

**Department of Health and Human Services**

**DEPARTMENTAL APPEALS BOARD**

**Civil Remedies Division**

Fireside Lodge Retirement Center, Inc.,  
(CCN: 67-5147),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-15-526

Decision No. CR4715

Date: September 28, 2016

**DECISION**

Petitioner, Fireside Lodge Retirement Center, Inc., is a long-term care facility located in Fort Worth, Texas, that participates in the Medicare program. Based on a survey completed August 26, 2014, the Centers for Medicare & Medicaid Services (CMS) determined that the facility was not in substantial compliance with multiple Medicare requirements, including those that require the facility to report and investigate unexplained injuries and those that require the facility to treat pressure sores properly. CMS also determined that the facility's deficiencies posed immediate jeopardy to resident health and safety and has imposed civil money penalties (CMPs) of \$6,150 per day for seven days of immediate jeopardy (\$43,050) and \$800 per day for 30 days of substantial noncompliance that was not immediate jeopardy (\$24,000). Petitioner appeals, and CMS has moved for summary judgment, which Petitioner opposes.

I grant CMS's motion.

As discussed below, the undisputed evidence establishes that: from August 20 through September 25, 2014, the facility was not in substantial compliance with Medicare

program requirements; from August 20 through 26, those deficiencies posed immediate jeopardy to resident health and safety; and the penalties imposed are reasonable.

## Background

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

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

In this case, on August 26, 2014, surveyors from the Texas Department of Aging and Disability Services (state agency) completed the facility's annual recertification survey.<sup>1</sup> Based on their findings, CMS determined that the facility did not comply substantially with the following program requirements:

- 42 C.F.R. § 483.13(c) (Tag F224 – staff treatment of residents: prohibit neglect) at scope and severity level L (widespread substantial noncompliance that poses immediate jeopardy to resident health and safety);

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<sup>1</sup> On August 19, 2014, the state agency also completed the facility's annual life safety code (LSC) survey, citing deficiencies at scope and severity levels D (one deficiency) and F (three deficiencies). CMS Ex. 2 at 5; see CMS Ex. 2 at 9. In its hearing request, Petitioner challenged the LSC findings. Thereafter, CMS submitted no evidence and made no arguments with respect to the LSC survey. Referring to the LSC and some of the health deficiencies, CMS nevertheless argues that its determinations "on the unchallenged deficiencies are final and binding." CMS Motion for Summary Judgment (MSJ) at 16-17. I agree that the LSC survey is off the table, but CMS – not Petitioner – is responsible for that. Because it came forward with *no* evidence, not even a statement of deficiencies, CMS has not met its *prima facie* burden with respect to the LSC survey. See *Evergreene Nursing Care Ctr.*, DAB No. 2069 at 7-8 (2007). Nevertheless, as the following discussion establishes, the deficiencies cited under 42 C.F.R. §§ 483.13(c), 483.25(c), and 483.75, by themselves, justify the penalties imposed.

- 42 C.F.R. § 483.13(c)(1)(ii)-(iii) and 483.13(c)(2)-(4) (Tag F225 – staff treatment of residents: investigate and report allegations of abuse) at scope and severity level L;
- 42 C.F.R. § 483.13(c) (Tag F226 – policies to prohibit abuse and neglect) at scope and severity level L;
- 42 C.F.R. § 483.25(c) (Tag F314 – quality of care: pressure sores) at scope and severity level H (pattern of substantial noncompliance that causes actual harm);
- 42 C.F.R. § 483.25(h) (Tag F323 – quality of care: accident prevention) at scope and severity level E (pattern of substantial noncompliance that causes no actual harm with the potential for more than minimal harm);
- 42 C.F.R. § 483.35(i) (Tag F371 – dietary services: sanitary conditions) at scope and severity level F (widespread substantial noncompliance that causes no actual harm with the potential for more than minimal harm);
- 42 C.F.R. § 483.60(b), (d), and (e) (Tag F431 – pharmacy services/consultation, labeling, and storage) at scope and severity level F;
- 42 C.F.R. § 483.70(h) (Tag F465 – physical environment: other environmental conditions) at scope and severity level F;
- 42 C.F.R. § 483.70(h)(4) (Tag F469 – physical environment: other environmental conditions – pest control) at scope and severity level F; and
- 42 C.F.R. § 483.75 (Tag F490 – administration) at scope and severity level L;

CMS Ex. 2 at 5; CMS Ex. 7.

