Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Bartley Healthcare Nursing and Rehabilitation,

Petitioner,

v.

Centers for Medicare and Medicaid Services.

Docket No. C-11-644

Decision No. CR2684

Date: January 11, 2012

DECISION

I grant summary judgment to the Centers for Medicare and Medicaid Services (CMS) and find Petitioner, Bartley Nursing and Rehabilitation, was not in substantial compliance with federal Medicare requirements. The undisputed evidence shows that Petitioner discharged a resident without the required preparation and orientation and without a legitimate post-discharge plan of care that was developed with the participation of the resident's family. Further, I find that a per-instance civil money penalty (PICMP) of $6,200 is reasonable.

I. Procedural History

Petitioner, also referenced as "the facility" in this decision, is a nursing home located in Jackson, New Jersey. On October 25, 2010, the New Jersey State Department of Health and Senior Services (state agency) conducted a complaint survey to determine whether Petitioner was in compliance with federal participation requirements. The surveyors determined that Petitioner was not in compliance, at an immediate jeopardy level, with 42 C.F.R. § 483.12(a)(7), relating to preparation for a safe and orderly resident discharge, and 42 C.F.R. § 483.25, relating to quality of resident care. By notice letter dated November 15, 2010, CMS imposed a PICMP of $6,200 against the facility.

Petitioner filed a request for hearing by letter dated January 17, 2011, which was received by the Departmental Appeals Board on July 30, 2011. This case was assigned to me for hearing and decision. On August 1, 2011, I issued an Acknowledgment, Initial Pre-Hearing Order, and Order to Show Cause because my review of Petitioner's hearing request raised questions about the timeliness of its hearing request. On August 8, 2011, Petitioner filed its response to my Order to Show Cause and established good cause for the late receipt of its hearing request by showing it sent a timely request directly to CMS.

On October 31, 2011, CMS filed its Prehearing Brief and Motion for Summary Judgment (CMS Br.) accompanied by 52 exhibits (CMS Exs. 1-52). In its motion, CMS further alleged that Petitioner was also not in substantial compliance with 42 C.F.R. 483.20(l) requiring a discharged resident to have a discharge summary that includes a "post-discharge plan of care that is developed with the participation of the resident and his or her family, which will assist the resident to adjust to his new living environment."[1] 42 C.F.R. § 483.20(l)(3). CMS claimed this further supported the CMP it imposed upon Petitioner. Petitioner requested, and was granted, an extension of time to file its exchange. On January 17, 2012, Petitioner filed its Prehearing Brief and Opposition to Motion for Summary Judgment (P. Br.) accompanied by 13 exhibits (P. Exs. 1-13). I admit all exhibits to the record absent any objection from the parties.

II. Case Background

The following background facts are not disputed. This case revolves around issues related to the discharge one of Petitioner's residents, who is identified in the state survey and in this decision as "Resident 3" for privacy reasons. At the time of his discharge, Resident 3 was a 76-year-old insulin-dependent, 204-pound man on numerous medications, who was paralyzed on the left side of his body with weakness on the right side of his body. Resident 3 needed total assistance with almost all activities of daily living (ADL) and was at risk for aspiration.

Petitioner discharged Resident 3 at approximately 5:00 p.m. one evening to the house he shared only with his 77-year-old wife, who herself was recently discharged from Petitioner's facility after rehabilitation for a broken femur. There was no nursing or other professional medical assistance awaiting his arrival at home and no outside nursing or other professional medical assistance arrived at his home the next day. When he tried to enter his home, his wheelchair could not fit through the doorway, and he needed to wait in his garage approximately one hour until a wheelchair that could fit into his house was brought to him. On his person, Resident 3 brought a discharge summary that contained 8

[1] CMS may allege additional violations not included in its original notice letter if CMS provides sufficient notice to a petitioner during the pre-hearing process. *See, e.g.*, *Alden Town Manor Rehab. & HCC*, DAB No. 2054, at 17-19 (2006).

prescriptions for 11 different medications that Resident 3 took on a regular basis, all which needed to be expeditiously filled because Petitioner sent no medication home with him.

