Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Lake Cook Terrace Nursing Center,
(CCN: 14-5809),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-11-125

Decision No. CR2530

Date: April 20, 2012

DECISION

Petitioner, Lake Cook Terrace Nursing Center (Petitioner or facility), is a long-term care facility located in Northbrook, Illinois, that participates in the Medicare program. Based on a survey completed September 23, 2010, the Centers for Medicare & Medicaid Services (CMS) determined that the facility was not in substantial compliance with multiple Medicare program requirements and that one of its deficiencies posed immediate jeopardy to resident health and safety. CMS imposed civil money penalties (CMPs) of $3,050 per day for one day of immediate jeopardy, and $200 per day for 38 days of substantial noncompliance that was not immediate jeopardy, for a total penalty of $10,650.

Here, Petitioner challenges just two of 23 deficiencies cited. Petitioner also challenges the immediate jeopardy finding.

For the reasons set forth below, I find that the facility was not in substantial compliance with the challenged program requirements; its deficiencies posed immediate jeopardy to resident health and safety; and 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 September 23, 2010, CMS determined that the facility was not in substantial compliance with multiple program requirements, specifically:

- 42 C.F.R. §§ 483.10(e) and 483.75(l)(4) (Tag F164 – resident rights: personal privacy/confidentiality of records) 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. § 483.12(a)(4)-(6) (Tag F203 – notice requirements prior to transfer/discharge) at scope and severity level D (isolated instance of noncompliance that causes no actual harm with the potential for more than minimal harm);

- 42 C.F.R. §§ 483.13(b) (Tag F223 – resident behavior and facility practices/freedom from abuse) at scope and severity level J (isolated instance of immediate jeopardy);

- 42 C.F.R. §§ 483.13(c)(1)-(c)(4) (Tag F225 – resident behavior and facility practices/staff treatment of residents) 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. § 483.13(c) (Tag F226 – resident behavior and facility practices/ policies to prohibit neglect and abuse) at scope and severity level F;

- 42 C.F.R. § 483.15(a) (Tag F241 – quality of life – dignity) at scope and severity level E;

- 42 C.F.R. § 483.15(b) (Tag F242 – quality of life – self-determination and participation) at scope and severity level G (isolated instance of noncompliance that causes actual harm but is not immediate jeopardy);

- 42 C.F.R. § 483.15(e)(1) (Tag F246 – quality of life – accommodation of needs) at scope and severity level E;

- 42 C.F.R. § 483.20(k)(3)(i) (Tag F281 – resident assessment/comprehensive care plans – services provided) at scope and severity level D;

- 42 C.F.R. §§ 483.20(e) and 483.20(m) (Tag F285 – resident assessment/coordination and preadmission screening for mentally ill and mentally retarded) at scope and severity level D;

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

- 42 C.F.R. § 483.25(i) (Tag F325 – nutrition) at scope and severity level D;

- 42 C.F.R. § 483.25(k) (Tag F328 – treatment/care of special needs) at scope and severity level D;

- 42 C.F.R. § 483.35(c) (Tag F363 – dietary services/menus and nutritional adequacy) at scope and severity level F;

- 42 C.F.R. § 483.35(d)(1)-(2) (Tag 364 – dietary services/food) at scope and severity level E;

- 42 C.F.R. § 483.35(d)(3) (Tag F365 – dietary services/food/individual needs) at scope and severity level D;

- 42 C.F.R. § 483.35(f) (Tag F368 – dietary services/frequency of meals) 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;

- 42 C.F.R. § 483.60(b), (d), and (e) (Tag F431 – pharmacy services) at scope and severity level E;

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

- 42 C.F.R. § 483.70(f) (Tag F463 – physical environment/resident rooms) at scope and severity level D;

- 42 C.F.R. § 483.70(h) (Tag F465 – physical environment) at scope and severity level E; and

- 42 C.F.R. § 483.75(m)(1) (Tag F517 – emergency planning) at scope and severity level F.

