Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Rafael Convalescent Hospital
(CCN: 05-5310),

Petitioner

v.

Centers for Medicare and Medicaid Services.

Docket No. C-10-807

Decision No. CR2444

Date: October 6, 2011

DECISION

Petitioner, Rafael Convalescent Hospital (Petitioner or facility), is a long-term care facility located in San Rafael, California, that participates in the Medicare program. Based on a survey completed March 19, 2010, the Centers for Medicare and Medicaid Services (CMS) determined that the facility was not in substantial compliance with Medicare program requirements and imposed a civil money penalty of $1,650 per day for 67 days of noncompliance (March 19 – May 24, 2010), for a total penalty of $110,550.

Petitioner concedes that it was not in substantial compliance with all program requirements, but challenges twelve of seventeen deficiencies, and argues that the penalty imposed is not reasonable.[1]

For the reasons set forth below, I find that only a substantial penalty is likely to produce corrective action that will endure, and I affirm, as reasonable, the $1,650 per day penalty.

[1] CMS cited an additional deficiency under 42 C.F.R. § 483.35(i) (Tag F341 – food storage), which it has decided not to pursue.

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. The regulations require that each facility be surveyed once every twelve months, and 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.

Here, following its March 19, 2010 recertification survey, CMS determined that the facility was not in substantial compliance with multiple program requirements, specifically:

- 42 C.F.R. § 483.10(b)(11) (Tag F157 -- notification of change);
- 42 C.F.R. § 483.13(c) (Tags F225 and F226 -- staff treatment of residents; abuse/neglect policies);
- 42 C.F.R. § 483.15(a) (Tag F241-- quality of life – dignity);
- 42 C.F.R. § 483.15(e)(1) (Tag F246 -- reasonable accommodation);
- 42 C.F.R. § 483.15(h)(1) (Tag F252 -- sanitary and home-like environment);
- 42 C.F.R. § 483.10(d) and 42 C.F.R. § 483.20(k) (Tag F280 -- comprehensive care plans);[2]
- 42 C.F.R. § 483.25(h) (Tag F323 -- accident prevention);
- 42 C.F.R. § 483.25(i) (Tag F325 -- nutrition);

[2] The statement of deficiencies cited these regulations incorrectly. CMS Ex. 1. All agree that the above citations are correct. *See* Order Following Prehearing Conference at 2 (Jan. 26, 2011).

- 42 C.F.R. § 483.25(l) (Tag F329 -- unnecessary drugs);
- 42 C.F.R. § 483.60(b), (d), and (e) (Tag F431 -- pharmacy services);
- 42 C.F.R. § 483.65 (Tag F441 -- infection control);
- 42 C.F.R. § 483.70(d)(1) and (d)(2) (Tag F461 -- resident rooms);
- 42 C.F.R. § 483.75(i) (Tag F501 -- medical director/policies);
- 42 C.F.R. § 483.75(l)(1) (Tag F514 -- clinical records);
- 42 C.F.R. § 483.75(l)(3) (Tag F516 -- safeguarding records); and
- 42 C.F.R. § 483.75(m)(1) (Tag F517 -- emergency planning).

CMS Ex. 1. CMS subsequently determined that the facility returned to substantial compliance on May 25, 2010. CMS Ex. 3.

CMS has imposed against the facility a CMP of $1,650 per day for 67 days (March 19 – May 24, 2010), for a total CMP of $110,550.

Petitioner timely requested a hearing, challenging some of the deficiencies cited. As discussed below, the facility did not challenge five of them, which are therefore final and binding and provide a sufficient basis for imposing a penalty.

On May 2 and 3, 2011, I convened a hearing, via video teleconference, from the offices of the Departmental Appeals Board in Washington, D.C. Counsel and witnesses convened in San Francisco, California. Mr. Greg B. Sherman and Mr. Mark Reagan appeared on behalf of Petitioner. Ms. Claire D. de Chazal and Mr. Michael Propst appeared on behalf of CMS. I have admitted into evidence CMS Exhibits (CMS Exs.) 1-36 and Petitioner's Exhibits (P. Exs.) 1-7, 9-17, P. Ex. 18 pages 1-47, 59-67, 74, 76-84, P. Exs. 19-20, and P. Exs. 22-48. Order Following Prehearing Conference (Jan. 26, 2011); Transcript (Tr.) at 5-6.

The parties have filed pre-hearing briefs (CMS Pre-Hrg. Br.; P. Pre-Hrg. Br.), post-hearing briefs (CMS Post-Hrg. Br.; P. Post-Hrg. Br.), and reply briefs (CMS Reply; P. Reply).

II. Issues

Based on the uncontested deficiencies, there is no dispute that Petitioner was not in substantial compliance with Medicare program requirements, and I must affirm a CMP of at least $50/day.

