**Department of Health and Human Services**

**DEPARTMENTAL APPEALS BOARD**

**Civil Remedies Division**

Lexington Place Nursing and Rehabilitation
(CCN: 67-5793),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-14-1742

Decision No. CR4831

Date: April 26, 2017

# DECISION

Lexington Place Nursing and Rehabilitation (Lexington or Petitioner) challenges the determination of the Centers for Medicare & Medicaid Services (CMS) that from April 22, 2014 through June 18, 2014, Lexington was not in substantial compliance with various Medicare program participation requirements with which a skilled nursing facility (SNF) such as Lexington must comply, and that Lexington's noncompliance posed immediate jeopardy to its residents' health and safety from April 22, 2014 through May 21, 2014. Petitioner further challenges the enforcement remedies imposed by CMS. For the reasons that follow, I conclude that Petitioner was not in substantial compliance with the Medicare participation requirements at 42 C.F.R. §§ 483.20(k)(3)(i) & (ii), 483.25, 483.75, and 483.75(*l*), and that CMS did not clearly err in determining that Petitioner's noncompliance with §§ 483.25 and 483.75 posed immediate jeopardy to the health and safety of Petitioner's residents.[1] Accordingly, I conclude that there is a basis for imposing enforcement remedies, including civil money penalties (CMPs), on Petitioner for the duration of its noncompliance. Finally, I conclude that CMPs of $5,800

[1] All citations to the C.F.R. are to the version in effect at the time of CMS's enforcement action.

per day from April 22, 2014 through May 21, 2014, and $1,000 per day from May 22, 2014 through June 18, 2014, for a total of $202,000, are reasonable in both amount and duration.

## I. Background

The Social Security Act (Act) sets forth requirements for a SNF's participation in the Medicare program and authorizes the Secretary of Health and Human Services (the Secretary) to promulgate regulations implementing those statutory provisions. 42 U.S.C. § 1395i-3. The Secretary's regulations are found at 42 C.F.R. Parts 483 and 488. To participate in the Medicare program, a SNF must maintain substantial compliance with program participation requirements. To be in substantial compliance, a SNF's deficiencies may "pose no greater risk to resident health or safety than the potential for causing minimal harm." 42 C.F.R. § 488.301. A deficiency is a violation of a participation requirement established by sections 1819(b), (c), and (d) of the Act, 42 U.S.C. § 1395i-3(b), (c), and (d), or the Secretary's regulations at 42 C.F.R. pt. 483, subpt. B. Therefore, a facility may violate a statutory or regulatory requirement, but it is not subject to enforcement remedies if the violation does not pose a risk for more than minimal harm. "Noncompliance" means "any deficiency that causes a facility to not be in substantial compliance." 42 C.F.R. § 488.301.

The Secretary contracts with state agencies to conduct periodic surveys to determine whether SNFs are in substantial compliance. 42 U.S.C. § 1395aa(a); 42 C.F.R. § 488.10. The Act also authorizes the Secretary to impose enforcement remedies against SNFs that are not in substantial compliance with the program participation requirements. 42 U.S.C. § 1395i-3(h)(2). The regulations specify the enforcement remedies that CMS may impose. 42 C.F.R. § 488.406. Among other enforcement remedies, CMS may impose a per-day CMP for the number of days a SNF is not in substantial compliance or a per-instance CMP for each instance of the SNF's noncompliance. 42 C.F.R. § 488.430(a). A per-day CMP may range from either $50 to $3,000 per day for less serious noncompliance, or $3,050 to $10,000 per day for more serious noncompliance that poses immediate jeopardy to the health and safety of residents, 42 C.F.R. § 488.438(a)(1), while the authorized range for a per-instance CMP is $1,000 to $10,000, 42 C.F.R. § 488.438(a)(2).[2] "Immediate jeopardy" exists when "the provider's noncompliance with

[2] CMS recently increased the CMP amounts to account for inflation in compliance with the Federal Civil Penalties Inflation Adjustment Improvements Act of 2015, 104 Pub. L. No. 114-74, 129 Stat. 584, 599. The new adjusted amounts apply to CMPs assessed after August 1, 2016, for deficiencies occurring on or after November 2, 2015. *See* 81 Fed. Reg. 61538-01 (Sept. 6, 2016). As the deficiencies alleged in this case occurred prior to November 2, 2015, the increased CMP amounts do not apply in this case.

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.

If CMS imposes a CMP based on a noncompliance determination, then the facility may request a hearing before an Administrative Law Judge (ALJ) to challenge the noncompliance finding and enforcement remedy. Act § 1128A(c)(2), 42 U.S.C. § 1320a-7a(c)(2); Act § 1819(h)(2)(B)(ii), 42 U.S.C. § 1395i(h)(2)(B)(ii); Act § 1866(h)(1), 42 U.S.C. § 1395cc(h)(1); 42 C.F.R. §§ 488.408(g), 488.434(a)(2)(viii), 498.3(b)(13). The hearing before an ALJ is a *de novo* proceeding. *CarePlex of Silver Spring*, DAB No 1683 (1999) (holding that ALJs hold de novo hearings based on issues permitted under the regulations and ALJ review is not a quasi-appellate review); *see also Claiborne-Hughes Health Ctr. v. Sebelius*, 609 F.3d 839, 843 (6th Cir. 2010) (The Departmental Appeals Board (DAB) "reviewed the finding under the *de novo* standard that the ALJ would have applied."). A facility has a right to appeal a "certification of noncompliance leading to an enforcement remedy." *See* 42 C.F.R. § 488.408(g)(1); *see also* 42 C.F.R. §§ 488.330(e), 498.3. However, CMS's choice of remedies and the factors CMS considered when choosing remedies are not subject to review. 42 C.F.R. § 488.408(g)(2).

In regard to the burden of proof, CMS must make a *prima facie* case that the SNF failed to comply substantially with federal participation requirements and, if this occurs, the SNF must, in order to prevail, prove substantial compliance by a preponderance of the evidence. *Hillman Rehab. Ctr.*, DAB No. 1611 at 8 (1997); *see Batavia Nursing & Convalescent Inn*, DAB No. 1911 (2004); *Batavia Nursing & Convalescent Ctr.*, DAB No. 1904 (2004); *Emerald Oaks*, DAB No. 1800 (2001); *Cross Creek Health Care Ctr.*, DAB No. 1665 (1998).

Lexington is a SNF located in Houston, Texas, that participates in the Medicare program. On April 23, 2014, the Texas Department of Aging and Disability Services (state agency) commenced a complaint survey of Petitioner's facility in response to a report from Lexington that on April 22, 2014, two facility residents died at the hands of a third resident. CMS Exhibit (Ex.) 1 at 1; CMS Ex. 2 at 1-2. Surveyors for the state agency initially exited the facility on May 7, 2014, notifying Lexington that it was not in substantial compliance with four separate program requirements applicable to SNFs, but without declaring immediate jeopardy. Petitioner's Exhibit (P. Ex.) 11 at 1; P. Ex. 14 ¶ 19. However, the surveyors returned thereafter and continued the survey until their final exit on May 23, 2014. Based on the entire survey, the state agency concluded that Lexington was not in substantial compliance with additional SNF program requirements and, most significantly, that some of those deficiencies were at the immediate jeopardy level. CMS Ex. 2. The state agency's determination of immediate jeopardy focused on the April 22, 2014 homicides and the environmental factors at Petitioner's facility that allegedly contributed to the homicides. *See* CMS Ex. 2 at 2-26, 73-99, 107-38.

Based on the survey, CMS issued an initial determination on June 11, 2014, in which it found that Petitioner was not in substantial compliance with 11 Medicare participation requirements, including four at the immediate jeopardy level (42 C.F.R. §§ 483.13(c), 483.25, 483.75, and 483.75(h)) and seven at the non-immediate jeopardy level (42 C.F.R. §§ 483.20(d) and 483.20(k)(1), 483.20(k)(3)(i), 483.20(k)(3)(ii), 483.20(m) and 483.20(e), 483.25(c), 483.25(d), and 483.75(*l*)(1)).[3] CMS Ex. 1 at 1. In a subsequent August 27, 2014 letter, CMS further found that Petitioner returned to substantial compliance on June 19, 2014. CMS Ex. 1 at 5. Due to these findings, CMS imposed a $5,800 per-day CMP for 30 days from April 22, 2014 through May 21, 2014, and a $1,000 per-day CMP for 28 days from May 21, 2014 through June 18, 2014, for a total CMP amount of $202,000.[4] CMS Ex. 1 at 5.

Petitioner timely requested a hearing to challenge the deficiencies cited in the June 11, 2014 initial determination and the associated $5,800 and $1,000 per-day CMPs imposed. Following receipt of Petitioner's hearing request, I issued an Acknowledgment and Prehearing Order that established a prehearing exchange schedule for the parties. In that order, I directed the parties to file briefs, proposed exhibits, and written direct testimony for all witnesses they wanted to present in this case. I also set forth guidelines for the parties to file a motion for summary disposition.

In compliance with my prehearing order, CMS filed a prehearing brief (CMS Br.) and 43 proposed exhibits (CMS Exs. 1-43), as well as a motion for summary disposition. Petitioner opposed CMS's motion and filed its prehearing brief (P. Br.), 33 proposed exhibits (P. Exs. 1-33), objections to various portions of CMS's pre-filed witness direct testimony, and a request to cross-examine CMS's witnesses. CMS did not object to any of Petitioner's exhibits nor did it seek to cross-examine any of Petitioner's witnesses.

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[3] The June 11, 2014 initial determination included a finding that Petitioner was not in substantial compliance with 42 C.F.R. § 483.12(a)(3), but CMS subsequently declined to pursue this alleged deficiency because it was deleted as a result of the Informal Dispute Resolution process. *See* P. Br. at 10.

[4] In its June 11, 2014 initial determination, CMS also imposed a prospective denial of payments for new admissions (DPNA) effective June 21, 2014, and a termination of Petitioner's Medicare and Medicaid provider agreement (termination) effective November 23, 2014. CMS Ex. 1 at 2-3. Because Petitioner returned to substantial compliance on June 19, 2014, CMS rescinded the DPNA and the termination in its August 27, 2014 letter, CMS Ex. 1 at 5, so neither of these remedies is at issue here.

In an August 19, 2015 order, I denied CMS's motion and scheduled the case for a hearing by video teleconference. Following my denial of CMS's motion for summary disposition, Petitioner moved for leave to request documents, depose witnesses, and designate a rebuttal expert on September 30, 2015. Thereafter, I held a telephone prehearing conference on October 14, 2015, and issued an order summarizing the conference on October 19, 2015, in which I explained that I denied Petitioner's September 30 motion and overruled Petitioner's objections to CMS's witness testimony.[5] In my order, I also noted that I was admitting CMS's and Petitioner's proposed exhibits into the record, with the caveat that I was only admitting CMS's pre-filed witness direct testimony (CMS Exs. 33-42) provisionally on condition that the witnesses appear at the video hearing. Hearing Transcript (Tr.) at 13-14.[6] I further directed CMS to produce its ten witnesses at the hearing for cross-examination.

Subsequent to the October 14, 2015 prehearing conference, Petitioner filed several documents, including a request for subpoenas of various categories of documents, a motion for leave to file an amended exhibit and witness list that included a request to submit a revised version of P. Ex. 29 along with the amended list and the revised version of P. Ex. 29, and a request for a subpoena for one of CMS's witnesses (Dr. Janet Appleby). CMS did not respond to Petitioner's request to submit a revised version of P. Ex. 29, but it did file opposition briefs to the document subpoena request and to the motion for leave to file an amended exhibit and witness list, to which Petitioner in turn filed written replies. In my order dated October 29, 2015, I denied Petitioner's document and witness subpoena requests, but ordered CMS to produce Dr. Appleby for cross-examination at the hearing or face exclusion of her written direct testimony (CMS Ex. 33) and I granted Petitioner's motion to file an amended exhibit and witness list.

