Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Luling Care Center,
(CCN: 67-6292),

Petitioner,

v.

Centers for Medicare & Medicaid Services

Docket No. C-13-884

Decision No. CR4082

Date: July 31, 2015

DECISION

In this case, we again consider a long-term-care facility's obligation to investigate and report allegations of abuse made by someone whom facility staff consider unreliable.

Petitioner, Luling Care Center, is a long-term-care facility, located in Luling, Texas, that participates in the Medicare program. Based on a complaint investigation survey, completed March 22, 2013, and a follow-up survey, completed May 16, 2013, the Centers for Medicare & Medicaid Services (CMS) determined that, from March 17 through June 11, 2013, the facility was not in substantial compliance with Medicare program requirements and that, from March 17 through 22, its deficiencies posed immediate jeopardy to resident health and safety. CMS imposed civil money penalties (CMPs) of $6,550 per day for six days of immediate jeopardy, followed by $200 per day for 81 days of substantial noncompliance that was not immediate jeopardy. Petitioner appeals, and CMS has moved for summary judgment.

As discussed below, the undisputed evidence establishes that, from March 17 through June 11, 2013, the facility was not in substantial compliance with Medicare program

requirements and that, from March 17 through 22, 2013, its substantial noncompliance posed immediate jeopardy to resident health and safety. The penalties imposed are reasonable.

Background

The Social Security Act (Act) sets forth requirements for nursing facilities to participate in the Medicare program, and authorizes the Secretary of Health and Human Services to promulgate regulations implementing those statutory provisions. Act § 1819. The Secretary's regulations are found at 42 C.F.R. Part 483. To participate in the Medicare program, a nursing facility must maintain substantial compliance with program requirements. To be in substantial compliance, a facility's deficiencies may pose no greater risk to resident health and safety than "the potential for causing minimal harm." 42 C.F.R. § 488.301.

The Secretary contracts with state survey agencies to conduct periodic surveys to determine whether skilled nursing facilities are in substantial compliance. Act § 1864(a); 42 C.F.R. § 488.20. Each facility must be surveyed annually, with no more than 15 months elapsing between surveys. Facilities must be surveyed more often, if necessary, to ensure that identified deficiencies are corrected. Act § 1819(g)(2)(A); 42 C.F.R. §§ 488.20(a), 488.308. The state agency must also investigate all complaints. Act § 1819(g)(4).

In this case, surveyors from the Texas Department of Aging and Disability Services (state agency) completed a complaint investigation survey on March 22, 2013. Based on their findings, CMS determined that the facility was not in substantial compliance with multiple program requirements, specifically:

- 42 C.F.R. § 483.13 (c)(1)(ii)-(iii), (c)(2)-(4) (Tag F225 – staff treatment of residents: investigate/report allegations of abuse), at scope and severity level L (widespread immediate jeopardy);

- 42 C.F.R. § 483.13(c) (Tag F226 – policies to prohibit abuse and neglect) at scope and severity level L;

- 42 C.F.R. § 483.75 (Tag F490 – administration) at scope and severity level L; and

- 42 C.F.R. § 483.75(e)(2)-(3) (Tag F494 – administration: nurse aide training) at scope and severity level E (pattern of substantial noncompliance that causes no actual harm with the potential for more than minimal harm).[1]

CMS Ex. 3.

Surveyors returned to the facility and completed a follow-up survey on May 16, 2013. Based on these findings, CMS determined that the facility's deficiencies no longer posed immediate jeopardy but that its substantial noncompliance continued. CMS exhibits (Exs.) 2, 4. Thereafter, CMS determined that the facility returned to substantial compliance on June 12. CMS Ex. 5.

CMS imposed against the facility CMPs of $6,550 per day for six days of immediate jeopardy (March 17 through 22) and $200 per day for 81 days of substantial noncompliance that was not immediate jeopardy (March 23 through June 11), for a total penalty of $55,500 ($39,300 + $16,200 = $55,500). CMS Ex. 5.