The remaining issues are:

1. From March 19 through May 24, 2010, was the facility in substantial compliance with the following Medicare program requirements:

   42 C.F.R. § 483.15(a) – Tag F241 (quality of life – dignity);

   42 C.F.R. § 483.15(e)(1) – Tag F246 (reasonable accommodation);

   42 C.F.R. § 483.15(h)(1) – Tag F252 (sanitary and home-like environment);

   42 C.F.R. § 483.25(h) – Tag F323 (accident prevention);

   42 C.F.R. § 483.25(i) – Tag F325 (nutrition);

   42 C.F.R. § 483.25(l) – Tag F329 (unnecessary drugs);

   42 C.F.R. § 483.60(b), (d), and (e) – Tag F431 (pharmacy services);

   42 C.F.R. § 483.65 – Tag F441 (infection control);

   42 C.F.R. § 483.70(d)(1) and (d)(2) – Tag F461 (resident rooms);

   42 C.F.R. § 483.75(i) – Tag F501 (medical director/policies);

   42 C.F.R. § 483.75(l)(3) – Tag F516 (safeguarding records); and

   42 C.F.R. § 483.75(m)(1) – Tag F517 (emergency planning).[3]

2. Is the CMP imposed – $1,650 per day – reasonable?

[3] Ultimately, I do not consider all of the contested deficiencies but make findings sufficient to justify the penalty imposed. *Senior Rehab. and Skilled Nursing Ctr.*, DAB No. 2300 at 6 n.5 (2010), *aff'd, Senior Rehab. and Skilled Nursing Ctr .v. HHS*, 405 F. App'x 820 (5th Cir. 2010).

III. Discussion

A. CMS's unchallenged determinations that the facility was not in substantial compliance with 42 C.F.R. §§ 483.10(b)(11), 483.13(c), 483.20(k), and 483.75(l)(1) are final and binding and justify a significant penalty. [4]

CMS's findings of noncompliance that result in the imposition of a remedy are considered initial determinations that an affected party, such as Petitioner, may appeal. The regulations governing such actions dictate that CMS send notice of the initial determination to the affected party, setting forth the basis for and the effect of the determination, and the party's right to a hearing. 42 C.F.R. §§ 498.20(a)(1), 498.3, 498.5. The affected party may then challenge the determination by filing a hearing request within 60 days of its receiving the notice. 42 C.F.R. § 498.40. An initial determination is final and binding, unless reversed or modified by a hearing decision (or under circumstances not applicable here). 42 C.F.R. § 498.20(b).

In this case, CMS sent the appropriate notice, and Petitioner requested a hearing. In both its hearing request and other submissions, Petitioner challenges only some of the deficiencies cited. See discussion below; P. Pre-Hrg. Br. at 2. CMS's determinations that the facility was not in substantial compliance with 42 C.F.R. §§ 483.10(b)(11) (Tag F157), 483.13(c) (Tags F225 and F226), 483.10(d), and 483.20(k) (Tag F280), and 483.75(l)(1) (Tag F514) are therefore final and binding.

Because we have a final and binding determination that the facility was not in substantial compliance, CMS has the discretion to impose one or more of the enforcement remedies listed in 42 C.F.R. § 488.406, which include the per day CMP imposed here. Act § 1819(h); 42 C.F.R. § 488.402. So long as CMS has a basis for imposing a remedy, I have no authority to review its determination to do so (42 C.F.R. § 488.438(e)), nor may I review CMS's choice of remedy. 42 C.F.R. § 488.438(a)(1)(ii).

Here, CMS has chosen a per day penalty, which, by law, must be at least $50 per day. 42 C.F.R. §§ 488.408(d)(1)(iii), 488.438(a)(1)(ii).

Because the quality of a facility's noncompliance affects the amount of the CMP (see penalty discussion below), I consider briefly the particulars of the uncontested deficiencies.

---

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

1. **42 C.F.R. § 483.10(b)(11)**. The facility must protect and promote the rights of each resident. In this regard, it must immediately inform the resident, consult the resident's physician, and (if known) notify the resident's legal representative, or interested family member, when there is: a significant change in the resident's physical, mental, or psychosocial status (*i.e.*, a deterioration in health, mental or psychosocial status in either life-threatening conditions or clinical complications); or a need to alter treatment significantly (*i.e.*, a need to discontinue an existing form of treatment due to adverse consequences or to commence a new form of treatment). 42 C.F.R. § 483.10(b)(11).

