Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

In the Case of:	)	
Hilltop Haven Nursing Home, (CCN: 67-5576),	)	Date: May 2, 2008
Petitioner,	)	Docket No. C-06-297
	)	Decision No. CR1782
v.	)	
Centers for Medicare & Medicaid Services.	)	

DECISION

Petitioner, Hilltop Haven Nursing Home, violated 42 C.F.R. § 483.13(c), as alleged by a survey of the facility completed November 3, 2005. There is a basis for imposition of a per instance civil money penalty (PICMP) of $7000, and that amount is reasonable. Withdrawal of approval for Petitioner to conduct a nurse aide training and competency evaluation program (NATCEP) for a period of two years from November 3, 2005 through November 2, 2007, was required based upon imposition of a civil money penalty (CMP) of not less than $5000. Social Security Act (Act), §§ 1819(f)(2)(B); 1919(f)(2)(B); 42 C.F.R. §§ 483.151(b)(2), (b)(2)(iv), and (e)(1).

I. Background

Petitioner is a long-term care facility located in Gunter, Texas. Petitioner is authorized to participate in the federal Medicare program as a skilled nursing facility (SNF) and in the Texas State Medicaid program as a nursing facility (NF). The Texas Department of Disability Services (state agency) completed a survey of Petitioner's facility on November 3, 2005, and issued a statement of deficiencies (SOD). CMS Exhibit (CMS Ex.) 4. The Centers for Medicare & Medicaid Services (CMS) notified Petitioner by letter dated January 6, 2006, that it was imposing the remedies of: termination of Petitioner's provider agreement, effective March 3, 2006, if Petitioner did not return to substantial compliance before that date; a PICMP of $8000, based on the alleged violation

of 42 C.F.R. § 483.13(c) (Tag F 224[1]); denial of payment for new admissions (DPNA), effective January 21, 2006; and directed in-service training. CMS also advised Petitioner that its authority to conduct a NATCEP was withdrawn. CMS Ex. 1. Petitioner timely requested a hearing by letter dated March 6, 2006, and the case was assigned to me for hearing and decision on March 15, 2006. CMS notified Petitioner by letter dated April 28, 2006, that it had rescinded the remedies of termination and a DPNA, and that the PICMP for the violation of 42 C.F.R. § 483.13(c) (Tag F 224) had been adjusted downward to $7000. CMS Ex. 29. On August 10, 2006, I issued an Order Limiting Issues for Hearing, granting a CMS motion to limit the issues for hearing and ruling that the only deficiency at issue concerned the alleged violation cited at 42 C.F.R. § 483.13(c) (Tag F 224), which was the basis for the $7000 PICMP and Petitioner's loss of authority to conduct a NATCEP.

I held a hearing in Dallas, Texas, from August 29 through 31, 2006, and the proceedings are recorded in a transcript (Tr.) with pages numbered 1-812. The parties offered and I admitted as evidence CMS Exs. 1-5, 8-15, 20-21, 23-24, and 27-30. Tr. 29, 30, 48, 49, 59, 60, 61, 62, 64, 65, 72, 73, 74, 75, 78, 798. Petitioner's Exhibits (P. Exs.) 1-25 were admitted. Tr. 81. CMS called to testify: Cheryl Lee Cannon, a nurse surveyor for the

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[1] A "Tag" designation refers to the part of the State Operations Manual (SOM), Appendix PP, "Survey Protocol for Long-Term Care Facilities," "Guidance to Surveyors," that pertains to the specific regulatory provisions allegedly violated. The cited deficiencies are set forth in the SOD, Form 2567L, prepared by state agency surveyors. Each deficiency includes a scope and severity (SS) level, such as "SS-J." Scope and severity levels are used by CMS and state agencies when selecting remedies. A scope and severity level is designated by an alpha character, A through L, selected by CMS or the state agency from the scope and severity matrix published in the SOM at section 7400E. A scope and severity level of A, B, or C indicates a deficiency that presents no actual harm, but has the potential for minimal harm. Facilities with deficiencies of a level no greater than C remain in substantial compliance. 42 C.F.R. § 488.301. A scope and severity level of D, E, or F indicates a deficiency that presents no actual harm, but has the potential for more than minimal harm that does not amount to immediate jeopardy. A scope and severity level of G, H, or I indicates a deficiency that involves actual harm that does not amount to immediate jeopardy. Scope and severity levels J, K, and L are deficiencies that constitute immediate jeopardy to resident health or safety. Letters A, D, G, and J indicate an isolated occurrence; letters B, E, H, and K indicate a pattern of occurrences; and letters C, F, I, and L indicate widespread occurrences. The matrix, which is based on 42 C.F.R. § 488.408, specifies which remedies are required and optional at each level based on the frequency of the deficiency. *See* SOM, section 7400E.

state agency (Tr. 108-208); Amy Bliss, a social services surveyor for the state agency (Tr. 332-74); Leena Volmer, a nurse surveyor for the state agency (Tr. 378-482); and Daniel J. McElroy, a CMS nurse consultant (Tr. 483-502). Petitioner called to testify: Marie Ruth Konecny, a nurse surveyor for the state agency (Tr. 215-26); Cheryl Lynn Morgan, nurse consultant (Tr. 227-325); Ann Wedgwood-Stauch, a dietitian surveyor for the state agency (Tr. 503-40); Suzanna Woodard, Petitioner's Director of Nursing (DON) (Tr. 541-651); David Robert Boggs, Petitioner's Administrator (Tr. 666-716); and Karen Kimberly Johnson-Cook, Petitioner's parent company's Assistant Vice-President of Clinical Services (Tr. 718-83). The parties submitted post-hearing briefs (CMS Brief and P. Brief, respectively) and reply briefs (CMS Reply and P. Reply, respectively).

II. Discussion

A. Findings of Fact

The following findings of fact are based upon the June 29, 2006 stipulation of the parties, (Jt. Stip.), the transcript of the hearing, and the exhibits admitted. Citations to exhibit numbers related to each finding of fact may be found in the Analysis section of this decision if not indicated here.

1. Resident 1 was admitted to Petitioner's facility on June 7, 2004. CMS Ex. 14, at 7.

2. The physician's order for Resident 1's admission states that Resident 1 is not capable of understanding or exercising her rights due to her diagnosis of Alzheimer's disease and dementia. P. Ex. 10, at 1.

3. Resident 1's admitting diagnoses included a history of respiratory arrest, anemia, depressive disorder, generalized osteoarthrosis involving multiple sites, atypical psychosis, a history of aspiration pneumonia due to inhalation of food or vomitus, and Alzheimer's disease. CMS Ex. 14, at 7.

