Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Heritage Hills Living & Rehabilitation Center,
(CCN: 37-5317),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-13-233

Decision No. CR4255

Date: September 25, 2015

DECISION

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

Petitioner, Heritage Hills Living & Rehabilitation Center, is a long-term care facility, located in McAlester, Oklahoma, that participates in the Medicare program. Based on a survey completed August 24, 2012, the Centers for Medicare & 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 (CMPs) of $10,000 per day for one day of immediate jeopardy, followed by $300 per day for 34 days of substantial noncompliance that was not immediate jeopardy.

Petitioner concedes that it was not in substantial compliance but challenges the deficiencies cited at the immediate jeopardy level (42 C.F.R. §§ 483.13(b) and(c)), the immediate jeopardy determination itself, and the amount of the CMP imposed for the one day of immediate jeopardy.

For the reasons set forth below, I find that, on August 23, 2012, the facility was not in substantial compliance with 42 C.F.R. §§ 483.13(b) and (c), that its deficiencies posed immediate jeopardy to resident health and safety, and that the penalty imposed is reasonable.

Background

The Social Security Act (Act) sets forth requirements for nursing facilities to participate 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 survey skilled nursing facilities in order to determine whether they 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, and 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 Oklahoma State Department of Health (state agency) completed a complaint investigation survey on August 24, 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 posed immediate jeopardy to resident health and safety)**;[1]

- **42 C.F.R. § 483.13(c) (Tag F226 – policies to prohibit abuse and neglect) at scope and severity level L (widespread noncompliance that posed immediate jeopardy to resident health and safety)**;

- 42 C.F.R. § 483.15(h)(2) (Tag F253 – quality of life: housekeeping and maintenance services) at scope and severity level E (pattern of noncompliance that caused no actual harm with the potential for more than minimal harm);

[1] Petitioner has not appealed most of the deficiencies cited. This list highlights, in bold, those that are the subject of this appeal.

- 42 C.F.R. § 483.15(h)(6) (Tag F257 – quality of life: comfortable and safe temperature levels) at scope and severity level E;

- 42 C.F.R. § 483.20(g) – (j) (Tag F278 – resident assessment: accuracy/coordination/certification) at scope and severity level E;

- 42 C.F.R. §§ 483.20(k)(2); 483.10(d)(3) (Tag F280 – resident assessment: comprehensive care plans; and resident rights: free choice) at scope and severity level E;[2]

- 42 C.F.R. § 483.25 (Tag F309 – quality of care) at scope and severity level E;

- 42 C.F.R. § 483.25(d) (Tag F315 – quality of care: urinary incontinence) at scope and severity level E;

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

- 42 C.F.R. § 483.25(*l*) (Tag F329 – quality of care: unnecessary drugs) at scope and severity level E;

- 42 C.F.R. § 483.35(i) (Tag F371 – dietary services: sanitary conditions) at scope and severity level E;

- 42 C.F.R. § 483.40(b) (Tag F386 – physician services: physician visits) at scope and severity level E;

- 42 C.F.R. § 483.60(c) (Tag F428 –pharmacy services: drug regimen review) at scope and severity level E;

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

- 42 C.F.R. § 483.70(f) (Tag F463 – physical environment: resident call system) at scope and severity level D (isolated instance of noncompliance that caused no actual harm with the potential for more than minimal harm);

[2] Although the survey report form correctly describes the regulatory requirements, it misnumbers the subparagraphs. CMS Ex. 1 at 43.

- 42 C.F.R. § 483.75 (Tag F490 – administration) at scope and severity level F (widespread noncompliance that caused no actual harm with the potential for more than minimal harm);

- 42 C.F.R. § 483.75 (*l*)(1) (Tag F514 – administration: clinical records) at scope and severity level E.

CMS Ex. 1.[3]

Surveyors revisited the facility on October 8. Based on their findings, CMS determined that the facility returned to substantial compliance on September 27, 2012. CMS Ex. 7 at 2.

CMS imposed against the facility CMPs of $10,000 per day for one day of immediate jeopardy (August 23, 2012) and $300 per day for 34 days of substantial noncompliance that was not immediate jeopardy (August 24 through September 26), for a total penalty of $20,200. CMS Ex. 7 at 2.

