Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Embassy Health Care Center,
(CCN: 14-5316),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-11-773

Decision No. CR2587

Date: August 13, 2012

DECISION

Petitioner, Embassy Health Care Center (Petitioner or facility), is a long-term care facility located in Wilmington, Illinois, that participates in the Medicare program. Everyone agrees that one of its employees deliberately slapped a resident three times, and another employee witnessed the assault but delayed reporting it. Based on this and other cited deficiencies, the Centers for Medicare & Medicaid Services (CMS) determined that the facility was not in substantial compliance with Medicare program requirements and imposed a civil money penalty (CMP) of $150 per day for 84 days of substantial noncompliance (April 22 through July 14, 2011), for a total penalty of $12,600.

Here, CMS moves for summary judgment, which Petitioner opposes.

For the reasons set forth below, I grant CMS's motion. The undisputed evidence establishes that the facility was not in substantial compliance with the challenged program requirements for the period alleged and that 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. 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 a survey completed April 22, 2011, CMS determined that the facility was not in substantial compliance with multiple program requirements, specifically:

- 42 C.F.R. § 483.13(c) (Tag F226 – resident behavior and facility practices/ policies to prohibit neglect and abuse) at scope and severity level D (isolated instance of noncompliance that caused no actual harm with the potential for more than minimal harm);

- 42 C.F.R. § 483.15(g)(1) (Tag F250 – quality of life – medically-related social services) at scope and severity level E (pattern of noncompliance that causes no actual harm with the potential for more than minimal harm);

- 42 C.F.R. § 483.15 (h)(1) (Tag F252 – quality of life – safe, clean, comfortable environment) at scope and severity level E;

- 42 C.F.R. § 483.15(h)(2) (Tag F253 – quality of life – housekeeping and maintenance services) at scope and severity level E;

- 42 C.F.R. § 483.20(k)(3)(ii) (Tag F282 – resident assessment/comprehensive care plans – services provided) at scope and severity level D;

- 42 C.F.R. § 483.25(h) (Tag F323 – quality of care – accident prevention) at scope and severity level E;

- 42 C.F.R. § 483.35(a) (Tag F361 – dietary services/staffing) at scope and severity level E;

- 42 C.F.R. § 483.35(b) (Tag F362 – dietary services/sufficient staff) at scope and severity level E;

- 42 C.F.R. § 483.35(i) (Tag F371 – dietary services/sanitary conditions) at scope and severity level F (widespread noncompliance that causes no actual harm with the potential for more than minimal harm);

- 42 C.F.R. § 483.45(a) (Tag F406 – specialized rehab services) at scope and severity level E;

- 42 C.F.R. § 483.65 (Tag F441 – infection control) at scope and severity level E.

CMS Ex. 6.

Thereafter, the state agency received a confidential complaint from an unidentified medical center. The complaint alleged that the facility sent one of its residents to the emergency room for a psychiatric evaluation, claiming that she was self-mutilating and refused to eat. Medical center staff saw no evidence of these conditions. But when they attempted to return the resident to the facility, facility staff not only refused to pick her up, they said that they would not let her in the door if she returned (according to the complaint). CMS Ex. 41, at 2-3 (Granberry Decl. ¶ 4); CMS Ex. 54, at 2.

Responding to this complaint, surveyors revisited the facility on July 1, 2011. CMS Ex. 41, at 2-3 (Granberry Decl. ¶¶ 4-6). Based on their findings, CMS determined that the facility was then not in substantial compliance with 42 C.F.R. § 483.12(a)(4)-(6) (Tag F203 – transfer and discharge rights: notice requirements). CMS Exs. 2, 38.

On August 2, 2011, surveyors revisited the facility a second time. Based on their findings, CMS determined that the facility achieved substantial compliance on July 15, 2011. CMS Ex. 2.

CMS has imposed against the facility a CMP of $150 per day for 84 days of substantial noncompliance (April 22 through July 14, 2011), for a total CMP of $12,600.

