

Department of Health and Human Services
DEPARTMENTAL APPEALS BOARD
Appellate Division

Madison County Nursing Home
Docket No. A-17-98
Decision No. 2895
September 17, 2018

**FINAL DECISION ON REVIEW OF
ADMINISTRATIVE LAW JUDGE DECISION**

Madison County Nursing Home (MCNH or Petitioner), a skilled nursing facility (SNF) in Mississippi that participates in Medicare, requested review of the Administrative Law Judge decision, *Madison County Nursing Home*, DAB CR4851 (2017) (ALJ Decision). The ALJ granted summary judgment in favor of the Centers for Medicare & Medicaid Services (CMS), concluding that MCNH was not in substantial compliance with Medicare participation requirements for safeguarding and managing resident funds. The ALJ also determined that he had no authority to review CMS's determination that MCNH's noncompliance posed immediate jeopardy and that the \$10,000 per-instance civil money penalty (CMP) imposed by CMS for MCNH's noncompliance was reasonable.

For the reasons discussed below, we affirm the ALJ Decision.

Legal Background

To participate in Medicare, a SNF must be in "substantial compliance" with the participation requirements in 42 C.F.R. Part 483, subpart B. 42 C.F.R. §§ 483.1, 488.400.¹ A "deficiency" is a "failure to meet a participation requirement." *Id.* § 488.301. A SNF is not in "substantial compliance" when it has one or more deficiencies that have the potential for causing more than minimal harm to residents. *Id.* The term "noncompliance," as used in the regulations, is synonymous with lack of substantial compliance. *Id.* (defining "noncompliance").

¹ On October 4, 2016, CMS issued a final rule that redesignated and revised the participation requirements for long-term care facilities effective November 28, 2016. *See* Final Rule, Medicare and Medicaid Programs; Reform of Requirements for Long-Term Care Facilities, 81 Fed. Reg. 68,688, 68,726 (Oct. 4, 2016). Unless specified otherwise, this decision cites to the version of the regulations in effect in October 2013, when the surveys that provided the bases for CMS's determination were performed. *See Carmel Convalescent Hosp.*, DAB No. 1584, at 2 n.2 (1996) (applying regulations in effect on the date of the survey and resurvey).

State agencies under contract with CMS perform onsite surveys to evaluate SNFs' compliance with the requirements. 42 C.F.R. §§ 488.10(a), 488.11. Adverse survey findings are reported on a form called a "Statement of Deficiencies."

CMS may impose enforcement remedies, including a per-day and/or per-instance CMP, on a SNF that is not in substantial compliance. 42 C.F.R. §§ 488.400, 488.402(b), (c), 488.406. CMS determines the amount of a CMP based on multiple factors, which include the "seriousness" of the noncompliance. *Id.* §§ 488.404(b), 488.438(f). "Seriousness" encompasses scope ("isolated," "pattern," or "widespread") and severity (whether the deficiency constituted no actual harm with a potential for minimal harm; no actual harm with a potential for more than minimal harm that is not immediate jeopardy; actual harm that is not immediate jeopardy, or immediate jeopardy). *Id.* § 488.404(b). "Immediate jeopardy means a situation in which the provider'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." *Id.* § 488.301.

Among the participation requirements, section 483.10 imposes on each facility the duty to "protect and promote the rights of each resident." Subsection 483.10(c)(2) provides that "[u]pon written authorization of a resident, the facility must hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility" The SNF must deposit any resident's personal funds in excess of \$50 in an interest bearing account separate from the facility's operating accounts, *id.* § 483.10(c)(3), and establish and maintain a system that assures a full and complete separate accounting of each resident's personal funds entrusted to the facility, *id.* § 483.10(c)(4).

Section 483.13(c) requires a SNF to "develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property." The regulations define "misappropriation of resident property" to mean "the deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident's belongings or money without the resident's consent." 42 C.F.R. 488.301.

The overarching requirement governing facility administration, set out in the introductory paragraph of section 483.75, provides that 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."

Case Background

The Mississippi Department of Health (state agency) conducted a complaint survey and a partial extended survey of MCNH in October 2013. CMS Ex. 3, at 1. The state agency found that MCNH was not in substantial compliance with multiple Medicare participation requirements and that the noncompliance posed immediate jeopardy to

resident health and safety beginning November 2, 2012, and ending October 23, 2013. CMS Ex. 5, at 1-3. The state agency also determined that the noncompliance constituted substandard quality of care.² *Id.*

On December 6, 2013, CMS issued a determination, based on the survey findings, that MCNH was not in substantial compliance with: 42 C.F.R. §§ 483.10(c)(2)-(5), 483.13(c), and 483.75. CMS Ex. 6. CMS also determined that MCNH's noncompliance posed immediate jeopardy to MCNH residents and that its noncompliance with section 483.13(c) constituted substandard quality of care. CMS imposed multiple remedies against MCNH, including a per-instance CMP of \$10,000.³ *Id.* CMS determined that MCNH returned to substantial compliance effective January 16, 2014. CMS Ex. 36.

MCNH requested an ALJ hearing to contest the CMS findings and remedies. CMS moved for summary disposition. MCNH opposed CMS's motion, asserting that insofar as the case was ripe for summary disposition, it should be in MCNH's favor and that MCNH was entitled to judgment as a matter of law. P. Br. at 7.

The ALJ Decision

The ALJ concluded that summary judgment was appropriate because the parties did not dispute the key facts material to the outcome of the case, but instead, "the legal significance of those facts." ALJ Decision at 2, 13. The ALJ listed a series of 21 "facts" that were "either not disputed by the parties or, where there [was] a dispute, [the] Petitioner's version of the facts to the extent it [was] supported by evidence in the record." ALJ Decision at 9-12, and n.2. We note that MCNH's request for review does not dispute any of the facts enumerated by the ALJ, which we summarize as follows:

- MCNH had "Resident Trust Fund Policies," which provided, among other things, that it "will, upon written authorization by the resident or responsible party, accept responsibility for holding, safeguarding and accounting for the resident's personal funds The responsibility for the accuracy of the records remains with [Petitioner]." ALJ Decision at 10 (quoting CMS Ex. 13, at 12).

² "Substandard quality of care" means one or more deficiencies related to 42 C.F.R. §§ 483.13, 483.15, or 483.25 that constitute either immediate jeopardy; a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm. 42 C.F.R. § 488.301.

