Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Somerset Place,
(CCN: 14-E163),

Petitioner

v.

Centers for Medicare and Medicaid Services.

Docket No. C-10-386

Decision No. CR2164

Date: June 22, 2010

DECISION GRANTING SUMMARY DISPOSITION TO CENTERS FOR MEDICARE AND MEDICAID SERVICES

I grant summary disposition to the Centers for Medicare and Medicaid Services (CMS) and against Petitioner, Somerset Place, sustaining CMS's determination to impose remedies consisting of: termination of Petitioner's Medicaid provider agreement; denial of payment for new Medicaid admissions for each day of a period beginning on November 30, 2009 and running through February 6, 2010; and civil money penalties of $6,050 per day for each day of a period beginning on January 8, 2010 and running through February 7, 2010. I deny Petitioner's cross motion for summary disposition.

I. Background

Petitioner is a 450-bed nursing facility in Chicago, Illinois. It provides long-term care to mentally-ill residents. Petitioner participated in Illinois' Medicaid program. Its participation in Medicaid is governed, in part, by section 1919 of the Social Security Act (Act), and its implementing regulations at 42 C.F.R. Parts 483 and 488. 42 C.F.R. Part 498 governs Petitioner's hearing rights in this case.

Federal compliance surveys were conducted at Petitioner's facility on January 15 (January Survey) and February 5 (February Survey) 2010. At each of these surveys, the federal surveyors found multiple instances of immediate jeopardy level noncompliance with participation requirements. CMS concurred with these findings and imposed the remedies that I describe in the opening paragraph of this decision.

Petitioner requested a hearing, and the case was assigned to me for a hearing and a decision. CMS moved for summary disposition, and Petitioner opposed the motion. Petitioner also filed a cross motion for summary disposition.[1] CMS filed a total of 100 proposed exhibits (CMS Ex. 1 – CMS Ex. 100), and Petitioner, in opposition, filed a total of 14 proposed exhibits (P. Ex. 1 – P. Ex. 14). I receive all of these exhibits into the record, and I cite to them in this decision when appropriate.

II. Issues, Findings of Fact and Conclusions of Law

A. Issues

The issues in this case are whether:

1. Petitioner manifested immediate jeopardy level noncompliance with Medicaid participation requirements; and

2. CMS's remedy determinations were reasonable.

B. Findings of Fact and Conclusions of Law

CMS alleges that Petitioner manifested four immediate jeopardy level deficiencies. In this decision, I address three of those deficiencies, which I find that the undisputed material facts support. These deficiencies are Petitioner's immediate jeopardy level failures to:

- Investigate allegations of abuse or mistreatment of residents as 42 C.F.R. § 483.13(c)(2) requires;

- Provide its residents with adequate supervision and to protect them from foreseeable accident hazards as 42 C.F.R. § 483.25(h) requires; and

[1] Petitioner's brief, which is 49 pages long, violates the requirement in my initial pre-hearing order that pre-hearing briefs not exceed 25 pages. Petitioner neither moved for leave to file a brief that exceeds my page limit nor did it provide an excuse for violating my pre-hearing order. I considered rejecting the brief but, instead, allowed CMS to file a reply brief not exceeding 15 pages.

- 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 as 42 C.F.R. § 483.75 requires.

I do not address a fourth alleged deficiency, consisting of Petitioner's alleged failure to protect residents against abuse, because I find that disputed issues of material fact exist surrounding this allegation of noncompliance. However, I find that it is not necessary that I decide this allegation to sustain the remedies that CMS determined to impose. The undisputed material facts establishing noncompliance with the requirements of 42 C.F.R. §§ 483.13(c)(2), 483.25(h), and 483.75 provide ample justification for CMS's remedy determinations.

In deciding this case, I am mindful that I am entering summary disposition. I have made no findings of noncompliance that are based on disputed facts. Nor have I drawn inferences favorable to CMS from the undisputed material facts where other inferences favorable to Petitioner might reasonably be drawn.

I make the following findings of fact and conclusions of law (Findings).

1. Undisputed material facts establish that Petitioner failed to comply with the requirements of 42 C.F.R. § 483.13(c)(2).

In relevant part, the applicable regulation requires that a facility must ensure that:

> *all* alleged violations involving mistreatment, neglect, or abuse, . . . are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures . . . .

42 C.F.R. § 483.13(c)(2) (emphasis added). The requirement to report "all" allegations means exactly what it says. The regulation affords no discretion to a facility's staff to decide what allegations are sufficiently credible to be reportable. Failure to report an allegation of abuse is noncompliance with the regulation, even if the staff finds the allegation not to be believable.

There is an obvious reason for this categorical requirement. The reporting requirement is an assurance that unbiased fact finders will review an abuse allegation. It is, potentially, in a facility's self-interest not to report allegations of abuse or neglect. Such allegations, if substantiated, may put a facility at a risk of being subjected to remedies for noncompliance with regulations governing abuse and neglect. Requiring that all allegations be reported eliminates any possible conflict of interest on the facility's part.

CMS offered facts to show that Petitioner failed to report a resident's allegation of sexual abuse to the Illinois State survey agency. It was discovered at the January Survey that, on December 17, 2009, a resident who is identified as Resident # 273 reported that another resident exposed himself to her. CMS Ex. 29 at 2. Petitioner's staff did not report that incident.

The resident's allegation was an allegation of sexual abuse, and the regulation required Petitioner to report it. Failure to report the allegation clearly violated the requirements of 42 C.F.R. § 483.13(c)(2).

