Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Capitol House Nursing and Rehabilitation Center,
(CCN: 19-5476)

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-11-803

Decision No. CR2898

Date: August 23, 2013

DECISION

Petitioner Capitol House Nursing and Rehabilitation Center challenges the determination of the Centers for Medicare & Medicaid Services (CMS) that it was not in substantial compliance with program participation requirements based on a survey completed June 28, 2011. Specifically, Petitioner challenges the CMS findings of noncompliance of 42 C.F.R. §§ 483.25(h), 483.15(g)(1), and 483.75 and the associated remedies of denial of payment for new admissions (DPNA) and three per instance civil money penalties (PICMP) of $4,000, $4,000, and $2,000, respectively. Petitioner also challenges findings based on a survey completed on May 27, 2011. However, the survey completed on May 27, 2011, is not properly before me because CMS did not impose associated remedies. For the reasons discussed below, I sustain CMS's imposition of the PICMPs and DPNA.

I. Background

Petitioner is a long-term care facility located in Baton Rouge, Louisiana. Petitioner participates in the Medicare and Medicaid programs. The Louisiana Department of Health and Hospitals (state agency) completed a complaint survey of Petitioner's facility on May 27, 2011. The state agency determined that Petitioner was noncompliant with

participation standards. Then, on June 28, 2011, the state agency completed a follow-up survey of Petitioner's facility. The state agency determined that Petitioner was noncompliant with participation standards, including citations that represented immediate jeopardy (IJ).

In a July 29, 2011 letter, CMS notified Petitioner that that it proposed the following enforcement remedies: termination effective November 27, 2011 if substantial compliance was not reached before that date; a PICMP in the amount of $2,000 each for tags F-250, F-272, F-309, F-323, and F-490, levied in the June 28 survey; and a DPNA effective August 13, 2011. P. Prehearing (PH) Br. at 3; CMS (Exhibit) Ex. 1 at 3-6. The state agency found Petitioner had returned to substantial compliance on August 26, 2011, and on September 22, 2011 issued a notice revising the previous proposed remedies. CMS Ex. 1 at 1-2. CMS revised the penalties and rescinded the termination. The DPNA was already imposed and in effect from August 13, 2011, through August 25, 2011, but payments for new admissions would resume beginning August 26, 2011. CMS also revised the PICMPs to $4,000 for F-250, $4,000 for F-323, and $2,000 for F-490 and CMS rescinded the previously imposed PICMPs for F-272 and F-309. CMS Ex. 1 at 1-2.

Petitioner requested an administrative law judge (ALJ) hearing based on the May 27 survey on August 3, 2011. This case was docketed C-11-656. On September 21, 2011, Petitioner filed a second hearing request challenging the June 28 survey. This appeal was docketed as C-11-803 and Petitioner's appeal docketed as C-11-656 was consolidated into C-11-803, by order issued on September 22, 2011.

I conducted a hearing in New Orleans, Louisiana on April 11, 12, and 13, 2012, during which CMS witness Becky Knight (Surveyor Knight), a surveyor with the state agency, testified. A 637-page transcript (TR.) was prepared. I continued the hearing by deposition and declaration. CMS chose to rest its case in chief after completion of Surveyor Knight's testimony, but Petitioner submitted the testimony of four witnesses submitted as exhibits. In addition to the transcript of the hearing, the evidentiary record consists of CMS Exs. 1-8 and Petitioner's Exs. 1-10 (including P. Ex. 5A).

Both parties filed post-hearing briefs (CMS Br. and P. Br.) and post-hearing reply briefs (CMS Reply and P. Reply).

II. Issues

1. Whether Petitioner was in substantial compliance with participation requirements in the Medicare and Medicaid programs, and if not;

2. Whether the enforcement remedies imposed are reasonable.

III. Statutory and Regulatory Framework

The Social Security Act (Act) establishes the requirements that a long-term care facility must meet to participate in the Medicare and Medicaid programs, and authorizes the Secretary of Health and Human Services (Secretary) to promulgate regulations implementing those statutory requirements. Act §§ 1819, 1919.[1] Specific Medicare participation requirements for long-term care facilities are at 42 C.F.R. Part 483. A long-term care facility must remain in substantial compliance with program requirements to participate in Medicare. 42 C.F.R. § 483.1(b). "Substantial compliance" means "a level of compliance with the requirements of participation such that any identified deficiencies pose no greater risk to resident health or safety than the potential for minimal harm." 42 C.F.R. § 488.301. By contrast, "noncompliance" means "any deficiency that causes a facility not to be in substantial compliance." *Id.* A "deficiency" is a violation of a statutory or regulatory participation requirement. *Id.*

The Act authorizes the Secretary to impose enforcement remedies against a long-term care facility for failure to comply substantially with the federal participation requirements. *See* Act § 1819(h); 42 C.F.R. § 488.402. The Secretary may not continue Medicare payments to a long-term care facility for more than six months after the facility is first found not to be in substantial compliance. Act § 1819(h)(2)(C). If a facility does not return to substantial compliance within three months, the Secretary must deny payments for all individuals admitted to the facility after that date – commonly referred to as the mandatory or statutory denial of payments for new admissions (DPNA). *See* Act § 1819(h)(2)(D). The Act also grants the Secretary discretionary authority to impose other remedies, including termination, a discretionary DPNA, CMPs, appointment of temporary management, and other remedies such as a directed plan of correction. Act § 1819(h)(2)(B).

The Secretary has delegated to CMS and the states the authority to impose remedies against a long-term care facility not in substantial compliance with program participation requirements. State agencies survey facilities on behalf of CMS to determine whether the facilities comply with federal participation requirements. 42 C.F.R. §§ 488.10-.28, 488.300-.335. The regulations specify the enforcement remedies that CMS may impose if a facility is not in substantial compliance with Medicare requirements. *See* 42 C.F.R. § 488.406.

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[1] The Act, as amended, is available at http://www.ssa.gov/OP_Home/ssact/ssact.htm. On this website, each section of the Act contains a reference to the corresponding chapter and code in the United States Code.

CMS may impose a per-day CMP for the number of days a facility is not in substantial compliance or a PICMP for each instance of the facility's noncompliance. 42 C.F.R. § 488.430(a). A PICMP, which CMS imposed in this case, may range from $1,000 to $10,000, and the range is not affected by the scope and severity of the facility's noncompliance. 42 C.F.R. § 488.438(a)(2).

