Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

In the Case of:	)	
	)	
Oakwood Nursing Center, Inc.,	)	
(CCN: 10-5183),	)	Date: September 03, 2009
	)	
Petitioner,	)	
	)	Docket Nos. C-08-737
- v.	)	C-09-194
	)	Decision No. CR2001
Centers for Medicare &	)	
Medicaid Services.	)	
	)	

DECISION

I sustain the determination of the Centers for Medicare & Medicaid Services (CMS) to impose the following remedies against Petitioner, Oakwood Nursing Center, Inc.:

- Civil money penalties of $5050 per day for each day of a period that began on July 2, 2008 and which ran through July 16, 2008; and

- Civil money penalties of $3400 per day for each day of a period that began on October 31, 2008 and which ran through November 22, 2008.[1]

[1] CMS imposed additional civil money penalties against Petitioner in amounts of $200 per day for each day of a period that began on May 22, 2008 and which ran through July 6, 2008, and of a period that began on July 17, 2008 and which ran through October 30, 2008. Petitioner did not contest the imposition of these penalties. Furthermore, and by virtue of the noncompliance that I find in this decision, additional remedies were imposed against Petitioner consisting of a denial of payment for new Medicare admissions for each day of a period that began on August 1, 2008 and which ran through November 22, 2008, and loss of authority to conduct nurse aide training. Petitioner has not challenged

(continued…)

I. Background

Petitioner is a skilled nursing facility located in Ocala, Florida. It participates in the Medicare program and its participation is governed by sections 1819 and 1866 of the Social Security Act (Act) as well as by implementing regulations at 42 C.F.R. Parts 483 and 488. Its right to a hearing in this case is governed by regulations at 42 C.F.R. Part 498.

Petitioner requested hearings to challenge CMS's determination to impose the remedies that I discuss in the opening paragraph of this decision and the two cases were assigned to me for a hearing and a decision. I consolidated them and I held a hearing by telephone on June 10, 2009. During the hearing I received into evidence exhibits from CMS which I identified as CMS Ex. 1 – CMS Ex. 38, and CMS Ex. 40 – CMS Ex. 50. I received into evidence exhibits from Petitioner which I identified as P. Ex. 1 – P. Ex. 23. I heard the cross examination testimony of several of CMS's witnesses whose sworn direct testimony had been received as CMS exhibits.

II. Issues, findings of fact and conclusions of law

A. Issues

The issues in this case are whether:

1. Petitioner failed to comply substantially with Life Safety Code and Medicare participation requirements;

2. Petitioner proved to be clearly erroneous CMS's determinations of immediate jeopardy level noncompliance; and

3. CMS's civil money penalty determinations are reasonable in amount and duration.

B. Findings of fact and conclusions of law

I make findings of fact and conclusions of law (Findings) to support my decision in this case. I set forth each Finding below as a separate heading.

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[1](…continued)
CMS's authority to impose these additional remedies assuming that I sustain CMS's determinations of noncompliance. Therefore, I do not address them specifically in this decision.

1. Petitioner failed to comply substantially with Life Safety Code and Medicare participation requirements.

The noncompliance findings that are at issue here were made at two surveys of Petitioner's facility. The first survey was conducted on July 2, 2008 (July survey) and it addressed Petitioner's compliance with the Life Safety Code. Numerous instances of noncompliance were found at this survey including one instance of immediate jeopardy level noncompliance.[2] The second survey was completed on October 31, 2008 (October survey) and it addressed complaints concerning Petitioner's compliance with Medicare regulations governing discharge and transfer of residents. At this survey three instances of immediate jeopardy level noncompliance were identified.

I address all of the immediate jeopardy level deficiencies that were identified at the two surveys. In this Finding I decide the issue of Petitioner's compliance with Life Safety Code and Medicare participation requirements. In Finding 2 I decide the issue of whether Petitioner's noncompliance was at the immediate jeopardy level.

a. Petitioner failed to comply with Life Safety Code requirements.

Regulations governing participation in Medicare by skilled nursing facilities state that a facility:

> must be designed, constructed, equipped, and maintained to protect the health and safety of residents, personnel and the public.

