

ENFORCEMENT

Recent Developments in Nursing Homes

No. 267

April 2022

IN THIS ISSUE:

CENTERS FOR MEDICARE & MEDICAID SERVICES

- CMS Lifts Multiple Blanket Waivers for Nursing Facilities Issued during the Public Health Emergency, Including Nurse Aide Training Waiver1
- CMS Revises January 2022 Guidance on COVID-19 Health Care Vaccinations for Staff.....4
- CMS to Reduce Funding to Kansas by Nearly \$350,000 When State Refuses to Enforce the Vaccine Mandate for Nursing Home Staff6

OTHER FEDERAL ISSUES

- Congressman Bobby Rush Asks Energy & Commerce Committee to Hold Hearing on Private Equity and Nursing Homes; *Skilled Nursing News* Reports REITs Argue Private Owners Are of Greater Concern6

REPORTS

- HHS Releases First-Ever Report on Change of Ownership of Nursing Homes (and Hospitals)7
- National Consumer Voice for Quality Long Term Care Releases Data Showing that Higher Staffing Levels Mean Less Abuse of Residents8
- National Academy of Sciences, Energy and Medicine’s Committee on the Quality of Care in Nursing Homes Issues Report Calling for Major Reforms8

- Long Term Care Community Coalition Releases Policy Brief on Direct Care Minimum Spending Laws10
- Trella Health Reports “Decrease in Voluntary Skilled Nursing” Facility Admissions11
- National Investment Center Reports More Medicare-Covered Residents in Nursing Homes Due to Omicron12
- Bureau of Labor Statistics Reports Nursing Homes Lost 2,500 Workers in March 202212

DEPARTMENTAL APPEALS BOARD

APPELLATE DIVISION

- Panel Vacates ALJ Hughes’s 2019 Summary Judgment Decision Sustaining Five Immediate Jeopardy Deficiencies Cited at Florida Nursing Facility; Finds Genuine Factual Disputes; Remands Case to ALJ13

CIVIL REMEDIES DIVISION

- Deciding Ohio Nursing Facility’s Appeal without a Hearing, ALJ Rogall Sustains Immediate Jeopardy Deficiency for Failure to Provide Basic Life Support to Full Code Resident, Cited at Nursing Facility in 2018; Sustains Per Instance Civil Money Penalty of \$19,50017
- ALJ Rogall Sustains Two Deficiencies Cited at New Jersey Nursing Facility in 2018, Including Immediate Jeopardy Quality of Care Deficiency; Sustains Two Per Instance Civil Money Penalties Totaling \$25,40519
- Following a Hearing by Videoconference, ALJ Thomas Sustains Immediate Jeopardy Abuse Deficiencies, Captured on Hidden Camera Placed in Residents’ Rooms by State Attorney General and Cited at Ohio Nursing Facility in 2016; Sustains Per Day Civil Money Penalties Totaling \$74,05321
- Deciding Arkansas Nursing Facility’s Appeal on the Parties’ Written Exchanges, ALJ Kessel Sustains Deficiency Cited at Nursing Facility for Safe, Sanitary, and Comfortable Environment (Infection Control) Cited in 2020; Sustains Per Instance Civil Money Penalty of \$5,00024

- In Summary Judgment Decision, ALJ Hughes Sustains Quality of Care Deficiency Cited at Texas Nursing Facility in 2019; Sustains Per Instance Civil Money Penalty of \$21,39325
- Deciding Indiana Nursing Facility’s Appeal on the Written Record, ALJ Anderson Sustains Immediate Jeopardy Abuse Deficiencies Cited at Facility in 2019; Sustains Per Day Civil Money Penalties Totaling \$19,12427
- Following Video Teleconference, ALJ Weyn Sustains Harm-Level Accident Hazards/Supervision Deficiencies Cited at Illinois Nursing Facility in 2017; Sustains Per Day Civil Money Penalties Totaling \$37,87530
- Deciding Indiana Nursing Facility’s Appeal on the Record, ALJ Rogall Sustains Three Abuse-Related Deficiencies and Care Plan Deficiency Cited at the Facility in 2017; Sustains Per Day Civil Money Penalties Totaling \$99,99034
- Deciding Missouri Nursing Facility’s Appeal on the Written Record, ALJ Kessel Sustains Five Deficiencies Cited at Nursing Facility in 2019; Sustains Per Day Civil Money Penalties Totaling \$101,00036

FEDERAL LITIGATION

- Federal District Court in New York Approves Class Action Settlement of Lawsuit by Filipino Nurses Charging Nursing Employment Agency and Others with Violations of Federal Trafficking Victims Protection Act; Plaintiff Nurses to Receive \$3,211,305.0639