Petitioner timely requested review, challenging the deficiencies cited at the immediate jeopardy level – 42 C.F.R. §§ 483.13(b), 483.13(c), and 483.13(c)(1)(i). Petitioner also challenges the immediate jeopardy determination itself and the amount of the CMP imposed for its one day of immediate jeopardy.[4]

The parties agree that this matter may be decided based on their written submissions, without an in-person hearing. Unopposed Motion to Stay Proceedings and Request for Briefing Schedule (November 1, 2013); Order Cancelling Hearing and Establishing Briefing Schedule (November 4, 2013).

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[3] Citing CMS's October 19, 2012 notice letter, CMS includes among its list of deficiencies: noncompliance with 42 C.F.R. §§ 483.10(b)(11) (Tag F157); 483.35 (c) (Tag F363); and 483.35(d)(1)-(2) (Tag F364). CMS Opening Br. at 19, *citing* CMS Ex. 7 at 1. However, the survey report form did not mention these deficiencies. CMS Ex. 1.

[4] The facility also sought informal dispute resolution (IDR) through the state process. 42 C.F.R. § 488.331. Apparently, the IDR panel amended the surveyors' recommended scope and severity findings for tags F223 (42 C.F.R. § 483.13(b) and (c)(1)(i)) and F226 (42 C.F.R. § 483.13(c)), among others. The IDR panel lowered the scope and severity findings from immediate jeopardy to scope and severity level E. CMS explicitly rejected the IDR determination. CMS Ex. 25 at 5-7 (McElroy Decl. ¶8). Petitioner argues that CMS had no authority to do so. In fact, it is well-settled that CMS ultimately determines whether a facility is in substantial compliance and whether immediate jeopardy exists. Act §§ 1819(h)(1)(2); *Britthaven of Chapel Hill*, DAB No. 2284, at 7-9 (2009).

The parties filed pre-hearing briefs (CMS Pre-hrg. Br.; P. Pre-hrg. Br.). CMS subsequently filed what it titles an opening brief (CMS Br.). Petitioner filed a response (P. Response) and CMS filed a Reply (CMS Reply).[5] I admitted into evidence CMS Exhibits (Exs.) 1-25 and P. Exs. 1-11. Summary of Prehearing Conference and Order Establishing Procedure for Hearing at 2 (Aug. 22, 2013).

Issues

Based on the uncontested issues, the facility was not in substantial compliance with Medicare program requirements from August 24 through September 26, 2012, and the $300 per day penalty for 34 days of substantial noncompliance (total: $10,200) is reasonable. The remaining issues are:

1. Was the facility in substantial compliance with the Medicare requirements governing abuse and staff treatment of residents, 42 C.F.R. §§ 483.13(b) and (c);

2. If, on August 23, 2012, the facility was not in substantial compliance with 42 C.F.R. §§ 483.13(b) and (c), did those deficiencies pose immediate jeopardy to resident health and safety; and

3. If the facility was not in substantial compliance with 42 C.F.R. § 483.13(b) and (c), is the penalty imposed – $10,000 for one day – reasonable.

Discussion

1. The facility was not in substantial compliance with 42 C.F.R. §§ 483.13(b) and (c) because its staff allowed one of its residents to abuse other residents as well as facility staff. Staff did not follow the facility's policies and procedures for preventing abuse and failed to implement the interventions set forth in the resident's care plan for addressing his abusive behaviors.[6]

[5] CMS, apparently inadvertently, filed its reply four days late. Counsel was ill and lost track of the deadline. Petitioner objected to the late filing and asked that I sanction CMS by not considering the contents of its tardy submission. I find good cause for the late filing and no prejudice to Petitioner, so I decline to sanction CMS. Moreover, my decision would remain the same, whether or not I considered the contents of CMS's reply.

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

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 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).

Facility policies. The facility had written policies and procedures for preventing abuse, and those policies generally reflect program requirements. They adopt the regulatory definition of abuse (§ 488.301) and define verbal abuse as "oral, written, or gestured language," including disparaging and derogatory terms aimed at residents, regardless of the victim's age, ability to comprehend, or disability. Examples include threats of harm or "saying things to frighten" the resident. The policies define mental abuse as including "humiliation, intimidation, harassment, threats of punishment, or deprivation." CMS Ex. 20 at 1.