42 C.F.R. § 483.70. In order to comply with this requirement a facility must meet the applicable provisions of the 2000 edition of the Life Safety Code of the National Fire Protection Association. 42 C.F.R. § 483.70(a)(i). The Life Safety Code incorporates by reference another code, the 1999 edition of the National Fire Alarm Code and, so, a facility must meet these additional requirements as well.

CMS offered overwhelming proof that Petitioner failed to comply with Life Safety Code requirements. The surveyors who conducted the July survey found that Petitioner failed to comply with the Life Safety Code at an immediate jeopardy level of scope and severity because it did not have an automatic sprinkler system on its premises. CMS Ex. 45; CMS Ex. 46; CMS Ex. 48; CMS Ex. 49; Life Safety Code, sections 19.1.6.2; 19.1.6.3; 19.1.6.4; 19.3.

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[2] The term "immediate jeopardy" is defined at 42 C.F.R. § 488.301 to mean noncompliance that is so egregious as to cause or to have the likelihood of causing serious injury, harm, impairment, or death to a resident or residents of a skilled nursing facility.

An automatic sprinkler system is not mandated in all facilities but it is mandated *if* a facility is constructed without certain other fire prevention safeguards. An automatic sprinkler system was mandated here, because Petitioner's facility had: non-rated ceiling tile assembly throughout its structure; ceiling tiles that were not of a uniform manufacture; and roof trusses with exposed steel beams. Moreover, Petitioner's management could not demonstrate that a one hour fire rated ceiling assembly was being used to protect the steel roof supports. *Id.* The problems posed by these structural deficits were exacerbated because: the facility had exposed duct work which passed through the ceiling tile assembly; its ceiling tile assembly lacked dampers to prevent the passage of smoke in the event of a fire; the facility had recessed light fixtures throughout that were not tented or one hour fire rated; and the facility's ceiling tiles were not clipped into place. *Id.*

Petitioner presented no evidence to rebut the surveyors' noncompliance findings and, evidently, does not contest them. Its arguments concerning the Life Safety Code deficiencies reduce to arguments of law concerning CMS's authority to impose civil money penalties for those deficiencies and I address them below, at Finding 3.[3]

b. Petitioner failed to comply with Medicare participation requirements.

The three immediate jeopardy level deficiencies that were identified at the October survey were alleged failures by Petitioner to comply with the following Medicare participation requirements.

- 42 C.F.R. § 483.12(a). This regulation establishes criteria for transfer and discharge of skilled nursing facility residents. Subsection (a)(5) of this regulation requires generally that residents be given a minimum of 30 days' notice before being transferred from a facility.

- 42 C.F.R. § 483.12(a)(7). This subsection requires that a facility that transfers a resident must provide the resident with sufficient preparation and orientation to ensure safe and orderly transfer or discharge from the facility.

[3] There were several additional non-immediate jeopardy level findings of Life Safety Code violations made by the surveyors who conducted the July survey and Petitioner has not challenged any of them. These noncompliance findings are, therefore, administratively final.

- 42 C.F.R. § 483.15(g)(1). This subsection requires a facility to provide each resident with medically-related social services in order to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being.

These three subsections are written so as to protect the rights and well-being of individuals who are by definition unable to protect themselves. Residents of a skilled nursing facility are among the most helpless individuals in our society. They are in nursing facilities because they are utterly dependent on others to provide for their basic needs and for their survival. Transfer from a facility for an individual who is so helpless can be a traumatic – even life endangering experience – and, for that reason, the regulations impose on a facility's management and staff the obligation to do the utmost to protect its residents and their family members from the trauma associated with transfer. The regulations require nothing less than a careful and compassionate effort in the case of each transfer to make the move as physically and emotionally painless as is possible.

Petitioner decided to close its facility in September 2008. Doing so necessitated the transfer and or discharge of residents. The decision to close the facility imposed on Petitioner's management and staff the heavy burden of assuring that each of Petitioner's approximately 60 residents be treated with the utmost respect, compassion, and dignity and it required Petitioner to comply with all regulatory requirements governing resident discharges and transfers.

The evidence presented by CMS depicts a glaring failure by Petitioner to carry out its obligations to its residents. The evidence paints a picture of an enterprise that was determined to accomplish the discharge/transfer process hastily and without regard for the niceties of protecting its residents' rights. As a consequence, residents were not provided with the care and attention they were entitled to and Petitioner's management flagrantly disregarded regulatory requirements governing transfers of residents.