The discharge summary also contained medical notes for Resident 3 to be catheterized every eight hours as needed, to receive an insulin injection for his diabetes each evening, and to be transferred to his bed via a sling lift, just delivered to his house at 4:00 p.m., which required the assistance of at least two people.

Resident 3 remained at his home for approximately 22 hours before Petitioner readmitted him back to its facility. He did not receive his insulin injection nor any of his other medications during this period of discharge. The only medical care he received was from Petitioner's staff who came to his house the day after his discharge at the request of Resident 3's family and state workers and not as part of his discharge planning or post-discharge plan of care.

III. Issues

a. Whether Petitioner was in substantial compliance with:

42 C.F.R. § 483.12(a)(7), or

42 C.F.R. § 483.20(l)(3)[2]; and, if so,

b. Whether the $6,200 CMP that CMS imposed is reasonable.

"*Substantial compliance* means 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." 42 C.F.R. § 488.301 (italics in original).

CMS bases the level of seriousness of a violation on an assessment of scope (whether the deficiency is isolated, a pattern, or widespread) and severity (the degree of harm, or potential harm, to resident health and safety posed by the deficiency). The highest level of severity is "immediate jeopardy," defined as "a situation in which the provider's noncompliance . . . has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident." 42 C.F.R. § 488.301. Here, I have no authority to review CMS's determination that Petitioner's noncompliance constituted immediate jeopardy. *See, e.g.*,

[2] I do not find it necessary to decide CMS's allegation of substantial noncompliance under 42 C.F.R. § 483.25 considering I am finding violations of these other regulations more than adequately support the CMP that CMS imposed. *See, e.g.*, *Claiborne-Hughes Health Center v. Sebelius, et al.*, 609 F.3d 839, 847 (6th Cir. 2010).

Oaks of Mid City Nursing & Rehab Ctr., DAB No. 2375, at 23-24 (2011) (explaining how an Administrative Law Judge (ALJ) may not review CMS's scope and severity determination in cases involving the imposition of PICMPs and no substandard quality of care findings); *see also Hanover Hill Health Care Ctr.*, DAB CR 2617, at 3-4 (2012) (explaining that when CMS imposes a penalty of $5,000 or more, a state agency cannot approve a nurse aid training program regardless of any immediate jeopardy finding, which ultimately precludes ALJ review of CMS's immediate jeopardy finding involving a PICMP).

IV. Discussion

a. Summary judgment is appropriate.

Summary judgment is appropriate when a case presents no issue of material fact, and its resolution turns on questions of law. *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 247-48 (1986); *Livingston Care Ctr. v. U.S. Dep't. of Health & Human Servs.*, 388 F.3d 168, 173 (6th Cir. 2004); *see also Ill. Knights Templar Home*, DAB No. 2274, at 3-4 (2009) (*citing Kingsville Nursing Ctr.*, DAB No. 2234, at 3-4 (2009)). The moving party may show the absence of a genuine factual dispute by presenting evidence so one-sided that it must prevail as a matter of law or by showing that the non-moving party has presented no evidence "sufficient to establish the existence of an element essential to [that party's] case, and on which [that party] will bear the burden of proof at trial." *Livingston Care Ctr.*, 388 F.3d at 173 (quoting *Celotex Corp. v. Catrett*, 477 U.S. 317, 323-24 (1986)). To avoid summary judgment, the non-moving party must then act affirmatively by tendering evidence of specific facts showing that a dispute exists. *Matsushita Elec. Indus. Co. v. Zenith Radio Corp.,* 475 U.S. 574, 586 n.11 (1986); s*ee also Vandalia Park,* DAB No. 1939 (2004); *Lebanon Nursing & Rehab. Ctr.,* DAB No. 1918 (2004).

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

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

In examining the evidence for purposes of determining the appropriateness of summary judgment, I must draw all reasonable inferences in the light most favorable to the non-moving party. *Brightview Care Ctr.*, DAB No. 2132, at 2, 9 (2007); *Livingston Care Ctr.*, 388 F.3d at 172; *Guardian Health Care Ctr.,* DAB No. 1943, at 8 (2004); *but see*, *Cedar Lake*, DAB No. 2344, at 7 (2010); *Brightview*, DAB No. 2132, at 10 (entry of summary judgment upheld where inferences and views of non-moving party are not reasonable). However, drawing factual inferences in the light most favorable to the non-moving party does not require that I accept the non-moving party's legal conclusions.