4. Resident 1's quarterly assessment, minimum data set (MDS), with an assessment reference date of September 6, 2005, the last date of the observation period, indicated that she had short and long term memory problems; was severely cognitively impaired; was easily distracted; mental function varied over the course of the day; had periods of restlessness; sometimes made herself understood but that was limited to making concrete requests; she was assessed as rarely or never able to understand others; she had a sad, pained, worried facial expression; made repetitive physical movements; she was assessed as being physically abusive, which is described on the MDS form to indicate others were hit shoved, scratched, or sexually abused; she displayed socially inappropriate or disruptive behavioral

symptoms; she was totally dependent on staff for bed mobility and transfers; locomotion on the unit required supervision and with the physical assistance of one; she could not stand without help; and she received both an antipsychotic and antidepressant medication. CMS Ex. 14, at 8-12; P. Ex. 2.

5. Resident 1 spoke Spanish, not English, and communication was noted to be difficult due to the language barrier. P. Ex. 8, at 1, 3, 4.

6. Resident 1 was very mobile in her wheelchair with poor safety awareness and incidents of bumping into walls, tables, and other residents and entering other resident's rooms. P. Ex. 8, at 4, 5, 7, 8, 10, 12, 13.

7. Nurse's notes record numerous instances of Resident 1's aggressive behavior towards other residents:

   a. On June 8, 2004, the resident "holds on to everyone she can reach." P. Ex. 8, at 1.

   b. On June 28, 2004, the resident was up in her wheelchair, propelling self, oblivious to surroundings, bumping into objects, grabbing at staff and other residents, and redirection was not always successful. P. Ex. 8, at 10.

   c. On July 10, 2004, she was in the hallway moving around grabbing at anyone who got close to her. CMS Ex. 14, at 21.

   d. On July 13, 2004, she was up in her wheelchair, grabbing at staff and other residents and she could not be redirected. P. Ex. 8, at 16; CMS Ex. 14, at 23.

   e. On July 14, 2004, at 4:00 a.m., she was noted to continue to be up and grabbing at other residents. CMS Ex. 14, at 24.

   f. On July 18, 2004, Resident 1 was noted to be grabbing and pushing family members, staff, and others. CMS Ex. 14, at 25.

   g. On July 19, 2004, the resident was up in her wheelchair, grabbing at other residents and trying to bite them. P. Ex. 8, at 19-20; CMS Ex. 14, at 25-26.

   h. On July 20, 2004, she was noted to continue to try to pull at other residents and staff. P. Ex. 8, at 20; CMS Ex. 14, at 26.

i. On July 24, 2004, the resident was wheeling herself in the hallway and the nurse and CNA witnessed her run into another resident's wheelchair and Resident 1 mashed her forearm[2] between her and the other resident's wheels resulting in a 2 cm skin tear with bruising to the surrounding tissue. P. Ex. 8, at 21.

j. Other incidents of Resident 1 pushing, slapping, grabbing, pulling hair, running into visitors, staff, and other residents with her wheelchair, and taking food from other residents are noted on July 27, 28, 29, 30, 31, 2004, August 1, 6, 7, 8, 9, 10, 2004. P. Ex. 8, at 24, 25, 26, 27, 28, 30, 31, 32.

k. On August 10, 2004, a care plan meeting was conducted with Resident 1's responsible party at the request of nursing staff to discuss the resident's aggressive behavior toward other residents, including hair pulling, pushing, grabbing, and squeezing arms, it was agreed that the resident's physician would evaluate and change medication as needed, and the responsible party was advised that Petitioner had to protect other residents and Resident 1 could be discharged to home if necessary. P. Ex. 8, at 32-35.

l. On August 11, 2004, Resident 1's medications were changed. P. Ex. 8, at 34.

m. Nurse's notes record that between the medication change on August 11, 2004 to March 21, 2005, Resident 1 continued to run into others with her wheelchair, to grab staff and other residents and that she had to be separated at times by staff, despite additional medication changes. P. Ex. 8, at 36-79.

n. On March 21, 2005, Resident 1 was noted to be aggressive, combative, trying to bite, attempting to self-transfer, she caused a superficial abrasion to the left lower leg below knee, and staff could not calm her but medication seemed to decrease the behaviors. P. Ex. 8, at 79.

o. On March 22, 2005, Resident 1 wheeled herself into another resident's room and hit the resident's family and tried to push the resident down and Resident 1 had to be removed by staff. P. Ex. 8, at 79.

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[2] The second-line of the note indicates the left forearm was mashed between the wheels, but the third-line states that there was a 2 cm skin-tear to the right forearm. P. Ex. 8, at 21.

p. Nurse's notes show that Resident 1's aggressive behaviors continued between March 22 and June 1, 2005.[3] P. Ex. 8, at 79-81.

q. On June 1, 2005, Resident 1 propelled her wheelchair into another resident, grabbed the other resident's left hand, and caused a 1 cm skin tear when the other resident pulled the hand away; and she was reported to have grabbed and pulled at other residents and had to be separated several times. P. Ex. 8, at 81.

r. On July 4, 2005, Resident 1 was reported to be up and down hall all shift, grabbing other residents and objects; redirection was unsuccessful; she grabbed one resident and bit her hand causing injury; and she was noted to require constant supervision. P. Ex. 8, at 82.

s. Nurse's notes show that Resident 1's aggressive behaviors continued between July 4, 2005 and November 2, 2005, except for August and September when no specific incidents of aggressive behavior are noted.[4] P. Ex. 8, at 83-91.

8. A July 9, 2005 targeted behaviors symptoms assessment, signed by a physician, stated that Resident 1 "will pick at others near her [and] pull [them] towards her;" other behaviors noted are physical combativeness and agitation, uncooperativeness, wandering, and restlessness, and symptoms of disorientation, confusion, and anxiety. CMS Ex. 14, at 20.

9. Care plan entries dated March 23, 2005, June 21, 2005, and September 13, 2005 show that Resident 1 was physically aggressive towards staff and residents due to her diagnosis of Alzheimer's disease and her atypical psychosis, and that she "pushes, shoves, pulls, wanders in and out of rooms, tugs at peers, staff; will roll her [wheelchair] into others;" the entry dated September 13, 2005, states she pats at staff and peers and "grasps hold - tugs" at peers and is a risk for causing disruption, skin tears, and bruising of peers. CMS Ex. 14, at 42.

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[3] I note however that Petitioner has produced few nurse's notes for April 2005 and none for May 2005. *See* P. Ex. 8, at 80-81.

[4] I note that Petitioner has produced few nurse's notes for August and September 2005. *See* P. Ex. 8, at 80-81. The absence of notes of aggressive behavior is at odds with the MDS assessment that Resident 1 engaged in physically abusive behavior during the seven-day assessment period that ended on September 6, 2005. *See* Finding of Fact 10.