CMS presented the testimony of two former members of Petitioner's staff who were at the facility during critical dates in September and October 2008 when the facility was in the process of being closed and the residents were being transferred. I find their testimony to be graphic, compelling, and credible on all key points.

These witnesses – Kathleen Harkins, Petitioner's interim administrator in early October, and Hedye Massey, formerly a social worker at Petitioner's facility – describe a transfer process that was expedited for the purpose of moving residents out of Petitioner's facility as quickly as possible. CMS Ex. 37; CMS Ex. 38. And, they describe actions by Petitioner's management that flagrantly disregarded the rights and needs of the residents. *Id.*

Ms. Harkins' testimony is especially compelling. She testified that she was present at Petitioner's facility in the capacity of acting administrator for about six weeks in 2008, beginning on October 6 of that year and continuing through mid-November. CMS Ex. 37, at 1. She testified that, despite her job title, she was essentially a figurehead. Decisions concerning resident transfers were made by another individual, Terry Carpenter, who had been appointed by Petitioner's owners to oversee the transfer process. *Id.* at 2-3.

Ms. Harkins was appalled at the conditions she observed when she arrived at the facility. *Id*. at 2. Residents had been transferred without being given a choice as to where they were sent. *Id.* Some of the residents were not told where they were being transferred. *Id*. at 5. Rather, they were loaded into cars or vans and driven to other facilities in communities that were remote from Petitioner's facility. *Id.* Often, residents' families were not notified about the transfer. Family members who visited Petitioner's facility for visits with residents were shocked to find out that their loved ones were no longer there. *Id*. at 2. Moreover, although Petitioner's management informed residents' families on October 24, 2008 that the facility would close on November 23, 2008, Mr. Carpenter's actual goal was to have residents out of the facility effective immediately. *Id.* at 3. At a meeting of Petitioner's department managers on October 27, 2008, Mr. Carpenter informed those present that his goal was to have all residents out of the facility by the end of that week. *Id.*

Ms. Harkins testified that, not only were residents rushed out of Petitioner's facility in violation of the requirement that they be given 30 days' notice of a transfer, but that the process of planning and implementing transfers was done with total disregard for professionally accepted standards governing such actions. CMS Ex. 37, at 4. She averred that, in addition giving each resident and his or her family 30 days notice of a transfer, Petitioner was obligated to accomplish at least the following before effectuating a transfer: (1) meeting with residents or their representatives to explain the reason for the transfer; (2) engaging in detailed discharge planning which included taking sufficient time to assure that each resident's individual needs were addressed; (3) meeting with as many family members of each resident as was possible; (4) providing the residents and their family members with placement choices; (5) notifying the State health care agency about each transfer; and (6) notifying other facilities so that their staff could come and assess each resident prior to a transfer. *Id.*

Ms. Harkins averred that, in fact, no discharge planning actually occurred. In fact, Petitioner performed none of the actions that she described as being essential prerequisites to transferring residents. CMS Ex. 37, at 4. She asserted that, not only was Petitioner's social worker not permitted to provide discharge planning, but she was fired when she attempted to intervene on residents' behalf. *Id.*

Ms. Massey corroborated Ms. Harkins' testimony in important respects. Ms. Massey described an operation in October 2008 that was conducted by Mr. Carpenter and personnel from Petitioner's management company in the back rooms of Petitioner's facility from which they directed resident transfers. CMS Ex. 38, at 2. She testified that she was unable to perform her normal duties which included providing discharge planning for residents who were to be transferred because Mr. Carpenter and his staff excluded her from being involved in resident transfers. *Id.* She averred that residents who were transferred from Petitioner's facility in October 2008 did not receive discharge planning. *Id.*

Ms. Massey testified that she was advised by members of residents' families that the residents had not received discharge planning. She asserted that, in some instances, residents had no idea where they were being transferred to. CMS Ex. 38, at 2. She averred that in October 2008 she was asked by a member of Mr. Carpenter's staff to write discharge notes and to certify that discharge planning had been accomplished for multiple residents of Petitioner's facility. *Id.* at 2-3.
She refused to do so because she hadn't provided discharge planning and didn't believe that anyone else had performed it. *Id.* According to Ms. Massey, Mr. Carpenter directed her to falsify resident records and told her that someone else from his staff would do it if she refused. *Id.* at 3. Mr. Carpenter then fired her. *Id.*