A long-term care facility may request a hearing before an administrative law judge (ALJ) to challenge a noncompliance finding and enforcement remedies. Act §§ 1128A(c)(2), 1866(h); 42 C.F.R. §§ 488.408(g), 498.3(b)(13). The hearing rights of a long-term care facility are established by federal regulations at 42 C.F.R. Part 498. 42 C.F.R. § 498.3(d). A finding of noncompliance that results in the imposition of a remedy specified in 42 C.F.R. § 488.406 is an initial determination for which a facility may request a hearing. 42 C.F.R. § 498.3(b)(13). Unless the finding of noncompliance results in the actual imposition of a specified remedy, the finding is not an "initial determination" and the facility is not entitled to review. 42 C.F.R. § 498.3(d)(10)(ii). *Golden Living Center-Grand Island Lakeview*, DAB No. 2364 (2011); *Fountain Lake Health & Rehab., Inc.*, DAB No. 1985 (2005); *Lakewood Plaza Nursing Center*, DAB No. 1767 (2001); *The Lutheran Home -Caledonia*, DAB No. 1753 (2000); *Schowalter Villa*, DAB No. 1688 (1999); *Arcadia Acres, Inc.*, DAB No. 1607 (1997).

If the facility has a right to a hearing, the hearing before the ALJ is *de novo*. *The Residence at Salem Woods*, DAB No. 2052 (2006); *Cal Turner Extended Care*, DAB No. 2030 (2006); *Beechwood Sanitarium*, DAB No. 1906 (2004); *Emerald Oaks*, DAB No. 1800 (2001); *Anesthesiologists Affiliated*, DAB CR65 (1990), *aff'd*, 941 F.2d 678 (8th Cir. 1991). The choice of remedies or factors CMS considered when choosing remedies is not subject to review. 42 C.F.R. § 488.408(g)(2). A facility may only challenge the scope and severity level of noncompliance if a successful challenge would affect the range of the CMP that may be imposed or impact the facility's authority to conduct a nurse aid training and competency evaluation program (NATCEP). 42 C.F.R. § 498.3(b)(14), (d)(10)(i).

The standard of proof, or quantum of evidence required, is a preponderance of the evidence. CMS has the burden of coming forward with the evidence and making a *prima facie* showing of a basis for imposition of an enforcement remedy. Petitioner bears the burden of persuasion to show by a preponderance of the evidence that it was in substantial compliance with participation requirements or any affirmative defense. *Batavia Nursing & Convalescent Center*, DAB No. 1904 (2004), *aff'd*, 129 F. App'x. 181 (6th Cir. 2005); *see Hillman Rehab. Center*, DAB No. 1611 (1997), *aff'd*, No. 98-3789, 1999 WL 34813783 (D.N.J. May 13, 1999).

IV. Discussion

A. Scope of review

Petitioner does not have a right to a hearing related to the deficiencies issued based on the survey completed May 27, 2011, or the citations based on F-272 or F-309 based on the survey completed June 28, 2011, because CMS did not impose associated remedies.

The parties disagree about scope of review, that is, the range and identity of survey findings to be debated in these proceedings. Petitioner claims that it has the right to challenge "each and every finding of noncompliance" from the May 27 and June 28 surveys, arguing that CMS imposed the DPNA based on the findings of noncompliance in both surveys. P. PH Br. at 8-9; P. Br. at 1; P. Ex. 1; P. Ex. 4. CMS argues that the only reviewable citations are the three deficiencies from the June 28 survey that had corresponding PICMPs, did not further discuss the remedies imposed, and addressed only the findings of noncompliance that had associated PICMPs in its briefings. CMS PH Br. at 4. CMS asserts that if I find that the facility was not in substantial compliance with program requirements, CMS has a basis to impose the DPNA remedy and I do not have authority to review the reasonableness of, or modify, that remedy. CMS PH Br. at 14; CMS Reply at 1-2. However, CMS does not address Petitioner's argument that the DPNA was based on all the findings of noncompliance in both the May 27 and June 28 surveys. Based on its presumption that the DPNA was based on both surveys, Petitioner argues that CMS failed to make a prima facie showing of noncompliance from the May 27 survey, or the deficiencies that did not have corresponding PICMPs from the June 28 survey. P. PH Br. at 10-11.

The imposition of an enforcement remedy and not the citation of a deficiency triggers the right to a hearing under 42 C.F.R. Part 498. I find that the PICMPs and DPNA were imposed on the findings of noncompliance with F-Tags F250, 323, and 490 of the June survey. Even if Petitioner's arguments were correct, it would not change the outcome of this case because there is sufficient basis to impose the DPNA on the basis of the deficiencies linked to the PICMPs. The parties agree that these IJ deficiencies linked to the PICMPs are at issue in this case. And as discussed later, these deficiencies provide a fully-adequate basis to impose the DPNA.

B. Findings of Fact and Conclusions of Law

I make numbered findings of fact and conclusions of law (Findings) to support my decision. I set them forth below as separate headings, in bold and italic type, and discuss each in detail.[2]

[2] I have reviewed the entire record, including all the exhibits and testimony. Because the Federal Rules of Evidence do not control the admission of evidence in proceedings of this

The deficiencies in this case arise primarily from Petitioner's care of Resident 70 (R70). R70 was a 63-year-old man who had a long history of being in and out of acute-care hospitals because of violent and aggressive behaviors associated with schizophrenia. P. Ex. 5 at 201-221. R70's diagnoses included schizophrenia; paranoia; chronic personality disorder; psychosocial problems related to long history of mental illness; chronic subdural hematoma; hyperlipidemia; cataracts; prostate cancer; and arthritis. P. Ex. 5 at 90, 201, 203, 217.

Although the parties characterize the events giving rise to the cited deficiencies differently, the following facts are not in dispute and the following is a timeline of events related to R70 - derived primarily from Petitioner's own timeline of events:

> *February 14, 2011*: Petitioner admitted R70 to its facility. P. Ex. 5 at 90, 201, 203.
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> *February 17*: Petitioner's staff noted concern that in the middle of the night R70 was staying in the bathroom for a long time, insisting that he was bathing. P. Ex. 5 at 76-77, 90, 264-265.
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> *February 18:* The Social Services Director (SSD) documented performing the initial social service history of R70. P. Ex. 5 at 385, 386; CMS Ex. 2 at 25.
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> *February 23:* The SSD documented a second interaction with R70 related to his admission. P. Ex. 5 at 385; CMS Ex. 2 at 25.
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> *March 23:* In the morning, R70 refused his monthly Haldol D injection. P. Ex. 5 at 91. Later that afternoon, R70 requested to meet with the SSD. Nursing explained it was after hours and noted R70 was agitated. P. Ex. 5 at 266-267.
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> *March 24:* In the morning, R70 eloped (left the facility without signing out) and was returned to the facility by local police. R70 had been causing a disturbance at a drugstore and bank. P. Ex. 5 at 91, 267. R70 was agitated, using profanity, and

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kind (*see* 42 C.F.R. § 498.61), I may admit evidence and determine later, upon a review of the record as a whole, what weight or relevance, if any, I should accord that evidence or testimony. To the extent that any contention, evidence, or testimony is not explicitly addressed or mentioned, it is not because I have not considered that material. Rather, it is because I find in the context of this record as a whole that the evidence is not relevant, or that the contentions are not supported by the weight of credible evidence or testimony.

stated that he was trying to contact the FBI because people were stealing from him and posting nude photos of him on the internet. P. Ex. 5 at 91, 267, 385. The SSD documented that she and the Director of Nursing (DON) attempted calm R70 down following the incident. P. Ex. 5 at 385.