CMS Exhibit (CMS Ex.) 1. CMS subsequently determined that the facility returned to substantial compliance on October 18, 2010. Petitioner's Exhibit (P. Ex.) 2.

CMS has imposed against the facility CMPs of $3,050 per day for one day of immediate jeopardy (September 9, 2010) and $200 per day for 38 days of substantial noncompliance that was not immediate jeopardy (September 10 – October 17, 2010), for a total CMP of $10,650.

Petitioner timely requested a hearing to challenge the two deficiencies cited at scope and severity levels J and G: 42 C.F.R. §§ 483.13(b) and 483.15(b) (Tags F223 and F242, respectively). P. Post-hrg. Br. at 2. As discussed below, CMS's determinations with respect to the remaining deficiencies are therefore final and binding and provide a sufficient basis for imposing a penalty.

On September 1, 2011, I convened a video hearing from the offices of the Departmental Appeals Board in Washington, D.C. Counsel and witnesses convened in Chicago, Illinois. Mr. Craig Herkal appeared on behalf of CMS. Mr. Gary Weintraub appeared on behalf of Petitioner. I have admitted into evidence CMS Exs. 1-11 and P. Exs. 1-51. Order Following Prehearing Conference (July 22, 2011); Transcript (Tr.) 4, 7.

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, from September 9 through October 17, 2010, the facility 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 September 9 through October 17, 2010, was the facility in substantial compliance with 42 C.F.R. § 483.13(b) (Tag F223), which requires that residents be free from abuse, and 42 C.F.R. § 483.15(b) (Tag F242), which governs the residents' rights to self-determination and participation;

2. If, on September 9, 2010, the facility was not in substantial compliance with 42 C.F.R. § 483.13(b), did that deficiency pose immediate jeopardy to resident health and safety; and

3. Are the CMPs imposed – $3,050 for one day of immediate jeopardy and $200 per day for 38 days of substantial noncompliance that was not immediate jeopardy – reasonable?

Order Following Prehearing Conference (July 22, 2011); Tr. 6-7.

III. Discussion

A. 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. [1]

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 to challenge just two of the 23 deficiencies cited: 42 C.F.R. §§ 483.13(b) and 483.15(b). P. Pre-hrg. Br. at 2. CMS's determination that the facility was not in substantial compliance with the remaining cited participation requirements, listed above, is therefore final and binding.

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

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 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).

I discuss below why I find $200 per day not only reasonable, but modest.

B. The facility was not in substantial compliance with 42 C.F.R. § 483.13(b), because, without exploring alternatives, it required an exceptionally resistant resident to shower, even though showering caused him substantial mental anguish, and his resulting behaviors jeopardized his safety and the safety of facility staff.

Program requirements. The regulation governing resident behavior and facility practices mandates that each resident "has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion." 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 4 (2011); *Britthaven, Inc., d/b/a Britthaven of Smithfield*, DAB No. 2018 at 4 (2006).

Resident 8 (R8). The challenged deficiencies here revolve around R8. R8 was an 82-year-old man suffering from serious mental illness (variously diagnosed as unspecified psychosis, schizophrenia, bipolar disorder or schizoaffective disorder), seizure disorder, glaucoma with deteriorating vision, hypertension, coronary artery disease, and osteoarthritis. CMS Ex. 6 at 1, 17; CMS Ex. 9 at 2 (Shepard Decl. ¶ 9); P. Exs. 18, 30, 44, 46, 47. He had significant behavior problems. He used a wheelchair. CMS Ex. 6 at 14 (reporting a fall when attempting to rise from his wheelchair); P. Ex. 50 at 1 (Martinez Decl. ¶ 5); Tr. 27.

Virtually everyone agrees that R8 intensely disliked showers. He regularly refused them, and, when compelled to take one, was prone to attacking staff and/or accusing them of rape and other forms of abuse. CMS Ex. 6 at 16, 19; *see* P. Ex. 43; Tr. 68-69. He had a history of elopement attempts to avoid being showered. CMS Ex. 6 at 17; *see also* CMS Ex. 6 at 16; CMS Ex. 6 at 19 (reporting that R8 had a "long history" of resistance to care, "especially during shower time"); CMS Ex. 9 at 2 (Shepard Decl. ¶ 6) (confirming R8's "continual resistance" to showering); P. Exs. 40, 43.

