**Department of Health and Human Services**

**DEPARTMENTAL APPEALS BOARD**

**Civil Remedies Division**

Dutchtown Care Center
(CCN: 26-5672),

Petitioner,

v.

Centers for Medicare and Medicaid Services.

Docket No. C-12-153

Decision No. CR2722

Date: March 13, 2013

# DECISION

Petitioner Dutchtown Care Center challenges the determination of the Centers for Medicare and Medicaid Services (CMS) that it was not in substantial compliance with program participation requirements. Petitioner also challenges CMS's imposition of a per-instance civil money penalty (PICMP) in the amount of $10,000. For the reasons discussed below, I find Petitioner was not in substantial compliance with program participation requirements, and that a PICMP of $10,000 is a reasonable enforcement remedy.

## I. Background

Petitioner is a skilled nursing facility located in St. Louis, Missouri. The Missouri Department of Health and Senior Services (state agency) conducted a complaint survey of Petitioner on September 26, 2011, and found Petitioner to be out of substantial compliance with the participation requirement at 42 C.F.R. §§ 483.13(b) and 483.13(c)(1)(i) (Tag F223, scope and severity level J).

By letter dated September 29, 2011, CMS notified Petitioner that it was imposing the following remedies: a PICMP of $10,000 for the deficiency at Tag F223; a denial of payment for new admissions (DPNA) effective September 30, 2011, and continuing until Petitioner achieved substantial compliance or its provider agreement was terminated; and termination of Petitioner's provider agreement on October 19, 2011, unless Petitioner alleged corrections and it was verified that immediate jeopardy to resident health and safety had been removed.

By letter dated October 13, 2011, CMS notified Petitioner that, based on a revisit survey conducted on October 12, 2011, it found that Petitioner had removed the immediate jeopardy, and therefore, its provider agreement would not be terminated on October 19, 2011. CMS informed Petitioner that it had not attained substantial compliance with federal requirements. CMS advised Petitioner that the DPNA, which was effective September 30, 2011, would remain in effect until Petitioner had achieved substantial compliance or its provider agreement was terminated. CMS advised Petitioner further that it would impose a per day CMP of $100 per day if it did not attain substantial compliance at the revisit.

By letter dated November 17, 2011, CMS notified Petitioner that a November 16, 2011 revisit established that Petitioner had achieved substantial compliance effective November 10, 2011. Consequently, CMS rescinded the DPNA as of November 10, 2011.[1]

Petitioner, through its Administrator, filed its request for hearing by a letter dated November 22, 2011. The case was docketed as C-12-153 and assigned to me for hearing and decision on November 29, 2011.

Petitioner filed an Entry of Appearance, which brought legal counsel into these proceedings, on December 1, 2011. On December 12, 2011, Petitioner filed a Motion for Leave to File Amended Request for Hearing, and attached to that Motion its proposed Amended Request for Hearing. CMS filed a Motion to Dismiss on December 16, 2011. On December 21, 2011, Petitioner filed a Response to CMS's motion to dismiss. Also, on December 21, 2011, CMS filed an opposition to Petitioner's motion for leave to file an amended request for hearing. On January 5, 2012, I issued a Ruling on Pending Motions and Order Establishing Procedures and Schedule for Pre-hearing Exchanges. I granted Petitioner's Motion for Leave to File Amended Request for Hearing, and denied CMS's motion to dismiss.

[1] As I note below, CMS filed a Motion to Dismiss. CMS attached the letters of September 29, 2011, October 13, 2011, and November 17, 2011, as exhibits to its motion.

I conducted an in-person hearing in St. Louis, Missouri on September 17-18, 2012. CMS offered exhibits (CMS Exs.) 1 through 10, which I admitted into evidence. Transcript (Tr.) 15. Petitioner offered exhibits (P. Exs.) 1 through 12, which I admitted. Tr. 16, 59, 171.

CMS called one witness, Surveyor Cassie Blum. Petitioner called the following witnesses: Mary Johnson, R.N., Petitioner's former Assistant Director of Nursing (ADON); Cheri Branch, R.N., Petitioner's former Director of Nursing (DON); Lily Landy, Petitioner's Administrator; and William Kuntz, M.S., licensed psychologist. The parties filed post-hearing briefs (P. Br. and CMS Br.) and post-hearing reply briefs (P. Reply and CMS Reply).

## II. Issues

The issues in this case are:

1. Whether Petitioner was out of substantial compliance with participation requirements; and

2. Whether the remedies imposed are reasonable.

## III. Applicable law

The statutory and regulatory requirements for participation by a long-term care facility are found at sections 1819 (SNF) and 1919 (NF) of the Social Security Act (Act) and at 42 C.F.R. Part 483.[2] Section 1819(h)(2) of the Act vests the Secretary of Health and Human Services (Secretary) with authority to impose enforcement remedies against a SNF for failure to comply substantially with the federal participation requirements established by sections 1819(b), (c), and (d) of the Act.[3] Pursuant to 1819(h)(2)(C), the Secretary may continue Medicare payments to a SNF not longer than six months after the date the facility is first found not in compliance with participation requirements. Pursuant to 1819(h)(2)(D), if a SNF does not return to compliance with participation requirements within three months, the Secretary must deny payments for all individuals admitted to the facility after that date – commonly referred to as the mandatory or

[2] All references are to the 2011 version of the Code of Federal Regulations (C.F.R.), which was in effect at the time of the survey, unless otherwise indicated.