³ CMS also notified MCNH that, as a result of its noncompliance, provisions for prohibiting approval of a nurse aide training and competency evaluation program (NATCEP) for 2 years might be applicable. CMS Ex. 6. MCNH was not conducting an NATCEP at the time of the institution of penalties; "therefore it technically did not 'lose' its approval of such a program." RR at 12 n.9.

- MCNH’s “Abuse Policy & Procedure” stated that residents have “the right to be free from . . . misappropriation of resident property,” defined as “the deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a resident’s belongings or money without the resident’s consent.” ALJ Decision at 9 (quoting CMS Ex. 13, at 2).
- MCNH accepted personal funds from multiple residents and placed funds in excess of \$50 in trust in an account separate from MCNH’s operating accounts. ALJ Decision at 10 (citing CMS Ex. 10, at 1, 4, 6, 9, 15, 22, 27, 29, 32, 33; CMS Ex. 11; P. Ex. 6, at 2 ¶ 4).
- MCNH purchased a surety bond covering the total amount of funds held in the resident trust account. ALJ Decision at 10 (citing P. Ex. 1, at 2; P. Ex. 6, at 2 ¶ 4).
- Prior to the October 2013 surveys, MCNH usually appointed its Director of Social Services to manage the resident trust account and carry out MCNH’s Resident Trust Fund Policies, although MCNH had another employee conduct a monthly balancing and reconciliation of the bank statements related to the trust account. ALJ Decision at 10 (citing P. Ex. 6, at 4, 5-6 ¶¶ 11, 17).
- MCNH hired a social worker, ANR, as Director of Social Services in November 2011, and trained ANR in January 2012 to take over management of the resident trust account beginning in February 2012. ANR served as the Resident Trust Fund Account Manager through August 2013. ALJ Decision at 10 (citing P. Ex. 6, at 4 ¶ 12, 5 ¶ 16).
- On October 14, 2013, while the survey was ongoing, a surveyor requested documentation for a resident trust account transaction dated July 25, 2013. ALJ Decision at 11 (citing P. Ex. 6, at 6 ¶ 18).
- MCNH’s general practice was to keep “a copy of the check,” drawn from the resident trust account, “and the form indicating where the resident or legal representative would have signed for the authorization with two witnesses.” ALJ Decision at 11 (quoting P. Ex. 6, at 6 ¶ 18).
- MCNH’s Administrator asked ANR for the documentation supporting the July 25, 2013 transaction, and she was unable to produce it. ALJ Decision at 11 (citing P. Ex. 6, at 6 ¶ 18).
- Ultimately, this transaction raised the suspicions of the resident involved, her son, and MCNH staff and led MCNH’s Administrator to call for an internal audit and investigation, and thereafter an independent accounting firm audit of all resident

trust fund account transactions for the past 12 months. ALJ Decision at 11 (citing P. Ex. 6, at 6-8 ¶¶ 20-25).

- On September 1, 2013 ANR was replaced as the Resident Trust Fund Account Manager. ALJ Decision at 10 (citing P. Ex. 6, at 5 ¶ 16).
- The independent audit revealed that while ANR acted as the Resident Trust Fund Account Manager, during a period beginning in November 2012 through October 2013, there were numerous instances of suspicious activity related to the account that affected multiple residents. ALJ Decision at 11 (citing P. Ex. 6, at 5, 7-8 ¶¶ 16, 23-28).
- The auditor’s investigation revealed that, due to suspicious activity and/or clerical errors, an amount totaling \$3,117 for multiple residents was “in question.” ALJ Decision at 11 (citing P. Ex. 6, at 8-9 ¶¶ 25-28).
- MCNH admitted that ANR “concocted and executed a devious, long-running fraud against [Petitioner] and its residents,” intentionally “misappropriat[ed] larger and larger amounts” over time until she was removed as Resident Trust Fund Account Manager, and “stole approximately \$1,110 from one resident between July 25 and August 26, 2013.” ALJ Decision at 11-12 (quoting P. Ex. 6, at 9-10, ¶¶ 31-32; P. Br. at 6, 9-11, 17).
- To cover up her fraudulent scheme, ANR “forg[ed] signatures and creat[ed] documents to give the appearance of appropriate transactions” ALJ Decision at 12 (quoting P. Ex. 6, at 10 ¶ 31).

Granting summary judgment in favor of CMS, the ALJ determined that MCNH was responsible for ANR’s misconduct for purposes of assessing its compliance with the Medicare participation requirements. Through ANR’s deliberate fraudulent activities and intentional misappropriation of money from several residents’ accounts over the course of many months, the ALJ determined, MCNH violated sections 483.10(c)(2), 483.13(c), and 483.75. In reaching this conclusion, the ALJ accepted for summary judgment purposes that MCNH had established fraud controls, policies and procedures to protect resident funds, but determined those policies and procedures were “insufficient to free [MCNH] from responsibility for ANR’s fraud and misappropriation.” ALJ Decision at 14.⁴ The ALJ further determined that MCNH’s deficiencies constituted noncompliance

⁴ MCNH asserted that it had fraud controls in place, which included criminal record checks, staff education, witness and signature requirements, monthly balancing, and quarterly statements to residents/family members. P. Br. at 11.

with the participation requirements because they had at least the potential to cause more than minimal harm to residents. The ALJ next concluded that he had no authority to address CMS's finding that MCNH's noncompliance posed immediate jeopardy. Lastly, the ALJ determined that the amount of the CMP was reasonable.

Standard of Review

We review whether summary judgment is appropriate de novo, construing the facts in the light most favorable to the non-moving party and giving that party the benefit of all reasonable inferences. *See Pearsall Nursing & Rehab. Ctr.*, DAB No. 2692, at 5 (2016) (citing *Livingston Care Ctr.*, DAB No. 1871, at 5 (2003), *aff'd*, *Livingston Care Ctr. v. U.S. Dept. of Health & Human Servs.*, 388 F.3d 168, 172-73 (6th Cir. 2004)).

Our standard of review on a disputed conclusion of law is whether the ALJ Decision is erroneous. *Guidelines -- Appellate Review of Decisions of Administrative Law Judges Affecting a Provider's Participation in the Medicare and Medicaid Programs*, <https://www.hhs.gov/about/agencies/dab/different-appeals-at-dab/appeals-to-board/guidelines/participation/index.html>.