March 26: R70 received his monthly Haldol D injection. P. Ex. 5 at 91, 268, 331.

April 13: R70 was observed as growing increasingly protective of his room, blocking hall and bath door to keep staff out. Nursing staff was required to call-out to R70 to assure his well-being. P. Ex. 5 at 91; CMS Ex. 2 at 18.

April 14: R70 wielded a butter knife at staff; told staff to remove his roommate's possessions from the room they shared. P. Ex. 5 at 92; CMS Ex. 2 at 18.

April 15: R70 ordered nurse to get out of his room, using profanity. P. Ex. 5 at 92.

April 18 & 25: Nursing staff noted R70 to be anxious. P. Ex. 5 at 92.

April 28: R70 was found standing over R58 with knife (or scissors) in hand stating, "say something, I'll stab you m-----f------, you killed my brother and I'm going to kill you." P. Ex. 5 at 92, 270; CMS Ex. 2 at 19.

April 29: R70 isolated himself in room, blocked both doors, and refused to allow staff into his room. P. Ex. 5 at 92; CMS Ex. 2 at 19.

May 1: R70 eloped (left without signing out) again and threatened a woman at a local store, stating "I'll stab you in your head," and called her vulgar names. P. Ex. 5 at 92, 271; CMS Ex. 2 at 19. Nursing staff noted that R70's behaviors were escalating. P. Ex. 5 at 271. Police came to the facility and interviewed R70. No charges were filed against R70 at that time. CMS Ex. 2 at 20.

May 3: **PEC**[3]**-** Dr. Holder certified that R70 was a danger to himself and others. Dr. Holder noted that R70's erratic behavior was increasing, and that R70 was currently violent and abusive towards staff and refusing medication. P. Ex. 5 at 272. Nursing staff noted that the SSD informed them of the PEC. CMS Ex. 2 at 20. A sheriff deputy escorted R70 out of the facility. P. Ex. 5 at 274.

May 20: Petitioner readmitted R70. CMS Ex. 2 at 20. P. Ex. 5 at 93, 274.

[3] A Physician Emergency Certificate (PEC) is an involuntary admission to an inpatient treatment facility for observation, diagnosis, and treatment. LA. REV. STAT. § 28:53.

May 22: R70 threatened two other residents and told one resident: "I'll break your neck." P. Ex. 5 at 93; CMS Ex. 2 at 20.

May 23: R70 was seen exiting another resident's room; when questioned, he stated "the television was too loud[;] I turned it down." CMS Ex. 2 at 20.

May 27: Nursing staff noted that R70 paced constantly and demonstrated episodes of anxiety/anger. CMS Ex. 2 at 20; P. Ex. 5 at 93. R70 threatened another resident by stating that he would stab him with a knife. Three nurses intervened and searched R70 for weapons. No weapons were found but R70 remained agitated and shut the door in the nurse's face. CMS Ex. 2 at 20; P. Ex. 5 at 93.

May 28: R70 was observed pacing in his room and ambulating in the hall slightly agitated at 2:00 AM. CMS Ex. 2 at 20-21; P. Ex. 5 at 93, 276.

June 2: R70 refused his evening Rispirdol. P. Ex. 5 at 93.

June 3: R70 was observed obstructing his door at night. When nursing staff were able to enter, they found a wood-handled object in R70's hand. A nurse released the wooden object and returned it to a hiding place. CMS Ex. 2 at 21; P. Ex. 5 at 93.

June 5: R70 refused to allow the housekeeper to clean his room, obstructing the housekeeper by cursing and using various obscenities. CMS Ex. 2 at 21; P. Ex. 5 at 93, 277.

June 6: R70 refused PM care, and was observed murmuring to himself. CMS Ex. 2 at 22; P. Ex. 5 at 93, 277.

June 7: 1:10 AM, R70 remained awake, and agitated, criticizing his roommate for his incontinence. CMS Ex. 2 at 22; P. Ex. 5 at 93, 277. At 6:10 AM, R70 chased CNAs with a razor and threatened to cut the neck of another resident while holding the razor in his hand. CMS Ex. 2 at 22-23; P. Ex. 5 at 93-94, 277-279. Police arrived and found R70 carrying a small garden rake and a razor. Police persuaded R70 to relinquish the weapons. A body search of R70 was conducted but no other weapons were found. CMS Ex. 2 at 23; P. Ex. 5 at 94, 278-279. **PEC** - NP Melancon certified that R70 was a danger to himself and others, and currently violent. P. Ex. 5 at 279. Petitioner discharged R70 to the acute hospital for emergency treatment in accordance with the PEC. P. Ex. 5 at 242.

June 16: Petitioner readmitted R70. P. Ex. 5 at 94, 280; CMS Ex. 2 at 24.

June 21: R70 was involved in an altercation with another resident in which R70 threatened to "cut" the other resident. The administrator and DON intervened. P. Ex. 5 at 95, 282. The DON, SSD, and QA Nurse contacted R70's sister, who stated that R70 could not live with her, that R70 had come at her with a knife last year. P. Ex. 5 at 282. The DON contacted Nursing Home Psychological Services (NHPS), the facility's contracted psychological services provider, to make immediate arrangements for an on-site psychological evaluation. P. Ex. 5 at 95, 214, 282. R70 was observed calling another resident, without provocation, a "b----" and a "dog" without provocation. The DON attempted to counsel R70 without success and described him as very agitated. P. Ex. 5 at 281;CMS Ex. 2 at 24.

June 22: NHPS conducted the assessment of R70. NHPS recommended (1) immediate assessment for inpatient psychological treatment if R70's aggressive behavior increased, (2) the facility follow emergency protocol for R70 as needed, and (3) counseling services by a NHPS supportive counselor. NHPS would conduct a full psychological evaluation upon its next visit to rule out bipolar disorder or any other psychological issues that might have been contributing to R70's agitation and to his verbally - and physically - aggressive behavior. P. Ex. 5 at 213.