[3] Section 1919(h)(2) of the Act gives similar enforcement authority to the states to ensure that NFs comply with their participation requirements established by sections 1919(b), (c), and (d) of the Act.

statutory DPNA. In addition to the authority to terminate a noncompliant SNF's participation in Medicare, the Act grants the Secretary authority to impose other enforcement remedies, including a discretionary DPNA, CMPs, appointment of temporary management, and other remedies such as a directed plan of correction. Act § 1819(h)(2)(B).

The Secretary has delegated to CMS and the states the authority to impose remedies against a long-term care facility that is not complying substantially with federal participation requirements. "*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 (emphasis in original). A deficiency is a violation of a participation requirement established by sections 1819(b), (c), and (d) of the Act or the Secretary's regulations at 42 C.F.R. Part 483, subpart B. 42 C.F.R. § 488.301. State survey agencies survey facilities that participate in Medicare on behalf of CMS to determine whether the facilities are complying with federal participation requirements. 42 C.F.R. §§ 488.10-.28, 488.300-.335. The regulations specify the enforcement remedies that CMS may impose if a facility is not in substantial compliance with Medicare requirements. 42 C.F.R. § 488.406.

CMS may impose a CMP for the number of days a facility is not in substantial compliance or for each instance of noncompliance. 42 C.F.R. § 488.430(a). The regulations specify that a CMP that is imposed against a facility on a per day basis will fall into one of two ranges of penalties. 42 C.F.R. §§ 488.408, 488.438. The upper range of a CMP, $3,050 per day to $10,000 per day, is reserved for deficiencies that pose immediate jeopardy to a facility's residents and, in some circumstances, for repeated deficiencies. 42 C.F.R. §§ 488.438(a)(1)(i), (d)(2). "*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." 42 C.F.R. § 488.301 (emphasis in original). The lower range of a CMP, $50 per day to $3,000 per day, is reserved for deficiencies that do not constitute immediate jeopardy but either cause actual harm to residents, or cause no actual harm but have the potential for causing more than minimal harm. 42 C.F.R. § 488.438(a)(1)(ii). A per instance CMP may range from $1,000 to $10,000, and the range is not affected by the presence of immediate jeopardy. 42 C.F.R. § 488.438(a)(2).

The Act and regulations make a hearing before an administrative law judge (ALJ) available to a long-term care facility against which CMS has determined to impose an enforcement remedy. Act §§ 1128A(c)(2), 1866(h); 42 C.F.R. §§ 488.408(g), 498.3(b)(13). The hearing before an ALJ is a *de novo* proceeding. *The Residence at Salem Woods*, DAB No. 2052 (2006); *Cal Turner Extended Care*, DAB No. 2030 (2006); *Beechwood Sanitarium*, DAB No. 1906 (2004); *Emerald Oaks*, DAB No. 1800, at 11 (2001); *Anesthesiologists Affiliated*, DAB CR65 (1990), *aff'd*, 941 F.2d 678 (8th Cir.

1991). A facility has a right to appeal a "certification of noncompliance leading to an enforcement remedy." 42 C.F.R. § 488.408(g)(1); 42 C.F.R. §§ 488.330(e), 498.3. However, the choice of remedies, or the factors CMS considered when choosing remedies, is not subject to review. 42 C.F.R. § 488.408(g)(2). A facility may only challenge the scope and severity level of noncompliance that CMS determined, if a successful challenge would affect the range of the CMP that may be imposed or impact the facility's authority to conduct a NATCEP. 42 C.F.R. § 498.3(b)(14), (d)(10)(i). The CMS determination as to the level of noncompliance, including the finding of immediate jeopardy, "must be upheld unless it is clearly erroneous." 42 C.F.R. § 498.60(c)(2); *Woodstock Care Ctr.*, DAB No. 1726, at 9, 38 (2000), *aff'd*, 363 F.3d 583 (6th Cir. 2003). The Board has long held that the net effect of the regulations is that a provider has no right to challenge the scope and severity level assigned to a noncompliance finding, except in the situation where that finding was the basis for an immediate jeopardy determination. *See, e.g.*, *Ridge Terrace*, DAB No. 1834 (2002); *Koester Pavilion*, DAB No. 1750 (2000). ALJ review of a CMP is subject to 42 C.F.R. § 488.438(e).

The standard of proof, or quantum of evidence required, is a preponderance of the evidence. CMS has the burden of coming forward with the evidence and making a *prima facie* showing of a basis for imposition of an enforcement remedy. Petitioner bears the burden of persuasion to show by a preponderance of the evidence that it was in substantial compliance with participation requirements or any affirmative defense. *Batavia Nursing & Convalescent Ctr.*, DAB No. 1904 (2004), *aff'd*, 129 F. App'x. 181 (6th Cir. 2005); *Batavia Nursing & Convalescent Inn*, DAB No. 1911 (2004); *Emerald Oaks*, DAB No. 1800; *Cross Creek Health Care Ctr.*, DAB No. 1665 (1998); *see Hillman Rehab. Ctr.*, DAB No. 1611 (1997), *aff'd*, No. 98-3789, 1999 WL 34813783 (D.N.J. May 13, 1999).