As I have stated, Ms. Harkins and Ms. Massey corroborate each other's testimony. I find their testimony to be extremely persuasive even without additional corroboration. The two witnesses were cross-examined during the June 10, 2009 hearing and nothing that transpired during the hearing impeached their credibility. And, although I would find these witnesses' testimony credible without additional supporting evidence, CMS offered a wealth of additional evidence which provides ample corroboration and support for what these two witnesses said.

Their testimony was closely supported by Robert Mondrone, an administrator from another facility, who has 24 years' experience in facility administration. CMS Ex. 34. Mr. Mondrone testified that he was periodically present at Petitioner's facility during the last few days of October and the first few days of November 2008. He averred that, although Petitioner gave most of its residents notice of the facility's closing in late October 2008, it actually transferred or discharged all of them by the end of the first week of November. *Id.* at 2. He testified that Petitioner's management told family members of residents that the residents had to be out of the facility on the same day that they were notified of the impending shutdown. *Id.* at 3.

Mr. Mondrone testified that he had never seen a transfer/discharge process run so poorly as that which he witnessed at Petitioner's facility, describing the atmosphere at the facility as constituting "widespread chaos." *Id.* at 2. He characterized the transfer process as being run "like a production line" from a back room at Petitioner's facility

with residents being systematically excluded from the decision making process. *Id.* at 3. Mr. Mondrone asserted that he saw no evidence that Petitioner took steps to assist any of its residents with transfer. There were no specific plans developed for transfer, no discussions between the facility's social services staff and residents and their families, and no team meetings between Petitioner's staff and residents and their families to assist with the transfer process. *Id.* at 2-3.

Additional support for CMS's contentions comes as testimony given by residents' relatives. The nephew of a resident testified that, near the end of October 2008, he was called by Petitioner regarding the transfer of his aunt who was then a resident of Petitioner's facility. CMS Ex. 36, at 1-2. This telephone call was the only call that he received from Petitioner concerning his aunt's transfer. *Id.* at 2. He was told that his aunt would be transferred either that evening or the following day and that he must choose one of two facilities as a transfer site. *Id.* at 1-2. Neither of the two facilities was geographically close to Petitioner's facility. The sister of another resident testified that in late October her brother told her that he was being pressured by Petitioner's management to move as soon as possible from Petitioner's facility to another facility. CMS Ex. 35, at 1-2. She was able to relocate him to another facility in the vicinity of Petitioner's facility. But, she effectuated this transfer without any help from Petitioner and in the face of constant pressure from Petitioner's management to move her brother as fast as possible. *Id.* at 2.

The witnesses' testimony is substantiated by Petitioner's own resident records. In September, 2008 Petitioner transferred four of its residents – who are identified in the October survey report as Residents #s 13, 14, 16, and 17 – to other facilities without providing these residents with the required 30 day notice of intent to transfer. CMS Ex. 1, at 3-5. The facility records for Residents #s 13, 14, and 17 are devoid of any evidence that Petitioner provided these residents with social services during the transfer process. CMS Ex. 1, at 21-24.

I have considered Petitioner's arguments and evidence and find them not to be persuasive. In many respects Petitioner simply avoids coming to grips with CMS's specific allegations of noncompliance. Rather, it relies on broad and bland assertions that it provided appropriate notice and planning for residents who were transferred without providing detailed evidence that would support these statements. In other instances, Petitioner purports to rely on evidence that proves its compliance which, on close examination, either does not support Petitioner's assertions or undercuts them.

Petitioner filed the affidavit of Terry Carpenter, the individual who orchestrated the discharge of Petitioner's residents in September and October 2008. P. Ex. 5. Mr. Carpenter's testimony is remarkable in that it fails to come to grips with the specific allegations of noncompliance made by CMS and supported by CMS's witnesses. For example, Mr. Carpenter says nothing that refutes Ms. Harkins' explicit assertion that Mr.