Cedar Lake, DAB No. 2344, at 7; *Guardian*, DAB No. 1943, at 11 ("A dispute over the conclusion to be drawn from applying relevant legal criteria to undisputed facts does not preclude summary judgment if the record is sufficiently developed and there is only one reasonable conclusion that can be drawn from those facts.").

Drawing all reasonable inferences in Petitioner's favor, I find the undisputed facts lead to the reasonable conclusion that the facility was not in substantial compliance with program requirements. My findings of fact and conclusions of law are summarized in the bold, italicized headings of this decision.

b. Petitioner was not in substantial compliance with 42 C.F.R. § 483.12(a)(7) because the undisputed evidence shows Petitioner released Resident 3 to his home without proper preparation and orientation to ensure a safe and orderly discharge.

The regulation at 42 C.F.R. § 483.12(a)(7) requires:

> *Orientation for transfer or discharge*. A facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility.

1. Petitioner did not confirm, before releasing Resident 3, that nursing and aide services were awaiting Resident 3 at his house.

It is undisputed that Resident 3 was not able to care for himself at home. He was originally admitted to Petitioner's facility on March 13, 2010 from a rehabilitation hospital after a stroke. He was diagnosed with cerebral vascular disease (a prior stoke), hemiplegia (paralysis on left side of his body), hemiparesis (right sided weakness), hypertension, diabetes mellitus, and depression. CMS Ex. 50, ¶ 7. His Minimum Data Set (MDS) completed on October 23, 2010, the day after his return to the facility, indicates that Resident 3 needed extensive assistance with almost all ADLs, including transfer, dressing, personal hygiene, and locomotion in a wheelchair. CMS Ex. 22, at 10-11. For bed mobility, transfer, and toilet use, Resident 3 was assessed as requiring "two+" persons to physically assist him. *Id.* Resident 3's care plan identified Resident 3 to be at risk for aspiration due to prior stoke with left side hemiparesis, dysphagia, past aspiration pneumonia, and respiratory failure. CMS Ex. 23, at 16.

CMS alleges Petitioner's Assistant Director of Nursing and Social Worker informed a state worker that arrangements had been made for skilled nursing services with the Visiting Nurse Association of Central New Jersey (VNACJ) to begin within 48 hours of Resident 3's discharge. CMS Ex. 47, ¶ 13. Petitioner also alleges that its Social Worker made phone calls, two days in advance of Resident 3's discharge, to arrange for services

of a nurse aide obtained from a home health agency to be available to Resident 3 starting on the day of his discharge.

For purposes of summary judgment, I will accept as true that Petitioner made these phone calls and that the Social Worker believed the outside services would be available two days later at Resident 3's home. It is undisputed that Petitioner was relying on these outside services to educate Resident 3's family, after discharge to his home, on how to assist in testing Resident 3's glucose levels, injecting his insulin, and operating a sling lift that required the assistance of at least two persons. However there is no dispute that Petitioner released Resident 3 without confirming that nursing or aide services were standing by, in place, to assist Resident 3 with his medical needs when he arrived home.

The effect of discharging Resident 3 to his home without confirming the presence of professional care services resulted in Resident 3's untrained family members assuming the responsibility to provide him the medical care he needed. The regulation requires the Petitioner to "ensure a safe and orderly discharge from the facility." This would require that Petitioner confirm services were in place at the time of Resident 3's discharge to care for his many medical needs, especially considering Petitioner arranged for those particular nursing services only two days prior. To do otherwise meant discharging a resident to untrained caretakers who could cause more than minimal harm by not administering medication, injecting the medication incorrectly, or causing the resident to fall and hurt himself through an untrained transfer using the sling lift which had just arrived the day of Resident 3's discharge.