Petitioner timely requested review.

CMS now moves for summary judgment, which Petitioner opposes. In addition to its motion and brief (CMS Br.), CMS submits 24 exhibits, which are numbered CMS Exs. 1-22 and 25-26 (numbers 23 and 24 were not used). Petitioner submits its own brief and response to CMS's motion (P. Br.), with no additional exhibits.

Issues

The issues before me are:

1. Was the facility in substantial compliance with Medicare participation requirements from March 17 through June 11, 2013;

2. If, from March 17 through 22, the facility was not in substantial compliance with Medicare participation requirements, did its deficiencies then pose immediate jeopardy to resident health and safety; and

3. If the facility was not in substantial compliance with Medicare participation requirements, are the penalties imposed reasonable.

[1] Although Petitioner appealed all four of the deficiencies cited, CMS has not pursued the deficiencies cited under section 483.75(e)(2)-(3).

Discussion

Summary judgment. Summary judgment is appropriate if a case presents no genuine issue of material fact, and the moving party is entitled to judgment as a matter of law. *Ill. Knights Templar Home*, DAB No. 2274, at 3-4 (2009), and cases cited therein.

The moving party may show the absence of a genuine factual dispute by presenting evidence so one-sided that it must prevail as a matter of law, or by showing that the non-moving party has presented no evidence "sufficient to establish the existence of an element essential to [that party's] case, and on which [that party] will bear the burden of proof at trial." *Livingston Care Ctr. v. Dep't of Health & Human Servs.*, 388 F.3d 168, 173 (6th Cir. 2004) (quoting *Celotex Corp. v. Catrett*, 477 U.S. 317, 322 (1986)). To avoid summary judgment, the non-moving party may not simply rely on denials, but must act affirmatively by tendering evidence of specific facts showing that a dispute exists. *Matsushita Elec. Indus. Co. v. Zenith Radio Corp.*, 475 U.S. 574, 586 n.11 (1986); *Ill. Knights Templar*, DAB No. 2274, at 4; *Livingston Care Ctr.*, DAB No. 1871, at 5 (2003). *See also Vandalia Park*, DAB No. 1939 (2004); *Lebanon Nursing & Rehab. Ctr.*, DAB No. 1918 (2004).

In examining the evidence for purposes of determining the appropriateness of summary judgment, I must draw all reasonable inferences in the light most favorable to the non-moving party. *Brightview Care Ctr.*, DAB No. 2132, at 2, 9 (2007); *Livingston Care Ctr.*, 388 F.3d at 172; *Guardian Health Care Ctr.*, DAB No. 1943, at 8 (2004); *but see*, *Brightview*, DAB No. 2132, at 10 (entry of summary judgment upheld where inferences and views of non-moving party are not reasonable). However, drawing factual inferences in the light most favorable to the non-moving party does not require that I accept the non-moving party's legal conclusions. *Cf. Guardian Health Care Ctr.*, DAB No. 1943, at 11 ("A dispute over the conclusion to be drawn from applying relevant legal criteria to undisputed facts does not preclude summary judgment if the record is sufficiently developed and there is only one reasonable conclusion that can be drawn from those facts.").

1. ***CMS is entitled to summary judgment because the undisputed evidence establishes that the facility's administration and staff did not immediately report or thoroughly investigate a resident's allegations of abuse; and they made no efforts to prevent potential abuse while an investigation was pending. The facility was therefore not in substantial compliance with 42 C.F.R. §§ 483.13(c); 483.13(c)(1)(ii)-(iii),(2)-(4;) and 483.75.***[2]

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

Program requirements. "Abuse" means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. 42 C.F.R. § 488.301.