Resident 7 (R7) was an 82-year-old woman, who, with her husband, R26, was admitted to the facility on September 2, 2008. She suffered from dementia, Parkinson's Disease, depression, diabetes with neurological manifestations, anemia, anorexia, and hypertension. CMS Ex. 12 at 1, 11. To treat these conditions, her physician prescribed multiple medications, including Aricept (used to treat symptoms of Alzheimer's), Remeron (an anti-depressant), metoprolol (a beta blocker), and Cozaar (an anti-hypertensive). CMS Ex. 12 at 2, 27, 29, 32. In January and February 2010, R7 repeatedly refused to take her medications. According to CMS's review of the medication administration records, which Petitioner does not dispute, she refused to take her noon, 2:00 p.m., 4:00 p.m., and 8:00 p.m. medications for nine days in January and ten days in February. CMS Pre-Hrg. Br. at 9; CMS Post-Hrg. Br. at 2; CMS Ex. 1 at 7; CMS Ex. 12 at 27-48; *see* CMS Ex. 35 at 2, 3 (Boggs Decl. ¶¶ 9, 11) (explaining that, according to standard nursing practice, a nurse circles her initials on the medication sheet to signify that the resident did not take the prescribed dose).

The facility did not tell R7's physician about this significant, and potentially dangerous, change in her status, much less consult him about any potential treatment changes or interventions that he might order to address the situation. This failure put the facility out of substantial compliance with 42 C.F.R. § 483.10(b)(11).

2. **42 C.F.R. § 483.13(c)**. Facilities must develop and implement written policies and procedures that prohibit resident neglect. 42 C.F.R. § 483.13(c). "Neglect" means failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. 42 C.F.R. § 488.301. *See Jennifer Matthew Nursing & Rehab. Ctr.*, DAB No. 2192 at 19 (2008). Among other requirements, the facility must ensure that all alleged violations involving neglect are "reported immediately" to the facility's administrator and to the appropriate state officials. 42 C.F.R. § 483.13(c)(2). It must have evidence that all alleged violations are thoroughly investigated, and the results of any investigation must be reported to the administrator, or his designee, and to the appropriate state officials within five working days of the incident. 42 C.F.R. § 483.13(c)(3), (4).

The facility had in place a written policy for reporting and investigating abuse. Consistent with the regulation, it required staff to report to the appropriate state agencies

"[a]ll alleged/suspected violations." CMS Ex. 29 at 3. The policy mandated that all staff, consultants, family members, attending physicians, visitors, and others "promptly report any incident or suspected incident of neglect or resident abuse, including injuries of an unknown source" to the administrator or his designee. CMS Ex. 29 at 10. The policy also directed the facility administrator, or his designee, to appoint an individual to investigate any "incident or suspected incident of resident abuse, neglect, injury of an unknown source, resident-to-resident abuse, and/or resident-to-staff abuse." CMS Ex. 29 at 4. The policy directed the investigator to review the resident's medical record and to interview those involved, including the resident (as appropriate), the person reporting the incident, all witnesses, the resident's attending physician (as appropriate), family, staff and visitors who had contact with the resident during the 48 hours prior to the incident, the accused, and others. All witness interviews had to be written up, signed, and dated by the witness. The investigator had to compile a written report, and the administrator had to provide a copy of that report to the appropriate state agencies. CMS Ex. 29 at 4-5.

Even though multiple incidents of alleged abuse and injuries of unknown origin occurred at the facility, staff did not report them to the facility administrator; no one investigated as required, and the facility did not report the incidents to the appropriate state agency. CMS Ex. 34 at 2-3 (Pochini Decl. ¶¶ 9, 10, 12). In fact, the facility's abuse coordinator, Assistant Director of Nursing (ADON), Abshalom Jacob (also referred to as Management Staff A), told Surveyor Peggy Pochini that no allegations had been reported to the state agency *for an entire year* (since March 2009). CMS Ex. 34 at 2 (Pochini Decl. ¶ 9); CMS Ex. 23 at 23-24; CMS Post-Hrg. Br. at 2.

Below, I discuss in greater detail the instances in which R26 physically and verbally abused his wife (R7). While Petitioner maintains that it otherwise responded appropriately to R26's actions, it admits that it neither formally investigated nor reported these incidents of spousal abuse. Nurses' notes establish that, on October 2, 2009, October 4, 2009, October 25, 2009, and January 6, 2010, R26 likely abused his wife. Indeed, on January 6, a nurse wrote that she witnessed him hitting and verbally abusing her. CMS Ex. 12 at 13, 15, 18-19; CMS Ex. 21 at 15, 17. Yet, the abuse coordinator did not implement any of the required interventions. Nor did he report the incidents to the appropriate state agency. CMS Post-Hrg. Br. at 2; CMS Ex. 23 at 15; CMS Ex. 34 at 2-3 (Pochini Decl. ¶¶ 9, 10).