2. Petitioner discharged Resident 3 to family members who were either unable or unwilling to provide care to Resident 3.

Petitioner was aware that Resident 3, prior to his stoke, was previously the primary care giver for his wife, who had alcohol dementia. P. Ex. 12, at 9, 15. Petitioner was also aware that Resident 3's 77-year-old wife was the only person living in Resident 3's home and was recently discharged from Petitioner's facility after rehabilitation for a broken femur. It was also undisputed Resident 3's daughter did not reside in Resident 3's home, she returned to her home on the evening of the discharge at 7:00 p.m., and she did not arrive again to Resident 3's home until the next morning. It is further undisputed that no other family member was involved with regard to Resident 3's discharge planning.

CMS claims that Resident 3's family immediately complained to state officials about his discharge. On October 19, 2010, the state agency allegedly received a telephone complaint from Resident 3's daughter in which she stated that Petitioner, for the first time that morning, discussed Resident 3's October 21st discharge home. Resident 3's daughter stated that Resident 3 had a catheter, required a sling lift for transfers, had a prior stroke, had no use of his legs or left hand, and had limited use of his right hand. CMS Ex. 9; CMS Ex. 51, ¶¶ 10-11. Resident 3's daughter allegedly stated that all previous

conversations with Petitioner's staff focused on the discharge of her father to another facility, and no training had been provided to the family regarding Resident 3's care. CMS Ex. 47, ¶ 11; CMS Ex. 10, at 3.

During this time, CMS claims that Resident 3's daughter called both Petitioner's facility and the state agency. Resident 3's daughter allegedly told the state agency that neither she, her father, nor her mother had been instructed on how to administer insulin by injection,[3] and Petitioner sent no medications home with her father. CMS Ex. 47, ¶ 21; CMS Ex. 48, ¶ 12. No one was available from the nursing services organization that Petitioner arranged to come the evening of Resident 3's discharge. CMS Ex. 51, ¶ 24. No nurse aide from any other nurse aide agency could be located to come to Resident 3's home. *Id.* at ¶ 26. A nurse from a service came the following day to do an evaluation of Resident 3, not provide services, and it allegedly took five days after an evaluation to arrange for a visit from a nurse. Resident 3's daughter allegedly attempted to contact the doctor who prescribed her father's insulin, but the doctor's clinic was closed for the evening. Resident 3's daughter allegedly complained that the family had not been trained on how to use a sling lift. The state agency representatives allegedly informed Resident 3's daughter not to use the sling lift because it was dangerous without proper training on its use. CMS Ex. 47, ¶ 32; CMS Ex. 48, ¶ 21.

Petitioner argues Resident 3's daughter and wife were "sabotaging family member[s]" because they did not cooperate with the recommendations of the discharge plan and never filled the prescriptions attached to the discharge plan. P. Br. at 2, 9-10, 24. However, if I draw the inference, for summary judgment purposes, that Resident 3's family was able, but simply not willing to administer his medical care, Petitioner was still not in substantial compliance with this requirement. To prepare for a safe discharge, Petitioner had a duty, during the discharge planning process, to interact with Resident 3's family to ascertain whether they were willing to provide medical care to him once it discharged him. It is unreasonable to infer that Petitioner had no idea that Resident 3's family members would not provide his medical care (which included the undisputed requirements of insulin injections and "two +" assistance with bed transfers, mobility, and toileting) before Resident 3's discharge, and I accordingly do not make that inference. Petitioner clearly had the ability to ascertain unequivocally whether Petitioner's family was willing to provide Resident 3's care before it discharged Resident 3, especially if Petitioner was not going to confirm the presence of nursing services at Resident 3's house at the time of discharge. I find that Petitioner did not do so.

Petitioner does not dispute that it did not train Resident 3's family to administer his insulin and argues that *Carehouse Convalescent Hospital*, DAB No. 1799 (2001), and *Ontario Care Center*, DAB CR713 (2000), provide that Petitioner has no affirmative duty

[3] Prior to his stroke, Resident 3 was receiving oral diabetic medications and not insulin. P. Ex. 8, at 13.

to establish care for a resident outside of its premises because it is an environment that is outside the control of the facility. P. Br. at 21.

