Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Brookewood Nursing and Rehabilitation Center,
(CCN: 04-5287),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-13-276

Decision No. CR3824

Date: April 30, 2015

DECISION

In this case, we again consider a long term care facility's obligation to protect its residents from the abusive behaviors of others.

Petitioner, Brookewood Nursing and Rehabilitation Center, is a long-term care facility, located in De Queen, Arkansas, that participates in the Medicare program. Based on a complaint investigation survey, completed September 20, 2012, and a follow-up survey completed November 14, 2012, the Centers for Medicare and Medicaid Services (CMS) determined that the facility was not in substantial compliance with Medicare program requirements and that its deficiencies posed immediate jeopardy to resident health and safety. CMS imposed civil money penalties of $4,050 per day for 58 days of immediate jeopardy, followed by $600 per day for 56 days and then $50 per day for 21 days of substantial noncompliance that was not immediate jeopardy. Petitioner appeals.

For the reasons set forth below, I find that, from July 23 through December 4, 2012, the facility was not in substantial compliance with Medicare program requirements and that, from July 23 through September 18, 2012, its substantial noncompliance posed immediate jeopardy to resident health and safety. The penalties imposed are reasonable.

I. Background

The Social Security Act (Act) sets forth requirements for nursing facility participation in the Medicare program, and authorizes the Secretary of Health and Human Services to promulgate regulations implementing those statutory provisions. Act § 1819. The Secretary's regulations are found at 42 C.F.R. Part 483. To participate in the Medicare program, a nursing facility must maintain substantial compliance with program requirements. To be in substantial compliance, a facility's deficiencies may pose no greater risk to resident health and safety than "the potential for causing minimal harm." 42 C.F.R. § 488.301.

The Secretary contracts with state survey agencies to conduct periodic surveys to determine whether skilled nursing facilities are in substantial compliance. Act § 1864(a); 42 C.F.R. § 488.20. Each facility must be surveyed annually, with no more than fifteen months elapsing between surveys. 42 C.F.R. § 488.308(a). Facilities must be surveyed more often, if necessary, to ensure that identified deficiencies are corrected. Act § 1819(g)(2)(A); 42 C.F.R. §§ 488.20(a); 488.308. The state agency must also investigate all complaints. Act § 1819(g)(4).

In this case, surveyors from the Arkansas Department of Human Services (state agency) completed a complaint investigation survey on September 20, 2012. Based on their findings, CMS determined that the facility was not in substantial compliance with multiple program requirements, specifically:

- 42 C.F.R. §§ 483.13(b) and 483.13(c)(1)(i) (Tag F223) (abuse and staff treatment of residents), at scope and severity level K (pattern of noncompliance that poses immediate jeopardy to resident health and safety);

- 42 C.F.R. §§ 483.13(c)(1)(ii)-(iii), 483.13(c)(2)-(4) (Tag F225 – investigate/report allegations of abuse) at scope and severity level K;

- 42 C.F.R. § 483.13(c) (Tag F226 – policies to prohibit abuse and neglect) at scope and severity level K;

- 42 C.F.R. § 483.75 (Tag F490 – administration) at scope and severity level K.

CMS Ex. 3.

Surveyors returned to the facility and completed a follow-up survey on November 14, 2012. CMS determined that the facility's deficiencies no longer posed immediate jeopardy but that its substantial noncompliance continued. Thereafter, CMS determined that the facility returned to substantial compliance on December 5. CMS Ex. 1 at 4-8, 16; CMS Ex. 2.

CMS imposed against the facility CMPs of $4,050 per day for 58 days of immediate jeopardy (July 23 – September 18, 2012), $600 per day for 56 days of substantial noncompliance that was not immediate jeopardy (September 19 – November 13, 2012), and $50 per day for an additional 21 days of substantial noncompliance that was not immediate jeopardy (November 14 – December 4, 2012), for a total penalty of $269,550 ($234,900 + $33,600 + $1,050 = $269,550). CMS Ex. 1 at 4. Petitioner timely requested review.

The parties have filed opening briefs (CMS Br.; P. Br.) and exhibits, which included the written direct testimony of their witnesses. CMS submitted 27 exhibits (CMS Exs. 1-27) and Petitioner submitted 17 exhibits (P. Exs. 1-17). Following a pre-hearing conference, I admitted into evidence CMS Exs. 1-27 and P. Exs. 1-17. Summary of Pre-hearing Conference and Order Establishing Procedures for Hearing (June 14, 2013). Thereafter, because neither party elected to cross-examine any witnesses, we did not convene an in-person hearing. Order (July 22, 2013). Each party submitted a closing brief (CMS Cl. Br; P. Cl. Br.) and a reply (CMS Reply; P. Reply).

CMS attached to its closing brief, marked as Closing Brief Exhibit A (CMS Ex. A), a copy of the facility's compliance history. Petitioner attached to its closing brief, marked as Attachments FN 82, FN 85, and FN 86, copies of email correspondence between facility employees and state agency and CMS employees.[1]

In the absence of any objections, I admit into evidence CMS Ex. A and Petitioner's Attachments (P. Attach.) FN 82, FN 85, and FN 86.

II. Issues

The issues before me are:

1. Was the facility in substantial compliance with Medicare participation requirements from July 23 through December 4, 2012;

2. If, from July 23 through September 18, 2012, the facility was not in substantial compliance with Medicare participation requirements, did its deficiencies then pose immediate jeopardy to resident health and safety; and

3. If the facility was not in substantial compliance with Medicare participation requirements, are the penalties imposed reasonable.

[1] The "FN" refers to the footnotes in Petitioner's closing brief that cite the email correspondence.