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[5] Although I overruled Petitioner's objections to various hearsay statements CMS introduced into evidence in my October 19, 2015 Summary of Prehearing Conference and Order Establishing Procedures for Hearing (at 3), Petitioner later requested again that I exclude those statements. P. Post Hearing Br. at 2 n.1. I decline to reconsider my original ruling. I further note that, insofar as the statements Petitioner objects to are statements to surveyors by Petitioner's staff (and perhaps Deer Oaks staff to the extent the statements related to treatment provided to Petitioner's residents pursuant to the contract between Petitioner and Deer Oaks), those statements would likely not be hearsay under Fed. R. Evid. 801(d)(2). *See Carehouse Convalescent Hosp.*, DAB No. 1799 at 46-47, n.20 (2001).

[6] My October 19, 2015 order only references P. Exs. 1-28. However, I clarified on the record during the subsequent video hearing that I admitted P. Exs. 1-33 at the prehearing conference. Tr. at 14.

Thereafter, CMS and Petitioner each filed an additional motion. CMS moved to substitute a witness (Daniel McElroy) due to the unavailability of one of the witnesses (Susan LeBlanc) for whom it pre-filed written direct testimony. Petitioner's motion requested leave to file a rebuttal exhibit out of time. Each party filed an opposition brief responding to the other's motion, and each replied in writing to the other's opposition brief. In my order dated November 3, 2015, I denied Petitioner's motion and granted CMS's motion while limiting Mr. McElroy's testimony to the scope of the specific matters addressed in Ms. LeBlanc's written direct testimony.[7]

I held a video hearing on November 5, 2015, at which Petitioner's counsel cross-examined nine of CMS's witnesses (Dr. Janet Appleby, Mary Montgomery, Jacquelyne Malonson, Neira Roman, Blanca Cortes-Vargas, Jerry Jackson, Rose Bailey, Theresa Kpando, and Catherine Palmer). Tr. at 3. Because CMS produced those nine witnesses at the hearing, I admitted their pre-filed written direct testimony (CMS Exs. 33-41) into the record; I excluded CMS's pre-filed written direct testimony of Ms. LeBlanc (CMS Ex. 42) as she did not appear at the hearing. Tr. at 13-14.

After the hearing CMS and Petitioner filed post-hearing briefs (CMS Post Hearing Br. and P. Post Hearing Br.) and Petitioner filed a reply brief (P. Reply).

## II. Issues

The issues presented are:

1. Whether Petitioner was in substantial compliance with Medicare program participation requirements at 42 C.F.R. §§ 483.13(c), 483.20(d), 483.20(e), 483.20(k)(1), 483.20(k)(3)(i), and (ii), 483.20(m), 483.25, 483.25(c), 483.25(d), 483.75, 483.75(h), and 483.75(*l*)(1) from April 22, 2014, through June 18, 2014;[8]

2. If Petitioner was not in substantial compliance with Medicare program participation requirements, whether CMS's determination that immediate

[7] CMS ultimately withdrew Mr. McElroy as a witness at the hearing. Tr. 230.

[8] In this decision, I have not discussed all of these deficiencies because the deficiencies I uphold below are sufficient to justify both a finding of noncompliance and the imposition of the remedies proposed by CMS. *See Claiborne-Hughes Health Ctr.*, 609 F.3d 839, 847 (6th Cir. 2010); *Carrington Place of Muscatine*, DAB No. 2321 at 20-21 (2010).

jeopardy existed at the facility from April 22 through May 21, 2014, is clearly erroneous; and

3. If Petitioner was not in substantial compliance with Medicare program participation requirements, whether the CMPs imposed by CMS are reasonable in amount and duration.

## III. Jurisdiction

I have jurisdiction to hear and decide this case. 42 U.S.C. §§ 1320a-7a(c)(2), 1395i-3(h)(2)(B)(ii); 42 C.F.R. §§ 488.408(g), 488.434(a)(2)(viii), 498.3(b)(13).

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

My findings of fact and conclusions of law are set forth in italics and bold font followed by detailed factual and legal analyses.

### *A. Petitioner's treatment of Resident 3 reveals that Petitioner failed to comply substantially with Medicare participation requirements at 42 C.F.R. §§ 483.25 and 483.75, and thereby placed its residents in immediate jeopardy.*

#### *1. About two months before Resident 3 killed his roommates (Residents 1 and 2) on April 22, 2014, Resident 2 told a licensed professional counselor, for whom Petitioner contracted to provide care to Residents 2 and 3, that he feared Resident 3 and that he wanted his room changed; however, neither the licensed professional counselor nor anyone from his practice informed Petitioner of this and Petitioner took no action that might have avoided the deaths of Residents 1 and 2.*

Resident 3 was admitted to Petitioner's facility on September 29, 2011. CMS Ex. 16 at 1. At the time of admission, Resident 3 was a 53-year-old Spanish-speaking male with a history of diabetes, gastrointestinal illness, malnutrition, vascular disease, weakness, asthma, atrial fibrillation, bradycardia, and deep vein thrombosis, and a diagnosis of acute venous embolism and thrombosis of unspecified deep vessels of lower extremity. CMS Ex. 16 at 1-2. Shortly after admitting Resident 3, Petitioner listed multiple current diagnoses, including: asthma, general muscle weakness, abnormality of gait, lack of coordination, muscle disuse atrophy, cardiac dysrhythmia, atrial fibrillation, diabetes mellitus without complication, and hepatomegaly. CMS Ex. 16 at 1. By November 7, 2011, Petitioner had Resident 3's mental status assessed, which assessment concluded that he was depressive and suffered from anxiety. CMS Ex. 16 at 3. Resident 3's initial mental health treatment plan included target goals for treatment of anger, anxiety,

confusion, irritability, memory loss, paranoia/suspiciousness, depression, loss of pleasure/interest, nervous/worried, attention/concentration problems, and sleep disturbance. CMS Ex. 16 at 4. The plan also included a therapy goal of stabilizing or reducing affective or cognitive symptoms and a recommendation that Resident 3 be provided individual therapy twice a week for six months to reduce his affective or cognitive symptoms. CMS Ex. 16 at 4. Resident 3 was also prescribed and administered several different drugs to help control his symptoms. CMS Ex. 17 at 10-13, 18-23, 25, 28-30, 35, 40, 42, 45-51, 54; CMS Ex. 18. The clinical complexity of his mental health issues included moderately severe chronicity of the conditions, moderately severe co-morbid medical health problems, moderately severe intensity of the current symptom constellation, and moderately severe cognitive level of functioning or impairments. CMS Ex. 16 at 4.

Petitioner did not directly provide psychological and psychiatric services to residents, like Resident 3, who needed mental health services. Instead, Petitioner had contracts with psychological and psychiatric services providers (mental health providers), such as Deer Oaks Consultation Services (Deer Oaks) and Boris Rubashkin, MD and Associates, to provide such services to its residents. CMS Ex. 17 at 10-13, 18-23, 25, 28-30, 35, 42, 44-52 (forms for "Boris Rubashkin, MD and Associates" in Resident 3's medical records); CMS Ex. 25 (psychological services agreement between Deer Oaks and Petitioner); P Ex. 13 at 1 ¶ 4. These mental health providers communicated with Petitioner's staff in several different ways, including through psychological progress notes, psychiatric review/mental status reports, and medication orders found in residents' clinical records. CMS Ex. 15 at 2-4, 36-37, 132-34; CMS Ex. 17; P. Ex. 13 at 3-5 ¶¶ 10-17; P. Ex. 14 at 3-4 ¶ 12; P. Ex. 22. Periodically, the mental health providers along with Petitioner's staff also performed and signed reviews of resident clinical treatment plans. CMS Ex. 15 at 132-34; CMS Ex. 17 at 7-9, 39-41, 53-55. Finally, the mental health providers and Petitioner's staff met quarterly for psychology meetings to confer in person about the residents receiving mental health services. P. Ex. 14 at 3-4 ¶¶ 11-13.

Despite these methods of communication, it does not appear that Petitioner's staff and the mental health providers had perfectly aligned communicative expectations. According to testimony from Petitioner's Director of Nursing (DON), Charles Kolawole; Petitioner's Administrator, Jesse Sias; and one of Petitioner's social workers, Valericia Deflanders, the mental health providers would come to them with any problems they discovered with Petitioner's residents. P Ex. 12 at 2 ¶ 6; P. Ex. 14 at 2 ¶¶ 5-6; P. Ex. 20 at 2 ¶ 7. However, a psychiatric nurse practitioner from Boris Rubashkin, MD and Associates, Donna Edwards, testified that it was either the psychiatrist, Dr. Boris Rubashkin, or Petitioner's staff—including nurses, the DON, social workers, and the assistant DON (ADON)—who would come to her if there were problems with Petitioner's residents. P Ex. 13 at 1-2 ¶ 4. Dr. Rubashkin similarly testified that he "usually rel[ies] on reports from the [nursing home] staff" and that the staff "usually do[es]" call him if they notice any problems. P. Ex. 22 at 1-2 ¶¶ 4-6. Neither Dr. Rubashkin nor Nurse Practitioner

Edwards testified that their practice was to report any problems to Petitioner's staff despite DON Kolawole's, Administrator Sias's, and Social Worker Deflanders's testimony that they relied on such reporting.[9]

In 2013 and early 2014, Resident 3 received mental health services from Dr. Rubashkin, Nurse Practitioner Edwards, and Jesus Perez, a licensed professional counselor working for Deer Oaks. CMS Ex. 6 at 9; CMS Ex. 17; P. Exs. 13, 22. Resident 3's medical records from that period contain multiple psychological progress notes from his frequent therapy sessions, psychiatric review/mental status reports, and periodically updated versions of Resident 3's clinical treatment plan. CMS Ex. 17. The psychiatric reviews generally indicate that Resident 3's risk of committing physical violence was "mild"[10] or "not evident," his risk for psychosis was either "mild" or "moderate," and his risk for complications or decompensation was either "moderate" or "high." CMS Ex. 17 at 11-13, 18-23, 25, 28-30, 35, 42, 44-51. The psychiatric review from March 31, 2014, which lists his risk of committing physical violence as "mild," his risk of psychosis as "moderate," and his risk of complications or decompensation as "high," also states that Resident 3 reported he was "[g]rimacing more in front of people, able to control it." CMS Ex. 17 at 42. The psychological services progress notes show that his risk for homicidal or aggressive behavior was "none," while his risk for delusions or hallucinations was "current" in every progress note except one dated April 9, 2014, that lists his risk for delusions or hallucinations as "none." CMS Ex. 17 at 14-17, 24, 26-27, 31-34, 36-38, 43.

Two separate clinical treatment plans of review for Resident 3 contain additional information regarding the status of his various conditions from January 2013 through March 2014. In the earlier clinical treatment plan of review, dated August 26, 2013, Resident 3 was assessed as having, among other things, no hostility (marked as "none"), "very mild" suspiciousness, and "moderate" hallucinations, and his total score on the brief psychiatric rating scale (BPRS) was 40.[11] CMS Ex. 17 at 53. In the later plan of review, dated March 31, 2014, Resident 3 was assessed as having increased levels of

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[9] A Deer Oaks staff member who worked with some of Petitioner's residents claimed during an interview with one of the state agency's surveyors that he generally would report to Petitioner's staff if any residents were suicidal, aggressive, or violent. CMS Ex. 6 at 10. However, I do not credit this claim for reasons that I explore further below.

[10] According to Nurse Practitioner Edwards, a marking of "'[m]ild' represents very little cause for concern on the scale on our form" and it "mean[s] that the risk is possible but remote." P. Ex. 13 at 4 ¶12 .