Facility residents have the right to be free from verbal, sexual, physical, and mental abuse. 42 C.F.R. § 483.13(b). To this end, a facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents. 42 C.F.R. § 483.13(c). It must ensure that all alleged violations are reported immediately to the facility administrator and appropriate state officials. The facility must have evidence that all alleged violations are thoroughly investigated, and it must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator (or designated representative) and to the appropriate state officials within five working days of the incident. If the violation is verified, the facility must take appropriate action. 42 C.F.R. § 483.13(c)(2), (3), and (4) (Tags F225, F226).

The facility must also be governed in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. 42 C.F.R. § 483.75 (Tag F490).

The incident. Resident 1 (R1) was a 60-year old man, who suffered from a long list of impairments, including epilepsy, recurrent seizures, depression, hereditary peripheral neuropathy, muscle weakness, and anxiety. CMS Ex. 20 at 1, 20, 41. He required total assistance for activities of daily living. CMS Ex. 10 at 1; CMS Ex. 20 at 12, 16-17.

The parties agree that, on March 16, 2013, two nurse aides (referred to as "A" and "B") were providing R1with incontinent care, when he accused Nurse Aide B of inappropriate touching; he started yelling "rape." Then or sometime thereafter, he also claimed that Nurse Aide B put a sheet over his head and hit him in the face.[3] He repeated the accusations to a medication aide (referred to as "Medication Aide C"), who entered the room. CMS Ex. 1 at 4, 6-8; CMS Ex. 10 at 2, 4; CMS Ex. 15 at 1, 3; *see* P. Br. at 2, 3. Not one of these staff members reported R1's allegations. The following day, R1 complained to a third nurse aide, who reported his allegations to the charge nurse on duty and then called the Director of Nursing (DON) to report the incident. CMS Ex. 1 at 6; CMS Ex. 14; CMS Ex. 15 at 4, 6; CMS Ex. 22 at 3 (Martin Decl. ¶ 7); *see* P. Br. at 3.

[3] Petitioner questions when R1 first claimed that a nurse aide hit him and suggests that he made no such claim to Nurse Aides A and B or Medication Aide C. P. Br. at 2, *but see* CMS Ex. 10 at 2, 4. For summary judgment purposes, I accept Petitioner's position but find it not material.

In the meantime, an unidentified person or persons reported the abuse allegations to the state agency. CMS Ex. 22 at 1-2, 4-5 (Martin Decl. ¶¶ 3,4, 7). A state survey team arrived at the facility on March 22 to investigate the charges. CMS Ex. 22 at 1 (Martin Decl. ¶ 3).

Failures to report. CMS faults the facility for its response to R1's allegations of abuse. First, CMS maintains that the facility violated the regulations and its own policies because Nurse Aide A, Nurse Aide B, and Medication Aide C did not report R1's allegations to the facility's administrators. Second, after a different nurse aide finally told the DON, neither she nor any other facility representative immediately reported the allegations to the state agency.

The facility's written policies require staff to report immediately to the charge nurse any incident of abuse or suspected abuse. The report should include the resident's name, time and place of the incident, name of alleged perpetrator, names of witnesses, an examination of the resident, and physician notification. CMS Ex. 9 at 2.

Petitioner concedes that the nurse aides and the medication aide failed to report R1's allegations to the facility administration or to anyone else. CMS Ex. 1 at 7-8; CMS Ex. 12; CMS Ex. 13; CMS Ex. 14; CMS Ex. 22 at 2-5 (Martin Decl. ¶ 7); CMS Br. at 9; P. Br. at 3. Petitioner also admits that the facility's DON, who was the facility's abuse coordinator, did not report the allegations to the state agency until March 22, after the survey team arrived at the facility. But, according to Petitioner, these employees were not required to report the allegations. Petitioner alleges that the nurse aides and medication aide were not required to report because they were present when R1 made the allegations and knew them to be false.[4]

This argument ignores the plain language of the regulation – the facility "must ensure that *all* alleged violations are reported immediately to the facility administrator" (emphasis added) – and makes no practical sense. Individual staff members are not given the option of deciding whether to report allegations. As Judge Kessel pointed out in *Somerset Place*, DAB CR2164, at 3 (2010), there is an "obvious reason" for the regulation's categorical requirement: It assures that the allegation will be reviewed by an unbiased fact finder rather than an employee whose self-interest dictates that she not report.