Discussion⁵

1. *Summary judgment is appropriate.*

Summary judgment is appropriate when there is no genuine dispute about a fact or facts material to the outcome of the case and the moving party is entitled to judgment as a matter of law. *Celotex Corp. v. Catrett*, 477 U.S. 317, 322-25 (1986). The party moving for summary judgment has the initial burden of demonstrating that there is no genuine issue of material fact for trial and that it is entitled to judgment as a matter of law. *Celotex*, 477 U.S. at 323. If the moving party carries that burden, "the nonmoving party must come forward with 'specific facts showing that there is a genuine issue for trial.'" *Matsushita Elec. Indus. Co. v. Zenith Radio Corp.*, 475 U.S. 574, 587 (1986) (quoting Fed. R. Civ. P. 56(e)).

"To defeat an adequately supported summary judgment motion, the non-moving party may not rely on the denials in its pleadings or briefs, but must furnish evidence of a dispute concerning a material fact – a fact that, if proven, would affect the outcome of the case under governing law." *Senior Rehab. & Skilled Nursing Ctr.*, DAB No. 2300, at 3

⁵ The ALJ Decision addressed several procedural and evidentiary matters prior to discussing whether summary judgment was appropriate. ALJ Decision at 5-9. Among the preliminary matters, the ALJ overruled objections by CMS to multiple MCNH exhibits. We need not decide whether the ALJ erred or abused his discretion in any of those rulings since they were not material to his decision and are not material to ours.

(2010), *aff'd*, *Senior Rehab. & Skilled Nursing Ctr. v. Health & Human Servs.*, 405 F. App'x 820 (5th Cir. 2010). A party “must do more than ‘show that there is some metaphysical doubt as to the material facts Where the record, taken as a whole, could not lead a rational trier of fact to find for the nonmoving party, there is no genuine issue for trial.’” *Mission Hosp. Reg'l Med. Ctr.*, DAB No. 2459, at 5 (2012) (quoting *Matsushita*, 475 U.S. at 586-587), *aff'd*, *Mission Hosp. Reg'l Med. Ctr. v. Sebelius*, No. SACV 12-01171 AG (MLG), 2013 WL 7219511 (C.D. Cal. 2013), *aff'd sub nom. Mission Hosp. Reg'l Med. Ctr. v. Burwell*, 819 F.3d 1112 (9th Cir. 2016).

In examining the evidence to determine the appropriateness of summary judgment, the adjudicator must draw all reasonable inferences in the light most favorable to the non-moving party. *Brightview Care Ctr.*, DAB No. 2132, at 2, 9 (2007). Drawing factual inferences in the light most favorable to the non-moving party does not require that a reviewer draw unreasonable inferences or accept the non-moving party's legal conclusions. *Brightview* at 10; *Cedar Lake Nursing Home*, DAB No. 2344, at 7 (2010).

MCNH's request for review does not take exception to any of the facts enumerated by the ALJ and summarized above. Rather, MCNH contends that the ALJ improperly granted summary judgment in favor of CMS because “the property which was misappropriated by a rogue employee of MCNH was at all times safeguarded and protected by a surety bond.” Request for Review (RR) at 1-2. Consequently, MCNH says, it was in substantial compliance because “at no time was there any potential for more than minimal harm to the residents at issue” *Id.* at 1. MCNH further alleges that the ALJ should have reviewed CMS's immediate jeopardy designation based on equitable principles because, MCNH alleges, CMS has engaged in affirmative misconduct in its treatment of MCNH. The immediate jeopardy finding, MCNH further contends, is clearly erroneous. Lastly, MCNH argues that the \$10,000 CMP amount is unreasonable.⁶

MCNH's arguments do not raise any genuine dispute about a fact or facts material to the outcome of this case. Rather, MCNH's contentions in part challenge the ALJ's determinations about the legal consequences of the undisputed facts and in part relate to inferences drawn from the undisputed facts. We therefore conclude that summary judgment is appropriate, and, for the reasons detailed below, we reject MCNH's arguments.

⁶ MCNH also asserted that CMS's Response Brief was untimely because CMS filed it 31 days after MCNH filed its July 24, 2017 Request for Review of the ALJ Decision. Reply at 1 n.2. CMS's submission was timely. As stated in the Board's acknowledgment of MCNH's Request for Review, CMS's response brief was due 30 days after CMS received the Request for Review. “The date CMS received an e-mail from DAB E-File that the case was docketed, July 25, 2017, is considered the date of receipt,” the Board explained. A-17-98 Acknowledgment of Request for Review at 1. CMS's August 24, 2017 submission was therefore timely.

2. *MCNH was not in substantial compliance with 42 C.F.R. §§ 483.10(c)(2), 483.13(c), and 483.75 based on the undisputed facts.*

a. *MCNH is responsible for ANR's misconduct for purposes of evaluating its compliance with the Medicare participation requirements.*

MCNH contends on appeal, as it did before the ALJ, that all of the “cited violations of federal regulations in this matter” arose from “a rogue MCNH employee implementing a devious plan of fraud and theft to misappropriate multiple small amounts of money from individual residents’ trust accounts over time.” RR at 9-10. MCNH argued that it should not be held responsible for ANR’s “intentional and calculated fraudulent and criminal actions,” which she committed against MCNH as well as its residents. Petitioner Br. (P. Br.) at 1. Moreover, MCNH said that it fully complied with the participation requirements through its numerous fraud controls, policies and practices, and it could not reasonably have suspected ANR of misfeasance. *Id.* at 11-13. MCNH also asserted that the circumstances in this matter were distinguishable from those at issue in *Emerald Oaks*, DAB No. 1800 (2001), which CMS cited to support its claim that MCNH could not disown ANR’s misconduct. P. Br. at 13-14; CMS Br. at 10. *Emerald Oaks*, MCNH said, involved a nurse “acting within the scope of her employment by providing care to residents, she just provided it poorly.” P. Br. at 13 (citing *Emerald Oaks* at 7 n.3). In contrast, MCNH asserted, ANR “deliberately concealed” her fraudulent activities, she acted alone, her misconduct was not “care-related,” and her theft was not within the scope of her employment. P. Br. at 13-14.

