Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Morton Bakar Center,
(CCN: 55-5611),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-16-863

Decision No. CR4994

Date: December 15, 2017

DECISION

Morton Bakar Center (Petitioner or "the facility") is a skilled nursing facility (SNF) located in Haywood, California, that participates in the Medicare program. Following a complaint survey that was completed on June 21, 2016, the Centers for Medicare & Medicaid Services (CMS) determined that the facility was not in substantial compliance with Medicare program requirements and that one of the deficiencies posed immediate jeopardy to resident health and safety. CMS imposed a per-instance civil money penalty (CMP) of $3,500; imposed a denial of payment for new admissions (DPNA), effective July 27, 2016 through August 10, 2016; and informed Petitioner that it would be prohibited from conducting a Nurse Aide Training and Competency Evaluation Program (NATCEP).

The survey cited two deficiencies; however, Petitioner contests only the deficiency cited under 42 C.F.R. § 483.13(c) (Tag F226, Facility policies – abuse and neglect policies and procedures) at the scope and severity level of J, and the imposition of the $3,500 per-instance CMP. For the reasons discussed below, I find that there is no genuine dispute as to any material fact, and CMS is entitled to judgment as a matter of law

because the facility was not in substantial compliance with Medicare program requirements, CMS's immediate jeopardy determination was not clearly erroneous, and the CMP imposed is reasonable.

I. Background

The Social Security Act (Act) sets requirements for SNF participation in the Medicare program. The Act authorizes the Secretary of the United States Department of Health & Human Services (Secretary) to promulgate regulations implementing those statutory provisions. Act § 1819 (42 U.S.C. § 1395i-3). The Secretary's regulations are found at 42 C.F.R. part 483.[1]

A facility must maintain substantial compliance with program requirements in order to participate in the program. 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 agencies to conduct periodic surveys to determine whether SNFs are in substantial compliance with the participation requirements. Act § 1864(a) (42 U.S.C. § 1395aa(a)); 42 C.F.R. §§ 488.10, 488.20. The Act and its implementing regulations require that facilities be surveyed on average every twelve months, and more often if necessary, to ensure that identified deficiencies are corrected. Act § 1819(g)(2)(A) (42 U.S.C. § 1395i-3(g)(2)(A)); 42 C.F.R. §§ 488.20(a), 488.308.

Petitioner self-reported the suspected abuse of a resident by an employee to the California Department of Public Health (state agency) on May 31, 2016. CMS Exhibit (Ex.) 9. On June 21, 2016, the state agency conducted a complaint survey, finding that the facility was not in substantial compliance with 42 C.F.R. § 483.13(b), (c)(1)(i) (Tag F223, right of residents to be free from abuse) at the scope and severity level of "G," and 42 C.F.R. § 483.13(c) (Tag F226, facility policies and procedures that prohibit abuse) at the scope and severity level of "J."[2] CMS Ex. 1. By letter dated July 12, 2016, CMS agreed with

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[1] Federal long-term care facility regulations substantially changed beginning on November 28, 2016. 81 Fed. Reg. 68,688 (October 4, 2016). Based on the date of the survey, which preceded the regulatory revisions, I refer to the regulations that were in effect at the time of the survey.

[2] Scope and severity levels are used by CMS and state survey agencies when selecting remedies. The scope and severity level is designated by letters A through L. Pub. 100-7, State Operations Manual, § 7400.5.1 (Factors That Must be Considered When Selecting Remedies), "Assessment Factors Used to Determine the Seriousness of Deficiencies Matrix" (table), *https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/som107c07.pdf* (last visited December 12,

the state agency's determination that Petitioner was not in substantial compliance with participation requirements, that immediate jeopardy[3] to resident health and safety was identified on June 21, 2016, and abated that same day. CMS Ex. 11 at 1. CMS also determined that Petitioner provided substandard quality of care,[4] and imposed a per-instance CMP of $3,500 for Petitioner's noncompliance with 42 C.F.R. § 483.13(c).[5] CMS Ex. 11 at 2. CMS also imposed a denial of payment for new admissions (DPNA), pursuant to 42 C.F.R. § 488.417(a), effective July 27, 2016, and prohibited the facility from conducting a NATCEP as a result of the finding of substandard quality of care, imposition of the DPNA, and imposition of a CMP.[6] CMS Ex. 11 at 2. By letter dated August 17, 2016, CMS informed Petitioner that it had returned to substantial compliance, effective August 10, 2016. CMS Ex. 12 at 2. CMS lifted the DPNA, effective August 10, 2016. CMS Ex. 12 at 2.

