident 2, the video of Resident 3 and the video of Resident 4 described above, and the discovery of these recordings in a bar in New Orleans, demonstrate that Springhill repeatedly failed to protect and promote its residents' rights of personal privacy and confidentiality. The videos and image show that over the course of more than a month (beginning May 2, 2011 and ending on June 4, 2011), Springhill staff, while on duty, made numerous unauthorized recordings of four vulnerable residents who were unaware that they were being filmed and unable to protect themselves against these infractions. The recordings were made without the residents' consent to be photographed or videotaped and violated the confidentiality statements signed by the CNAs when they were hired, which stated that they would not copy or in any manner disclose the contents of any resident medical records or information concerning a resident. CMS Exs. 20-22.

The videos and image were personal and graphic, showing one resident completely naked, one partially clothed, and the others in bed, and they vividly depict the residents' physical and cognitive impairments. They were taken while the residents were receiving personal care from facility staff. The cell phone containing the videos and image was left in a public establishment. That the cell phone was found and turned over to law enforcement authorities before the images were disseminated or posted on YouTube (which CNA B indicated was her intention) was, we agree with the ALJ, "sheer serendipity." ALJ Decision at 10.

Furthermore, the Board has previously found that where the evidence shows that a facility has been so out of compliance with program requirements that its residents have been placed in immediate jeopardy, an ALJ may reasonably infer that the facility was not administered as required under section 483.75. *Asbury Ctr. at Johnson City*, DAB No. 1815, at 11 (2002); *see also Odd Fellow & Rebekah Health Care Facility*, DAB No. 1839 (2002). As discussed below, Springhill's repeated failures to protect and promote its residents' dignity and right to privacy and confidentiality under sections 483.15(a), 483.10(e), and 483.75(l)(4) resulted in actual harm and posed the likelihood of serious harm to facility residents, creating immediate jeopardy. We therefore conclude that Springhill's noncompliance ultimately reflected a failure on the part of managers to administer the facility in a manner enabling it to effectively attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident as required under section 483.75.

We reject Springhill's arguments that it substantially complied with the participation requirements.

Springhill acknowledges that the actions of CNAs B and K "with respect to privacy and dignity of residents," were "completely unacceptable." Tr. at 5-6. Springhill argues, however, that the CNAs' actions should not be attributed to the facility because it made "reasonable efforts to protect residents against adverse [e]ffects that are reasonably foreseeable" and "took all necessary and appropriate measures to ensure resident safety and privacy at the facility . . . ." P. Br. at 6, 14, *citing Martha & Mary Lutheran Servs.*, DAB No. 2147, at 6 (2008). According to Springhill, CNAs B and K "who were involved in the inappropriate imaging of residents," and CNA B, "who inappropriately spoke to residents, were appropriately screened, trained and supervised by Springhill . . . ." P. Br. at 4; P. Reply at 1, 3.[4] "Despite the rigorous screening and extensive training" of these employees, Springhill contends, CNAs B and K "purposely chose to engage in actions which were in direct opposition to Springhill ... policy and practice and were also in direct opposition to their extensive training." P. Br. at 4, 14-15; P. Reply at 1, 3.

Springhill argues that the ALJ "completely ignored the myriad of safeguards" that the facility put in place and "imposed his own judgment with respect to the requirement that an adverse event be reasonably foreseeable." P. Br. at 6. Springhill also asserts that the ALJ held it to a "strict liability" standard and that prior Departmental Appeals Board "rulings reflect the correct conclusion that 42 C.F.R. 483.13(b) [staff treatment of residents prohibiting abuse and neglect] does not make a facility strictly liable for all incidents of abuse that occur." P. Reply at 2, *citing, inter alia, Oakwood Manor Nursing Ctr.*, DAB CR818 (2001) (ALJ Decision); *Gateway Nursing Ctr.*, DAB CR1963 (2009) (ALJ Decision); *see also* Tr. at 6.

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[4] Springhill also argues that the ALJ erred in finding a "pattern of 'chilling mistreatment by CNAs B, K, and W'" and "insinuat[ing]" that CNA W should have been terminated. P. Br. at 6, *citing* ALJ Decision at 10; 9, n.2. Springhill asserts that CNA W was unaware of the recordings and did not mistreat residents, and that the state agency "accepted that [CNA W] was NOT involved in the abuse or neglect of residents in any way, as demonstrated by the agency's acceptance of Springhill's allegation of compliance terminating the employment of [CNAs B and K]." *Id.* at 6-7 (emphasis in original).