Thereafter, CMS determined that, as of August 27, the facility's deficiencies no longer posed immediate jeopardy, and, as of September 26, the facility returned to substantial compliance. CMS has imposed against the facility penalties of \$6,150 per day for seven days of substantial noncompliance that posed immediate jeopardy to resident health and safety (August 20 – 26) and \$800 per day for 30 days of substantial noncompliance that did not pose immediate jeopardy (August 27 – September 25), for penalties totaling \$67,050. CMS Ex. 2 at 1-4.

CMS now moves for summary judgment. Petitioner opposes. The parties filed initial briefs (CMS Br.; P. Br.) and proposed exhibits. With its brief, CMS submitted 11

exhibits (CMS Exs. 1-11). Petitioner submitted 6 exhibits (P. Exs. 1-6). CMS subsequently filed a motion for summary judgment (CMS MSJ) and Petitioner filed a response (P. Response).

## Issues

As a threshold matter, I consider whether summary judgment is appropriate.

On the merits, the issues are:

1. From August 20 through September 25, 2014, was the facility in substantial compliance with the Medicare program requirements;
2. If, from August 20 through 26, 2014, the facility was not in substantial compliance, did its deficiencies then pose immediate jeopardy to resident health and safety; and
3. If the facility was not in substantial compliance, are the penalties imposed (\$6,150 per day for seven days and \$800 per day for 30 days) reasonable.

## Discussion

Summary judgment. Summary judgment is appropriate if a case presents no genuine issue of material fact, and the moving party is entitled to judgment as a matter of law. *Bartley Healthcare Nursing and Rehab.*, DAB No. 2539 at 3 (2013), *citing Celotex Corp. v. Catrett*, 477 U.S. 317, 322-25 (1986); *Ill. Knights Templar Home*, DAB No. 2274 at 3-4 (2009), and cases cited therein.

The moving party may show the absence of a genuine factual dispute by presenting evidence so one-sided that it must prevail as a matter of law or by showing that the non-moving party has presented no evidence “sufficient to establish the existence of an element essential to [that party’s] case, and on which [that party] will bear the burden of proof at trial.” *Livingston Care Ctr. v. Dep’t of Health & Human Svcs.*, 388 F.3d 168, 173 (6th Cir. 2004) (quoting *Celotex Corp. v. Catrett*, 477 U.S. 317, 323-24 (1986)). To avoid summary judgment, the non-moving party must then act affirmatively by tendering evidence of specific facts showing that a dispute exists. *Matsushita Elec. Indus. Co. v. Zenith Radio Corp.*, 475 U.S. 574, 586 n.11 (1986); *see also Vandalia Park*, DAB No. 1939 (2004); *Lebanon Nursing & Rehab. Ctr.*, DAB No. 1918 (2004). The non-moving party may not simply rely on denials, but must furnish admissible evidence of a dispute concerning a material fact. *Ill. Knights Templar Home*, DAB No. 2274 at 4; *Livingston Care Ctr.*, DAB No. 1871 at 5 (2003).

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

1. ***CMS is entitled to summary judgment because the undisputed evidence establishes that, contrary to regulatory requirements and the facility's own policies for preventing resident mistreatment, neglect, and abuse, its administration and staff did not report or investigate a resident's unexplained fracture. The facility was therefore not in substantial compliance with 42 C.F.R. § 483.13(c).***<sup>2</sup>

Program requirements: Facilities must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents. 42 C.F.R. § 483.13(c). Among other requirements, it must ensure that all alleged violations involving mistreatment, neglect, and abuse – *including injuries of unknown source* – are reported immediately to the facility administrator and appropriate state officials. The facility must have evidence that all alleged violations are thoroughly investigated, and it must prevent potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator (or designated representative) and to the appropriate state officials within 5 working days of the incident. If the violation is verified, the facility must take appropriate corrective action. 42 C.F.R. § 483.13(c)(2), (3), and (4).