The resident himself told the surveyors that "over his protests and at times active resistance to care, two or three staff members would forcibly remove his clothes and shower him." Tr. 46. He said that this happened every time he showers, which is three times a week. *See also* CMS Ex. 4 at 25; Tr. 38, 91 (confirming that R8 told Surveyor Mildred Ayala that the facility forced him to take showers and he gives up). R8's roommate told Surveyor Ayala that he recalled hearing R8 screaming while being taken to the shower, although the roommate could not specify when that occurred. Tr. 96-97.

In her written direct testimony, Petitioner's witness, Nurse Aide Gloria Gonzalez, understated R8's resistance to showering, saying "sometimes" he is "compliant with showering. Sometimes he is not. Often, when he is not, he will say he wants to do it later in the day, and we will try again later." P. Ex. 51 at 1 (Gonzalez Decl. ¶ 4). Under cross-examination, however, she conceded that, for years, R8 had resisted showering and became angry and upset at shower time. Tr. 68-69. She testified that she had never seen him angry except when he was compelled to shower. Tr. 85.[2]

In any event, to the extent that Nurse Aide Gonzalez implied that R8's resistance to showering was not a serious problem, the facility's own documents belie that implication. They show that R8's resistance to showering – and the facility's response – were serious, long-standing problems that jeopardized the resident's health and safety, as well as the safety of facility staff:

- A social services note dated October 17, 2005, for example, describes R8's response to staff telling him that he was scheduled for a shower: "[H]e told me that if I touch him, he was going to slit my throat [with] a razor. . . ." When told that he had to be supervised while showering, he responded, "[I]f anyone comes near me, I am going to kill them. . . ." P. Ex. 3.

- According to a nurse's note, written at 8:00 a.m. on June 23, 2006, after he behaved aggressively during breakfast, staff wheeled R8 to the nurses' station to wait for his scheduled shower. The nurse describes him as "resentful," then aggressive and angry. He threatened to call the police and he kicked the garbage. When the nurse gave him a dose of PRN (as needed) Ativan, he spit it out; she then injected him with the medication. Two nurse aides restrained him and took him, kicking and fighting, into his room. P. Ex. 19.

[2] In this regard, Nurse Aide Gonzalez must have been the exception among facility employees. The record amply demonstrates that R8 reacted angrily to a variety of situations, although, it seems, not as consistently or intensely as he did to showering. *See*, *e.g.*, P. Post-hrg. Br. at 5-10.

- According to an entry in a complaint log, dated September 22, 2008, R8 complained that he had been "raped" in the shower that morning and described a brutal (and highly unlikely) physical altercation with staff. Investigators concluded that he was having a delusion. CMS Ex. 6 at 9-10. It seems that once they verified that R8 had mis-identified the nurse aide who showered him that day, they stopped the investigation and took no further action. *See* Tr. 37. This is a common theme with respect to the facility's investigations of R8's complaints. The resident was unquestionably unreliable and prone to hyperbolic accusations. Once investigators determined that one or more of his accusations could not be true, they stopped investigating. I find it insufficient for the facility to dismiss his complaints this way. When a resident is involved in a physical or verbal altercation with staff, the facility must report the incident to the appropriate agencies and must conduct a thorough investigation, which includes assessing the resident for injuries, interviewing appropriate staff and other witnesses, and documenting the findings. It should also look for ways to prevent a recurrence.

- A note written by Nina Luker, PRSC (Psychosocial Rehabilitative Service Coordinator) dated September 6, 2009, says that the resident refuses to take showers, and that staff found the behavior difficult to alter because of the resident's physical and verbal aggression. P. Ex. 40.