Petitioner points out that, from October 18 until December 4, 2012, CMS also denied the facility payment for new admissions (DPNA). Petitioner argues that I should review whether imposing this remedy is reasonable. But such review is beyond my authority. I may review CMS's finding of noncompliance that results in its imposing a remedy. 42 C.F.R. § 498.3(b)(13). I may *not* review CMS's choice of remedy nor the factors it considered in determining the remedy. 42 C.F.R. §§ 488.408(g)(2); 498.3(d)(14); *Beverly Health & Rehab. Servs., Inc. v. Thompson*, 223 F. Supp. 73, 111 (D.D.C. 2002) (holding that the "determination of what remedy to seek is beyond challenge."). I therefore decline to consider whether the DPNA is reasonable.

Petitioner also challenges CMS's finding that the facility's deficiencies constituted a "pattern" of noncompliance. P. Cl. Br. at 19. Again, my authority is limited. I may review CMS's scope and severity findings (which include finding a pattern of noncompliance) only if a successful challenge would affect the range of the CMP or if CMS has made a finding of substandard quality of care that results in the loss of approval of a facility's nurse aide training program. 42 C.F.R. § 498.3(b)(14). The finding of immediate jeopardy here is reviewable because it affects the range of the CMP, moving it from a category 2 remedy ($50 – $3,000 per day) to a category 3 remedy ($3,050 – $10,000 per day). The scope of the deficiency (i.e., pattern of noncompliance) does not.[2]

III. Discussion

A. The facility was not in substantial compliance with 42 C.F.R. §§ 483.13(b) and (c) and 483.75 because its administration and staff allowed one of its residents to abuse her roommates; administration and staff failed to intervene, investigate, or report, as required by the regulations and as called for in the facility's written policies and procedures.[3]

Program requirements: "Abuse" means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. 42 C.F.R. § 488.301.

Facility residents have the right to be free from verbal, sexual, physical, and mental abuse. 42 C.F.R. § 483.13(b) (Tag F223). To this end, a facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse

[2] Nevertheless, I am authorized to consider scope and severity in determining whether the penalty imposed is reasonable. 42 C.F.R. § 488.404. As discussed below, the deficiencies here were not isolated; they involved three residents and multiple staff members.

[3] My findings of fact and conclusions of law are set forth, in bold and italics, as captions in the discussion section of this decision.

of residents. 42 C.F.R. § 483.13(c). It must ensure that all alleged violations are reported immediately to the facility administrator and appropriate state officials. The facility must have evidence that all alleged violations are thoroughly investigated, and it must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator (or designated representative) and to the appropriate state officials within 5 working days of the incident. If the violation is verified, the facility must take appropriate action. 42 C.F.R. § 483.13(c)(2), (3), and (4) (Tags F225, F226).

The facility must also be governed 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. 42 C.F.R. § 483.75 (Tag F490).

The facility's abuse policies. CMS has expressed no criticism of the facility's written policies and procedures for preventing abuse, and those policies generally reflect program requirements. Consistent with the regulations, the policies aim at protecting facility residents from abuse, including verbal and mental abuse. The policies reflect the regulatory definition of abuse (§ 488.301) and define verbal abuse as "any use of oral, written, [or] gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within hearing distance, regardless of their age, ability to comprehend or disability." Mental abuse "includes, but is not limited to, humiliation, harassment, threats of punishment or deprivation that are likely to provoke fear or alarm." CMS Ex. 12 at 12, 13.

The policies direct "any person(s) witnessing or having knowledge of potential or actual abuse" to report *immediately* to the administrator (or designee). In the alternative, the witness may report to the charge nurse, who then must follow the reporting procedures. CMS Ex. 12 at 14; *see also* CMS Ex. 12 at 1, 5. The witness must complete a written report that includes names, dates and times, those involved, witnesses, and other pertinent information. CMS Ex. 12 at 14. The report must be submitted to the facility administrator within 24 hours. CMS Ex. 12 at 14.

Elsewhere, the policies say that "immediately" after an incident is discovered, the charge nurse must complete an incident and accident report. The director of nursing (DON) "immediately" receives a copy of the report for review and investigation. CMS Ex. 12 at 6.

The facility administrator (or designee) must investigate thoroughly all allegations, making sure that the investigation is timely and effective. The administrator is given the original report "after the required follow-up documentation is completed" by a licensed nurse or physician. CMS Ex. 12 at 6. Within 24 hours of the incident's occurrence, the administrator must notify the resident's representative and state and federal agencies of

the incident. At the same time, the administrator (or designee) must take steps to prevent "further potential abuse" while the investigation is in progress. CMS Ex. 12 at 1, 6, 7.

Results of the investigation must be reported to state (specifically, the Office of Long Term Care) and federal agencies within five working days. The investigative report must include: 1) name and age of the residents involved; 2) cognitive level of any resident with disabilities; 3) description of the incident; 4) date and approximate time of the incident; 5) where the incident took place; 6) type and location of any injuries; 7) name and title of the person who discovered or observed the incident; 8) name and title of the person to whom the incident was reported; 9) list of people in the area at the time of the incident; 10) name and title of the person suspected; and 11) names of people outside the facility who were notified of the incident, the date and time they were notified, and the name of the individual who notified them. CMS Ex. 12 at 2, 6-7.

With respect to resident-on-resident abuse, the policy is explicit: "If the accused is a resident or resident's roommate, the individual should be *placed in a supervised temporary separation* in order to ensure that the rights of the residents-at-large will be protected." CMS Ex. 12 at 1, 9 (emphasis added). The policy directs the DON (or designee) to assess the residents involved (victim and perpetrator) and to document the findings in the residents' medical records and care plans. The DON must notify the resident's physician of the allegation, status of the investigation, and the resident's condition. CMS Ex. 12 at 2, 6.