On August 30, 2016, Petitioner requested a hearing before an administrative law judge (ALJ). I issued an Acknowledgment and Pre-Hearing Order on August 31, 2016. CMS filed a Pre-Hearing Brief and Motion for Summary Judgment (CMS Br.) along with fourteen exhibits (CMS Exs. 1-14), and Petitioner submitted a Pre-Hearing Brief and Opposition to Motion for Summary Judgment (P. Br.), along with six exhibits (P. Exs. 1-6). In the absence of any objections, I accept all submitted exhibits.

2017); *see* 42 C.F.R. § 488.408. As relevant here, a scope and severity level of "J" indicates an isolated deficiency that posed immediate jeopardy to resident health or safety. A deficiency with a scope and severity of "G" indicates an isolated deficiency that caused actual harm that is not immediate jeopardy.

[3] Immediate jeopardy exists when "the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident." *See* 42 C.F.R. § 488.301.

[4] Substandard quality of care, as applicable here, "means one or more deficiencies related to participation requirements under . . . § 483.13, Quality of life . . . which constitute . . . immediate jeopardy to resident health or safety . . . ." 42 C.F.R. § 488.301.

[5] The Act authorizes the imposition of enforcement remedies against SNFs that are not in substantial compliance with program participation requirements, and these regulations specify the enforcement remedies that can be imposed. 42 U.S.C. § 1395i-3(h)(2); 42 C.F.R. § 488.406. Among other enforcement remedies, CMS may impose a per-day CMP for the number of days an 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).

[6] *But see* 42 C.F.R. § 483.151(b)(3) (listing a CMP of "not less than $5,000" as being a condition that precludes NATCEP approval).

Petitioner does not challenge the deficiency cited under 42 C.F.R. § 483.13(b), (c)(1)(i), and it does not challenge the imposition of a DPNA and the prohibition of it conducting a NATCEP. P. Br. at 1. Therefore, I need not address this deficiency or the uncontested remedies, which are administratively final.

II. Issues

The issues are:

1. Is summary judgment appropriate;

2. Was Petitioner in substantial compliance with 42 C.F.R. § 483.13(c);

3. If Petitioner was not in substantial compliance with 42 C.F.R. § 483.13(c), did the deficiency pose immediate jeopardy to resident health and safety; and

4. If Petitioner was not in substantial compliance, is a $3,500 per-instance CMP reasonable?

III. Findings of Fact, Conclusions of Law, and Analysis[7]

A. Summary judgment is appropriate because the material facts are not in dispute.

Summary judgment is appropriate when there is no genuine dispute as to any issue of material fact for adjudication and/or the moving party is entitled to judgment as a matter of law. *Senior Rehab. & Skilled Nursing Ctr.*, DAB No. 2300 at 3 (2010); *see Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 248 (1986). The moving party must show that there are no genuine issues of material fact requiring an evidentiary hearing and that it is entitled to judgment as a matter of law. *Anderson*, 477 U.S. at 248. If the moving party meets its initial burden the non-moving party must "come forward with 'specific facts showing that there is a genuine issue for trial . . . .'" *Matsushita Elec. Indus. Co. v. Zenith Radio*, 475 U.S. 574, 587 (1986). "To defeat an adequately supported summary judgment motion, the non-moving party may not rely on the denials in its pleadings or briefs, but must furnish evidence of a dispute concerning a material fact – a fact that, if proven, would affect the outcome of the case under governing law." *Senior Rehab.*, DAB No. 2300 at 3. In determining whether there are genuine issues of material fact for hearing, an ALJ must view the evidence in the light most favorable to the non-moving party, drawing all reasonable inferences in that party's favor. *Id.*

[7] Findings of fact and conclusions of law are in bold and italics.