- Three nurse aides told Social Services Director Nelly Diaz that, on New Years Day 2010, R8 physically and verbally abused them when they tried to shower him. CMS Ex. 6 at 11. R8 explained to Director Diaz that "every time they take my clothes off [without] me consenting to it, I feel raped." CMS Ex. 6 at 15. *See also* P. Ex. 43 (identifying R8's refusal to shower and his "frequently" falsely accusing staff of rape, beatings, and torture).

- According to a subsequent psychiatric admissions note, dated January 5, 2010, the facility sent R8 to the emergency room, where he told the staff that

> 3 CNAs (Certified Nurse Aides) raped me last Friday. I went to the social worker this morning to tell her that I wanted to file a police report and the social worker told me that I needed to tell her first. I got mad and hit some cabinets. I hit a CNA last Friday in self-defense as she was trying to rape me. I did not hit anybody today.

P. Ex. 44. According to the nursing home staff (the report goes on) the resident

> became highly agitated yesterday morning and hit a CNA in the face when she reminded him about taking a shower. He

> then went to the administrator's office where he knocked over cabinets and attempted to hit the administrator.

P. Ex. 44.

June 24, 2010 incident. During the initial tour of the facility on September 7, 2010, R8 said to Surveyor Licheal Shepard, "[P]lease help me. I am tired of being raped in this facility every time I get showered." Tr. 28. When questioned, he explained that when his clothes were forcibly removed, "he felt like it was rape." He also said that, in June, when women nurse aides "had forcibly removed his clothing and showered him," he tried to elope in order to report the forcible showering to the police, because staff would not listen to him. CMS Ex. 9 at 2 (Shepard Decl. ¶ 5); CMS Ex. 5 at 14.

R8 showed the surveyors old bruises on his arms and legs, as well as an injury to his ear (recent tear). He told Surveyor Shepard that the ear injury happened when he resisted staff's efforts to shower him. Tr. 53-54. Facility staff produced no records showing that they had investigated these injuries, which, aside from R8's claims, are unexplained. Tr. 54.

R8's statements obviously got the surveyors' attention, and they decided to investigate the June incident specifically, as well as the facility's general practice with respect to R8 and showers.

Given the extent and seriousness of R8's resistance to showering, the facility produced surprisingly little documentation to show that it monitored the problem. Nurse Aide Gonzalez testified that the facility keeps shower records, and that she was supposed to write whether the resident refused his shower, although she was vague about whether they kept such records in 2010. Tr. 83-84. When Surveyor Shepard asked the facility for R8's shower records for the preceding year, "I barely got two out of the facility for the last three years." Tr. 46. And, notwithstanding her repeated requests, the facility could not or would not produce complete documentation of the shower incidents. "Many shower records are missing . . . ." Tr. 45.

The available records include social service notes, a complaint log entry, and an abuse report:

- According to the complaint log, on June 24, 2010, R8 complained to the social services office that he had been raped in the shower room. When asked to explain, he said that "every time they take my clothes off [without] my consenting to it, I feel rape[d]." CMS Ex. 6 at 15.

- A social service progress note dated June 24, 2010, written at 2:30 p.m., says that R8 became upset "when he was approach[ed] by his aide for [a] shower." He

attempted to elope in response, explaining later that he did so because he was upset. CMS Ex. 6 at 12-13. In a "specialized services" note, dated June 24, 2010, PRSC Luker reiterates that R8 resists "some care," such as showers, refuses to wear a wanderguard, and "[t]hese behaviors are not easily altered and are connected to his elopement attempt today." CMS Ex. 6 at 16.

- The June 24, 2010 elopement report says that "in the past, he has attempted to elope because he does not want a shower," but it calls for no changes in the resident's care plan or any facility practice. CMS Ex. 6 at 17.