The ALJ did not find that CNA W abused residents; he said that the images "show a chilling pattern of resident mistreatment, involving several residents and CNAs B, K, and W, lasting over a period of almost two months." ALJ Decision at 10. The description of the video of Resident 3 shows that CNA W was in the same room and could hear CNA B making demeaning comments about the resident's body. CNA W was thus involved because she observed CNA B's mistreatment of Resident 3 and did not correct or report CNA B to management. The ALJ logically questioned why CNA W's employment was not terminated in light of Springhill's allegation it had a "zero tolerance" policy for abuse. ALJ Decision at 9, n.2. The state agency's acceptance of the facility's plan of correction (POC), which included terminating CNAs K and B, and counseling but not terminating CNA W, does not show that the state agency found CNA W uninvolved in any violation of resident rights. The acceptance of the POC only shows that the steps taken by Springhill were sufficient to return to substantial compliance.

The ALJ correctly concluded that Springhill "cannot disavow responsibility for the actions of its employees." ALJ Decision at 9. As the Board has explained, for the purpose of evaluating a facility's compliance with the Medicare and Medicaid participation requirements, the facility acts through its staff and cannot dissociate itself from the consequences of its employees' actions. *Beverly Health Care Lumberton*, DAB Ruling No. 2008-5 (Denial of Petition for Reopening Decision No. 2156) at 6-7 (2008); *Emerald Oaks*, DAB No. 1800, at 7, n.3 (2001); *North Carolina State Veterans Nursing Home, Salisbury,* DAB No. 2256 (2009). In *Beverly Health Care Lumberton,* for example, the Board addressed an incident of alleged resident abuse by a CNA and a nurse's failure to report the incident promptly. The Board explained that a facility receiving Medicare and Medicaid funds for its services commits to meeting the participation requirements and "can act only through its agents and employees who make and implement policies, provide care, and perform the various responsibilities called for ... to protect and ensure the welfare of residents." DAB Ruling No. 2008-5, at 6-7. A facility whose staff has been found not in substantial compliance with federal requirements, the Board stated, "is itself subject to administrative enforcement remedies" and cannot avoid remedies by disowning the acts and omissions of its employees "since the facility elected to rely on them to carry out its commitments." *Id. (citations omitted).*

Springhill also is mistaken in contending that the ALJ held it to a "strict liability" standard. The ALJ held Springhill to standards set forth in the Medicare and Medicaid participation regulations, which is not tantamount to applying "strict liability." *Tri-County Extended Care Ctr.*, DAB No. 2060, at 5 (2007); *see also Martha & Mary Lutheran Servs.*; *Lake Mary Health Care*, DAB No. 2081 (2007). The Board previously has noted that "strict liability" is a tort concept that is inapplicable in proceedings conducted under 42 C.F.R. Part 498.[5] *Briarwood Nursing Ctr.,* DAB No. 2115, at 11 n.8; *Jennifer Matthew Nursing & Rehab. Ctr.*, DAB No. 2192 (2008). The issue here is not Springhill's tort liability but its compliance with regulatory standards of resident dignity, privacy, confidentiality, and facility administration. In this case, the illicit image and videos documenting staff mistreatment of residents were made by staff while on duty and assigned to assist residents with various activities of daily living. Electing to meet its commitments to provide care and protect residents' rights through these employees, Springhill cannot now reasonably claim that their misconduct was in effect irrelevant for the purpose of evaluating the facility's compliance.