Consistent with the regulations, the policies aim to protect facility residents from all abuse, including verbal and mental abuse: residents "are to be protected from any abuse by anyone," including other residents. According to the policy, *any* facility employee who becomes aware of *any* abuse must *immediately* report the matter to the facility administrator. The administrator, in turn, must report the "allegations and incidents of resident abuse" to the state agency. CMS Ex. 20 at 1.

Elsewhere, the policies direct staff to report immediately to the charge nurse, director of nursing (DON), or administrator all allegations of abuse or neglect. CMS Ex. 20 at 8. If reported to the charge nurse, she must immediately notify the facility administrator and DON. The facility must promptly investigate all such complaints. The charge nurse, DON and/or administrator must immediately assess the resident victim for signs of harm, and staff must immediately notify the resident's physician and responsible party. CMS Ex. 20 at 2, 4. The administrator must, within 24 hours, report to the state agency, by telephone, all alleged violations. CMS Ex. 20 at 6. As soon as an incident report is completed by the administrator, the facility must submit it to the state agency; it must be submitted no later than 5 days after the incident occurs. CMS Ex. 20 at 6.

The policy also mandates that, during the investigation, the facility protect its residents from further harm. Among other interventions for preventing resident conflicts, the facility must keep the involved residents away from each other, and all staff should monitor them. CMS Ex. 20 at 6.

Resident 13's (R13's) aggressive behavior and the facility's response. The challenged deficiencies here revolve around the facility's response to the behavior of one of its residents, R13. R13 was a 55-year-old man, admitted to the facility in November 2011. He suffered from uncontrolled diabetes, renal failure, hypertension, and hyperlipidemia. His left leg had been amputated above the knee because of complications from his diabetes. P. Ex. 3; CMS Ex. 16. Although capable of standing and some walking (with a prosthesis), he generally navigated the facility by means of a wheelchair. CMS Ex. 16 at 5.

Shortly after his admission, R13 began to display aggressive and abusive behaviors toward residents and staff. As the following list of incidents establishes, facility staff repeatedly disregarded both the facility policies for addressing abuse and the Medicare requirements. Early on, the facility amended R13's care plan to address his abusive behaviors, but staff did not follow those instructions. When his abuse continued, they did not attempt to find ways to help him control himself. Specifically:

- On **December 14, 2011**, R13 made "inappropriate remarks" to female staff, which made them uncomfortable. To address this problem, his care plan directed staff to counsel him about how his remarks make them feel. If that did not change his behavior, they were to *notify his physician* and *request a psychiatric evaluation*. The plan also called for an older or a male nurse aide to assist with his care. CMS Ex. 16 at 10.

- On **January 28, 2012**, R13 was wheeling himself around the facility and became "verbally aggressive" with residents and staff, threatening physical violence. When a nurse intervened, he rose from his wheelchair, stood about a foot in front of her with his hands out, and threatened to knock her down. She told him to calm down. He sat back down, stared at her for a while, and left. CMS Ex. 16 at 17; *see* CMS Ex. 16 at 13.

  Staff prepared an incident report, which indicates that they notified R13's physician of the incident. But they did not ask for a psychiatric evaluation and they did not revisit his care plan. Although the facility administrator signed the report, his signature is not dated so I cannot tell when he learned of the incident. No one reported the incident to the appropriate state officials. They did not investigate. The resident victims of R13's aggression are not identified, and no evidence suggests that staff made any effort to assess the impact R13's threats had on them.

- On **March 15, 2012**, a facility visitor approached the nurses to report that two male residents were in the lobby "fixin' to fight." The nurse observed R13 in his wheelchair with his fists clenched, threatening another male resident. The nurses removed the second resident from the area and attempted to calm R13. But he continued to threaten them until one of the nurses called the police. While awaiting their arrival, a nurse monitored R13's whereabouts, according to the nurse's note. R13 eventually calmed down and spoke to the three policemen who responded to the facility's call. After they left, he told the nurses that "it would take more than [three policemen]" to stop him. The nurse again spoke to him about his behavior, and he denied that he would hit any of the residents. CMS Ex. 16 at 15; P. Ex. 8 at 1-3 (Scott Decl. ¶¶ 4, 8, 9, 12, 13, 16, 17).