The facility is supposed to keep at the nurses' station a list of residents known to be at risk for abusing others. CMS Ex. 12 at 9. A resident may be subject to discharge from the facility if her abusive conduct is substantiated. CMS Ex. 12 at 2.

Finally, the facility must correct substantiated allegations of abuse, neglect, or mistreatment, and document the correction. CMS Ex. 12 at 14.

Resident 1 (R1) was a 73-year-old woman whose diagnoses included transient ischemic attack, coronary artery disease, diabetic neuropathy, depression, and anxiety. CMS Ex. 5 at 1.

From at least as early as January 2011, R1's care plan identified her "socially inappropriate behavior." She would claim, falsely, that others took her belongings. She was often angry and unhappy. The plan directed staff to notify her son of the behaviors, to "intervene to ensure safety of others by confronting [R1] with known untruths," and to remind her to lock her valuables in a safe. The plan also said that if R1's needs could not be met and she continued to be unhappy and angry, social services staff should assist her to find a more suitable living environment. CMS Ex. 5 at 20.

R1 occupied the most desirable room in the facility. Not only was it the facility's largest room, it was the only one with a private bath and walk-in closet. P. Ex. 1 at 3 (Battiest Decl.).

It seems that R1 did not like having a roommate and made miserable the lives of those unfortunate enough to share her room. *See, e.g.*, CMS Ex. 5 at 7 (quoting R1 complaining that her roommate was "getting on her nerves"); CMS Ex. 5 at 8 (describing R1 as crying because she did not like her roommate); CMS Ex. 5 at 18 (listing 10 "Roommates that R1 Has Had"); CMS Ex. 6 at 32 (indicating that, since her admission, R1 had 10 to 15 roommates). Yet the facility continued to place residents in her room and, as the following discussion shows, made minimal – if any – efforts to protect them from her abuse.

Specifically:

Resident 6 (R6) was R1's roommate in July 2012. R6 was 67 years old and suffered from a variety of ailments, including chronic obstructive pulmonary disease, congestive heart failure, Parkinson's disease, depression, and anxiety. CMS Ex. 7 at 1. She had been acutely ill for several days when, on the morning of **July 23, 2012**, she complained to the facility's social services director that R1 was "very mean." R1 had been "cussing her" and accused her of stealing. R1 told R6 that she was "glad" R6 was sick. Social Services Director Cindy Webb, PhD, described R6 as "crying and very upset." R6 told Social Services Director Webb that she was willing to move anywhere to get away from her roommate. CMS Ex. 7 at 5; P. Ex. 13 at 3 (Webb Statement); *see* P. Ex. 9 (R6 Decl.). Social Services Director Webb promised that she would "work on getting [R1] moved out of the room," which R6 agreed "would be fine." P. Ex. 13 at 3 (Webb Statement).

Social Services Director Webb reported R6's complaints "to (unspecified) department supervisors." P. Ex. 13 at 3 (Webb Statement). The facility administrator, Dana Battiest, did not report or investigate R6's complaints. In fact, no evidence suggests that anyone informed her of the problem at that time.

R6 was moved out of the room on July 25, 2012. CMS Ex. 14 at 3 (Smith Decl. ¶ 8).

On September 19, R6 told the survey team that R1's objectionable behavior started on day one, when she accused R6 of taking $150. "She didn't want anyone in the room but her." R6 said that she was afraid of her roommate and slept outside every night. "Most of the time I was sitting there crying. Nobody did a thing – they said they would." They did not move me "until my nerves were shot." According to the resident, staff administered her medications and snacks outside the room. CMS Ex. 6 at 4.

Following the July incident, R1's behavior did not improve. A social history update, dated August 30, 2012, describes her as "selfish at times and complains a lot. She is *always hateful to her roommates*." According to her family, "she has been like that her whole life." CMS Ex. 5 at 27 (emphasis added).

Resident 2 (R2) was a 79-year-old woman suffering from hypertension, non-insulin-dependent diabetes, depression, and other ailments, who became R1's roommate on August 29, 2012. CMS Ex. 6 at 1; P. Ex. 1 at 3 (Battiest Decl.).

At 4:00 a.m., on **September 6, 2012**, R6 told Licensed Practical Nurse (LPN) Jewel Sons that R1 had been mean to R2. R6 reported that R1 threw a bracelet at R2 and hit her in the head. She also pinched R2's foot with a "grabber." In response, R2 refused to go into her room all night; instead, she stayed up visiting another resident and watching TV. CMS Ex. 6 at 5. LPN Sons has admitted that she did not immediately report the complaint and did not investigate. She did not even ask R2 about it "because it was hearsay" and she considered R6 a trouble-maker. P. Ex. 17 at 3 (Sons statement). Two hours after hearing the complaint, LPN Sons mentioned it during the shift change.

A nurse's note indicates that, at 6:15 that morning, a nurse and a nurse aide encouraged R2 to go to bed and elevate her swollen feet and ankles. But the resident refused. She told the nurse aide that she would not sleep in her bed. At about that time, the nursing shifts changed. At 6:40 a.m., another nurse, identified as LPN Latisha Castillo, spoke to R2. R2 told her that her roommate (R1) had been yelling and calling her names. She confirmed that R1 used a "grabber" device to pinch her feet, claiming that she was snoring. R1 cussed at her. R2 advised LPN Castillo that she slept in a chair in the front lobby in order to avoid her roommate. CMS Ex. 6 at 5, 10-11; CMS Ex. 5 at 6; P. Ex. 16 at 3 (Castillo Decl.).