Petitioner timely requested hearings challenging the April and July survey findings, which we docketed under case numbers C-11-537 and C-11-773, respectively. Because the two cases involved the same survey cycle and presented common questions of law and fact, I consolidated them under Docket No. C-11-773. CMS now moves for summary judgment. The parties filed prehearing briefs (CMS Br.; P. Br.). CMS then submitted a motion for summary judgment and supporting memorandum (CMS MSJ) and

Petitioner filed a memorandum in opposition to summary judgment (P. Opp.). CMS submitted 56 exhibits (CMS Exs. 1-56), and Petitioner submitted 20 exhibits (P. Exs. 1-20).

II. Issues

I consider first whether summary judgment is appropriate.

On the merits, the issues before me are: 1) from April 22 through July 14, 2011, was the facility in substantial compliance with Medicare program requirements; and 2) if the facility was not in substantial compliance, is the penalty imposed, $150 per day, reasonable.

III. Discussion

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

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

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

In examining the evidence for purposes of determining the appropriateness of summary judgment, I must draw all reasonable inferences in the light most favorable to the non-moving party. *Brightview Care Ctr.*, DAB No. 2132 at 2, 9 (2007); *Livingston Care Ctr.*, 388 F.3d at 172; *Guardian Health Care Ctr.*, DAB No. 1943 at 8 (2004); *but see Cedar Lake Nursing Home*, DAB No. 2344 at 7; *Brightview Care Ctr.*, DAB No. 2132 at 10

(entry of summary judgment upheld where inferences and views of non-moving party are not reasonable). However, drawing factual inferences in the light most favorable to the non-moving party does not require that I accept the non-moving party's legal conclusions. *Cedar Lake*, DAB No. 2344 at 7; *Guardian*, DAB No. 1943 at 11 ("A dispute over the conclusion to be drawn from applying relevant legal criteria to undisputed facts does not preclude summary judgment if the record is sufficiently developed and there is only one reasonable conclusion that can be drawn from those facts.").

A. CMS is entitled to a summary judgment finding that the facility was not in substantial compliance with 42 C.F.R. § 483.13(c), because everyone agrees that a staff member slapped a resident three times, and the staff member who witnessed this abuse delayed reporting it.[1]

Here, the undisputed facts establish that a staff member slapped a facility resident multiple times. Although another staff member witnessed the assault, he delayed reporting it, in contravention of facility policy and 42 C.F.R. § 483.13(c).

Program requirements. Facility residents have the right to be free from verbal, sexual, physical, and mental abuse. 42 C.F.R. § 483.13(b). Abuse is defined as "the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish." 42 C.F.R. § 488.301. The phrase "willful infliction" means that the actor must have acted deliberately, not that the actor must have intended to inflict injury or harm. *Merrimack County Nursing Home*, DAB No. 2424 at 5 (2011); *Britthaven, Inc., d/b/a Britthaven of Smithfield*, DAB No. 2018 at 4 (2006). Facilities must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents. 42 C.F.R. § 483.13(c). Staff must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. All alleged violations involving mistreatment or abuse must be reported "immediately" to the facility's administrator and appropriate state officials. 42 C.F.R. § 483.13(c)(2).

Here, consistent with the regulations, the facility's abuse prevention policy "affirms the right" of facility residents "to be free from abuse, neglect, misappropriation of resident property, corporal punishment and involuntary seclusion." The policy prohibits mistreatment, neglect, or abuse of residents. Among other specifics, it calls for "immediately protecting residents involved in identified reports of possible abuse," and having systems in place to investigate "promptly and aggressively" all reports and allegations of mistreatment. According to the policy, physical abuse includes "hitting,

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

slapping, pinching, kicking, and controlling behavior through corporal punishment." P. Ex. 1, at 1; CMS Ex. 37, at 1.