Carpenter had announced that he intended to transfer all of Petitioner's residents by the end of the last week of October 2008. Nor did he deny Ms. Massey's assertion that he directed her to falsify resident records to make it appear as if the residents had received transfer counseling when, in fact, they had not.

Mr. Carpenter does not rebut the specific allegations of CMS's witnesses that Petitioner failed to provide individualized discharge planning for its residents who were transferred. Rather, he states, without elaboration, that Petitioner's social workers worked with families of residents and the residents themselves to resolve disagreements "between resident and family members (and between family members) on where a resident should be transferred." P. Ex. 5, at 2.

Petitioner asserts that the transfers of Residents #s 13, 14, 16, and 17 were exempted from the regulatory requirement that Petitioner provide 30 days' advance notice because they were "resident and/or family initiated transfers." Petitioner's post-hearing brief at 7.

Petitioner's assertions are simply not supported by the record. There is no evidence to show that any of these four residents requested transfers on their own volition much less is there evidence to show that Petitioner was simply acting to effectuate the residents' desires.

For example, in the case of Resident # 13, there is nothing in the exhibit cited by Petitioner – CMS Ex. 15 – that supports a finding that the resident made an informed and voluntary transfer request and that Petitioner was merely carrying out the resident's wishes. If anything, the exhibit supports the opposite conclusion. There is evidence in that exhibit that makes it obvious that the resident was not capable of making an informed decision about a transfer. Petitioner's staff described the resident as confused on more than one occasion and related that the resident hallucinates. CMS Ex. 15, at 1, 2. That confusion was evident when staff spoke to the resident on September 23, 2008 about transferring her. The resident:

> began getting tearful . . . [and] talking about a doctor that was going to court and was going to be on trial for sexual assault and then her comments became noncoherent.

Id. at 2. It was only in that context that the resident was reported to say that she would like to go to some place new. *Id.* It was cruel for Petitioner's management to act on a statement like that as if it was a voluntary request given the resident's obvious confusion and emotional duress.

Petitioner contends that no 30-day notice was required prior to transferring Resident # 14 "because this transfer was initiated by the resident and family." Petitioner's post-hearing brief at 8. Petitioner introduced no evidence that supports this contention. Petitioner cites to a document that it characterizes as "the official '3008' form that AHCA [the Florida State health care agency] recognizes for transfers of residents" evidently as support for its argument that the resident and her family voluntarily sought a transfer. *Id.;* P. Ex. 22, at 4. However, this document contains nothing supporting Petitioner's assertion of a voluntary request. On the other hand, the document lists "dementia" as the resident's principal diagnosis and I infer from this that the resident would have been incapable of making a meaningful voluntary transfer request. *Id.* There is nothing in the records cited by Petitioner to show that the resident's family made a transfer request on the resident's behalf.

Petitioner contends that "[t]he transfer of Resident # 16 was initiated by a family request." Petitioner's post-hearing brief at 8. This contention is belied by the record. The evidence cited by Petitioner as support for its assertion – CMS Ex. 17 – contains nothing that suggests a family request to transfer Resident # 16. At most, it supports a conclusion that the family agreed to transfer the resident to another facility (Lakewood Nursing Center) in response to a directive by Petitioner's administration that the resident be transferred. CMS Ex. 17, at 4, 6. Agreement to a transfer in the face of management pressure is no defense to a failure to provide requisite notice and discharge planning for this resident.

As respects Resident # 17 Petitioner asserts that the resident's transfer was "initiated by the resident." Petitioner's post-hearing brief at 8. There is absolutely nothing in the exhibit cited by Petitioner – CMS Ex. 18 – that supports this contention. On the other hand, the exhibit strongly supports an inference that Petitioner's staff failed to do discharge planning for the resident. On September 24, 2008, a social worker made the following entry in the resident's record:

> Received notice from the Administrator that Res transferring to another SNF [skilled nursing facility]. This SW did not participate in this Res D/C plan. Administrator made all D/C arrangements.