[11] In order to be discharged from psychiatric/psychological care, Resident 3 needed his BPRS score decreased to less than 30. CMS Ex. 17 at 40, 54.

each of these symptoms, including "moderately severe" hostility, "moderate" suspiciousness, and "moderately severe" hallucinations, as well as a total BPRS score of 56. CMS Ex. 17 at 39. The March 31, 2014 clinical treatment plan of review also contains a handwritten note stating that Resident 3 "is highly delusional and hallucinates." CMS Ex. 17 at 40.

Other medical records for Resident 3 relate to his mental health. Behavioral monitoring sheets for Resident 3 indicate that he did not engage in violent behavior between January 1, 2014 and April 21, 2014. CMS Ex. 16 at 23, 28, 38, 50, 53. However, facility personnel noted on April 15, 2014, that Resident 3 "ha[d] a history of thinking people are poisoning his food or talking about him." P. Ex. 2 at 1.

Resident 3's living situation had an effect on his mental health. According to the testimony of Nurse Practitioner Edwards, which I credit to the extent I discuss it, when she started treating Resident 3, he was in a two-person room where he "was like stone" and would "isolate himself and do nothing." P. Ex. 13 at 2 ¶ 7. In May 2013, Resident 3 moved into a new, four-person room with three other Spanish-speaking roommates, Residents 1, 2, and 4, and "began to get better." P. Ex. 13 at 2, 4-5 ¶¶ 7, 12, 15. Nurse Practitioner Edwards periodically visited Resident 3 (as well as with one of his roommates, Resident 2) and, over time, she also noticed improvements in his mood and behavioral symptoms, in part because of his room switch. CMS Ex. 17 at 47; *see also* P. Ex. 22 at 4-5 ¶¶ 13-17. Petitioner's Activities Director and Wellness Director, SuWon Moore, also thought Resident 3 improved after his room switch. P. Ex. 25 at 3 ¶ 8. According to Nurse Practitioner Edwards, Dr. Rubashkin, and many of Petitioner's staff, Resident 3 got along well with his roommates. P. Ex. 12 at 6 ¶ 22; P. Ex. 13 at 3 ¶ 8; P. Ex. 14 at 1-2 ¶ 4; P. Ex. 15 at 2 ¶ 5; P. Ex. 16 at 1-2 ¶ 5; P. Ex. 17 at 2 ¶ 5; P. Ex. 19 at 2 ¶ 8; P. Ex. 21 at 2 ¶ 11; P. Ex. 22 at 3 ¶ 9; P. Ex. 23 at 2 ¶ 8; P. Ex. 24 at 1-2 ¶ 4; P. Ex. 25 at 2-3 ¶¶ 6-8; P. Ex. 28 at 1 ¶ 4.

Despite this, on April 22, 2014, Resident 3 attacked Residents 1 and 2, and Residents 1 and 2 died as a result of the attack. CMS P. Br. at 3; Tr. 206-07; CMS Ex. 2 at 74. Blanca Mares-Venegas, a certified nurse assistant (CNA) on duty at the time of the killings, testified credibly about the grisly scene she discovered when she walked into the room after the deed: Resident 1 was "slumped over his bed" and there was "brain matter on the floor." P. Ex. 28 at 2 ¶¶ 8-9. Another CNA who was on duty that night, Frances Ayanru, testified credibly that "[t]he blood was dripping all over the floor." P. Ex. 15 at 3 ¶ 14. Paramedics happened to be at Petitioner's facility with another Resident and responded to "the Code"; however, Resident 1 was already dead and Resident 2 died shortly thereafter in the hospital. CMS Ex. 2 at 74; P. Ex. 17 at 3 ¶ 15; P. Ex. 28 at 2-3 ¶¶ 10-11. Petitioner's staff and paramedics initially thought that Residents 1 and 2 were shot, but the police later found the weapon used to kill them—the arm of a wheelchair—in a trash can in the lobby. CMS Ex. 2 at 7; P. Ex. 15 at 3 ¶ 15; P. Ex. 17 at 3 ¶ 12; P. Ex. 28 at 2-3 ¶¶ 11-12, 15. Resident 3 was not immediately a suspect; however, the police

noticed blood on the wheelchair that Resident 3 was occupying. P. Ex. 28 at 3 ¶ 15. Ultimately, the police arrested Resident 3, and Petitioner discharged him into their custody. CMS Ex. 2 at 74; CMS Ex. 19 at 7. Many of the staff members testified that they were shocked to find out what had happened and that they did not see it coming. P. Ex. 15 at 3 ¶ 17; P. Ex. 16 at 2 ¶ 6; P. Ex. 17 at 4 ¶ 17; P. Ex. 20 at 3 ¶ 12; P. Ex. 21 at 2 ¶ 13; P. Ex. 23 at 2 ¶ 10; P. Ex. 25 at 3 ¶ 13.

As already mentioned, Petitioner self-reported this incident to the state agency, leading to the state agency's survey. During the survey, Surveyor Neira Roman interviewed Mr. Jesus Perez, the licensed professional counselor who treated Residents 1, 2, and 3 prior to the homicides, and took notes during the interview. CMS Ex. 6 at 9-10. According to Surveyor Roman's notes, Mr. Perez indicated that about two months before the interview, Resident 2 had expressed that he was afraid of Resident 3 because Resident 3 was mean to him and yelled at him and that he (Resident 2) wanted to switch rooms as a result. CMS Ex. 6 at 9-10. Mr. Perez claimed that at the time, he did not think Resident 2's situation was urgent because Resident 2 did not sound desperate, so he only noted the incident in his personal notes and did not put it into his notes for Petitioner's staff. CMS Ex. 6 at 9. Mr. Perez planned to report the incident to Petitioner's staff at the quarterly psychology meeting on March 31, 2014, but he did not make it to the meeting and instead gave his notes to his supervisor. CMS Ex. 6 at 9. He did not know whether his supervisor reported the incident, however. CMS Ex. 6 at 10. Mr. Perez also informed Surveyor Roman that Resident 3 had delusions that Petitioner's staff was poisoning his food, that people were looking into his bedroom window and laughing about him, and that people walking in the hallways were calling him crazy. CMS Ex. 6 at 9; CMS Ex. 34 at 2 ¶ D.

The evidence from the March 31, 2014 quarterly psychological meeting shows that no one from Deer Oaks reported what Resident 2 said to Mr. Perez. That the meeting occurred is evidenced by Clinical Treatment Plan Reviews for both Residents 2 and 3 completed and signed by staff members for Petitioner and the mental health providers (including Deer Oaks) on that date. CMS Ex. 15 at 132-34; CMS Ex. 17 at 39-41. The same individuals representing Petitioner and the mental health providers at the meeting signed both residents' reviews. CMS Ex. 15 at 134; CMS Ex. 17 at 41. Resident 2's Clinical Treatment Plan Review does not mention his expressed desire to switch rooms due to his fear of Resident 3. CMS Ex. 15 at 132-34. Social Worker Deflanders also testified that she was at the meeting and that "no one mentioned any changes for . . . Resident #3." P. Ex. 20 at 2 ¶ 9. Consistent with this is the testimony from Dr. Appleby and Surveyor Roman that their interviews revealed that Petitioner's staff was not told about Resident 2's expression of his fear of Resident 3 during the March 31, 2014 quarterly psychological meeting. CMS Ex. 33 at 2 ¶ I.C; CMS Ex. 34 at 2 ¶¶ I.E & I.F. Resident 2 continued to live with Resident 3 after the meeting, right up until his death at Resident 3's hands. P. Ex. 21 at 2 ¶ 11.

***2. Petitioner was not in substantial compliance with 42 C.F.R. § 483.25 at the immediate jeopardy level because Petitioner failed to effectively coordinate care and promote effective communication between its staff and the contracted mental health providers, and this failure contributed to the deaths of Residents 1 and 2.***

The quality of care regulation at 42 C.F.R. § 483.25 states that "[e]ach resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care." CMS argues that Petitioner did not substantially comply with § 483.25 in several ways. CMS's primary argument is that Petitioner "failed to coordinate care and communicate effectively with psychiatric and psychological service providers for Resident 3's psychiatric conditions" in violation of § 483.25. CMS Post Hearing Br. at 11; *see also id.* at 12, 21. CMS also argues that Petitioner "failed to provide effective training to the staff regarding residents with psychiatric diagnoses" and "failed to use the plan of care regarding Resident 3's psychiatric and psychological evaluations, assessments, and progress notes to develop interventions to address his recurrent issues of delusions, hallucinations, hostility, and anxiety," both in violation of § 483.25. *Id.* at 11-12; *see also id.* at 13-14. CMS argues that both of these violations "posed immediate jeopardy to the health and safety of [Petitioner's] residents." *Id.* at 15. CMS cites various pieces of evidence in support of these arguments. *Id.* at 12-14.

Petitioner counters that it substantially complied with § 483.25. Petitioner does not contest that it was responsible for ensuring adequate communication and coordination of care between its staff and the mental health providers. However, Petitioner contends that Resident 3's clinical record "is replete with communications" to Petitioner's staff from his psychiatrist, psychiatric nurse practitioner, and counselor, evidencing an adequate system of coordination and communication between Petitioner's staff and the mental health providers. P. Post Hearing Br. at 12-13, 18. Petitioner further contends that it provided its staff with effective training that "address[ed] the recognition, documentation, and/or prevention of problem behaviors by residents" and that it provided Resident 3 with "both psychological and nursing care plans that addressed his observed behavioral problems." *Id.* at 13-14, 18. Petitioner also contends that CMS has failed to substantiate with admissible evidence its arguments that Petitioner did not substantially comply with § 483.25. *Id.* at 12, 14, 18.

For the reasons that follow, I conclude that CMS has established a *prima facie* case that Petitioner did not substantially comply with § 483.25 and Petitioner has failed to rebut CMS's *prima facie* case. I premise my conclusion that Petitioner did not substantially comply with § 483.25 on the inadequacy of Petitioner's system of communication between its staff and the mental health providers, particularly Deer Oaks, and on my further conclusion that CMS did not clearly err in determining that this inadequacy posed

immediate jeopardy to the health and safety of Petitioner's residents. Consequently, I do not address CMS's other arguments concerning Petitioner's noncompliance with § 483.25.

The record reveals that there were several avenues of communication between the mental health providers and Petitioner's staff. Dr. Rubashkin and Nurse Practitioner Edwards from Boris Rubashkin, MD and Associates and Counselor Perez from Deer Oaks regularly visited several of Petitioner's residents, including Resident 2 and Resident 3, and communicated with Petitioner's staff through written psychological progress notes, psychiatric review/mental status reports, and medication orders found in the residents' clinical record. CMS Ex. 15 at 2-4, 36-37, 132-34; CMS Ex. 17; P. Ex. 13 at 3-5 ¶¶ 10-17; P. Ex. 14 at 3-4 ¶ 12; P. Ex. 22. The mental health providers, in conjunction with Petitioner's staff, performed and signed periodic reviews of resident clinical treatment plans. CMS Ex. 15 at 132-34; CMS Ex. 17 at 7-9, 39-41, 53-55. The mental health providers and Petitioner's staff also conferred in person at quarterly psychology meetings. P. Ex. 14 at 3-4 ¶¶ 11-13.

Despite these methods of communication between the mental health providers and Petitioner's staff, other evidence in the record reveals a troubling disconnect between the two. According to DON Kolawole, Administrator Sias, and Social Worker DeFlanders, the mental health providers would come to them with any problems. P Ex. 12 at 2 ¶ 6; P. Ex. 14 at 2 ¶¶ 5-6; P. Ex. 20 at 2 ¶ 7. However, Nurse Practitioner Edwards testified that it was either the psychiatrist, Dr. Rubashkin, or Petitioner's staff—including nurses, the DON, social workers, and the ADON—who would come to her if there were problems. P Ex. 13 at 1-2. Dr. Rubashkin similarly testified that he "usually rel[ies] on reports from the [nursing home] staff" and that the staff "usually do[es]" call him if they notice any problems. P. Ex. 22 at 1-2 ¶¶ 4-6. Neither Dr. Rubashkin nor Nurse Practitioner Edwards testified that their practice was to report any problems to Petitioner's staff despite several members of Petitioner's staff testifying that they relied on such reporting.[12] This evidence of the potentially conflicting communicative expectations of Petitioner's staff and the mental health providers (i.e., Petitioner's staff expected the mental health providers to inform them of any problems and vice versa) suggests that there was a serious communicative gap between the two.