- The abuse report form for the June 24, 2010 incident says that R8 accused a male CNA of sexual abuse. CMS Ex. 6 at 18. According to the report, R8 "has a long history of being resistive to care, especially during shower time," and that he "may make false accusations toward staff." CMS Ex. 6 at 19. Although he accused a male CNA of abusing him, investigators found that the CNAs assisting him in the shower were all female – Rosalba Sanchez, Gloria Gonzalez, and Dora Hernandez. An entry indicates that Dora Hernandez was terminated (although the record is silent as to the reasons for her termination). CMS Ex. 6 at 19. Staff reported the incident to the resident's family, but not to the state agency or attending physician. CMS Ex. 6 at 20.[3]

At the time of the survey, Nurse Aide Gonzalez told the surveyors that R8 "was mad because he doesn't shower. I went to get [Nurse Aide] Rosalbo to help remove the clothes. He started fighting[;] do not give me shower[;] called bad words[;] he kept hitting at us . . . ." CMS Ex. 5 at 8.

In her written declaration, Nurse Aide Gonzalez altered her statements in subtle but significant ways. She claimed that

> Rosalba and I were assigned to assist R8 with his shower on June 24, 2010.[4] He had not taken a shower in several days. He had twice refused in the prior several days and had not showered on those days. We escorted him to the shower

[3] Petitioner claims that R8 suffered no physical harm from this confrontation, but, given the inadequacy of the facility's investigation and its failure to report the incident to the appropriate authorities – which were cited as deficiencies and which Petitioner did not contest – the question of any physical injuries must remain unresolved, a fact that can hardly inure to the facility's benefit.

[4] Curiously, Nurse Aide Gonzalez does not mention that another nurse aide, the recently-terminated Dora Hernandez, participated in the showering incident, even though facility records confirm that the third nurse aide was there. CMS Ex. 6 at 19.

> room and were able to assist him in taking off his shoes and socks. When we were helping him take his shirt off over his head, he became agitated and was waving his arms. After his shirt was removed, however, he took his shower. We did not rip his clothes off or otherwise mistreat him, nor have I ever done so. I certainly had no intention to cause him any physical or mental harm.

P. Ex. 51 at 1-2 (Gonzalez Decl. ¶ 5).

At the hearing, Nurse Aide Gonzalez testified that, prior to the June 24 incident, she had been instructed to leave a resident alone if he did not want to take a shower. She also admitted that R8 did not want to shower that day. When asked whether she left him alone, as instructed, she evaded a direct answer: "Well, it had been a number of days since he had had a shower. And I didn't force him. He got upset. But I didn't force him." Tr. 72-73.

She also claimed under cross-examination that the resident removed his own clothes, although in her written declaration, she said that "we were helping him take his shirt off over his head" when he "became agitated and was waving his arms." Tr. 76. When counsel pointed out the apparent inconsistency, she said: "When he was taking off his shirt and I assisted him, but I didn't do it for him." Tr. 76-77. Then she said, "Maybe he got upset when I tried to help him. But he was taking off his clothes himself. I didn't do it for him." Tr. 77.

She ultimately admitted that R8 became angry, was fighting the aides, and calling them bad names. Yet, they continued to shower him. Nurse Aide Gonzalez justified the nurse aides' actions: "Well, yes. He was already in the bathroom, and he had already taken off his clothes. And he did get upset, but he didn't tell us not to bathe him. . . . He was angry, but he didn't tell us no." Tr. 79. And later she said: "If he hadn't wanted to, he would have gotten up. But there's a seat there in the shower. And he was seated." Tr. 87.[5]

I did not find Nurse Aide Gonzalez credible. Her testimony was internally inconsistent and contradicted the facility's contemporaneous notes, her prior statements to the surveyors, and common sense. I do not find it credible that R8 went willingly to the

[5] Because R8 is an unreliable informant, we will never know for sure what was going through his mind at the time (although he later suggested that he "just gave up."). Thankfully, he did not register his displeasure by getting up and attempting to leave the bathroom. He was unstable on his feet, used a wheelchair to get around, and could not safely have extricated himself from the situation, especially if faced with three nurse aides determined to complete his shower.

shower, voluntarily removed his own clothes, suddenly became angry and abusive, but willingly continued his shower. I find it far more likely that, consistent with the social service notes and Nurse Aide Gonzalez's remarks to the surveyors, R8 became upset when the aide approached him for a shower, that he resisted, that Nurse Aide Gonzalez enlisted additional help, and that, against his will, the aides compelled him to take his shower. CMS Ex. 5 at 8; CMS Ex. 6 at 12-13.