The Board has repeatedly held that a SNF acts through its staff and administrators, who as agents of their employers “make and implement policies, provide care, and perform the various responsibilities called for” by federal programs. *Beverly Health Care Lumberton*, DAB Ruling No. 2008-05, Denial of Petition for Reopening of DAB No. 2156, at 6 (2008); *Springhill Senior Residence*, DAB No. 2513, at 14 (2013) (for the purpose of evaluating facility compliance with Medicare participation requirements, a facility acts through staff and cannot dissociate itself from the consequences of its employees’ actions); *Kindred Transitional Care & Rehab. – Greenfield*, DAB No. 2792, at 14 (2017) (a facility “is properly held responsible” for employee misfeasance “by virtue of the obligations it assumes as a condition for receiving federal healthcare program monies”). Therefore, a SNF “whose administration and staff have been found not to be substantially complying with federal requirements is itself subject to administrative enforcement remedies” and “cannot avoid such remedies merely by attempting to disown the acts and omissions of its own staff and administration since the facility elected to rely on them to carry out its commitments.” *Beverly*, DAB Ruling No. 2008-05, at 6.

Furthermore, the Board previously has determined that a facility's responsibility for employee misconduct is not limited to circumstances where employees improperly or poorly executed assigned duties. Rather, the Board has made clear, an employee's deliberate wrongdoing – and even criminal misconduct – may properly be imputed to the facility where the employee had “the means and opportunity” to commit the misfeasance, by virtue of his or her assigned duties and facility access. *Kindred* at 14 (holding facility responsible for nursing assistant's sexual abuse and attempted sexual abuse of residents where employee “was in the facility and had access to the residents because the facility placed in him in the position to provide personal care to the residents, in the course of which he committed these acts”); *Springhill* at 14 (holding facility responsible for illicit images and videos of residents taken by nursing assistants while on duty and assigned to assist residents with activities of daily living).

Consistent with prior Board decisions, we conclude that the ALJ did not err in imputing ANR's misconduct to MCNH for purposes of evaluating whether MCNH complied with the Medicare participation requirements. MCNH acknowledged that it hired, trained and appointed ANR to serve as its Resident Trust Fund Account Manager for a period of more than one year. While ANR undisputedly abused that position by engaging in fraud and theft and deliberately concealed her misconduct from her employer, she had access to the resident funds and was able to carry out the misconduct because of the fiduciary duties and responsibilities that MCNH assigned to her, as the ALJ observed. ALJ Decision at 13. Moreover, we agree with the ALJ that “the fact that ANR was even able to act alone in misappropriating funds speaks to the inadequacy of Petitioner's safeguards for the resident trust account.” *Id.* at 15. Accordingly, we conclude that MCNH cannot disown ANR's misfeasance for purposes of evaluating its compliance with the Medicare participation requirements.

Furthermore, the fact that ANR's misconduct was not “care-related” does not make MCNH any less responsible for it. SNFs have a regulatory duty to develop and implement policies and procedures to protect residents from misappropriation of funds, just as they must to protect residents from abuse and neglect. ALJ Decision at 15 (citing 42 C.F.R. § 483.13(c)); *see also* Final Rule, Medicare & Medicaid Programs; Survey, Certification and Enforcement of Skilled Nursing Facilities and Nursing Facilities, 59 Fed. Reg. 56116, 56117 (Nov. 10, 1994) (stating that the enforcement scheme “was built on the assumption that *all* requirements must be met and enforced and that requirements take on greater or lesser significance depending on the circumstances and resident outcomes in a particular facility” (emphasis added)). Indeed, section 483.13(c), by its own terms, makes clear that misappropriation of resident property is no less improper staff treatment of residents than mistreatment, abuse or neglect.

Staff treatment of residents. The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.

42 C.F.R. § 483.13(c) (emphasis added); *see also* 42 C.F.R. § 483.13(c)(2) (providing that “all alleged violations involving mistreatment, neglect, or abuse, including . . . misappropriation of resident property are reported immediately to [the persons identified in the regulation]” (emphasis added)). In addition, as discussed below, a violation of resident rights (including misappropriation of resident property) may carry the potential for more than minimal harm or even severe harm. Accordingly, we not only agree with the ALJ that there is “no reason to hold Petitioner to a lower standard in this case simply because its staff is accused of misappropriation rather than abuse or neglect[,]” ALJ Decision at 15, but conclude that the regulations do not permit such a lower standard.

We also note that the rationale for holding a facility responsible for the actions of dishonest or incompetent employees applies equally to care-related and non-care-related staff. Facilities carry out their responsibilities for meeting the participation requirements “in part through their selection, training and supervision of their staff.” *Life Care Ctr. of Gwinnett*, DAB No. 2240, at 12-13 (2009) (holding facility responsible for failing to implement anti-neglect policies as demonstrated by the actions of staff). Therefore, a facility is in the best position “to take action to prevent incompetent or dishonest individuals from harming residents.” *Id.* Sanctions on facilities for failing to develop or implement policies and procedures to prohibit misappropriation of resident funds serve the same goal, in part, as sanctions for failing to develop or implement policies and procedures to prevent resident neglect or abuse – to encourage “facilities to maintain hiring, training and supervision practices that protect residents.” *Id.* Therefore, to permit facilities to avoid sanctions where an employee assigned to manage resident funds engages in fraud or theft would allow facilities to “cut corners on staffing, training or supervision,” yet escape responsibility, and would thus disincentivize facilities from taking actions to prevent recurrence. *Id.*

Accordingly, we conclude that MCNH was accountable for ANR’s misconduct for the purpose of assessing MCNH’s compliance with the Medicare participation requirements.

- b. *Undisputed facts demonstrate that MCNH failed to meet the participation requirements in 42 C.F.R. §§ 483.10(c)(2), 483.13(c), and 483.75.*⁷

As set out above, section 483.10(c)(2) imposed on MCNH the duty “[u]pon written authorization of a resident,” to “hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility[.]” To comply with section 483.10(c)(2), MCNH developed written Resident Trust Fund Policies, which incorporated the language of the regulation and provided that “[t]he responsibility for the accuracy of the records remains with MCNH.” *Id.* CMS Ex. 13, at 12. We accept for purposes of summary judgment that MCNH trained ANR on these and other established facility policies and procedures for holding and managing residents’ personal funds in trust. P. Ex. 6, at 5 ¶¶ 15, 16. Nevertheless, it is undisputed that over the course of nearly a year, ANR mismanaged and misappropriated funds from multiple residents’ accounts by forging signatures and creating false documents, and she stole approximately \$1,110 from one resident between July 25 and August 26, 2013. P. Br. at 6, 9-11, 17; P. Ex. 6, at 9-10 ¶¶ 31, 32. As the ALJ noted, MCNH itself characterized ANR’s misconduct as “theft.” ALJ Decision at 12 n.3 (citing P. Br. at 9). Based on these uncontested facts and the facility’s responsibility for ANH’s misconduct discussed above, we conclude that MCNH failed to meet its regulatory duties under section 483.10(c)(2). Simply put, MCNH residents’ rights to have their personal funds held, safeguarded and properly managed were plainly violated through ANR’s deliberate theft and deception.