There is no merit to Springhill's reliance on the Board's Decision in *Mary and Martha Lutheran Services* or its assertion that the ALJ here "gave only lip service to the Board's actual language" in upholding the ALJ's findings of noncompliance in that case. P. Br. at 6. *Mary and Martha* is distinguishable because it involved resident-to-resident abuse, cited by CMS under section 483.13(c), not, as here, staff violations of residents' rights to

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[5] Black's Law Dictionary (9th ed. 2009), defines "strict liability" to mean liability "that does not depend on actual negligence or intent to harm, but that is based on the breach of an absolute duty to make something safe."

dignity, privacy and confidentiality, cited under sections 483.15(a), 483.10(e) and 483.75(l)(4). Even if CMS had cited Springhill's noncompliance under section 483.13(c), *Mary and Martha* would not support Springhill's argument because the violation here involved **staff-to-resident** mistreatment. The Board has stated that because a facility is responsible for its staff's actions, "considerations of foreseeability are inapposite when staff abuse has occurred." *Gateway Nursing Center*, DAB No. 2283, at 8 (2009). Springhill also reads into the Board decision in *Mary and Martha* a limitation not found there. Although *Mary and Martha* did involve a "mounting pattern of **known** abuse," as Springhill states, *id.* (emphasis in original), contrary to Springhill's suggestion, the Board did not indicate that it viewed that factual context as a limitation on the principle that facility staff must make all reasonable efforts to protect residents from foreseeable adverse incidents.

In any event, the record does not support Springhill's claim that it took all necessary and appropriate measures to ensure resident safety and privacy. For example, Springhill asserts that it has "extensive and stringent pre-employment screening programs in place" that apply to all direct care staff. P. Br. at 7, citing P. Ex. 10, at 2; Tr. at 6-7. Springhill's Administrator testified that "background screening includes, but is not limited to, abuse registry verification, criminal background checks, past work history, drug screening, and credit history." P. Ex. 10, at 2; *see also* P. Ex. 10, at 7 (Testimony of Springhill Staff Development Coordinator). According to the Administrator, "any number of things" will cause the facility "to stop the application process and reject the candidate for hire." *Id.* For example, "[e]rrors or falsification of job history, poor credit history, positive drug screening results, [or] poor references ... will halt the application process." *Id.* Springhill describes its hiring standard as a "hard line position . . . to meet the facility's commitment to hiring professional, competent, well trained staff." P. Br. at 7, citing P. Ex. 10, at 2; Tr.at 7. According to Springhill, both CNAs B and K "went through this rigorous pre-employment screening process" and there "were NO issues noted with any of the screenings for these CNAs." P. Br. at 7-8; P. Ex. 10, at 2 (emphasis in original).

Contrary to these assertions, the documentation in the record relating to Springhill's decision to hire CNA B shows that the facility never verified any prior employment reference for her. The "Confidential Reference Request" form used by Springhill asked the institution identified by the applicant as her prior employer to verify the dates of her employment and her position or title. P. Ex. 2, at 12. In addition, the reference form asked why she left, whether the facility would re-hire her, the quality of her work, productive output, attendance, cooperation and initiative. *Id.* The only reference form in CNA B's employment records, for the William F. Green facility, was not completed. *Id.* In a section on the form titled "Other comments" is a handwritten note: "Unable to verify as Wm F. Green uses a charge per reference service 'The work#'. This based on interview – 90 day probation." *Id.* When Springhill's counsel was asked about this document during oral argument, she stated that the institution named by CNA B as her reference "did not want to participate with respect to any type of ... employment

verification or any type of employment reference … because they were having some issues with terminations and hirings that were leading them to be a little bit nervous about that process." Tr. at 9. She further stated that under these circumstances, it was Springhill's policy to ask for a second or third reference, but acknowledged that there is no evidence in the record that Springhill attempted to obtain another reference for CNA B. Tr. at 10-11.

Similarly, the evidence relating to Springhill's decision to hire CNA K contradicts the facility's claim that "[a]ny type of poor reference … will halt the application process." Tr. at 7. The sole "Confidential Reference Request" in the record for CNA K states that the reason she left her prior employer was that she was "laid off," without further explanation. The questions on the form about whether the prior employer would rehire the employee, the quality of her work, her productive output, and whether she was cooperative were left blank. *Id.* Furthermore, Springhill has presented no evidence that it attempted to obtain a second reference for CNA K. That Springhill hired both CNAs B and K without obtaining the employment reference information sought by the facility's own form and without attempting to obtain additional references for these employees belies its assertion that it took a "hard line position" when hiring direct care staff.