The material facts in this case are not disputed; therefore, there is no genuine dispute as to any material fact that requires a hearing. The parties do not dispute the following material facts: that an incident of suspected abuse occurred on May 30, 2016; that the facility investigated the suspected abuse, and during the course of the investigation, the suspected abuser completed her shift that same day and worked the following morning, with an instruction to not have contact with the resident she had allegedly abused; and, that the facility's abuse policy instructs that a suspected abuser may not have contact with the alleged victim of abuse but is not prohibited from caring for other residents while the suspected abuse is investigated.

It is undisputed that on May 30, 2016, at approximately 11:50 am, an employee of Petitioner, CNA # 1, inappropriately touched a resident, Resident #1. *See* P. Br. at 2 (Petitioner's assertion that it is "Undisputed that CNA1 inappropriately reached at Resident 1 and pushed at Resident 1."); P. Br. at 15 (Petitioner's explanation that the "events . . .were determined by [Petitioner's] administration to be inappropriate touching . . . ."); P. Br. at 20 ("The physical contact by CNA 1 is conceded to be unacceptable . . . and for that reason CNA 1 was put on administrative leave and terminated."); CMS Ex. 8 at 2 (facility's statement that "[b]ased on staff and resident interviews[,] there was evidence of physical contact between [CNA # 1] and [Resident # 1]"); CMS Ex. 9 (facility report of suspected abuse). Although Petitioner disputes CMS's assertion in its brief that CNA # 1 "hit" Resident # 1, it does not dispute that CNA # 1 pushed at Resident # 1 (P. Br. at 2), nor does it deny that the incident was suspected to be physical abuse.[8] P. Br. at 5 ("The Morton Bakar Center . . . timely reported the May 30, 2016 incident of the suspected abuse to the California Department of Public Health, the Ombudsman's Office, the Alameda County Sherriff's Department and the CNA Licensing Board."). For purposes of reference to this incident in a manner consistent with the facts not disputed by the parties, I will refer to the May 30, 2016 incident as being an allegation of abuse, or suspected abuse, at the time it was investigated on May 30-31, 2016.

Petitioner initiated an investigation after CNA # 1 self-reported the incident. P. Ex 2 at 2-3 (testimony of the Assistant Director of Nursing that CNA # 1 self-reported the suspected abuse); CMS Ex. 8 (facility's investigation report); *see* CMS Ex. 5 at 3 (facility abuse policy requirement that the facility will immediately initiate an investigation when a suspected incident of resident abuse is reported); *see also* CMS Br. at 2; P. Br. at 2, 5. Petitioner's abuse policy provides that "[i]f an employee of [the] facility has been accused of resident abuse, he/she will be immediately removed from contact with the

[8] Petitioner did not challenge CMS's finding that CNA # 1 committed abuse. *See* P. Br. at 1 ("Petitioner here appeals the determination of Immediate Jeopardy F-tag 226 and the civil [money] penalty imposed as to that deficiency as set forth on the June 21, 2016 report of the entity reported incident.").

resident." CMS Ex. 5 at 3. With respect to the victim of suspected abuse, the facility's policy instructs that "[t]he Administrator/Designee will take all measures to protect the resident from further potential abuse," (CMS Ex. 5 at 3), yet the policy does not address the protection of other residents from a suspected abuser who is under investigation. CMS Ex. 5. In particular, the facility's policy does not prohibit a suspected abuser from caring for residents while he or she is under investigation for suspected abuse. CMS Ex. 5. The parties do not dispute that after CNA # 1 self-reported the incident regarding Resident # 1, she continued to work the remainder of that shift and also worked the following morning, with the only limitation being that she not have contact with Resident # 1. P. Ex. 1 at 3 (testimony of Regional Director of Operations of Petitioner's parent company); *see* CMS Br. at 2; P. Br. at 3-4, 6. CNA # 1 was ultimately terminated after the facility completed its investigation of the May 30, 2016 incident. P. Ex. 1 at 6; *see* P. Br. at 18.