I find these failures to investigate and report particularly disturbing because they are not simply attributable to the errors of low-level staff but involve management failings. Both ADON Jacob and Unit I Manager, June McLanahan, R.N. (who supervised the staff on R7's unit), knew of alleged abuse and failed to follow the facility's anti-neglect policies. Unit Manager McLanahan specifically admits knowing about the January 6 incident and describes some interventions, but she does not claim to have implemented any of the facility's anti-neglect policies. In fact, she does not mention those policies. P. Ex. 33 at 1-3. (McLanahan Decl. ¶¶ 1, 2, 7, 9, 11, 14). Similarly, ADON Jacob's testimony leaves

no doubt that he was fully aware of the dangerous behaviors, particularly the October 25 incident. He claims, vaguely, that he "spoke with the two residents," and he "spoke with staff." But he does not mention the facility's anti-neglect policies. Tr. at 154-56; *see* P. Ex. 27 at 1-2 (Jacob Decl. ¶ 4, 6, 7).

CMS cites additional incidents involving other residents. Both R1 and R13 suffered injuries of unknown origin. The facility neither investigated nor reported them. CMS Ex. 23 at 24; CMS Ex. 34 at 3 (Pochini Decl. ¶ 12).

Thus, the undisputed evidence establishes that the facility repeatedly failed to implement its policies and procedures for prohibiting resident neglect, in violation of 42 C.F.R. § 483.13(c).

3. **42 C.F.R. § 483.20(k)**. The facility must develop a comprehensive care plan for each resident to meet the resident's medical, nursing, mental, and psychosocial needs that are identified in the resident's comprehensive assessment. The plan must be prepared by an interdisciplinary team that includes the attending physician, a registered nurse responsible for the resident, and other appropriate staff, depending on the resident's needs. The plan must be reviewed and revised after each assessment.

R7's care plan identified as a problem that her medical conditions required multiple medications. According to the plan, her interdisciplinary team would perform a medication review at each care conference and whenever a significant change of condition occurred. Medication issues affecting her care were to be "identified and resolved" as the need arose. CMS Ex. 12 at 22.

As discussed above, R7 began refusing her medications in January 2010. Facility staff completed R7's quarterly assessment on February 16, 2010, and her care planning conference occurred on February 23. CMS Ex. 12 at 4, 5, 8. Yet, the responsible registered nurse, Unit Manager McLanahan, did not even know that R7 had been refusing medications. CMS Ex. 12 at 4, 8. The interdisciplinary team did not identify the problem and, instead, wrongly concluded that there had been no significant change. They made no changes to R7's care plan. In fact, the team specifically noted that R7 had a positive response to an increased dosage of Remeron (up from 15 to 30 mg. at bedtime), which she took for "depression [manifested by] poor appetite." CMS Ex. 12 at 4, 31. Of course, she repeatedly had been refusing her Remeron and was eating less. CMS Ex. 12 at 27, 28, 31. And, according to her quarterly assessment, her weight had dropped from 122 to 115 pounds since August 2009. CMS Ex. 12 at 6.

The interdisciplinary team considered none of these problems and did not revise R7's care plan to address the medication issue or the weight loss. CMS Ex. 12 at 6; CMS Ex. 35 at 5 (Boggs Decl. ¶ 26). It was therefore not in substantial compliance with 42 C.F.R. § 483.20(k).

4. **42 C.F.R. § 483.75(l)(1)**. The facility must maintain clinical records on each resident, in accordance with accepted professional standards and practices that are complete, accurate, readily accessible, and systematically organized.

R22 was admitted to the facility on January 25, 2010, following knee surgery. CMS Ex. 18 at 8. Her physician ordered stitches removed in two weeks (by February 8, 2010). CMS Ex. 18 at 6. But her records did not indicate where the stitches were located or whether they had been removed. CMS Ex. 18 at 4; CMS Ex. 36 at 3-4 (Carnahan Decl. ¶ 18).

R23 was admitted to the facility on March 4, 2010, but her clinical record did not include an admission care plan, which should have been completed within a week of her admission. CMS Ex. 19 at 4; CMS Ex. 36 at 3-4 (Carnahan Decl. ¶ 18).

B. The facility was not in substantial compliance with 42 C.F.R. § 483.25(h) because it did not provide R7 and R26 the supervision they needed to meet their needs and mitigate foreseeable risks of harm from accidents.