Substantial evidence in the record also supports the ALJ's conclusion that Springhill's CNA training program "failed in application." ALJ Decision at 10. Springhill asserts that it has "extensive orientation and on-the-job training" for CNAs, including "instruction on . . . preventing, recognizing and reporting of abuse," as well as the facility's "zero tolerance policy with respect to any type of resident abuse . . . ." P. Br. at 9; P. Ex. 7. Springhill's abuse prevention policy states that the facility will provide residents, families and staff with information on how and to whom they may report concerns, incidents and grievances; that the facility will identify, correct and intervene in situations in which abuse or neglect is more likely to occur; and that staff will be supervised to identify inappropriate behavior such as using derogatory language, rough handling and ignoring residents while providing care. P. Ex. 7, at 1-2. Springhill also argues that CNAs B and K "were educated on and acknowledged their understanding of [Springhill's] policy regarding confidentiality and privacy prior to providing resident care." P. Br. at 9.

Although CNA K successfully completed Springhill's in-class and clinical training programs, the record shows that she failed to understand the facility's abuse, resident dignity and privacy policies. Specifically, CNA K stated in her survey interview that she did not report CNA B's filming Resident 4, "Because I don't get into other people' business. . . . Because I don't get involved with stuff like that; it didn't have anything to do with me." CMS Ex. 1, at 16. When asked what her responsibility was when she witnessed abuse, CNA K answered, "I guess report but is that abuse that would be

invading her [Resident 4's] privacy[?]" *Id.* When asked if abuse was the only behavior she was responsible to report, CNA K replied, "Yes if she [CNA B] would have hit her [Resident 4], cursed her, sexually abused her, hurt her but I guess that is hurting her. I just didn't think of it like that." *Id.*

The survey interviews of CNA K demonstrate that even after her in-class training, testing and clinical preceptorship, CNA K did not understand her duty to report resident privacy violations or nonphysical abuse. Similarly, CNA W's failure to report CNA B's verbal mistreatment of Resident 3 indicates that CNA W also did not understand her duty to report staff violations of resident dignity, such as making derogatory comments to a resident about his physical appearance. Thus, while Springhill had written policies addressing the regulatory requirements, the ALJ could reasonably infer from this evidence that Springhill's CNA training program did not effectively educate staff about resident rights. This evidence also shows that not all of the noncompliant conduct at issue was simply the result of purposeful choices to engage in actions that employees knew were in direct opposition to facility policies, as Springhill argues.

The record, moreover, does not substantiate Springhill's claim that it "appropriately supervised" the CNAs. P. Br. at 4. Most notably, while the misconduct took place over an extended period of time and involved four different residents, Springhill admits that "[p]rior to the date on which the survey team provided" facility administrators "with an opportunity to review the CD," no administrators or other staff members were aware of the CNAs' actions. P. Br. at 14. In addition, Springhill did not include in its submissions any information about its policies or procedures for supervising CNAs following their initial training, such as periodic or random monitoring. When asked during oral argument whether there were any such policies or procedures, counsel for Springhill stated only that after completing their training, the CNAs would have been supervised by the "LPN floor nurse" as well as an "RN unit supervisor charge nurse." Tr. at 18. In light of the lack of evidence about the nature of this supervision or about whether the facility had policies and procedures for regularly monitoring its CNAs, the ALJ could reasonably infer from the number of incidents of misconduct, the lengthy period of time during which those incidents took place, Springhill's failure to realize the misconduct was taking place, and the discovery of the videos in a public place, that the facility's oversight of the CNAs was insufficient. ALJ Decision at 9.

We sustain the ALJ's conclusion that CMS's immediate jeopardy determination was not clearly erroneous.

As noted, "immediate jeopardy" is defined as "a situation in which 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.

CMS's immediate jeopardy finding "must be upheld unless it is clearly erroneous." 42 C.F.R. § 498.60(c)(2). "The 'clearly erroneous' standard ... is highly deferential and places a heavy burden on the facility to upset CMS's finding regarding the level of noncompliance." *Yakima Valley School*, DAB No. 2422, at 8 (2011) (citing cases).

Consistent with the regulations and CMS guidance, the Board has recognized that serious harm or injury can be psychological as well as physical in nature. *See, e.g., Somerset Nursing & Rehab. Facility*, DAB No. 2353 (2010); SOM, Appendix Q – Guidelines for Determining Immediate Jeopardy, III. Principles (stating that "psychological harm is as serious as physical harm" and "the identification and removal of Immediate Jeopardy, either psychological or physical, are essential to prevent serious harm, injury, impairment, or death for individuals").