Facility policies. The facility had in place written policies and procedures for preventing abuse and neglect and for investigating grievances and complaints. Consistent with the regulations, those policies require that all injuries of unknown source be "promptly and thoroughly investigated by facility management." CMS Ex. 5 at 4.

According to the policies, the facility's assistant administrator (or designee) is in charge of investigating injuries of unknown source and all other allegations, grievances, and

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<sup>2</sup> My findings of fact and conclusions of law are set forth, in bold and italics, as captions in the discussion section of this decision.

complaints. Among other requirements, the investigators must, *at a minimum*: review the resident's medical record; interview the person reporting the incident, any witnesses, the resident herself (as appropriate), her roommate (as appropriate), her attending physician (as appropriate), staff members on all shifts who had contact with the resident during the 48-hour period prior to the time of the incident, and family members who had contact with the resident during the 48-to-72-hour period prior to the incident; the investigator must review all events preceding the incident. CMS Ex. 5 at 4. Witness reports must be reduced to writing, signed by the witness, and dated. CMS Ex. 5 at 5.

The investigator-in-charge must notify "the ombudsman" that the investigation is being conducted and invite him/her to participate. If the ombudsman declines, that fact should be noted in the investigation record. The ombudsman must be notified of the investigation's results and of any corrective actions. The investigator must compile a written report of the results of the investigation and provide the facility administrator with a report within five working days of the incident. The administrator must report the results to the state agency within five days of the reported incident. CMS Ex. 5 at 5.

Resident 13 (R13). R13 was a 99-year-old woman suffering from heart failure, Alzheimer's disease, anxiety, and a psychotic disorder. CMS Ex. 3 at 1, 49. She was at high risk for falls and used a wheelchair for mobility. CMS Ex. 3 at 7, 15; P. Ex. 1 at 14. From the time of her admission (June 2012), she had apparently been receiving hospice care. P. Ex. 1 at 15.

A nursing note, entered at 1:38 p.m. on June 17, 2014, reports that R13 complained of right knee and leg pain. She had 2+ pitting edema, which describes moderate swelling. The nurse notified the resident's physician and her grandson. R13 underwent x-rays and a venous dopplar study. CMS Ex. 3 at 4, 11, 30; P. Ex. 1 at 7. The x-ray showed a tibial compression fracture of the right knee (i.e., a break in the bone that disrupts osseous tissue and collapses the affected bone). CMS Ex. 3 at 14; CMS Ex. 7 at 5. Her physician referred her to an orthopedist. CMS Ex. 3 at 11. A nursing note dated June 19 again describes 2+ pitting edema and bruising to the right knee. The resident complained of pain when turned and repositioned. CMS Ex. 3 at 30; P. Ex. 1 at 7.

R13's fracture was not mentioned in the facility's resident incident worksheets. CMS Ex. 3 at 17-19. The facility did not report or investigate. CMS Ex. 8 at 3 (LeBlanc Decl. ¶ 3). The facility's assistant administrator, who, as the designated "abuse coordinator," was responsible for investigating injuries of unknown source, told the surveyors that she had not investigated because no one reported the injury to her. ("I can't investigate if I'm not aware of the incident.") CMS Ex. 5 at 4; CMS Ex. 6 at 1; CMS Ex. 8 at 4 (LeBlanc Decl. ¶ 3).

Petitioner disputes none of this but points out that R13 was at risk for “spontaneous fractures” as well as falls and argues that “[i]t is not illogical to surmise” that she sustained the fracture “spontaneously during a routine transfer before or after breakfast . . .” P. Reply at 15; see P. Ex. 2 at 3 (Maxvill Decl.) (attending physician opining that, in the absence of evidence of improper care or force, R13 *could* have sustained a spontaneous fracture).