In a written declaration, LPN Castillo confirms R2's complaints, and adds that R2 woke up to find a bracelet in her bed. R1 told R2 that she'd thrown it at her to awaken her because she was snoring. P. Ex. 16 at 3 (Castillo Decl.). LPN Castillo reported R2's complaints to Administrator Battiest. CMS Ex. 5 at 6; CMS Ex. 6 at 5, 10-11; P. Ex. 16 at 3.

R2 filed a grievance, complaining that her roommate threw a bracelet at her and hit her in the foot with a grabstick. The facility's response was minimal; staff met with R1's son, who said he would contact his uncle for advice. CMS Ex. 6 at 32. The administrator did not investigate further or take steps to protect R2 from R1. She did not report the incident to the appropriate state agency.

In her own written declaration, R2 confirms that R1 poked her with a grabber stick while she napped, accused her of stealing money, and demanded that she leave the room when R1 had certain visitors. R2 also confirms that R1 threw a bracelet at her and that she (R2) reported the incidents to the activities director. P. Ex. 3.

Even after all of this, facility staff made no significant changes to R1's care plan, but continued with interventions that had proved ineffective. A plan entry, dated September 6, 2012, again describes R1's behavior as "socially inappropriate"; it says that R1 falsely accused others of taking her belongings, was "often angry and unhappy," and did not get along with other residents, "especially roommates." She frequently instigated arguments. CMS Ex. 5 at 22. Again, staff were directed to "intervene to ensure safety of others by confronting with known untruths." CMS Ex. 5 at 22. The social services staff (and others) seem to have disregarded the longstanding plan intervention directing them to "assist [R1] to find a more suitable living environment" if the resident "continued to be unhappy and angry." *See* CMS Ex. 5 at 20.

R2 filed a second grievance on **September 18, 2012**, complaining that R1 verbally and mentally abused her. According to DON Jessica Houser, RN, on September 18, Activities Director Sarah Short told her and Administrator Battiest that R2 complained that R1 had been mean. Specifically, R2 said that R1 poked her in the foot while she was sleeping and threw a bracelet at her.[4] She said that R1 "would pour coffee on her and not let her use the bathroom." P. Ex. 2 at 3 (Short Decl.); P. Ex. 14 at 3 (Houser Decl.); CMS Ex. 6 at 30. R2 voiced similar complaints to Nurse Surveyor Paula Smith. She told the surveyor that R1 would not allow her to use the bathroom and, as a result, she wet herself. R1 poured coffee on R2 (Sept. 18 Incident Report). *See* CMS Ex. 14 at 3 (Smith Decl. ¶ 8).

This time, the facility moved R2 out of the room and instructed R1's family that she would have to leave the facility. CMS Ex. 6 at 32-33. The facility noted that R1 had numerous roommates; she could not get along with the other residents or her own family. The report describes her as "very manipulative with staff and other residents." CMS Ex. 6 at 34.

September 18 Incident Report. The facility finally prepared an incident report, which accurately characterizes the September 18 incident as abuse – verbal, physical, and emotional/mental. CMS Ex. 6 at 29. The report summarizes the incident as follows:

[4] The description of this incident is so similar to that of the September 6 incident that, initially, it seemed that only one incident occurred, which the facility reported 12 days later. However, the parties agree that R1 repeated her September 6 behavior on September 18. Moreover, the evidence establishes that many of these behaviors were common for R1. *See, e.g.*, CMS Ex. 5 at 20, 27; CMS Ex. 7 at 5.

> Sara Short, Activities Director, went into [R2's] room to visit with her. [R2] proceeded to tell [her] how miserable she is. Sara asked her to elaborate on what she meant. [R2] said "my roommate [R1] is mean to me." "She [pokes] my feet at night with her hand grabber when I start snoring. She pours coffee on me, tells me I am crazy and I don't belong here and how fat my daughter is as well as she blocks the bathroom door and tells me I can't use it that she owns this place and I have to wet in my pullup." "She also will not let me and my family visit in our room and when she has company she tells me to leave the room and she will come get me when I can come back then laughs and says that will be never!" Administrator, Dana Battiest, and DON, Jessica Houser, [were] notified immediately. The DON and Administrator spoke with [R2] in the Administrator's office and she repeated what she told Sara Short.

CMS Ex. 6 at 30. According to the report, R2 was "immediately removed from the room and placed in a separate room, on a separate hall, to prevent further abuse." CMS Ex. 6 at 30-31.[5]

Surveyor Smith interviewed R2 on September 19, 2012. R2 told her that she had been afraid of R1 from the day she was admitted to the room because R1 accused her of stealing money. R2 told the surveyor that she sat crying "many days" and had complained to the facility administrator and the housekeepers. CMS Ex. 14 at 3 (Smith Decl. ¶ 8).

R1 was discharged from the facility on **September 18, 2012**. CMS Ex. 5 at 5.

Petitioner now denies that R1 abused either of her roommates, characterizing their interactions as "daily disagreements" and "a roommate dispute." P. Cl. Br. at 10; P. Ex. 1 at 3 (Battiest Decl.). According to Administrator Battiest, "no signs of abuse were noted by any of the staff or reported by either resident." P. Ex. 1 at 3 (Battiest Decl.). This is plainly incorrect, inasmuch as the facility's September 18 incident report characterizes R1's exchange with R2 as verbal, physical, and emotional/mental abuse. CMS Ex. 6 at 29.

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[5] According to Petitioner, facility policy directed staff to supervise R1, one-on-one, while the facility investigated the allegations of abuse. Petitioner concedes that staff disregarded that directive. It justifies the staff's failure to follow policies by claiming, without support, that they "did not believe one-to-one sitting was necessary. . . ." P. Br. at 5-6.