[4] According to Petitioner, the nurse aide who finally reported the allegations acted properly because she did not witness the incident and "could not attest to [the allegations'] baselessness." P. Br. at 3-4. But the medication aide did not witness the incident either; she entered the room as Nurse Aide B was leaving, and R1 repeated the allegations to her. CMS Ex. 1 at 8. According to Petitioner's theory, she should have reported the allegation. Of course, as this discussion underscores, all staff must report all such allegations.

Petitioner also argues that, in failing to report the allegations to the state agency, the DON acted in accordance with state and federal regulations. Under Texas state law, a facility is required to report only if it "has cause to believe that the physical or mental health or welfare of a resident has been or may be adversely affected by abuse, neglect, or exploitation caused by another person. . . ." P. Br. at 4 (citing 22 Tex. Admin. Code § 19.602(a)). According to Petitioner, because the federal regulation instructs facilities to report allegations "in accordance with state law through established procedures," the federal regulation defers to the state law. So, because she ultimately found no abuse, the DON was not required to report. P. Br. at 3-4.

Petitioner's argument fails for several reasons. First, the phrase "in accordance with state law through established procedures" refers to the procedures the facility should follow in reporting the allegation; it does not address whether the facility must report. The Departmental Appeals Board has consistently ruled that the facility must report *all* allegations, without regard to a state's reporting requirements. The pertinent question is not whether any abuse occurred or whether the facility had reasonable cause to believe that any abuse occurred, but whether there is an allegation that facility staff abused a resident. *Britthaven, Inc.*, DAB No. 2018, at 15 (2006) (citing *Cedar View Good Samaritan*, DAB No. 1897, at 11 (2003)).

Second, Petitioner's argument does not consider the regulatory requirement that a facility report the allegations "immediately." The facility is required to report before it completes its thorough investigation and is in a position to know whether the abuse occurred. *See* P. Ex. 9 at 4 (facility abuse/neglect policy requiring that the facility administrator or her designee "immediately obtain basic information required for a telephonic report to the [state agency] if indicated per regulations . . . and make the report before further investigation.").

Third, even if I accepted the premise underlying Petitioner's argument – that the federal regulation defers to the state rule – Petitioner would not prevail here. Because R1 complained, the facility necessarily had "cause to believe" that his health or welfare "may" have been "adversely affected by abuse . . . caused by another person." I therefore see no conflict between the state rule and the federal reporting requirement that all alleged violations be reported.

Inadequate efforts to protect residents. CMS next alleges that the facility did nothing to prevent potential abuse while its investigation was pending.

According to the facility's written policies, when the charge nurse learns of the allegation, she must examine the resident to determine the extent of the injury or the absence of injury. She must immediately notify the facility administrator "regardless of

the hour or the severity of the allegation and/or injury." CMS Ex. 9 at 3. "Employees accused of resident abuse *will be suspended from work* and prohibited from Luling Care Center until the administrator completes the investigation and the Quality Assurance Committee meets to review the results of the investigation." CMS Ex. 9 at 3 (emphasis added).

No one examined R1 until the following day. According to the facility, the charge nurse and DON each assessed R1, but he was not seen by a physician or at the hospital. CMS Ex. 14; CMS Ex. 22 at 3 (Martin Decl. ¶ 7).

Petitioner concedes that "no staff members were formally suspended" while the investigation was pending. P. Br. at 4. In fact, the accused, Nurse Aide B, continued working with residents throughout. CMS Ex. 19 at 3, 7, 8, 11 (showing that Nurse Aide B worked on March 18, 19, 20).