CMS does not fault the facility's written policy. However, the regulation requires that policies be "implemented," and implementing a policy requires more than drafting and maintaining documents. Staff must follow the policy. As the Departmental Appeals Board has long recognized, examples of neglect or abuse can demonstrate that the facility has not implemented its policies. *Barn Hill Care Ctr.*, DAB No. 1848 at 9-12 (2002); *Emerald Oaks*, DAB No. 1800 at 18 (2001); *see also The Cottage Extended Care Ctr.*, DAB No. 2145 at 4 n.4 (2008); *Liberty Commons Nursing & Rehab. Ctr. – Johnston*, DAB No. 2031 at 7-17 (2006), *aff'd*, *Liberty Nursing & Rehab. Ctr. – Johnston v. Leavitt*, 241 F. App'x 76 (4th Cir. 2007); 59 Fed. Reg. 56,130.

Undisputed facts. Although the record includes few details regarding Resident 29 (R29), he apparently suffered from bipolar and schizoaffective disorders, as well as other impairments, and resided on the facility's "behavioral unit." CMS Ex. 28, at 1, 24. The facility admits that, at approximately 3:00 to 3:30 a.m. on April 15, 2011, R29 kicked Nurse Aide Rosie Armstrong who, "in turn, smacked R29 in the face three times." P. Opp. at 3; P. Ex. 3, at 1 (Jude Decl. ¶ 4).[2] Nurse Aide Brent Watters witnessed the incident – in fact, according to his written statement, he was holding the resident's arms when the incident occurred – but, contrary to facility policy, he did not report it until he started his 2:00 p.m. shift later that day. P. Ex. 3, at 1 (Jude Decl. ¶ 4); CMS Ex. 28, at 15.

Thereafter, the facility terminated Nurse Aide Armstrong's employment and disciplined Nurse Aide Watters. P. Ex. 2; P. Ex. 3, at 1-2 (Jude Decl. ¶¶ 4, 5); P. Ex. 4.

Petitioner argues that it was in substantial compliance with section 483.13(c) because: 1) Nurse Aide Armstrong's treatment of R29 was not egregious enough to constitute abuse; and 2) the facility had in place reasonable procedures to prevent abuse (particularly after the abuse occurred). I reject both arguments.

Without question, slapping a resident falls within the regulatory definition of abuse ("willful infliction of . . . intimidation or punishment with resulting physical harm, pain or mental anguish."). Even if this were debatable (which it is not), the facility's own policy specifically lists "slapping" as a form of abuse. P. Ex. 1, at 1; CMS Ex. 37, at 1.

[2] CMS determined that striking R29 three times in the face while he may have been restrained caused no actual harm. Although I find this determination baffling – a slap across the face is physically painful as well as humiliating – I have no authority here to review the deficiency's scope and severity. *See* 42 C.F.R. §§ 498.3(b)(14), 498.3(c)(10)(ii).

Thus, the facility itself recognized that slapping a resident constitutes abuse, and I may reasonably hold it to that standard. *See Agape Rehab. of Rock Hill*, DAB No. 2411 at 7, 18 (2011); *Senior Rehab. & Skilled Nursing Ctr*., DAB No. 2300 (2010), *aff'd, Senior Rehab. & Skilled Nursing Ctr. v. HHS*, 405 F. App'x 820 (5th Cir. 2010) (quoting *Sheridan Health Care Ctr*., DAB No. 2178 at 15 (2008) and holding that the facility's protocol represents 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); *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").

