Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Brenham Nursing and Rehabilitation Center,
(CCN: 67-5799),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-13-1068

Decision No. CR3312

Date: July 28, 2014

DECISION

I sustain the determination of the Centers for Medicare & Medicaid Services (CMS) to impose civil money penalties against Petitioner, Brenham Nursing and Rehabilitation Center, consisting of the following:

- Penalties of $6,600 per day for each day of a period that began on April 22, 2013 and that ran through April 25, 2013; and

- Penalties of $2,000 per day for each day of a period that began on April 26, 2013 and that ran through May 24, 2013.

The total amount of the civil money penalties that I sustain is $84,400.

I. Background

Petitioner is a skilled nursing facility in the State of Texas. It participates in the Medicare program. CMS determined to impose the remedies that I recite in the opening paragraph of this decision and Petitioner requested a hearing to challenge CMS's determination.

The case was assigned originally to another administrative law judge and then reassigned to me. I held a hearing on May 12, 2014. I received into evidence from CMS exhibits that are identified as: CMS Ex. 1; CMS Ex. 2; CMS Ex. 4 – CMS Ex. 18; CMS Ex. 21 – CMS Ex. 28: CMS Ex. 53 – CMS Ex. 58; CMS Ex. 60; CMS Ex. 63; CMS Ex. 64; CMS Ex. 66; CMS Ex. 67; CM Ex. 75; CMS Ex. 76; CMS Ex. 86 – CMS Ex. 88; CMS Ex. 90 – CMS Ex. 98; CMS Ex. 101; CMS Ex. 103. I received into evidence from Petitioner exhibits that are identified as: P. Ex. 1 – P. Ex. 44.

II. Issues, Findings of Fact and Conclusions of Law

A. Issues

The issues are whether: Petitioner failed to comply substantially with Medicare participation requirements; CMS's determination of immediate jeopardy level noncompliance is clearly erroneous; and CMS's remedy determinations are reasonable.

B. Findings of Fact and Conclusions of Law

Many of the material facts of this case are essentially undisputed even if the parties dispute the inferences to be drawn from the facts and their legal significance. This case centers on the care that Petitioner and its staff gave to one of its residents, a 101-year old woman who is identified in relevant exhibits as Resident # 4. By all accounts the resident was frail, demented, and helpless. She suffered from osteoporosis, pressure sores, depression, and anxiety. CMS Ex. 26 at 49, 58. She had severe cognitive impairment to the extent that she was unaware of the current season, the location of her room at Petitioner's facility, the names and faces of Petitioner's staff, or even that she was in a nursing facility. *Id.* at 81. The resident was totally dependent on Petitioner's staff for care and her condition was exacerbated by the fact that she was resistant to receiving care. *Id.* at 17 – 18, 31, 58, 59, 81.

On April 12, 2013, two nursing assistants on Petitioner's staff discovered that the resident had extensive bruising. CMS Ex. 26 at 161; CMS Ex. 97 at 7. The bruises were massive, covering much of Resident # 4's body. CMS Ex. 15 at 1; CMS Ex. 101 at 3. Bruising was continuous and extended from the resident's breast and under both of her arms below both sides of her rib cage. The bruises wrapped around the resident's posterior thoracic area. There was extensive bruising and swelling on the resident's left elbow. Resident # 4's left foot had a six-inch by two-inch bruise that extended from the ankle to the toes and the ankle was swollen. *Id.*

To this day the cause of the resident's bruises and other injuries remains unknown. As I shall discuss, Petitioner and its staff made only half-hearted efforts, at best, to learn how and why the resident was hurt.

After discovering the bruising on April 12 the two nursing assistants reported what they had seen to the evening shift charge nurse. The resident's extensive bruising stunned the charge nurse. She reported her findings to Petitioner's director of nursing. CMS Ex. 13 at 1; CMS Ex. 15 at 3 – 4. She subsequently completed an incident report. CMS Ex. 4 at 29; CMS Ex. 26 at 157 – 158; CMS Ex. 101 at 4 – 5.

There is no evidence showing that the report to the director of nursing prompted him to initiate an extensive investigation into the causes of Resident # 4's bruising or even into the extent and seriousness of the resident's injuries. There is nothing to show, for example, that Petitioner's management appointed any individual to coordinate an investigation. No extensive interviews were conducted of Petitioner's staff. No attempt was made to identify all of the personnel or residents who might have had access to Resident # 4 prior to April 12 or on that date. No efforts were made to determine whether the resident might have been subjected to physical violence or to determine whether any individual posed an ongoing threat to the welfare of this resident or of other residents. No investigation was initiated into the possibility that an accident hazard of some sort might have been the cause of the resident's injuries.