Petitioner explains that the DON allowed Nurse Aide B to continue working because she did not realize that Nurse Aide B was the alleged perpetrator. She thought that Nurse Aide B was a witness, and the facility was not obligated to suspend an employee who witnessed abuse but did not participate. P. Br. at 4. Petitioner acknowledges that the DON did not suspend Nurse Aide A either and suggests, without support, that he "would not be working anyway." P. Br. at 4. The evidence does not support this assertion.[5] Sign-in sheets indicate that Nurse Aide A worked on March 19 and 20. CMS Ex 19 at 3, 8. The Investigative Report, prepared by the DON, says that Nurse Aide A was not scheduled to work on R1's hall and would not be assigned to the resident "until [the] allegation is cleared." CMS Ex. 10 at 3. That an alleged abuser is not scheduled to work with the alleged victim does not satisfy the regulation; the facility must protect all residents from a potential abuser.

In any event, the facility plainly violated federal requirements and its own policies by allowing an alleged abuser to continue offering resident care while an abuse investigation was pending.

Inadequate investigation. Finally, CMS characterizes the facility's investigation as inadequate. The undisputed evidence amply supports CMS's position.

[5] I am not required to accept unsupported allegations. As noted above, to withstand summary judgment, the non-moving party must furnish evidence of a dispute concerning a material fact. *Illinois Knights Templar*, DAB No. 2274, at 4. But even if Petitioner established that Nurse Aide A were not scheduled to work while the investigation was pending, that fact would not be material.

Petitioner concedes that, in her investigation report, the DON mistakenly identified Nurse Aide A, rather than Nurse Aide B, as the alleged perpetrator. P. Br. at 3. I consider this a serious error that establishes that the DON conducted an inadequate investigation. One of the most – if not the most – critical elements of a complaint investigation is identifying correctly the perpetrator of the alleged abuse. Yet, throughout her report, the DON simply gets it wrong. CMS Ex. 10. To make this mistake, she had to have disregarded all of the other reports and the witness statements. *See* CMS Ex. 15.

Preventing abuse. Thus, the facility was not in substantial compliance with 42 C.F.R. § 483.13(c). Staff did not immediately report to the facility administrator (or designee) allegations of abuse. The individual charged with coordinating the facility's response to abuse allegations did not timely report to the appropriate state officials. The facility did not follow its own policies for protecting its residents from abuse while an investigation was pending and its investigation – which identified the wrong person as the alleged perpetrator – was woefully inadequate. I also find that the facility failed to implement its written policies and procedures that prohibit resident abuse. Multiple staff – including the administrator's designee – failed to satisfy the reporting requirements set forth in the facility policies. The designee most responsible for implementing the policies disregarded them in significant ways. She allowed an accused abuser to continue caring for residents and she conducted an inadequate investigation. These deficiencies put the facility out of substantial compliance with 42 C.F.R. § 483.13(c).

Administration. A finding of substantial noncompliance in the facility's administration may derive from findings of substantial noncompliance in other areas. *Stone County Nursing & Rehab. Ctr*., DAB No. 2276, at 15-16 (2009).

> [W]here a facility has been shown to be so out of compliance with program requirements that its residents have been placed in immediate jeopardy, the facility was not administered in a manner that used its resources effectively to attain the highest practicable physical, mental, and psychosocial well-being of each resident.

Odd Fellow & Rebekah Health Care Facility, DAB No. 1839, at 7 (2002); *Asbury Ctr. at Johnson City*, DAB No. 1815, at 11 (2002). As discussed below, I find that the facility's deficiencies posed immediate jeopardy to resident health and safety, which, by itself, justifies the finding that the facility was not in substantial compliance with 42 C.F.R. § 483.75.

Moreover, as the above discussion establishes, the failures here were directly attributable to administrative, as well as staff, failures. The facility's administration disregarded facility policies in failing to investigate thoroughly and report allegations of resident abuse. It also fell short in protecting residents from a potential abuser. The facility was

therefore not administered in a manner that used its resources effectively to attain or maintain the highest practicable physical, mental, and psychosocial well-being of its residents and was not in substantial compliance with 42 C.F.R. § 483.75.