In responding to these facts, Petitioner does not deny that it failed to report the abuse allegation. Rather, it argues at length that the underlying allegation of sexual abuse was baseless. Petitioner's Brief at 16-18. According to Petitioner, there are "genuine issues of material fact as to whether any sexual abuse occurred." *Id.* at 16. But, whether sexual abuse actually occurred is irrelevant. Petitioner had an absolute responsibility to report the alleged sexual abuse, even if subsequent investigation proved the allegation to be without merit.

2. Undisputed material facts establish that Petitioner failed to comply with the requirements of 42 C.F.R. § 483.25(h).

The applicable regulation requires a facility to provide supervision and other support to its residents to assure that these residents are protected against all foreseeable accidents. A facility's duty to its residents is to take every reasonable measure to protect them. It must assess its residents and its own premises to ascertain all foreseeable accident hazards and risks. It must identify all reasonable measures that are necessary to protect its residents. And, it must implement those measures.

CMS asserts that Petitioner and its staff failed egregiously to comply with these requirements.

- CMS contends that, as of both the January and February Surveys, Petitioner failed wholesale to supervise the 64 residents in its facility who were smokers and who its staff had identified as being at a high risk for starting fires or causing smoking related damages. CMS asserts that the undisputed facts establish that Petitioner's staff failed to comply with Petitioner's policy requiring that resident's rooms be searched for smoking contraband. As a consequence, smoking materials and other dangerous items were secreted in residents' rooms. Numerous incidents were identified in late 2009 and in January 2010. CMS Ex. 9 at 136-50. CMS contends that Petitioner's guards failed to pat down female residents, who returned to the facility from off-premises visits, thereby enabling them to bring smoking and other hazardous materials into the premises. *Id.* at 152-53. It contends also that Petitioner failed to enforce its own policy directing that smokers, who were identified as unsafe, attend group meetings to discuss safe smoking behavior.

Residents were essentially free to come and go from these meetings as they liked. CMS Ex. 9 at 132-50; CMS Ex. 38 at 2-3. The results of this inattention, according to CMS, were potentially disastrous. A resident, identified as Resident # 321 assisted another resident, identified as Resident # 353, to start a fire in her room by supplying that resident with matches. CMS asserts that Petitioner's failure to supervise its residents who smoked continued even after the surveyors provided Petitioner with the results of the January Survey. Indeed, according to CMS, as of the February Survey, widespread instances of unsupervised smoking and of failures to check residents for contraband continue. CMS Ex. 83; CMS Ex. 96.

- CMS argues that Petitioner's staff failed to keep track of residents whose access to the exterior of Petitioner's premises was supposed to be restricted. It contends that Petitioner's security guards failed to check the identification of residents leaving the facility and were unable to determine precisely which of Petitioner's residents had restricted access to the exterior. CMS Ex. 9 at 151-53. To support its assertions, CMS points to documented instances in which residents on restriction left the facility unaccompanied. CMS Ex. 9 at 153-57. In one instance, a resident eloped the facility and did not return for a month. *Id.*; CMS Ex. 95 at ¶ 15; CMS Ex. 37 at 7; CMS Ex. 21 at 44. CMS contends that residents who had histories of aggressive behavior or who had been identified as elopement risks were allowed to leave Petitioner's premises accompanied only by other residents who were selected to serve as escorts. CMS Ex. 9 at 186-90.

- CMS contends that Petitioner failed to prevent numerous incidents in which residents became involved in altercations with other residents. Instances of resident against resident altercations were discovered at both the January and February Surveys. At the January Survey, it was determined that, between September and December 2009, Petitioner's staff documented over fifty incidents of such altercations. These incidents included events in which: a resident struck others in the face and head; a resident threw an aluminum ashtray at a resident and struck other residents; a resident bit another resident on the wrist; a male resident physically attacked a female resident while she was by herself in a stairway; and a resident was assaulted so severely that the resident sustained a concussion and required hospital treatment. CMS Ex. 9 at 158-84; CMS Ex. 32 at 245-59; CMS Ex. 23 at 67; CMS Ex. 15 at 76; CMS Ex. 21 at 13; CMS Ex. 42 at 64-65, 86. CMS contends that additional incidents were identified at the February Survey including instances in which a resident who was known for aggressive behavior and assaults, and who had tested positive for drugs, threatened and pushed other residents around. CMS contends that Petitioner's staff failed to modify this resident's care plan to impose measures that might protect other residents.

The facts, which CMS asserts, paint a picture of a facility in which staff lost control over the residents. Petitioner's failure to supervise and protect residents posed obvious risks, and Petitioner and its staff clearly identified those risks. For example, Petitioner established a policy requiring residents to smoke only inside a designated smoking area to assure that they would be supervised when they smoked. CMS Ex. 50 at 1; CMS Ex. 95 at ¶ 11. The only reasonable inference that I can draw from the existence of this policy is that Petitioner's staff knew that there were potentially great dangers associated with allowing residents – many of whom suffered from serious mental disorders – to smoke unsupervised. However, based on the facts that CMS offered, Petitioner and its staff failed utterly to enforce these policies. The facts that CMS offered show, for example, that residents commonly smoked in areas that were off limits to smoking, and Petitioner's staff failed to stop this behavior. CMS Ex. 95 at ¶ 10; CMS Ex. 94 at ¶¶ 6-7; CMS Ex. 9 at 136-50.