Facility responses. The facility did not seem to have in place a coherent policy for addressing R8's behaviors. According to Nurse Aide Gonzalez, staff were supposed to leave the resident alone and report to the nurse when the resident resisted showering. Tr. 69-70. She claimed that those instructions were in writing, but the record contains no such written instruction. Tr. 70.[6]

The outline from a June 10, 2010 in-service training session on dealing with an agitated resident (which Nurse Aide Gonzalez apparently did not attend) tells staff, among other instructions, to keep the environment calm, follow the care plan, and work as a team. It says, "When possible, don't pressure or become forceful with an easily agitated resident" and don't "[f]orce the resident to do anything." CMS Ex. 8 at 54, 55; Tr. 81. It does not say to leave the resident alone or report to the nurse. Tr. 80-82; CMS Ex. 8.

R8's care plan, dated January 4, 2010, identifies as a problem R8's refusal to shower. It sets as a goal that he "will comply with care delivery, specifically with regard to showers at least 2 days per week." An April 4, 2010 entry, however, indicates that the goal was not met, but says "extend to 7/1/10." That goal was also apparently not met, because the next entry says "the resident will shower [one time weekly] by 9/28/10." P. Ex. 43. To achieve these goals, the plan calls generally for more evaluations and psychotherapy "to be provided by [a] psychologist." It tells staff to "create a warm, safe, and inviting environment for care," and to "emphasize soothing, kind, slow and compassionate

[6] Nurse Aide Gonzalez's testimony raised questions about her ability to understand and follow instructions that are conveyed in English. She testified in Spanish with the assistance of an interpreter. When asked whether she agreed with specific written instructions, found at CMS Ex. 8 at 55, she testified that she could not understand them because they were written in English. Tr. 82. But she also claimed that she learned facility policies by means of written and verbal instructions and the written resident care plans, all of which were in English. Tr. 70.

speech." Finally, if the resident displays aggression, "staff will maintain calm and *will ask for further assistance from other staff as needed*." P. Ex. 43.[7] (emphasis added).

But keeping the environment calm while compelling R8 to take a shower was plainly unworkable, if not altogether impossible. Remarkably, no evidence suggests that the facility addressed this problem in any meaningful way. I see no evidence that facility staff asked him why he resisted showers or considered, as part of his care plan, how they could meet his hygiene needs in a way that was less stressful to him and to staff.[8] Surveyors specifically asked Nurse Aide Gonzalez why staff did not offer him an alternative, like a tub bath or "wash up," but she said that she did not know. CMS Ex. 5 at 8.

I see absolutely no evidence that Nurse Aide Gonzalez or any other staff member intended to hurt R8. But, as the Departmental Appeals Board (Board) has ruled, to find abuse under section 483.13(b), I need not find that staff intended to inflict injury or harm. So long as staff acted deliberately, and their actions caused injury or harm, the regulation is violated. *Merrimack County Nursing Home*, DAB No. 2424 at 5 (2011). Moreover, as Surveyor Ayala explained, the staff here lacked the expertise needed to keep R8 from harm. Tr. 102-03. They did not know what to do. By failing to recognize and address the problem in an effective way, the facility put R8 and facility staff in harm's way.

Health care professionals charged with caring for the mentally ill must protect them from the anguish that can be part of their disease process. Tr. 101. For R8, the prospect of showering plainly filled him with an irrational level of dread, which he could not control. Facility staff were required to shield him from this pain, and they did not. Instead of finding an alternative to the treatment he found so objectionable, they deliberately repeated the same practice. So, even though the individual staff members did not set out to harm R8, they did.