Indeed, the credible evidence shows that even the most basic care for Resident # 4 was, inexplicably, delayed. The resident – even though she suffered from osteoporosis and was vulnerable to sustaining fractured bones as a consequence – was not sent for x-rays for nearly two weeks after the bruising was discovered. She was finally sent for x-rays on the initiative of a nurse practitioner, who decided on her own and without an order or request from Petitioner's management that x-rays should be taken. CMS Ex. 101 at 4. Petitioner did not inform Resident # 4's treating physician about the injuries sustained by his patient until April 23, 2013, 11 days after the bruising was first observed. CMS Ex. 15 at 4.[1] Petitioner's medical director was not informed of the resident's bruising until April 22, 2013. CMS Ex. 15 at 4 – 5.

[1] The "Resident Accident or Incident Report" prepared by Petitioner's staff on April 12, 2013, indicates that Petitioner's physician was informed of the bruising on April 12. That conflicts with the physician's statement that he did not learn of Resident # 4's injuries until April 23, 2013. CMS Ex. 15. I find the physician's statement to be the more credible evidence of when he was informed. Petitioner does not identify any evidence that corroborates the comment in its incident report. It has not offered nurses' notes, records of phone or other communications with the physician, or physician's orders to show that the physician was advised of the bruising on April 12. Given that, the best and most credible evidence of when the physician was first informed is the physician's own recollection.

Both the treating physician and the medical director opined, after learning about the resident's injuries, that abuse was certainly a possible cause of the resident's bruising. Both physicians believed that Petitioner should have reported to the Texas State Agency the possibility that Resident # 4 had been abused. CMS Ex. 97 at 7 – 8. Yet, Petitioner made no notification to that agency and was not prompted by either physician's concern to initiate a wide-ranging or comprehensive investigation into the cause or causes of the resident's bruising.

Petitioner's management hypothesized that the resident's bruising might be the consequence of a blood disorder. However, management waited four days from the first report of the resident's bruising – until April 16, 2013 – to order laboratory tests. CMS Ex. 15 at 2; CMS Ex. 26 at 197. The test results ruled out a blood disorder as a cause of the bruising. CMS Ex. 97 at 7. But, with those results in hand, Petitioner's management made no effort to investigate thoroughly alternative hypotheses as to the cause or causes of the resident's bruising.

Subsequently, Petitioner's management theorized that Resident # 4 had been injured while being transferred in a device known as a Hoyer Lift. *See* CMS Ex. 15 at 4. I take notice that a Hoyer Lift is a machine that utilizes a sling to transfer debilitated or helpless individuals from a location such as a bed to another location such as a wheelchair. However, Petitioner's management made no credible efforts to determine whether a botched Hoyer Lift transfer was the cause of the resident's injuries and the theory that transfer with a Hoyer Lift was the cause is not grounded in fact. Both of the nursing assistants who provided care to the resident denied using a Hoyer Lift to transfer her. CMS Ex. 97 at 7. One of the nursing assistants later related to a surveyor that she had been instructed by Petitioner's director of nursing to say that she had used a Hoyer Lift to transfer Resident # 4 despite the fact that she denied using that device. *Id.*

The inference that I draw from Petitioner's management's response to the information that it received about Resident # 4's injuries was that it was at best indifferent to the very real possibility that neglect or abuse might have been the cause of those injuries. Management failed to react meaningfully to initial reports about the resident's injuries. It waited ten days to report the injuries to responsible physicians and it failed to organize an extensive or in-depth investigation into the injuries' cause. It advanced a couple of theories as to the cause of the bruising but these theories either led to no dispositive findings (the possibility of a blood disorder causing the bruising) or were not fact-based (that a botched Hoyer Lift transfer caused the bruising). And, Petitioner failed to follow up at all when these theories proved to be baseless.

CMS alleges that Petitioner failed to comply substantially with several regulations that govern skilled nursing facilities' participation in the Medicare program. These regulations are: 42 C.F.R. §§ 483.13(c)(1)(ii) – (iii), (c)(2) – (4) (describing a skilled nursing facility's duty to report and investigate allegations of abuse); 483.13(c) (imposing

on a skilled nursing facility the duty to implement policies and procedures to prevent neglect and abuse of residents); and 483.75 (requiring a skilled nursing facility to be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each of its residents). The facts and evidence that I discuss above are ample support for the conclusion that Petitioner contravened all or parts of these regulations. Furthermore, the evidence establishes not to be clearly erroneous CMS's determination that Petitioner's noncompliance with the regulations was so egregious as to constitute immediate jeopardy for the facility's residents.