10. Resident 1's MDS with the assessment reference date of September 6, 2005, shows that physically abusive behavior by Resident 1 was observed during the seven-day assessment period. CMS Ex. 14, at 9.

11. Facility records dated October 22, 2005, show that Resident 1 grabbed Resident 2's hand as Resident 2 ambulated by her, resulting in Resident 2 falling and injuring herself. CMS Ex. 14, at 5-6, 28; CMS Ex. 15, at 7, 43.

12. Later on October 22, 2005, nurse's notes indicate that Resident 1 was propelling herself around and was reaching out and grabbing at objects or staff. CMS Ex. 14, at 29.

13. A report related to the October 22, 2005 incident with Resident 2 notes that Resident 1 "frequently reaches out & hits or grabs others, usually employees" and that the intervention used was to redirect the resident. CMS Ex. 14, at 5-6.

14. During the survey on November 1, 2005, Surveyor Bliss observed Resident 1:

    a. At 12:18 p.m., in the dining room, in a straight-backed geri-chair, at a dining room table with her back facing everyone else, alone at table. CMS Ex. 14, at 4; Tr. 335.

    b. Staff were not in the dining room for approximately 15 minutes during her observation. Tr. 337.

    c. At 12:28 p.m., Resident 1 was sitting alone at the table and was observed to grab and pull the chair toward her. CMS Ex. 14, at 4; Tr. 337.

    d. At 12:32 p.m., Resident 1 was fidgeting and restless in her chair and staff did not react. CMS Ex. 14, at 4; Tr. 337.

    e. Staff served Resident 1 a lunch tray around 12:47 p.m. and subsequently checked and brought her something different, but did not otherwise interact with Resident 1. Tr. 336, 344-45.

    f. At 12:56 p.m., Resident 1 was grunting and throwing food. CMS Ex. 14, at 4; Tr. 337-38.

g. At approximately 12:59 p.m., Resident 1 threw an empty, rigid, plastic glass at another resident who was reclined in a geri-chair and staff removed the glass from the second resident's lap. CMS Ex. 14, at 4; Tr. 338, 353, 361, 367-68.

h. Resident 1 grabbed the lower part of a resident's cloth clothes protector (bib) and tugged on it; no staff were there, and Surveyor Bliss intervened, asked Resident 1 to let go, and redirected her. Tr. 338-39, 370-73.

i. Resident 1 was able to move her upper body freely in the geri-chair and could stretch. Tr. 339, 343.

j. Surveyor Bliss concluded that facility staff took inadequate interventions to prevent Resident 1 from reaching other residents. Tr. 344-45.

15. On the morning of November 2, 2005, at approximately 11:35 a.m., Surveyor Cannon observed Resident 1, who was sitting in a wheelchair, strike another resident on the chest; no staff was present and the surveyor asked a hospice aide to intervene who moved the residents apart and then went to find the charge nurse. CMS Exs. 4, at 6; 28; Tr. 127-31, 136, 190-91, 195.

16. Nurse's notes dated November 2, 2005, with the times 1130 and 1200, state that Resident 1 got up unassisted several times; she was redirected by staff to her chair three times; she got up again, walked to another resident and took the resident's hand; Resident 1 got up unassisted and went to another resident and pulled on the resident's left cheek; she was redirected to her geri-chari, again with assistance from housekeeping; and the physician and Director of Nursing were notified. P. Ex. 8, at 88-89; P. Ex. 22, at 4.

17. During the survey on November 2, 2005, Surveyor Volmer observed Resident 1:

a. At noon, propelling herself in a wheelchair with RN Kim Cook near her. CMS Ex. 13, at 1.

b. At 12:30 p.m., Resident 1 grabbed another resident's arm, RN Cook moved her a couple of feet, but kept her in the dining room. CMS Ex. 13, at 1; Tr. 386-88.

c. At approximately 12:32 p.m., Resident 1 struck Surveyor Volmer as she walked past and RN Cook removed Resident 1 from the dining room. Tr. 389-90.

d. At 2:05 p.m., Surveyor Volmer observed Resident 1 in the dining room in a geri-chair and she continued to attempt to hit and grab at people walking or wheeling past. CMS Ex. 13, at 3; Tr. 391.

e. At 2:15 p.m., Surveyor Volmer observed Resident 1 grabbing at another resident as a CNA was attempting to wheel the resident past Resident 1 and another CNA came to assist and held Resident 1 back so that they could pass. CMS Ex. 13, at 3; Tr. 392.

f. At 2:30 p.m., Resident 1, who was seated in a geri-chair in the hall unmonitored, grabbed Surveyor Volmer's wrist as she attempted to walk past Resident 1 and the resident's fingers had to be pried loose. CMS Ex. 13, at 4; Tr. 393-94.

18. Social work progress notes dated August 11, 2004, show that Resident 1's daughter was advised that the resident was endangering other residents and that if the resident's aggressive behaviors were not controlled she would have to be moved. P. Ex. 11, at 2.

19. Social work progress notes dated June 7, 2005, show Resident 1 was assessed as being at risk for overstimulation and dangerous behavior incidents with other residents and that use of "individual rummage props" (a diversion activity) was ineffective due to her poor attention. CMS Ex. 14, at 63; P. Ex. 11, at 5.

20. Resident 1's care plan related to her aggressive behavior with dates July 29, 2004, August 6 and 10, 2004, September 16, 2004, October 27, 2004, November 22, 2004, December 7, 2004, December 21, 2004, January 11, 2005, and March 9, 2005 (P. Ex. 9, at 2), shows that:

a. Resident 1 was assessed as having repeated episodes of aggression toward other residents including hair pulling, pushing, grabbing and squeezing arms, holding on, disruptive behavior, rolling her wheel chair into other residents, and wandering into and out of other resident's rooms; and

b. Care planned interventions included: medicating, anticipating needs, explaining procedures and giving time to adjust, intervening to protect rights and safety of others, diverting Resident 1's attention, removing Resident 1 from the situation, monitoring, engaging in structured activities, use of a geri-chair with attached table as a trial (beginning September 16, 2004 but discontinued January 11, 2005), and evaluation by psychiatrist.

21. Care planned interventions for Resident 1 dated March 23, 2005, June 21, 2005, and September 13, 2005 related to her physical aggression included: medication; anticipating resident needs; explaining procedures so the resident could adjust; intervening to protect the rights and safety of others; diverting Resident 1's attention and removing her if necessary; diverting Resident 1's attention with activities; monitoring her; and assessing for risk of sensory overload. CMS Ex. 14, at 42-43; P. Ex. 9, at 5-6.