Regulatory requirements. Under the statute and the "quality-of-care" regulation, each resident must receive, and the facility must provide, the necessary care and services to allow a resident to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the his/her comprehensive assessment and plan of care. To this end, the regulation mandates that the facility "ensure" that each resident's environment remains as free of accident hazards as possible. 42 C.F.R. § 483.25(h)(1). It must "take reasonable steps to ensure that a resident receives supervision and assistance devices designed to meet his assessed needs and to mitigate foreseeable risks of harm from accidents." *Briarwood Nursing Ctr.*, DAB No. 2115 at 5 (2007); *Guardian Health Care Ctr.*, DAB No. 1943, at 18 (2004) (*citing* 42 C.F.R. § 483.25(h)(2)). The facility must anticipate what accidents might befall a resident and take steps to prevent them. A facility is permitted the flexibility to choose the methods it uses to prevent accidents, but the chosen methods must constitute an "adequate" level of supervision under all the circumstances. *Briarwood*, DAB No. 2115 at 5; *Windsor Health Care Ctr.*, DAB No. 1902 at 5 (2003); *see Burton Health Care Ctr.*, DAB No. 2051 at 9 (2006) (holding that determining whether supervision/assistive devices are adequate for a particular resident "depends on the resident's ability to protect himself from harm").

As a threshold matter, the facility's undisputed failure to follow its own protocols for preventing neglect means that the facility was not taking reasonable steps to protect its residents from harm. I may reasonably rely on the facility's protocol as evidence of professional standards of quality, as well as the facility's "own judgment as to what must be done to attain or maintain its residents' highest practicable physical, mental and

psychosocial well-being, as required by section 483.25." *Agape Rehab. of Rock Hill*, DAB No. 2411 at 7, 18 (2011); *Senior Rehab. and Skilled Nursing Ctr.*, DAB No. 2300 (2010), *aff'd, Senior Rehab. and Skilled Nursing Ctr. v.* 405 F. App'x 820 (5th Cir. 2010) (*quoting Sheridan Health Care Ctr.*, DAB No. 2178 at 15 (2008)); *Spring Meadows Health Care Ctr.*, DAB No. 1966 at 18 (2005) (holding that "it is reasonable to presume that the facility's policy reflects professional standards of quality, absent convincing evidence to the contrary").

Moreover, by not investigating R7's "falls" and other allegations of abuse, the facility lost the opportunity to analyze and correct its problems, which also put it out of substantial compliance with 42 C.F.R. § 483.25(h). *Century Care of Crystal Coast*, DAB No. 2076 at 21 (2007), *aff'd*, No. 07-1491, 2008 WL 2385505 (4th Cir. 2008).

The facility violated the quality-of-care regulation in other respects. As noted above, R7 and R26 were admitted to the facility on September 2, 2008. R26 suffered from Alzheimer's Disease, and staff subsequently identified him as physically aggressive, making sexual advances, striking out at caregivers, and using foul language. CMS. Ex. 21 at 5; P. Ex. 25 at 2, 3.

From the time of their admission, R7 and R26 shared a bed, apparently at the insistence of family members. P. Ex. 35 at 1 (Lair Decl. ¶ 5).

At 1:30 a.m. on October 2, 2009, staff found R7 on the floor of their room, her arm hanging through the bed's side rail. When questioned, R7 said, "he pushed me out." When R26 denied it, she called him a liar. CMS Ex. 12 at 13-14, 25; CMS Ex. 21 at 17; P. Ex. 24 at 12; *see* CMS Ex. 21 at 5 (noting the facility's social worker reported that the "resident had episodes of pushing his wife out of their bed").

A staff member, named Juanita Pfeiffer, completed a document called a "Post Fall Assessment." It reiterates that R7 was "found on floor" with her arm through the side rail and describes her as "very verbal [and] angry [and] a little afraid." The assessment says that "husband is the factor. He seems in punishing mode now." The document also says that R7 sleeps heavily but that her husband awakens her off and on. It notes that R26 removes and hides the bed alarm. The document contains no real recommendations to prevent further falls but, instead, concludes with "[R7] is angry [and] afraid that it will happen again. He laughed when I told they may be separated." P. Ex. 24 at 12.

A nurse's note, written at 6:30 a.m. on October 2, says that staff checked on the residents hourly, apparently over the five hours between 1:30 and 6:30 a.m. CMS Ex. 12 at 14. According to Diana Ingram, R.N., a nurse consultant who has no personal knowledge of these events but reviewed certain materials, "[t]he care plan was updated to show that Resident 7 would be checked frequently and that the family and physician would be notified." P. Ex. 38 at 4 (Ingram Decl. ¶ 11). But R7's care plan is in the record, and no

changes were made to it between August 5, 2009 and October 24, 2009. P. Ex. 24 at 1-2; Tr. at 268.

It appears that Nurse Consultant Ingram was not referring to an actual care plan, but something she later characterized as a "short term care plan" calling for frequent checks. Tr. at 269-74. Petitioner submitted no such document, and no facility employee explained or even referred to it, much less claimed to have followed it. *See* P. Exs. 27 (Jacob Decl.), 28 (Gendelman Decl.), 30 (Seamus Egan Decl.), 31 (Tim Egan Decl.), 33 (McLanahan Decl.), 40 (Bokarius Decl.), 41 (Adelstein Decl.). Nurse Consultant Ingram's description of the document is also confusing. In her written declaration, she mis-identified it as a care plan, and, under cross-examination, she conveyed only that the document said, "under October 2nd, 'Fall, husband pushed me out'" and "Monitor something times 72 hours. It could be a V – I can't read that – or it could be Q shift." Tr. at 270-71.