June 23: **PEC -** Dr. Holder certified that R70 had homicidal ideations, was threatening staff and residents, that R70 was currently homicidal and dangerous to others. R70 had threatened to "cut" a resident, and weapons were in easy access to R70. Dr. Holder noted "repeated behavior with [R70] involving razor blade, knife, scissors," noted that the "medical restraint" (Haldol) had been used but was not adequate, observed that R70's "homicidal ideations continued to increase," and concluded that R70 "is a real threat to safety of staff/residents." P. Ex. 5 at 284. Petitioner discharged R70 to the acute hospital for emergency treatment in accordance with the PEC. *Id*.

June 28: Petitioner readmitted R70. P. Ex. 5 at 96, 285.

July 6: R70 cursed and threatened to cut another resident. R70 began rapidly approaching as if to attack the other resident. DON stepped in and told R70 to return to his room. P. Ex. 5 at 102.

July 7: **PEC -** R70 was discharged first to the acute-care hospital, and then found appropriate placement at a facility for the psychologically impaired. P. Ex. 5 at 97.

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1. ***Petitioner failed to comply substantially with the requirement to provide medically-related social services to R70 to attain or maintain his highest practicable mental and psychosocial well-being as required by 42 C.F.R. § 483.15(g)(1) (Tag F-250).***

Section 483.15(g)(1) requires that a long-term care facility participating in the Medicare and Medicaid programs "must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident." *Brookshire Health Care Center*, DAB No. 2190 (2008); *Park Manor Nursing Home*, DAB No. 2005 (2005); *Harmony Court*, DAB No. 1968 (2005); *Vandalia Park*, DAB No. 1939 (2004); *Ivy Woods Health Care and Rehabilitation Center*, DAB 1933 (2004); *Milpitas Care Center*, DAB No. 1864 (2003).

CMS asserts that the facility failed to have a process in place to implement social service interventions for R70, whom the facility knew had diagnoses of paranoia and schizophrenia with recent homicidal thoughts, depression, with mental and psychosocial difficulties. CMS PH Br. at 6, citing CMS Ex. 4 at 5-10, 13-19, CMS Ex. 7 at 28-50, 62. I agree, and in agreeing note that the evidence of Petitioner's failure is as dramatic as it is overwhelming.

Petitioner failed to assess and care-plan for R70's violent and dangerous behaviors, to evaluate the "triggers" that precipitated those behaviors, and to develop or implement interventions to address R70's behaviors. During R70's four-month stay he was sent to the hospital outside the facility though a PEC four times, police intervention was required both inside and outside the facility three times, he somehow secured a total of five weapons (*e.g.*, knives, scissors, razors) and threatened to cut or stab facility staff, other residents, and victims outside the facility eight times. Yet, R70's chart contains only three short entries by the SSD. P. Ex. 5 at 385. It took four months for someone at the facility to request an outside psychological consultation. The facility's Interdisciplinary Team (IDT) never met to discuss R70's behaviors. The IDT could have — and I find here that they should have — conferred and consulted with the various disciplines and staff leaders to develop effective and safe interventions to limit R70's outbursts, thereby protecting staff, other residents, local store- and bank-clerks, and R70 himself from abuse, assault, and injury approaching criminal violence. But Petitioner never care-planned for R70's aggressive and violent behaviors. It was not until the fourth month that Petitioner started to track R70's behavior, to review for "triggers" or patterns. The facility failed to implement sufficient interventions to address R70's dangerous behaviors, and certainly never took proactive steps to prevent or decrease the severity or frequency of R70's violent and aggressive behaviors.

Petitioner was perfectly aware of R70's psychiatric history and special needs. Petitioner admitted R70 from the inpatient geriatric psychiatric unit of the local hospital. R70's hospital records clearly informed Petitioner that R70 struggled with serious mental illness

that often manifested itself in highly aggressive behavior. The hospital records stated that R70 is "well-known" to the inpatient service because of his multiple hospitalizations and long history of schizophrenia. Prior to his hospitalization, R70 resided at a nursing facility, but the facility found it necessary to hospitalize R70 on a PEC related to agitation, paranoia, and homicidal thoughts. Specifically, R70 cursed, threatened others, and attempted to hit a door with a chair. The records showed that R70 also had a history of multiple suicide attempts, as well as efforts at treatment through electroconvulsive therapy. P. Ex. 5 at 201. The plain truth is that when it admitted R70, Petitioner's facility had before it a body of data perfectly predictive of what R70's next four months of conduct would be like in every frightening detail.

The State Operations Manual(SOM) states that "'Medically-related social services' means services provided by the facility's staff to assist residents in maintaining or improving their ability to manage their everyday physical, mental, and psychosocial needs." SOM, App. PP at F250. The SOM further provides examples of medically-related social services. These services might include:

- identifying and seeking ways to support residents' individual needs through the assessment and care planning process;
- arranging for counseling services (such as arranging for a psychologist or licensed professional to evaluate for ongoing or intermittent counseling);
- making referrals and obtaining services from outside entities (such as outpatient therapy);
- providing alternatives to drug therapy or restraints by understanding and communicating to staff why residents act as they do, what they are attempting to communicate, and what needs the staff must meet; (such as working with or training staff on the best way to approach a particular resident with schizophrenia);
- assisting staff to discuss health care choices and their ramifications with residents (such as choosing to refuse medication or other treatment);
- working with staff to enhance the residents' dignity in recognition of each resident's individuality (such care planning privacy issues);
- Finding options that most meet the physical and emotional needs of each resident;
- participating on the IDT (such as brainstorming with the other disciplines to develop effective and safe interventions);
- discharge planning (such as helping a resident get on a waiting list for alternative housing or treatment);

The SOM clarifies that "[w]here needed services are not covered by the Medicaid State plan, nursing facilities are still required to attempt to obtain these services." *Id.*

When admitting R70, Petitioner should have — indeed *must have* — known that R70 would require significant support, suprvision, and management to meet his needs and to assure his safety and the safety of its other residents and staff. Because Petitioner admitted R70 with the primary diagnosis of a serious mental illness marked by disturbing actions, and because it knew that R70 had been violent, suicidal, and homicidal in the past, Petitioner's SSD should have been on heightened alert to the need for enhanced involvement in the care and treatment of R70, for extra vigilance in protecting the other residents from R70's behaviors, and for interventions as proactive as possible to minimize R70's violent, aggressive, assaultive, and extremely dangerous outbursts. Yet during R70's entire four-month tumultuous stay, the SSD only documented three interactions with R70: the first two notes were related to an initial assessment and the third was related to the first incident where R70 exhibited threatening, aggressive, or violent behavior. P. Ex. 5 at 385.

The licensed mental health counselor who conducted R70's psychosocial evaluation at the acute-care hospital recommended that R70 participate in outpatient follow-up. P. Ex. 5 at 222. R70's attending physician also recommended an outpatient treatment plan. P. Ex. 5 at 203. The SSD informed the surveyor that she was not able to locate a day program or any other placement for R70. CMS Ex. 2 at 26. However, she did not specify when this alleged search began and there is no documentation in Petitioner's records or anywhere else of any such search or research related to it. There is absolutely no documented or otherwise-supported evidence that the SSD or any other staff member researched outpatient treatment options for R70 as recommended at admission.