Petitioner also submits written declarations from the residents themselves. The residents describe R1's abusive behavior, but neither realizes that she was abused. P. Exs. 3, 9. The residents may not have recognized abuse, but, based on the regulatory definition as well as the facility's own policy definitions, R1 verbally and mentally abused them both. The uncontroverted evidence establishes that R1 deliberately swore at them, ridiculed them, and falsely accused them of stealing, leaving them tearful and upset. Her comments were disparaging and derogatory. She forced them out of their own room and would not allow them visitors. She denied them access to the bathroom and physically attacked R2 several times. These actions constitute abuse.

Petitioner concedes that a "reasonable person could potentially view the incident on September 18, 2012, as an incident of resident-to-resident abuse," and, unlike the earlier grievances, staff "interpreted this report as an allegation of potential abuse," triggering a report and investigation. P. Cl. Br. at 10. But R1's September 6 conduct was virtually identical to her September 18 conduct: swearing, name-calling, pinching (with grabber device), and throwing a bracelet. Petitioner has not explained why the conduct should not also have triggered a report and investigation on September 6, as indeed it should have.

The regulations and facility policies require the facility to report and investigate thoroughly *all alleged violations*. Even if I agreed that the July 23 and September 6 incidents were not abuse (which I do not), they were significant enough to trigger the facility's obligation to investigate and report.

Petitioner does not claim to have reported these incidents but suggests that it investigated and, finding no evidence of abuse, declined to report. P. Cl. Br. at 16. Listening to a resident's complaint hardly qualifies as an investigation, and Petitioner submits no incident reports or other documentation establishing that anyone investigated these incidents beyond speaking to the victims.

Social Services Director Webb reported R6's July 23 complaints "to the department supervisors," but neither she nor Administrator Battiest claims that anyone reported them to the administrator or that Administrator Battiest took any action. *See* P. Ex. 1 (Battiest Decl.); P. Ex. 13 (Webb Decl.); CMS Ex. 10 at 2 (indicating that Administrator Battiest did not remember July 23 incident). With respect to R2's September 6 complaints, LPN Sons admits that, contrary to facility policies, she did not investigate at all and waited two hours before reporting to anyone. P. Ex. 17 at 3 (Sons Decl.); P. Ex. 16 (Castillo Decl.); *see* CMS Ex. 12 at 14 (requiring any person with knowledge of potential abuse to report immediately and complete a written report for the administrator). When she learned of the allegations, LPN Castillo appropriately notified Administrator Battiest, who spoke to R2 and her daughter, offering the resident a room change, but otherwise took no action. P. Ex. 1 (Battiest Decl.).

Nor am I persuaded that the facility discharged its duties to protect its residents from abuse by offering to move them to less desirable rooms, a "solution" that seems to punish the victim by requiring her to disrupt her living situation and move to a smaller room with fewer amenities at an unknown location with an unknown roommate.[6] Besides, the facility would not allow R1 to occupy the room by herself. P. Ex. 13 at 4 (Webb Decl.) ("It was explained to [R1 and R6] that Medicaid does not allow for private room billing in the nursing facility."). Inevitably, someone else would have moved in with R1, placing that individual at risk for abuse.

According to its policies, the facility was supposed to maintain and post a list of residents at risk for abusing others. CMS Ex. 12 at 9. Facility staff were unable to produce such a list. CMS Ex. 14 at 4-5 (Smith Decl. ¶ 10). Petitioner claims it had no such list because none of its residents were likely to abuse others. P. Cl. Br. at 17. From at least as early as January 2011, R1's care plan identified her "socially inappropriate" behavior, specifically described some abusive behaviors (falsely accusing others), and directed staff to "intervene to ensure the safety of others. . . ." CMS Ex. 5 at 20. Certainly, by July 23, 2012, when she abused R6, the facility was on notice that R1 was at risk for abusing others. This establishes that the facility housed at least one resident who, according to facility policies, should have been on that list.

Finally, Petitioner argues that section 483.13(c)(1)(i) prohibits staff abuse only, not resident-to-resident abuse, so the facility did not violate that provision. P. Cl. Br. at 12. This argument fails. Facilities are absolutely obligated to keep their residents free from abuse, without regard to its source. 42 C.F.R. § 483.13(b). Section 483.13(c)(1)(i) puts the onus on the facility to protect its residents by developing and implementing policies that prevent abuse, including resident-to-resident abuse. *See, e.g., Martha and Mary Lutheran Services*, DAB No. 2147, at 12-13 (2008) (finding substantial noncompliance with section 483.13(c) where facility staff failed to implement facility policies and procedures to prevent resident-to-resident abuse). Because the facility here did not implement its own policies for preventing abuse, it was not in substantial compliance with section 483.13(c).

Administration. A finding of substantial noncompliance in the facility's administration may derive from findings of substantial noncompliance in other areas.

> [W]here a facility has been shown to be so out of compliance with program requirements that its residents have been placed in immediate jeopardy, the facility was not

[6] R6 initially declined the facility's offer to relocate her. She apparently agreed only after she personally found herself an acceptable alternative. P. Ex. 9.

> administered in a manner that used its resources effectively to attain the highest practicable physical, mental, and psychosocial well-being of each resident.

Asbury Ctr. at Johnson City, DAB No. 1815, at 11 (2002); *Odd Fellow and Rebekah Health Care Facility*, DAB No. 1839, at 7 (2002); *Stone Cnty. Nursing and Rehab. Ctr*., DAB No. 2276, at 15-16 (2009). As discussed below, I find that the facility's deficiencies posed immediate jeopardy to resident health and safety, which, by itself, justifies the finding that the facility was not in substantial compliance with 42 C.F.R. § 483.75.