The facts that CMS provided also show Petitioner's understanding that certain of its residents were not sufficiently trustworthy to leave the facility unattended. These facts further demonstrate that Petitioner's staff and, in particular, its security guards abdicated their responsibility to assure that residents' whereabouts were known at all times. Similarly, the facts that CMS presented show Petitioner's staff's wholesale failure to prevent altercations between residents and to protect residents from assault.

The failures that are depicted from CMS's offered facts, if not disputed by Petitioner, amount to noncompliance with the requirements of 42 C.F.R. § 483.25. They establish Petitioner's and its staff's massive failure to develop means to protect residents against obvious hazards and a parallel failure to implement protective policies.

I am not holding Petitioner strictly liable for the security breaches, the altercations, and the policy infractions that occurred at its facility. There may be times where unfortunate events occur despite a facility's best efforts to prevent them from happening. But, here, the facts that CMS offered lead only to the conclusions that Petitioner either failed to recognize that it had systemic problems on its hands or that it failed to address those problems despite knowing about them.

Petitioner does not adduce any facts that call into dispute those that CMS relies on. Rather, it argues that CMS either failed to offer facts that establish noncompliance or that any problems that CMS identified were unavoidable and beyond Petitioner's ability to control. I find these arguments to be without merit. Petitioner's arguments amount to a shrugging off of responsibility for protecting its residents against known harm. Essentially, Petitioner contends that it should be allowed to collect federal reimbursement for the services it provides to these residents, even if those services do not include giving the residents the supervision and protection that is required by law. That is an untenable assertion as is made evident by Petitioner's specific arguments in response to the facts offered by CMS.

Petitioner does not deny that there were residents who possessed contraband or who smoked in areas that Petitioner had designated as off limits to smoking. Nor does it deny that residents failed to attend mandatory smoking safety sessions. It defends against these undisputed facts by arguing that the events and incidents that CMS identified were unavoidable and that, therefore, Petitioner is not responsible for their occurrence.

Petitioner asserts that it was helpless to prevent unauthorized smoking materials from getting into its premises. Petitioner's Brief at 23.

> Somerset cannot foreclose community access to residents who are able to function independently in the community. Additionally, the inspection of residents returning from the community is limited to bags and purses and pat downs of clothing, pockets, and hoods . . . Due to the potential for sexual and physical abuse and dignity issues, the inspection policy forbids security pat downs near residents' private areas . . . As a result, residents can and do sneak smoking materials and other contraband into the facility by hiding it on their person in places where they know security cannot lawfully conduct a pat down. . . .

Id. at 23-24. These assertions raise no disputed facts. First, Petitioner effectively admits CMS's allegation that residents were smuggling contraband into Petitioner's premises. Moreover, Petitioner squarely avoids addressing CMS's contention concerning the failure of Petitioner to take action in the face of knowledge that residents were smuggling smoking materials and contraband into the facility. CMS is not alleging that guards failed to pat down residents in their "private areas" but that guards often failed to pat down or search returning residents at all. CMS Ex. 9 at 151-53. Moreover, the excuse given to the surveyors for the failure to search returning residents was that male guards could not conduct body searches of female residents. Petitioner has not offered any explanation for its failure to employ female guards for that purpose.

The acknowledged failure of Petitioner's efforts to prevent residents from smuggling contraband into the facility put Petitioner on notice that a highly dangerous situation existed on the premises. Petitioner knew that it had residents who were not trustworthy to smoke unsupervised. It knew also that residents were obtaining contraband smoking materials and smoking unsupervised. Residents were also obtaining and consuming illegal drugs. That knowledge imposed on Petitioner the duty to take all reasonable steps – including, if necessary, banning smoking on its premises altogether – to protect its residents against potentially disastrous consequences. Asserting helplessness in the face of this situation is not asserting a credible defense.

Petitioner asserts that a genuine issue of material fact exists concerning whether Resident # 321 provided Resident # 353 with the matches that she used to start a fire in her room. Petitioner's Brief at 22. This is so, according to Petitioner, because "CMS's allegations are wholly unsupported by the evidence." *Id.* In fact, both Resident # 321 and Resident

353 gave statements in which they acknowledged that Resident # 321 was the source of the matches that Resident # 353 used to start the fire. CMS Ex. 28 at 33. Petitioner offers no facts to challenge these statements. However, it is irrelevant who supplied Resident # 353 with the matches that she used to start a fire. The salient facts are that the resident gained access to contraband (matches) and that Petitioner, through failure to enforce its smoking policies, allowed contraband on its premises.

Petitioner does not deny that Resident # 321 – who it had determined to be an unsafe smoker – failed to attend mandatory group meetings that were intended to address unsafe smoking practices. Petitioner's Brief at 23. Thus, Petitioner admits CMS's allegation that Petitioner failed to enforce attendance at mandatory meetings for unsafe smokers. Its defense is that it could not enforce attendance, because residents have a right to refuse treatment. I find this defense to be without merit. First, Petitioner has offered no evidence showing that Resident # 321 – or any other resident, for that matter – consciously refused treatment. Petitioner offers nothing at all showing that the staff discussed treatment with the resident and that she willfully refused to accept it.