A skilled nursing facility must: ensure that all allegations of neglect or abuse are reported to appropriate authorities including the facility administration and relevant State Agency; thoroughly investigate all allegations of abuse and neglect and prevent potential abuse while an investigation is ongoing; and report the results of all investigations to the facility administrator and appropriate State authorities within five days of the incident prompting the investigation. 42 C.F.R. § 483.13(c)(2) – (4). Petitioner failed to comply with any of these requirements.[2]

Petitioner violated the requirements of 42 C.F.R. § 483.13(c)(2) because it made no report to the Texas State agency concerning the possibility that Resident # 4 had been injured as a consequence of abuse or neglect. Petitioner did not make that notification initially nor did it do so after it had communicated with the resident's physician and its medical director, both of whom opined that a report was appropriate.

In its defense Petitioner asserts that it made the "reasonable business and professional conclusion that the bruising incident did not meet the guidelines for reporting accidents and incidents to the state agency . . . ." Petitioner's post-hearing brief at 8.[3] However,

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[2] CMS has not offered evidence to show that Petitioner failed to comply with subparts (c)(1)(ii) and (iii) of 42 C.F.R. § 483.13. These subparts address a facility's duties not to employ individuals who have been found guilty of abusing, neglecting or mistreating individuals and to report actions by a court of law against an employee that would show unfitness for service on facility staff.

[3] Petitioner bases much of its defense on the testimony of one witness, Ms. Mardie Kay Ellington, a nurse consultant hired by Petitioner as an expert. P. Ex. 44. I find her testimony not to be credible. Ms. Ellington was not a witness to any of the events that are at issue here. Rather, she reviewed some of the evidence in the case and pronounced herself satisfied that Petitioner was compliant with regulatory requirements. That testimony adds nothing to the case. More important, I find her opinions simply not grounded in reality. Ms. Ellington opined, for example, that Petitioner adequately investigated the possibility that Resident # 4 was abused, but the facts do not support that conclusion in the least.

review of the evidence relied on by Petitioner for this assertion shows that its management could not possibly have come up with a "reasonable business and professional conclusion" because it did virtually nothing to identify the root cause of the resident's injuries.

Petitioner's reasoning is essentially circular. It contends that it didn't report the incident because it didn't perceive a need to report it. However, the evidence shows conclusively that Petitioner's management and staff never bothered to find out whether there was abuse involving Resident # 4. The evidence supports a conclusion, rather, that Petitioner's management and staff blinded themselves to the possibility of abuse and then relied on their failure to get to the bottom of the issue to justify their not reporting it.

Petitioner asserts that, among other things, its staff created a "Resident Accident or Incident Report" that documented the injuries to Resident # 4. Petitioner's post-hearing brief at 7; CMS Ex. 26 at 178 – 79. But, this report is not a report of an investigation. To call it cursory would be to understate the lack of information in the report. Although the report documents that the resident was bruised it says nothing about the causes of the bruises. There is no analysis at all of what happened and why.

Petitioner asserts also that it interviewed a "key nurse aide." Petitioner's post-hearing brief at 7; CMS Ex. 26 at 182. That interview report, in its entirety, says this:

> When getting . . . . [Resident # 4] up for a shower I noticed multiple bruises under her arms and down the sides of her back and breasts. I notified the nurse.

Id. That laconic statement is the sum and substance of the interviews that Petitioner conducted with its staff. No attempt was made to ascertain what employees might have interacted with Resident # 4 in the hours before she was found bruised. No dialogue took place between Petitioner's management and staff concerning the possible source or cause of the resident's injuries.

Any reasonable person considering the extent and severity of the resident's bruises might have thought of at least four possible causes for those bruises: (1) an underlying medical condition; (2) an accidental injury such as a fall resulting from the resident's lack of stability or dementia; (3) an injury committed by staff inadvertently while providing care; or (4) an injury caused by some deliberate and abusive action such as an assault. Each of those possibilities raises a myriad of additional questions in turn. For example, when considering the possibility of an assault, one would surely want to know who had access – whether that person was another resident or a staff member – to Resident # 4. An investigator would want to know if anyone had animus towards the resident. He or she would want to learn whether any staff member or another resident had a history of abusive behavior. He or she would interview all people who potentially might have

interacted with the resident *and* all people who might have witnessed another person interacting with the resident. And, all of that would be carefully and completely documented.