Because the undisputed material facts support a finding of substantial noncompliance with 42 C.F.R. § 483.13(c)(3), as will be addressed below, summary judgment is appropriate.

B. Petitioner was not in substantial compliance with 42 C.F.R. § 483.13(c)(3) because its policy would not prevent further potential abuse of residents during the course of an investigation of suspected abuse, as evidenced by the fact that CNA # 1 continued to care for residents after she self-reported the May 30, 2016 incident of suspected abuse and the investigation was pending.

The regulations provide that SNFs must "[n]ot use verbal, mental, sexual, or physical abuse, corporal punishment or involuntary seclusion." 42 C.F.R. § 483.13(c)(1)(i). Similarly, Petitioner's stated policy is that "[e]ach resident has the right to be free from abuse, corporal punishment, and involuntary seclusion." CMS Ex. 5 at 1. In furtherance of the requirement that SNFs not engage in abuse, 42 C.F.R. § 483.13(c) requires SNFs to "develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property." Noncompliance with 42 C.F.R. § 483.13(c) may be established where an SNF either fails to develop policies or procedures adequate to prevent abuse or fails to implement such policies. *See, e.g.*, *Southpark Meadows Nursing & Rehab. Ctr.*, DAB No. 2703 at 6 (2016) (finding the SNF noncompliant with 42 C.F.R. § 483.13(c) where it failed to implement existing policies to prevent neglect); *Glenoaks Nursing Ctr.*, DAB No. 2522 at 14 (2013) (finding the SNF noncompliant where it failed to develop policies to prevent elopement). As required by 42 C.F.R. § 483.13(c), which directs that a facility "must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property," Petitioner has implemented an abuse policy. *See* CMS Ex. 5.

In its motion for summary judgment, CMS contends that Petitioner failed to substantially comply with 42 C.F.R. § 483.13(c) because it developed and implemented an inadequate abuse policy; specifically, CMS alleges that Petitioner had a flawed abuse policy that permitted an employee suspected of abuse to continue caring for residents that same day and the following day while the allegation was still under investigation.[9] CMS Br. at 10-13. CMS contends that the "obligation to protect residents from potential abuse is not limited to the subject of the allegation of abuse under investigation," and that Petitioner's policy did not "prevent further potential abuse while the investigation [was] in progress" as required by 42 C.F.R. § 483.13(c)(3). CMS Ex 11 at 12.

In opposition, Petitioner contends that it substantially complied with 42 C.F.R. § 483.13(c) because, as required by its abuse reporting policy, CNA # 1 promptly reported the abuse of Resident # 1 and the facility directed her not to have contact with Resident # 1 while she continued to work during the investigation. P. Br. at 17-18. Petitioner further contends that it substantially complied with 42 C.F.R. § 483.13(c) and that CNA # 1's presence, immediately after she self-reported the incident, did not place other residents at risk of abuse because CNA # 1 was "a long time, trained and trusted employee," Resident #1 did not suffer a "cognizable injury" as a result of the incident, and the incident was initiated by Resident # 1 yelling and spitting at CNA # 1. P. Br. at 14, 17-18. Petitioner emphasizes that, as required by its policy, CNA # 1 was not permitted to have contact with Resident # 1 and Resident # 1 was not at risk for further abuse by CNA # 1. P. Br. at 17-18. While Petitioner argues that "no facts . . . suggest that CNA 1's continued presence posed a potential harm to other residents," it does not squarely address that CNA # 1's continued care of residents was authorized by a policy that CMS faulted as being deficient. P. Br. at 18; CMS Br. at 11-13.