## IV. Findings of Fact, Conclusions of Law, and Analysis

### A. Petitioner was not in substantial compliance with 42 C.F.R. §§ 483.13(b) and 483.13(c)(1)(i) (Tag F223).[4]

[4] In listing the participation requirement (regulation) that corresponds to Tag F223, the Statement of Deficiencies (SOD) cites "483.13(b), 483.13(b)(1)(i)." The citation to "483.13(b)(1)(i)" is in error, as there is no such subsection. The surveyors recite the language of 42 C.F.R. § 483.13(c)(1)(i) under Tag F223, and I recognize that the surveyors' reference to 42 C.F.R. § 483.13(b)(1)(i) was a clerical error.

The SOD also contains a deficiency citation under 42 C.F.R. § 483.13(c)(1)(ii)-(iii), (c)((2)-(4) (Tag F225); however, neither party has addressed the allegations pertaining to this citation. Because I resolve this case fully based on the F223 citation, it is not necessary for me to discuss Tag F225.

Before I discuss Tag F223, I note that, in its prehearing brief, CMS attempted to add a new deficiency citation to these proceedings, claiming that Petitioner's care of Resident 1 violated the "dignity" regulation at 42 C.F.R. § 483.15(a) (Tag F245). Petitioner objected to the addition of this alleged deficiency. Because I resolve this case fully by affirming the deficiency citation under Tag F223, it is not necessary for me to discuss the alleged "dignity" deficiency. Moreover, as discussed below, Petitioner's violation of Tag F223 fully justifies the PICMP.

Section 1819(c)(1)(A)(ii) of the Act requires that a SNF protect its residents and promote their "right to be free from physical or mental abuse, corporal punishment, involuntary seclusion, and any physical or chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms." The Secretary has provided by regulation that a "resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion." 42 C.F.R. § 483.13(b). The facility must "[n]ot use verbal, mental, sexual, or physical abuse, corporal punishment or involuntary seclusion." 42 C.F.R. § 483.13(c)(1)(i). The regulations define "abuse" to be "the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. 42 C.F.R. § 488.301. The phrase "willful infliction" means that the actor must have acted deliberately, not that the actor must have intended to inflict injury or harm. *Merrimack County Nursing Home*, DAB No. 2424, at 4 (2011); *Britthaven, Inc., d/b/a Britthaven of Smithfield*, DAB No. 2018, at 4 (2006).

CMS's allegations of noncompliance with 42 C.F.R. §§ 483.13(b) and 483.13 (c)(1)(i) arise out of an incident involving one resident, Resident 1, on September 8, 2011. The SOD alleges, based on interview and record review, that Petitioner failed to protect Resident 1 from emotional injury when its staff forced her to take a bath against her will. The SOD alleges that Resident 1 cried, yelled, and screamed that she did not want a bath. The SOD alleges further that, after the incident, Resident 1 was distraught and fearful for several days. CMS Ex. 1, at 1.

**Incident of September 8, 2011**

On September 8, 2011, during a morning census staff meeting, Petitioner's Administrator, Lily Landy, announced that she had received complaints about Resident 1's body odor and stated that it was necessary to give Resident 1 a bath. After the meeting, Cheri Branch, R.N., Petitioner's Director of Nursing at the time, Mary Johnson, R.N., Petitioner's ADON at the time, and a CNA went to Resident 1's room. ADON Johnson told Resident 1 that she had to have a bath because of her odor. Resident 1 responded that "she doesn't want a bath, and she doesn't get baths, she takes bed baths." Tr. 97. Resident 1 asked to speak to the Administrator. ADON Johnson left the room to get Administrator Landy, but the Administrator was unavailable. When Petitioner's staff was transferring Resident 1 from her bed to the wheelchair using the Hoyer lift (a

mechanical lift), Resident 1 was screaming that she didn't want to have a bath. Resident 1 then grabbed the bed siderails and shook the lift. Resident 1 continued to scream, yell, and protest loudly as she was wheeled down the hallway to the tub room. During the bath, R1 was crying and whimpering. After the bath, Resident 1 was transferred back to her wheelchair, dressed, and returned to her room.

**Discussion**

Resident 1 was admitted to Petitioner's facility on December 31, 2009, with diagnoses that included late effects of acute poliomyelitis, left femur fracture, acute kidney failure, coronary artery disease, congestive heart failure, head lice, and depressive disorder. CMS Ex. 1, at 1; CMS Ex. 4, at 12, 14-16. Resident 1's care plan dated August 19, 2011, stated, among other things, that she was "at risk for skin impairment 2/2 weakness and decreased mobility r/t disease process. [Resident 1] is obese and often gets excoriated under her abdominal folds." P. Ex. 1, at 19. The goal with respect to R1's skin was to keep it free from skin breakdown with good skin integrity. As an approach, the care plan directed staff to "[k]eep skin clean & dry. Wash with soap, rinse & dry." P. Ex. 1, at 19. Resident 1's care plan noted that Resident 1 "[p]refers bed baths for bathing however with encouragement she will shower/bath tub." P. Ex. 1, at 18. Earlier care plans dated January 1, 2011 and April 8, 2011 contained identical notations concerning Resident 1's skin and her preference for bed baths. P. Ex. 1, at 2-3, 10-11. According to a care plan dated January 12, 2010, which appears to have been in effect through April 12, 2011, Resident 1was to "be kept clean and odor free daily." The care plan noted, under "Problem" that Resident 1 "requires physical help in part of bathing activity (during full-body bath, sponge bath, including transferring in/out of tub/shower; exclude washing of back and hair.)" Among other approaches, the plan directed staff to "bathe to prevent odor as necessary." CMS Ex. 4, at 11.