Petitioner did none of that. Rather, its management conducted a cursory interview of one staff member and that staff member was not asked about anything other than her observation of the resident's injuries.

Petitioner also asserts that its director of nursing determined that the bruising that was sustained by Resident # 4 was caused during a transfer via a Hoyer Lift and that the resident's low hemoglobin and prothrombin time contributed to the bruising. Petitioner's post-hearing brief at 7. However, and as I have discussed, the evidence supports neither of those conclusions. The credible evidence is that not only was a Hoyer Lift not used to transfer Resident # 4, but also that staff told the director of nursing that they did not transfer the resident via the lift. And, the credible evidence also supports the conclusion that no underlying blood disorder contributed to the resident's bruising.

Petitioner says that it took other actions such as amending the resident's plan of care and making follow-up assessments of the resident's condition. Petitioner's post-hearing brief at 8. But these actions, whether or not they were necessary and/or beneficial, have nothing to do with the need to report and investigate the possibility that the resident was abused.

Petitioner violated the requirements of 42 C.F.R. § 483.13(c)(3) because it did not thoroughly investigate the possibility that Resident # 4 was abused. I have discussed in detail all of the failures by Petitioner's management and staff to investigate the nature and causes of Resident # 4's bruising. In truth, Petitioner conducted not even a shadow of an investigation. The evidence offered by CMS and Petitioner shows not even a cursory review of the resident's situation with the intent of either identifying whether the resident had been abused or determining the source of abuse, if it occurred.

There were certainly multiple individuals – residents and staff – who had access to Resident # 4 and who might have harmed her. Petitioner obtained a statement from only one member of its staff and that statement didn't even touch on the possibility of abuse. Beyond that, Petitioner did nothing. And, even the care that it provided to the resident in the wake of the discovery of her injuries was cursory and uncoordinated. Blood tests were not ordered until four days after the bruises were discovered. X-rays weren't ordered until 11 days had transpired and then, on the order of a nurse practitioner and not at the request of Petitioner's management.

Petitioner hangs its defense here on its assertion that a CMS witness conceded at the hearing that an investigation was conducted. Petitioner's post-hearing brief at 9; *see* Tr. at 89. But, the fact that someone on Petitioner's staff is said to have conducted an

"investigation" (the term is undefined in the witness' testimony) is meaningless. There is no evidence to show that Petitioner conducted the thorough investigation that is demanded by the regulation.

Petitioner violated the requirements of 42 C.F.R. § 483.13(c)(4) because it did not notify State authorities of the results of any investigation that it conducted into the potential abuse of Resident # 4. Of course, Petitioner did not conduct an investigation as is mandated by regulation so it is axiomatic that it didn't provide the State with the sort of notification that is contemplated by the regulation.

The essential requirement of 42 C.F.R. § 483.13(c) is that a skilled nursing facility must develop and implement policies and procedures that prohibit mistreatment, neglect, or abuse of residents. CMS alleges, and the evidence supports the conclusion, that Petitioner failed to implement its own anti-neglect and abuse policies in the case of Resident # 4.

Petitioner's policy concerning "accidents and incidents" consists of a two-page document that incorporates by reference the abuse investigation standards of the Texas Department of Aging and Disability Services. CMS Ex. 27 at 1. Those standards may be found at:

http://www.dads.state.tx.us/providers/communications/2006/letters/PL2006-43.pdf.

The standards include guidelines for reporting possible incidents of resident-to-resident abuse but no guidelines that address specifically those incidents that might comprise staff-to-resident abuse.[4] But, assuming that Petitioner intended these guidelines to cover all forms of potential abuse, they require, at a minimum, that a facility report to State authorities all incidents that require medical attention. They require that the facility conduct and document a thorough investigation of each incident and develop a plan of action designed to prevent recurrence.

Petitioner manifestly did not comply with these policies. The bruising sustained by Resident # 4 required medical attention, even if Petitioner supplied that attention belatedly. That triggered the necessity for reporting and conducting a thorough investigation and Petitioner failed completely to perform either of these duties.

An implicit element of 42 C.F.R. § 483.13(c) is that a facility must train its staff adequately so that policies respecting neglect and abuse may be implemented effectively.

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[4] If Petitioner interprets these guidelines to apply only to resident-to-resident abuse, then Petitioner would have had no policy in place to deal with possible staff-to-resident abuse and that would be a regulatory violation. Moreover, Petitioner had no way of knowing whether Resident # 4's bruises resulted from resident-to-resident or staff-to-resident abuse without thoroughly investigating the incident that led to the bruising.