One might argue, perhaps, that failure to attend a mandatory meeting constitutes voting with one's feet and is, constructively, a refusal to accept treatment. But, if that is so, Petitioner cannot simply abdicate its responsibility to provide care to the resident, and, more importantly, it cannot abdicate its responsibility *to protect other residents*. Petitioner's staff knew Resident # 321 to be an unsafe smoker. The resident had possessed contraband and may have distributed contraband to another resident. If that resident refused treatment designed to address the risks that such behavior caused, then, that refusal imposed on Petitioner and its staff the obligation to develop urgently other treatment that would protect its other residents from Resident # 321's proclivities. For example, Resident # 321's apparent continued defiance of Petitioner's smoking policies might have been grounds to deny her smoking privileges altogether. Or, persistent refusal by the resident to cease obviously dangerous behavior might have been a basis for Petitioner to demand that she transfer from Petitioner's facility. But, simply ignoring the problem – as is demonstrated by Petitioner's failure to take any additional measures in the face of the resident's failure to attend mandatory meetings to address her unsafe smoking behavior – was no solution at all.

Petitioner asserts that it provided the resident with "frequent and extensive 1-to-1 personal supervision to address her behaviors." As support for this argument, Petitioner cites to nurses notes covering a period of approximately six months. *See* CMS Ex. 23 at 156-253. But, Petitioner has not identified any specific intervention or therapy that was intended to remediate the resident's proclivity to violate Petitioner's smoking restrictions. Furthermore, Resident # 321's failure to attend mandatory smoking education group meetings was not the only problem associated with that intervention. CMS offered facts to show that Petitioner had no system in place to identify which of its residents were

supposed to attend the group meetings. CMS Ex. 9 at 132. Moreover, the facts offered by CMS show that the curriculum of the meeting remained the same each week and offered nothing by way of individualized approaches to deal with problems that repeat offenders caused. *Id.* Petitioner did not even answer these allegations.

Petitioner does not deny CMS's allegations concerning unauthorized absences and elopements by residents. Petitioner's Brief at 25. Instead, Petitioner contends that residents "have a right to access the community and refuse treatment." *Id.* In other words, Petitioner asserts that it is powerless to intervene if residents choose to ignore restrictions on their access to the community and to come and go from the facility as they please.

Petitioner asserts that its policy on resident access to the community – which Petitioner acknowledges that it failed to enforce – is a "therapeutic plan and not a CMS requirement." Petitioner's Brief at 25-26. From this, Petitioner seems to contend that frequent unauthorized absences from its premises and even elopements were merely a refusal by residents to accept treatment. And, Petitioner contends that it was impotent to do anything about those residents who "refused treatment," because every resident has the right to refuse treatment.

One might argue that a mentally competent resident in a facility has a right to make an intelligent and informed decision about whether or not to accept care. But, no facts in this case support an inference that the residents who left Petitioner's premises without authorization or who eloped were competent individuals who made intelligent and informed decisions. Petitioner's facility is for mentally disturbed individuals. Protecting these individuals from the hazards of unrestricted access to the community – contrary to Petitioner's assertion – *is* a requirement that was imposed on Petitioner by 42 C.F.R. § 483.25(h), because such individuals were persons who could not be trusted to be away from Petitioner's facility unsupervised. Petitioner had a duty to protect them. Petitioner could not evade its responsibility by asserting that residents who left its premises without authorization or who eloped the premises were simply asserting their "rights."

Moreover, this is not a case of a few individuals who consciously decided not to comply with prescribed care. CMS offered facts to show Petitioner's staff's wholesale failure to protect its residents. Some residents' refusal to abide by facility rules is no justification for the staff's failure even to attempt to enforce those rules. The fact that some residents left the premises unauthorized is, thus, no defense to a failure by Petitioner's staff to have a system that would identify those residents who were restricted from leaving the premises unaccompanied. Nor is it a defense to CMS's assertion that some residents were allowed to leave the facility accompanied only by other residents without any system in place to assure that the residents would be safe while out in the community unsupervised.

What is most disturbing about Petitioner's arguments is that they defy the reality of what was occurring at Petitioner's facility. CMS alleges, and Petitioner does not deny, that residents with access to the outside community were bringing contraband into the facility. This then, is not a case of a few residents defying the rules. Rather, the picture painted by CMS – and not denied by Petitioner – is of a facility that had become thoroughly corrupted, because lax security measures enabled residents to use the premises for hazardous and illegal activities. Those facts should have caused Petitioner to impose, on an urgent basis, strict security measures and to do whatever was necessary to root out contraband and illegal activities. Yet, the undisputed facts show essentially that Petitioner acted as if it was impotent to change its residents' environment.

Moreover, Petitioner has offered no facts to show that residents actually made knowing and informed choices to refuse care. It has not provided me with any documents showing, for example, that facility staff advised specific residents that leaving the premises unauthorized was risky but that they chose to do so in spite of that advice.

Furthermore, Petitioner has not shown that residents who allegedly "refused care" by leaving the premises without authorization were determined to be mentally competent to make such decisions. Indeed, the only facts that I have to consider show precisely the opposite to have been the case. Petitioner's staff put residents on departure restriction, *because they had psychiatric problems*. Asserting, as Petitioner does, that these residents had a right to refuse care notwithstanding their psychiatric problems defies reality.