We also conclude that the undisputed facts demonstrate that MCNH failed to meet the requirements in section 483.13(c) to “develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.” Applying section 483.13(c) in cases of neglect, the Board has stated that noncompliance “can be based on either failure to develop policies or procedures adequate to prevent neglect, or failure to implement such policies.” *Glenoaks Nursing Ctr.*, DAB No. 2522, at 12 (2013); *see also Southpark Meadows Nursing & Rehab. Center*, DAB No. 2703, at 6 (2016). In the same context, the Board has held, “multiple or sufficient examples of neglect may support a reasonable inference that a facility has failed to develop or implement policies and procedures that prohibit

⁷ CMS also argued before the ALJ that MCNH did not substantially comply with 42 C.F.R. § 483.10(c)(3), requiring a facility to deposit each resident’s personal funds exceeding \$50 in an interest-bearing account. The ALJ concluded that he need not address this allegation because the allegations he did address supported the imposition of remedies and the reasonableness of the CMP amount. ALJ Decision at 13 n.4 (citing *Claiborne-Hughes Health Ctr. v. Sebelius*, 609 F.3d 839, at 847 (6th Cir. 2010); *Carrington Place of Muscatine*, DAB No. 2321, at 20-21 (2010)). For the reasons discussed above, we agree that MCNH’s other deficiencies justified the imposition and reasonableness of the CMP amount. Consequently, we concur in the ALJ’s conclusion that it is not necessary to address whether MCNH complied with section 483.10(c)(3).

neglect.” *Dumas Nursing and Rehab., L.P.*, DAB No. 2347, at 15 (2010) (citations omitted). “The focus,” however, “is not simply on the number or nature” of the incidents, but on whether the facts surrounding the incidents “demonstrate an underlying breakdown” or “systemic problem” in the facility’s implementation of its policies. *Oceanside Nursing & Rehab. Ctr.*, DAB No. 2382, at 11 (2011); *Columbus Nursing & Rehab. Ctr.*, DAB No. 2247, at 28 (2009).

The same principles logically apply where misappropriation of resident funds is at issue. Accordingly, to satisfy the requirements of section 483.13(c), MCNH was required not only to develop written policies to protect residents from deliberate, exploitive or wrongful use of resident property or money, but also to implement such policies. Here, we accept for summary judgment purposes that MCNH developed written policies and procedures to prohibit the misappropriation of resident property, including policies and processes for holding and safeguarding resident funds in trust. *See CMS Ex. 13*, at 1-4, 12-14. We conclude, however, that the undisputed facts show that MCNH did not satisfy its duty to implement those policies. It is undisputed that the individual hired and assigned by MCNH as the Resident Trust Fund Account Manager engaged in a deliberate and wrongful scheme to exploit residents by steeling and mismanaging their money. She directly and repeatedly violated facility policy, her fraudulent activities involved multiple residents, and her misconduct took place over a period of nearly a year. Given the frequency, duration, and scope of her misfeasance, we agree with the ALJ that the only reasonable inference is that MCNH’s “implementation of its anti-misappropriation policy broke down at a fundamental level.” ALJ Decision at 17-18.

The facility administration requirements provide that a SNF “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. MCNH argued that it “had fraud controls” and “multiple policies and procedures in place which prohibit theft, exploitation and/or misappropriation of resident property.” P. Br. at 11-13. In addition, MCNH asserted, due to ANH’s intentionally deceptive practices, management could not reasonably have suspected or detected that she was engaging in misappropriation. *Id.* at 10-11. These assertions appear to be an argument that management was administering facility resources effectively to ensure the well-being of its residents, as required under section 483.75. We disagree.

The Board has determined that “a finding that a facility was noncompliant with section 483.75 may, in appropriate circumstances, derive from findings of noncompliance with other participation requirements.” *Oceanside* at 15-16 (citing *Stone Cnty. Nursing & Rehab. Ctr.*, DAB No. 2276, at 15-16 (2009) (citing cases)). We agree with the ALJ that such circumstances exist in this case. ANR’s misconduct was not limited to a single instance of misappropriation of money from one resident’s trust account. Rather, she engaged in numerous suspicious activities, forged signatures, created false documents

and repeatedly violated facility documentation procedures over the course of nearly a year, mismanaging funds in multiple residents' accounts. That these activities continued unchecked over many months plainly demonstrates that MCNH lacked the supervisory and administrative mechanisms necessary to ensure that it met its regulatory obligations.

c. *MCNH was not in substantial compliance because its deficiencies posed the potential for more than minimal harm to resident health or safety.*

As stated above, “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 causing minimal harm.” 42 C.F.R. § 488.301 (also defining “noncompliance” as “any deficiency that causes a facility to not be in substantial compliance”). Therefore, summary judgment in favor of CMS is proper only if, giving MCNH the benefit of all reasonable inferences, the undisputed facts show that its deficiencies posed the potential for more than minimal harm to resident health or safety.