Petitioner relies on *Carehouse* as a factually indistinguishable case where the Board upheld an ALJ's finding of compliance with discharge requirements. Petitioner points to the facts that the facility's staff in *Carehouse* discussed discharge plans with the resident and his wife prior to the day of discharge, and, on the day of discharge, the facility provided teaching with respect the resident's medications, and the resident verbalized understanding that his wife would help him. P. Br. at 19-20. However, I find *Carehouse* factually distinguishable considering the ALJ also relied on evidence that the facility provided additional teaching to the resident's wife when she arrived to pick up her husband. *Carehouse*, DAB No. 1799, at 46. Here, there is no dispute that Petitioner did not provide Resident 3's wife with teaching for the post-discharge care of her husband. This is a critical fact considering it is also undisputed that Resident 3 was not able to administer his own medical care and his wife was the only family member living with him.

Petitioner relies on *Ontario* for the premise that, in a "strikingly similar set of facts," an ALJ concluded that a discharge was safe and properly planned for despite problems that followed the discharge. P. Br. at 18. Petitioner further argues this case established that Petitioner had no affirmative duty to train a caregiver to administer insulin for a resident once outside of its premises. ***Id.***

In *Ontario*, the ALJ's finding had to do with requirements of a different deficiency, 42 C.F.R. § 483.15(g), relating to providing medically related social services to residents so that residents may attain their highest practicable levels of physical, mental, and psychosocial well-being. The ALJ reached his conclusion with the understanding that it was reasonable for the petitioner not to discharge the resident until petitioner had assurances that the resident's family had approved the resident's discharge. *Ontario*, DAB CR713, at 11. Here, Petitioner did not get this assurance from Resident 3's family and did not confirm that professional caregivers were in place at the time of Resident 3's discharge. It was totally unacceptable under the requirements of 483.12(a)(7) to discharge Resident 3 to his family, without confirming that professional care services were in place, and expect Resident 3's family to inject his insulin and safely use a sling lift with no training.

3. Petitioner did not provide any medications to Resident 3 upon his discharge.

It is undisputed that Resident 3 was on multiple medications including Plavix (an anticoagulant), Norvasc (an antianginal used to treat high blood pressure and chest pain), Simvastin (to control high cholesterol), Lyrica (to relieve neuropathic pain from diabetes), Flomax (to treat hyperplasia or enlarged prostate), Remeron (an antidepressant), a transdermal patch of Lidoderm (painkiller), and had a standing order

for 14 units Lantus (insulin), by subcutaneous injection at bedtime (9:00 p.m.). During his stay in the facility, staff monitored Resident 3's diabetes by a fingerstick every morning before breakfast, had orders for transfers by sling lift, aspiration precautions, diabetic diet, and thin liquids. CMS Ex. 24, at 1-3.

Petitioner discharged Resident 3 to his home and, just a few hours later, he required an injection of insulin, even though Petitioner had not trained anyone in his family on how to do so and provided no medication upon discharge. I find this failure of the facility to provide at least minimal amounts of critical medications for Resident 3, such as his insulin, puts him in jeopardy and is a violation of the regulations. *See, e.g.*, *Sorrento Care Ctr*., DAB CR2511, at 23 (2012) ("[S]ending a diabetic away without the means for testing his blood and without critical medications puts him in jeopardy.")

In addition to not receiving his insulin, there is no dispute that during the 22 hours that Resident 3 was home, he received no medications at all. Based on Resident 3's prescriptions, he should have received Lantus, Lyrica, Norvasc, Remeron, and Simvastatin the night of his discharge. CMS Ex. 20, at 8-9; CMS Ex. 25, at 13-17. It was foreseeable that these prescriptions would not be filled the same day of Resident 3's discharge considering the late hour of the discharge and considering Resident 3's family was also tasked with figuring out how to move Resident 3 using a two-person assist sling lift that Petitioner had just had delivered that same afternoon. The risk of untreated medical conditions such as diabetes, pain, high blood pressure, high blood cholesterol, and depression, had the potential for more than minimal harm to Resident 3's health and safety.