Nor am I persuaded that the facility's purportedly "reasonable procedures" for preventing abuse kept it in substantial compliance, notwithstanding the actions of staff.[3] First, I do not agree with the facility administrator, Jodie Foster Jude, R.N. (nee Jodie Foster), when she contends that the facility "did all it could to ensure that it looked out for R29's safety and well-being by having in place the proper preventative measures and by taking the necessary follow-up action upon learning the facts of the incident." P. Ex. 3, at 1 (Jude Decl. ¶ 5). Certainly, Nurse Aide Armstrong was not looking out for R29's safety and well-being when she repeatedly struck him. Nurse Aide Watters was not looking out for the resident's safety and well-being when he delayed reporting the assault. As Administrator Jude concedes, Nurse Aide Watters should have called the director of nursing (a position she held at the time of the incident) or the assistant director of nursing "the minute the incident occurred." P. Ex. 3, at 1 (Jude Decl. ¶ 5). His failure to do so allowed the abuser ongoing contact with the resident for at least the remainder of her shift, an additional three hours. CMS Ex. 28, at 3. It is well-settled that the facility is accountable for such staff conduct and does not avoid that responsibility by subsequently disciplining the individuals involved in the abuse/neglect. *See, e.g.*, *North Carolina State Veterans Nursing Home, Salisbury*, DAB No. 2256 at 10-15 (2009); *Emerald Oaks*, DAB No. 1800 at 7 n.3 (2001).

[3] Petitioner also claims that "whether [the facility] employed reasonable procedures is clearly a question of fact," which precludes my entering summary judgment. P. Opp. at 11. The reasonableness of the facility's procedures is not a question of fact, but a conclusion of law. That distinction doesn't matter here, however. First, CMS has not alleged that the procedures themselves were inadequate; CMS charges that the facility did not adequately implement its procedures. Second, notwithstanding the facility's subsequent efforts to implement its "reasonable procedures," the undisputed actions of nurse aides Armstrong and Watters put the facility out of substantial compliance.

Thus, without regard to any other deficiency findings, the facility's noncompliance with section 483.13(c) puts the facility out of substantial compliance with program requirements and more than justifies the relatively low penalty imposed here.[4]

B. CMS's unchallenged determination that the facility was not in substantial compliance with multiple program requirements is final and binding, and, based on those deficiencies, CMS may impose a penalty.

CMS argues that seven of the eleven deficiencies cited during the April survey -- 42 C.F.R. §§ 483.15 (h)(1), 483.15(h)(2), 483.20(k)(3)(ii), 483.25(h), 483.45(a), and 483.65 -- are final and binding because Petitioner failed to challenge them.

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 determinations dictate that CMS send notice 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).

Following the April survey, CMS sent the appropriate notice, and, by letter dated June 17, 2011, Petitioner requested a hearing. In that hearing request, Petitioner lists, by tag number, the eleven deficiencies cited and demands a hearing to challenge them, as well as the scope and severity findings "in connection with the F tags" and the CMPs. Petitioner's Hearing Request at 2 (June 17, 2011).

Simply listing the deficiency tags does not satisfy the requirements for an adequate hearing request, however. The request must "identify the specific issues, and the findings of fact and conclusions of law with which the affected party disagrees" and must "specify the bases for contending that the findings and conclusions are incorrect." 42 C.F.R. § 498.40(b). On its face, Petitioner's hearing request did not satisfy this requirement. Attached to the request is a copy of the facility's Informal Dispute Resolution (IDR) submissions to the state agency.[5] Those submissions, however, address only the

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[4] Because the abuse finding justifies the penalty imposed, I decline to address the deficiencies cited under 42 C.F.R. §§ 483.35(a), 483.35(b) and 483.35(i)(2). *See*, *e.g.*, *Senior Rehab. & Skilled Nursing Ctr.*, DAB No. 2300 at 6 n.5.

[5] States must offer facilities an informal opportunity to dispute survey findings. 42 C.F.R. § 488.331.

deficiency cited under 42 C.F.R. § 483.35(i) (Tag F371 – dietary services/sanitary conditions). They say nothing about the seven deficiencies that CMS identifies as unchallenged.