Petitioner failed to provide meaningful training to its staff. There is no evidence to show that several of Petitioner's staff members ever received training about policies intended to protect residents against neglect or abuse. CMS Br. at 14, citing CMS Ex. 13 at 1; P. Ex. 5 at 1 – 4; P. Ex. 7 at 1; P. Ex. 11; P. Ex. 12; P. Ex. 15; P. Ex. 16; P. Ex. 18. In response, Petitioner contends that it provided training for all of its staff on such policies. It states that three of Resident # 4's caregivers signed acknowledgments confirming that they received training on Petitioner's prohibition of abuse policy and procedures. P. Ex. 5 at 1, 4. However, Petitioner only attaches signed acknowledgments from two of the three caregivers it alleges signed the acknowledgments. The other exhibits Petitioner cites do not show that staff were trained on these or related policies. Petitioner's post-hearing brief at 6, citing P. Ex. 7; P. Ex. 8 at 4; P. Ex. 9; P. Ex. 11; P. Ex. 12 (and P. Ex. 15); P. Ex. 14; P. Ex. 16; P. Ex. 18; P. Ex. 44 at 2 – 3 ¶¶ 7, 10. But, and as CMS points out, Petitioner – its general assertions aside – did not offer proof that specific members of its staff actually did receive training other than acknowledgments that for four individuals (including two caregivers) the individuals were trained on the facility "Prohibition of Abuse Policy and Procedure." P. Ex. 5.

Petitioner violated the requirements of 42 C.F.R. § 483.75 because it was not effectively and efficiently managed. That is evidenced by the failure of Petitioner's director of nursing to take any meaningful action to report and investigate the possibility of abuse after Resident # 4's bruising had been brought to his attention. The nursing director not only failed to conduct a meaningful investigation but he developed a theory as to the source of the resident's injuries (botched use of a Hoyer Lift) that was unsupported by any facts whatsoever. The failure of management to assure that the bruising of Resident # 4 was reported, and its failure to assure that the resident's treating physician and the facility's medical director were notified promptly, is an additional failure of management.

CMS determined all of the foregoing noncompliance to comprise immediate jeopardy for Petitioner's residents and it did so for good reasons. "Immediate jeopardy" is defined as noncompliance that is so egregious as to cause or to be likely to cause serious injury, harm, impairment, or death to one or more residents of a facility. Here, Resident # 4 sustained a serious injury by any measure, sustaining massive bruising. However, it is not the injury sustained by the resident that constitutes immediate jeopardy. It is the probability that other residents might be injured similarly that comprises the jeopardy in this case. Petitioner's management and staff had no way of knowing – given their failure to investigate the cause of Resident # 4's bruising – whether the resident remained vulnerable to some predatory or abusive individual. They had no way of knowing whether other residents were similarly vulnerable. In looking the other way, management and staff left the facility's residents exposed to the real probability of serious harm. Indeed, to this day no one has ever determined the source of Resident # 4's injuries and hence, there remains no assurance at Petitioner's facility that the source of the injuries has been identified and that recurrences can be prevented.

Petitioner asserts that CMS's findings of immediate jeopardy are clearly erroneous. According to Petitioner any regulatory violations that it committed were "technical violation[s] at best . . . ." Petitioner's post-hearing brief at 14. But, it offers no evidence to explain why its noncompliance was "technical" or that CMS's findings were clearly erroneous. Essentially, Petitioner argues that the Texas State agency did not make findings of immediate jeopardy level noncompliance until about April 24, 2013, 12 days after the bruising involving Resident # 4 was first reported within Petitioner's staff. It argues that, by then, the resident's bruises were healing and that there had been no recurrences. Therefore, according to Petitioner, any problems that might have occurred were already in the past and could not be the basis for findings of immediate jeopardy.

But, and as I have observed, the bruising sustained by the resident is not the essential element of immediate jeopardy. The immediate jeopardy in this case consists of Petitioner's cavalier failure to deal with the implications of the bruising and the probability for new harm to Resident # 4 and to other residents caused by this failure. Petitioner had no way of knowing whether an abusive individual lurked on its staff or among its residents because it made no effort to find out whether that was so. Consequently, Petitioner could not protect its residents because it did not know whether there had been abuse and if so, what constituted its cause.