Petitioner does not deny that on September 8, 2011 Resident 1 vigorously protested that she did not want to have a bath and physically resisted staff's efforts to give her a bath. However, Petitioner argues that Resident 1 suffered no harm from the bath incident, either physically, mentally or psychologically. Petitioner contends that because bed baths were not adequately addressing Resident 1's hygiene needs, its staff acted reasonably and out of necessity in giving Resident 1 a tub bath. Petitioner claims that its staff had to balance Resident 1's preference not to have a bath against the need to protect her health and that of the other residents from the adverse conditions presented by her body odor, as well as to preserve the other residents' rights "to enjoy their meals and other social interactions in an environment that is absent the serious body odor of another resident." Petitioner's Prehearing Memorandum at 3. Petitioner contends that its staff determined that Resident 1's wishes were outweighed by these other larger concerns that affected both her and the other residents.

I find that the evidence in this case establishes that, on September 8, 2011, Petitioner's staff subjected Resident 1 to both physical and mental abuse when they forced her to take a bath, despite her vehement and tearful protests that she did not want one. The conduct of Petitioner's staff, in ignoring Resident 1's explicit wishes and using physical coercion to make her take a bath clearly frightened, intimidated, and emotionally harmed Resident 1. Consequently, Petitioner failed to comply substantially with the requirements of 42 C.F.R. §§ 483.13(b) and 483.13(c)(1)(i).

As the record shows, the unfortunate bath incident involving Resident 1 grew out of Administrator Landy's comments to staff in the September 8, 2011 morning "standup meeting" that "R1needs a bath."[5] Tr. 160-61. According to Administrator Landy, in the days prior to the bath incident, she had received complaints from two residents and a family member of another resident about Resident 1's body odor. Tr. 159-60. Administrator Landy testified that she personally verified that Resident 1 had a body odor when she served the resident her lunch. Tr. 160. When asked about the statement in Resident 1's August 19, 2011 care plan that the resident preferred bed baths but would shower or use the bathtub, Administrator Landy stated that Resident 1was present at the care plan meetings and would have had input or been aware of this statement in her care plan. Tr. 175-76; *see* P. Ex. 1, at 18.

When I questioned Administrator Landy as to whether she expected staff to act on her statement that Resident 1 needs a bath, she responded, "I expected that the staff would go and clean her up." Tr. 199-200; *see* Tr. 193. On cross-examination, Administrator Landy testified that she had a "reasonable expectation" that Resident 1 would be given a bath the same day. Tr. 206. She testified that she was aware that Resident1 normally received bed baths, but also stated "[a]t that point in time I didn't think it mattered to the resident." Tr. 193, 194. If the resident had refused the bath, Administrator Landy stated that she would have expected staff to return later in the day to give her the bath. Tr. 206. According to Administrator Landy, she "expected the staff to free the resident of the odor" and that bed baths were not doing an adequate job of keeping Resident 1 clean. Tr. 206.
Administrator Landy acknowledged on cross-examination that residents have the right to refuse treatment, but when asked whether a resident has the right to refuse baths, she replied, "I think that depends." Tr. 204. She stated that "[a] resident has a right to refuse,

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[5] Petitioner's counsel, in questioning Administrator Landy, gives the date of the census meeting as September 9. Tr. 160. I note that this date is incorrect. The record reflects that the census meeting and the bath incident took place on September 8, 2011.

According to Administrator Landy, the attendees at the census meeting were the charge nurses from each floor; the DON, the ADON, social worker, MDS care plan coordinator, staffing coordinator, activities director, dietary manager, and housekeeping supervisor. Tr. 161.

but a resident does not have to inflict that on other residents." Tr. 209. She explained that Resident 1's odor was being inflicted on other residents and their visiting family members. Tr. 209. Administrator Landy explained that they would not give a bath to a resident who has a known phobia of baths or of getting into a bathtub but that Resident 1 did not have such a phobia, only a preference for bed baths over baths. Tr. 204.