On the other hand, Petitioner also quotes research suggesting that R13’s fracture was likely not “spontaneous”: “In the geriatric population, osteoporosis is a well[-] documented cause of spontaneous fractures of the hip and vertebra, but *not of non-hip leg fractures.*” P. Br. at 12 (emphasis added), quoting an article from a publication of the Wisconsin Medical Directors Association, *Disuse Osteoporosis in the Nursing Home Setting*; see also P. Br. at 12, quoting Kane and Goodwin, *Elder Mistreatment: Abuse, Neglect and Exploitation in an Aging America* at 347 (National Academies Press 2002) (“Two types of bone fractures are known to occur spontaneously: vertebral fractures in osteoporotic older women, and hip fractures.”).

But the question is not whether R13, in fact, suffered a spontaneous fracture (which we will never know because the facility did not investigate her injury). The question is whether facility staff followed the regulations and the facility’s own policies requiring them to report and investigate this very serious injury of unknown source. Her injuries could have been caused by an unreported fall (for which she was at risk) or by her knee hitting something as she was wheeled around a corner; it could have been caused by rough handling; or, as Petitioner speculates, it might have been caused by a “routine transfer.” P. Br. at 11. Given her age and fragility, “routine” handling might not have been sufficient to keep her safe. If so, her care plan could have included instructions to staff to exercise extra care in handling her. As Petitioner’s articles point out, “[i]t is very important for both nurses and nursing assistants to be aware of the softness and fragility of bones, particularly leg bones, in their immobile nursing home population, and to be as gentle as possible when providing care.” P. Br. at 14, quoting *Disuse Osteoporosis in the Nursing Home Setting*.

I reject Petitioner’s argument that this incident represents a random, isolated episode that does not put the facility out of substantial compliance with section 483.13(c). The Departmental Appeals Board has repeatedly emphasized that, in considering a facility’s compliance with section 483.13(c), the focus “is not simply on the number or nature of the instances of neglect (i.e., failure to provide necessary care or services) but on whether the facts . . . surrounding such instance(s) demonstrate an underlying breakdown in the facility’s implementation of the provisions of an anti-neglect policy.” *Oceanside Nursing & Rehab. Ctr.*, DAB No. 2382 at 11 (2011); see *Columbus Nursing & Rehab. Ctr.*, DAB No. 2247 at 27 (2009) (holding that CMS need not show multiple incidents of abuse in order to cite noncompliance under section 483.13; instead, the question is “whether the

circumstances presented, viewed as a whole, demonstrate a systemic problem in implementing policies and procedures.”). Here, multiple staff at all levels must have known about R13’s serious injury. Yet, it seems that no staff member considered reporting or investigating the incident. This establishes that the facility had a systemic problem in implementing its policies and procedures.

Petitioner also seems under the misapprehension that the facility need not report incidents unless it determines that they constitute abuse or neglect. I see no evidence to support Petitioner’s suggestion that facility staff considered the issue, determined that the fracture was spontaneous, and decided that it need not be reported. Not one note mentions any such assessment. In any event, the regulations require the facility to report and investigate thoroughly *all* injuries of unknown source. Staff do not get to pick and choose which injuries to report. *See Ill. Knights Templar Home*, DAB No. 2369 at 11, 12 (2011); *Britthaven, Inc.*, DAB No. 2018 at 15 (2006), *citing Cedar View Good Samaritan*, DAB No. 1897 at 11 (2003). In *Illinois Knights Templar*, the Board, quoting ALJ Kessel’s earlier opinion, noted good reasons for this reporting requirement: requiring the facility to report the allegations “assures that a neutral third party (the State) will be apprised of the allegations and will be in a position to take protective action if necessary.” DAB No. 2369 at 12-13, *quoting* DAB CR2203 at 10 (2010).

R13 suffered a serious injury of unknown source, and the facility failed to report or investigate. The facility was therefore not in substantial compliance with 42 C.F.R. § 483.13(c).