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[9] The Statement of Deficiencies charged substantial noncompliance with 42 C.F.R. § 483.13(b) (based on CNA # 1's abuse of Resident # 1) and 42 C.F.R. § 483.13(c) (based on the failure of another employee, CNA # 2, to report the abuse of Resident # 1 that CMS alleges she purportedly witnessed). CMS Ex. 1. Facts presented in the Statement of Deficiencies in support of these deficiencies include that CNA # 1 inappropriately touched Resident # 1, CNA # 1 self-reported that she committed abuse, and that Petitioner allowed her to finish her shift and work the following morning, with the directive that she stay away from Resident # 1. CMS Ex. 1 at 2-3. Based on these same facts, CMS argued in its brief that Petitioner did not substantially comply with 42 C.F.R. § 483.13(c)(3) when it allowed CNA # 1 to continue caring for residents while she was under investigation for abuse (CMS Br. at 10-13), and Petitioner responded to CMS's argument in its brief. P. Br. at 17-18. The Board has held that the regulations do not prohibit CMS from relying on facts set forth under a different citation when considering whether a facility has violated an additional participation requirement. *Azalea Court*, DAB No. 2352 at 12 (2010), *aff'd*, *Azalea Court v. U.S. Dep't of Health & Human Servs.*, 482 F. App'x 460 (11th Cir. 2012).

I find that Petitioner violated 42 C.F.R. § 483.13(c) because its abuse policy allowed an employee who was under investigation for suspected physical abuse to continue to care for residents during the pendency of the investigation. Petitioner acknowledges that its abuse reporting policy only required it to prohibit contact between the suspected abuser and the suspected victim of that abuse. P. Br. at 17-18. Petitioner argues that its policy did not place any residents at risk, and that it allowed CNA # 1 to continue caring for residents because "[t]here were no facts to suggest that [her] continued presence posed a potential harm to other residents." P. Br. at 18. Petitioner further explained that it based this determination on the "longstanding known history of this particular employee," and "the facts that gave rise to the conduct at issue." P. Br. at 18.

Accepting all of the facts in the light most favorable to Petitioner (i.e., that CNA # 1 was a "long time, trained, and trusted employee"; that Resident # 1 was "spitting and yelling" at CNA # 1 during the incident; that CNA # 1 did not hit Resident # 1 in the face but was involved in "physical contact" that was "unacceptable;" and that "there is no cognizable injury known to have resulted" from the physical contact (P. Br. at 14, 17, 18, 20)), Petitioner's arguments fail because it has not demonstrated that its abuse policy would prevent further abuse while an investigation was in progress, as required by section 483.13(c)(3). Further, Petitioner has not demonstrated that allowing CNA # 1 to continue working that same day and the following day, in compliance with its abuse policy, substantially complied with section 483.13(c)(3), which required it to prevent further *potential* abuse while an allegation of abuse was being investigated. Through CNA # 1's self-report on May 30, 2016, Petitioner was on notice that CNA # 1 may have abused a resident. Without investigating the matter, Petitioner determined, consistent with its abuse policy, that Petitioner could continue caring for *other* residents. P. Ex. 1 at 3. Thus, *immediately after* potentially abusing one resident, CNA # 1 was allowed to continue to care for other residents. Having not investigated the matter, Petitioner did not know if the allegation was true. Nor did Petitioner determine, through an investigation, whether CNA # 1's mental state was conducive to caring for other residents in a non-abusive manner without being a danger to the other residents. And, Petitioner did not have close supervision over CNA # 1 to make sure she adhered to the directive to not have contact with Resident # 1 for the remainder of the day and the following day, such that she would not have an opportunity to abuse Resident # 1 again or potentially interfere with the investigation.[10] *See* P. Ex. 2 at 6 (written testimony that the Assistant Director of Nursing made rounds that included the nursing station on May 30, 2016 and "verified that CNA 1 had no further contact with Resident 1."). By allowing CNA # 1 to

[10] Not only could CNA # 1 have potentially faced criminal charges, but she also could have been subject to reporting to her state's nurse aide registry. *See* 42 C.F.R. § 483.13(c)(1)(ii)(A), (B) (stating that a facility must not employ an individual who has been found guilty of abuse or has had a finding entered into a state nurse aide agency concerning abuse).

care for residents before it had completed an investigation, Petitioner allowed a suspected abuser to render care before it had assessed whether CNA # 1 had committed abuse and could cause "further potential abuse" to other residents. *See* 42 C.F.R. § 483.13(c)(3). It was not reasonable for Petitioner to allow CNA # 1 to care for residents while it conducted its investigation, and this is evidenced by the fact that Petitioner terminated CNA # 1's employment at the conclusion of its investigation. P. Br. at 18.