CMS imposed civil money penalties against Petitioner for immediate jeopardy level noncompliance at $6,600 per day. It imposed non-immediate jeopardy level penalties of $2,000 per day for the period after Petitioner abated its immediate jeopardy level noncompliance but during which it remained out of compliance at a lower level than immediate jeopardy. Petitioner has not challenged the duration of its noncompliance. In other words, although it denies that it was noncompliant, it has not argued that if it was noncompliant, it abated its noncompliance on a date that is earlier than CMS determined that Petitioner attained compliance. Petitioner has challenged the dollar amount of the penalties, arguing that the penalty amounts are arbitrary. Therefore, what remains to be decided is whether the penalty amounts are reasonable.

I find that both the $6,600 per day immediate jeopardy level penalties and the $2,000 per day non-immediate jeopardy level penalties are reasonable. They are amply justified by the seriousness of Petitioner's noncompliance and by Petitioner's culpability.

Penalties for immediate jeopardy level noncompliance may be imposed in a range of from $3,050 to $10,000 per day. Penalties for non-immediate jeopardy level noncompliance may be imposed in a range of from $50 to $3,000 per day. 42 C.F.R. § 488.438(a)(1)(i), (ii). The determination of where within these ranges penalty amounts should lie is not an exact science but it depends on weighing evidence that addresses regulatory factors for determining penalty amounts set forth at 42 C.F.R. §§ 488.438(f)(1) – (4) and 488.404 (incorporated by reference into 42 C.F.R. § 488.438(f)(3)). These

factors may include the seriousness of a facility's noncompliance, its culpability for noncompliance, its compliance history, and its financial condition.

I find the penalty amounts to be justified in this case for two reasons. First, Petitioner's noncompliance was extremely serious. The injuries sustained by Resident # 4 suggested the reasonable possibility that she had been badly beaten by an abusive individual, either a member of Petitioner's staff or another resident. That possibility in turn raised the frightening possibility that a predator was on the loose in Petitioner's facility, an individual who had shown the capacity to inflict grievous injuries on a demented and helpless elderly woman and who might be in a position to do it again. Confronted with that possibility, Petitioner's management chose to do nothing. It made no effort to conduct a meaningful investigation, failed to notify immediately the resident's treating physician and the facility's medical director, failed to order medical tests immediately that might have either revealed the true cause of the resident's injuries or enabled appropriate treatment of the injuries that she had sustained, and failed to notify State authorities who, had they known, might have ordered or implemented protective measures at Petitioner's facility. Doing nothing meant that Resident # 4 and all other residents of the facility were left unprotected, potentially additional victims to an un-apprehended abuser.

Second, Petitioner's culpability is especially high in this case because the injuries to Resident # 4 were detected and reported immediately to management by Petitioner's staff. Management was on notice right away that something potentially very serious and dangerous had happened on the premises. And, yet, management did nothing. It not only ignored the very ominous evidence of potential abuse but it in effect directed the staff to invent a story to explain the resident's bruising – that the bruising was the consequence of a botched Hoyer Lift transfer – that had no basis in fact and that management knew had no basis in fact. So, management not only ignored the possibility of abuse but it attempted to cover up that possibility. All the while, Resident # 4 and other residents were left unprotected.

Petitioner complains that CMS imposed the penalties without providing any meaningful explanation or rationale. That is no defense because the evidence amply justifies the penalties whether or not CMS provided a detailed explanation for its penalty determination. However, CMS did provide Petitioner with the report of the survey that led to the penalty determination and that survey report contains extensive explanation for CMS's findings. CMS Ex. 4.

Petitioner also asserts that penalties that CMS imposed based on findings of a survey made after the events that are at issue here were rescinded as the consequence of an independent dispute resolution proceeding (IDR). Evidently, it asserts that if those penalties were found ultimately to be unjustified then so are the penalties that are at issue

here. The findings that were rescinded at IDR are based on different evidence than that which is at issue here and are, therefore, irrelevant.

Petitioner argues that its compliance history does not support the penalties that were imposed, pointing out that the facility had not previously been penalized while managed by Petitioner. That may be so, but the seriousness of Petitioner's noncompliance and its culpability are sufficient to justify the penalty amounts.

Finally, Petitioner complains that CMS failed to take into consideration Petitioner's financial condition in determining the penalty amounts. But, Petitioner has offered no evidence to show that it lacks the wherewithal to pay the penalties that are at issue here. CMS is not required to prove a negative. If Petitioner believed that its financial condition made it impossible for it to pay the penalties that are at issue then it should have presented evidence to prove that.

/s/
Steven T. Kessel
Administrative Law Judge