2. ***CMS is entitled to summary judgment because it came forward with evidence establishing that facility staff did not adequately assess or treat a resident’s pressure sore, and Petitioner tendered no evidence disputing the facts underlying CMS’s conclusions. The undisputed evidence therefore establishes that the facility was not in substantial compliance with 42 C.F.R. § 483.25(c).***

Program requirements. Under the statute and the “quality of care” regulation, each resident must receive, and the facility must provide, the necessary care and services to allow a resident to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the resident’s comprehensive assessment and plan of care. Act § 1819(b); 42 C.F.R. § 483.25. To this end, the facility must (among other requirements) ensure that a resident who enters the facility without pressure sores does not develop them unless his/her clinical condition shows that they were unavoidable, based on the resident’s comprehensive assessment. 42 C.F.R. § 483.25(c)(1). If the resident already has pressure sores, the facility must ensure that he/she receives the treatment and services necessary to promote healing, prevent infection, and prevent new sores from developing. 42 C.F.R. § 483.25(c)(2).



In assessing the facility's compliance with this requirement, the relevant question is: did the facility "take all necessary precautions" to promote healing, prevent infection, and prevent new sores from developing. If it did so, and the resident develops sores anyway, I could find no deficiency. But if the evidence establishes that the facility fell short of taking all necessary precautions, it has violated the regulation. *Senior Rehab. & Skilled Nursing Ctr.*, DAB No. 2300 at 13-14 (2010), *aff'd*, *Senior Rehab. & Skilled Nursing Ctr. v. HHS*, No. 10-60241 (Dec. 20, 2010); *Koester Pavilion*, DAB No. 1750 at 32 (2000).

Resident 2 (R2). R2 was an 84-year-old woman admitted to the facility on November 5, 2011, suffering from Alzheimer's disease, hypertension, arthritis, osteoporosis, depression, and cataracts. CMS Ex. 4 at 1, 8, 22-23; CMS Ex. 9 at 2 (Hooks Decl.). She was severely cognitively impaired and depended on staff for all activities of daily living. CMS Ex. 4 at 12, 15-16, 19; CMS Ex. 9 at 2, 3 (Hooks Decl.). She used a wheelchair for mobility and was completely incontinent of bladder and bowel. CMS Ex. 4 at 20-21.

According to a December 18, 2013 assessment, R2 was then at mild risk of developing a pressure sore. By March 17, 2014, she was at high risk. CMS Ex. 9 at 3 (Hooks Decl.). A July 8, 2014 entry to her care plan documents a *stage 2* pressure ulcer on her left buttock. CMS Ex. 4 at 51, *see* CMS Ex. 4 at 29-30; CMS Ex. 9 at 3 (Hooks Decl.). Care plan entries dated July 28 and August 13, 2014, include no assessment or staging information. CMS Ex. 4 at 51. Inconsistent with the care plan entry, R2's skin assessment flow sheet entries, dated July 8, July 17, and July 23, 2014, document a *stage 1* pressure sore with granulation. CMS Ex. 4 at 49; CMS Ex. 9 at 3 (Hooks Decl.). Flow sheet entries dated August 7 and 13 do not indicate a stage. CMS Ex. 4 at 49. Each entry is virtually identical until August 7 (when the wound width appeared to decline – from 1.5 cm to 1.0 cm) and August 13 (when the wound width is greater than it had ever been, going from 1.0 to 4 cm.); the entries do not reflect any deterioration. *Id.*; CMS Ex. 7 at 29; CMS Ex. 9 at 3 (Hooks Decl.).

A physician order, dated August 13, 2014, instructed staff to cleanse the left inner buttock with wound cleaner, pat dry, pack the wound bed with Therahoney sheet (a moist medium that helps remove dead tissue), cover the wound with Maxorb (an absorbent wound dressing), and secure with Exuderm sacrum dressing every two days and as needed. CMS Ex. 4 at 50; *see* CMS Ex. 4 at 51; CMS Ex. 9 at 3 (Hooks Decl.).

On August 19, 2014, Surveyor Sheila Hooks, R.N., observed a licensed vocational nurse (LVN) treating R2's pressure ulcer, which was "unstageable" because yellow slough (dead tissue in the process of separating from viable tissue) obscured the wound. CMS Ex. 9 at 3-4 (Hooks Decl.). Surveyor Hooks describes the wound: "The pressure ulcer had yellow slough . . . inside the wound bed and the edges had a dried appearance. The center of the pressure ulcer bed had a black discoloration. The right side of the wound bed had a dried-brown discoloration." CMS Ex. 9 at 4.