Petitioner offered facts concerning two of its residents, Resident # 336 and Resident # 341, as ostensible proof that it was supervising adequately those residents who left the premises. According to Petitioner, Resident # 336 was placed on restriction "only because he was newly admitted and generally such new residents are restricted to the facility for the first seven days after admission for observation and assessment." Petitioner's Brief at 26. And, according to Petitioner, the resident was assessed as being safe in the community during his first week at the facility. As respects Resident # 341, Petitioner asserts that the resident – who was on leave restriction – "unexpectedly bolted and ran through . . . [an] open door to escape the facility." *Id.* Petitioner argues that its staff gave chase and then notified the local police about the resident's elopement. Furthermore, according to Petitioner, it had "no authority to prohibit a resident who was assessed as safe in the community from accessing the community." *Id.* at 26-27. Finally, according to Petitioner, it could not reasonably foresee that the resident would elope.

These assertions simply beg the question of Petitioner's failure to supervise its residents. CMS does not premise its allegations of noncompliance primarily on Petitioner's failure to prevent unauthorized departures from its premises by Resident # 336 and Resident # 341. The thrust of CMS's allegations is that Petitioner had no system in place that would

assure that residents who left the premises only did so when authorized. The consequence of that systemic failure was that Petitioner's facility had become rife with contraband and unlawful activity. Petitioner would not be excused from failing to have such a system even if the care it gave to the two residents was not proof of noncompliance.

Furthermore, Petitioner's assertions concerning the two residents do not support inferences that it provided adequate care, even with respect to these individuals. In the case of Resident # 336, Petitioner is not asserting that the resident was authorized to leave the premises unsupervised but only asserting that he was assessed as being "safe" to leave the premises at some point after he had been placed on restriction. That does not respond to allegations that Petitioner failed adequately to supervise the resident when he was restricted from leaving the premises without supervision. CMS Ex. 9 at 155-56; CMS Ex. 37 at 7. As regards Resident # 341, Petitioner's assertion that the resident was free to leave the premises is belied by the fact that the facility had placed the resident on departure restriction the day before the resident eloped. Moreover, Petitioner has offered no justification for allowing the resident to be in the vicinity of an open door to the outside, through which the resident eloped.

Petitioner makes two arguments concerning the numerous resident against resident altercations that were documented at its facility. First, it contends that it was essentially powerless to prevent such altercations. According to Petitioner, "altercations were caused by conditions . . . [that it] could not control (*e.g.*, residents acting out regardless of . . . [its] reasonable precautions) or could not reasonably foresee." Petitioner's Brief at 28.

However, Petitioner has not offered any facts describing the "reasonable precautions" that it allegedly took to prevent resident against resident altercations. Nor has it provided facts to show that the altercations that occurred were unforeseeable. Consequently, the facts do not support Petitioner's assertions that altercations were either unavoidable or unforeseeable.

Second, Petitioner contends that disputed issues of fact exist concerning *some* of the residents who became involved in altercations. For example, Petitioner cites the case of Resident # 339, an individual who bit the hand of another resident during a dispute over some food. Petitioner does not deny the altercation occurred. Rather, it contends that it could not have foreseen that the altercation would occur, because the resident suffers from a schizoaffective disorder. Petitioner's Brief at 28. It cites the case of Resident # 330, who also bit another resident. Again, Petitioner does not dispute that the incident occurred. But, according to Petitioner, Resident # 330 suffered from schizophrenia and manic depression and that, therefore, its staff could not have foreseen that the use of a racial slur by another resident would have precipitated the attack that occurred. *Id.*

I do not disagree with Petitioner that the precise incidents, which resulted in altercations involving these and other specific residents, might not have been foreseeable. But, what should have been obvious to Petitioner and its staff is that the probability of resident against resident altercations was very high. Surveyors found that over 50 such incidents had occurred at Petitioner's facility in the weeks prior to the December Survey, and Petitioner has not denied that any of them occurred. The only reasonable inference that I can draw from the volume of resident against resident altercations is that the resident population at Petitioner's facility lived in constant jeopardy of being attacked. The unsafe environment should have prompted Petitioner to take urgent measures to protect its residents against attacks by other residents. Petitioner, however, has offered no facts showing that it recognized the problem, assessed the causes, and developed effective measures to deal with it.

What Petitioner and its staff *knew* about its residents – including those specific residents whose cases are cited by Petitioner – is that these were mentally unstable individuals whose disorders made them prone to engage in inappropriate conduct, including altercations with other residents. That was evident both from the specific conditions manifested by individual residents and from the overall nature of Petitioner's facility, a facility that was specifically intended to house individuals suffering from mental disorders. That knowledge put Petitioner on notice that it had to develop mechanisms to protect its residents. Saying that "stuff happens," or that a specific incident might not be foreseeable at the moment that it occurred, is simply no defense. Petitioner's arguments amount to an excuse for doing nothing effective in the face of a highly dangerous situation.

3. Undisputed material facts establish that Petitioner failed to comply with the requirements of 42 C.F.R. § 483.75.

CMS's allegations that Petitioner's facility was not administered in an efficient and effective manner derive essentially from CMS's allegations of other deficiencies. The thrust of CMS's argument is that responsibility for Petitioner's failures to protect its residents must lie with Petitioner's management inasmuch as the management's duties included preventing the kinds of systemic failures that were present at the facility. As additional evidence of poor management, CMS cites a statement that Petitioner's administrator made to the effect that Petitioner was powerless to prevent residents from bringing contraband into the facility. CMS Ex. 22 at 30.

The evidence that CMS relied on – even without considering CMS's allegations that abuse occurred at the facility and which I find to be disputed – provides a strong basis for me to conclude that the facility was neither efficiently nor effectively managed. The only reasonable inference that I can draw from the wholesale smuggling of contraband into the

premises, the residents' casual defiance of smoking policies, the numerous unauthorized departures by residents from the premises, and the many resident against resident altercations, is that Petitioner's management had lost control over the resident population. That is more than enough to support a finding of noncompliance.

