Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

St. Anne's Convalescent Center,
(CCN: 235415),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-11-283

Decision No. CR2537

Date: May 4, 2012

DECISION

Petitioner, St. Anne's Convalescent Center (Petitioner or facility), is a long-term care facility located in Detroit, Michigan, that participates in the Medicare program. After one of its residents was seriously injured by an improperly-applied hand mitt, the Centers for Medicare and Medicaid Services (CMS) determined that the facility was not in substantial compliance with Medicare program requirements governing restraints (42 C.F.R. § 483.13(a)) and staff treatment of residents (42 C.F.R. § 483.13(c)) and that its deficiencies posed immediate jeopardy to resident health and safety. CMS imposed civil money penalties (CMPs) of $6,000 per day for 38 days of immediate jeopardy (August 31-October 7, 2010) and $250 per day for four days of substantial noncompliance that was not immediate jeopardy (October 8-11, 2010).

Petitioner concedes that it was not in substantial compliance for the duration alleged, and that, on August 31, 2010, its deficiencies posed immediate jeopardy to resident health and safety. It does not challenge the $250 per day CMP. Petitioner challenges: 1) CMS's determination as to the duration of the immediate jeopardy; and 2) the amount of the penalty imposed for the period of immediate jeopardy.

For the reasons set forth below, I find that, from September 1-October 7, 2010, the facility's deficiencies posed immediate jeopardy to resident health and safety and that the $6,000 per day CMP, imposed for the period of immediate jeopardy, is 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. The state agency must also investigate all complaints. Act § 1819(g)(4).

In this case, responding to the facility's report of a resident injury, the Michigan Department of Licensing and Regulatory Affairs (State Agency) sent a surveyor to investigate. The surveyor, James Kriz, R.N., completed an extended survey on October 11, 2010. CMS Exs. 1, 7, 8, 12, 29 at 1-2 (Kriz Decl.¶ 8). Based on his findings, CMS determined that the facility was not in substantial compliance with Medicare requirements governing resident behavior and facility practices, specifically, 42 C.F.R. §§ 483.13(a) (Tag F221-restraints) and 483.13(c) (Tag F225-staff treatment of residents), and that, from August 31, 2010 through October 7, 2010, its deficiencies under section 483.13(a) posed immediate jeopardy to resident health and safety. CMS Exs. 7, 8. CMS subsequently determined that the facility returned to substantial compliance on October 12, 2010. CMS Ex. 7.

Based on these deficiencies, CMS imposed CMPs of $6,000 per day for 38 days of immediate jeopardy (August 31-October 7, 2010) and $250 per day for four days of substantial noncompliance that was not immediate jeopardy (October 8-11, 2010). CMS Ex. 7.

In this appeal, Petitioner challenges CMS's determinations as to the duration of the immediate jeopardy period (beyond one day) and the amount of the penalty imposed for that time. P. Cl. Br. at 1-2.

The parties agree that this case should be decided on the written record, without an in-person hearing. Order Following Prehearing Conference (September 7, 2011); P. Cl. Br. at 1.

The parties filed opening briefs (CMS Br.; P. Br.), and closing briefs (CMS Cl. Br.; P. Cl. Br.). I have admitted into evidence CMS Exhibits (Exs.) 1-30 and P. Exs. 1-5. Order Following Prehearing Conference (September 7, 2011).

II. Issues

The issues before me are:

1. From September 1-October 7, 2010, did the facility's deficiencies pose immediate jeopardy to resident health and safety?

and

2. Was the penalty imposed for the period of immediate jeopardy – $6,000 per day – reasonable?

III. Discussion

A. CMS's determination as to the duration of the period of immediate jeopardy is consistent with statutory and regulatory requirements.[1]

Program requirements. The Act explicitly limits a facility's use of restraints. They may only be imposed to insure the resident's physical safety and upon the written order of a physician that "specifies the duration and circumstances under which the restraints are to be used." Act § 1819(c)(1)(A)(ii). The regulation governing resident behavior and facility practices echoes the statutory requirements and mandates that each resident "has the right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms." 42 C.F.R. § 483.13(a).