CMS Ex. 18, at 8.[4]

Petitioner cites to the cross-examination testimony of Mr. Mondrone as support for its contention that the transfers of its residents were "appropriate." Petitioner's post-hearing brief at 9; Tr. at 73-74. Petitioner does not explain what it means by that term nor did its

[4] The social worker who wrote and signed this note is an individual other than Ms. Massey. The note provides additional support for Ms. Massey's and Ms. Harkins' testimony that Petitioner transferred residents without performing discharge planning.

counsel do so when he asked Mr. Mondrone whether some of the transfers were appropriate. *Id.* I will not speculate as to what counsel or Mr. Mondrone thought the word "appropriate" meant, but there is, in fact, nothing in Mr. Mondrone's testimony to suggest that he agreed that Petitioner complied with regulatory requirements in transferring its residents. *Id.*

Much of Petitioner's case appears to be built around the theory that it should be excused from complying with regulatory requirements because the staff and management of facilities who *accepted* transfers of Petitioner's residents acted diligently to protect the residents' interests and welfare. Petitioner's post-hearing brief at 9-10. That is no defense. It may be that other facilities were more caring than was Petitioner and that they acted to protect the residents whose transfers they accepted. But that gave no license to Petitioner to ignore its obligations under the regulations. Moreover, nothing that other facilities did or could have done would have insulated Petitioner's residents from the shock of being pushed out the door of Petitioner's facility by Petitioner's management.

Petitioner asserts also that it advised residents and their family members that they could return to Petitioner's facility after it became operational again. Petitioner's post-hearing brief at 10. But, assuming the truth of this statement, it provides no excuse for the way in which Petitioner handled resident transfers. There is simply nothing in the regulations governing transfers that permits a facility to ignore its obligations to residents when transferring them premised on the possibility that the residents might return to the facility at some date in the future.

Petitioner relies on the testimony of four individuals – Brenda Boucher, Lita Flowers, Cynthia Evans, and Victoria Medley – to support its assertion that it handled resident transfers in accordance with regulatory requirements. P. Ex. 6; P. Ex. 7; P. Ex. 8; P. Ex. 9. I find the testimony of these individuals to be unpersuasive. Their affidavits are essentially boilerplate documents, virtually identical in content, which provide very little substance. Much of the language in these affidavits essentially repeats verbatim the contents of Mr. Carpenter's affidavit without providing any additional information.

Ms. Boucher and Ms. Flowers both assert in identical language that the transfers of Residents #s 13, 14, 16, and 17 were requested either by the residents themselves or by members of the residents' families. P. Ex. 6, at 2; P. Ex. 7, at 2. However, neither of these witnesses cites to any documentation that supports these assertions. Moreover, their testimony is deliberately vague. Ms. Boucher states that "Oakwood's representatives merely talked to the residents about transferring to another facility...." And Ms. Flowers states that "I spoke with the resident and the responsible party (usually a family member) identified on the 'face sheet' about the transfer," without providing any details about the alleged conversations. *Id.*

All four of the affiants describe in virtually identical words the process that Petitioner used to transfer residents. P. Ex. 6, at 2-3; P. Ex. 7, at 3-4; P. Ex. 8, at 2-3; P. Ex. 9, at 2-3. Their description of the process does not address any of the allegations made by CMS nor does it rebut the testimony of CMS's witnesses and supporting exhibits. There is nothing in these witnesses' testimony that supports a conclusion that Petitioner performed individualized discharge planning for any of the residents who were transferred. For example, the affiants all say that directors or coordinators from other facilities met with residents privately or in Petitioner's common areas. Assuming that to be true that does not substitute for the requirement that *Petitioner* perform and coordinate discharge planning, on an individualized basis, for each of its residents. Moreover, there is nothing in the affidavits which discloses what was discussed between the residents and the directors and coordinators nor do the affidavits present any evidence to show that *all* of Petitioner's residents or their family members had the benefit of these meetings.

Petitioner argues also that it should be immune from allegations of noncompliance because residents who were interviewed after they had been transferred expressed few or no complaints or even assert that they are happier in their new facilities than they were at Petitioner's facility. Petitioner's post-hearing brief at 11; P. Ex. 10 – P. Ex. 14. This is a "no harm no foul" argument that has no relevance to the issue of Petitioner's compliance with regulatory requirements. That some residents may have been relatively uninjured by the transfers effectuated by Petitioner or may in fact be happier in their new facility than they were at Petitioner's facility is no defense to Petitioner's failure to protect those residents during the process.