[12] As I noted above, see *supra* note 9, Mr. Perez, the Deer Oaks counselor, claimed during his interview with Surveyor Roman that he generally would report to Petitioner's staff if any residents were suicidal, aggressive, or violent. CMS Ex. 6 at 10. However, in light of Mr. Perez's failure to report to Petitioner's staff that Resident 2 was afraid of Resident 3 and wanted to change rooms, this claim is not credible. CMS Ex. 6 at 9-10.

Confirming and illustrating the existence of this serious communicative gap is the incident involving Resident 2 that Mr. Perez revealed to Surveyor Roman. According to Mr. Perez, in early March 2014, Resident 2 expressed that he was afraid of Resident 3 and consequently wanted to switch rooms. Mr. Perez did not report this incident directly to Petitioner's staff; instead, he noted it in his personal notes and reported it to his supervisor. He claimed that he was planning to bring up the incident at the quarterly psychology meeting on March 31, 2014, but he did not make it to the meeting and could not confirm that the incident was ever reported to Petitioner's staff.[13] CMS Ex. 6 at 9-10. The mental health providers and Petitioner's staff did have their quarterly psychology meeting on March 31, 2014; at the meeting, the same individuals from the mental health providers and Petitioner's staff completed and signed both Resident 2's and Resident 3's Clinical Treatment Plan Review. CMS Ex. 15 at 132-34; CMS Ex. 17 at 39-41. Importantly, Resident 2's March 31, 2014 Clinical Treatment Plan Review does not mention his expressed desire to switch rooms because of his fear of Resident 3. CMS Ex. 15 at 132-34. Furthermore, Petitioner did not place Resident 2 in a new room, and he continued to live with Resident 3 until the night of his death. Social Worker Deflanders, who attended the meeting, also testified that at the meeting, "no one mentioned any changes for . . . Resident #3." P. Ex. 20 at 2 ¶ 9. The evidence thus shows that Deer Oaks staff never informed Petitioner's staff of Resident 2's complaint against Resident 3 because of a communicative gap between the two.

Mr. Perez's failure to communicate the incident involving Residents 2 and 3 to Petitioner's staff coupled with the mismatched communicative expectations of the mental health providers and Petitioner's staff undermines Petitioner's arguments that it had an adequate system of coordination and communication between its staff and the mental health providers. Based on this evidence, I find that Petitioner failed to effectively coordinate care and promote effective communication between its staff and the mental health providers. I further find that this failure interfered with Petitioner's duty to provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of Petitioner's residents in general, and Residents 1, 2, and 3 in particular, in violation of 42 C.F.R. § 483.25. I therefore conclude that Petitioner's failure to effectively coordinate care and promote effective communication between its staff and the mental health providers shows Petitioner was not in substantial compliance with § 483.25.

I also conclude that CMS's determination that Petitioner's violation of § 483.25 posed immediate jeopardy to resident health and safety is not clearly erroneous. Immediate

[13] Petitioner neither submitted written direct testimony from Mr. Perez to refute Surveyor Roman's interview notes nor sought a subpoena to compel Mr. Perez to testify at the hearing in this case.

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. The regulation does not require that a resident *actually* be harmed. *Lakeport Skilled Nursing Ctr.*, DAB No. 2435 at 8 (2012). I must uphold CMS's determination as to the level of a facility's substantial noncompliance (which includes an immediate jeopardy finding) unless it is "clearly erroneous." 42 C.F.R. § 498.60(c). The "clearly erroneous" standard imposes on facilities a heavy burden to show no immediate jeopardy, and the DAB has sustained determinations of immediate jeopardy where CMS presented evidence "from which '[o]ne could reasonably conclude' that immediate jeopardy exists." *See, e.g.*, *Barbourville Nursing Home*, DAB No. 1962 at 11 (2005) (citing *Florence Park Care Ctr.*, DAB No. 1931 at 27-28 (2004)), *aff'd, Barbourville Nursing Home v. United States Dep't of Health & Human Servs.*, 174 F. App'x 932 (6th Cir. 2006); *see also, e.g.*, *Easley v. Cromartie*, 532 U.S. 234, 242 (2001) ("In applying [the clearly erroneous] standard, . . . a reviewing court must ask whether, 'on the entire evidence,' it is 'left with the definite and firm conviction that a mistake has been committed.'"). Additionally, "[i]nadequate survey performance does not . . . [i]nvalidate documented deficiencies." 42 C.F.R. § 488.318(b).

Petitioner contends that even assuming it violated 42 C.F.R. § 483.25, any violation was not causally connected to the deaths of Residents 1 and 2 and thus did not pose immediate jeopardy to resident health and safety. P. Post Hearing Br. at 23. In support of this contention, Petitioner asserts that a variety of evidence in the record shows that Resident 3 did not have violent tendencies and gave no hint that he was at risk for committing any physical violence, let alone homicide. *Id.* at 11-14. Petitioner contends that this evidence demonstrates that it "could not have . . . reasonably anticipated or prevented" Resident 3's homicidal actions. *Id.* at 12. Petitioner also calls into question the method by which CMS called immediate jeopardy, contending that the improper method of calling immediate jeopardy confirms that there in fact was no immediate jeopardy. *Id.* at 23-25.

Petitioner is not wrong to assert that there is much evidence suggesting that Resident 3 did not have violent tendencies. In particular, there is no evidence that Resident 3 engaged in violent behavior in the months leading up to the killings, and he had no apparent history of violence. CMS Ex. 16 at 23, 28, 38, 50, 53; P. Ex. 22 at 3 ¶ 9. By most accounts, Resident 3 got along with his roommates, and he participated in frequent therapy sessions. CMS Ex. 17; P. Ex. 12 at 6 ¶ 22; P. Ex. 13 at 2 ¶ 8; P. Ex. 14 at 1-2 ¶ 4; P. Ex. 15 at 2 ¶ 5; P. Ex. 16 at 1-2 ¶ 5; P. Ex. 17 at 2 ¶ 5; P. Ex. 19 at 2 ¶ 8; P. Ex. 21 at 2 ¶ 11; P. Ex. 22 at 3 ¶ 9; P. Ex. 23 at 2 ¶ 8; P. Ex. 24 at 1-2 ¶ 4; P. Ex. 25 at 2-3 ¶¶ 6-8; P. Ex. 28 at 1 ¶ 4. In addition, the psychiatric reviews for Resident 3 indicate that his risk of physical violence was either "mild" or "not evident" and the psychological services progress notes for him show that his risk for homicidal or aggressive behavior was "none." CMS Ex. 17 at 11-38, 42-51.

However, other evidence raises questions about Resident 3's potential for violence. Many of those same psychiatric reviews indicate that Resident 3's risk for psychosis was "moderate," and on March 31, 2014—the same day as the quarterly psychology meeting—Resident 3 self-reported that he was "[g]rimacing more in front of people," although he claimed that he was "able to control it." CMS Ex. 17 at 11-13, 18-22, 30, 35, 42, 46-51. The psychiatric review from March 31, 2014, also indicated that his risk of physical violence was "mild," which is more than "not evident." CMS Ex. 17 at 42. Furthermore, many of the psychological services progress notes show that he had "current" delusions/hallucinations. CMS Ex. 17 at 16-17, 24, 26-27, 31-34, 36-38. In addition, Resident 3's March 31, 2014 clinical treatment plan of review produced at the quarterly psychology meeting indicated that several key symptoms that afflicted Resident 3 had increased since the previous August 26, 2013 clinical treatment plan of review. CMS Ex. 17 at 39, 53. Specifically, Resident 3's suspiciousness increased from "very mild" to "moderate," his hallucinations increased from "moderate" to "moderately severe," and, most concerning, his hostility went from "none" to "moderately severe." CMS Ex. 17 at 39, 53. The March 31, 2014 clinical treatment plan of review also contains a note that Resident 3 "is highly delusional and hallucinates." CMS Ex. 17 at 40. According to Mr. Perez, Resident 3 had delusions that Petitioner's staff was poisoning his food, that people were looking into his bedroom window and laughing about him, and that people walking in the hallways were calling him crazy. CMS Ex. 6 at 9; CMS Ex. 34 at 2 ¶ D. A notation from Petitioner's staff on April 15, 2014, corroborates that Resident 3 "ha[d] a history of thinking people are poisoning his food or talking about him." P. Ex. 2 at 1.

Although the foregoing evidence, which Petitioner's staff had available for review, suggests Resident 3 suffered some deep problems and posed at least some risk of physical violence, it does not clearly show Resident 3 as a man on the verge of homicide in the time leading up to the deaths of Residents 1 and 2. The problem, however, is that this picture is incomplete and distorted because of Petitioner's own failings. Petitioner was responsible for ensuring that there was effective communication between its staff and the mental health providers. Yet as I have already found, it failed to do so, and as a result, Deer Oaks staff did not report to Petitioner's staff that Resident 2 expressed to Mr. Perez that he was sufficiently afraid of Resident 3 that he wanted to move to a new room. Without this information, Petitioner's staff lacked a complete picture of the risks of violence that Resident 3 posed.

In the circumstances of this case, the distortion created by Petitioner's failure to ensure that Deer Oaks staff told Petitioner's staff about Resident 2's expression of his fear of Resident 3 turned out to be very serious. Shortly after Resident 2 expressed his fear, Resident 3 killed him. By itself, this strongly indicates that Petitioner's staff had an incomplete view of Resident 3, as multiple staff members testified that they did not see the killings coming. P. Ex. 15 at 3 ¶ 17; P. Ex. 16 at 2 ¶ 6; P. Ex. 17 at 3-4 ¶¶ 13, 17; P. Ex. 20 at 3 ¶ 12; P. Ex. 21 at 2 ¶ 13; P. Ex. 23 at 2 ¶ 10; P. Ex. 25 at 3 ¶ 13.

Even without the benefit of hindsight, however, Resident 2's expression of fear would have been crucial information for Petitioner's staff to have at the time it happened. The evidence presented shows that Resident 2 was in near constant company with Resident 3, much more so than was Petitioner's staff or staff for the mental health providers. Resident 2 was thus in a unique position to regularly observe Resident 3's behavior. Therefore, even from Petitioner's perspective prior to the homicides, Resident 2's expression of his fear of Resident 3 could and likely would have put some of the other troubling signs about which Petitioner did know (e.g., his delusions and hallucinations related to a fear of poisoning, his grimacing problem, etc.) into perspective and alerted Petitioner to the potential danger Resident 3 posed. This should and likely would have spurred Petitioner to take some action beyond what was contained in Resident 3's care plan to mitigate the potential danger.

In light of the foregoing, I am not persuaded that Petitioner's violation of 42 C.F.R. § 483.25 was not causally connected to Resident 3 killing Resident 1 and Resident 2 or that it did not pose immediate jeopardy to resident health and safety, as Petitioner contends. After reviewing all the evidence presented, I am not "left with the definite and firm conviction that a mistake has been committed." *Easley*, 532 U.S. at 242. To the contrary, I conclude that although there is significant evidence suggesting Resident 3 was not homicidal or violent, that evidence is insufficient to show that CMS's immediate jeopardy determination is clearly erroneous.