  Licensed Practical Nurse (LPN) Barbara Scott was the charge nurse on duty during this incident. In a written declaration, she claims that the threatened resident suffers from dementia and was not even aware that R13 was upset with him. Even if true – and I see no evidence that anyone assessed the victim – the victim's ability to comprehend does not make the conduct any less abusive, as reflected in the facility's written policies. CMS Ex. 20 at 1.

  LPN Scott also claims that she was not afraid of R13 because he made no advances and that she called the police solely because "when [R13] saw a police officer, he would instantly calm down." P. Ex. 8 at 2 (Scott Decl. ¶¶ 10, 11). I do not find this credible. Bringing three policemen (who are neither psychiatrists nor any other type of healthcare professional) into a long-term care facility is an extreme measure, not an appropriate response to an inconsequential and non-frightening incident. Obviously, R13's care plan did not instruct staff to call the police in order to control his behavior. Indeed, if I believed that R13's interdisciplinary team considered this an appropriate intervention (which I do not), I would consider that a very serious problem.

  Facility staff did not notify R13's physician, request a psychiatric evaluation, modify R13's care plan, report, or investigate the incident. That the facility administrator was not aware of an incident requiring police intervention also suggests a significant breakdown in reporting and violates facility policies and the Medicare regulations. CMS Ex. 20 at 1, 8; 42 C.F.R. § 483.13(c)(2).

- During the evening of **March 29**, one of the female nurse aides was giving R13 his shower when he repeatedly slapped his genitals against her. She attempted to redirect him, without success. She tried to leave the shower room, but he blocked her exit. Eventually, she was able to slip around him and get away. She reported

the incident to the LPN on duty, who spoke to R13 about his "inappropriate behaviors" that made the nurse aide "feel very uncomfortable [and] upset." He told the nurse that he wouldn't do it again. CMS Ex. 16 at 16; P. Ex. 8 at 3 (Scott Decl. ¶¶ 18, 25).

The victim of R13's aggression submitted no testimony. Instead, Petitioner supplies a written declaration from LPN Scott, who did not witness the incident but wrote the above-described nurse's note. CMS Ex. 16 at 16. In contrast to that March 29 note, she now attempts to minimize, if not justify, R13's behavior. In her written declaration, she concedes that R13 "tried to touch a certified nurse aide inappropriately and his genitals were hitting her buttocks when she tried to redirect him." P. Ex. 8 at 3 (Scott Decl. ¶ 18). But then she suggests that the genital contact might not have been intentional, that the nurse aide did not express concern, and was able to remove herself from the shower. P. Ex. 8 at 3-4 (Scott Decl. ¶¶ 23, 24, 29). Contrast this with LPN Scott's contemporaneous note, in which she wrote that R13 "repeatedly tried to touch [the nurse aide] inappropriately"; that he "slapped his penis against her buttocks after she had attempted to re-direct him several [times]"; and that "he was blocking her from exiting the shower room" until "finally she was able to move enough around him to get out"; and he made the nurse aide "feel very uncomfortable and upset." CMS Ex. 16 at 16. I find LPN Scott's contemporaneous note more reliable than her after-the-fact and potentially self-serving declaration. *See Woodland Oaks Healthcare Facility*, DAB No. 2355, at 7-9 (2010) (finding that the ALJ properly assigned greater weight to contemporaneous nursing notes than to after-the-fact descriptions), and *citing United States v. McCoy*, 242 F.3d 399, 408 n.15 (D.C. Cir. 2001) (rejecting the proposition that a court cannot resolve credibility dispute without directly observing the witnesses' demeanor).

This was a very disturbing incident. Yet, facility staff did not notify R13's physician, request a psychiatric evaluation, modify R13's care plan, report, or investigate.