22. A new care plan related to Resident 1's physical aggression dated November 2, 2005, lists interventions including: medication; anticipating needs; explaining procedures specifically with Spanish speaking staff when possible; intervening to protect the rights and safety of others; monitoring; providing opportunities for positive interaction; and use of a geri-chair with table top in place during episodes of agitation with release and repositioning every two hours for ten minutes. CMS Ex. 14, at 61-62; P. Ex. 9, at 24-25.

23. Physician's orders from Resident 1's admission to her discharge, dated June 12, 2004 through November 4, 2005, include orders for use of a seatbelt and alarm while the resident was up in her wheelchair, use of a geri-chair with a tray or table attached as a form of restraint in August and September 2004 and November 2005, and various psychotropic drugs in various doses, not all necessarily intended to address the resident's aggressive behavior but with that possible collateral effect. P. Ex. 10, at 1-20.

24. The evidence shows that Petitioner attempted interventions to address Resident 1's behaviors, including: in-services for staff training; adjusting her care plan; medication adjustments; psychiatric evaluations; social work evaluations; meeting with the resident's family to explore treatment alternatives; use of a geri-chair to help decrease agitation; use of a seat belt with an alarm to keep her seated when up; one on one supervision when needed; use of Spanish speaking aides; provision of Spanish tapes; engagement of Resident 1 in activities to use her motor skills; training on redirection techniques; and working with the resident's daughter to formulate a workable treatment plan, despite the daughter's resistance (P. Brief at 7-8), none of which individually or collectively were effective to control Resident 1's aggressive behaviors.

25. Resident 1 was sent to the hospital on November 2, 2005 at the insistence of the surveyors, re-admitted, and eventually discharged to her daughter's care on November 6, 2005. P. Ex. 8.

26. Petitioner's policies offered and admitted as evidence include the following titles with the effective dates indicated: Resident to Resident Abuse, 11/03/05; Unmanageable Resident/Patients, 04/01/98; Abuse Reporting, 04/01/99; Abuse and/or Resident Neglect Investigation, 04/01/99; Accident and Incident Reports, 04/01/99. CMS Ex. 21; P. Ex. 13, 14, 15.

27. Petitioner's policy Number 32-102-00, subject: Abuse Reporting, effective date 04/01/99, revision date 3/25/04 states: "Our facility will not condone resident abuse by anyone, including staff members, other residents, consultants, volunteers, staff or other agencies serving the resident, family members, legal guardians, sponsors, friends or other individuals." P. Ex. 14, at 1.

B. Conclusions of Law

1. Petitioner timely requested a hearing and I have jurisdiction.

2. Petitioner had policies in effect at the time of the November 2005 survey that satisfied its obligation to develop policies under 42 C.F.R. § 483.13(c) to prohibit mistreatment, neglect, abuse of residents or the misappropriation of their property.

3. Petitioner violated 42 C.F.R. § 483.13(c) (Tag F 224), because it failed to implement its policies to protect its residents from the aggressive behaviors of Resident 1, as demonstrated by repeated instances of aggressive behavior by Resident 1 toward others, including residents, staff, surveyors, and visitors over more than a year.

4. Petitioner's violation of 42 C.F.R. § 483.13(c) provides a basis for the imposition of a PICMP and the $7000 PICMP imposed is reasonable.

5. The scope and severity of the deficiency is not subject to review, as the scope and severity of the deficiency has no effect on the range of PICMP which may be imposed and it has no impact upon the withdrawal of Petitioner's authority to conduct a NATCEP. 42 C.F.R. § 498.3(b)(14); 488.438(a)(2); *see* 42 C.F.R. §§ 498.3(d)(10)(ii), 488.438(e).

6. Petitioner's loss of its authority to conduct a NATCEP is mandatory for the period November 3, 2005 through November 2, 2007, as I sustain a CMP of more than $5000. Act, §§ 1819(f)(2)(B); 1919(f)(2)(B); 42 C.F.R. §§ 483.151(b)(2), (b)(2)(iv), and (e)(1).

C. Issues

The issues in this case are:

1. Whether there is a basis for the imposition of an enforcement remedy; and

2. Whether the remedies imposed are reasonable.

D. Applicable Law

The statutory and regulatory requirements for participation in the Medicare and Medicaid programs by a long-term care facility are found at sections 1819 and 1919 of the Act and at 42 C.F.R. Part 483. Sections 1819 and 1919 of the Act vest the Secretary with authority to impose CMPs and PICMPs against a long-term care facility for failure to comply substantially with federal participation requirements.

Pursuant to the Act, the Secretary has delegated to CMS and the states the authority to impose remedies against a long-term care facility that is not complying substantially with federal participation requirements. Facilities that participate in Medicare may be surveyed, on behalf of CMS, by state survey agencies in order to determine whether the facilities are complying with federal participation requirements. 42 C.F.R. §§ 488.10-488.28, 488.300-488.335. Pursuant to 42 C.F.R. Part 488, CMS may impose a PICMP or per day CMP against a long-term care facility when a state survey agency concludes that the facility is not complying substantially with federal participation requirements. 42 C.F.R. §§ 488.406; 488.408; 488.430. The regulations specify that a CMP which is imposed against a facility on a per day basis will fall into one of two ranges of penalties. 42 C.F.R. §§ 488.408, 488.438. The upper range of CMP, from $3050 to $10,000 per day, is reserved for deficiencies that constitute immediate jeopardy to a facility's residents, and, in some circumstances, for repeated deficiencies. 42 C.F.R. §§ 488.438(a)(1)(i), (d)(2). The lower range of CMP, from $50 per day to $3000 per day, is reserved for deficiencies that do not constitute immediate jeopardy, but either cause actual harm to residents, or cause no actual harm, but have the potential for causing more than minimal harm. 42 C.F.R. § 488.438(a)(1)(ii). When a PICMP is imposed for an instance of noncompliance, the range of penalty is $1000 to $10,000 per instance. 42 C.F.R. § 488.438(a)(2). The regulations at 42 C.F.R. Part 488 also give CMS a number of other remedies that can be imposed if a facility is not in compliance with Medicare requirements. *Id.*

Pursuant to 42 C.F.R. § 488.301, *"[i]mmediate jeopardy* means a situation in which 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." (Emphasis in original). Further, *"[s]ubstantial compliance* means a level of compliance with the requirements of participation such that any identified deficiencies pose no greater risk to resident health or safety than the potential for causing minimal harm." *Id.* (emphasis in original).