Here, the ALJ concluded that CMS's immediate jeopardy finding was not clearly erroneous because "the forcible manner in which CNA B fed Resident 1" was likely to cause serious harm, illness or death. ALJ Decision at 10. In addition, the ALJ concluded, "each of the four residents' dignity and self-respect was compromised" by the CNAs' conduct. *Id.* "The video taping of the residents and the potential exposure of these videotapes to public view," the ALJ stated, "was likely to harm the residents' psychosocial well-being." *Id.* at 11. Resident 3, the ALJ found, sustained actual psychosocial harm, reflected in his statement to the surveyors that he was humiliated and angry because he had been videotaped without his consent. *Id.* The ALJ noted that Springhill did not directly argue that the CNAs' misconduct did not constitute immediate jeopardy, but asserted that no action or failure on the facility's part constituted immediate jeopardy because it had taken all necessary steps to ensure resident safety and privacy. *Id.* The ALJ rejected that argument and concluded that Springhill failed to prove that CMS's determination of immediate jeopardy was clearly erroneous. *Id.*

We find no fault in the ALJ's analysis. The record shows that the way in which CNA B fed Resident 1 was likely to cause Resident 1 serious physical injury, illness or death. Resident 1's medical records document that she suffered from malnourishment and dysphagia, and she was at risk for aspiration. CMS Ex. 12, at 33; CMS Ex. 16, at 3-4. Staff caring for Resident 1 had been directed to feed her pureed food following facility guidelines, "safe swallowing precautions," and "compensatory swallowing strategies," including "allow[ing] plenty of time … to chew and swallow." CMS Ex. 1, at 35; CMS Ex. 16, at 3-4. When the surveyors showed the Speech Therapist the video of CNA B feeding Resident 1, the Speech Therapist stated that the resident was not properly positioned for eating; she was given multiple portions before she was allowed to swallow; she was fed "way too fast;" the "portions were too large;" her vocal quality was "wet, which suggests residue in the pharynx;" and "staff did not alternate between liquids and solids." CMS Exs. 1 at 35-36; 16, at 3-4. The Speech Therapist "explained that the main two dangers [of] being fed in this manner are pneumonia and asphyxiation…." *Id.* When asked what could have happened to the resident, the Speech Therapist replied that

the resident "could have choked but the worst thing that could have happened is that [she] could have aspirated some of the food in her lungs, which could cause aspiration pneumonia, which could have killed her." *Id.*

Moreover, the evidence shows that CNA B's force-feeding and verbal denigration of Resident 1 did cause the resident serious mental anguish. As shown in the May 29, 2011 videos, after Resident 1 told the CNA that a large portion of food she had been fed was "too much" and that she "couldn't eat anymore," the CNA continued to feed "large spoonfuls of food" to the resident "hurriedly," while calling her demeaning names, forcing her to apologize, characterizing her food as "guts," and yelling at the resident to "Shut up!...drink up!" CMS Exs. 1, at 32-33; 16, at 3. That the CNA's actions caused Resident 1 serious mental anguish is evident in the resident "scream[ing], 'Quit,'" "yell[ing] that she didn't want any more," and "scream[ing] to be left alone." CMS Exs. 1, at 33-34; 16, at 3-4.

CMS did not clearly err in determining that Resident 3 suffered serious psychological harm, and that the other residents likely experienced psychosocial harm or mental anguish, as a consequence of the CNAs' mistreatment and Springhill's failure to ensure the residents' privacy and confidentiality. As the ALJ found, when Resident 3 was shown the video taken of him on May 19, he told the surveyors that he was humiliated and "mad as hell" that the recording had been made without his knowledge or permission, and because it could be posted on the Internet. ALJ Decision at 11, *citing* CMS Ex. 16, at 6. CMS could reasonably conclude based on these statements that Resident 3 suffered serious psychological harm.

CMS could also reasonably infer that CNA B's demeaning statements to Residents 1 and 4 caused serious psychological harm even though Residents 1 and 4 could not fully express their feelings because of their cognitive impairments. As counsel for Springhill stated, Springhill instructs its CNAs that "verbal abuse can occur even with residents who are deemed to be incompetent." Tr. at 12. Counsel for Springhill also explained that even when staff provide care to "residents who are deemed to be comatose, [staff] cannot use those derogatory terms or . . . engage in those behaviors within the hearing distance of a resident or family regardless of their age or their ability to comprehend." *Id.* Thus, Springhill recognizes that CNA B's denigrating statements and behaviors posed psychological harm to Residents 1 and 4 even though the residents were cognitively impaired.