Petitioner argues that 42 C.F.R. § 483.15(g)(1) does not require that the social services are provided only by a SSD. Petitioner argues that those critical services can properly be provided by anyone at the facility, including nursing staff, however credentialed, qualified, or experienced. In this vein, Petitioner presents several arguments including: that the facility's entire staff provided social services to R70; that the IDT provided social services to R70; that the DON provided social services to R70 because R70 preferred to work with a male; and that the SSD was present almost all of the time when the DON provided social services to R70. P. Br at 24; P. Ex. 8 at 102-103; P. Ex. 9 at 16-17.

Although Petitioner asserts that any staff member *can* provide social services, that assertion is meaningless because the record does not support Petitioner's assertion that anyone *actually did so* in any comprehensive or meaningful way. For example, Petitioner's assertion that the DON provided social services in the place of the SSD because of R70's preference to work with a male was never care planned as an intended intervention. Although the nursing notes frequently state "DON notified," the notes very rarely point to DON Starkey's actual involvement or provision of frequent social

services. Moreover, there was one nursing note penned by DON Starkey that indicated the SSD was involved, but the note only states that the SSD called R70's sister, and reflects no actual involvement with R70 himself. P. Ex. 5 at 282.

Additionally, even when R70 specifically requested social services, the SSD remained unresponsive. Specifically, the evening of March 23, 2011, R70 requested to meet with the SSD. DON Starkey testified that the SSD met with R70 the following morning of March 24. P. Ex. 8 at 174-175. However, there is no documentation indicating that the SSD met with R70 on the morning of March 24 as requested, even though the SSD made a notation that very afternoon. P. Ex. 5 at 385. The record shows that the SSD failed to meet with R70 as requested and allowed him to leave the premises — at which time his behavior escalated into a situation which could have been gravely perilous to R70 and others. Because of the SSD's unresponsiveness, Petitioner may have actually exacerbated R70's serious and dangerous behaviors and the dangers to others that they directly and unmistakably created.

Petitioner had R70 involuntarily committed to an inpatient psychiatric facility four times in four months: on May 3 (P. Ex. 5 at 272), on June 7 (P. Ex. 5 at 279), on June 23 (P. Ex. 5 at 284), and finally on July 7 (P. Ex. 5 at 97). According to the PEC protocol the physician may execute an emergency certificate only when the physician determines that the individual is "in need of immediate care and treatment in a treatment facility" because the physician "determines the person to be dangerous to self or others or to be gravely disabled." LA. REV. STAT. § 28:53.

Petitioner argues that it provided psychiatric treatment including evaluation, therapy, and medication review, through each PEC. P. Br. at 25-27; P. Answer Br. at 7. Petitioner explains, "A PEC is actually a resource used by long-term care facilities when a patient requires unique treatment due to mental illness." P. Br. at 26, citing P. Ex. 9 at 18. Petitioner asserts that "[p]articularly in the Baton Rouge area, the PEC is the best and nearly the only option for a geriatric-psychiatric patient who is in need of in depth treatment and medication review." P. Br. at 26, citing P. Ex. 9 at 42.

On the other hand, Petitioner also argues that the PEC "interventions" were responsible for R70's behaviors increasing in frequency and these PEC "psychiatric evaluations" were "actually the catalyst for a significant number of R70's outbursts." P. Br. at 27, citing P. Ex. 8 at 112. Petitioner argues that the record supports DON Starkey's assertion that "after R70 was sent for psychiatric evaluations, his behaviors became more frequent." P. Br. at 27, citing, P. Ex. 5 at 834-841, P. Ex. 4 (timeline of events).

Under the guidance to surveyors, one example of medically-related social services is making referrals and obtaining services from outside entities. Petitioner states that by having R70 admitted for inpatient treatment through a PEC, it was providing social services by making referrals and obtaining services from outside entities. P. Answer Br.

at 9, citing SOM, Appendix PP. Petitioner's administrator testified that he felt that they should have been given some credit for doing that. It is true that discharge to an intensive therapy program is perhaps an option in providing medically-related social services, however, that is not where the social services begin. Discharging a resident on a PEC is not a valid way of providing medically necessary social services or an appropriate starting point to obtain a psychiatric or psychological evaluation. The facility must provide a number of intermediate interventions and services to the resident and not simply wait until the resident has decompensated into bizarre, terrifying, combative, and weapon-wielding outbursts.

CMS asserts that Petitioner failed to be proactive in that the facility failed to assess "triggers" for R70's behaviors, implement approaches to address "triggers" or behaviors, care plan, or instruct staff on how to deal with R70's behaviors. Petitioner counters that there is no evidence that it is "even possible with a schizophrenic" to be proactive with assessing possible "triggers" for R70's behaviors. P. Answer Br. at 8. Petitioner argues that I should rely on Dr. Holder's testimony, that it is "nearly impossible to predict the behaviors of a schizophrenic, or to be 'proactive' in attempting to limit the outbursts." P. Br. at 27, citing P. Ex. 10 at 4. Dr. Holder further testified that "staff acted appropriately in responding to R70's behaviors after the fact with verbal counseling, redirecting, and one-time doses of Haldol." *Id*. Petitioner also argues that "when [DON] Starkey took proactive measure, such as calling the police during R70's outburst, the facility is persecuted and accused of failing to provide care to R70. . . ." P. Answer Br. at 3. Calling the police to intervene once a resident has decompensated is far from proactive. Petitioner is not charged with responsibility for predicting R70's behavior, but rather with taking proactive steps to minimize the severity or frequency of outbursts so far as practicable for R70. However, Petitioner did not attempt preventative interventions and its argument — that such interventions would be fruitless — is without merit.

In the case of R70, the nursing staff should have monitored R70's behaviors to see if they could identify "triggers" or patterns in his behavior well before the end of his fourth month. For instance, review of the timeline shows that R70 was "territorial" about his room and did not adjust to having a roommate. It would have been an easy intervention to provide R70 with a private room but maintain a safe environment for R70 within his room to assure his safety and access to him. Further, he valued privacy punctiliously, and he preferred to bathe himself privately in his own bathroom without staff assistance. Social services or the facility is responsible for assuring for a home-like environment, control, dignity, privacy. SOM, App. PP at F250. Although Petitioner identified R70's preference to clean himself in his room, they did not address this as a privacy issue or offer approaches to accommodate or ameliorate his discomfort with the facility's normal routines. P. Ex. 5 at 849.