Petitioner's hearing request thus preserved only one issue with respect to the April survey – its compliance (or noncompliance) with 42 C.F.R. § 483.35(i). Nevertheless, Petitioner had another opportunity to articulate additional bases for its appeal. In my initial prehearing order, I directed the parties to submit pre-hearing briefs and warned that the briefs "must contain any argument that a party intends to make" and that "I may exclude an argument and evidence that relates to such argument if a party fails to address it in its pre-hearing brief." Acknowledgment and Initial Pre-hearing Order at 4, ¶ 7 (June 23, 2011). Petitioner's pre-hearing brief addresses the deficiencies cited under section 483.35(i), and adds three additional issues: its compliance with sections 483.13(c) (abuse); 483.35(a) (dietary staffing); and 483.35(b) (dietary support personnel). It mentions 483.13(g)(1) (medically-related social services) but offers no arguments as to its position on that issue.

Because it has proffered no arguments challenging CMS's determinations regarding section 483.13(g)(1) and the remaining six deficiencies cited during the April survey (which are listed above), Petitioner has waived those issues, and CMS's determination that the facility was not in substantial compliance with those requirements is therefore final and binding. *See* CMS Exs. 1, 6.

We thus have a final and binding determination that the facility was not in substantial compliance with program requirements as of the April survey, so 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 diem 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).

Finally, I may not review CMS's scope and severity finding, because a successful challenge would not affect the range of the CMP or the status of the facility's nurse aide training program (if it has one). 42 C.F.R. §§ 498.3(b)(14); 498.3(d)(10).

C. CMS is entitled to a summary judgment finding that the facility was not in substantial compliance with 42 C.F.R. § 483.12(a)(4)-(6) because the undisputed evidence establishes that the facility expelled one of its residents without timely and adequate notice.[6]

Program requirements. With limited exceptions, the facility may not involuntarily discharge its residents, but must permit them to remain. Among the exceptions: the transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility. 42 C.F.R. § 483.12(a)(2)(i). However, before a facility transfers or discharges a resident, it must so notify the resident and, if known, a family member or legal representative "in writing and in a language and manner they understand." 42 C.F.R. § 483.12(a)(4)(i). The written notice must include the following: 1) the reason for the transfer/discharge; 2) the effective date of transfer/discharge; 3) the location to which the resident is transferred/discharged; 4) a statement that the resident has the right to appeal the action to the state; 5) the name, address and telephone number of the state's long-term-care ombudsman; 6) for residents with developmental disabilities, the mailing address and telephone number of the state agency responsible for protecting the developmentally disabled; and 7) for mentally ill residents, the mailing address and telephone number of the state agency responsible for protection and advocacy of mentally ill individuals. 42 C.F.R. § 483.12(a)(4), (6). Unless the resident's health and safety dictate otherwise (or the resident has not resided in the facility for 30 days), the facility must provide the notice "at least 30 days before the resident is transferred or discharged." 42 C.F.R. § 483.12(a)(5).[7]

Undisputed facts: Resident 21(R21). R21 was a 46-year-old woman who had been admitted to the facility in September 2007. CMS Ex. 19, at 5. She had a long list of diagnoses, including opiate withdrawal, schizoaffective disorder, depression, syncope, anxiety, and chronic pain. CMS Ex. 19, at 8. Nevertheless, she apparently had no legal guardian and was capable of acting on her own behalf. According to her care plan,

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[6] Petitioner suggests that, unless CMS affirmatively establishes that the facility was not in substantial compliance as of the July revisit, the facility would be entitled to an earlier compliance date. This is not necessarily so. Generally, to establish an earlier onset date, the facility must affirmatively demonstrate that it has achieved substantial compliance. *Premier Living & Rehab Ctr.*, DAB No. 2146 at 23 (2008); *Lake City Extended Care Ctr.*, DAB No. 1658 at 12-15 (1998); CMS Ex. 38. Here, however, CMS seems to agree that, but for the deficiency cited under 42 C.F.R. § 483.12, CMS would have found an earlier correction date.