4. Petitioner did not provide any physical home assessment prior to his discharge.

Petitioner acknowledges guidelines for sufficient preparation before a discharge require a facility to take steps under its control to assure safe transportation. P. Br. at 12. Petitioner also acknowledged that an example of an appropriate orientation would include trial visits to the resident home, if possible. *Id.*

It is undisputed that Resident 3 arrived at his home about 5:00 p.m. with a single ambulance driver. Due to steep stairs and the fact that Resident 3's wheelchair was too wide, the single driver could not get Resident 3 into his home. Resident 3 remained in his garage for an additional hour until two more drivers arrived with a different wheelchair to fit within the doors of his home and finally assisted Resident 3 inside.

At a minimum, a home evaluation, had it been conducted, would also have determined that Resident 3 needed a narrower wheelchair to enter his home and two ambulance attendants to deal with the steep steps. More importantly, considering it was undisputed that Resident 3 would not be receiving 24-hour nursing services, Petitioner performed no

home evaluations to even assess whether Resident 3's elderly and frail wife was actually capable to care for her husband during the time that a nurse or aide was not on duty.

c. Petitioner was not in substantial compliance with 42 C.F.R. § 483.20(l)(3) because Petitioner did not develop a post-discharge plan of care with Resident 3's family that assisted the resident to adjust to his new home environment.

The regulation at 42 C.F.R. § 483.20(l) requires:

> *Discharge summary*. When a facility anticipates discharge a resident must have a discharge summary that includes…
>
> > (3) A post-discharge plan of care that is developed with the participation of the resident *and his or her family*, which will assist the resident to adjust to his or her new living environment.

(emphasis added).

Attached to Resident 3's discharge plan were four pages of Resident 3's electronic medical record (EMR) that contained detailed lists of physician orders and medications and two pages that included prescriptions for 11 different medications and a prescription for the visiting nurse association to do diabetic training. CMS Ex. 39, at 3-8. Petitioner asserts the EMR was a clear document that was understandable to a layperson and does not dispute that these were required instructions for Resident 3's post discharge care. P. Br. at 7. As discussed previously, Petitioner sent no medications or supplies for insulin administration home with Resident 3. Petitioner also concedes it did not include all documentation of family care discussions leading up to the discharge in the written plan. P. Br. 23-24.

I find Petitioner did not develop Resident 3's post-discharge plan of care with the participation of his family. Although Petitioner had Resident 3 sign off on the plan, it is undisputed that Resident 3's family members did not see his post-discharge plan of care until he arrived home with it.

I further find Petitioner did not develop a post-discharge plan of care that assisted the resident to adjust to his new home environment. There was no contact information on Resident 3's discharge plan for his family to call about medical assistance. The first two pages of Resident 3's post-discharge plan of care were almost completely blank except for a note that visiting nurse services were to be obtained through "VNACJ." CMS Ex. 39, at 1-2. The discharge summary did not include a telephone number or any other contact information for these nursing services. The discharge summary also did not include the name of the aide service company that was supposed to provide supplemental

care to Resident 3 after discharge or a telephone number or other contact information for this company.

The post-discharge plan of care also contained an order relating to the catheterization of Resident 3. CMS claims Resident 3's daughter, in the midst of a lot of confusion, contacted the state agency about this order, and the state agency representative called Petitioner. Petitioner's charge nurse reportedly explained that Resident 3 was currently not on a catheter, he was utilizing diapers, and that the straight catheter order was an old order. CMS Ex. 47, ¶ 26; CMS Ex. 48, ¶ 17. Petitioner does not dispute that Resident 3 did not need a catheter at the time of his discharge.

The order specifically called for "Straight cath resident every 8 hrs prn for abdominal discomfort and/or urinary retention using 14 fr catheter, schedule: every 8 hours (PRN)" which was an order for Resident 3 to use a catheter every 8 hours as needed. There was no indication that this order had been discontinued before Resident 3's discharge. Therefore, the EMR on the post-discharge plan of care was not only confusing to a layperson, but it was also inaccurate.

The post-discharge plan of care did not fully explain aspiration precautions. In the EMR, there was an order for "Aspiration precautions/Head of Bed elevated at all times." However, nothing defines what „aspiration precautions" are, or what aspirations precautions should be taken, other than that the head of the bed should be elevated. The EMR does list that Resident 3 needed a chopped/thin liquid diet but did not make clear that this diet was part of the "aspiration precautions" needed. CMS Ex. 20, at 7.