Petitioner's contention that CMS employed an improper method for calling immediate jeopardy does not change this conclusion. Although Petitioner expended significant time at the hearing and in its briefs questioning the propriety of the immediate jeopardy determination, Tr. at 22-39, 94-106, 116-35, 175-77; P. Br. at 1, 22-23; P. Post Hearing Br. at 2, 23-25; P. Response at 21-22, my foregoing analysis shows that CMS adequately documented Petitioner's immediate jeopardy noncompliance with § 483.25. Consequently, even assuming *arguendo* that the surveys at issue here were performed inadequately, as Petitioner contends, this assumed inadequacy is irrelevant to the outcome. *See* 42 C.F.R. § 488.418(b)(2).

### *3. Petitioner was not in substantial compliance with 42 C.F.R. § 483.75 at the immediate jeopardy level for the same reasons it was not in substantial compliance with 42 C.F.R. § 483.25 at the immediate jeopardy level.*

The regulation at 42 C.F.R. § 483.75 provides that:

> A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or

> maintain the highest practicable physical, mental, and psychosocial well-being of each resident.

The regulation also includes specific requirements with federal, state, and local laws and professional standards and in other areas, including licensure; training; registry verification; in-service education; staff qualifications; provision of laboratory, radiology and other diagnostic services; and clinical records. 42 C.F.R. § 483.75(a)-(p). The language of § 483.75 is such that any failure of management that adversely affects a resident constitutes a violation. *See, e.g.*, *Stone Cty. Nursing & Rehab. Ctr.*, DAB No. 2276 at 15 (2009) ("[A] determination that a SNF failed to comply substantially with section 483.75 may be derived from findings that the SNF was not in substantial compliance with other participation requirements." (citing *Life Care Ctr. at Bardstown*, DAB No. 2233 at 28(2009) and *Britthaven, Inc. d/b/a Britthaven of Smithfield*, DAB No. 2018 at 22 (2006))).

As stated in one case:

> The administrative deficiency [at 42 C.F.R. § 483.75] is a derivative deficiency based on findings of other deficiencies . . . where 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.

*Asbury Ctr. at Johnson City*, DAB No. 1815 at 11 (2002); *see also Odd Fellow & Rebekah Health Care Facility*, DAB No. 1839 (2002).

CMS argues that Petitioner did not substantially comply with § 483.75 based on a variety of administrative failures and that this noncompliance posed immediate jeopardy to its residents' health and safety. Any failure of management that adversely affects a resident constitutes a violation of § 483.75. I have already found that Petitioner violated Medicare participation requirements at § 483.25 and that this violation posed immediate jeopardy. The same evidence that supports that deficiency finding also supports my conclusion that Petitioner failed to comply with the administration requirement and that this failure posed immediate jeopardy to Petitioner's residents.

### *B. Petitioner's nursing documentation reveals that Petitioner failed to comply substantially with 42 C.F.R. §§ 483.20(k)(3)(i), 483.20(k)(3)(ii), and 483.75(l)(1).*

#### *1. Petitioner's staff failed to assess and properly record the behavior of numerous residents, assess and properly record the pain of several residents, and administer medications as well as additional nourishment to several residents.*

Petitioner had a policy for dealing with behavioral assessment and monitoring. CMS Ex. 28. In the case of a resident "being treated for problematic behavior or mood," Petitioner's staff was supposed to document, among other things, the "[n]umber and frequency of episodes." CMS Ex. 28 at 1. According to DON Kolawole's testimony, nursing staff was trained "to enter a '0' when a behavior was not observed rather than leaving a blank space." P. Ex. 12 at 3-4 ¶ 12. He emphasized the importance of this practice during the survey "because a blank space on the behavior sheets could be construed as indicating that no observation had occurred at all." P. Ex. 12 at 3-4 ¶ 12. He noted also that "[w]hen a nurse makes an error, it is [his] policy to document the error." P Ex. 12 at 4 ¶ 14. His testimony is consistent with training documents that pre-date the survey. P. Ex. 31 at 29-30.

According to the written direct testimony of Jerry Jackson, RN, one of the state agency's surveyors, Petitioner's nursing staff, despite their training and Petitioner's behavioral monitoring policy, left blanks on behavioral monitoring sheets for 25 different residents who were supposed to be receiving behavioral monitoring for various behaviors. CMS Ex. 37 at 3-10. At the hearing, Surveyor Jackson testified that on May 16, 2014, during his time participating in the survey of Petitioner's facility, he reviewed and made copies of the behavioral monitoring sheets for the month of May for those residents "to document . . . that there were blanks in the behavioral monitoring." Tr. 184-86. He further testified at the hearing, consistent with his written direct testimony, that on a later date, either May 19, 20, or 21, 2014, he again reviewed those behavioral monitoring sheets and found that someone had filled in the blanks after his initial review on May 16. Tr. 186; CMS Ex. 37 at 3-10. I credit this testimony, as it is consistent with DON Kolawole's own testimony that "three nurses took it upon themselves to go back through some of the behavior sheets and fill in a '0' where previously there had been blanks" even though he never "instruct[ed] the nurses to make these changes."[14] P. Ex. 12 at

[14] Doing so would apparently violate professional standards set forth in a publication titled "Long Term Care Health Information and Documentation Guidelines" put forth by the American Health Information Management Association. CMS Ex. 2 at 54-55. Neither party included a copy of the relevant portion of the Guidelines in the record,

4 ¶ 13. Moreover, Petitioner concedes that members of its staff "took it upon themselves to go back and supplement behavioral monitoring sheets for a number of residents by filling in '0' where there had been blank spaces." P. Post Hearing Br. at 15. According to the Statement of Deficiencies (SOD), the failure by Petitioner's staff to complete the behavioral monitoring sheets constituted a pattern of no actual harm with the potential for more than minimal harm in that it "placed each of [Petitioner's] 142 residents at risk by prov[id]ing faulty information to caregivers making healthcare decisions." CMS Ex. 2 at 31-32.

Medical records reveal further problems with care given to several residents. For ease of reference, I include the allegations from the SOD relating to each resident at issue followed by the medical records evidence contained in the record, organized by resident.

**Resident 2**

The SOD allegations related to problems with Resident 2's care are as follows:

> Record review of [Resident 2]'s April 2014 physician orders revealed orders for Lactulose 10 gm/ml solution, give 30 ml to equal 20 gm 2 times per day; Tylenol, 1,000 mg 2 times per day; Pepcid, 20 mg, once daily in the morning; Aspirin, 325 mg once daily in the morning; Geodon, 40 mg once daily in the morning; Depakene, 250 mg per 5 ml, 750 mg to be given (equals 15 ml) 2 times per day; Temazepam, 15 mg once daily at bedtime and Ativan, 1 mg once daily at 8 pm.
>
> Record review of [Resident 2]'s April 2014 [Medical Administration Record (MAR)] sheet revealed the following medications were not documented as being given per doctor's orders: Lactulose on 4/6/14 at 4:00pm; Tylenol on 4/9/14 at 9:00pm; Pepcid on 4/9/14 at 6:30am; Ativan on 4/9/14 at 8:00pm; Aspirin on 4/22/14 at 6:30am; Geodon on 4/6/14 at 8:00am; Depakene on 4/10/14 at 8:00am; Temazepam on 4/9/14 at 8:00pm.
>
> Record review of [Resident 2]'s April 2014 physician orders revealed an order for pain to be assessed and documented each shift. Record review of [Resident 2]'s April 2014 Pain Medication & Pain Assessment sheet revealed on the

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however; the reference to them comes secondhand from the Statement of Deficiencies. I therefore do not rely on these Guidelines for my decision.

> following dates and times, there was no documentation that an assessment had been performed: 4/4/14 during the 6 to 2 shift, 4/18/14 during the 2 to 10 shift, and 4/22/13 during the 10 to 6 shift.
>
> Record review of [Resident 2]'s April 2014 physician orders revealed an order for a peanut butter sandwich and milk to be given to the resident daily at bedtime. Record review of [Resident 2]'s April 2014 Supplements and Dietary sheet revealed on 4/9/14 at 8:00pm, there was no documentation the doctor's order had been followed.
>
> Record review of [Resident 2]'s April 2014 physician orders revealed an order that the resident be given Penugard Oral Rinse to swish and rinse 2 times per day in the morning and night after meals. Record review of [Resident 2]'s April 2014 Treatment Administration Record sheet revealed on 4/6/14 at 9:00 am and on 4/18/14 at 9:00 pm, there was no documentation the doctor's orders had been followed.

CMS Ex. 2 at 56-57.

Resident 2's medical records contain information that sheds light on the claims in the SOD regarding the problems with Resident 2's care. Resident 2's doctor ordered various medications for Resident 2 to take orally, including Lactulose twice per day, Tylenol at two separate dosages (650 mg every 4 hours as needed and 1000 mg every 12 hours), Pepcid once every morning, Ativan once every morning at 8:00am and once every evening at 8:00pm, Aspirin once every morning, Geodon once every morning and once every evening, Depakene twice per day with meals, and Temazepam once per day at bedtime. CMS Ex. 15 at 18-21. The doctor also ordered pain monitoring during every shift, administration of Penugard Oral Rinse twice per day in the morning and night after meals, and provision of a peanut butter sandwich and milk every day at bedtime. CMS Ex. 15 at 21-22. Related to the SOD's allegations, Resident 2's medical records revealed the following: Resident 2 received his Lactulose dose on 4/6/14 at 4:00pm (contrary to the SOD's allegations); he did not receive his Tylenol dose on 4/9/14 at 9:00pm; he did receive his Pepcid dose on 4/9/14 at 6:30am (contrary to the SOD's allegations); he did not receive his Ativan dose on 4/9/14 at 8:00pm; he did not receive his Aspirin dose on 4/22/14 at 6:30am; he was offered, but refused his Geodon dose on 4/6/14 at 8:00am (contrary to the SOD's allegations); he did not receive his Depakene dose on 4/10/14 at 8:00am; and he did not receive his Temazepam dose on 4/9/14 at 8:00pm; he was not given a pain assessment on 4/4/14 during the 6 to 2 shift, 4/18/14 during the 2 to 10 shift,

and 4/22/13 during the 10 to 6 shift; he was not given a peanut butter sandwich and milk on 4/9/14 at 8:00pm; and he was offered and refused Penugard oral rinse on 4/6/14 at 9:00am (contrary to the SOD's allegations) but was not given the rinse on 4/18/14 at 9:00pm. CMS Ex. 15 at 12-13, 26, 28, 30, 34, 39.

**Resident 3**

The SOD allegations related to problems with Resident 3's care are as follows:

> Record review of [Resident 3]'s April 2014 physician orders revealed an order for Cardizem, 120 mg, daily at 8 am. Record review of [Resident 3]'s April 2014 MAR sheet revealed on 4/4/14 at 8 am, Cardizem was not documented as given.
>
> Record review of [Resident 3]'s April 2014 physician orders revealed an order for Artificial Tears, 2 drops to be administered in each eye 2 times per day. Record review of [Resident 3]'s April 2014 MAR sheet revealed on 4/4/14 at 8 am, the space to document administration of Artificial Tears was blank.
>
> Record review of [Resident 3]'s April 2014 physician orders revealed an order for Colace, 100 mg to be administered 3 times per day. Record review of [Resident 3]'s April 2014 MAR sheet revealed on 4/15/14 at 12 pm, the space to document administration of Colace was blank.
>
> Record review of [Resident 3]'s April 2014 physician orders revealed an order for the resident's pain level to be assessed and documented each shift. Record review of [Resident 3]'s April 2014 Pain Medication and Pain Assessment Record sheet revealed on the following dates/shifts there was no documentation the order was followed:
> 4/1/14 on the 6 to 2 shift,
> 4/5/14 on the 2 to 10 shift,
> 4/6/14 on the 2 to 10 shift,
> 4/18/14 on the 2 to 10 shift and on
> 4/22/14 on the 10 to 6 shift.
>
> Record review of [Resident 3]'s April 2014 physician orders revealed an order, dated 4/7/14, with instructions for the resident to be given a full sandwich at bedtime. Record

review of [Resident 3]'s April 2014 Supplements and Dietary sheet revealed on 4/8/14, 4/17/14, and 4/18/14, the resident did not receive a full sandwich at bedtime, however, there were no notes explaining why the doctor's order had not been followed.