Moreover, as the above discussion establishes, the failures here were directly attributable to administrative, as well as staff, failures. The facility's administration disregarded facility policies in failing to investigate thoroughly and report resident abuse. It also fell short in protecting residents from R1's abusive behavior and failed to maintain a list of residents with such behavior issues, as called for in the facility policies. The facility was therefore not administered in a manner that used its resources effectively to attain or maintain the highest practicable physical, mental and psychosocial well-being of its residents and was not in substantial compliance with 42 C.F.R. § 483.75.

State IDR Findings. In addition to pursuing this appeal, Petitioner disputed the survey findings by means of the state's IDR (Independent Dispute Resolution) process. 42 C.F.R. § 488.331. Petitioner claims that, based on findings of the state IDR panel, the facility's deficiencies existed for four hours only – from 8:30 a.m. until 12:30 p.m. on September 18. P. Cl. Br. at 23; P. Attach. FN 85. According to Petitioner, because CMS did not explicitly reject the IDR findings, it is bound by them. P. Cl. Br. at 23-25. Petitioner's argument is puzzling because the IDR determinations make no such finding with respect to the duration of the noncompliance. To the contrary, for each of the deficiencies cited, the panel recommended that the deficiency "remain as cited." CMS Ex. 13 at 2, 37, 38, 40. The panel refers to the hours 8:30 a.m. until 12:30 p.m. to point out that the evidence presented "did not include what actions the [f]acility took to protect all the other [r]esidents from [R1] on 9/18/12 from 8:30 a.m. until 12:30 p.m. when discharged. . . ." CMS Ex. 13 at 3, 38, 39, 41. Pointing out the absence of evidence on a narrow factual point obviously does not qualify as a "finding" that would merit CMS's response.

Moreover, to the extent that Petitioner is independently challenging the duration of the immediate jeopardy and substantial noncompliance findings, the challenge fails. The regulations provide that, once a facility has been shown to be noncompliant, the remedies imposed "continue until . . . [t]he facility has achieved substantial compliance as determined by CMS or the [s]tate based upon a revisit or after an examination of credible written evidence that it can verify without an on-site visit" or until the facility is terminated. 42 C.F.R. § 488.454(a). Based on this, the Departmental Appeals Board

(Board) "has long held that CMS is not obliged to 'provide affirmative evidence of continuing noncompliance for each day that a remedy is in place.'" *Golden Living Ctr. – Frankfort*, DAB No. 2296, at 20 (2009), *citing Coquina Ctr.*, DAB No. 1860, at 23 (2002); *Regency Gardens Nursing Ctr.*, DAB No. 1858 (2002). The *facility* must demonstrate that it has corrected the noncompliance and implemented measures to prevent its recurrence. *Golden Living Ctr.*, DAB No. 1860, at 20. Petitioner has not met this burden.

With respect to the duration of immediate jeopardy, R1 began menacing her roommate at least as early as July 23 (probably earlier), causing serious harm. So long as the facility exposed residents to R1's abusive behavior, the likelihood of serious harm continued and did not abate until R1's discharge on September 18. Thus, CMS properly found that the facility's noncompliance posed immediate jeopardy to resident health and safety from July 23 through September 18, 2012.

R1's discharge may have removed the immediate jeopardy, but it did not bring the facility into substantial compliance. The facility's deficiencies were systemic. Among other problems, staff were unaware of the facility's policies for preventing abuse. They plainly did not recognize abuse (or chose to overlook it) and did not understand their obligations to investigate and report. The facility has provided neither argument nor evidence to establish that it corrected these underlying problems and achieved substantial compliance any earlier than December 4, 2012.

B. CMS's determination that, from July 23 through September 18, 2012, the facility's deficiencies posed immediate jeopardy to resident health and safety is not clearly erroneous.

Immediate jeopardy. Immediate jeopardy exists if a facility's noncompliance has caused or is likely to cause "serious injury, harm, impairment, or death to a resident." 42 C.F.R. § 488.301. CMS's determination as to the level of a facility's noncompliance (which would include an immediate jeopardy finding) must be upheld unless it is "clearly erroneous." 42 C.F.R. § 498.60(c). The Board has observed repeatedly that the "clearly erroneous" standard imposes on facilities a "heavy burden" to show no immediate jeopardy, and has sustained determinations of immediate jeopardy where CMS presented evidence "from which '[o]ne could reasonably conclude' that immediate jeopardy exists." *Barbourville Nursing Home*, DAB No. 1962, at 8 (2004), *citing Koester Pavilion*, DAB No. 1750 (2000); *Daughters of Miriam Ctr.*, DAB No. 2067, at 7, 9 (2007).

Here, at least two facility residents were subjected to the abusive conduct of their roommate, a situation likely to cause them serious harm. And the resulting distress they endured is well-documented. R6 was described as "crying and very upset." CMS Ex. 7 at 5. She complained that her "nerves were shot." CMS Ex. 6 at 4. R2 described how

"miserable" she was. CMS Ex. 6 at 30. She had been "crying for many days." CMS Ex. 14 at 3. Moreover, the residents refused to sleep in their own beds at night, preferring to avoid potential abuse by sitting up or wandering the facility. CMS Ex. 6 at 4, 5, 10-11. Indeed, after a night spent outside her room, R2's feet and ankles were swollen and should have been elevated. Yet, she refused to go to her bed, because doing so would mean encountering her abusive roommate. CMS Ex. 6 at 5.