On October 4, 2009, staff again found R7 on the floor, and she again said that her husband had pushed her out of bed. CMS Ex. 12 at 15, 25; CMS Ex. 21 at 5. A staff member partially filled out another Post Fall Assessment form, which did not describe the incident but recommended separate beds. P. Ex. 24 at 13. According to the social worker's notes, she and Unit I Manager McLanahan met with the residents' daughters on the afternoon of October 5, 2009, to discuss putting the residents in separate beds. CMS Ex. 12 at 25-26. A nursing note dated October 7 indicates that R7 was given a separate bed ("kept safe and comfortable in her own bed"), and a note dated October 8 quotes her saying that she liked her new bed. CMS Ex. 12 at 17. A social worker's note dated October 7 confirms that the residents "now sleep in separate beds." CMS Ex. 12 at 26.

A nurse's note dated October 25 describes R7 as "visibly shaking [and] crying, refusing to go to dining room to eat lunch [with] husband." She said that her husband beat her under the table and cursed at her in front of everyone in the dining room. Although staff attempted to feed her at the nurses' station, she refused to eat. CMS Ex. 12 at 18-19. I note that, in describing this incident, Unit Manager McLanahan omits any reference to R7's shaking and crying and accusing her husband of beating her, stating that R26 "upset" R7 who "expressed that she did not want to eat lunch" with him. P. Ex. 33 at 2 (McLanahan Decl. ¶ 11). Such selective testimony does not enhance a witness's credibility.

ADON Jacob testified that, after this incident, he met with both residents and then spoke to his unit manager and director of staff development, telling them to "speak to staff about what's acceptable and what's not acceptable." Tr. at 155. No records were kept of these encounters, which he characterizes as "informal." ADON Jacob is vague as to the content of the "informal" instructions. Unit Manager McLanahan describes telling staff that the couple "needed to be closely supervised and separated when they verbalized or otherwise expressed that they were annoyed with each other," but "the mere fact that they

were arguing did not necessarily require separation." P. Ex. 33 at 2 (McLanahan Decl. ¶ 12). I do not consider such conversations with unidentified staff adequate to address the problem of spousal abuse.

Unit Manager McLanahan also claims that the facility's "administration considered and rejected the idea of preventing the residents from eating together" but "determined that the residents would need to be supervised when they ate together and separated when [there] were verbal or other cues that indicated that the residents needed to be separated." P. Ex. 33 at 2-3 (McLanahan Decl. ¶ 13).

Petitioner also suggests that R7 may have been delusional because she later accused staff of swearing at her. P. Post-Hrg. Br. at 4. Inasmuch as the facility did not investigate R7's October 25 allegations against R26 or her later allegations against staff, it is not in a position to challenge the veracity of her allegations on either occasion. In any event, the charge that her husband beat her had to be taken seriously. R26 had demonstrated aggression toward his wife and others. At a minimum, R7's complaints put the facility on notice that the couple needed especially close supervision. When eating together, staff needed to pay special attention to ensure that he was not assaulting her under the table.

Nurse Practitioner Susan Degutes, who worked with R26's attending physician, assessed R26 on October 30, 2009. Remarkably, facility nursing staff did not tell her about the incidents of October 2, 4, and 25. They said R26 was "doing ok" and that he and his wife were in single beds in the same room. P. Ex. 25 at 3; Tr. at 143-44. According to Petitioner's consultant, Psychiatrist Vladimir Bokarius, these omissions were justified because the nurse practitioner should confine herself to her "physical health assessment;" she "is nothing to do with psychology, nothing to do with psychiatry and very little to do with behavior so it's actually great for her to write a note like that," but "it's not in the realm of her profession." Tr. at 146. I reject this remarkable opinion. Staff should immediately have consulted the attending physician (which includes his nurse practitioner) following each of the incidents. 42 C.F.R. § 483.10(b)(11). I find no justification for its misleading her in this way. R26 had recently behaved in an aggressive and dangerous manner (to himself as well as his wife); he was not "doing ok."

At 3:00 a.m. on January 6, 2010, a nurse heard R26's bed alarm and witnessed him "hitting his wife in bed" and verbally abusing her. CMS Ex. 21 at 15. The nurse wrote that she separated the residents, monitored them the rest of the night, and reported the incident to the AM nurse. CMS Ex. 21 at 15.