Petitioner's defense to CMS's allegations is to argue that they rest on a flawed premise, namely, that Petitioner was noncompliant with other participation requirements. Petitioner's Brief at 29. However, and as I discuss in detail at Findings 1 and 2, the undisputed material facts of this case plainly establish Petitioner's noncompliance. I find no dispute as to whether Petitioner's facility was effectively or efficiently managed.

4. CMS's findings of immediate jeopardy are established by the undisputed material facts, and there are no facts to suggest that such findings are clearly erroneous.

"Immediate jeopardy" is a situation in which a facility's noncompliance with participation requirements is so egregious as to cause, or to be likely to cause, serious injury, harm, impairment, or death to one or more residents. 42 C.F.R. § 488.301. CMS presented facts, which if undisputed, provide ample support for the conclusion that Petitioner manifested immediate jeopardy level noncompliance.

First, Petitioner's failure to report an alleged incident of abuse showed Petitioner's and its staff's disregard for the rights of residents and a failure to treat seriously a situation that could have been extremely dangerous were it determined to have occurred. What is more troubling is not that Petitioner failed to report this alleged episode of abuse but that the failure to report it showed Petitioner's and its staff's lack of comprehension as to what is reportable and why. As I discuss above, at Finding 1, the reason why facilities must report all allegations of abuse, no matter how flimsy such allegations may with hindsight appear to be, is that facilities cannot be trusted to keep abuse investigations totally in house. An inherent conflict of interest exists between a facility's interest in not being subjected to sanctions and its duty to get to the bottom of, and address, any and all allegations of abuse. The risk is that a facility will sweep allegations under the rug to avoid the opprobrium and penalties that may be levied in the event that abuse allegations are verified.

Petitioner argues that CMS's determination of immediate jeopardy concerning the failure to report allegations of abuse is clearly erroneous, because no serious harm resulted from the failure to report. As support for this contention, Petitioner points to facts allegedly showing that the resident who claimed to have been abused suffered no apparent injury or lasting effects from the alleged abuse. Petitioner's Brief at 18.

However, the issue is not whether the resident who made allegations of abuse was actually harmed by abuse. Rather, it is whether Petitioner, by not understanding the nature of its duty to report allegations of abuse to appropriate State officials, exposed all of its residents to the likelihood of severe harm, or worse, in the event that they were abused and reported it to Petitioner's staff. Petitioner has adduced no facts to rebut the facts that CMS relied on and which lead to the inference that residents were in jeopardy as a consequence of Petitioner's failure to report allegations of abuse.

Second, Petitioner's failures to supervise and protect its residents created obvious jeopardy for these individuals. The undisputed facts of this case establish that Petitioner's facility contained contraband, including pyrotechnic material, such as matches. A resident used prohibited matches to set fire deliberately to her room. Residents openly flaunted Petitioner's smoking policy. Residents who were restricted from leaving the facility due to the hazards imposed by their mental illnesses were allowed to leave, either unsupervised, or with inadequate supervision. Fights and altercations among residents occurred with depressing frequency, and at least one resident was so seriously injured in an altercation that the resident needed hospital treatment.

All of these problems were as a consequence of a facility management that was lax in enforcing existing policies or in developing interventions that might protect the residents. The undisputed facts of this case establish a laissez faire attitude by management that clearly contributed to the uncontrolled resident environment. Even now, Petitioner's primary response to the problems that I have just outlined is, essentially, that it was powerless to address them.

Petitioner makes two principal arguments to support its contention that a dispute exists as to whether the determination of immediate jeopardy level failure to supervise and protect residents was clearly erroneous. First, Petitioner relies on its assertion that a dispute exists that there was actual noncompliance with 42 C.F.R. § 483.25. Additionally, Petitioner asserts that, if noncompliance existed, the February Survey abated it and that, therefore, there was no immediate jeopardy as of that survey.

I reject Petitioner's first argument for the same reasons that I found its defenses to the allegations of noncompliance with 42 C.F.R. § 483.25 to be without merit. As to its second argument, I find no disputed issues of fact as to whether the February Survey abated Petitioner's noncompliance. The undisputed facts show continuing noncompliance with the requirements of 42 C.F.R. § 483.25.

Petitioner argues that CMS's finding of Petitioner's continued failure to enforce its smoking policies and to protect vulnerable residents against the introduction of contraband to the facility is based on the same false premise that allegedly invalidates the January Survey findings: "that – merely because unsafe smoking incidents were noted during the revisit – … [Petitioner] was providing inadequate supervision." Petitioner's

Brief at 37. But, that was not the premise for CMS's findings of continued noncompliance. The noncompliance findings made at the February Survey, to be sure, were grounded on continued incidents of smoking in violation of Petitioner's policies and on the continued presence of contraband at the facility. Petitioner disputes none of the facts establishing these findings. However, CMS's findings were also grounded on the fact that Petitioner had not implemented any changes in its overall policies and procedures to eliminate the introduction of contraband into the facility. In fact, Petitioner has not pointed to any overall changes in its policies, programs, or procedures that it implemented in response to the January Survey findings.