Springhill does not directly contest CMS's determination that the CNAs' conduct posed immediate jeopardy to Residents 1-4; nor does Springhill directly challenge the ALJ's analysis of the immediate jeopardy issue. Rather, Springhill argues that the immediate jeopardy finding was the result of CMS imposing a "strict liability standard" with respect to the facility's obligation "to adopt and implement policies and procedures to avoid occurrences of mistreatment, neglect and abuse." P. Br. at 16, citing 42 C.F.R.

§ 483.13(c). Springhill reiterates that it "had no knowledge of the clandestine actions of [CNAs B and K], despite having all adequate safeguards, policies and training in place." *Id.* What Springhill appears to be saying is that but for the finding of noncompliance, CMS could not have determined the level of that noncompliance. That is correct but irrelevant. CMS did find noncompliance, and we have concluded that the ALJ did not err in upholding that finding and that substantial evidence supports it. In upholding the ALJ's conclusion on that issue, we also rejected Springhill's "strict liability" argument. Springhill makes no relevant argument for overturning the ALJ's conclusion that CMS's immediate jeopardy determination was not clearly erroneous, and we find no basis for doing so.

We affirm the ALJ's conclusion that the CMP imposed was reasonable in duration and amount.

A long-term care facility found to be not in substantial compliance is subject to various enforcement remedies, including CMPs. 42 C.F.R. §§ 488.402(b), (c), 488.406, 488.408. CMS may impose per-instance or per-day CMPs. 42 C.F.R. § 488.408(d)(1)(iii)-(iv), (e)(1)(iii)-(iv). "CMS's decision to impose a per-day CMP as opposed to some other remedy, such as a per-instance CMP, is a choice committed to CMS's discretion by the regulations [that] is not subject to review." *Kenton Healthcare, LLC,* DAB No. 2186, at 28, *citing* 42 C.F.R. §§ 488.408 (listing per-day and per-instance CMPs as separate and distinct remedies from among which CMS may choose); 488.408(g)(2) (a facility may not appeal the choice of remedy, including the factors considered by CMS in selecting the remedy); 498.3(d)(11) (the choice of remedy to be imposed on a provider is not subject to appeal); 42 C.F.R. § 488.438(e)(2) (where a basis for imposing a CMP exists, the ALJ cannot review CMS's exercise of discretion to impose a CMP).

The range of the per-day CMP amounts for immediate jeopardy noncompliance is $3,050-$10,000 per day. 42 C.F.R. §§ 488.408(e)(1)(iii), 488.438(a)(1)(i). The range for noncompliance that is not immediate jeopardy is $50-$3,000 per day. 42 C.F.R. §§ 488.408(d)(1)(iii), 488.438(a)(1)(ii). When CMS imposes one or more remedies, those remedies continue until "[t]he facility has achieved substantial compliance, as determined by CMS or the State based upon a revisit or after an examination of credible written evidence that it can verify without an on-site visit . . . ." 42 C.F.R. § 488.454(a)(1).

An ALJ (or the Board) determines de novo whether a CMP is reasonable based on the factors specified in section 488.438. *See* 42 C.F.R. § 488.438(e), (f). Those factors are: (1) the facility's history of noncompliance; (2) its financial condition — that is, its ability to pay a CMP; (3) the severity and scope of the noncompliance, and "the relationship of the one deficiency to other deficiencies resulting in noncompliance"; and (4) the facility's degree of culpability, which includes neglect, indifference, or disregard for resident care,

comfort or safety. 42 C.F.R. §§ 488.438(f), 488.404(b), (c)(1). With respect to the culpability factor, however, "[t]he absence of culpability is not a mitigating circumstance in reducing the amount of the penalty." *Id.* § 488.438(f)(4).