MCNH argues that “the actions taken by [ANR] simply never posed any danger to patient health or safety.” Reply at 4. According to MCNH, CMS failed to meet its initial burden on summary judgment “if for no other reason that the simple, undisputed fact in the record that ‘Petitioner purchased a surety bond covering the total amount held in the trust account on behalf of Petitioner’s residents.’” RR at 9 (quoting ALJ Decision at 10 (emphasis in RR)). Because the surety bond covered the entirety of funds in the patient trust accounts and was “untouchable by the employee,” MCNH says, there “was simply no potential that the residents could actually suffer any loss” or “mental anguish (as alleged by the ALJ) over this situation.”⁸ RR at 10 (emphasis in RR). “The circumstances also show that none of the money taken was earmarked for or affected resident care,” MCNH says, and “no involved resident knew the theft had even happened until after the facility discovered the theft, and all money was returned to the residents by the facility.” Reply at 5. Moreover, MCNH asserts, “a loss of confidence, no matter how ‘profound,’ does not equal danger to patient health or safety.” *Id.*

The regulations require every SNF to “purchase a surety bond, or otherwise provide assurance satisfactory to [CMS], to assure the security of all personal funds of residents deposited with the facility.” 42 C.F.R. § 483.10(c)(7). The CMS State Operations Manual (SOM), in turn, describes a “surety bond” as “an agreement between the

⁸ We note that the surety bond MCNH obtained contains conditions. MCNH has not addressed those conditions or what effect, if any, they might have on the ability of residents to recover any losses or the timing of any such recovery. See P. Ex. 1, at 1.

principal (the facility), the surety (the insurance company), and the obligee (. . . either the resident or the State acting on behalf of the resident), wherein the facility and the insurance company agree to compensate the resident (or the State on behalf of the resident) for any loss of residents' funds that the facility holds, safeguards, manages, and accounts for." CMS Pub. 100-07, App. PP (Guidance to Surveyors for Long Term Care Facilities).

A surety bond is only effective to repay funds stolen from resident accounts, however, if the fraud or theft is discovered, and, importantly, only pays after the fraud is discovered. A surety bond provides for compensation of financial loss once it is discovered; it does not prevent the loss. While the theft remains uncovered, the resident's financial well-being is threatened or compromised.⁹ Here, it is undisputed that ANR's misconduct lasted for nearly a year and was not exposed until one resident's responsible party (son) raised questions about withdrawals from the resident's account and the state agency surveyor asked for documentation of several resident trust account transactions. In light of these facts, we reject Petitioner's claim that its purchase of a surety bond meant that there was no possibility that a resident would suffer any financial loss because of its deficiencies. Accordingly, we cannot reasonably infer that MCNH's deficiencies posed no potential for residents to suffer significant financial losses.

Furthermore, MCNH's argument that there was no threat to patient health or safety disregards the potential for psychosocial harm that may result from the misappropriation of resident property or money. Psychological harm is as cognizable a form of injury as physical harm for purposes of evaluating deficiencies with the Medicare participation requirements. *Kindred* at 23 (citing, *inter alia*, *Springhill* at 18; SOM, App. Q (Guidelines for Determining Immediate Jeopardy) at 3 ("[p]sychological harm is as serious as physical harm"), 4-6 (Issues with associated "Immediate Jeopardy Triggers" include failure to protect from psychological harm)). In addition, program requirements take into account that nursing home residents are a vulnerable population; most have serious physical and mental impairments or conditions. *Daughters of Miriam Ctr.* DAB No. 2067, at 13-14 (2007). Accordingly, the Board has concluded that a facility's failure to timely investigate the misappropriation of resident property may constitute noncompliance. *Rosewood Care Ctr. of Swansea*, DAB No. 2721 (2016), *aff'd sub nom.*, *Rosewood Care Ctr. of Swansea v. Price*, 868 F.3d 605 (7th Cir. 2017).

⁹ Under the Mississippi Vulnerable Adults Act, any nursing home resident is considered a vulnerable person and exploitation against vulnerable persons includes theft or misuse of a resident's resources for another person's profit, advantage or unjust enrichment. Miss. Code Ann. § 43-47-5 (2018).

Moreover, CMS’s current guidance for nursing home surveyors, which reflects enhanced knowledge about resident safety and health outcomes, recognizes misappropriation of nursing home resident property or money as a source of psychosocial harm, including mental anguish. Instructive for our purposes, the SOM investigative protocol for an allegation of misappropriation of resident property directs surveyors, among other things, to review interdisciplinary notes that relate to the alleged misappropriation for documentation of any change in the resident’s mood and demeanor before and after the alleged misappropriation, such as “distrust,” “fear,” “angry outbursts,” “tearfulness,” “agitation,” “panic attacks” and “changes in sleeping patterns.” SOM, App. PP, F602.¹⁰ The SOM also instructs surveyors to take into account that “[f]acility staff are in a position that may be perceived as one of power over a resident.” *Id.*

In light of the fact that ANR held a position of trust and authority as Director of Social Services and Resident Trust Fund Account Manager, and recognizing that nursing home residents are a vulnerable population, susceptible to at least psychosocial harm from misappropriation of their property or money, we concur in the ALJ’s conclusion that MCNH’s deficiencies created a potential for more than minimal harm. ALJ Decision at 19. As the ALJ recognized, while “the sums stolen were relatively small, the real issue is that Petitioner’s residents entrusted Petitioner with that money, and Petitioner’s employee[’s] misappropriation of that money represents a serious breach of that trust.” *Id.* at 21 n.6. Thus, “the only reasonable inference that [may be drawn] from the undisputed facts of this case is that ANR’s misconduct carried *at least* the potential to cause more than minimal harm to Petitioner’s residents.” *Id.* at 19 (emphasis in ALJ Decision). By virtue of ANR’s position and the nature of the misfeasance, we agree with the ALJ, her misconduct – for which, we have concluded, MCNH is ultimately responsible – posed the potential for more than minimal harm to resident health.

¹⁰ The SOM contains CMS interpretive guidance; it does not have the force and effect of law. *Beverly Health & Rehab. Servs. v. Thompson*, 223 F. Supp. 2d 73, 99-106 (D.D.C. 2002), *aff’g Beverly Health & Rehab. – Spring Hill*, DAB No. 1696 (1999). The current version of Appendix PP, “Guidelines to Surveyors for Long Term Care Facilities,” (Rev. 173, 11-22-17), is available in PDF format on the CMS website at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/index.html>.) Appendix Q of the SOM, “Guidelines for Determining Immediate Jeopardy,” does not include examples of misappropriation in the list of “trigger” circumstances for surveyors to investigate for immediate jeopardy, as noted by MCNH. P. Br. at 19 (citing P. Ex. 20 (SOM App. Q)). Appendix Q expressly states, however, that the immediate jeopardy “triggers” listed are “general examples and ... not all-inclusive.” Moreover, that the earlier version of Appendix PP did not describe the psychosocial harm that may result from misappropriation of resident property and that Appendix Q does not expressly list misappropriation of resident property as an immediate jeopardy “trigger” does not preclude CMS, the ALJ, or us from considering whether MCNH’s deficiencies posed the potential for more than minimal harm.