Record review of [Resident 3]'s April 2014 physician orders revealed an order for the resident to receive a full pitcher of water with each meal. Record review of [Resident 3]'s April 2014 Supplements and Dietary sheet revealed on the following dates/times, there was no documentation the doctor's orders were followed:
4/1/14 at 12 noon,
4/4/14 at 7 am and 12 noon,
4/5/14 at 5 pm,
4/6/14 at 5 pm, and
4/18/14 at 5 pm.

Record review of [Resident 3]'s April 2014 physician orders revealed an order for the resident to receive a full sandwich in between meals. Record review of [Resident 3]'s April 2014 Supplements and Dietary sheet revealed on the following dates/times, there was no documentation the doctor's orders were followed:
4/1/14 at 2 pm,
4/4/14 at 10 am and 2 pm,
4/5/14 at 7 pm,
4/6/14 at 7 pm, and
4/18/14 at 7 pm.

Record review of [Resident 3]'s April 2014 physician orders revealed an order, with a start date of 1/15/14, for Klonopin (Generic: Clonazepam,) 1 mg, 3 times per day. Record review of [Resident 3]'s April 2014 MAR sheet revealed on 4/9/14, at 8 am and on 4/9/14 at 2 pm, the medications were not given due to medications not being delivered by the pharmacy.

> Record review of [Resident 3]'s MAR for April 2014 revealed on [sic] order for Klonopin, 1 mg three times a day, with a start date of 4/16/14, was not documented as being given on 4/18/14 at 8:00 pm.

CMS Ex. 2 at 58-60.

Resident 3's medical records contain information that relate to the claims in the SOD regarding the problems with Resident 3's care. Although there is no doctor's order for Cardizem for Resident 3 in the record, Resident 3's MARs imply that an order was given on 7/5/12 for Resident 3 to receive Cardizem once daily, and Resident 3's comprehensive care plan, which was originally dated 8/22/13 and last updated 1/29/14, directs Petitioner's staff to administer Cardizem for Resident 3's hypertension as ordered. CMS Ex. 18 at 3, 6; P. Ex. 1 at 3. Resident 3's medical records show that Resident 3 did not receive his daily Cardizem dose on 4/4/14. CMS Ex. 18 at 3, 6.

A doctor's order dated 3/28/14 directs Petitioner's staff to administer two drops of Artificial Tears to both of Resident 3's eyes twice per day. CMS Ex. 19 at 6. Resident 3's medical records show that Resident 3 did not receive his eye drops on 4/4/14 at 8:00am. CMS Ex. 18 at 2.

A doctor's order dated 10/18/11 directs Petitioner's staff to give Resident 3 Colace three times per day. CMS Ex. 19 at 3. Resident 3's medical records show that Resident 3 did not receive his Colace dose on 4/15/14 at noon. CMS Ex. 18 at 2.

A doctor's order dated 9/29/11 directs Petitioner's staff to monitor Resident 3's pain every shift and record it. CMS Ex. 19 at 2 and 5. Resident 3's comprehensive care plan also directs Petitioner's staff to monitor and reassess Resident 3's "pain, frequency, intensity." P. Ex. 1 at 5. Resident 3's medical records show that Resident 3's pain level was not assessed/documented on 4/1/14 during the 6:00am - 2:00pm shift, 4/4/14 during the 6:00am - 2:00pm shift, 4/5/14 during the 2:00pm - 10:00pm shift, 4/6/14 during the 2:00pm - 10:00pm shift, 4/18/14 during the 2:00pm - 10:00pm shift, and 4/22/14 during the 10:00pm - 6:00am shift. CMS Ex. 16 at 26.

Contrary to the SOD, the record does not contain a doctor's order dated 4/7/14 related to sandwiches for Resident 3. There is a doctor's order dated 10/6/11 that directs Petitioner's staff to give Resident 3 a full sandwich between meals and at bedtime. CMS Ex. 19 at 4. The Supplements/DTY sheet for April 2014 indicates that this order was still in effect by April 2014. CMS Ex. 16 at 16. Resident 3's comprehensive care plan also calls for a "[f]ull sandwich in between meals and at bedtime." P. Ex. 1 at 7. However, a doctor's order and a nursing note dated 4/1/14 indicates that a nurse practitioner ordered that Resident 3's bedtime sandwich be discontinued. CMS Ex. 16 at 6. Nothing in the

record suggests the order for a bedtime sandwich was reinstated. Resident 3's medical records show that he was not given a bedtime sandwich on 4/5, 4/6, 4/8, 4/17, or 4/18 and that he was not given a full sandwich between meals on 4/1/14 at 2:00pm, 4/4/14 at 10:00am and 2:00pm, 4/5/14 at 7:00pm, 4/6/14 at 7:00pm, and 4/18/14 at 7:00pm. CMS Ex. 16 at 16, 21. The failure to provide Resident 3 a full sandwich between meals went against doctor's orders and Resident 3's care plan, but the record does not establish that the failure to provide Resident 3 a sandwich at bedtime violated a current doctor's order or Resident 3's care plan as of 4/1/14.

The record does not contain a doctor's order for a full pitcher of water with each meal for Resident 3, but Resident 3's comprehensive care plan calls for a large pitcher of water with all meals. P. Ex. 1 at 6. Resident 3's medical records show that he was not given a full pitcher of water with his meal on 4/1/14 at noon, 4/4/14 at 7:00am and noon, 4/5/14 at 5:00pm, 4/6/14 at 5:00pm, and 4/18/14 at 5:00pm. CMS Ex. 16 at 16, 21.

Resident 3's psychiatric records contain an order for Klonopin, 1 mg at "8 - 2 - 8" (indicating 8:00am, 2:00pm, and 8:00pm), dated 1/15/14. CMS Ex. 17 at 23, 25. Nursing medication notes in Resident 3's medical records show that Resident 3's dose of Klonopin was not administered on 4/9/14 at 8:00am and 2:00pm because Klonopin was "not available." CMS Ex. 16 at 22, 42-43. Resident 3's medical records also show that he was not given his dose of Klonopin on 4/7/14 at 8:00pm or on 4/18/14 at 8:00pm. CMS Ex. 18 at 1, 10.

**Resident 6**

The SOD allegations related to problems with Resident 6's care are as follows:

> Record review of Resident #6's MAR for the month of April 2014 revealed the following medications were not documented as being given on 4/29/14: Pepcid at 4:00 pm; Metoprolol at 8:00 pm and Xanax at 4:00pm.
> Record review of Resident #6's care plan revealed a diagnosis of anxiety disorder, malnutrition and hypertension with onset dates of 1/3/14. The approaches included " meds/labs as ordered: Xanax" ; " meds/labs as ordered: Pepcid and provide cardiac meds as ordered: ...Metoprolol ..."

CMS Ex. 2 at 60.

Resident 6's medical records provide conflicting information regarding claims in the SOD about the problems with Resident 6's care. Resident 6's medical records contain doctor's orders for Xanax, Pepcid, and Metropolol, and his care plan called for use of Xanax, Pepcid, and Metropolol. CMS Ex. 21 at 9, 17, 28, 31, 33-34, 38. One of the

MARs in Resident 6's medical records suggests that he was given his 4:00pm doses of Xanax and Pepcid and his 8:00pm dose of Metropolol on 4/29/14. CMS Ex. 21 at 2 and 12. However, a separate MAR in the records submitted by CMS suggests that Resident 6 was not given multiple doses of drugs in April 2014, including the 8:00 pm dose of Metropolol on 4/29/14. CMS Ex. 21 at 22. This MAR contradicts the MAR showing that dose was given. *Compare* CMS Ex. 21 at 12 *with* CMS Ex. 21 at 22.

**Resident 11**

The SOD allegations related to problems with Resident 11's care are as follows:

> Record review of Resident #11 ' s MAR for the month of April 2014 revealed Aricept, 10 mg was not documented as being administered on 4/30/14 at 8:00pm.
>
> Record review of Resident #11's care plan revealed a diagnosis of dementia without behaviors with an onset date of 12/25/13. The approaches included " Aricept 10 mg ..."

CMS Ex. 2 at 60-61.

Resident 11's medical records include a care plan with an instruction for Petitioner's staff to administer Aricept to Resident 11 orally once per day at bedtime. There are no MARs for Resident 11 in the record that track the actual administration of Aricept to Resident 11.

**Resident 12**

The SOD allegations related to problems with Resident 12's care are as follows:

> Record review of Resident #12's MAR for February 2014 revealed Ultram was not documented as given on 4/23/14.
>
> Record review of Resident #12's care plan revealed a diagnosis of generalized pain with an onset date on 2/6/14. The approaches included " medication as ordered: Ultram ... "

CMS Ex. 2 at 61. Neither party submitted medical records for Resident 12.

### *2. Petitioner was not in substantial compliance with 42 C.F.R. § 483.20(k)(3)(i) because it failed to ensure its staff followed its behavioral monitoring policy.*

The regulation at 42 C.F.R. § 483.20(k)(3)(i) provides that "[t]he services provided or arranged by the facility must . . . [m]eet professional standards of quality." According to the DAB, "it is 'reasonable to presume' that [a facility's own] policies reflect professional standards of quality." *See Perry County Nursing Ctr.*, DAB No. 2555 at 9 (2014) (quoting *Sheridan Nursing Care Ctr.*, DAB No. 2178 at 32 (2008)). Further, the DAB has made clear that a facility "acts through its staff and cannot disown the consequences of the actions of its employee." *Gateway Nursing Ctr.*, DAB No. 2283 at 8 (2009). Employees are the agents of their employers, "empowered to make and carry out daily care decisions." *Emerald Oaks*, DAB No. 1800 at 7, n.3 (2001). "Electing to meet its commitments to provide care and protect residents' rights through these employees, [a facility] cannot . . . reasonably claim that their misconduct [i]s in effect irrelevant for the purpose of evaluating the facility's compliance." *Springhill Senior Residence*, DAB No. 2513 at 14 (2013).

The evidence shows, and Petitioner concedes, that Petitioner's staff left blank spaces on behavioral monitoring sheets for many of its residents that needed behavioral monitoring—25 residents, according to Surveyor Jackson's unrebutted testimony. CMS Ex. 37 at 3-10; P. Ex. 12 at 4 ¶ 13; P. Post Hearing Br. at 15. This violated Petitioner's behavioral monitoring policy, as clarified by training on that policy provided by Petitioner to its nursing staff, that Petitioner's staff was supposed to document the "[n]umber and frequency of episodes," including when no episodes occurred, for residents receiving "treatment for problematic behavior or mood." CMS Ex. 28 at 1; P. Ex. 12 at 3-4 ¶ 12. Moreover, as Petitioner admits, several of Petitioner's staff members went back and improperly back-filled these blanks on the behavioral monitoring sheets. CMS Ex. 37 at 3-10; P. Ex. 12 at 4 ¶ 13; P. Post Hearing Br. at 15. These facts give rise to two possibilities: (1) Petitioner's staff did monitor the behavior of the residents in question and simply documented them improperly, or (2) Petitioner's staff did not monitor the behavior of the residents in question and then falsely documented that they did so. In both situations, Petitioner's staff did not properly follow Petitioner's behavioral monitoring policy. I presume that this policy reflects professional standards of quality. *See Perry County*, DAB No. 2555 at 9. Therefore, Petitioner's staff's failure to follow the policy properly shows that Petitioner failed to ensure the services it provided to its residents met professional standards of quality in violation of § 483.20(k)(3)(i). Furthermore, this failure gave rise to the possibility that caregivers for the affected residents would receive faulty information and thus had the potential to cause more than minimal harm to those residents. In light of this evidence, I conclude that CMS has carried its burden of establishing a *prima facie* case of Petitioner's noncompliance with § 483.20(k)(3)(i).