This was a very serious incident that was again not properly investigated or reported. Unit Manager McLanahan suggests that she learned that something happened on January 6, although she again mischaracterizes the incident, claiming that "the residents were arguing and the facility acted to separate them." She says that she "spoke with [R26]," reminding him to respect his wife. P. Ex. 33 at 3 (McLanahan Decl. ¶ 14). She

apparently did not document the conversation. ADON Jacob does not even mention the incident.

A Resident Care Conference Summary, dated March 9, 2010, says that R7 "expressed 'she wants to be in a room without him'" and that the facility planned to move R26 to another unit because of his behavior against his spouse. CMS Ex. 21 at 9.

A nursing note, dated March 13, says that R26 visited his wife in the dining room that morning and "became loud [and] aggressive with her." She asked to return to her room because she was not feeling well. CMS Ex. 21 at 13.

Finally, Surveyor Karen Boggs testified, credibly, that she observed R26 "hitting or tapping [R7's] legs during dinner on March 17, 2010." Staff neither responded nor intervened. CMS Ex. 35 at 3 (Boggs Decl. ¶ 16); Tr. at 113-14. In fact, Surveyor Boggs did not see any staff member monitoring the couple's behavior during dinner. Tr. at 115. Petitioner challenges this testimony, but offers no reasonable argument or evidence to undermine its reliability. Instead, Petitioner points to May 2010 entries in R7's care plan, which obviously did not even exist at the time of the survey. Petitioner also cites: a May 21, 2010 progress note that says that R7 likes to sit with her husband, but they have to be supervised; a May 21, 2010 social worker progress note that says that R7 and R26 have supervised visits; and a March 14, 2010 nursing note that says the residents had been in the TV room together that morning. P. Ex. 24 at 8-10; CMS Ex. 21 at 13. From this thinnest of evidence, Petitioner argues that, "[i]n light of this increased supervision, Surveyor Boggs' testimony that staff failed to observe Resident 26 'hitting' or 'tapping' Resident 7's leg strains credibility." P. Post-Hrg. Br. at 7. None of these notes tell us anything about what was happening at the dinner table on March 17.

Petitioner also argues that Surveyor Boggs' testimony is inconsistent with the note she wrote at the time she made the observation, which says that R26's hand was in R7's lap during dinner. CMS Ex. 24 at 10. I agree that the surveyor's testimony is more detailed than her note, but I do not see them as inconsistent, and both establish that the surveyor was specifically observing what went on between the two during dinner. No staff member has come forward to claim responsibility for supervising the residents at meals then, or any other time, from which I can reasonably infer that no staff member was watching; only the surveyor was watching. Nor does Petitioner explain what procedures it had in place to assure that staff were closely observing the couple during meals, which suggests that it had no specific procedures in place.

Petitioner insists that the residents' strongest desire was to stay together, so the facility "was *required* to respect the right of the residents to share a room together," at least until March 9, 2010, when R7 "stated that she no longer wanted to share a room with her husband." P. Post-Hrg. Br. at 3 (emphasis in original). I do not see much support in R7's record for the proposition that she insisted on staying with her husband, and I am

concerned about what appear to be significant miscommunications to family as to the seriousness of the incidents. According to the residents' daughter, in late 2009, ADON Jacob told her that the facility wanted her parents to have separate beds "because my mother had fallen out of bed a few times." P. Ex. 35 at 1 (Lair Decl. ¶ 6). This obviously greatly misrepresents what occurred; her mother did not fall out of bed – she was pushed. It seems that facility staff did not convey to the resident's family the seriousness of the situation or the dangers posed to R7 (and, for that matter, to R26, who might have seriously injured his wife or himself). In any event, the residents' daughter plainly did not understand or accept that her father was repeatedly physically abusing her mother.

Accepting the proposition that the residents and/or their family insisted that they not be separated makes it all the more critical that the facility develop and implement interventions that would keep R7 safe while honoring the couples' desire to stay together. And the facility did not develop a coherent approach for ensuring that R7 would be safe. At most, individual staff members instituted *ad hoc* and short-lived approaches. Knowing that a husband is prone to physically abusing his wife, as the evidence conclusively establishes here, the facility nevertheless regularly left them alone and unsupervised. Ignoring its own protocols, it did not investigate; it did not report the incidents; it did not alter the residents' care plans. It was therefore not in substantial compliance with 42 C.F.R. § 483.25(h).

C. The penalty imposed -- $1,650 per day -- is reasonable.

To determine whether a CMP is 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 section 488.438(f) 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. 1638 at 8 (1999).

Here, the penalty imposed -- $1,650 per day -- is in the middle of the penalty range ($50-$3,000) for per-day CMPs where the facility's deficiencies do not pose immediate jeopardy to resident health and safety. 42 C.F.R. §§ 488.408(d), 488.438(a)(1).