In this case, CMS imposed a CMP of $5,550 per day effective May 2, through June 23, 2011; CMS imposed a CMP of $100 per day effective June 24, through June 30, 2011, for a total CMP amount of $294,850. In doing so, CMS rejected the state agency's recommendation to impose a per-instance CMP of $1,000.[6]

Springhill argues that the amount of the CMP is "extraordinarily high" and that it represents CMS's "attempt … to impose a strict liability standard" on the facility "for information regarding the clandestine actions of [CNAs B and K] – information which the facility could not have known prior to the entrance of the survey team." P. Br. at 17-18. "If any period of non-compliance may be said to exist," Springhill asserts, "any period of immediate jeopardy runs only from June 21, 2011 (when the facility first became aware of the actions of [CNAs B and K]) through June 23, 2011, when all parties agree that the jeopardy was abated, and that any period of noncompliance at a 'D' level ends on June 30, 2011." P. Br at 18.

Once again, Springhill's "strict liability" argument is irrelevant. To show the CMP amount to be unreasonable, Springhill must show that it is not reasonable under the regulatory criteria cited above for that determination. As discussed below, Springhill has not even tried to make such a showing. Nor has Springhill provided any evidence that it "could not have known" about the CNAs' conduct prior to the entrance of the survey team on June 21. Indeed, as indicated above, the ALJ could reasonably infer that, if the facility was implementing its policies as stringently as it claims, it would have known. Moreover, as discussed above, in the long-term care enforcement context, a nursing facility cannot avoid a finding of noncompliance by disavowing responsibility for its employees' actions.

With respect to the duration of the penalty, we agree with the ALJ that it was not clear error for CMS to conclude that the conditions posing immediate jeopardy existed as of May 2, 2011, the date the first recording/image of a Springhill resident was made, and that those conditions continued unabated, as reflected by the additional recordings and the absence of intervening action to address the noncompliance, until June 23, 2011. ALJ Decision at 12. The record further supports the conclusion that the jeopardy was abated no earlier than June 23, 2011, by which time Springhill had terminated CNAs B and K; reported CNA B to the state agency and local law enforcement authorities; counseled CNA W; checked YouTube, Twitter, and Facebook for resident images; completed

[6] The ALJ noted, "As Petitioner recognizes, the state agency's suggestion of a per instance CMP is only a recommendation," which the ALJ found "surprisingly low and would hardly yield corrective action." ALJ Decision at 12.

resident interviews to determine if there were any other similar violations; continued in-servicing staff on abuse, neglect, cell phone use, resident rights, and confidentiality requirements; and continued monitoring for "resident rights violations." *Id.* at 2-3. CMS Ex. 1, at 2-3. The SOD further shows, and Springhill does not deny, that substantial compliance was achieved no earlier than June 30, 2011, when the facility completed in-servicing staff and had conducted sufficient random monitoring to assure the facility's return to substantial compliance.

With respect to the penalty amounts assessed in this case, the ALJ explained, "Unless a facility contends that a particular regulatory factor does not support that CMP amount, the ALJ must sustain it." ALJ Decision at 13, *citing Coquina Ctr.,* DAB No. 1860 (2002). In this case, Springhill did not introduce evidence or argument regarding its financial condition or ability to pay the CMP. With respect to its history of noncompliance, Springhill also did not challenge CMS's assertion that it was found noncompliant with the quality of care provisions in a 2010 survey. ALJ Decision at 13. With regard to the facility's culpability, we agree with the ALJ that Springhill "failed to protect the health, dignity, and privacy of four residents when members of its staff ridiculed and videotaped them without their consent and forcibly fed one resident," and that the "exposure of these vulnerable residents to staff who could subject them to abuse with such impunity is highly concerning." *Id.* Accordingly, we concur in the ALJ's determination that the per-day amounts of the CMPs imposed, in the lower half of the range for the immediate jeopardy period, and in the very low part of the range for the non-immediate jeopardy period, were "especially reasonable" in light of the nature of the deficiencies and the facility's culpability. *Id.*

Sections 1819(f)(2)(B) and 1919(f)(2)(B) of the Act and 42 C.F.R. § 483.151(b)(2)(iv), prohibit approval to operate a NATCEP at any facility that has been assessed a CMP of not less than $5,000. Accordingly, we sustain the ALJ's determination that loss of approval of Springhill's NATCEP program was required by law.

Conclusion

For the reasons discussed above, we affirm the ALJ Decision.

/s/
Judith A. Ballard

/s/
Leslie A. Sussan

/s/
Sheila Ann Hegy
Presiding Board Member