The Act and regulations make a hearing before an administrative law judge (ALJ) available to a long-term care facility against whom CMS has determined to impose a CMP or a PICMP. Act, § 1128A(c)(2); 42 C.F.R. §§ 488.408(g), 498.3(b)(13). The hearing before an ALJ is a *de novo* proceeding. *Anesthesiologists Affiliated, et al.,* DAB CR65 (1990), *aff'd.,* 941 F. 2d 678 (8th Cir. 1991). A facility has a right to appeal a "certification of noncompliance leading to an enforcement remedy." 42 C.F.R § 488.408(g)(1); *see also* 42 C.F.R. §§ 488.330(e), 498.3. However, the choice of remedies by CMS or the factors CMS considered when choosing remedies are not subject to review. 42 C.F.R. § 488.408(g)(2). A facility may only challenge the scope and severity level of noncompliance found by CMS if a successful challenge would affect the amount of the CMP that could be collected by CMS or impact upon the facility's NATCEP. 42 C.F.R. §§ 498.3(b)(14), (d)(10)(i). CMS's determination as to the level of noncompliance "must be upheld unless it is clearly erroneous." 42 C.F.R. § 498.60(c)(2). This includes CMS's finding of immediate jeopardy. *Woodstock Care Center,* DAB No. 1726, at 9, 38 (2000), *aff'd., Woodstock Care Center v. Thompson,* 363 F. 3d 583 (6th Cir. 2003). The Departmental Appeals Board (the Board) has long held that the net effect of the regulations is that a provider has no right to challenge the scope and severity level assigned to a noncompliance finding, except in the situation where that finding was the basis for an immediate jeopardy determination. *See, e.g., Ridge Terrace,* DAB No. 1834 (2002); *Koester Pavilion,* DAB No. 1750 (2000). Review of a CMP by an ALJ is governed by 42 C.F.R. § 488.438(e).

Pursuant to sections 1819(b)(5) and 1919(b)(5) of the Act, SNFs and NFs may only use nurse aides who have the required training and competency evaluation. Sections 1819(e) and 1919(e) of the Act impose upon the states the requirements to specify what NATCEP programs they will approve that meet the requirements established by the Secretary and a process for reviewing and approving those programs using criteria set by the Secretary. Pursuant to sections 1819(f)(2) and 1919(f)(2), the Secretary was tasked to develop requirements for approval of NATCEP programs and the process for review of those programs. The Secretary promulgated regulations at 42 C.F.R. Part 483, Subpart D. Pursuant to 42 C.F.R. § 483.151(b)(2) and (e)(1), a state may not approve and must withdraw any prior approval of a NATCEP offered by a skilled nursing facility that: (1) has been subject to an extended or partial extended survey under sections

1819(g)(2)(B)(i) or 1919(g)(2)(B)(i) of the Act, unless the survey shows the facility was in compliance with participation requirements; (2) has been assessed a CMP of not less than $5000; or (3) has been subject to termination of its participation agreement, denial of payment for new admissions, or the appointment of temporary management.

When a penalty is proposed and appealed, CMS must make a *prima facie* case that the facility has failed to comply substantially with federal participation requirements. *"Prima facie"* means that the evidence is "[s]ufficient to establish a fact or raise a presumption unless disproved or rebutted." *Black's Law Dictionary* 1228 (8th ed. 2004); *see also Hillman Rehabilitation Center*, DAB No. 1611, at 8 (1997), *aff'd., Hillman Rehabilitation Center v. U.S. Dep't. of Health and Human Services,* No. 98-3789 (G.E.B.), slip. op. at 25 (D. N.J. May 13, 1999). To prevail, a long-term care facility must overcome CMS's showing by a preponderance of the evidence. *Batavia Nursing and Convalescent Center,* DAB No. 1904 (2004); *Batavia Nursing and Convalescent Inn,* DAB No. 1911 (2004); *Emerald Oaks,* DAB No. 1800 (2001); *Cross Creek Health Care Center,* DAB No. 1665 (1998); *Hillman Rehabilitation Center,* DAB No. 1611.

E. Analysis

1. Petitioner violated 42 C.F.R. § 483.13(c).

The only alleged violation of the regulation at issue before me is alleged in the SOD dated November 3, 2005, as a violation of 42 C.F.R. § 483.13(c) (Tag F 224). The regulation states, in pertinent part:

> (c) *Staff treatment of residents.* The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.

42 C.F.R. § 483.13(c). The regulation includes four subsections. The first specifies that a facility must not "use" verbal, mental, sexual or physical abuse, corporal punishment, or involuntary seclusion; that a facility cannot employ anyone who has been found guilty of abusing, neglecting, or mistreating a resident or who has been reported to the state nurse registry for such conduct or misappropriation of resident property; and that a facility must report to the state any court action against any employee that indicates the employee is unfit to serve as a nurse aide or other facility staff. The second subsection requires that a facility must ensure all alleged violations[5] involving mistreatment, neglect, abuse, injuries

[5] It is not clear to which violations the drafters referred, violations of its policies, violations of the Secretary's regulations, violations of state law, violations of the Act, or

of unknown source, and misappropriation of a resident's property be reported. The third subsection requires that a facility have evidence that it thoroughly investigated all alleged violations,[6] while preventing additional potential abuse. The fourth subsection requires that the results of the investigation be reported and that corrective action be taken.

"Abuse" is "the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish." 42 C.F.R. § 488.301. The Survey and Certification Operations Branch, Region VI of CMS issued Regional Survey and Certification Letter No. 00-03 on January 19, 2000. CMS Ex. 30. In Letter No. 00-03, CMS recognized that because "abuse" as defined by the regulation requires an element of willfulness, it was not appropriate to cite a facility for abuse under Tag F 223 where the incident under investigation involved conduct of a demented resident because the element of willfulness could not be shown. Surveyors were instructed to investigate such incidents for possible citation under other regulations.

Surveyors were also instructed by Letter No. 00-03 to consider citing a facility under Tag F 224 for neglect because the facility failed to protect other residents from behavior of a demented resident that posed a threat to other residents or the demented resident, or under Tag F 226 for failure to implement policies and procedures. "Neglect" is defined as "failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness." 42 C.F.R. § 488.301. Considering the definition of neglect and the discussion in Letter No. 00-03, it is apparent that CMS, at least staff in Region VI, believe it permissible to cite a facility for neglect for failure to provide goods and services necessary to protect its resident population from physical harm, mental anguish, or mental illness arising from the behavior of a demented resident. In the alternative, CMS Ex. 30 indicates that CMS, at least staff of Region VI, concluded it permissible to cite a facility for failure to issue and implement policies intended to protect its resident population from harmful behavior of a demented resident.

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violation of some standard-of-practice. In the context of this regulation, the most sensible construction would be violation of Petitioner's policies and procedures that prohibit mistreatment, neglect and abuse of residents or misappropriation. However, the best result may be achieved by simply ignoring the (probably unintended) requirement that there be a "violation" of something, and reading the subsection to require reporting and investigation of "any allegation of" mistreatment, neglect, abuse, injuries of unknown source, or misappropriation.