It is obvious that whatever urgency existed with taking care of Resident 1's odor issue was created entirely by Administrator Landy, whose testimony indicates that she expected her staff to carry out her implicit orders at once. DON Branch, ADON Johnson, and a CNA thus immediately went to Resident 1's room to carry out her directive.[6] Although Resident 1 emphatically stated that she did not want a bath, and that she was to be given bed baths instead of baths, these employees ignored her explicit desire not to have a tub bath and told her in no uncertain terms that she would be getting a bath that morning. The situation escalated, with Resident 1 yelling and screaming that she did not want a bath and physically resisting staff's efforts to lift her out of her bed by the mechanical lift into her wheelchair. Tr. 107, 120-21. Apparently as a last-ditch effort, Resident 1 grabbed the side rails of her bed during the transfer, and, while continuing to scream and cry in protest, started to shake the lift as she was suspended in it. Petitioner disputes Resident 1's statement, as related by Surveyor Blum, that staff had to pry Resident 1's fingers loose from the side rails. P. Br. at 7; Tr. 40. Rather, according to Petitioner, both DON Branch and ADON Johnson told Resident 1 to take her hand off the rails, and she did. Tr. 107, 120. While the manner in which Resident 1's grasp was freed of the side rails may be in question, it is evident that she put up a vigorous struggle as she was being transferred to her wheelchair. In fact, Petitioner, citing the testimony of DON Branch and ADON Johnson, acknowledges that "[f]rom the time they lifted Resident 1 on the Hoyer lift through wheeling her down the hallway she was loud and screaming she did not want to take the bath." P. Br. at 8. According to DON Branch and ADON Johnson, once Resident 1 was lifted from the wheelchair into the tub for her bath, she was no longer physically resisting or loudly protesting, but was "whimpering and crying," and had ceased "screaming stop, stop, stop." Tr. 110-111, 121, 128.

Petitioner asserts that its treatment of Resident 1 was "caring, compassionate and nurturing . . . fully acknowledging of the fact that Resident 1 did not desire being given a tub bath." P. Br. at 24. On this evidence, however, I find quite to the contrary. Rather than being reassured by staff as Petitioner claims she had been, Resident 1 was put in a vulnerable situation in which she faced not only intimidating conduct, but also physical coercion. Resident 1clearly expressed her wishes, both verbally and physically, that she did not want to have a bath and wished to remain in her bed. However, her screaming and cries of protest fell on deaf — or worse, uncaring — ears. Over her vociferous

[6] According to Surveyor Blum's interview notes, Resident 1 told Surveyor Blum that she had been sleeping when DON Branch woke her up to tell her that she was going to get a bath. CMS Ex. 2, at 1.

objections, the DON and the ADON made it clear to Resident 1 that she would be getting a bath immediately and then proceeded forcibly to get her out of her bed using the Hoyer lift. Even when Resident 1 grabbed the side rails of her bed, staff made no effort to accede to her wishes, but continued with removing her from her bed against her will, and then ignored her screams and cries as they wheeled her to the tub room. There can be no dispute that Petitioner's staff inflicted a situation of intimidation and indignity, together with at least a measure of physical coercion and apprehension, upon Resident 1 and forced a bath upon her, and in doing so caused her to experience severe mental, emotional, and physical distress. This record shows that Petitioner's staff did so in an abrupt and confrontational fashion, with no efforts at persuasion, reassurance, or explanation. Their motivation in so acting is not difficult to discover: their Administrator's comments at the morning meeting put them on notice that she "expected staff would go and clean her up." Tr. 199-200. Had they not acted on her comments, the Administrator "would want to know the reason why." Tr. 200.

Resident 1 had a right as a nursing home resident to refuse to take a bath in a bathtub. Surveyor Blum testified that once Resident 1 told Petitioner's staff that she refused a bath, "[i]t should have been dropped and another avenue should have been explored." Tr. 44-45, *see* Tr. 87-88, 90. Petitioner's witness, DON Branch, testified on cross-examination that when a resident has refused treatment, the next step a nursing home would take is "usually we get the families involved but she really didn't have any, get the doctor involved, try to see maybe another staff member could get her to do what needed to be done." Tr. 125. DON Branch acknowledged that staff did not call Resident 1's doctor or attempt to get in touch with a former roommate of Resident 1 whom she referred to as "nephew." Tr. 125-26.[7] When asked what staff did, DON Branch stated "[w]e just really tried to convince her to take a bath." Tr. 125. When asked if that approach was working, DON Branch replied, "No" and stated further that "it seemed like that was something that we really had to do." Tr. 125, 126.

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[7] Surveyor Blum's interview notes include an interview with Resident 1's physician, Dr. Mahadevan. Dr. Mahadevan told Surveyor Blum that Petitioner's staff did not inform him of the incident with Resident 1 and he learned about it from the resident herself. Dr. Mahadevan acknowledged that Resident 1's hygiene had been poor over the years, but stated that staff acted inappropriately in forcing her to take a bath. He stated that he has known Resident 1 for 15 years, and that staff should have contacted him so he could have talked to her. Dr. Mahadevan also added, "I'm sure every day there, she will be suspicious that something else will happen to her." CMS Ex. 9, at 1. I realize that because Dr. Mahadevan did not testify at the hearing, Petitioner did not have an opportunity to cross-examine him regarding his statements to the surveyor. Petitioner has not, however, disputed Dr. Mahadevan's statements.

The Interpretive Guidelines contained in the State Operations Manual (SOM) is instructive and provides the following:

> If the resident refuses a bath because he or she prefers a shower or a different bathing method such as in-bed bathing, prefers it at a different time of day or on a different day, does not feel well that day, is uneasy about the aide assigned to help or is worried about falling, the staff member should make the necessary adjustments realizing the resident is not refusing to be clean but refusing the bath under the circumstances provided. The facility staff should meet with the resident to make adjustments in the care plan to accommodate his or her preferences.