- On **April 5, 2012**, one of the women residents reported that R13 was making her sick with his vulgar remarks. In order to avoid him, she said, she would no longer go outside but would retreat to her room if he tried to talk to her. The LPN spoke to R13, asking that he not discuss with other residents "private, intimate matters" because it made them uncomfortable. CMS Ex. 16 at 16. Months later, the victim of R13's remarks complained to one of the state surveyors about R13's vulgarities. Visibly upset and crying, she told the surveyor that the incident had greatly upset her and that she tried to stay away from R13. CMS Ex. 19 at 3; CMS Ex. 23 at 5, 6 (Cox Decl.).

- On **April 8,** R13 was apparently at it again. A visibly upset woman resident complained that R13 "was saying very sexually vulgar things" to her and "had to be stopped." The nurse then spoke to R13 about the accusations, and he denied them. The nurse then suggested that he stay away from the complainant's side of the facility so that she could not make accusations. He said that it was a good idea and went to his room. CMS Ex. 16 at 19.

  A care plan entry dated **April 10, 2012**, indicates that R13 had been frequenting the hall in the wing that housed women. One of those women complained that she felt uncomfortable with him there. The entry also notes that, while being showered, he hit a nurse aide's leg with his genitals. According to the entry, staff told R13 that he should not go down the women residents' hall or be inappropriate with female staff. CMS Ex. 16 at 10.

With respect to the April 5 and 8 episodes, Petitioner maintains that they involved the same resident/victim and suggests, simultaneously, that: 1) this woman is too easily upset by the most trivial matters; and 2) although she did not like his vulgar language, she was not really upset at all and continued to talk and smoke with R13. P. Response at 6; P. Ex. 9 at 1-2 (McCracken Decl. ¶¶ 5, 6, 8, 10, 11, 14). By any objective standard, R13's remarks were abusive; the facility's contemporaneous documents establish that the victim was upset by his remarks; and months later (as the surveyors discovered and Petitioner concedes) the incident was still upsetting to her.

Again, facility staff did not notify R13's physician, request a psychiatric evaluation, modify R13's care plan, report, or investigate.

- On **May 16, 2012**, R13 was threatening to kick another resident. He told the LPN that the other resident had been kicking the door, "so I told him I was gonna kick him!" The LPN told him that he could not threaten another resident for any reason, but he continued to maintain that he would kick or hit the other resident if he wanted to. He hit the sofa several times with his fist, insisting that he could knock out anybody he wanted to knock out. The LPN advised him to report to staff any disturbing incidents, "but he continued to speak aggressively." He was apparently so aggressive that the LPN called the police. R13 told her he was "not scared of no cop even if they got a gun." Staff separated the residents while they waited for the police. After the police arrived, R13 denied making any threats and seemed to calm down, although he told the officers that he could knock someone out. CMS Ex. 16 at 19-20; P. Ex. 8 at 4-5 (Scott Decl. ¶¶ 36, 37, 38, 43).

  The nurse prepared an incident report, which indicates that staff attempted to contact R13's physician, leaving a message. I saw no evidence that they successfully consulted him, however. The report is incomplete in that it does not mention the police. In describing steps taken, it says only "removed [resident]

from situation, redirected." CMS Ex. 16 at 12. The report is signed by the DON and the facility administrator, but their signatures are not dated so I can't tell when they were notified of the incident.

A care plan entry, dated May 16, 2012, confirms that R13 threatened another resident with bodily harm and was removed from the situation. Staff told him that he should report to staff members when he becomes agitated, rather than threatening other residents. According to the care plan entry, the resident agreed. CMS Ex. 16 at 10.

Again, even though she doesn't claim that anyone assessed him, LPN Scott now maintains that, because the victim of R13's threats is demented, he did not even know that R13 was upset with him. P. Ex. 8 at 5 (Scott Decl. ¶¶ 39, 40). She admits that she called the police but maintains that she did so only because it would calm R13 down. P. Ex. 8 at 5 (Scott Decl. ¶¶ 45, 46). As discussed above, calling in the police is not an appropriate intervention for addressing a resident's chronic behavior problems. Neither facility policy nor R13's care plan suggested that staff should do so as a means of controlling the resident's outbursts.