[6] *See* footnote 5. The drafters use of the term "violations" in this subsection seems to refer to violations of the policies of Petitioner adopted pursuant to the requirement of 42 C.F.R. § 483.13(c).

The SOM under Tag F 224 interprets the intent of 42 C.F.R. § 483.13(c) to be that each resident has the right to be free from mistreatment, neglect, and misappropriation of the resident's property and that a facility has a duty to identify residents who are at risk for "abusing" other residents. The regulation is interpreted to impose a duty upon a participating facility to develop interventions to prevent occurrences, monitor for changes that would trigger abusive behavior, and reassess interventions on a regular basis. SOM, Guidance to Surveyors, Tag F 224. The SOM discussion of Tag F 226, a tag that is also based upon 42 C.F.R. § 483.13(c), states that the intent of the regulation is, inter alia, that a facility must develop and "operationalize" polices and procedures to prevent abuse, neglect, mistreatment, and misappropriation and that a facility must do "all that is within its control to prevent occurrences." SOM, Guidance to Surveyors, Tag F 226. Although the SOM does not have the force and effect of law, the provisions of the Act and regulations interpreted by the SOM clearly do have such force and effect. *State of Indiana by the Indiana Department of Public Welfare v. Sullivan*, 934 F.2d 853 (7th Cir. 1991); *Northwest Tissue Center v. Shalala*, 1 F.3d 522 (7th Cir. 1993). Thus, while the Secretary and his delegee, CMS, may not seek to enforce the provisions of the SOM, the provisions of the Act or regulations as interpreted by the SOM are enforceable.

The Departmental Appeals Board (the Board) addressed the scope of the regulation at 42 C.F.R. § 483.13(c) in its decision in *Martha & Mary Lutheran Services*, DAB No. 2147 (2008). That case involved the failure of a facility to protect its residents adequately against a verbally and physically aggressive resident. There, the Board sustained the ALJ's determination comparing a facility's duty under 42 C.F.R. § 483.13 to protect all its residents from neglect with its obligation, under 42 C.F.R. § 483.25(h)(2), to provide individual residents with adequate supervision and assistance devices to protect against accidents. The Board noted that the latter provision has been interpreted to require a facility to implement "all reasonable efforts to protect residents against adverse events that are reasonably foreseeable," and also held that a facility's "[f]ailure to protect a resident against a known or foreseeable hazard - including the possibility that a resident might be physically abused or assaulted by another resident whose aggressive behavior has become known to a facility's staff - is a failure by a facility to provide services that are necessary to prevent physical harm or mental anguish and is, thus, neglect." *Martha & Mary Lutheran Services*, DAB No. 2147, at 6, citing DAB No. CR1595, at 3 (2007); *see also Emerald Oaks*, DAB No. 1800, at 17 (2001).

The language of 42 C.F.R. § 483.13(c) is actually clear as to the obligation it imposes upon a participating long-term care facility. A provider must: (1) develop and (2) implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. Although the title of the subsection, "[s]taff treatment of residents" could be read to focus the section upon staff actions toward residents, the substantive language of the section does not limit the

obligation of the facility to regulating or controlling staff and resident interaction. Rather, the substantive language of the section imposes a general obligation upon a provider to prohibit mistreatment, neglect, and abuse of its residents or the misappropriation of their property, without limiting the focus of the required policies to a specific source, i.e., staff, visitors, or other residents. Decisions of the Board in the cases cited above are not inconsistent with my interpretation.

Petitioner objects that it was not properly charged with a violation of 42 C.F.R. § 483.13(c) (Tag F 224). Petitioner argues that the regulation is a "policy formulation/implementation tag, which does not pertain to whether a facility 'neglected' one of its residents." P. Brief at 4-5; P. Reply at 1-2. In support of its position Petitioner cites my decision in *Heron Pointe Health and Rehabilitation*, DAB CR1401 (2006). However, the situation in *Heron Pointe* is readily distinguishable. In *Heron Pointe*, I found that the surveyors and CMS charged that the facility neglected a specific resident by failure to assess, monitor and care plan for that specific resident. I further concluded that there was no question in that case whether the facility had developed and implemented the required policy to prohibit neglect. Thus, the charge in that case was not properly cast in terms of neglect as a violation of 42 C.F.R. § 483.13(c), but rather the alleged neglect should have been charged as violations of the specific regulations that required delivery of the goods and services that CMS alleged were not delivered or provided that resident.

In this case, unlike *Heron Pointe*, the charge is that Petitioner failed to implement its policy against neglect or mistreatment of its residents, which is a proper charge. The surveyors charge in the SOD that Petitioner violated 42 C.F.R. § 483.13(c) because:

> (1) Petitioner failed to provide psychosocial assessment and interventions for Resident 1 for her behaviors that posed the risk of injury to other residents;[7] and
>
> (2) Petitioner failed to develop and implement a policy and procedure to manage resident-to-resident altercations.

CMS Ex. 4, at 1-2. The SOD reflects that the surveyors' second allegation focused on the fact that Petitioner had no policy that prohibited resident-to-resident abuse or mistreatment and that the activities of Resident 1 and Petitioner's response demonstrated

[7] Neither the surveyors nor CMS were clear as to how this allegation fits within the scope of 42 C.F.R. § 483.13(c). CMS does not argue in its post-hearing briefing that this allegation is the basis for finding a violation of 42 C.F.R. § 483.13(c).

that no such policy had been implemented.[8] Counsel for CMS argued in his opening statement that Petitioner failed to provide necessary services to protect its residents from the aggressive behavior of Resident 1 and the harm that may have occurred to other residents or Resident 1 as a result of those behaviors. Tr. 86-87. In its post-hearing brief, CMS argues Petitioner failed to develop and implement a policy to protect its residents from the acts of other residents. CMS Brief at 10-12, 15-16. Surveyor Cheryl Lee Cannon testified that she participated in drafting the Tag F 224 citation of the SOD. Her understanding is that the regulation requires a facility to implement polices and procedures to prevent neglect, abuse, and misappropriation. In this case, her testimony indicates the intent behind citing a violation of 42 C.F.R. § 483.13(c) was to allege that Petitioner failed to implement policies and procedures "to prevent injuries to one or more residents in the facility from resident 1." Petitioner was not cited for resident-to-resident abuse. Tr. 110, 161-66, 170-71. On cross-examination, Surveyor Cannon agreed with counsel's characterization that Petitioner was negligent with regard to incidents involving Resident 1 and Resident 2, 28, 29, and 30. Tr. 174-79. Petitioner called Surveyor Marie Konecny and she testified based upon her notes at CMS Ex. 11, at 1, that immediate jeopardy was cited by the surveyors based upon a violation of 42 C.F.R. § 483.13, neglect. However, she did not participate in preparing the citation under Tag F 224. Tr. 217, 223. Surveyor Leena Volmer testified that she participated in the citation of Tag F 224 and that she believed it was based upon her observation of Resident 1 being aggressive with other residents who were at risk for harm and Petitioner's staff not intervening appropriately to protect the other residents. Tr. 380-81, 398, 460, 462-63. Surveyor Ann Wedgwood-Stauch testified that the Administrator was asked to produce Petitioner's abuse policy and he presented the sex abuse policy which is not what the surveyors were looking for because it was only part of the policy, "[i]t wasn't really a complete policy." Tr. 533-34.