Interpretive Guidelines, § 483.15(b), Appendix PP, State Operations Manual.[8]

I am not persuaded by Petitioner's position that in this case Resident 1's state of cleanliness posed a health threat to herself and other residents, and that the need to protect her health and that of the other residents, as well as to preserve the residents' rights not to be "inflicted" by her body odor, was overriding. Resident 1's odor presented a problem that Petitioner's staff was required to address. However, once Resident 1 stated she received bed baths and refused a tub bath, facility staff should have attempted to meet her hygiene needs in a way that would not cause her any distress or make her feel her rights were being violated. In fact, according to Resident 1's care plan, she preferred to have bed baths, but "with encouragement she will shower/bath tub." P. Ex. 1, at 18. However, I find no evidence that Petitioner's Administrator, the DON, or the ADON attempted to follow her care plan or make any adjustments to address the situation in any meaningful way. The fact that Administrator Landy was offended by Resident 1's odor and did not want her odor "inflicted" on others hardly justifies the scene that arose over forcibly getting Resident 1 out of bed, into the wheelchair, and down the hallway past other public parts of the facility into the bath area. Petitioner's staff offered Resident 1 no choice with respect to taking care of her body odor, nor made any efforts to deal with the situation using a lower level of physical coercion. They failed to consider other, less traumatic avenues to persuade Resident 1 to take a bath. There is no justification for Petitioner's staff's actions in physically subjecting Resident1 to an involuntary bath, which, in and of itself, could be considered physical abuse.

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[8] Although the SOM does not have the force and effect of law, the provisions of the Act and regulations interpreted clearly do have such force and effect. *State of Indiana by the Indiana Department of Public Welfare v. Sullivan*, 934 F.2d 853 (7th Cir. 1991); *Northwest Tissue Center v. Shalala*, 1 F.3d 522 (7th Cir. 1993). Thus, while the Secretary may not seek to enforce the provisions of the SOM, she may seek to enforce the provisions of the Act or regulations as interpreted by the SOM.

Moreover, Petitioner has not offered a shred of evidence that Resident 1's odor was in danger of adversely affecting her health or that of the other residents such that it "require[d] immediate attention." P. Br. at 12. As stated above, I find that any urgency about the situation was artificially created by Administrator Landy, who apparently expected staff to lose no time in carrying out her comment — or rather, her thinly-disguised order — that Resident 1 needed and was to be given a bath. As for Petitioner's claim that its staff was motivated only by a desire to promote Resident 1's well-being when they gave her a bath, this is highly doubtful, considering the anguish that Resident 1 suffered at the hands of its staff.

As further support for its argument that Resident 1 suffered no psychological or emotional injury from the bath incident, Petitioner offered the testimony of her treating psychologist, Dr. Kuntz, M.S. Dr. Kuntz testified that he is not an employee of Petitioner, but is employed by a private agency called Senior Services and paid directly by them. Tr. 230. Dr. Kuntz testified that he had been counseling Resident 1 for approximately a year prior to the bath incident. Tr. 230. He stated that he met with Resident 1 weekly, and that the day of the bath incident, September 8, 2011, happened to be a regularly scheduled counseling session with her. Tr. 232. Dr. Kuntz saw Resident 1 after her bath for about forty-five minutes. Tr. 232, 250. According to Dr. Kuntz, he and Resident 1 discussed the bath incident for about ten minutes, and then they moved on to other topics, such as her desire to go home. Tr. 232-33. When asked to describe her state, Dr. Kuntz testified that

> [Resident 1] was a little bit agitated, upset, -- angry . . . . At times she was actually even that day saying that she was glad that it happened and it was behind her. She kind of realized that she needed to have a bath, but she didn't like the way that it happened. She felt like she was forced to do it against her will; that she was not allowed to really say no. She was not happy about it.

Tr. 232.

In Dr. Kuntz's opinion, Resident 1's "psychological state was not made worse because of the bath." Tr. 234. Dr. Kuntz stated that Resident 1feared baths because she had fallen previously while taking a bath but that having the bath helped her feel less fearful. Tr. 234, 236. Dr. Kuntz expressed his opinion that Resident 1 "was a little agitated, possibly a little confused" by the bath incident, but she was not "traumatized" or "devastated" by it. Tr. 235-36. According to Dr. Kuntz, Resident 1was more "positive" in subsequent counseling sessions and told him she "does like living at [Petitioner's facility] overall" and that she felt "well cared for." Tr. 235; *see* P. Ex. 5, at 8-9. When asked about his phone interview with Surveyor Blum, Dr. Kuntz stated that Surveyor Blum's summary

contained statements that he had not made. Tr. 240; *see* CMS Ex. 9, at 2. Dr. Kuntz testified that he told Surveyor Blum he did not believe Resident 1 had suffered any emotional abuse. Tr. 240-41.