Petitioner has a dismal compliance history. In every annual survey since April 2006, the facility was out of substantial compliance with multiple program requirements. Indeed, the sheer number of deficiencies cited every year, as well as the number of repeat deficiencies, suggests a facility for which only a very significant penalty is likely to produce much in the way of enduring corrective actions.

- In March 2009, the facility was not in substantial compliance with 13 requirements (10 health and 3 life safety code);
- In April 2008, 10 deficiencies were cited (7 health and 3 life safety code);
- In February 2007, 12 deficiencies were cited (7 health and 5 life safety code); and
- In April 2006, 11 deficiencies were cited (7 health and 4 life safety code).

CMS Ex. 9.[5]

Many of the deficiencies cited during the March 2010 survey had been cited in prior years. Among them:

- Section 483.13(c) (Tag F226) (staff treatment of residents; abuse/neglect policies) was cited in 2009 and 2008;
- Section 483.15(a) (Tag F241) (quality of life – dignity) was cited in 2007;
- Section 483.25(h) (Tag F323) (accident prevention) was cited in 2008 and 2009 at the G level of scope and severity (isolated instance of actual harm that is not immediate jeopardy);
- Section 483.25(l) (Tag F329) (unnecessary drugs) was cited in 2007;

[5] For each of these years, additional deficiencies were cited, but at scope and severity levels B (pattern of noncompliance causing no actual harm with the potential for no more than minimal harm) and C (widespread noncompliance causing no actual harm with the potential for no more than minimal harm). Although the facility should correct its A, B, and C level deficiencies, they do not constitute substantial noncompliance, so I do not include them in my consideration of facility history.

- Sections 483.60(b),(d), and (e) (Tag F431) (pharmacy services) were cited in 2006, 2007, and 2009;

- Section 483.65 (Tag F441) (infection control) was cited in 2007 and 2009; and

- Section 483.75(m)(1) (Tag F517) (emergency planning) was cited in 2007.[6]

When Congress passed nursing home reform legislation in 1987, it expressed particular concern about what it characterized as a "yo-yo or roller coaster phenomenon" – nursing homes that were chronically out of compliance when surveyed, temporarily corrected their deficiencies, but then lapsed into noncompliance.[7] To prevent this, Congress gave CMS the authority to impose significant penalties. But the penalty must not be "just another cost of doing business"; particularly for facilities that display chronic noncompliance, it must be significant enough to produce real and enduring corrections. I do not know whether a penalty of $1,650 per day is sufficient to induce lasting corrections for this chronically deficient facility. However, based on facility history alone, it seems unlikely that any lower penalty would do so.

Petitioner does not claim that its financial condition affects its ability to pay the CMP.

With respect to the other factors, the facility's failure to investigate or report any incidents of suspected – and even verified – abuse is very serious and, by itself, justifies a significant penalty. That professional staff knew about the alleged abuse but did not report it to the administrator or to the state agency greatly increases the facility's culpability for the deficiencies cited under sections 483.13(c) and 483.25(h).

---

[6] I recognize that I have not reviewed all of these repeat citations. Based on the facility history and other factors discussed here, I would find the penalty reasonable, even if I did not consider that some of those deficiencies were repeated during the March 2010 survey. CMS Ex. 9 at 1.

[7] The House Report cited findings from the General Accounting Office that 41 percent of skilled nursing facilities were, during three consecutive inspections, out of compliance with requirements likely to affect patient health and safety. These skilled nursing facilities were nevertheless able to remain in the program for years by making just enough corrections to prevent termination whenever time they were caught. H.R. REP. NO. 100-391(I) (1987). The House Report also discussed a study by the Institute of Medicine of the National Academy of Sciences, which found that large numbers of nursing homes were "chronically out of compliance when surveyed, may or may not" have been subject to mild sanctions, temporarily corrected their deficiencies under a plan of correction, "and then quickly lapse[d] into noncompliance until the next annual survey." *Id.* at 471; *see Heartland Manor at Carriage Town*, DAB No. 1664 at 17 (1998).

I also found particularly disturbing staff's failure to consult R7's attending physician when she began refusing her medications. Then, even though she was regularly refusing the medication ordered to combat her anorexia and she had lost a significant amount of weight, her interdisciplinary team did not identify a problem, much less revise her care plan to address the medication issue or the weight loss. This demonstrates further indifference and disregard for the resident's care, comfort, and safety, for which the facility is culpable.

IV. Conclusion

From March 19 through May 24, 2010, the facility was not in substantial compliance with Medicare participation requirements, specifically 42 C.F.R. §§ 483.10(b)(11), 483.13(c), 483.20(k), 483.25(h), and 483.75(l)(1), and I affirm, as reasonable, the penalty imposed.

/s/
Carolyn Cozad Hughes
Administrative Law Judge