As CMS has made its *prima facie* case, Petitioner bears the ultimate burden of persuading me that it substantially complied with § 483.20(k)(3)(i). *Hillman*, DAB No. 1611 at 8. Petitioner makes several arguments on this point. First, Petitioner argues that CMS bases this deficiency on allegations that the DON directed nursing staff "to go back and add in new information after the surveyor had reviewed the behavior sheets and found missing information," allegations that the DON denies in his testimony and that Petitioner alleges are unsubstantiated because they are not supported by admissible evidence. P. Ex. 12 at 4 ¶ 13; P. Post Hearing Br. at 15. As my analysis above shows, however, Petitioner's noncompliance with § 483.20(k)(3)(i) is not based on the DON's actions, but is instead based on the actions of the nurses who failed to comply with Petitioner's behavioral monitoring policy. That failure was complete the moment they left the behavioral sheets blank, regardless of what the DON did thereafter.[15]

On a related note, Petitioner argues that its nursing staff acting to back-date behavioral monitoring sheets was not an action directed by Lexington, relying on DON Kolawole's testimony. P. Post Hearing Br. at 15. Petitioner appears to be attempting to deflect responsibility for the misconduct of its staff away from itself and onto the individual staff members. This argument fails for two reasons. First and foremost, Petitioner's staff are its agents; Petitioner acts through its staff and cannot reasonably disclaim responsibility for misconduct by its staff when claiming it complied with the regulations. *See Springhill*, DAB No. 2513 at 14; *Gateway*, DAB No. 2283 at 8; *Emerald Oaks*, DAB No. 1800 at 7, n.3. Second, while the back-filling of the behavioral monitoring sheets may be and likely is in itself a separate violation of Petitioner's behavioral monitoring policy, the mere fact that they left spaces on the sheets blank was a violation of the policy and, by extension, a violation of § 483.20(k)(3)(i).

Petitioner also argues that CMS's evidence is insufficient to establish even a *prima facie* case that it "failed to monitor and document the behaviors of the residents at issue." P. Response at 10; *see also* P. Post Hearing Br. at 15. This argument misses the point, perhaps in part because it is a response to CMS's argument regarding why Petitioner did not substantially comply with § 483.20(k)(3)(i). *See* CMS Post Hearing Br. at 8-9. As I noted above, it is possible that Petitioner's staff monitored resident behaviors even in cases where the staff left blanks on resident behavioral monitoring sheets. Even were I to find that this happened here, however, Petitioner's staff still failed to provide behavioral

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[15] I therefore need not resolve the conflict between the anonymous reports by two of Petitioner's nurses to Surveyor Jackson, in which the nurses claimed that nursing management instructed them to back-fill empty spaces on behavioral monitoring sheets for various residents, and DON Kolawole's testimony that he did not give any such instruction. CMS Ex. 37 at 10; P. Ex. 12 at 4 ¶ 13. Nor need I rely on the anonymous reports for my decision.

monitoring services according to professional standards of quality because they made documentation errors that violated Petitioner's behavioral monitoring policy.

Petitioner finally argues that testimony from its witnesses, "taken as a whole, demonstrate[s] that [it] was not out of compliance with [§ 483.20(k)(3)(i)]." P. Reply at 10-11. To the contrary, as I have already found, DON Kolawole's testimony helps to establish Petitioner's noncompliance with § 483.20(k)(3)(i). Petitioner has not presented sufficient evidence to rebut this conclusion. I thus conclude that Petitioner has failed to establish that it substantially complied with § 483.20(k)(3)(i). Based on the foregoing, therefore, I conclude that Petitioner was not in substantial compliance with § 483.20(k)(3)(i).

### *3. Petitioner was not in substantial compliance with 42 C.F.R. § 483.20(k)(3)(ii) because it failed to provide multiple residents with services called for in their respective care plans.*

The regulation at 42 C.F.R. § 483.20(k)(3)(ii) provides that "[t]he services provided or arranged by the facility must . . . [b]e provided by qualified persons in accordance with each resident's written plan of care." A facility can be in noncompliance with § 483.20(k)(3)(ii) if it fails to comply with the plan of care, even if the facility's personnel are qualified to provide the services called for by the plan of care. *Oaks of Mid City Nursing & Rehab. Ctr.*, DAB No. 2375 at 18 (2011); *Woodland Oaks Healthcare Facility*, DAB No. 2355 at 15 (2010). When a facility's staff fails in multiple specific instances to follow care plans for multiple residents, those repeated failures demonstrate the facility's noncompliance with § 483.20(k)(3)(ii) because of the potential harm that may befall a resident if the facility's staff fails to provide that resident with crucial care (e.g., medication) in accordance with that resident's care plan.

Although the medical records evidence contradicts some of the SOD claims regarding Residents 2 and 3, that evidence substantiates many others and does not contradict a few additional claims, including those related to Residents 11 and 12.[16] In particular, medical records for Residents 2 and 3 reveal that Petitioner failed to ensure they received various services called for in their respective care plans. Resident 2 was not given (1) one of his ordered doses of Tylenol, (2) one of his ordered doses of Ativan, (3) one of his ordered doses of Aspirin, (4) one of his ordered doses of Depakene, (5) one of his ordered doses of Temazepam, (6) three of the pain assessments called for in his care plan, (7) one of the

[16] The conflicting MARs suggest that Resident 6 either was or was not administered various doses of medication. I have no basis to credit one MAR over the other. Therefore, I make no findings as to whether Petitioner properly cared for Resident 6 and do not rely on CMS's allegations related to Resident 6 to uphold this deficiency.

peanut butter sandwiches and milk called for in his care plan, and (8) one of the administrations of Penugard oral rinse called for in his care plan. CMS Ex. 15 at 12, 28, 30, 34, 39. Resident 3 was not given (1) one of his ordered doses of Cardizem, (2) one the administrations of Artificial Tears called for in his care plan, (3) one of his ordered doses of Colace, (4) six of the pain assessments ordered by his doctor and called for in his care plan, (5) five of the full sandwiches between meals ordered by his doctor and called for in his care plan, (6) six of the pitchers of water called for in his care plan, and (7) four of his ordered doses of Klonopin. CMS Ex. 16 at 16, 21-22, 26, 42-43; CMS Ex. 18 at 1-3, 6, 10. In addition, medical evidence does not contradict the SOD's allegations that Petitioner failed to provide Aricept to Resident 11 and Ultram to Resident 12 as called for in their care plans.

This evidence confirms, or at least does not refute the SOD's allegations, that Petitioner failed in multiple instances to provide Residents 2, 3, 11, and 12 with services in accordance with their plans of care, violating § 483.20(k)(3)(ii). The SOD further alleges that these failures had the potential to cause more than minimal harm to Petitioner's residents. CMS Ex. 2 at 55. This allegation is plausible in light of the number of instances where Petitioner failed to follow resident care plans. Although the evidence does not suggest that any of Petitioner's residents suffered actual harm from Petitioner's failures, any of them very well could have been harmed had Petitioner failed to provide important services called for in a resident's care plan. In light of the foregoing, I conclude that CMS has established a *prima facie* case that Petitioner was not in substantial compliance with § 483.20(k)(3)(ii).

As CMS established a *prima facie* case of Petitioner's noncompliance with § 483.20(k)(3)(ii), the burden shifts to Petitioner to demonstrate that it substantially complied with § 483.20(k)(3)(ii). *See Hillman*, DAB No. 1611 at 8. Petitioner makes several arguments in an attempt to do so, but those arguments do not persuade me that Petitioner substantially complied with § 483.20(k)(3)(ii).

Petitioner first contends that because CMS did not allege that Petitioner's staff were not qualified to provide services, CMS failed to allege that Petitioner violated § 483.20(k)(3)(ii). P. Post Hearing Br. at 16. Implicit in this contention is the further contention that a facility violates § 483.20(k)(3)(ii) only if its staff are not qualified to provide services. Petitioner also contends that CMS's allegations relate to failure to provide medications and that such allegations should be cited not under § 483.20(k)(3)(ii), but rather under 42 C.F.R. § 483.25(m), which prohibits both "medication error rates of 5 percent or greater" and "significant medication errors." *Id.* at 16, n.5. In the alternative, Petitioner contends that CMS's allegations related to this citation are "factually incorrect," claiming that Resident 2 refused his missed medication doses and that Resident 6 received all the medication doses CMS alleges he missed. *Id.* at 16. Petitioner also notes that CMS did not introduce MARs for Residents 11 and 12 to substantiate the SOD claims related to those residents. Finally, Petitioner does admit that

Resident 3 was not given three doses of medication contrary to his doctor's orders but nonetheless contends that "since Resident #3 received hundreds of medication doses each month, three medication documentation errors do not constitute a violation of professional standards." *Id.*

As an initial matter, Petitioner's contentions that CMS failed to allege that it violated § 483.20(k)(3)(ii) because CMS (1) did not allege that its staff were not qualified to provide services and (2) only alleged that Petitioner's staff committed medication errors that should be cited under § 483.25(m) rather than § 483.20(k)(3)(ii), are incorrect as a matter of law. Even assuming all members of Petitioner's staff were qualified, failures by those qualified staff members to provide the services called for in residents' plans of care, including administration of medication, still violate § 483.20(k)(3)(ii). *See Oaks of Mid City*, DAB No. 2375 at 18; *Woodland Oaks*, DAB No. 2355 at 15. And although Petitioner is correct that § 483.25(m) specifically covers medication errors, that does not mean that medication errors cannot also violate § 483.20(k)(3)(ii). When a resident's care plan calls for providing that resident certain medications, failure to provide those medications potentially violates both §§ 483.20(k)(3)(ii) and 483.25(m). In any event, CMS's allegations regarding Petitioner's alleged violation of § 483.20(k)(3)(ii) include not just medication errors, but also failure to provide Residents 2 and 3 with other services called for in their respective care plans (e.g., an oral rinse for Resident 2 and sandwiches for Residents 2 and 3).

As for Petitioner's contention that CMS's allegations relating to its violation of § 483.20(k)(3)(ii) are factually incorrect, I have already laid out in detail the multiple instances where Petitioner's staff failed to provide various services called for in care plans for Residents 2, 3, 11, and 12.[17] Petitioner offers no rebuttal evidence to contradict any of those failures, and far more failures occurred than the three to which Petitioner admits. Those failures render irrelevant Petitioner's contention that its three admitted medication errors did not violate professional standards and undermine Petitioner's more general contention that CMS's allegations related to Petitioner's violation of § 483.20(k)(3)(ii) are factually incorrect.

[17] I include Residents 11 and 12 in this analysis because Petitioner failed to present evidence to carry its burden of rebutting CMS's *prima facie* case and showing that it did provide Residents 11 and 12 with their medications, contrary to the SOD allegations. Simply because, as Petitioner points out, CMS did not also present such evidence does not undermine that *prima facie* case. In any event, even if I declined to rely on the SOD allegations related to Residents 11 and 12, I would still conclude that Petitioner did not substantially comply with § 483.20(k)(3)(ii) based on its repeated failure to provide Residents 2 and 3 with services called for in their respective care plans.

Petitioner has offered no persuasive arguments why § 483.20(k)(3)(ii) does not apply to the conduct cited by CMS as noncompliant with that requirement. Petitioner has also offered insufficient evidence to rebut CMS's *prima facie* case that Petitioner was not in substantial compliance with § 483.20(k)(3)(ii). I therefore conclude that Petitioner was not in substantial compliance with § 483.20(k)(3)(ii).