David R. Boggs, Petitioner's Administrator, testified that Petitioner had never been cited before for being deficient for not having required policies. Tr. 675. He testified that the surveyors asked him to produce the facility resident abuse policy. The facility had no policy that was specifically a resident abuse policy, but the facility had a general abuse policy. He testified that he gave the surveyors copies of the facility policies at P. Ex. 13,

[8] The surveyors state in the SOD that immediate jeopardy was abated when Resident 1 was removed from the facility, but a deficiency that posed more than minimal harm remained until Petitioner "implemented facility-wide" policies and procedures to respond to residents with aggressive behaviors. CMS Ex. 4, at 2.

14, and 15 during the morning on November 2, 2005.[9] Tr. 682-86, 91. P. Ex. 13 is a copy of Petitioner's policy entitled "Unmanageable Resident/Patient" that was in effect at the time of the survey. Tr. 682. Mr. Boggs interpreted Petitioner's policy entitled "Abuse Reporting" (P. Ex. 14) to address abuse, mistreatment, and neglect, including resident-to-resident conduct. Tr. 685-86. He testified that the policy at CMS Ex. 21, at 1-4, is a policy drafted to satisfy the surveyors' request for a resident-to-resident abuse policy. He testified that it was really just a provider notice that had been re-titled. Tr. 693-95.

Petitioner did not have a policy that specifically states that Petitioner prohibits mistreatment, neglect, and abuse of its residents or the misappropriation of their property, as required by 42 C.F.R. § 483.13(c). However, the unrebutted testimony of Administrator Boggs is that Petitioner had in effect before the survey the policies at P. Ex. 13-15. I am willing to conclude for purposes of this decision that, collectively, those policies satisfied Petitioner's obligation to develop policies under 42 C.F.R. § 483.13(c) to prohibit mistreatment, neglect, abuse, and misappropriation. Petitioner nevertheless violated 42 C.F.R. § 483.13(c) (Tag F 224), because it failed to implement its policies to protect its residents from the aggressive activities of Resident 1 as demonstrated by repeated instances of aggressive behavior by Resident 1 toward others, including residents, staff, surveyors, and visitors.

I have set out in detail in the Findings of Fact the many instances of aggressive behavior by Resident 1 from her admission to Petitioner in June 2004 through the conclusion of the survey on November 3, 2005. Petitioner urges me to conclude that the preponderance of the evidence demonstrates that it effectively managed Resident 1's behavioral issues. Petitioner asserts that psychosocial assessments and interventions were consistently provided and that, when interventions became ineffective, new ones were put into place. Petitioner's view is that Resident 1's care plans were updated and adjusted to meet her changing needs.

Suzanna Woodard, Petitioner's Director of Nursing (DON), testified that in her opinion Resident 1 was under fairly good control with no episodes of aggression for months prior to October 31, 2005, describing many interventions, most of which involved keeping the resident occupied. Tr. 545-50. Her opinion that Resident 1 was well-controlled is not credible given contemporaneous clinical records for Resident 1, except to the extent that she was referring only to the months of August and September 2005, when the minimal nursing notes and other records for that period show no instances of aggression. Tr. 600-

[9] Copies of these policies are also found at CMS Ex. 21, at 5-10, with dates suggesting they were received by the surveyors on November 3, 2005. Tr. 695-97.

01. Her opinion and the absence of nursing notes reflecting aggressive behavior by Resident 1 during August and September 2005 is, however, inconsistent with Resident 1's MDS, which shows that physically abusive behavior by Resident 1 was observed during the seven-day assessment period that ended on September 6, 2005. CMS Ex. 14, at 9. Ms. Woodard also minimized the incident on October 22, 2005 between Residents 1 and 2, asserting that there was no aggression by Resident 1 and that she simply reached out and took Resident 2's hand. Tr. 554-56. The evidence does not show DON Woodard was present when the incident occurred, and nurse's notes related to the incident say that Resident 1 grabbed Resident 2. P. Ex. 8, at 87; CMS Ex. 15, at 7.

Karen Kimberly Johnson-Cook, Nurse Consultant for Christian Care Centers, Petitioner's owner, testified that she was familiar with Resident 1's case and that with medication and all the other interventions Petitioner implemented, there were several months where Resident 1's significant behaviors that affected other residents were less than once a week. Resident 1's socially inappropriate behaviors of throwing food and resisting care were routine. Tr. 733-37. Thus, Ms. Cook recognized that at no time were Resident 1's significant behaviors that affected other residents completely controlled even though the frequency may have been reduced for a time to less than one such incident per week. Ms. Cook testified to providing one-on-one supervision to Resident 1, which was effective in calming the resident and preventing further resident-to-resident incidents. Tr. 751-63. She agreed on cross-examination that Resident 1 would not be able to distinguish whether she was hitting a surveyor, staff, or another resident. Tr. 784.

My Findings of Fact also list the many different interventions Petitioner attempted to control Resident 1's aggressive behaviors between June 2004 and November 2005. It is important to recognize that, despite the various interventions, Resident 1's aggressive behaviors continued even though less frequently after July 2005. Ms. Cook demonstrated that one-on-one supervision was effective, but the evidence does not show one-on-one supervision was an intervention that was adopted or used on a regular basis to control Resident 1's behavior and to protect other residents who might enter her reach. Petitioner's Policy Number 13-127-00 entitled "Unmanageable Resident/Patient" provides that unmanageable residents will not be retained by the facility. However, for more than a year Resident 1 continued to grab, hit, bite, and engage in other aggressive conduct. For more than a year, Petitioner's interventions continued to be shown to be inadequate to control Resident 1 and protect other residents from Resident 1's aggressive conduct. Petitioner did not follow its own policy and discharge Resident 1 until the surveyors insisted that Petitioner was not protecting its residents and Resident 1 needed to be in a facility more suited to control her behavior without risk to other residents or patients. I do not find credible Administrator Bogg's testimony that he did not believe that Resident 1 was ever unmanageable, hostile, or abusive. Tr. 711.