The facility's restraint policy says that "NO restraint should be the cause of injury or the potential cause of one." CMS Ex. 13 at 19 (emphasis in original). With respect to hand mitts, the policy notes that they are used when a resident has a history of injuring himself or pulling on his PEG (feeding) tube. The policy instructs staff to tie the mitts securely at the wrist, "but with space – 2 fingers – to allow for some movement and prevent abrasion." CMS Ex. 13 at 19.

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

Resident 101 (R101). The deficiency here centers around R101. R101 was a 75-year-old man who had suffered a stroke and was diagnosed with dementia and psychosis. CMS Ex. 9 at 5. His cognitive skills were severely impaired, and he was unable to answer questions. CMS Ex. 9 at 17; CMS Ex. 13 at 3. Among his many medications, he took Coumadin to prevent blood clots. CMS Ex. 9 at 38. He required tube feeding, and had an increased risk of skin breakdown. CMS Ex. 9 at 6, 20, 23.

R101 also apparently had a problem with scratching himself. In response, on March 23, 2010, his physician ordered bilateral hand mittens to decrease the scratching. The order directed staff to remove the mitts every two hours to assess his skin and provide range of motion exercises, then to reapply as needed. CMS Ex. 9 at 7; CMS Ex. 13 at 3.

At approximately 9:00 a.m. on August 31, 2010, Nurse Aide Ernestine Thornton found that one of R101's hand mitts was fastened at the wrist with a latex glove. His hand was swollen and his wrist was black where the latex had rubbed. CMS Ex. 3 at 5; *See* CMS Ex. 12 at 2; CMS Ex. 13 at 3, 7.

Facility staff did not immediately and accurately document all the ensuing events, so the record is a bit muddled as to their sequence. It appears that Nurse Aide Thornton took R101 to the floor nurse, Licensed Practical Nurse (LPN) Kara Lynch, who assessed the injury. CMS Ex, 13 at 3. LPN Lynch described the resident's right hand as "very swollen," with a dark bruise around the right wrist and opined that his right hand mitt had been applied too tightly. CMS Ex. 13 at 3, 5, 13.

They reported the injury to the nurse supervisor, LPN Peggye Jackson, who then reported to Director of Nursing (DON) Caroline Simmons and gave her the hand mitt and latex glove. CMS Ex. 3 at 5; CMS Ex. 13 at 3, 7, 11, 12.

The resident's physician was notified, and, according to LPN Lynch, staff attempted to contact the resident's guardian, but they were unable to reach him or to leave a message, and they apparently did not repeat the effort. CMS Ex. 13 at 13.

The resident was examined by his physician, facility Medical Director Sudhir Walavalkar, M.D., who described swelling of the right hand and wrist, and "dark multiple areas" around his wrist "secondary to the pressure of the restraint." CMS Ex. 9 at 15. X-rays revealed no fracture.

Someone told LPN Lynch to complete an incident report, which she did that day (August 31, 2010). Her report describes the injury and concludes that the right mitt was too tight, but it does not mention the latex glove. CMS Ex. 13 at 3, 13. The same day, DON Simmons completed a report of her "investigation." That report says that, based on her interviews with (unidentified) nursing staff, she concluded that "bilateral hand mittens

were applied too snug[ly], causing swelling and discoloration of the right wrist." To correct, the "hand mittens have been discontinued" and "staff will be inserviced for proper application of restraints [and] skin assessments/checks." CMS Ex. 13 at 6. The report says nothing about the latex glove, and, apparently, the facility made no effort to identify the staff member responsible for attaching it. Nor did they report the incident to the state agency, as required. 42 C.F.R. § 483.13(c)(2). I see no evidence that the DON (or anyone else) even considered whether staff had periodically checked and removed the restraint as ordered.

R101's physician discontinued the mittens on September 1, 2010. CMS Ex. 9 at 13.

By September 2, 2010, blisters had appeared on R101's wrist. CMS Ex. 13 at 3, 10. On September 8, the facility's wound care team described the injury to R101's right wrist: "1.3 circumferential pink base [and] minimal serosanguineous [composed of serum and blood] drainage." CMS Ex. 9 at 33, 53.

The matter might have ended there, except R101's family member (who had not been advised of the injury) visited the resident on September 12 and became upset when he saw the condition of the resident's wrist. CMS Ex. 13 at 3. As a result of his complaints, on September 13, the facility's administrator "became aware of a problem" with R101. [2] He launched the kind of investigation that should have been undertaken when the incident occurred, and he learned about the latex glove on September 15. CMS Ex. 13 at 3, 4.