Additionally, R70's most serious violent episodes seem to have been preceded by escalating patterns of what might be characterized as defiant, resistant, confrontational activity, such as becoming increasingly protective of his room and privacy, isolating himself and not allowing staff to enter his room, and demanding that his roommate's possessions be removed from their room. This could have given the staff an opportunity to decrease his anxiety or paranoid behavior prior to his more serious outbursts.

Despite the fact that Petitioner and its staff were inarguably on notice that they would be called on to be involved closely and constantly in managing the psychosocial well-being of R70, the SSD did relatively little to proactively address R70's needs. The SSD's involvement with R70's care and services for the most part ended on March 28, with the SSD's third and final notation following R70's first encounter with the police at Petitioner's facility. The three SSD notes reflect no "one-on-one" counseling or psychological consults for R70. TR. 71. SSD did not consult a psychologist until the survey at issue was underway, on June 22, 2011. TR. 72. A psychological or psychiatric evaluation could have assessed R70 for other psychiatric illness that might have complicated or frustrated his treatment. A clinician could have recommended interventions, approaches, and alternative treatment options if any were indicated. But in the face of numerous examples of R70's agitated, abusive, and violent behaviors, Petitioner failed to assess and care-plan his violent and aggressive behaviors and failed to implement interventions to address his behaviors. P. Ex. 5 at 307-309.

Petitioner was obliged to identify problems (e.g. schizophrenia exhibited by violent physical and verbal outbursts); to examine how they were exhibited (threatening and cursing at residents, staff, and outside individuals with words and/or aggressive posture, with and without weapons); to identify possible interventions (restrict access to sharp objects such as knives, scissors, and razors; provide a private room; staff accompany on outings; redirect by offering private time and or cleaning options); and to evaluate the effectiveness of the interventions actually carried out. If the interventions were not successful it was the facility's responsibility to create new or seek alternative interventions.

Under the regulation, a facility assesses and evaluates a residents' behavior and then develops and implements interventions to prevent the behavior from occurring or to allow the behavior to occur in a safe manner. *See Brookshire Healthcare Center,* DAB No. 2190 (2008). Petitioner did not meet this standard. Accordingly, the facility failed to comply substantially with the requirement to provide medically-related social services.

2. Petitioner failed to comply substantially with the accidents/hazards and supervision requirement at 42 C.F.R. § 483.25(h) (Tag F-323).

Section 483.25(h) references accidents[4] and states:

> (h) *Accidents.* The facility must ensure that –
> (1) The resident environment remains as free of accident hazards as is possible; and
> (2) Each resident receives adequate supervision and assistance devices to prevent accidents.

In *Meridian Nursing Center*, DAB No. 2265, at 3 (2009), the Board described the requirements of this subsection, stating:

> Section 483.25(h)(1) requires that a facility address foreseeable risks of harm from accidents "by identifying and removing hazards, where possible, or where the hazard is unavoidable because of other resident needs, managing the hazard by reducing the risk of accident to the extent possible." *Maine Veterans' Home – Scarborough*, DAB No. 1975, at 10 (2005). Section 483.25(h)(2) requires that a facility take "all reasonable steps to ensure that a resident receives supervision and assistance devices that meet his or her assessed needs and mitigate foreseeable risks of harm from accidents." *Briarwood Nursing Center*, DAB No. 2115, at 11 (2007), citing *Woodstock Care Center v. Thompson*, DAB No. 1726 (2000) (facility must take "all reasonable precautions against residents' accidents"), *aff'd*, *Woodstock Care Center v. Thompson*, 363 F.3d 583 (6th Cir. 2003).

The Board has also held that facilities "have the 'flexibility to choose the methods of supervision' to prevent accidents so long as the methods chosen are adequate in light of the resident's needs and ability to protect himself or herself from a risk." *Briarwood Nursing Center*, DAB No. 2115, at 5, *citing Liberty Commons Nursing and Rehab – Alamance*, DAB No. 2070, at 3 (2007).

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[4] The Board references the Medicare State Operations Manual (SOM) in defining an accident as:

> "an unexpected, unintended event that can cause a resident bodily injury," excluding "adverse outcomes associated as a direct consequence of treatment or care (e.g., drug side effects or reactions)." SOM Appendix PP, Guidance to Surveyors, Part 2, SOP 483.25 Quality of Care (Rev. 274, June 1995 (SOM Guidance).

Woodstock Care Center, DAB No. 1726, at 4.

The focus is on whether the facility took all reasonable steps to ensure that a resident receives supervision and assistance devices that met his or her assessed needs and mitigate foreseeable risk of harm from accidents. *Briarwood Nursing Center*, DAB No. 2115, at 11-12, citing *Woodstock Care Center v. Thompson*, 363 F.3d at 590.

> The regulation speaks in terms of ensuring that what is "practicable" and "possible" to do is done. What is thus required of facilities is not prescience but reason and professional judgment in assessing what can be done to make residents (given their special needs) safe, through removing accident hazards, providing appropriate devices, and ensuring adequate supervision.

Josephine Sunset Home, DAB No. 1908, at 14-15 (2004).

The Board has also held that the regulations permit facilities some flexibility in choosing the methods they use to prevent accidents, so long as the chosen methods constitute an adequate level of supervision. *Windsor Health Care Center*, DAB No. 1902 (2003), *aff'd Windsor Health Center v. Leavitt*, 2005 WL 858069 (6th Cir. April 13, 2005). A facility must anticipate what accidents might befall a resident and take steps — such as increased supervision or the use of assistance devices, for example — to prevent them. *Aase Haugen Homes*, DAB No. 2013 (2006).

In this case, Petitioner failed to supervise R70 adequately, to keep him safe from foreseeable accidents, and to assure that other residents such as R58 were adequately protected from R70. Petitioner failed to protect R70 from himself and potential outside dangers and failed to protect other residents, including R58, from R70.

Petitioner failed to protect R70 from foreseeable accidents/ hazards by not providing adequate supervision from foreseeable risks that could — and from some that did — occur. Petitioner failed to supervise R70 and allowed R70 to gain access to dangerous items such as a razor and knives. Petitioner failed to adequately supervise R70 from foreseeable risks, both by allowing him to elope and by allowing him independent leave of absence. Without supervision or discussion, Petitioner allowed R70 to leave the facility unattended, and twice those unattended forays required police intervention, once when his paranoid delusions led him to cause a disturbance at a drugstore and bank and in a later incident when he threatened to stab a woman at a shop.