[7] The facility "must" also sufficiently prepare and orient residents "to ensure safe and orderly transfer or discharge from the facility." 42 C.F.R. § 483.12(a)(7).

updated in February 2011, she wished to move to a less structured environment. The "tentative" plan calls for her to move to her own home, but indicates that, to make the transition, she needs a visiting nurse, and assistance from "home healthcare." The plan includes a significant list of interventions aimed at achieving a successful transition from facility to home: meeting with medical personnel to determine the services she would need in the community; meeting regularly with the resident to prepare her for discharge; contacting an appropriate home healthcare agency to set up needed services; teaching the resident follow-up care; and preparing a written "post-discharge plan of care." The facility was to complete a community living assessment, help the resident find housing, and provide her with appropriate phone numbers in case she needed additional help. The resident was also supposed to attend psychosocial groups aimed at managing symptoms and adjusting to community life. Her tentative discharge date was set at November 2, 2011. CMS Ex. 19, at 25.

According to a June 7, 2011 progress note, written by the facility's social services director, Stephanie Henrich, "Heidi from independent living" reported that R21 was "almost ready to place [in] the community, but first needs paperwork filled out by doctors." CMS Ex. 42, at 27. During the survey, Administrator Jude confirmed to Surveyor Byron Granberry that, as of June 8, the facility had not arranged a placement for R21. CMS Ex. 38, at 3; CMS Ex. 54, at 2 (Granberry Decl. ¶ 6).

Undisputed facts: facility policies. Neither party submitted a copy of the facility's written policy governing resident transfers and discharges. The parties nevertheless agree that facility policy makes the social services director, Stephanie Henrich, responsible for the residents' discharge plans. In that capacity, she is supposed to assess whether a resident is able to live in the community and to assist with living arrangements. She follows up after discharge to ensure that the resident is fully acclimated to his/her new environment. P. Ex. 18, at 1 (Henrich Decl. ¶ 1). Before the facility discharges a resident because the resident is harming herself or because the facility cannot continue to care for her, "it exhausts every way to see if a resident's needs could be met." If, for example, a resident chooses not to eat, the facility uses "support groups, medication, and redirection, to name a few, to see if a resident's behavior can be altered." P. Ex. 18, at 1 (Henrich Decl. ¶ 2). Ultimately, the facility recommends involuntary discharge only if it is unable to alter the resident's adverse behavior. P. Ex. 18, at 1 (Henrich Decl. ¶ 2). Under those circumstances, Social Services Director Henrich completes an involuntary discharge form, which gives the resident 30-days written notice of discharge and advises her of her right to a full hearing. The social services director sends copies to the appropriate state agency, and awaits a response.

> Sometimes, however, when the safety or health of individuals in a facility is endangered or the immediate discharge is required by the resident's urgent medical needs, the resident can be provided notice as soon as practicable, meaning, a 30-day advance notice is not required.

P. Ex. 18, at 1-2 (Henrich Decl. ¶ 4); *accord* P. Ex. 3, at 2 (Jude Decl. ¶ 6) (confirming that the facility policy requires "that in all involuntary discharge matters, the resident is provided a 30-day notice," unless "an immediate transfer or discharge is required by the resident's urgent medical needs.")

Undisputed facts: the events of June 8, 2011. On June 8, 2011, the facility sent R21 to the hospital.[8] At the same time, it gave her a "Notice of Involuntary Transfer and Discharge and Opportunity for Hearing." P. Ex. 20; CMS Ex. 42, at 5-7. According to the notice, the reason for the proposed transfer or discharge is that "the safety of individuals in this facility is endangered," citing 42 C.F.R. § 483.12(a)(2)(iii).[9] The notice indicates that the transfer/discharge is immediate, and the notice is signed by Social Services Director Henrich. P. Ex. 20.

The hospital subsequently attempted to discharge R21 and return her to the facility, but the facility refused to readmit her. Administrator Jude told Surveyor Granberry, "We didn't have a place to discharge R21[,] but R21 was refusing treatment[,] so we did an involuntary discharge. We sent R21 to the hospital twice[,] and every time she came back[,] she refused to eat[,] so the third time we sent R21 to the hospital without the thirty day notice of involuntary discharge[,] and would not accept her back. CMS Ex. 38; P. Ex. 54, at 2 (Granberry Decl. ¶¶ 4, 6).