- A nursing note reports that, on **July 23, 2012**, the LPN overheard "loud, angry conversation" in one of the halls. She observed R13 yelling because another resident, a confused woman, had entered his room and picked up his possessions. The LPN told the "very irate" R13 to put up a barrier or shut his door to prevent the confused resident from entering his room again. R13 calmed down. According to the nurse's note, the doctor was notified. CMS Ex. 16 at 21; *see* CMS Ex. 16 at 14; P. Ex. 8 at 5-6 (Scott Decl. ¶¶ 48, 52). No evidence suggests that staff sought a psychiatric consult, or that they reported or investigated the incident. The facility administrator did not sign the incident report, which suggests that he did not review it and may not have been notified.

  A July 23 care plan entry describes the incident but suggests no additional interventions. CMS Ex. 16 at 11.

  According to LPN Scott, she wrote the notes describing this incident. P. Ex. Ex. 8 at 5 (Scott Decl. ¶ 48). Again, she maintains that the victim of R13's outburst is demented and did not know that R13 was upset with her, although she points to no evidence that anyone assessed the victim. Even if true, that does not relieve the facility of its obligation to protect the demented resident from abuse and to assist R13 in effectively controlling his own behavior. P. Ex. 8 at 5-6 (Scott Decl. ¶¶ 49, 50).

- At one a.m. on **July 24, 2012**, R13 entered the facility lobby, yelling, "If in the morning I am missing anything, I am gonna use these (fist) to fix the problems." He then began hitting his left hand with his right fist "over and over." He threatened an individual by name. The nurse told him to go back to his room and go to bed. But two hours later, he was sitting in the doorway of his room, hitting his left hand with his right "over [and] over." CMS Ex. 16 at 23. Spending two late-night/early-morning hours in a doorway, making the same threatening gesture, is not healthy behavior. Yet, facility staff did not report it to R13's physician, request a psychiatric consult, or even mention it in the resident's care plan.

- The surveyors were in the facility on **August 20, 2012**. During dinner, they and facility staff observed an outburst in the dining room. R13 was yelling and threatening a confused resident who sat at a table across from his. The victim of his attack had apparently not approached R13, but had been talking to himself. A nurse tried, unsuccessfully, to calm R13. R13 stood, doubled up his fists, and told her that he could handle her as well. Staff called the facility administrator, who came to the dining room. R13 again stood, doubled up his fists, and threatened the administrator. R13 eventually calmed down and ate his meal. CMS Ex. 16 at 25; CMS Ex. 23 at 5, 6.

  No incident report was prepared. CMS Ex. 8 at 13. R13's physician was not notified.

  The facility continues to argue that no harm was done because the object of R13's rant was demented and did not understand that R13 was upset with him. P. Ex. 4 at 2 (Flocks Decl. ¶ 9). I see no evidence of an assessment; moreover, the facility was obligated to protect its demented residents from the abusive conduct of others.

Thus, overwhelming evidence establishes that, shortly after his admission, R13 began to engage in threatening and potentially dangerous behaviors – he sexually assaulted a nurse aide and held her in the shower room against her will; he threatened and menaced residents and staff; he made sexually explicit and disturbing remarks to at least one woman resident. Yet, staff ignored his care plan and the facility's policies for addressing his behaviors. In Petitioner's view, because R13 eventually calmed down – even if that required police intervention – they were not obliged to investigate, report, or try different strategies that might prevent recurrence of the abusive conduct.

Petitioner also suggests that R13 could not control his own behavior, so his actions were not "willful" and cannot be considered abuse. This argument fails for several reasons. First, R13 was unquestionably a troubled man engaging in behaviors that were dangerous to himself as well as others. But he had no psychiatric diagnosis, and Petitioner cites no

evidence to establish that he was unable to control himself or could not have learned to control himself. Indeed, the facility's interventions – limited as they might have been – were premised on the presumption that he *could* control his behaviors.

Second, without regard to the state of R13's impulse control, so long as his actions are "deliberate" rather than accidental or inadvertent, they are considered "willful" within the meaning of the regulation. *Merrimack County Nursing Home*, DAB No. 2424, at 5 (2011); *Cf. Singing River Rehab & Nursing Ctr*, DAB No. 2232, at 13 (2009) (suggesting that, so long as a mentally ill resident did not act "by accident," his conduct was abusive).