Petitioner also failed to protect R58 from R70, on both physical and emotional levels. It is clear that when R70 was admitted he was known to be aggressive toward staff. Once he was residing in the facility it immediately became obvious that he was aggressive toward all individuals, whether a resident at the facility, a nurse, a housekeeper, a bank clerk in town, or a shopper at a local store. Petitioner failed to keep R58 safe from R70's threats. But it is also hard to imagine that the other residents, among them R70's

roommate, were not frightened by R70. He frequently threatened other residents by exclaiming that he would stab them, which he often emphasizes by brandishing a knife or other weapon over the resident while making the threats. And it may be as well if I write as clearly as possible: it does not matter under the statutes and regulations I apply here whether the weapon in question was a butter knife or a Bowie knife, an old-fashioned cut-throat straight razor or a throw-away Bic. Despite Petitioner's arguments to the contrary — and on this record those arguments discredit their source and defy categorization as "reasonable" — butter knives and safety razors are dangerous weapons, entirely capable of inflicting pain, injury, and permanent damage, especially in the hands of an aggressive and uncontrolled paranoid schizophrenic like R70, and even more especially when those weapons are brought into play by an aggressor of that sort in the environment of a skilled nursing facility and its vulnerable population.

Petitioner argues that I should rely on the testimony of Dr. Holder, R70's treating physician, and DON Starkey over that of Surveyor Knight who, says Petitioner, lacked knowledge and experience with psychiatric patients, especially schizophrenics, and did not contribute to the F-Tag. P. Br. at 28. Now, Dr. Holder testified that R70 was not a danger to others, and specifically not a danger to R58. P. Ex. 10 at 2, 38. Yet, presumably this same Dr. Holder was describing the same patient in each of R70's PECs, in which Dr. Holder and NP Melancon *certified* that R70 *was* a danger to himself and/or others. In addition, these clinicians certified under penalty of perjury in supporting detail that:

- R70 was "violent toward staff & other [residents]";
- R70 "chased staff [with] razor blade [and] tried to hit another resident";
- R70's "homicidal ideations continue to increase";
- R70 "is a real threat to safety of staff/residents"; and
- "weapons [are] in easy access to [R70]."

P. Ex. 5 at 272, 279, 284.

I find the doctor's certifications in the PECs, when he found no difficulty in certifying that R70 was a danger to others, to be the more convincing evidence. P. Ex. 10 at 38; P. Ex. 5 at 272, 279, 284. For one thing, the PECs were sworn out contemporaneously with the events that led up to them. For another, it cannot be overlooked that there is an outcome in these proceedings that might color Dr. Holder's view, but in the PECs his only apparent interest would have been the safety of R70, the facility and the others who lived and worked there, and the local community in general. As a third consideration, it is objectively plain that R70's behavior as reported in Petitioner's records shows him to be dangerous. And it strains credulity for Petitioner to argue that although R70 was in fact violent and dangerous as certified to on the PEC form, but only "at that moment, immediately before and immediately after these incidents . . . ." P. Answer Br. at 7. A look at the timeline shows a different story and refutes such an embarrassing assertion:

the timeline creates a picture of Petitioner's inaction over the four-month period of R70's repeated outbursts and chronic aggression, of the threat of trouble manifested by querulous recalcitrance even in R70's most benign moods, and of their sudden escalation into raging violence.

If more explanation is needed for my rejection of Dr. Holder's testimony, it is here: nursing notes also support the information certified on the PECs. DON Starkey's testimony is not only unsupported by the evidence, but is directly contradicted by those nursing notes and thus by the nurses he supervised. For example, DON Starkey testified that R70 "never even made an aggressive move toward someone when he made a verbal threat." P. Ex. 8 at 75. And yet, in a note penned by DON Starkey himself, he cites an incident where "[R70] cursed and threatened to cut the fellow resident and began rapidly approaching as if to attack the other resident." P. Ex. 5 at 102.

The records speak for themselves, and I will let them do so here. In the June 7 incident, R70 very aggressively walked toward some nurses who were gathered at the nursing station demanding "Which one of you m----- f------ called me a b----, one of you b------ called me a b----." Wielding the razor in his hand, R70 chased the nurses into the break room while shouting extreme profanity. The nurses locked themselves into the bathroom in the break room to protect themselves. R70 then approached another resident in the hallway, stood over the resident's wheelchair, holding onto the wheelchair handle and daring the resident to tell R70 to let his wheelchair go. R70 shouted to the seated resident "I will cut your m----- f------ neck off, you m----- f-----." A brave nurse seized R70's raised hand — the hand that was gripping the razor — and managed to prevent R70 from striking the seated and defenseless resident. The nurse told the seated resident to self-propel the wheelchair away from R70; the seated resident complied, while R70 continued to shout obscenities at the retreating defenseless wheelchair-rolling victim of the attack. The nurse was able to redirect R70 to his room. The nursing staff called the DON who told the nurses to contact the police. CMS Ex. 2 at 22-23; P. Ex. 5 at 93-94, 277-279. Petitioner asserts that no one was in any real danger, and that the DON only suggested that the police be called out of "an abundance of caution." The nurses were clearly frightened by R70 — enough to lock themselves in the break room bathroom — and certainly R70's behavior was enough to frighten a vulnerable resident. And let us be plain: "an abundance of caution" is what suggests calling the police when one hears an unexplained noise under one's window in the middle of a dark night; considerations of life and death are what compel calling the police when directly confronted with a violent armed assault on a helpless victim whose usual protectors have been driven off by the assault.[5]

[5] I find that there is significant evidence to support a finding that Petitioner violated 498.25(h) with respect to its treatment of R70. Accordingly, I need not address whether Petitioner's care and treatment of R101 and R102 also violated the accidents/hazards regulation.

In summary of the few paragraphs above, these points stand out. First, Dr. Holder's testimony denying R70's dangerous nature is entitled to no weight at all, and to only as much respect as he apparently extended to this fact-finding process. Next, DON Starkey's suggestion that the June 7 incident fell short of a dangerous situation is beyond the most generous extension of credibility, for it is contradicted by every objective fact recorded at the time. Third, Petitioner's argument that the objects R70 used as weapons simply weren't weapons at all is singularly wrongheaded, given the recorded facts showing that in R70's hands they terrorized the victims of R70's attacks because they had the potential to do serious and lasting harm.

3. Petitioner failed to comply substantially with the administration regulation at 42 C.F.R. § 483.75 (Tag F-490).

A facility "must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident." 42 C.F.R. § 483.75.

The Board has held that a finding of noncompliance with respect to 42 C.F.R. § 483.75 may be derived from findings of noncompliance with other participation requirements. *Life Care Center of Tullahoma*, DAB No. 2304 at 45 (2010), *citing Stone County Nursing and Rehab. Center*, DAB No. 2276 at 15-16 (2009); *Cedar View Good Samaritan*, DAB No. 1897, at 23-24 (2003); *Asbury Center at Johnson City*, DAB No. 1815, at 11 (2002).