Employee assignment sheets were reviewed. They indicated that Nurse Aide Katrina Glenn cared for R101 on the afternoon/evening shift (3:00 p.m. to 11:30 p.m.) of August 30. In a signed statement, she said that the resident wore hand mitts during her shift, but she did not mention a latex glove. Nurse Aide Cassandra Hunter cared for R101 on the midnight shift of August 30-31. In her written statement, she did not mention applying hand mitts to R101 or using a latex glove, and she told DON Simmons and Administrator Beauvais that the resident wore no hand mitts during her shift. CMS Ex. 13 at 4, 8, 9.

All staff questioned denied applying the latex glove. CMS Ex. 13 at 4.

With respect to DON Simmons' failure to report the incident, Administrator Beauvais reported that the DON "was extremely busy at her desk and apparently did not understand in full what nurse supervisor [LPN Jackson] told her" when she reported the

[2] Administrator Beauvais's signature, dated September 1, is on the August 31 incident report, but that report said only that the resident had a swollen hand and bruise. It did not mention how the injury occurred or indicate the extent of the injuries, so Administrator Beauvais may not have recognized the seriousness of the problem when he signed that report. CMS Ex. 13 at 5.

incident on August 31. CMS Ex. 13 at 3. DON Simmons later claimed that she did not remember being told about the latex glove. CMS Ex. 13 at 3.

On September 16, LPN Lynch finally wrote a nurse's note describing the incident. The note says that Nurse Aide Thornton brought R101 to her with a "very swollen" right hand, and gave her the hand mitt. She called LPN Jackson to the floor to see R101's hand. The resident's physician was notified, and staff attempted to contact his guardian, but were unable to reach him or leave a message. She does not mention the latex glove, but says that that resident was slipping [his] hand out of gloves at times" and scratching himself." CMS Ex. 13 at 13.[3]

Facility investigators speculated that someone applied the latex glove to prevent R101 from removing the hand mitt, which he was apparently prone to do, but, as Administrator Beauvais declared, this "is obviously an incorrect use of the latex glove." CMS Ex. 13 at 4.

A wound team examined R101's wrist on September 15, 2010. They described a circumferential wound with a necrotic base of 0.5 cm, and serous drainage. CMS Ex. 9 at 34, 54.

Facility efforts to correct. In his summary dated September 21, 2010, Administrator Beauvais says that all residents in the facility with orders for restraints or assistive devices were checked and "all were applied correctly." He does not say when this occurred. He also says that, when questioned, all staff claimed that restraints/devices were checked every two hours in an appropriate manner. CMS Ex. 13 at 3. But the facility produced no records or other evidence to establish that it even had a procedure in place to insure that restraints were checked and the skin assessed as required, and no one contends that R101's improperly-applied hand mitt had been removed every two hours for skin assessment and range-of-motion exercises. Had staff done so, someone might have noticed the irregularity before the resident's injuries became so severe.

On September 14, 2010, the therapy department began in-service training on the proper application of restraints. CMS Ex. 13 at 3, 16-24.[4]

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[3] According to Surveyor Kriz, the Velcro strap used to secure R101's mitt was no longer functional, which violates nursing standards of practice. CMS Ex. 29 at 2 (Kriz Decl. ¶ 8). I see no evidence that the facility considered or investigated the possibility that the facility did not have a sufficient number of mitts that were in good repair.

[4] The parties agree that the training occurred on September 14, and one of the staff sign-in sheets is dated September 14. CMS Cl. Br. at 12; P. Cl. Br. at 4; CMS Ex. 13 at 23. The training documents themselves, however, say that the training took place on September 15. CMS Ex. 13 at 16.

On September 15, the facility finally reported the incident to the state agency. CMS Ex. 12 at 1.

On September 16, the facility suspended Nurse Aide Hunter. It counseled LPN Lynch, and promised "episodic education" for her. CMS Ex. 13 at 2, 4, 14. According to a report of the counseling session, DON Simmons admonished LPN Lynch for not documenting the incident in the resident's record, not notifying the family of the incident, and not making adequate rounds at the beginning of her shift (which could have meant earlier discovery of the injuries). As follow-up, the report says that the DON will monitor incident reports and documentation to assure that "all steps are carried out," and the DON will observe for walking rounds. CMS Ex. 13 at 15.