Third, the regulations and facility policies require the facility to report and investigate thoroughly *all alleged* violations. Even if I agreed that these incidents were not abuse (which I do not), they were significant enough to trigger the facility's obligation to investigate and report. 42 C.F.R. § 48313(c); CMS Ex. 20 at 1, 2, 4, 6.

Petitioner submits a statement from R13's physician, claiming, generally, that he was "well aware" of R13's behavior and did not "observe any change in behavior that would have required chemical restraints. . . ." P. Ex. 6 at 1 (Chacko Decl. ¶ 3, 4). This statement does not establish that the facility complied with regulations governing abuse. First, I reject any suggestion that the facility's only option was to chemically restrain R13. R13 might have benefitted from medication (which would not necessarily have constituted a restraint) or he might have benefitted from one of a multitude of other interventions. But the facility made no effort to find out.

Moreover, the physician does not describe the specific behavior of which he was "well aware." Based on the records, staff seldom reported the incidents to him. CMS Ex. 16 at 21. They rarely prepared incident reports. The evidence, or lack of it, suggests that the physician was not aware of the extent of R13's behavioral problems, and, if he were aware but declined to address the problem, he was not doing his job.

In any event, the facility was still required to keep its residents free from abuse. 42 C.F.R. § 483.13(b). Section 483.13(c)(1)(i) puts the onus on it to protect its residents by developing and implementing policies that prevent 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 keep its residents free from abuse and did not implement its own policies for preventing abuse, it was not in substantial compliance with sections 483.13(b) and 483.13(c).

2. CMS's determination that the facility's substantial noncompliance with 42 C.F.R. §§ 483.13(b) and (c) 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. 1931, at 27-28 (2004), *citing Koester Pavilion*, DAB No. 1750 (2000); *Daughters of Miriam Ctr.*, DAB No. 2067, at 7, 9 (2007).

Petitioner argues that R13 "never caused or was likely to cause serious injury, harm, impairment, or death to any resident." P. Response at 1-2. He did not strike another resident and, according to Petitioner, he "never verbally abused another resident." P. Response at 2. This latter claim is plainly incorrect. By the facility's own definition, gestures, as well as oral statements, can constitute verbal abuse, and verbal abuse includes threats of harm or "saying things to frighten" another resident. Intimidation, harassment, and threats of punishment constitute mental abuse. CMS Ex. 20 at 1.

As noted in the discussion above, R13 repeatedly threatened other residents (and staff) with physical violence; he yelled at them; he raised his fists to them; he stood out of his chair and menaced them. CMS Ex. 16 at 17 (January 28, 2012); CMS Ex. 16 at 15 (March 15, 2012); CMS Ex. 16 at 19-20 (May 16, 2012); CMS Ex. 16 at 21 (July 23, 2012); CMS Ex. 16 at 23 (July 24, 2012); CMS Ex. 16 at 25 (August 20, 2012). He sexually assaulted a nurse aide. CMS Ex. 16 at 16 (March 29, 2012). He repeatedly sexually harassed women staff and at least one resident. CMS Ex. 16 at 10 (December 14, 2011); CMS Ex. 16 at 16 (April 5, 2012); CMS Ex. 16 at 19 (April 8, 2012). On at least two occasions, his behavior was so threatening that staff called the police. CMS Ex. 16 at 15, 19-20.

Most of the residents who had been the objects of R13's outbursts and threats were confused and could not be interviewed, but the surveyors asked other residents about R13's behavior. The resident who complained about his sexually explicit remarks was plainly and seriously affected and so were others. They said that they were aware of R13's behaviors, and they avoided him. CMS Ex. 23 at 5 (Cox Decl.). The facility is their home; they should not have to retreat to their rooms or avoid going where they want to go in order to avoid abusive outbursts.

Based on all of this, I find that the facility's noncompliance caused serious harm and "was likely to cause" even more serious harm. CMS's determination that the facility's noncompliance posed immediate jeopardy to resident health and safety is therefore not clearly erroneous.