Petitioner argues that the surveyor notes of Surveyor Dorothy Fletcher at CMS Ex. 8, show that Petitioner was in compliance with Task 5G.[10] P. Brief at 15-16. Survey Task 5G addresses whether a facility developed and implemented policies and procedures required by 42 C.F.R. § 483.13(c). I have reviewed Surveyor Fletcher's notes and find nothing to indicate that she concluded Petitioner was in compliance with 42 C.F.R. § 483.13(c) or that Petitioner had implemented all its policies as required by the regulation. The SOD, which embodies the official findings and conclusions of the survey, certainly alleges a violation 42 C.F.R. § 483.13(c).

Petitioner argues that it had established good control of Resident 1 and that the aggressive behavior observed during the survey was actually the fault of the surveyors. P. Brief at 9-13; P. Reply at 2-7. I have already noted that during the period of August and September 2005, Petitioner's clinical records show no incidents of aggressive behavior, although an MDS done during the period records physically abusive behavior was observed during the seven-day period that ended September 6, 2005. However, I have also explained that the absence of evidence of aggressive behavior during August and September 2005, does not convince me that Petitioner had controlled Resident 1 or provided for protection of its residents when Resident 1 was aggressive. In fact, the incident with Resident 2 in October 2005 shows Petitioner had not controlled Resident 1 and had neglected to ensure its other residents were protected from harm when Resident 1 was aggressive. Petitioner asserts that Resident 1's behaviors were more pronounced on the third day of the survey because fire alarms went on and off for two hours due to the concurrent life safety code survey; her normal geri-chair had been taken away for repairs at the surveyors' request; and the presence of the surveyors in the facility upset the tenor of the facility. Actually, Findings of Fact 14 through 17 reflect that Resident 1's aggressive conduct was observed at various times during the second day, as well as the third day, of the survey. Petitioner argues that the events of the survey, including the chaos created by the fire alarm situation, were atypical. Once the surveyors left the unit and stopped agitating the residents, Resident 1 calmed down. P. Brief at 9-10, 13, 14. While I do not doubt that Resident 1 was more agitated during the survey, my decision does not turn on the events of the few days of the survey. Rather, I conclude that Petitioner assessed Resident 1 as engaging in aggressive actions toward others; Resident 1 engaged in aggressive conduct toward others repeatedly over more than a year at Petitioner's facility, resulting in obvious actual physical harm to some residents in the form of skin tears and a head injury; it was foreseeable that Resident 1 would continue to engage in aggressive conduct toward others; it was foreseeable that interventions that Petitioner had adopted focused on controlling Resident 1's behaviors were not consistently effective; and Petitioner knew or

[10] SOM, App. P., Part I -- Survey Procedures for Long Term Care Facilities, Task 5G.

should have known that it needed to take more aggressive interventions or steps to protect its other residents when Resident 1 was aggressive. However, Petitioner neglected to plan and implement interventions necessary to protect its residents as it was obliged to do by the regulation.

2. A $7000 PICMP is reasonable and withdrawal of Petitioner's authority to conduct a NATCEP was required.

If a facility is not in substantial compliance with program requirements, CMS has the authority to impose one or more of the enforcement remedies listed in 42 C.F.R. § 488.406, including imposing CMPs. CMS may impose a CMP for the number of days that the facility is not in substantial compliance or for each instance that a facility is not in substantial compliance. 42 C.F.R. § 488.430(a). There is only a single range of $1000 to $10,000 for a PICMP. 42 C.F.R. §§ 488.408(d)(1)(iv); 488.438(a)(2). In this case CMS has proposed a PICMP of $7000.

It is not for me to review the decision-making of CMS when determining the appropriateness of an enforcement remedy. Rather, I must assess *de novo* the reasonableness of a CMP proposed by CMS based on the factors set forth at 42 C.F.R. § 488.438(f). *Emerald Oaks*, DAB No. 1800. In determining whether the amount of the PICMP assessed here is reasonable, the following factors specified at 42 C.F.R. § 488.438(f) must be considered: (1) the facility's history of noncompliance, including repeated deficiencies; (2) the facility's financial condition; (3) the seriousness of the deficiencies as set forth at 42 C.F.R. § 488.404; and (4) the facility's degree of culpability.

Here I have no evidence regarding the facility's history and Petitioner has not asserted that its financial condition is such that it cannot pay the PICMP. However, I find that Petitioner's deficiency is serious, in that Resident 1's aggressive behavior led to injury to at least one resident and could have led to serious injury to herself or to other residents. Thus, I find that the $7000 PICMP imposed by CMS, which is in the upper middle range of PICMP, is not unreasonable based on the deficiency cited.

Petitioner has asserted that the loss of its NATCEP hurts not just itself, but the entire Gunter, Texas community, because Petitioner cannot hire and train individuals from its own community and the individuals it would like to hire are not able to travel elsewhere to acquire nurse aide training. P. Brief at 21. However, as I uphold a CMP of more than $5000, the state was required to withdraw approval of Petitioner's authority to conduct a NATCEP for two years. Act, §§ 1819(f)(2)(B), 1919(f)(2)(B) and 42 C.F.R. § 483.151(b)(2)(iv).

Petitioner argues that I should review and change the immediate jeopardy determination in this case. Petitioner asserts that a facility is entitled to challenge the level of noncompliance under 42 C.F.R. §§ 498.3(b)(14) and (d)(10)(i) if its NATCEP is affected, regardless of whether the proposed CMP is a per day or per instance CMP; and that CMS admitted in its motion to limit the scope of the hearing that Petitioner was entitled to challenge the level of noncompliance because substandard quality of care deficiencies were cited, and the facility's NATCEP was adversely affected. P. Reply at 7-8. Petitioner's arguments are without merit. The determination that the deficiency posed immediate jeopardy has no impact upon the decision in this case. There is only a single range for PICMPs, not two ranges as is the case with a per day CMP where the higher range is reserved for cases involving immediate jeopardy. Further, because I find a PICMP of more than $5000 appropriate, Petitioner must lose its approval to conduct a NATCEP without consideration for whether or not any deficiencies posed immediate jeopardy. Finally, out of an abundance of caution, I do not consider the immediate jeopardy declaration evidence of the seriousness of the deficiency for purposes of determining the appropriate PICMP to impose.

III. Conclusion

For the foregoing reasons, I conclude that Petitioner violated 42 C.F.R. § 483.13(c) and that a PICMP of $7000 is reasonable. Further, where a CMP of more that $5000 is imposed, the law requires the state agency to withdraw approval of a facility's NATCEP for two years.

/s/
Keith W. Sickendick
Administrative Law Judge