Petitioner's abuse policy does not comply with 42 C.F.R. § 483.13(c)(3). The regulation is clear and unambiguous: While a facility is investigating an allegation of abuse, the facility "must prevent further potential abuse while the investigation is in progress." 42 C.F.R. § 483.13(c)(3). Petitioner's seriously flawed policy did not prevent further potential abuse of *all* residents, but rather, arguably protected *only* the resident (or residents) who were the subject of a report of suspected abuse. CMS Ex. 5. I point out that a report of suspected abuse may only be based on a single known instance of suspected abuse, and after further investigation, other instances of abuse may come to light.[11] While Petitioner's policy presumably protects a known victim (or suspected victim) of staff-on-resident abuse, it does not protect any other residents during the course of an abuse investigation. CMS Ex. 5 at 3 (stating that the employee "will be immediately removed from contact with resident" but not addressing contact with other residents). Thus, Petitioner's policy did not prevent further *potential* abuse of *all* residents. Further, the policy did not identify any type, or degree of, suspected abuse that would result in an employee being barred from all contact with residents during the course of the investigation. Nor did it not require a "cooling off period" that would prevent an employee who had just physically assaulted a resident from caring for another resident *immediately after* committing such abuse. And it is concerning that an employee could remain in the resident care environment immediately after he or she had abused a resident, possibly able to influence co-workers and residents who could be asked for input during the investigative process, thereby potentially preventing abuse from being "thoroughly investigated" as required by section 483.13(c)(3). While Petitioner argues that CNA # 1 was a "long time, trained, and trusted employee" (P. Br. at 17), it is apparent that her lengthy history of employment did not prevent her from committing abuse, nor did the policy specify that a "long time, trained, and trusted" employee suspected of abuse should somehow be treated differently than any other employee suspected of abuse.[12]

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[11] For instance, as part of an investigation, a facility may question other residents to find out if they had been abused by a particular employee. These interviews may reveal previously unknown abuse. It is troubling to envision such interviews taking place while the abuser is allowed to care for and interact with these same residents.

[12] I note that the physical contact took place in front of a surveillance camera; it appears likely that the employee self-reported the incident because she knew the act had been recorded. CMS Ex. 3.

For the foregoing reasons, I find that Petitioner's abuse policy did not substantially comply with 42 C.F.R. § 483.13(c) because it allowed an employee suspected of abuse to continue caring for residents during an investigation and did not prevent further potential abuse.

C. The immediate jeopardy determination is not subject to review, as the per-instance CMP is not affected by whether or not there is immediate jeopardy and CMS's withdrawal of NATCEP approval was not based alone on substandard quality of care.

CMS asserts that the "J" level scope and severity of the deficiency is "not at issue" because a challenge would not affect the range of CMP or change the finding of substandard quality of care. CMS Br. at 4-5, *citing* 42 C.F.R. § 488.438(a)(2) (range of penalties for per-instance CMPs); 42 C.F.R. § 498.3(b)(14)(ii) (addressing challenges to scope and severity findings). CMS argues that any change in the level of scope and severity would not affect the range of the CMP, and that the NATCEP was required because a DPNA had been imposed. CMS Br. at 5. Petitioner, with little support, argues that "[t]he facts which form the stated basis for the deficiency (F-226) do not properly give rise to immediate jeopardy . . . ." P. Br. at 19. Petitioner did not respond to CMS's argument that the determination of immediate jeopardy is not reviewable.

The regulations are clear that an ALJ may review CMS's scope and severity findings (which includes a finding of immediate jeopardy) *only if* a successful challenge would affect: (1) the range of the CMP amounts that CMS could collect; or (2) a finding of substandard quality of care that results in the loss of approval of a facility's nurse aide training program. 42 C.F.R. § 498.3(b)(14), (d)(10)(i)-(ii); *NMS Healthcare of Hagerstown*, DAB No. 2603 at 6-7 (2014). A successful challenge would not affect the range of the CMP, because the CMP is within the range prescribed by 42 C.F.R. §§ 488.408(e)(1)(iv), 488.438(a)(2).