3. *The ALJ's conclusion that CMS's immediate jeopardy determination is not reviewable in this forum is free from error.*

The ALJ stated that under the governing regulations, an ALJ may review CMS's scope and severity findings (including a finding of immediate jeopardy) "only if a successful challenge would affect: (1) the range of the CMP amounts that CMS could collect; or (2) a finding of substandard quality of care that results in the loss of approval of a facility's NATCEP." ALJ Decision at 20 (citing 42 C.F.R. § 498.3(b)(14), (d)(10)(i)-(ii)). MCNH argued that its challenge fell into the first category. ALJ Decision at 20 (citing P. Reply at 3-4). The ALJ disagreed, explaining that because CMS imposed a per-instance CMP against MCNH, a successful challenge to the immediate jeopardy finding would not affect the range of the CMP amount that CMS could collect. Hence, the ALJ concluded, he had no authority to review the immediate jeopardy finding.

The ALJ's conclusion is correct. During the period of the surveys and CMS's determination, the monetary range for a per-instance CMP was \$1,000-\$10,000. 42 C.F.R. §§ 488.408(d)(1)(iv), (e)(1)(iv). This range applied to all per-instance CMPs, regardless of the level of noncompliance. *Id.*; compare 42 C.F.R. §§ 488.408(d)(1)(iii) and 488.408(e)(1)(iii) (providing two ranges for per-day CMPs, depending on the level of noncompliance). Because CMS imposed a "per-instance" CMP, and because per-instance CMPs are imposed within a single dollar range (\$1,000 to \$10,000), see 42 C.F.R. § 488.438(a)(2), a successful challenge to CMS's immediate jeopardy finding would not have affected the range of the CMP that could be imposed. See, e.g., *NMS Healthcare of Hagerstown*, DAB No. 2603, at 6-7 (2014), *appeal dismissed*, *NMS Healthcare of Hagerstown v. U.S. Dep't of Health & Human Servs.*, 619 F. App'x 225 (4th Cir. 2015). Furthermore, the second category does not apply either. Although the state agency made a substandard quality of care finding in this case that, as a matter of law, removed any authority MCNH may have had to conduct a NATCEP, MCNH acknowledged that it did not have a NATCEP when CMS issued its notices of noncompliance. RR at 12 n.9. We conclude that, because review of the immediate jeopardy finding would not affect the applicable CMP range, and because the substandard quality of care finding did not result in MCNH losing approval of a nurse aide training program, MCNH does not have a right to an ALJ hearing or Board review concerning CMS's immediate jeopardy determination. *Oaks of Mid City Nursing & Rehab. Ctr.*, DAB No 2375, at 23-24 (2011).

MCNH acknowledges the limitation imposed by the regulations, but contends that CMS's immediate jeopardy determination is subject to review "because equitable estoppel is allowed where there is affirmative misconduct on the part of CMS" and CMS engaged in such misconduct here. RR at 4. MCNH alleges that CMS imposed an immediate jeopardy designation "for a situation which clearly does not

justify it, and then intentionally took every step it could in an attempt to make that designation unappealable.” *Id.* at 1. According to MCNH, CMS acted in bad faith by twice revising the SOD with descriptive language to show there was an immediate jeopardy situation where it did not exist; by intentionally withholding independent informal dispute resolution (IIDR) process findings that immediate jeopardy did not exist; by unfairly singling out MCNH when multiple other facilities had similar misappropriation deficiencies but were cited at lower levels of noncompliance; and by imposing the per-instance CMP to preclude review of the immediate jeopardy designation on appeal. *Id.* at 2-3. “In light of the bad faith with which CMS has conducted this entire matter and which constitutes affirmative misconduct on CMS’s part,” MCNH asks for “equitable relief in the form of review of CMS’s [immediate jeopardy] finding, even though such a designation does not affect the range of penalties available for a per-instance civil monetary penalty.” Reply at 8; *see also* RR at 4.

ALJs and the Board are bound by applicable statutes and regulations, and may not ignore or refuse to apply those laws. *Experts Are Us, Inc.*, DAB No. 2322, at 10 (2010); *see also Sentinel Med. Labs., Inc.*, DAB No. 1762, at 9 (2001), *aff’d sub nom., Teitelbaum v. Health Care Fin. Admin.*, 32 F. App’x 865 (9th Cir. 2002). The regulations applicable to this case clearly preclude review of CMS’s immediate jeopardy determination because CMS elected to impose a per-instance CMP, and MCNH did not lose approval of NATCEP. They also preclude ALJ and Board review of CMS’s choice of alternative sanction or remedy, in this case the per-instance CMP to which MCNH objects. 42 C.F.R. § 498.3(d)(11). In sum, we are bound by the regulations, which do not recognize an exception for reviewing an immediate jeopardy determination based on principles of equity.

Moreover, MCNH’s allegation of “bad faith” on the part of CMS is based on a mischaracterization of the legal effect of IIDR findings. MCNH says that the IIDR **“overturned the [immediate jeopardy] finding, reducing all cited deficiencies from a K level scope/severity to non-[immediate jeopardy level] deficiencies.”** RR at 7 (emphasis in RR). CMS is not bound to follow or defer to an IIDR determination, however. “The informal dispute resolution process (which includes IIDR) offers facilities an informal opportunity to dispute survey findings.” *Kindred* at 21 (citing 42 C.F.R. §§ 488.331, 488.431; SOM, Ch. 7, §§ 7212, 7213). CMS is not required to accept informal dispute resolution results, and it “has the ultimate authority for the survey findings and imposition of CMPs.” *Kindred* at 21 (citing 42 C.F.R. § 488.431 (IIDR); SOM, Ch. 7, § 7213.3 (IIDR); SOM, Ch. 7, § 7213.4 (IIDR “is not intended to be a formal or evidentiary hearing nor are the results of the [IIDR] process an initial determination that gives rise to appeal rights pursuant to [42 C.F.R. § 498.3(b)]. The [IIDR] results are recommendations to the State and CMS and are not subject to a formal appeal.”)). Furthermore, “once CMS proceeds with enforcement action following completion of [a] state agency level investigation, on the facility’s appeal of CMS’s

deficiency citation to the ALJ, the outcome of the informal dispute resolution process is no longer the issue.” *Kindred* at 22.