2. CMS's determination that, from March 17 through 22, 2013, the facility's deficiencies posed immediate jeopardy to resident health and safety is not clearly erroneous.

Immediate jeopardy. Immediate jeopardy exists if a facility's noncompliance has caused or is likely to cause "serious injury, harm, impairment, or death to a resident." 42 C.F.R. § 488.301. CMS's determination as to the level of a facility's noncompliance (which would include an immediate jeopardy finding) must be upheld unless it is "clearly erroneous." 42 C.F.R. § 498.60(c)(2). The Board has observed repeatedly that the "clearly erroneous" standard imposes on facilities a "heavy burden" to show no immediate jeopardy, and has sustained determinations of immediate jeopardy where CMS presented evidence "from which '[o]ne could reasonably conclude' that immediate jeopardy exists." *Barbourville Nursing Home*, DAB No. 1962, at 11 (2005) (citing *Florence Park Care Ctr.*, DAB No. 1931, at 27-28 (2004)); *cf. Daughters of Miriam Ctr.*, DAB No. 2067, at 7, 9 (2007).

Here, multiple facility employees – including the employee specifically charged with implementing the facility's abuse policies – repeatedly disregarded those policies in critical respects: reporting, protecting the residents, and investigating. Such disregard of the policies in place to protect residents from abuse puts those residents at risk, and the situation is likely to cause serious harm. CMS's determination that the deficiencies posed immediate jeopardy to resident health and safety is therefore not clearly erroneous.

3. The penalties imposed – $6,550 per day for the days of immediate jeopardy and $200 per day for the days of substantial noncompliance that was not immediate jeopardy – are reasonable.

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

I consider whether the evidence supports a finding that the amount of the CMP is at a level reasonably related to an effort to produce corrective action by a provider with the

kind of deficiencies found, and in light of the above factors. I am neither bound to defer to CMS's factual assertions, nor free to make a wholly independent choice of remedies without regard for CMS's discretion. *Barn Hill Care Ctr.*, DAB No. 1848, at 21 (2002); *Community Nursing Home*, DAB No. 1807, at 22 *et seq*. (2002); *Emerald Oaks*, DAB No. 1800, at 9 (2001); *CarePlex of Silver Spring*, DAB No. 1683, at 8 (1999).

Here, CMS imposed a penalty of $6,550 per day for the period of immediate jeopardy, which is in the middle of the per-day penalty range for situations of immediate jeopardy ($3,050-$10,000). 42 C.F.R. §§ 488.408(e)(1)(iii), 488.438(a)(1)(i). The $200 per-day penalty is at the low to very low end of the range for CMPs where substantial noncompliance does not pose immediate jeopardy ($50-$3,000). 42 C.F.R. §§ 488.408(d), 488.438(a)(1)(ii).

Although it claims otherwise, the facility has a poor compliance history. For at least the five years preceding the March 2013 survey, it was consistently out of substantial compliance with program requirements. In addition to multiple life safety code deficiencies, the state agency cited it for health deficiencies that included problems with preventing abuse and with administration.[6]

- In July 2012, the annual survey that preceded this complaint investigation, the facility was not in substantial compliance with multiple program requirements at the immediate jeopardy level: 42 C.F.R. §§ 483.10(b)(11) (Tag F157- notification of changes); 483.20(k)(3) (Tag F281- services must meet professional standards of quality); 483.25(*l*) (Tag F329- unnecessary drugs); **483.75** (Tag F490- **administration**); and 483.75(j) (Tag F502- laboratory services). It was not in substantial compliance with the regulation governing dietary services/sanitary conditions (42 C.F.R. 483.35(i) – Tag F371) at scope and severity level F (widespread noncompliance that caused no actual harm with the potential for more than minimal harm). The facility paid a $7,500 CMP. CMS Ex. 26 at 1.