#### *4. Petitioner was not in substantial compliance with 42 C.F.R. § 483.75(l)(1) for the same reasons it was not in substantial compliance with 42 C.F.R. § 483.20(k)(3)(i).*

The regulation at 42 C.F.R. § 483.75(*l*)(1) provides that:

> (1) The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are—
>
> (i) Complete;
> (ii) Accurately documented;
> (iii) Readily accessible; and
> (iv) Systematically organized.

The SOD alleges that Petitioner fell short of this obligation by failing to ensure the clinical records of 30 residents were accurately documented and completed. In particular, the SOD alleges that records for 25 residents contained incomplete or blank spaces that were filled in at a later date. CMS Ex. 2 at 138-39. I have already found that Petitioner violated Medicare participation requirements at § 483.20(k)(3)(i) and that this violation posed a risk of more than minimal harm. The same evidence that supports that deficiency finding also supports my conclusion that Petitioner failed to comply with the administration requirement and that this failure posed a risk of more than minimal harm to Petitioner's residents.

### *C. Petitioner's noncompliance with 42 C.F.R. §§ 483.20(k)(3)(i) and (ii), 483.25, 483.75, and 483.75(l)(1) provide a basis for imposing enforcement remedies, including CMPs, on Petitioner for the duration of Petitioner's noncompliance.*

I have already concluded that Petitioner was not in substantial compliance with 42 C.F.R. §§ 483.20(k)(3)(i) & (ii), 483.25, 483.75, and 483.75(*l*) and that CMS did not clearly err in concluding that Petitioner's noncompliance with §§ 483.25 and 483.75 posed immediate jeopardy to the health and safety of Petitioner's residents. In light of those conclusions, I further conclude that there is a basis for imposing enforcement remedies on Petitioner, including a CMP in the upper range for the period of Petitioner's immediate

jeopardy noncompliance and a CMP in the lower range for the period of Petitioner's non-immediate jeopardy noncompliance. *See* 42 U.S.C. § 1395i-3(h)(2); 42 C.F.R. §§ 488.406, 488.430(a).

### *D. The CMPs imposed by CMS for the period of April 22, 2014 through June 18, 2014, are reasonable in both amount and duration in light of Petitioner's noncompliance with 42 C.F.R. §§ 483.20(k)(3)(i ) & (ii), 483.25, 483.75, and 483.75(l)(1).*

My authority to review the reasonableness of the amount of a CMP is limited by 42 C.F.R. § 488.438(e). The limitations are: (1) I may not set a CMP at zero or reduce it to zero; (2) I may not review the exercise of discretion by CMS in selecting to impose a CMP; and (3) I may only consider the factors specified by 42 C.F.R. § 488.438(f) when determining the reasonableness of a CMP amount. These factors include: (1) the facility's history of compliance; (2) the facility's financial condition; (3) the 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. Unless a facility contends that a particular regulatory factor does not support the CMP amount, the ALJ must sustain it. *Coquina Ctr.*, DAB No. 1860 at 32 (2002). My review of the reasonableness of a CMP amount is *de novo* and based upon the evidence in the record before me. I am not bound to defer to the CMS determination of the reasonable amount of a CMP to impose, but my authority is limited by regulation as already explained. I am to determine whether the amount of any CMP imposed is within reasonable bounds considering the purpose of the Act and regulations. *Emerald Oaks*, DAB No. 1800 at 10 (2001); *CarePlex of Silver Spring*, DAB No. 1683 at 14-16 (1999); *Capitol Hill Cmty. Rehab. & Specialty Care Ctr.*, DAB No. 1629 (1997).

As for the duration of the imposed CMPs, 42 C.F.R. § 488.454(a) provides in pertinent part that a CMP "continue[s] until . . . [t]he facility has achieved substantial compliance, as determined by CMS or the State based upon a revisit or after an examination of credible written evidence that it can verify without and on-site visit." Once CMS demonstrates that a facility is out of substantial compliance, the burden shifts to the facility to demonstrate its return to substantial compliance. *Premier Living & Rehab. Ctr.*, DAB No. 2146 at 23 (2008). "Under the regulations, the mere submission of a [plan of removal] d[oes] not establish that any cited deficiencies had been corrected." *Hermina Traeye Memorial Nursing Home*, DAB No. 1810 (2002).

For April 22, 2014 through May 21, 2014, the period during which CMS alleges that Petitioner's noncompliance posed immediate jeopardy to resident health and safety, CMS

imposed a CMP of $5,800 per day, CMS Ex. 1 at 5, which is in the lower half of the range permitted for CMP's involving immediate jeopardy. 42 C.F.R. § 488.438(a)(1)(i). For May 22, 2014 through June 18, 2014, the period during which CMS alleges that Petitioner's noncompliance did not pose immediate jeopardy to resident health and safety, CMS imposed a CMP of $1,000 per day, CMS Ex. 1 at 5, which is in the lower third of the range of the range permitted for CMP noncompliance that did not pose immediate jeopardy. 42 C.F.R. § 488.438(a)(1)(ii).

In arguing that the amounts of the imposed CMPs are unreasonable, Petitioner does not argue that any of the relevant regulatory factors do not support the CMP amounts.[18] P. Br. at 23; P. Post Hearing Br. at 25. For this reason alone, I could sustain the CMP amounts. *See Coquina Ctr.*, DAB No. 1860 at 32. Even considering the factors *de novo*, however, I conclude that CMPs of $5,800 per day for the period of Petitioner's immediate jeopardy noncompliance and $1,000 per day for the remaining period of Petitioner's non-immediate jeopardy noncompliance are reasonable. CMS did not submit evidence concerning Petitioner's history of compliance, and Petitioner did not submit evidence concerning its financial condition; thus, factors (f)(1) and (f)(2) do not bear on my analysis. However, two of the deficiencies I have sustained are very serious and interact negatively with two others, implicating factor (f)(3), and Petitioner's actions as a whole indicate at a minimum that it was neglectful of or indifferent to its residents' care and safety, implicating factor (f)(4).

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[18] Indeed, Petitioner's only argument that may relate to the amount of the immediate jeopardy CMP is that it "should not be penalized for the three weeks prior to the date that [the state agency] got around to making the determination that immediate jeopardy existed." CMS Post Hearing Br. at 25. This argument could also relate to the duration of the immediate jeopardy CMP, rather than its amount. Regardless, this argument amounts to an equitable argument, which I have no authority to consider when assessing the reasonableness of the CMP amount or duration. *See* 42 C.F.R. §§ 488.438(e)(3); 488.454(a). Even were I able to address this argument, I would not conclude the CMP is unreasonable in either amount or duration because of a delay in the state agency declaring immediate jeopardy. By regulation, poor survey performance neither "[r]elieve[s] a SNF . . . of its obligation to meet all requirements for program participation" nor "[i]nvalidate[s] adequately documented deficiencies." 42 C.F.R. § 488.318(b). Thus, a SNF that wishes to participate in the Medicare program bears the burden of complying with the regulations and should be in substantial compliance with those regulations at all times. SNFs that fail to maintain substantial compliance, such as Petitioner, are subject to enforcement remedies, including CMPs, for every day that they are not in substantial compliance. A SNF that relies on CMS or a state agency to inform it of its noncompliance runs the risk that it will be subject to an extended CMP, such as the immediate jeopardy level CMP to which Petitioner is subject here.

Petitioner's failure to comply substantially with 42 C.F.R. §§ 483.25 and 483.75 stems from a systemic communication failure between Petitioner's staff and the mental health providers. This communication failure was very serious because it contributed to the deaths of two of Petitioner's residents at the hands of a third resident and more generally posed immediate jeopardy to the health and safety of all of Petitioner's residents. This noncompliance is exacerbated by Petitioner's noncompliance with 42 C.F.R. §§ 483.20(k)(3)(i) and 483.75(*l*)(1), which arose from Petitioner's staff failing to follow Petitioner's behavioral monitoring policy by leaving blanks on behavioral monitoring sheets and improperly altering those sheets for various residents. Even in situations where the mental health providers properly communicated behavioral problems that needed monitoring to Petitioner's staff, the staff's improper utilization of behavior monitoring sheets increased the risk that improperly monitored behaviors could cause psychological or physical harm to the residents exhibiting those behaviors or to those around them. Finally, although not directly related to the other instances of noncompliance, Petitioner's noncompliance with 42 C.F.R. §§ 483.20(k)(3)(ii) by failing to provide various medications and other services to multiple residents in accordance with their care plans increases the justification for the CMP amounts imposed by CMS. Given that Petitioner bore the ultimate responsibility for ensuring (1) effective communication between its staff and mental health providers, (2) proper behavioral monitoring by its staff, and (3) residents received services in accordance with their plans of care, its failure to do these three things evinces at a minimum Petitioner's neglect of or indifference to its residents' care and safety. The foregoing serious instances of noncompliance that reveal Petitioner's apparent neglect of or indifference to its residents' care and safety would likely justify a close-to-maximum per-day CMP for both the immediate jeopardy and non-immediate jeopardy periods of noncompliance. CMS only imposed CMPs in the lower half of the range for immediate jeopardy noncompliance and in the lower third of the range for non-immediate jeopardy noncompliance. I conclude, therefore, that the CMPs imposed by CMS are reasonable in amount.

Petitioner more specifically challenges the reasonableness of the duration of the CMPs imposed. According to the SOD completed for the survey at issue here, although Petitioner removed the alleged immediate jeopardy conditions at its facility by May 23, 2014, it "remained out of compliance" with Medicare participation requirements because the state agency needed "more time to monitor the plan of removal [submitted by Petitioner] for effectiveness." CMS Ex. 2 at 3, 75, 109, 126. Also according to the SOD, Petitioner did not correct the cited deficiencies and return to substantial compliance with Medicare participation requirements until June 19, 2014. CMS Ex. 2 at 31, 73, 107, 125, 138. I have already concluded that Petitioner was not in substantial compliance with various Medicare participation requirements, and that noncompliance started at least as early as April 22, 2014. Petitioner therefore bears the burden of showing that it achieved substantial compliance prior to June 19, 2014, as CMS alleges. *See Premier Living*, DAB No. 2146 at 23.

Petitioner asserts that it achieved substantial compliance on or before May 22, 2014, as it completed the approved correction actions contained in its plan of removal on or before that date. P. Post Hearing Br. at 25. Petitioner puts forth no evidence in support of its conclusory assertion that it returned to substantial compliance prior to June 19, 2014, not even a copy of the plan of removal that allegedly shows that it returned to substantial compliance on or before May 22, 2014.[19] Petitioner has therefore failed to carry its burden to demonstrate it returned to substantial compliance prior to June 19, 2014. Consequently, I conclude that the CMPs imposed by CMS are reasonable not only in amount, but also in duration.

## V. Conclusion

Based on the foregoing, I conclude that Petitioner was not in substantial compliance with 42 C.F.R. §§ 483.20(k)(3)(i) & (ii), 483.25, 483.75, and 483.75(*l*), and that CMS did not clearly err in determining that Petitioner's noncompliance with §§ 483.25 and 483.75 posed immediate jeopardy to the health and safety of Petitioner's residents. Accordingly, I conclude that there is a basis for imposing enforcement remedies, including CMPs, on Petitioner for the duration of its noncompliance. Finally, I conclude that CMPs of $5,800 per day from April 22, 2014 through May 21, 2014, and $1,000 per day from May 22, 2014 through June 18, 2014, a total of $202,000, are reasonable in both amount and duration. Therefore, I order Petitioner to pay $202,000 to CMS.

_____/s/_____
Scott Anderson
Administrative Law Judge

[19] Even if Petitioner introduced a copy of its plan of removal, it is likely that it would not have been sufficient to demonstrate it returned to substantial compliance before June 19, 2014. *See Hermina Traeye*, DAB No. 1810.