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[7] As far back as November 2008, the facility set as a goal that R8 would take one to two showers per week without physical aggression. Proposed interventions were similar (and comparably ineffective) to those in the January 2010 plan: observe the resident's comfort levels and adjust interactions accordingly; explore the resident's reluctance; provide time-out with 1-1 counseling; give insight "as to possible outcome from" not complying with care interventions; consult MD or psychiatrist as needed; provide physical support and care; "explore preferences and intolerances." The plan also says that social services will work with the resident. P. Ex. 32.

[8] When Surveyor Shepard asked R8 why he didn't like showers, he told her that it was because he had glaucoma, and feared the impact of the shower water on his vision. CMS Ex. 9 at 2 (Shepard Decl. ¶ 9); Tr. 50. His reasoning may have been irrational, but the fear was likely very real to him.

The facility thus did not keep R8 free from physical and mental abuse and was not in substantial compliance with 42 C.F.R. § 483.13(b).[9]

C. CMS's determination that, on September 9, 2010, the deficiency cited under 42 C.F.R. § 483.13(b) posed immediate jeopardy to resident health and safety was not clearly erroneous.

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." *Florence Park Care Ctr.*, 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).

Without question, R8's sometimes extreme reaction to the prospect of a shower – and the absence of any clear instructions as to how staff should respond – endangered his physical safety and the safety of the staff charged with caring for him. Also without question, the facility's practice of requiring him to shower despite his vociferous objections, caused him significant mental anguish. CMS's immediate jeopardy determination is therefore not clearly erroneous.

D. The penalties imposed are 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.

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[9] Because I find that the multiple uncontested deficiencies here more than justify a $200 per day CMP, I need not consider whether the facility was in substantial compliance with 42 C.F.R. § 483.15(b). *Senior Rehab. and Skilled Nursing Ctr.*, DAB No. 2300 at 6, n.5 (2010), *aff'd, Senior Rehab. and Skilled Nursing Ctr. v. HHS*, No. 10-60241 (2011). On the other hand, section 483.15(b) guarantees each resident the right to "[c]hoose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care" and to "[m]ake choices about aspects of his or her life in the facility" that are significant to the resident. Plainly, the facility offered R8 no choice with respect to showering, which puts it out of substantial compliance with section 483.15(b).

§ 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); *Community Nursing Home*, DAB No. 1807 at 22 *et seq.* (2002); *Emerald Oaks*, DAB No. 1800 at 9-10 (2001); *CarePlex of Silver Spring*, DAB No. 1683 at 8 (1999).

CMS imposed a penalty of $3,050 for one day of immediate jeopardy, which is the minimum per day penalty for deficiencies constituting immediate jeopardy. 42 C.F.R. §§ 488.408(e)(iii); 488.438(a)(1)(i). The amount is therefore reasonable as a matter of law.

With respect to the period of substantial noncompliance that was not immediate jeopardy, CMS imposes a penalty – $200 per day – that is at the very low end of the applicable penalty range ($50 to $3,000). 42 C.F.R. §§ 488.408(d)(1)(iii); 488.438(a)(1)(ii). Considering the relevant factors, the penalty is modest. The facility has a less than exemplary history. It was not in substantial compliance at the time of any prior survey back to 2006, and three of the deficiencies cited during this survey had been cited before. CMS Ex. 2 at 1. Petitioner does not claim that its financial condition affects its ability to pay the CMP. Moreover, the sheer number of deficiencies, as well as their scope and severity, justifies increasing significantly the penalty imposed.

IV. Conclusion

From September 9 through October 17, 2010, the facility was not in substantial compliance with Medicare participation requirements. On September 9, 2010, its noncompliance with 42 C.F.R. § 483.13(b) posed immediate jeopardy to resident health and safety. I affirm as reasonable the penalties imposed – $3,050 for one day of immediate jeopardy and $200 per day for 38 days of substantial noncompliance that was not immediate jeopardy.

/s/
Carolyn Cozad Hughes
Administrative Law Judge