  Petitioner points out that, after a follow-up survey, the state agency agreed to reduce the immediate jeopardy findings, which I do not doubt. However, according to the enforcement history, the period of immediate jeopardy ran from July 3 through July 5. CMS Ex. 26 at 1. This does not establish a good compliance history.

- In July 2011, the facility was not in substantial compliance with 42 C.F.R. § 483.10(b)(11) (Tag F157- notification of changes) at scope and severity level E (pattern of noncompliance that caused no actual harm with the potential for more than minimal harm) and 42 C.F.R. § 483.25(i) (Tag F325- nutrition), also at scope and severity level E. CMS Ex. 26 at 2.

[6] I indicate in bold those earlier similar deficiencies.

- In May 2010, the facility was not in substantial compliance with multiple requirements, including **42 C.F.R. 483.75(f)** (Tag F498- **administration:** proficiency of nurse aides) at scope and severity level E. CMS Ex. 26 at 2.

- In November 2009, the facility was not in substantial compliance with **42 C.F.R. § 483.13(c)** (Tag F225- **staff treatment of residents: investigate/report allegations of abuse**) at scope and severity level E. CMS Ex. 26 at 2.

- In April 2009, the facility was not in substantial compliance with 42 C.F.R. § 483.65 (Tag F441- infection control) at scope and severity level F. CMS Ex. 26 at 2-3.

- In February 2008, the facility was not in substantial compliance with **42 C.F.R. § 483.75(*l*)(1)** (Tag F514 -**administration**: clinical records). CMS Ex. 26 at 3.

This history alone justifies increasing the per-day penalties well beyond the minimum amounts mandated by the regulations.

With respect to financial condition, the facility has the burden of proving, by a preponderance of the evidence, that paying the CMP would render it insolvent or would compromise the health and safety of its residents. *Van Duyn Home & Hosp.*, DAB No. 2368 (2011); *Gilman Care Ctr.*, DAB No. 2357 (2010). Petitioner points out that the facility has filed for bankruptcy but proffers no financial documentation or testimony to establish its inability to pay. To meet the standard for lowering a CMP based on financial condition, claims must be supported by compelling financial documentation. In *Guardian Care Nursing & Rehabilitation Center*, DAB No. 2260 (2009), for example, the facility could not even afford to represent itself on appeal. Its Medicaid census was 90%; its annual shortfall was $250,000; and it relied on charitable contributions for its continuing viability. The Board nevertheless criticized the absence of financial documentation and concluded that the facility had not established that additional resources would not be available. *But see Columbus Nursing & Rehab. Ctr.*, DAB No. 2505 (2013) (finding that the absence of documentation regarding the facility's financial condition did not preclude ALJ from concluding, based on witness testimony, that financial condition justified reducing the CMP).

Petitioner has not shown, nor even alleged, that paying the penalty would cause it to go out of business. The evidence therefore does not justify lowering the CMP based on its financial condition.

Applying the remaining factors, I find that the facility's widespread disregard for resident safety justifies the penalties imposed. The deficiencies went well beyond the actions (or inaction) of one or two individuals. The DON and multiple staff members repeatedly

disregarded facility policies when they declined to investigate, report, and protect the residents. The facility's administrator seems to have abdicated all responsibility for the actions of her designee, taking virtually no role in overseeing the DON's actions and insuring that she followed facility policies. The facility is culpable for these failings.

For these reasons, I find that the CMPs are reasonable.

Conclusion

The uncontroverted evidence establishes that, from March 17 through June 11, 2013, the facility was not in substantial compliance with Medicare participation requirements, and, from March 17 through 22, 2013, those deficiencies posed immediate jeopardy to resident health and safety. The penalties imposed – $6,550 per day for the period of immediate jeopardy, $200 for the period of substantial noncompliance – are reasonable.

I therefore grant CMS's motion for summary judgment.

/s/
Carolyn Cozad Hughes
Administrative Law Judge