Petitioner also addresses at length the additional incidents involving specific residents that CMS cited as continued evidence of noncompliance as of the February Survey. Petitioner's Brief at 37-43. It addresses findings made with respect to residents identified as Resident #s 96, 241, 98, and 207. *Id.* As respects Resident # 96, Petitioner contends that it did all that it could do to protect him against the hazards of unsupervised smoking. These protections, according to Petitioner, included: addressing the resident's unsafe smoking in his care plan; educating and reminding the resident to smoke only in designated smoking areas; and conducting random searches of his room when he displayed evidence of unsafe smoking. *Id.* at 38. Petitioner admits that, on February 2, 2010, just three days prior to the February Survey, an odor of marijuana was found on the resident and in his room. Petitioner then put the resident on 15-minute checks.

As respects Resident # 241, Petitioner asserts that it implemented its smoking policy for the resident by assessing the resident and addressing the resident's unsafe smoking practices in his care plan. Interventions allegedly consisted of: posting no smoking signs to remind the resident to smoke only in designated areas; encouraging him to attend safe smoking meetings; praising him for his attendance; providing him with activities as an alternative to his unsafe behavior; restricting him to the facility when he did not provide clean drug tests or was caught smoking inappropriately; requiring him to attend relapse prevention meetings; and observing him for illegal behavior. Petitioner's Brief at 39. Notwithstanding, a strong smell of smoke was observed in the resident's room on February 4, 2010, the day prior to the February Survey, and tobacco was found in the garbage can in his room.

Concerning Resident # 98, Petitioner acknowledges that on January 31, 2010, five days prior to the February Survey, burn holes were found in the resident's pillowcase caused by his smoking in his room. Petitioner's Brief at 40. On that date, the resident's room was searched and staff found matches and a cigarette carton containing four cigarettes. *Id.* Petitioner admits also that the resident had a history of violating Petitioner's smoking policy. These admitted violations occurred notwithstanding a care plan that included the following interventions: random room searches; quarterly smoking assessments; educating the resident about Petitioner's smoking policy; and praising him when he complied. *Id.* Petitioner asserts that it dealt with the January 31 findings by: putting the resident on 15-minute checks; requiring him to sign a behavioral contract stating that he

would be put on 30-day discharge with his next infraction; and completing a new smoking risk assessment. Nevertheless, on February 4, 2010, cigarette butts were found in the resident's room, and Petitioner responded by giving the resident notice that he would be discharged in 30 days. *Id.* at 41.

As for Resident # 207, Petitioner admits that the resident had a history of inappropriate smoking. Petitioner's Brief at 42. It asserts that it implemented a range of interventions on the resident's behalf including: one-on-one behavior counseling; a weekly incentive program to reward the resident for following Petitioner's policies; placing him on special observation after he had been found smoking inappropriately; and referring him to a smoking program. *Id.* Petitioner admits that on February 3, 2010, two days prior to the February Survey, the resident was found with contraband. In addition to smoking materials, a device that a member of Petitioner's staff described as a "make shift 'crack pipe'" was found in the resident's room, although no crack cocaine was found. Petitioner contends that it responded to these findings by sending the resident to a hospital and determining to discharge him on 30 days' notice.

For purposes of this decision, I accept as true all of Petitioner's representations about the history and conduct of the four residents, along with Petitioner's assertions about the interventions it attempted on the residents' behalf. I find that these facts do not amount to a defense against a continued finding of immediate jeopardy level noncompliance with the requirements of 42 C.F.R. § 483.25 as of the February Survey.

Although CMS cites specific examples of residents who violated Petitioner's smoking policy – and the four residents whose care I have discussed are among them – that is not the central thrust of CMS's argument. CMS contends that immediate jeopardy level noncompliance continued as of the February Survey because, and despite the noncompliance findings that were made in January, Petitioner had still not implemented *systemic changes* at its facility that would protect residents against wholesale violations of its smoking policy and the hazards associated with such violations.

What was lacking from Petitioner's response was any attempt by it to get to the root causes of the problem. The problem originated with an obvious inability on the part of Petitioner's staff to prevent contraband, including prohibited smoking materials and illegal drugs, from getting into the premises. Petitioner has not averred that, after the January Survey it tightened its security checks of residents or visitors entering the facility, nor has it averred that it developed a system that eliminated unauthorized departures by residents. In short, Petitioner's facility remained as vulnerable in February to the introduction of contraband as it was in January. That is ample basis for my conclusion of continued immediate jeopardy level noncompliance, and I make that conclusion even accepting Petitioner's assertions about the efforts it made on behalf of the four residents whose care I have discussed in detail.

Moreover, in discussing the care that it gave to the four residents, Petitioner once again falls back on the argument that it makes repeatedly concerning the many problems that existed at its facility. Essentially, it contends that it was helpless to protect the residents. That is an argument which, I conclude, finds no support in the facts that Petitioner alleged, because it is clear from the undisputed facts that Petitioner did not do all that it could do to protect its residents' welfare. The interventions that Petitioner implemented specifically for these residents were essentially meaningless so long as contraband was able to flow into Petitioner's facility. Petitioner did not take meaningful measures to prevent that from happening.

Petitioner provides no facts to show that it reformed its protocols between the January and February Surveys to protect its residents against unauthorized departures and elopements. That alone would be sufficient for me to find that there existed continued immediate jeopardy as of the February Survey.