On cross-examination, when questioned about the progress note he wrote following their September 8, 2011 session, Dr. Kuntz confirmed that Resident 1 was "upset," "angry," and "[felt] humiliated." Tr. 241-42; *see* P. Ex. 5, at 5. When asked whether he was aware that Resident 1 had been crying while being bathed, Dr. Kuntz stated that someone had mentioned that she was tearful, and he noted that Resident 1 "was actually tearful when [he] met her that day." Tr. 243. Expressing a reluctance to say that Resident 1 suffered "mental anguish," Dr. Kuntz chose to describe her as "distraught to the extent of not understanding some things, and agitated." Tr. 243. However, Dr. Kuntz stressed that Resident 1 had "somewhat of a hysterical personality and tends to overreact to a lot of facts" and stated "you have to keep that in context as you think about this incident." Tr. 244. Dr. Kuntz was of the impression that Resident 1 had a diagnosis of hysterical personality disorder although he was not sure if this was ever formally documented. Tr. 244. In Dr. Kuntz's opinion, Resident 1's tearfulness and feeling of humiliation was a manifestation of her tendency to be very dramatic. Tr. 252.

Dr. Kuntz admitted on cross-examination that he was not present during the bath incident and had heard "second and third hand descriptions of [it]." Tr. 246. According to Dr. Kuntz, he was not aware that Resident 1 had been screaming and crying while she was being rolled down the hallway toward the bath or that she had physically resisted being transferred from her bed to the wheelchair. Tr. 246-47. I asked Dr. Kuntz to assume, for purposes of a hypothetical question, that "Resident [1's] hands had to be removed from the bedrails against her will; that there was shaking in the Hoyer lift and some concern that she might fall out;" that Resident 1 cried out repeatedly in anguish or distress while being transported down the hall toward the bathing area; and that she was still crying in the bathtub. Tr. 249. I asked Dr. Kuntz if these hypothetical circumstances would change his view as to whether some form of abuse — physical, emotional, or psychological — had taken place. In response, Dr. Kuntz testified

> I think though that knowing this patient to be a rather hysterical person who would become very emotional it would be hard to discern how much of that is just her emotional reaction? . . . it's hard to make a judgment about abuse based on the patient's reaction. . . . I would determine if she was mistreated, if she was treated roughly, or if she was, -- there was no compassion shown to this patient.

Tr. 249-250.

In evaluating Dr. Kuntz's testimony, I find that he was substantially ignorant of the full factual context of what took place between Resident 1 and Petitioner's staff in the morning, prior to his session with her. Clearly, he had no knowledge of the details surrounding Resident 1's bath nor had he attempted to obtain information about the incident on his own. Dr. Kuntz opined that Resident 1 was not "traumatized" or "devastated" by the bath, but then admitted on cross-examination that he had been unaware of Resident 1's demeanor and reactions during the whole scene and had been unaware that she had physically resisted being removed from her bed to her wheelchair.

When asked to consider whether Resident 1 had been abused under the hypothetical scenario I presented, Dr. Kuntz repeated his opinion that Resident 1's reactions were attributable to her hysterical personality. I find that testimony troubling and Dr. Kuntz's view disingenuous: even when presented with a hypothetical situation — actually, a reasonable restatement of the real facts — describing Resident 1's extreme distress over being forced to take a bath, Dr. Kuntz remained unwilling even to acknowledge the possibility that she may have suffered any form of abuse. In essence, his position seemed to have been that simply because he believed Resident 1 to be emotionally labile and highly-strung, her anguish was trivial and her physical resistance irrelevant. For these reasons, I find Dr. Kuntz's testimony not credible or reliable, and give very little weight to it.

Petitioner also contends that because Resident 1appeared to have put the bath incident behind her, as indicated by her later statements that she was happy at the facility, the incident was therefore minimal, trivial, or inconsequential. I am not persuaded by this self-serving argument. Resident 1 suffered both mental and physical abuse as a result of the bath incident. Resident 1 screamed and protested during her forced transfer with the Hoyer lift and as she was wheeled to the shower room, but to no avail. Her resistance ended only when she was put in the tub, and, at that point, according to the record, she was reduced to crying and whimpering. It is inconsistent with the record for Petitioner to claim that the "true effect on her was minimal." P. Br. at 24. One could take the view that Resident 1's subsequent statements that she was satisfied with her care at the facility were based on the fact that she recognized that she was simply not in a position to hold a grudge openly. Resident 1 may have realized that she had to "get over" the bath incident since it would not help her situation to be angry at the people who basically held her life — or at the very least her personal dignity and privacy — in their hands.

Petitioner attacks the credibility of CMS's surveyor witness, Surveyor Blum, claiming that she was biased, and had an agenda in her testimony and her investigation. P. Br. at 21; *see* P. Reply at 3-6. Petitioner had the opportunity to cross-examine Surveyor Blum at the in-person hearing as to why she alleged a deficiency under Tag F223. I have been given no reason to believe Petitioner's claims that Surveyor Blum had predisposed conclusions before she began her investigation, or omitted or mischaracterized

information in the SOD. I find that Surveyor Blum's testimony is credible, and the statements in the SOD to be reliable.

Despite Resident 1's vociferous objections and physical resistance, Petitioner's staff used intimidation and force to make her take a bath. This traumatic situation caused Resident 1significant mental anguish and emotional and physical distress. I find that Petitioner's staff abused Resident 1 both mentally and physically, and was thus not in substantial compliance with 42 C.F.R. §§ 483.13(b) and 483.13(c)(1)(i).