2. Petitioner did not prove to be clearly erroneous CMS's determinations of immediate jeopardy.

The evidence offered by CMS strongly supports CMS's determinations that Petitioner's noncompliance with Life Safety Code and Medicare participation requirements posed immediate jeopardy for residents. Petitioner did not establish these determinations to be clearly erroneous.

a. Petitioner offered no evidence to prove to be clearly erroneous CMS's determination of immediate jeopardy level Life Safety Code noncompliance.

Petitioner offered neither evidence nor argument to refute CMS's finding of an immediate jeopardy level Life Safety Code deficiency.

Petitioner's failure to have a functioning sprinkler system in its facility posed obvious – and very serious – risks for residents of the facility. As is attested to by Vincent E. Avenatti, who conducted the July survey of Petitioner's facility:

> the facility's deficient practices resulted in the demolishment of the minimum protection required for the residents with unacceptable construction type without sprinkler coverage, de-compartmentalization and unacceptable corridor walls without sprinkler coverage. . . . These deficiencies constituted immediate jeopardy as they placed the residents at potential risk of injury and death in the event of a fire.

CMS Ex. 48, at 3. Mr. Avenatti's testimony becomes more compelling when considered in light of the nature of Petitioner's facility and people who lived there. Petitioner's residents were among society's most vulnerable individuals and among them were persons who would have been utterly helpless to protect themselves in the event of a fire.

b. Petitioner failed to prove to be clearly erroneous CMS's determination of immediate jeopardy level noncompliance with Medicare participation requirements.

The evidence supporting a finding of immediate jeopardy level noncompliance with Medicare participation requirements is very strong. As I discuss at Finding 1.b., Petitioner flagrantly disregarded the rights of its residents in effectuating their transfers to other facilities. In some instances it failed to give the residents the requisite 30-day notice of their impending transfers. In others, it gave the residents notice but made that notice essentially meaningless by pressuring residents to leave the facility on a greatly accelerated schedule. Petitioner failed on a wholesale basis to plan for the individual needs, wants, and desires of its residents and it misled members of residents' families as to their relatives' circumstances.

Behavior like this would be traumatic for anyone on the receiving end but would be especially so for individuals like those who were housed at Petitioner's facility. As I have discussed these persons were extraordinarily frail and vulnerable and were at risk for grave emotional and even physical distress as a consequence of being transferred in haste and without necessary planning. That is strong basis for concluding that residents of Petitioner's facility faced a likelihood of serious injury, harm, or even death as a consequence of Petitioner's actions.

The grave emotional distress experienced by at least some of Petitioner's residents as a consequence of Petitioner's actions is evidenced by the testimony of Allison Hillhouse, one of the surveyors who conducted the October survey. She testified that:

> Multiple residents and family members indicated to me that they were being pressured to move out as soon as possible – and they were shocked and upset at the sudden notice that the facility was closing. In fact, on October 28, 2008 facility staff informed me that the facility had already ordered them to start loading up residents and their belongings onto vans

> for transfer – often to other cities. These residents were extremely upset, many had no idea of where they were being sent – and often their responsible parties (i.e., family members) had not yet received notices that these residents were already being moved.

CMS Ex. 32, at 3-4. Petitioner did not rebut the evidence of immediate jeopardy level noncompliance. For the most part, it asserts that it did not violate residents' rights in orchestrating their transfer out of the facility. I have dealt with these assertions at Finding 1.b. and I need not revisit Petitioner's contentions and arguments here. Petitioner also relies heavily on its assertion that at least some of the residents were happier in their new quarters than they were while at Petitioner's facility. That is no defense. The fact that some of Petitioner's residents may have decided ultimately that they were better off at the facility that they were transferred to than at Petitioner's facility doesn't excuse Petitioner from its compliance obligations. Nor does it diminish the likelihood of harm that these residents were exposed to during the process of their being transferred out of Petitioner's facility.

3. CMS's civil money penalty determinations are reasonable.

CMS determined to impose immediate jeopardy level civil money penalties to remedy Petitioner's noncompliance with Life Safety Code and Medicare participation requirements. The Life Safety Code penalties are in amounts of $5050 per day for each day of a period that began on July 2, 2008 and which ran through July 16, 2008. The Medicare participation requirement penalties are in amounts of $3400 per day for each day of a period that began on October 31, 2008 and which ran through November 22, 2008.