Finally, Petitioner reiterates its arguments concerning its failure to protect residents from attacks by other residents. Essentially, it contends that it was as helpless to protect against resident against resident aggression in February as it was in January. I reject that assertion for the same reason that I rejected it previously. Petitioner also recites the case of a single resident, Resident # 299, as establishing facts that ostensibly would show that it abated immediate jeopardy by the February Survey. It discusses an altercation between Resident # 299 and another resident, Resident # 89, which occurred on January 29, 2010. Petitioner asserts that disputed issues of fact exist as to whether actual abuse was manifested in the altercation between the two residents. But, whether abuse existed – and indeed, whether the altercation caused lasting injuries – is irrelevant. The incident demonstrates a continued failure by Petitioner to protect residents against aggression by other residents.

As I have discussed above, the problem with resident against resident altercations is not addressed by looking at the specifics of any particular incident. What is striking about Petitioner's facility is the sheer quantity of such incidents – more than 50 occurring in the weeks prior to the January survey, and several more occurring in the period between the January and February Surveys – and the failure of Petitioner to look at these incidents as a systemic problem that required a revamping of Petitioner's overall policies designed to protect residents. Treating each of these incidents on a case-by-case basis does not get to the heart of the problem. What was evident about Petitioner's facility is that there was an overall lack of control and a general failure by Petitioner to guarantee its residents peace and security. Nothing offered by Petitioner shows a change in the fundamental condition of the facility between January and February 2010.

Finally, Petitioner has offered no facts to show that it reformed the management of its facility between the January and February Surveys. It simply reiterates its argument that no problem existed with its management, because CMS allegedly failed to show noncompliance with any of the other regulations cited in the January and February

Survey reports. I find that argument to be without merit here, as I have found it to be without merit previously.

5. The undisputed material facts establish CMS's remedy determinations to be reasonable.

The undisputed material facts of this case amply support the three remedies that CMS determined to impose. Indeed, Petitioner has offered no facts that would show the remedies to be unreasonable.

a. Termination of Petitioner's participation in Medicaid is reasonable as a matter of law.

The Act authorizes immediate termination of a nursing facility's participation in Medicaid, where a facility is found to manifest immediate jeopardy level noncompliance with participation requirements. Act § 1919(h)(5). The undisputed material facts of this case establish immediate jeopardy level noncompliance continuing through the February Survey. Consequently, termination of participation is authorized and is reasonable as a matter of law.

b. Denial of payment for new admissions is authorized as a remedy for Petitioner's noncompliance.

CMS is authorized to deny a State payments for new admissions to a nursing facility beginning with the date when the facility is found to be out of compliance with participation requirements. Act § 1919(h)(3)(C)(i). CMS determined to impose the remedy of denial of payment against Petitioner beginning with November 30, 2009 and running through February 6, 2010. Petitioner has offered no facts to show that it was complying with requirements on any of these dates. Consequently, the remedy is authorized.

c. Civil money penalties of $6,050 for each day of a period beginning with January 8, 2010 and running through February 7, 2010 are reasonable.

CMS may impose civil money penalties of up to $10,000 per day for each day of a nursing facility's noncompliance with participation requirements. Act § 1919(h)(3)(C)(ii). Implementing regulations provide that, to remedy immediate jeopardy level deficiencies, daily civil money penalties must fall within a range of from $3,050 to $10,000 per day. 42 C.F.R. § 488.438(a)(i). Regulations establish criteria for deciding where within this range an immediate jeopardy level penalty should fall. These criteria include: the seriousness of a facility's noncompliance; its compliance history; its culpability for noncompliance; and its financial situation. 42 C.F.R. §§ 488.438(f)(1) – (4); 488.404 (incorporated by reference into 42 C.F.R. § 488.438(f)(3)).

CMS argues that the seriousness of Petitioner's noncompliance, in and of itself, is sufficient to support penalties of $6,050 per day. It points to the many incidents of aggression against residents at the facility and the extreme hazards caused by flagrant noncompliance with smoking restrictions as a basis for the penalty amount. I agree. However, the undisputed material facts also show that Petitioner's culpability for noncompliance is quite high. The undisputed material facts of this case establish that for at least many weeks Petitioner's facility was one in which management had lost control over the residents. The residents in the facility were individuals with psychological problems and, by its own admission, Petitioner knew that many of them posed threats to themselves and to others. But Petitioner failed utterly to adopt systematic measures for curbing the unchecked violence and risky behavior that pervaded its premises. The result of Petitioner's inaction was that residents had easy access to contraband, including illegal drugs and pyrotechnic material. Residents lived at the facility under constant threat of violence. The lax management of the facility put residents in extreme danger.

Penalties of $6,050 per day are quite modest when measured against the seriousness of Petitioner's conduct and its culpability. They are at only the midpoint of the range of possible immediate jeopardy level penalties. They are certainly reasonable when considered in the context of the undisputed material facts of this case.

CMS initially alleged four immediate jeopardy level deficiencies and I have found three of them to be supported by the undisputed material facts. I conclude that it is unnecessary that I find the presence of all four of them to decide that the penalty amount of $6,050 per day is reasonable. Any one of the three deficiencies that I have found is by itself sufficient to support the full penalty amount.

Petitioner offered no facts to show that the penalties are unreasonable in either amount or duration aside from reiterating its contentions that Petitioner was always in compliance with participation requirements. I note, particularly, that Petitioner did not allege that its financial condition precludes it from paying the full penalty amount.[2]

/s/
Steven T. Kessel
Administrative Law Judge

[2] CMS offered undisputed facts showing that Petitioner earned profits from the facility in excess of $2 million.