According to Social Services Director Henrich, she had "no choice" but to involuntarily discharge R21 "due to concern for her safety and well-being;" R21 refused to eat or drink unless she was discharged, and, as a result, the resident's body atrophied and she became

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[8] Apparently, she had been discharged from another hospital the day before and, initially, showed no signs of distress or behavior problems. CMS Ex. 42, at 15. That night, however, according to a nurse's note, she insisted on calling her physician "repeatedly" at 1:00 a.m. and became agitated when her questions were not answered. She also reported having eaten two cheeseburgers and complained about loose stools. CMS Ex. 42, at 16.

[9] Section 483.12(a)(2)(iii) allows for transfer/discharge if the safety of individuals in the facility is endangered. Petitioner has not argued that R21 endangered the safety of facility residents. Social Services Director Henrich does not explain why she gave this reason for the discharge.

dehydrated.[10] The resident also spent excessive periods of time in the sun, refusing water despite the heat and humidity. She ignored staff warnings and stayed outside until her skin burned, according to Social Services Director Henrich. P. Ex. 18, at 2 (Henrich Decl. ¶ 4); *see* CMS Ex. 42, at 28.[11]

Administrator Jude echoes Social Services Director Henrich's assertion that R21 refused foods and liquids, which "caused her body to atrophy and become dehydrated," and that the resident spent excessive periods of time in the sun, refusing water despite the heat and humidity, ignoring staff warnings, and staying outside until her skin burned. P. Ex. 3, at 2 (Jude Decl. ¶ 6).

No one disputes that R21 lost weight; facility weight records document as follows her monthly weights over the six-month period immediately preceding her discharge:

December 2010:	154
January 8, 2011:	140
February 14, 2011:	135
March 15, 2011:	136
April 13, 2011:	136
May 18, 2011:	134
June 8, 2011:	134

CMS Ex. 45. Thus, although she lost 20 pounds over that six-month period, the undisputed evidence establishes that her weight was relatively stable for the four months

[10] Petitioner points to no underlying medical records to support this claim of body atrophy and dehydration. In fact, in a letter written after her discharge, her physician mentions the resident's weight loss, her threats to stop eating, and scratches and abrasions on her forearm. He says that she is "manipulative" and "anxious" and has changed doctors multiple times. "I do not want to continue as her doctor." He does not mention atrophy or dehydration. CMS Ex. 42, at 18. Nevertheless, whether the resident actually suffered these conditions is not material. For purposes of summary judgment, I accept the witnesses' representations.

[11] Petitioner has not argued that the facility discharged R21 because of self-mutilating behavior, nor does any witness make that claim. Although social service notes mention R21's scratching herself, no care plan entries suggest that the facility saw this as an immediate problem. CMS Ex. 42, at 28. R21's most recent care plan, dated May 5, 2011, identifies a history of self-injurious behavior, but says that she has not engaged in the behavior for two years. CMS Ex. 42, at 33. If this became a problem in June, facility staff were supposed to intervene by taking the approaches listed, including closely supervising her and removing sharp objects from her room. Nothing in the record or Petitioner's arguments suggests that they did so.

immediately prior to her discharge and that she remained heavier than her ideal body weight plus 10 pounds (IBW + 10), which the facility reported to be 126.5 pounds. CMS Ex. 45; *see* CMS Ex. 42, at 20 (January 12 nutrition progress note indicating that R21 gave up soda, hoping to achieve her desired weight of 115 pounds).

The facility identified weight loss as an issue for R21, although not a particularly serious problem. In a dietary intervention entry, dated January 25, 2011, the dietician recommended that R21 receive skim milk twice a day, no orange juice, no gravy, but double portions at lunch and dinner, "per the resident's request." CMS Ex. 30, at 43.