Surveyor Hooks describes the treatment the LVN provided: she measured the wound as 4 cm x 4 cm, but did not measure its depth. She took a Therahoney sheet, folded it into a small square, and applied it to the pressure ulcer bed. “The wound bed sank, and the outer edges of the bed separated around the pressure ulcer.” The LVN *did not* pack the wound, which left an empty space. She covered the wound with Maxorb and applied Optifoam Adhesive dressing (another highly absorbent dressing). CMS Ex. 9 at 4 (Hooks Decl.). Surveyor Hooks explains that the LVN did not follow the physician order because she did not pack the wound bed with the Therahoney wound dressing. The LVN should have pushed the dressing under the edges of the wound bed so there would be no empty space. CMS Ex. 9 at 4.<sup>3</sup>

When questioned, the LVN admitted that she had not assessed the wound for “undermining” or “tunneling,” but claimed that “hospice” does those measurements. CMS Ex. 9 at 4 (Hooks Decl.).

Surveyor Hooks also reviewed R2’s nutritional assessment and found that staff had not recommended any treatment for her pressure ulcer. CMS Ex. 9 at 4 (Hooks Decl.). Indeed, R2’s nutritional assessment does not even mention a pressure ulcer. The document, which is dated July 15, 2014 (one week after the sore was first reported), marks her “Decubiti/Skin Condition” as “clear.” CMS Ex. 4 at 53. (*See The Windsor Place*, DAB No. 2209 at 8 (2008) (indicating that the development of pressure sores affects nutritional needs).

Petitioner tendered no evidence suggesting a dispute concerning any of these facts. The undisputed facts thus establish that facility staff failed to follow the physician order for treating R2’s pressure sore, and they simply ignored that pressure sore when assessing her nutritional needs. The facility therefore failed to ensure that R2 received the treatment and services needed to promote healing, prevent infection, and prevent new sores from developing, which put it out of substantial compliance with 42 C.F.R. § 483.25(c).

3. ***CMS is entitled to summary judgment because the undisputed evidence establishes that the facility was not administered in a manner that enabled 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 facility was therefore not in substantial compliance with 42 C.F.R. § 483.75.***

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<sup>3</sup> Packing the wound helps it heal from the inside out. Without the packing, a wound might close at the top without healing the deeper areas.

Program requirements. The 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. 42 C.F.R. § 483.75.

A finding of substantial noncompliance in the facility's administration may derive from findings of substantial noncompliance in other areas.

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

*Asbury Ctr. at Johnson City*, DAB No. 1815 at 11 (2002); *Odd Fellow & Rebekah Health Care Facility*, DAB No. 1839 at 7 (2002); *Stone Cnty. Nursing & Rehab. Ctr.*, DAB No. 2276 at 15-16 (2009). As discussed below, I find that the facility's deficiencies posed immediate jeopardy to resident health and safety, which, by itself, justifies the finding that the facility was not in substantial compliance with 42 C.F.R. § 483.75.

Moreover, as the above discussion establishes, facility staff were not aware of (or disregarded) their responsibilities to report to the administration all injuries of unknown origin, which suggests that they were inadequately trained and supervised, for which the facility administration is accountable. Further, reporting such incidents to the state agency is an administrative responsibility.

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

***4. CMS's determination that, from August 20 through 26, 2014, the facility's substantial noncompliance posed immediate jeopardy to resident health and safety is not clearly erroneous.***

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

*Pavilion*, DAB No. 1750 (2000); *Daughters of Miriam Ctr.*, DAB No. 2067 at 7, 9 (2007).

Disregarding the possible cause of her injury meant that the facility did not know how to prevent its recurrence, which put R13 at ongoing risk of another serious injury. Moreover, that management and staff did not know how to respond to an unexplained injury (or opted not to respond) leaves residents unprotected from potential abuse or neglect, a dangerous situation for frail and vulnerable residents. *See Rosewood Care Ctr. at Swansea*, DAB No. 2721 at 12-13 (2016), *citing Rosewood Care Ctr. of Swansea*, DAB CR4408 at 8 (2005).