3. The one-day $10,000 penalty is reasonable.

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); *Community 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, CMS imposed a penalty of $10,000 per day for one day of immediate jeopardy, which is at the top of the range for a per day CMP ($3,050-$10,000) but is extremely modest considering what CMS might have imposed. 42 C.F.R. §§ 488.408(e)(1)(iii); 488.438(a)(1)(i). After all, the evidence suggests that, from as early as December 14, 2011, facility staff were aware of R13's behavior issues but failed to follow their own policies (and federal regulations) for preventing abuse. *See Plum City Care Ctr.*, DAB No. 2272, at 18-19 (2009) (observing that even a $10,000 per-instance CMP can be "a modest penalty when compared to what CMS might have imposed."); CMS Ex. 25 at 8 (McElroy Decl. ¶ 9) (pointing out that, had CMS imposed the minimum penalty of $3,050 per day for all the days that the facility failed to implement its anti-abuse policies, the penalty would have been $637,450 by August 24, 2012).

The facility has an abysmal compliance history. Its deficiencies have repeatedly posed immediate jeopardy to resident health and safety. Specifically:

- During the survey immediately prior to this one, completed October 12, 2011, it was not in substantial compliance with 42 C.F.R. § 483.35(i) (Tag F371 – dietary services: sanitary conditions) at scope and severity level K. The facility did not

subsequently maintain substantial compliance with this requirement because it was again not in substantial compliance with section 483.35(i) during this survey, albeit at a lower level of scope and severity (level E);

- For the survey completed August 11, 2010, the facility was not in substantial compliance with 42 C.F.R. § 483.10(b)(11) (Tag F157 – notification of changes) at scope and severity level K;

- For a survey completed February 23, 2010, the facility was not in substantial compliance with 42 C.F.R. § 483.25 (Tag F309 – quality of care) at scope and severity level K. The facility repeated this deficiency during this survey, although at scope and severity level E;

- On January 24, 2009, the facility was also not in substantial compliance with 42 C.F.R. § 483.25 (Tag F309) at scope and severity level K;

- On January 21, 2009, the facility was not in substantial compliance with 42 C.F.R. § 483.25 (Tag F309) at scope and severity level G (isolated instance of noncompliance that caused actual harm that was not immediate jeopardy);

- For the survey completed May 15, 2007, the facility was not in substantial compliance with 42 C.F.R. § 483.25 (h) (Tag F323 – quality of care: accident prevention) at scope and severity level K. Again, the facility was not in substantial compliance with this requirement during this survey, with the deficiency cited at scope and severity level E.

CMS Ex. 25 at 8-9 (McElroy Decl. ¶ 9). Thus, the facility's history, by itself, justifies a very significant penalty.

Petitioner does not claim that its financial condition affects its ability to pay this relatively modest CMP, and CMS points out that the total penalty here represents just 1.02% of the facility's annual gross Medicaid revenues.

With respect to the remaining factors, not only was the facility not in substantial compliance with sections 483.13(b) and (c), it was not in substantial compliance with 15 additional program requirements, several of which were repeat deficiencies. CMS Ex. 7 at 2. Once it determined that the immediate jeopardy was removed, CMS imposed a very low per day penalty, just $300, but the sheer number of violations, including repeat violations, could have justified a significant greater amount.

Moreover, the immediate jeopardy-level violations evidence wide-spread disregard for the R13's well-being as well as that of the other facility residents, particularly those least able to defend themselves, the demented. From the facility administration on down, staff

members repeatedly disregarded facility policies; they declined to investigate and report incidents of abuse; they did not try to find and implement workable interventions to help R13; they did not adequately protect residents from R13's outbursts. The facility is culpable for these failings.

For these reasons, I find that the CMP is reasonable.

Conclusion

The parties agree that, from August 24 through September 26, 2012, the facility was not in substantial compliance with Medicare participation requirements. I find that, on August 23, 2012, it was not in substantial compliance with 42 C.F.R. §§ 483.13(b) and (c) and that those deficiencies posed immediate jeopardy to resident health and safety. The penalties imposed – $10,000 per day for one day of immediate jeopardy and $300 per day for 34 days of substantial noncompliance that was not immediate jeopardy – are reasonable.

/s/
Carolyn Cozad Hughes
Administrative Law Judge