On September 22, verbal disciplinary warnings were issued to DON Simmons and Nurse Supervisor Jackson for failing to follow-through with an investigation regarding the latex glove incident. CMS Exs. 14, 15.

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 Departmental Appeals Board (Board) has observed repeatedly that the "clearly erroneous" standard imposes on facilities a "heavy burden" to show no immediate jeopardy and has sustained determinations of immediate jeopardy where CMS presented evidence "from which '[o]ne could reasonably conclude' that immediate jeopardy exists." *Barbourville Nursing Home*, DAB No. 1962 at 11 (2005); *Florence Park Care Center* DAB No. 1931 at 27-28 (2004), *citing Koester Pavilion*, DAB No. 1750 (2000); *Daughters of Miriam Center*, DAB No. 2067 at 7, 9 (2007).

The Board has also repeatedly held that, once immediate jeopardy is found, the facility bears the burden of demonstrating that corrective actions have abated the danger. *Oceanside Nursing and Rehabilitation Center*, DAB No. 2382 at 18 (2011); *Brian Center Health & Rehabilitation/Goldsboro*, DAB No. 2336 at 8 (2010); *Pinehurst Healthcare & Rehabilitation Center*, DAB No. 2246 (2009). CMS's determination that a facility's ongoing noncompliance remains at the level of immediate jeopardy during a given period "is subject to the clearly erroneous standard of review under [42 C.F.R. §] 498.60(c)(2)." *Life Care of Elizabethton*, DAB No. 2367 at 16 (2011), *quoting Brian Center*, DAB No. 2336 at 7-8 (2010).

Without question, the misuse of the latex glove and improper application of the hand mitt caused R101 serious injury. More than two weeks after its discovery, R101's wound had not healed. Further, as Surveyor Kirz points out, R101 was at heightened risk of injury

because he took the anticoagulant, Coumadin. Pressure from a too-tight mitt can cause capillaries to break (and, in fact, the resident's wrist was bruised), and his body's ability to stop the bleeding would be compromised by the medication. CMS Ex. 29 at 2-3 (Kriz Decl. ¶ 11).

To its credit, Petitioner does not pretend that the incident was anything other than very serious. It acknowledges that, as of August 31, 2010, the deficiency posed immediate jeopardy to resident health and safety. Petitioner claims, however, that staff took immediate steps to correct and that the deficiency no longer posed immediate jeopardy after that day, because staff removed the mitt and began treating the injuries. In the alternative, it argues that it removed the immediate jeopardy on September 14, 2010, when the facility began training its staff on the appropriate application of restraints and set up a system for checking restraints once per shift.

R101's plight exemplifies the serious injury/harm that can occur if facility staff misuse restraints. But, while what happened to R101 evidences substantial noncompliance at the level of immediate jeopardy, the incident itself does not constitute the underlying deficiency. *See Oceanside*, DAB No. 2382 at 18 (quoting *Regency Gardens Nursing Center*, DAB No. 1858 at 21 (2002), and holding that the facility's failure to meet a participation requirement "is what constitutes the deficiency, not any particular event that was used as evidence of the deficiency"). The facility here was deficient at the level of immediate jeopardy because:

- Staff did not understand the safe and proper use of restraints;
- Staff did not follow facility policy regarding the application of hand mitts;
- Staff did not follow physician orders regarding releasing a resident from restraint, assessing the skin, and providing range of motion exercises;
- The facility had no procedures in place to insure that staff safely applied and periodically checked and removed resident restraints;
- When a resident was injured, facility management botched the required investigation, failed to report timely the resident's injury to the state agency and the resident's guardian, and created misleading reports of the incident;[5] and

[5] By not investigating properly, a facility loses the opportunity to analyze and correct its problems. *Century Care of Crystal Coast*, DAB No. 2076 at 21 (2007), *aff'd* No. 07-1491, 2008 WL 2385505 (4th Cir. 2008).

- While recognizing the staff's need for training, the facility nevertheless delayed two weeks before it began to train them on the proper application and use of restraints.