***B. The immediate jeopardy determination is not subject to review in this case, as the amount of PICMP is not affected by whether or not there is immediate jeopardy.***

CMS concluded that the violation of 42 C.F.R. §§ 483.13(b) and 483.13 (c)(1)(i) posed immediate jeopardy. However, because CMS imposed a PICMP in this case, and not a per-day CMP, I need not consider CMS's finding that the deficiencies here constituted immediate jeopardy.

The regulations are clear that the scope and severity determination of immediate jeopardy can be appealed but only if the range of CMP that can be imposed could change or if the facility's nurse aide training program would be affected due to a finding of substandard quality of care. 42 C.F.R. §§ 498.3(b)(14)(i), (ii) and 498.3(d)(10)(i), (ii). It does not appear that Petitioner had a nurse aide training program. Further, there is but a single range for PICMPs and the amount of a PICMP is not affected by whether or not there is immediate jeopardy. 42 C.F.R. §§ 488.408; 488.438. Thus, the immediate jeopardy finding is not subject to appeal or to my review in this case.

***C. The $10,000 PICMP imposed is reasonable.***

I have concluded that Petitioner was not in substantial compliance with all program participation requirements due to a violation of 42 C.F.R. §§ 483.13(b) and 483.13 (c)(1)(i), Tag F223. Therefore, there is a basis for CMS to impose one or more of the enforcement remedies listed in 42 C.F.R. § 488.406, including a PICMP for each instance that a facility is not in substantial compliance. 42 C.F.R. § 499.430(a). CMS is authorized to impose a PICMP from $1000 to $10,000 per instance. 42 C.F.R. § 488.438(a)(2). In this case, CMS has imposed a PICMP of $10,000.

My review of the reasonableness of the PICMP imposed is *de novo* and is based upon the evidence in the record before me. In determining the reasonableness, I apply the factors listed at 42 C.F.R. § 488.438(f) which are: (1) the facility's history of noncompliance; (2) the facility's financial condition; (3) factors specified at 42 C.F.R. § 488.404; and (4) the facility's degree of culpability, which includes neglect, indifference, or disregard for resident care, comfort or safety. The absence of culpability is not a mitigating factor.

The factors at 42 C.F.R. § 488.404 include: (1) the scope and severity of the deficiency; (2) the relationship of the deficiency to other deficiencies resulting in noncompliance; and (3) the facility's prior history of noncompliance in general and specifically with reference to the cited deficiencies.

Petitioner argues that the $10,000 PICMP imposed by CMS is unreasonable and argues that, should it be determined that Petitioner is not in substantial compliance with participation requirements, the CMP should be reduced to the minimum PICMP amount of $1,000. Petitioner contends that its history of noncompliance shows that it has only been cited once for a deficiency, in 2005, regarding the treatment of wounds, and paid a CMP of $6,500. P. Br. at 26, citing Tr. 158; P. Prehearing Memorandum at 8.

Petitioner argues that it should not be held culpable for the bath incident. Petitioner states that if its staff was wrong for giving Resident 1 a bath, something it adamantly denies, then the error was with regards to the timing of the bath. Petitioner contends that its staff was only acting in furtherance of Resident 1's welfare and that of the other residents, there was a good faith belief that the bath was necessary, and Resident 1 was not injured. In Petitioner's view, imposing the maximum PICMP under these circumstances would serve to chill the "honest, good faith and informed professional judgment of professional health care providers on matters of care." P. Br. at 28.

Although Petitioner attempts to minimize the significance of its staff's actions, I conclude that the deficiency cited under F223 was serious and that Petitioner was culpable. The right of a resident to direct her own care constitutes an important part of the regulatory scheme. Here, even if Resident 1's odor and state of cleanliness were somehow shown to pose some kind of a health threat (and Petitioner has offered no evidence that it did), Petitioner's staff failed to consider alternative ways to accommodate Resident 1 before they used intimidation and force to remove her from her bed and get her to the shower room. Once Resident1 expressed her refusal of a bath, Petitioner's staff should have dropped their plan for a bath and explored other avenues to achieve the result they sought. Instead, Petitioner's staff ignored her protests, and continued with their efforts, even as she yelled and screamed and put up a vigorous struggle. Petitioner's staff exhibited a callous disregard for Resident 1's rights and failed to keep her free from physical and mental abuse. For these egregious failings, Petitioner is entirely culpable.

Petitioner has not asserted that its financial condition is such that it cannot pay the PICMP and has presented no evidence of its financial condition.

A $10,000 PICMP is the maximum amount of PICMP that CMS may impose for an instance of non-compliance. I conclude that the $10,000 PICMP is reasonable in light of the relevant factors.

## V. Conclusion

For the foregoing reasons, I conclude that Petitioner was not in substantial compliance with program participation requirements due to a violation of 42 C.F.R. §§ 483.13(b) and 483.13(c)(1)(i), cited as Tag F223. The $10,000 PICMP is a reasonable enforcement remedy.

/s/
Richard J. Smith
Administrative Law Judge