Because the facility's deficiencies were likely to cause and did cause serious harm to two facility residents, CMS's determination that the deficiencies posed immediate jeopardy to resident health and safety is not "clearly erroneous."

C. The penalties imposed –$4,050 per day for the days of immediate jeopardy and $600 per day, reduced to $50 per day, for the days of substantial noncompliance that was not immediate jeopardy – are reasonable.

Here, CMS imposed a penalty of $4,050 per day for the period of immediate jeopardy, which is at the very low end of the per-day penalty range for situations of immediate jeopardy ($3,050-$10,000). 42 C.F.R. §§ 488.408(e)(1)(iii); 488.438(a)(1)(i).

To determine whether the CMPs are reasonable, I apply the factors listed in 42 C.F.R. § 488.438(f): 1) the facility's history of noncompliance; 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 in 42 C.F.R. § 488.404 include: 1) the scope and severity of the deficiency; 2) the relationship of the deficiency to other deficiencies resulting in noncompliance; and 3) the facility's prior history of noncompliance in general and specifically with reference to the cited deficiencies.

I consider whether the evidence supports a finding that the amount of the CMP is at a level reasonably related to an effort to produce corrective action by a provider with the kind of deficiencies found, and in light of the above factors. I am neither bound to defer to CMS's factual assertions, nor free to make a wholly independent choice of remedies without regard for CMS's discretion. *Barn Hill Care Ctr.*, DAB No. 1848, at 21 (2002); *Cmty. Nursing Home*, DAB No. 1807, at 22 *et seq*. (2002); *Emerald Oaks*, DAB No. 1800, at 9 (2001); *CarePlex of Silver Spring*, DAB No. 1683, at 8 (1999).

As a threshold matter, Petitioner complains that the state agency recommended, and CMS initially considered, imposing four per instance CMPs, which would have totaled $10,000. P. Cl. Br. at 20; *compare* CMS Ex. 1 at 16-17 *with* CMS Ex. 1 at 1-13. But CMS opted to impose per day, rather than per instance, CMPs, which, given the duration of the noncompliance, resulted in a much higher penalty. First, it is well-settled that, when the state agency and CMS disagree as to remedies, CMS's determination applies.

See, e.g., 42 C.F.R. § 488.452(d)(2). Second, as discussed above, I have no authority to review CMS's selection of remedies or its decision-making processes. 42 C.F.R. §§ 488.408(g)(2); 498.3(d)(14).

With respect to the section 488.438(f) factors, I note first that the facility has a long and dismal history of substantial noncompliance:

- In June 2005, the facility was not in substantial compliance with multiple program requirements, at scope and severity level E (pattern of noncompliance with the potential for more than minimal harm). Deficiencies were cited under 42 C.F.R. § 483.20(k) (Tag F281), which relates to resident assessment: comprehensive care plans. Three deficiencies were cited under 42 C.F.R. § 483.25(a) and (c) (Tags F312, F314, and F316), which include requirements for quality-of-care. CMS imposed no remedies;

- In March 2006, the facility had F-level (widespread deficiencies with the potential for more than minimal harm) life safety code deficiencies. It had four quality-of-care deficiencies, cited under 42 C.F.R. § 483.25(g) (Tag F322); 42 C.F.R. § 483.25(h) (Tags F323, F324); and 42 C.F.R. § 483.25(m) (Tag F333). The quality-of-care deficiencies were cited at scope and severity level E. The facility was also not in substantial compliance with 42 C.F.R. §§ 483.35 (Tag F364) and 483.35(d) (Tag F371), which impose dietary services requirements. The facility was not in substantial compliance with 42 C.F.R. § 483.75(l) (Tag F514), administration requirements relating to clinical records, also at scope and severity level E. Again, CMS imposed no remedies;

- In July 2006, the facility was again not in substantial compliance with quality-of-care requirements related to preventing accidents, 42 C.F.R. § 483.25(h) (Tag F323). This deficiency was very serious; it was cited at scope and severity level K (pattern of noncompliance that poses immediate jeopardy to resident health and safety). CMS imposed a CMP of $3,250;

- In December 2006, the facility was not in substantial compliance with 42 C.F.R. § 483.10(c) (Tag F159), which includes requirements for safeguarding resident funds. The deficiency was cited at scope and severity level E. CMS imposed no remedies;

- In April 2007, the facility was again not in substantial compliance with life safety code requirements at scope and severity level F. It was again not in substantial compliance with quality-of-care requirements relating to accident prevention, 42 C.F.R. § 483.25(h) (Tag F323), and dietary services requirements, 42 C.F.R. § 483.35 (Tag F371), at scope and severity level E. Other deficiencies were cited under 42 C.F.R. § 483.10(b) (Tag F157), which governs residents rights:

notification of changes, and 42 C.F.R. § 483.25 (Tag F309), quality-of-care, at scope and severity level G (an isolated instance of noncompliance that causes *actual harm*). CMS imposed no remedies;

- In March 2008, the facility again had multiple deficiencies, including level D (an isolated instance of noncompliance with the potential for more than minimal harm) life safety code deficiencies; four quality-of-care deficiencies, violating 42 C.F.R. §§ 483.25(a) (Tag F312), 483.25(l) (Tag F329), and 483.25(m) (Tags F332, and F333), cited at scope and severity level E. It was again not in substantial compliance with dietary services requirements, 42 C.F.R. § 483.35(c) (Tag F363), also at scope and severity level E. CMS imposed no remedies;

- In January 2009, the facility had life safety code violations and dietary services deficiencies, 42 C.F.R. 483.35 (Tag F371), at scope and severity level F. CMS imposed no remedies;