According to R21's care plan, which recorded her weight as 150 pounds, she was at risk for weight loss related to her depression, chronic pain, and schizoaffective disorder. The plan's goal was for her to maintain her current weight plus or minus five percent. It mentions that she is a "picky eater" and buys from a local store. It calls for a regular diet plus snacks, says to offer substitutions for foods she dislikes, give her adequate time to complete her meals, and monitor her weight monthly, reporting significant changes to her physician, the dietician, and the administration. An entry dated April 11 notes that she does not drink all of the liquids she asks for on her meal tray (2 milks and 2 juices), so her liquids are cut to one milk/juice per tray, although she may have more. CMS Ex. 42, at 22.

A plan entry, dated May 12, 2011, says that the resident "continues to request [double] portions on meals she likes. She also continues to eat snacks, etc., purchased from local store instead of meals prepared here." CMS Ex. 42, at 23. Another entry, dated June 2, 2011, says "educated [resident] again on proper food nutrition – she tells me she can eat what she wants when she wants." CMS Ex. 42, at 23. A final entry, dated June 3, 2011, says that 20 cases of soda from the local grocery store were delivered and that the resident consumes soda all day. CMS Ex. 42, at 23.

Based on these undisputed facts, I find that the facility violated its own policies and federal requirements when it discharged R21 without adequate notice. First, nothing in R21's care plan addresses the extreme situation described by Social Services Director Henrich and Administrator Jude. Accepting as true their claims that the resident's refusal to eat caused dehydration, muscle atrophy, and other serious health issues, I would also have to conclude that, contrary to its policy, the facility did not "exhaust every way to see if [the] resident's needs could be met." *See* P. Ex. 18, at 1 (Henrich Decl. ¶ 2). The facility did not even address these issues in her care plan.

CMS does not fault the facility for sending the resident to an acute-care hospital for assessment and treatment. However, when hospital staff determined that she did not require further treatment and could safely return to the facility, it wrongfully refused to readmit her. An acute-care hospital is not an appropriate long-term-care placement, as facility staff well knew, or should have known. Accepting that the facility could no

longer meet the resident's needs, someone had to find her an appropriate placement elsewhere. The regulations place this responsibility squarely on the facility (where the resident had lived for four years). The facility abdicated that responsibility and denied the resident her right to a meaningful notice; it was therefore not in substantial compliance with 42 C.F.R. § 483.12(a)(4)-(6).

D. The penalty imposed is not unreasonably high.

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; *Community Nursing Home*, DAB No. 1807, at 22 *et seq*. (2002); *Emerald Oaks*, DAB No. 1800 at 9; *CarePlex of Silver Spring*, DAB No. 1638 at 8 (1999).

Here, the penalty imposed -- $150 per day -- is at the very low end 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. Multiple deficiencies have been cited during every survey for at least the last three years. CMS Ex. 3. Moreover, as I noted in a recent decision, this facility has been designated a "special focus facility," which means that, because of its significant history of noncompliance, it is subject to more careful monitoring. *See Embassy Health Care Ctr.*, DAB CR2464 at 21 (2011). By itself, the facility's history more than justifies a significant penalty.

Petitioner has not argued that its financial condition affects its ability to pay the $12,600 CMP.

I need not even consider the remaining factors in order to sustain this very low penalty. But considering those factors, I note that the sheer number of deficiencies sustained here justifies a penalty well above the minimum. Moreover, a staff member deliberately

assaulted a resident; a second staff member witnessed the assault but delayed reporting it. I find these failures very serious, evidencing a disregard for resident safety for which the facility is culpable. Finally, the callous manner in which the facility expelled a resident, without adequate notice or an appropriate placement, shows further disregard for the resident's comfort and safety.

IV. Conclusion

For these reasons, I grant CMS's motion for summary judgment. The undisputed evidence establishes that, from April 22 through July 14, 2011, the facility was not in substantial compliance with program requirements. The relatively minimal penalty imposed – $150 per day – is not unreasonably high.

/s/
Carolyn Cozad Hughes
Administrative Law Judge