We further find no merit in MCNH’s argument that CMS treats cases of misappropriation inconsistently and that this should be a basis for reviewing and reversing CMS’s immediate jeopardy determination here. MCNH avers that it has received far harsher treatment than other facilities whose noncompliance based on misappropriation of residents’ money involved larger sums of money, more residents, and longer periods of noncompliance. RR at 17. Moreover, MCNH contends, “CMS so clearly understands” that misappropriation of property cannot pose immediate jeopardy that it cited immediate jeopardy only four times in cases cited under Tag F-159 (facility management of resident personal funds) from February 5, 2009 through November 7, 2014. *Id.* at 16.

We first reject the notion that CMS is “inconsistent” simply because it chooses to impose different remedies in different cases when it is carrying out its responsibility to enforce the nursing home regulations. Moreover, the Board previously has held that “CMS’s treatment of other facilities cannot undercut [an appellant’s] responsibility to show that it was in compliance with the applicable legal requirements or remove CMS’s authority to take actions which it is authorized by statute and regulation to take in response to a facility’s noncompliance.” *Jewish Home of Eastern Pa.*, DAB No. 2254, at 14-15 (2009) (rejecting SNF request for Board to review and compare either the level of noncompliance or the choice of remedies in that case with those which SNF considered similarly-situated) (citations omitted), *aff’d*, *Jewish Home of Eastern Pa. v. Ctrs. for Medicare & Medicaid Servs.*, 693 F.3d 359 (3rd Cir. 2012). Accordingly, whether CMS has evaluated cases of misappropriation differently is not relevant for purposes of this appeal. As the Board stated in the *Jewish Home* case, “allegations by a party against which an action has been taken that the treatment accorded to it is harsher than that accorded to others similarly situated do not prohibit an agency of this Department from exercising its responsibility to enforce statutory requirements[.]” *Id.* at 15 (citations and internal quotation marks omitted); *see also NMS Healthcare of Hagerstown* (rejecting claim that ALJ erred by declining to compare CMS immediate jeopardy determination based on excessively hot water temperatures in residents’ rooms to determinations of scope and severity in other cases involving excessively hot water temperatures); *Crawford Healthcare & Rehab.*, DAB No. 2738, at 21 (2016) (rejecting argument that CMP amounts should be reduced based on comparison of penalty amount in another case which SNF alleged involved similar circumstances) (citing cases).

4. *The amount of the CMP is reasonable.*

On appeal of a CMS determination of noncompliance that led to the imposition of a CMP, a SNF may challenge the amount of the penalty on the ground that it is unreasonable. *See, e.g., Lutheran Home at Trinity Oaks*, DAB No. 2111, at 21 (2007). In evaluating whether the CMS-imposed penalty amount is reasonable, an ALJ (or the

Board) considers the factors specified in section 488.438(f) of the regulations. *Senior Rehab.* at 19-20. Those factors are: (1) the SNF's history of noncompliance; (2) the SNF's financial condition; (3) factors specified in 42 C.F.R. § 488.404 (i.e., the severity and scope of the noncompliance, and "the relationship of the one deficiency to other deficiencies resulting in noncompliance"); and (4) the SNF's degree of culpability, which includes neglect, indifference, or disregard for resident care, comfort or safety. 42 C.F.R. §§ 488.438(f), 488.404. An ALJ (and the Board) reviews the reasonableness of the CMP de novo, based on the facts and evidence contained in the appeal record. *Emerald Oaks* at 13; *CarePlex of Silver Spring*, DAB No. 1683, at 14-15 (1999).

As noted, during the period at issue here, the penalty amount for a per-instance CMP was \$1,000 to \$10,000, regardless of whether the noncompliance constituted immediate jeopardy. 42 C.F.R. § 488.438(a)(2), 488.408(d)(1)(iv). CMS imposed the maximum amount within that range, \$10,000, for MCNH's noncompliance. The ALJ concluded that amount was reasonable.

On appeal of the ALJ Decision, MCNH argues that the amount of the CMP is unreasonable because it was in substantial compliance. RR at 22. Alternatively, MCNH contends, if its deficiencies constituted noncompliance, the circumstances did not rise to the level of immediate jeopardy. *Id.* MCNH also says that "the CMP amount is unreasonable in light of the factors at 42 C.F.R. § 488.404, and should be lowered accordingly." *Id.* Before the ALJ, MCNH asserted that the CMP amount was unreasonable in light of its past history. Specifically, MCNH said, it had been cited for no immediate jeopardy deficiencies in at least the prior 12 years, no deficiencies related to sections 483.10(c)(2)-(5), 483.13(c), or 483.75 in any survey for at least the two years prior to the October 2013 surveys, and it had no prior history of misappropriation of resident property. P. Br. at 24-25. MCNH also contended that it was not culpable. *Id.* at 25.

Applying the relevant factors to the undisputed facts in this case, we conclude that the CMP amount imposed by CMS was reasonable. Accepting for purposes of summary judgement that MCNH had no recent history of noncompliance that posed immediate jeopardy or violations involving the same participation requirements at issue here, the seriousness of the deficiencies in this matter alone justifies the imposition of the maximum penalty amount in the per-instance CMP range. As discussed above, an MCNH employee who was in a position of trust and authority, and in whom MCNH had placed fiduciary responsibilities, engaged in a long-running fraud that involved numerous residents' accounts. While MCNH had policies and procedures designed to prevent misappropriation, the misfeasance occurred and continued for nearly a year. Thus, MCNH failed to comply with Medicare requirements for safeguarding residents' funds, protecting residents from misappropriation of their money, and effective administration, and these failures posed the potential for more than minimal harm to resident health and safety. Indeed, CMS determined that the deficiencies were so serious as to constitute

immediate jeopardy, and we have no authority to review that determination. Lastly, as noted by the ALJ, section 488.438(f)(4) of the regulations states that the “absence of culpability is not a mitigating circumstance in reducing the amount of the penalty.” Accordingly, even if we accepted that NCNH was not culpable, we could not reduce the CMP amount for that reason. Moreover, NCNH’s culpability argument is based on its argument that it cannot be held responsible for the theft committed by its employee, an argument we have rejected.

Conclusion

For the reasons discussed above, we affirm the ALJ Decision.

_____/s/
Leslie A. Sussan

_____/s/
Constance B. Tobias

_____/s/
Sheila Ann Hegy
Presiding Board Member