Thus, that the facility attended to R101's immediate needs on August 31 did not remove the immediate jeopardy, because the conditions leading to that injury continued unabated.

Check-off sheets purport to show that, effective September 1, restraints, along with more than 50 other nurse aide performance standards, were checked once every shift. P. Ex. 5. But these documents do not establish that the deficiencies no longer posed immediate jeopardy. The facility does not explain how they were implemented; at best, the documents address only one of the multiple problems listed above; and, ultimately, we have no evidence that they were effective. I note that checking a restraint just once every eight hours is insufficient to protect resident health and safety. An improperly-applied restraint can cause enormous harm if left in place for up to eight hours.

Similarly, the first training session did not remove the immediate jeopardy. Until the facility can demonstrate that the training was effective, i.e., that staff capably put that training in place and that it resolved the problem, the facility has not met its significant burden of demonstrating that it has alleviated the level of threat to resident health and safety. *Oceanside*, DAB No. 2382 at 19; *Premier Living and Rehab. Center.*, DAB CR1602 (2007), *aff'd* DAB No. 2146 (2008).

Petitioner provided the state agency with its immediate jeopardy abatement plan on October 8, 2010. CMS Ex. 18; CMS Ex. 29 at 3 (Kirz Decl. ¶ 14). In addition to the staff's immediate response – removing the hand mitt and sending R101 to the doctor – the plan calls for additional in-service training, which was first provided in mid-September and, apparently again on October 9, 2010. CMS Exs. 18, 23, 29 at 3 (Kriz Decl. ¶ 14).

On October 8, 2010, the facility also implemented compliance logs, which showed that staff were specifically monitoring the residents who wore hand mitts to insure that the mitts were properly applied and checked. CMS Ex. 21; CMS Ex. 29 at 3 (Kirz Decl. ¶ 16); P. Cl. Br. at 4. At this point, CMS determined that the immediate jeopardy had been removed. Surveyor Kriz opined that "it was crucial that [the facility] specifically monitor its residents who wore hand mitts because this allowed the facility to ensure that the training it provided to staff regarding the use and application of restraints was being implemented. Without this type of information, [the facility] would not know whether its in-service training was effective." CMS Ex. 29 at 3 (Kirz Decl. ¶ 17). Petitioner protests that these documents show little more than did the check-off sheets it started using on September 1 (P. Ex. 5), and I suppose there is some merit to that argument. The monitoring logs still do not show that staff removed the restraints, and assessed skin as necessary. Nevertheless, unlike the check-off sheets, the compliance logs focus

specifically on restraints, and CMS presumably understood how they were implemented (which I do not) and was satisfied that their use, together with the training and other corrections, removed the immediate jeopardy. It is not my role to second-guess CMS's judgment in this regard.

Thus, the facility has not met its burdens of establishing that it alleviated the immediate jeopardy any earlier than October 8.

B. The penalty imposed for the period of immediate jeopardy – $6,000 per day – is reasonable.

To determine whether a CMP is reasonable, I apply the factors listed in 42 C.F.R. § 488.438(f): 1) the facility's history of noncompliance; 2) the facility's financial condition; 3) factors specified in 42 C.F.R. § 488.404; and 4) the facility's degree of culpability, which includes neglect, indifference, or disregard for resident care, comfort or safety. The absence of culpability is not a mitigating factor. The factors in 42 C.F.R. § 488.404 include: 1) the scope and severity of the deficiency; 2) the relationship of the deficiency to other deficiencies resulting in noncompliance; and 3) the facility's prior history of noncompliance in general and specifically with reference to the cited deficiencies. I 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 Center*, 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).

CMS imposed a penalty of $6,000 per day, which is in the middle range for situations of immediate jeopardy ($3,050-$10,000). 42 C.F.R. §§ 488.408(e), 488.438(a)(1).

The facility has a significant history of substantial noncompliance, including immediate jeopardy. Since at least 2006, it has not been found in substantial compliance during any annual survey. In the annual survey immediately preceding this complaint investigation, (July 2010), facility deficiencies were widespread and posed immediate jeopardy to resident health and safety (scope and severity level L). In 2008, an isolated instance of noncompliance posed immediate jeopardy (scope and severity level J). And, in 2007, a pattern of noncompliance posed immediate jeopardy. CMS Ex. 24. Thus, facility history, by itself, justifies a significant increase in the amount of the penalty. Such consistent and serious noncompliance suggests that a substantial penalty – even an amount close to the maximum – would be justified to induce sustained corrective action.