In sum, the undisputed evidence shows Petitioner did not develop a written comprehensive post-discharge plan of care with proper participation of Resident 3's family members that assisted his adjustment home. Instead it sent Resident 3 home with written instructions that were, in part, outdated, confusing, and missing important information.

d. The $6,200 PICMP that CMS imposed is reasonable.

A $6,200 PICMP is in the middle range of PICMP that CMS may impose for an instance of noncompliance. In determining whether the PICMP imposed is reasonable, I apply the factors listed in 42 C.F.R. § 488.438(f): 1) the facility's history of non-compliance; 2) the facility's financial condition; 3) factors specified in 42 C.F.R. § 488.404; and 4) the facility's degree of culpability, which includes neglect, indifference, or disregard for resident care, comfort or safety. The absence of culpability is not a mitigating factor. The factors 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 non-compliance; and 3) the facility's prior history of non-compliance in general and specifically with reference to the cited deficiencies.

"Unless a facility contends that a particular regulatory factor does not support that CMP amount, the ALJ must sustain it." *Coquina Ctr.*, DAB No. 1860 (2002). Petitioner does not contend that its financial condition or compliance history should affect the CMP amount, and therefore I do not consider these factors in my finding.

Although I need not address whether the deficiencies rose to the level of immediate jeopardy, I find that the deficiencies are clearly serious. Petitioner's nurse and certified nursing assistant came to Resident 3's home the day following his discharge to oversee the situation and to provide care to Resident 3, not as part of the discharge process, but because no outside nurse or nurse aide from a home health agency had ever shown up at Resident 3's home on the day of his discharge, or the next day for that matter. Petitioner decided to readmit Resident 3 to the facility less than 24 hours after it had discharged him.

Petitioner asserts that Resident 3 returned to its facility on October 22 in the same condition as when he left. However, it is undisputed that during the hours that Resident 3 was at home without medical care, Resident 3 received no medication, including his insulin injection, and his clothes (including his diaper) had not been changed. I will assume for purposes of summary judgment that Resident 3 did not suffer actual harm to his health. However, the fact that Resident 3 did not suffer actual harm is not attributable to an appropriate or adequately planned discharge process. Petitioner did not ensure that nursing and home aide care awaited Resident 3 at his home, or that his family was willing to care for him or was trained in the use of a sling lift or insulin administration as required by his care plan and physician order. Improper use of the sling lift could have easily resulted in a serious fall for Resident 3. Petitioner did not adequately explain the aspirations precautions necessary for this resident, which also could have had serious, even deadly, consequences. Further, Petitioner discharged Resident 3 without providing any supply of medications to treat his serious medical impairments.

It is clear that Petitioner made multiple attempts to find Resident 3 another nursing home placement but was unable to do so, in part, because of problems with his Medicaid enrollment. P. Br. at 5. Petitioner then seems to have rushed to discharge Resident 3 to his home. The situation at Resident 3's home was nothing less than chaotic after his discharge. Petitioner's rush to discharge Resident 3 to his home without properly developing a post discharge plan, providing training to Resident 3's family, or ensuring nurse home health and aide services were in place at the time of discharge demonstrates a high degree of indifference and disregard for Resident 3's care, comfort and safety. Therefore, given the totality of circumstances surrounding Resident 3's discharge, including the facility's high degree of culpability, I find the amount of the PICMP that CMS imposed is reasonable.

V. Conclusion

Medicare requirements mandate nothing less than a careful, comprehensive, and compassionate process for each resident discharge to make the adjustment safe and orderly. The undisputed evidence shows the facility fell short of these requirements. I grant CMS's motion for summary disposition finding the undisputed evidence supports that Petitioner was not in substantial compliance with federal Medicare requirements relating to a discharge of one of its residents. Further I find the undisputed evidence supports that the $6,200 PICMP that CMS imposed is reasonable.

_____/s/_____
Joseph Grow
Administrative Law Judge