Civil money penalties of from $3050 to $10,000 per day are authorized for each day of immediate jeopardy level noncompliance. 42 C.F.R. § 488.438(a)(1)(i). Deciding on a penalty amount within this range must be based on evidence relating to factors which include: the seriousness of a facility's noncompliance; its noncompliance history; and its financial condition. 42 C.F.R. §§ 488.438(f)(1)-(4); 488.404 (incorporated by reference into 42 C.F.R. § 488.438(f)(3)).

I find the penalties that CMS determined to impose to be supported by evidence establishing the seriousness of Petitioner's noncompliance. Petitioner has not adduced evidence or arguments that support reducing the penalty amounts.

I note as a threshold to my discussion of penalty amounts that Petitioner did not argue that it lacks the financial wherewithal to pay the civil money penalties that CMS determined to impose.

The evidence pertaining to the immediate jeopardy level Life Safety Code deficiency establishes it to be extremely serious. Residents at Petitioner's facility were individuals who would be at great risk for injury or death in the event of any fire at the facility. But here, the risk to these residents was increased exponentially by the facility's failure to maintain a proper sprinkler system. The penalty amounts of $5050 per day are only slightly more than one half the total amount that could have been imposed and are certainly justified by the seriousness of the noncompliance.

Petitioner argues that the penalties for Life Safety Code noncompliance are unlawfully retroactive. It asserts that it first learned on July 17, 2008 that its Life Safety Code noncompliance was, in CMS's eyes, immediate jeopardy and that it acted immediately to abate the jeopardy. It argues that it should not be held accountable for something that it was unaware of and asserts that any penalties covering dates prior to July 17 are punitive.

This argument is incorrect as a matter of law. There is no language in either the Act or regulations which precludes CMS from imposing penalties to remedy noncompliance that predates the date of its discovery. To the contrary, regulations specifically authorize the imposition of civil money penalties for past noncompliance going back to the date of the survey that precedes the survey at which noncompliance is discovered. 42 C.F.R. § 488.430(b). Consequently, CMS was well within its rights to impose civil money penalties to remedy noncompliance on dates that predate the completion date of the July survey.

Moreover, Petitioner, by asserting that the penalties are unreasonably retroactive, attempts to stand on its head the regulatory scheme governing its Medicare compliance. As Petitioner would have it, its obligation to comply with Medicare participation requirements should be likened to a game of "catch" in which it should be able to avoid remedies so long as its noncompliance goes undetected. But, that is not how the law operates. A skilled nursing facility is charged by the Act and regulations with being in compliance at all times with Medicare participation requirements including Life Safety Code requirements. It is Petitioner's responsibility to know its obligations and to assure that it meets them.

Petitioner also asserts that the penalties for its Life Safety Code violation are excessive because it was given a waiver for a short period of time to allow it to function notwithstanding its noncompliance. I find no inconsistency between the waiver grant and CMS's penalty determination. As of July 17, 2008 Petitioner abated its Life Safety Code noncompliance by instituting a rigorous fire watch on its premises. In that circumstance a waiver might be justified if only for a short time to allow Petitioner to make arrangements to rectify its deficiency on a more durable basis. But, that says nothing about the period running up to and including July 16 when Petitioner was in egregious noncompliance with the Life Safety Code.

The evidence that relates to Petitioner's noncompliance with Medicare participation requirements other than Life Safety Code requirements also establishes noncompliance to have been egregious. The penalties imposed by CMS were well-justified by the seriousness of Petitioner's noncompliance. As I have discussed, Petitioner cavalierly, and in fact brutally, disregarded its residents' rights in order to usher them out of its facility as quickly as possible. The disregard for the rights of Petitioner's residents was shocking to those individuals when it was perpetrated by Petitioner's management and remains shocking to this day. The penalties that CMS determined to impose of $3400 per day for Petitioner's noncompliance were actually mild in comparison to what CMS would have been justified in imposing based on the seriousness of Petitioner's noncompliance.

/s/
Steven T. Kessel
Administrative Law Judge