With respect to financial condition, Petitioner argues that its financial condition renders it unable to pay the penalty and claims that "payment of $229,000 would impact the facility's continued operation." P. Cl. Br. at 10. I note first that the penalty imposed must be at least $3,050 per day for the period of immediate jeopardy, so Petitioner is

bound to pay a minimum of $116,900 without regard to its financial condition or any other factor ($115,900 + $1,000 for the additional four days of noncompliance). 42 C.F.R. § 488.438(a)(1). Thus, the actual amount in question is significantly less than $229,000.

The facility has the burden of proving, by a preponderance of the evidence, that paying the CMP would render it insolvent or would compromise the health and safety of its residents. *Van Duyn Home and Hospital*, DAB No. 2368 (2011); *Gilman Care Center*, DAB No. 2362 (2010). Here, Petitioner submits balance sheets dated December 31, 2010, and the declaration of Certified Public Accountant (CPA) Carol Wright, who says that, as of December 31, 2010, the facility had assets of $956,265, but "total [current] liabilities" of $4,112,309. P. Ex. 1 at 2 (Wright Decl. ¶ 5); P. Ex. 3. CMS, on the other hand, presents its own set of balance sheets. They show that, in December 2009, the facility had assets of $ 3,385,610 and "total current liabilities" of $2,998,964. CMS Ex. 28 at 12.

Comparing the balance sheets, I see that "accounts receivable" increased by about 15% – from $618,376 in December 2009 to $728,314 in December 2010 -- which suggests that the business was reasonably strong, even growing. *Compare* CMS Ex. 28 at 12 with P. Ex. 3 at 1. Its operating revenues declined only slightly (from $6,136,508 to $5,927,510 or by about 3%). Its operating expenses also declined slightly (from $6,241,224 to $6,094,582 or by about 2%). If anything, the facility should have been in comparable or slightly better financial shape at the end of 2010. *Compare* CMS Ex. 28 at 13 *with* P. Ex. 3 at 2.[6]

So what happened to turn this viable business around so precipitously? It appears that the facility's outstanding losses came from its making more than $2 million in loans to its affiliates and shareholders -- which it subsequently forgave -- not from operating the nursing home. P. Ex. 1 at 3 (Wright Decl. ¶ 5). Petitioner offers no details about those loans; it only maintains that they were extended and then forgiven because the borrowers are unable to repay them. Obviously, allowing a facility to avoid its financial obligations by the expedient of transferring assets to related entities presents the potential for much mischief. At a minimum, a facility must justify such actions, which Petitioner has not done here.

In any event, it seems that not making bad loans is more critical to the facility's ongoing viability than paying a comparatively low CMP. Petitioner has neither claimed nor

[6] Using what appears to be a different format for reporting assets and liabilities, which makes meaningful comparisons more difficult, a September 2010 balance sheet shows a moderate divergence between total assets ($1,356,870.88) and total liabilities ($1,870,729.15). CMS Ex. 28 at 3, 4.

established that paying the additional $112,100 above the minimum it must pay would render it unable to continue its operations and/or jeopardize resident health and safety.

With respect to the other factors, everyone agrees that the deficiency was serious. No one knows how long R101's hand was restrained before anyone bothered to check it,[7] but sufficient time elapsed to do considerable damage, which shows disregard for the resident's comfort and safety, for which the facility is culpable. Equally disturbing was the facility's response to the discovery of the latex glove and R101's injuries. No one even told the facility administrator the cause of the injuries; the facility did not report to the state agency nor to the family. No meaningful investigation ensued. Management recognized the need for training but, inexcusably, delayed it for two weeks. And the fault here was not limited to low-level staff, but involved all levels, up to and including the DON. The facility is culpable for these serious and systemic problems, which justify a very significant penalty.

IV. Conclusion

From September 1 through October 7, 2010, the facility's deficiencies posed immediate jeopardy to resident health and safety; and I affirm as reasonable the penalty imposed for that period ($6,000 per day).

/s/
Carolyn Cozad Hughes
Administrative Law Judge

[7] In the alternative, people saw it but did nothing, which is even worse.