Petitioner's failure to comply substantially with sections 483.15(g)(1) and 483.25(h) establishes that the facility was not administered effectively to help R70, R58, and others attain their highest practicable well-being. Additionally, the facility's administration failed to have a process in place to ensure that residents admitted with psychiatric disorders received psychological or psychiatric consultations once the resident began to exhibit aggressive or violent behaviors. The CMS surveyors found that Petitioner placed R70 in immediate jeopardy beginning on March 24th, when the police brought R70 back to the facility after R70 was exhibiting aggressive, bizarre, paranoid behavior at a local bank. The facility did not assure that R70 was provided an appropriate professional assessment or that the in-house SSD or IDT assessed R70 for causative factors, plan interventions, or monitor their effectiveness. Instead, the administration allowed R70's behavior to risk the health and safety of himself and the other residents, as well, of course, as the health and safety of Petitioner's own staff. On April 14, R70 threatened a nurse while brandishing a butter knife. On April 28, R70 threatened to kill R58 while standing over him with a knife or scissors. On May 1, R70 eloped and threatened to stab a woman at the store and police were called a second time.

It is the administration's responsibility to assure that the facility is operating in such a way that not only maintains the safety of the residents, but also that the facility attain or maintain the highest practicable physical, mental, and psychosocial well-being of each

resident. R70 was clearly a very challenging resident, but that is really the point: when the facility admitted R70 its administrators and staff accepted responsibility to assure R70's highest practicable physical, mental, and psychosocial well-being. Often it may be difficult to find appropriate placement for such a challenging resident, however, it remains the facility's responsibility to search for all available resources (outside psychological consultations, in-house assessments, outpatient therapy, private room, etc.) to address the resident's needs while at the facility. The facility failed to comply substantially with the administration requirement.

4. CMS's determination that the facility's noncompliance posed immediate jeopardy to resident health and safety is not clearly erroneous.

CMS concluded that the violations of 42 C.F.R. §§ 483.25(h), 483.15(g)(1), and 483.75 posed immediate jeopardy. However, because CMS imposed PICMPs in this case, and not per-day CMPs, I am not authorized to review CMS's finding that the deficiencies here constituted immediate jeopardy.

The scope and severity determination of immediate jeopardy can be appealed "only if a successful challenge on this issue would affect" the range of the CMP that can be imposed or if it would affect the facility's nurse aide training program. 42 C.F.R. §§ 498.3(b)(14)(i), (ii) and 498.3(d)(10)(i), (ii). Petitioner did not have an approved NATCEP. Further, there is but a single range for PICMPs and the amount of a PICMP is not affected by whether or not there is a finding of immediate jeopardy. 42 C.F.R. §§ 488.408; 488.438. Thus, the immediate jeopardy finding is not subject to appeal or my review in this case.

However, to the extent that a declaration of immediate jeopardy reflects upon the seriousness of the deficiency, it is reasonable for me to consider whether immediate jeopardy existed as an evidentiary matter for the reasonableness of the PICMPs. Immediate jeopardy is a situation in which a facility's noncompliance with one or more requirements of participation "has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident." 42 C.F.R. § 488.301. I must uphold CMS's determination as to the level of noncompliance unless it is clearly erroneous. 42 C.F.R. § 498.60(c). The "clearly erroneous" standard imposes a heavy burden on facilities to show that no immediate jeopardy was present as cited. The Board 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.

The "clearly erroneous" standard, the Board has explained, is highly deferential to the CMS determination and places a heavy burden on the facility to upset CMS's finding regarding the level of noncompliance. *See, e.g., Claiborne-Hughes Health Center*, DAB

No. 2179, at 20, (2008), *aff'd*, *Claiborne-Hughes Health Center v. Sebelius*, 609 F.3d 839 (6th Cir. 2010), *quoting Liberty Commons Nursing & Rehab Center*, DAB No. 2031 at 18 (2006), *aff'd*, *Liberty Commons Nursing & Rehab Center—Johnston v. Leavitt*, 241 F. App'x 76 (4th Cir. 2007). When CMS issued the nursing facility survey, certification and enforcement regulations, it acknowledged that "distinctions between different levels of noncompliance . . . do not represent mathematical judgments for which there are clear or objectively measured boundaries." 59 Fed. Reg. 56,116, 56,179 (1994). "This inherent imprecision is precisely why CMS's immediate jeopardy determination, a matter of professional judgment and expertise, is entitled to deference." *Daughters of Miriam Center*, DAB No. 2067, at 15 (2007).

Petitioner placed R70, R58, and other residents in immediate jeopardy when its staff failed to provide medically-related social services, prevent accidents and hazards, and provide sufficient administration. Petitioner knowingly took on a difficult, vulnerable, volatile, and violent Resident and then simply ignored any proactive steps they could have taken to avoid the problems of which they were well aware. Petitioner ignored warning signs, allowed R70 to obtain weapons on at least five occasions, and simply allowed R70's agitated behaviors to escalate until an emergency shot of Haldol and emergency inpatient treatment became necessary. It is nothing short of miraculous that no other residents were physically harmed. CMS's immediate jeopardy finding is, thus, not clearly erroneous.

5. The enforcement remedies imposed are reasonable.

To determine whether the PICMPs imposed are reasonable, I apply the factors listed in 42 C.F.R. § 488.438(f), which are: (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 listed 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.

In reaching a decision on the reasonableness of the CMP, I must 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 Petitioner with the kind of deficiency found, 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 Center*, DAB No. 1848, at 21 (2002).

The PICMPs of $4,000, $4,000, and $2,000 are at the low-to-middle penalty range for any scope and severity level of noncompliance. *See* 42 C.F.R. § 488.438(a)(2), which sets the range for PICMPs at $1,000 to $10,000. Overall, the PICMP is exceedingly modest when considering the possible penalty CMS could have imposed. Petitioner chose not to submit evidence relating to its financial condition or to argue that the remedy would risk its financial viability. Petitioner has a history of noncompliance. Moreover the factors established in 42 C.F.R. § 488.404, including the scope and severity, the relationship of the deficiency to the others resulting in noncompliance, and prior history of noncompliance in general, show that CMS was exceedingly modest in setting the level of its chosen penalties. The seriousness of Petitioner's violations, the serious lack of involvement of the SSD, the danger in which Petitioner's lapses placed R70 and the other residents, and management's lack of oversight, are overwhelming support for these CMPs. Petitioner's culpability is high: all the evidence of value demonstrates that the facility showed at the very least a profound indifference for residents' comfort, care, and safety.

I therefore find the penalties imposed are reasonable.

V. Conclusion

For the reasons discussed above, I find that Petitioner's facility was not in substantial compliance with Medicare participation requirements at 42 C.F.R. §§ 483.25(h), 483.15(g)(1), and 483.75, and that the PICMP enforcement remedies imposed are reasonable.

/s/
Richard J. Smith
Administrative Law Judge