- In October 2009, the facility was again not in substantial compliance with quality-of-care requirements, 42 C.F.R. § 483.25 (Tag F309) at scope and severity level D. CMS imposed no remedies;

- In February 2010, the facility had four quality-of-care deficiencies, 42 C.F.R. §§ 483.25 (Tag F309), 483.25(a) (Tag F312), 483.25(c) (Tag F314), and 483.25(l) (Tag F329). It was not in substantial compliance with 42 C.F.R. § 483.65 (Tag F441), which governs infection control and 42 C.F.R. § 483.70(f) (Tag F 463), which includes requirements for physical environment. All deficiencies were cited at scope and severity level E. CMS imposed no remedies;

- In August 2010, the facility was again not in substantial compliance with the quality-of-care requirements for preventing accidents, 42 C.F.R. § 483.25(h) (Tag F323), at scope and severity level D. It was not in substantial compliance with the administration requirements relating to laboratory services, 42 C.F.R. 483.75(j) (Tag 502), at scope and severity level E. CMS imposed no remedies;

- In January 2011, the facility had more life safety code deficiencies and was again not in substantial compliance with dietary services requirements, 42 C.F.R. § 483.35 (Tag F371), at scope and severity level F. It had deficiencies under 42 C.F.R. § 483.25(m) (Tag F333), which governs quality-of-care with respect to medication errors, at scope and severity level E. CMS imposed no remedies;

- In November 2011, the facility had more dietary services deficiencies, 42 C.F.R. § 483.35(c) (Tag F363), at scope and severity level F. CMS imposed no remedies;

- In March 2012, the facility was again not in substantial compliance with quality-of-care requirements for preventing accidents, 42 C.F.R. § 483.25(h) (Tag F323). These deficiencies were cited at scope and severity level H (pattern of *actual harm*). CMS imposed a penalty of $1,950;

- In July 2012, the facility was not in substantial compliance with life safety code requirements, at scope and severity level F, and the requirements for quality-of-care, 42 C.F.R. 483.25 (Tag F309). It was not in substantial compliance with 42 C.F.R. § 483.10(b)(11) (Tag F371), which addresses resident rights: notification of changes. CMS found a pattern of deficiencies serious enough to pose *immediate jeopardy* to resident health and safety (scope and severity level K). CMS imposed a $5,200 CMP.

CMS Ex. A.

Thus, twelve surveys, conducted over a period of seven years, found significant deficiencies. Notwithstanding the seriousness of many of the deficiencies cited, including findings of actual harm (April 2007), for the first six years, CMS imposed only one penalty, a $3,250 CMP, based on a finding of immediate jeopardy in July 2006. In March 2012, CMS imposed another relatively small penalty ($1,950), after finding a pattern of noncompliance that caused actual harm. The CMP did not produce long-standing corrective action. Four months later (July 2012), the facility still had deficiencies, and these posed immediate jeopardy to resident health and safety. CMS imposed another, higher CMP, $5,200. But this higher penalty was insufficient; just two months later, the survey that is the subject of this appeal again found deficiencies that posed immediate jeopardy.

This history alone justifies increasing the per day penalty beyond the minimum $3,050 mandated by the regulations. I consider the increase – to $4,050 – modest, especially considering how ineffective the lower penalties have been in inducing the facility to achieve and maintain substantial compliance.

With respect to financial condition, the facility has the burden of proving, by a preponderance of the evidence, that paying the CMP would render it insolvent or would compromise the health and safety of its residents. *Van Duyn Home and Hosp.*, DAB No. 2368 (2011); *Gilman Care Ctr.*, DAB No. 2357 (2010). Petitioner points out that CMS determined that immediate full payment of the CMP into an escrow account would create a financial hardship that would compromise the health and safety of residents. It therefore allowed the facility to make monthly payments of $22,462.50, until the account reached the full amount. P. Cl. Br. at 21; CMS Ex. 1 at 1-2. This suggests a cash-flow issue; it does not establish that the facility would be rendered insolvent nor that the health and safety of residents would be compromised if the facility were required to pay the penalty imposed here.

Moreover, Petitioner has proffered no financial documentation or testimony to establish its inability to pay. To meet the standard for lowering a CMP based on financial condition, claims must be supported by compelling financial documentation. In *Guardian Care Nursing & Rehab. Ctr.*, DAB No. 2260 (2009), for example, the facility could not even afford to represent itself on appeal. Its Medicaid census was 90%; its annual shortfall was $250,000; and it relied on charitable contributions for its continuing viability. The Board nevertheless criticized the absence of financial documentation and concluded that the facility had not established that additional resources would not be available. *But see Columbus Nursing and Rehab. Ctr.*, DAB No. 2505 (2013) (finding that the absence of documentation regarding the facility's financial condition did not preclude ALJ from concluding, based on witness testimony, that financial condition justified reducing the CMP).

Applying the remaining factors, I find that the facility's failing to protect R1's roommates justifies the penalties imposed. The deficiencies went well beyond the actions (or inaction) of one or two individuals. The facility administrator and multiple staff members repeatedly disregarded facility policies when they declined to investigate, report, and protect the residents. They are culpable for these failings.

For these reasons, I find that the CMPs are reasonable.

IV. Conclusion

From July 23 through December 4, 2012, the facility was not in substantial compliance with Medicare participation requirements, and, from July 23 through September 18, 2012, those deficiencies posed immediate jeopardy to resident health and safety. The penalties imposed – $4,050 per day for the period of immediate jeopardy, $600 per day and $50 per day for periods of substantial noncompliance – are reasonable.

/s/
Carolyn Cozad Hughes
Administrative Law Judge