In its July 2016 letter, CMS explained the following in support of its determination that it would withdraw NATCEP approval:

> As a result of the imposition (as noticed herein) of the *denial of payment for new admissions*, substandard quality of care and civil money penalty, this provision is applicable to your facility and you will receive further notification from the State in this connection. In light of the foregoing, you may finish any nurse assistant training class you are presently conducting; you may not, however, start another such class.

CMS Ex. 11 at 3 (emphasis added). CMS had imposed a DPNA pursuant to 42 C.F.R. § 488.417(a) because Petitioner was not in substantial compliance with program

requirements. CMS Ex. 11 at 2. Pursuant to 42 C.F.R. § 483.151(b)(3)(ii), the imposition of a DPNA results in a two-year period in which a NATCEP cannot be approved. *See also Sunshine Haven Lordsburg*, DAB No. 2456 at 3 (2012) ("Withdrawal of NATCEP approval is mandatory, among other reasons, where a facility has been assessed a CMP of $5,000 or more, had its Medicare participation terminated, or has been subject to a DPNA. Act § 1819(f)(2)(B)(iii)(I); 42 C.F.R. § 483.151(b)(2), (3)."). The withdrawal of approval for Petitioner's NATCEP was not based alone on a finding of substandard quality of care, but was also based on the imposition of the DPNA for substantial noncompliance. *See* 42 C.F.R. §§ 488.417(a), 388.301(definition of substantial noncompliance, which does not necessarily require a finding of immediate jeopardy). Therefore, I need not review the determination that the deficiency posed immediate jeopardy to resident health and safety. Regardless, even if it was necessary to address the immediate jeopardy deficiency, I would have found that immediate jeopardy unquestionably existed until June 21, 2016, the date Petitioner submitted a plan of correction; the facility, pursuant to its own policy, permitted a suspected physical abuser to care for its residents while an investigation was pending, and Petitioner's noncompliance was likely to cause serious injury, harm, impairment, or death to residents. 42 C.F.R. § 488.301.

D. The penalty imposed is reasonable

I examine whether the amount of a CMP is reasonable by applying 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) the 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 listed 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.

Here, CMS imposed a per-instance CMP of $3,500, which is on the low-end of the spectrum for a per-instance CMP ($1,000-$10,000),[13] and is modest considering what CMS could have imposed. 42 C.F.R. § 488.408(e)(1)(iv); *see Plum City Care Ctr.*, DAB No. 2272 at 18-19 (2009) (observing that even a $10,000 per-instance CMP can be "a modest penalty when compared to what CMS might have imposed"). Petitioner does not claim that its financial condition affects its ability to pay the CMP.

Petitioner contends that "the regulatory factors do not support a finding that the $3,500 CMP is reasonable." P. Br. at 20. Petitioner is correct to some extent, in that the

[13] CMP amounts increased, effective February 3, 2017, for violations occurring after November 2, 2015. *See* 82 Fed. Reg. 9,174 (February 3, 2017).

regulatory factors likely would have supported a much *higher* CMP. The immediate jeopardy deficiency here is very serious, in that a suspected abuser continued to care for residents after she had self-reported her potential abuse of a resident, and a single $3,500 CMP was imposed based only on the Petitioner's substantial noncompliance with 42 C.F.R. § 483.13(c), and did not encompass the related deficiency involving the abuse of a resident by an employee. *See* 42 C.F.R. § 488.404. Further, Petitioner has a history of noncompliance on recent surveys between February 2014 and April 2016, to include the same deficiencies that were cited in the June 2016 survey. CMS Ex. 13 at 1.

Therefore, I conclude that the $3,500 CMP was reasonable. In reaching this conclusion I reiterate that the per-instance CMP is at the low end of the wide range of CMPs allowed by regulation.

IV. Conclusion

For the reasons discussed above, I find that the facility was not in substantial compliance with the Medicare requirements, the deficiency posed immediate jeopardy to resident health and safety, and the $3,500 penalty imposed is reasonable.

/s/
Leslie C. Rogall
Administrative Law Judge