Because the facility's deficiencies were likely to cause serious harm to vulnerable facility residents, CMS's determination that the deficiencies posed immediate jeopardy to resident health and safety is not clearly erroneous.

### ***5. The penalties imposed are reasonable.***

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

I consider whether the evidence supports a finding that the amount of the CMP is at a level reasonably related to an effort to produce corrective action by a provider with the kind of deficiencies found, and in light of the section 488.438(f) factors. I am neither bound to defer to CMS's factual assertions nor free to make a wholly independent choice of remedies without regard for CMS's discretion. *Barn Hill Care Ctr.*, DAB No. 1848 at 21 (2002); *Cnty. Nursing Home*, DAB No. 1807 at 22 *et seq.* (2002); *Emerald Oaks*, DAB No. 1800 at 9 (2001); *CarePlex of Silver Spring*, DAB No. 1638 at 8 (1999).

Here, CMS imposes penalties of \$6,150 per day for each day of immediate jeopardy, which is in the mid-range for a per day CMP (\$3,050 to \$10,000). 42 C.F.R. §§ 488.408(e)(1)(iii); 488.438(a)(1)(i). For the period of substantial noncompliance that was not immediate jeopardy, CMS imposes a penalty of \$800 per day, which is at the lower end of the applicable penalty range (\$50 to \$3,000). 42 C.F.R. § 488.408(d)(1)(iii); 488.438(a)(1)(ii). Considering the relevant factors, these penalties are reasonable.

CMS does not argue that the facility's history justifies a higher CMP.

With respect to financial condition, the facility has the burden of proving, by a preponderance of the evidence, that paying the CMP would render it insolvent or would compromise the health and safety of its residents. *Van Duyn Home & Hosp.*, DAB No. 2368 (2011); *Gilman Care Ctr.*, DAB No. 2362 (2010). To meet the standard for lowering a CMP based on financial condition, a facility's claims must be supported by compelling financial documentation. In *Guardian Care Nursing & Rehabilitation Center*, DAB No. 2260 (2009), for example, the facility could not even afford to represent itself on appeal. Its Medicaid census was 90%; its annual shortfall was \$250,000; and it relied on charitable contributions for its continuing viability. The Board nevertheless criticized the absence of financial documentation and concluded that the facility had not established that additional resources would not be available. *But see Columbus Nursing & Rehab. Ctr.*, DAB No. 2505 (2013) (finding that the absence of documentation regarding the facility's financial condition did not preclude the ALJ from concluding, based on witness testimony, that its financial condition justified reducing the CMP).

Petitioner complains that it has already lost a significant amount of money and paying the penalties imposed will cost it even more. Because of the LSC survey findings, it had to install bathroom doors, at a cost of \$5,000. Even though CMS ultimately did not deny payments for new admissions, Petitioner maintains that the threat alone caused it to lose admissions over a two to three month period, and, because of this and other factors, its patient census is low. P. Ex. 3 at 3 (McGrath Decl. ¶¶ 6, 7, 8). The facility does not have cash on hand to pay the penalties. Nevertheless, Petitioner also concedes that it has been able to secure financing and (except for the fall-out from the survey findings) is generally on a secure footing financially. *Id* at 2, ¶ 6. Petitioner has not shown, nor even alleged, that paying the penalty would cause it to go out of business. The evidence therefore does not justify lowering the CMP based on its financial condition.

Applying the remaining factors, I find that the facility's administration and multiple staff members disregarded facility policies when they failed to report or investigate R13's serious injury, for which the facility is culpable. In addressing R2's pressure sore, nursing staff did not follow her physician's orders, and its dietary staff either did not know or disregarded her serious skin condition. These are serious omissions for which the facility is also culpable.

## **Conclusion**

For these reasons, I grant CMS's motion for summary judgment. The undisputed evidence establishes that, from August 20 through September 25, 2014, the facility was not in substantial compliance with program requirements, and, from August 20 through