STATE NEWS

- New York Attorney General Letitia James Is Investigating Nursing Facility Where Seven Residents Died40

STATE ENFORCEMENT NEWS

CRIMINAL ENFORCEMENT

- Illinois Nurse Pleads Guilty to Reckless Misconduct for Failing to Assess Nursing Home Resident and Provide CPR42

VOLUNTARY CLOSURE

- South Dakota Nursing Facility to Close45

NURSING HOME INDUSTRY NEWS

- Ignite Medical Resorts Expands into Texas with Four Facilities48
- Strawberry Fields Real Estate Investment Trust Plans to Go Public, Increase Its Portfolio49

CENTERS FOR MEDICARE & MEDICARE SERVICES

1. CMS LIFTS MULTIPLE BLANKET WAIVERS FOR NURSING FACILITIES ISSUED DURING THE PUBLIC HEALTH EMERGENCY, INCLUDING NURSE AIDE TRAINING WAIVER

The Centers for Medicare & Medicaid Services (CMS) will lift many of the blanket waivers of regulatory requirements for various health care providers that it issued at the beginning of the public health emergency in March 2020. In an April 7, 2022 update, CMS lifts 15 waivers for skilled nursing facilities, with effective dates in 30 or 60 days. The most significant change is ending the nurse aide training waiver in 60 days. CMS, “Update to COVID-19 Emergency Declaration Blanket Waivers for Specific Providers,” QSO-22-15-NH & NLTC & LSC (Apr. 7, 2022) (Memorandum from David R. Wright, Director, Quality, Safety & Oversight Group, to State Survey Agency Directors). CMS notes that states and individual facilities may still request regulatory waivers “for issues unique to their facility or location.” Memorandum 2.

In Background information, CMS expresses concern about how various waivers have negatively affected nursing home residents:

While the waivers of regulatory requirements have provided flexibility in how nursing homes may operate, they have also removed the minimum standards for quality that help ensure residents’ health and safety are protected. Findings from onsite surveys have revealed significant concerns with resident care that are unrelated to infection control (e.g., abuse, weight-loss, depression, pressure ulcers, etc.). We are concerned that the waiver of certain regulatory requirements has contributed to these outcomes and raises the risk of other issues. For example, by waiving requirements for training, nurse aides and paid feeding assistants may not have received the necessary training to help identify and prevent weight-loss. Similarly, CMS waived requirements for physicians and practitioners to perform in-person assessments, which may have prevented these individuals from performing an accurate assessment of the resident’s clinical needs, contributing to depression or pressure ulcers. Lastly, due to the waiver of certain lifesafety code requirements, facilities may not have had their fire prevention systems inspected to ensure they operate effectively to detect or prevent fire. As a result, CMS is very concerned about how residents’ health and safety has been impacted by the regulations that have been waived, and the length of time for which they have been waived.

Id. 1-2.

Nurse aide training waiver

In March 2020, CMS issued a blanket waiver for the requirement at 42 C.F.R. §483.35(d) that facilities not employ nurse aides for more than four months unless they meet training and certification requirements. CMS did not waive competency requirements.

Editor’s Note: When CMS issued the blanket waiver, the American Health Care Association announced a free on-line eight-hour training program for temporary nurse

aides (TNAs), which many states formally accepted as sufficient training for aides during the pandemic. See “Who’s Providing Care for Nursing Home Residents? Nurse Aide Training Requirements during the Coronavirus Pandemic” (CMA Special Report, Jul. 23, 2020), <https://medicareadvocacy.org/wp-content/uploads/2020/07/Report-Nurse-Aide-Training.pdf>

On April 8, 2021, CMS suggested “that states evaluate their NATCEP [Nurse Aide Training and Competency Evaluation Program] and consider allowing some of the time worked by the nurse aides during the PHE [public health emergency] to count toward the 75-hour training requirement. CMS, “Updates to Long-Term Care (LTC) Emergency Regulatory Waivers issued in response to COVID-19,”

QSO-21-17-NH (Apr. 8, 2021), <https://www.cms.gov/files/document/qso-21-17-nh.pdf>

The Center for Medicare Advocacy reported on states’ transition of TNAs into certified nurse assistants (CNAs). “Who Provides Care for Nursing Home Residents? An Update on Temporary Nurse Aides” (CMA Special Report, Sep. 15, 2021),

<https://medicareadvocacy.org/wp-content/uploads/2021/09/SNF-TNA-Report-09-2021.pdf>

CMS now terminates the waiver, except for a facility or aide that has “documentation that demonstrates their attempts to complete their training and testing (e.g., timely contacts to state officials, multiple attempts to enroll in a program or test).” *Id.* 5. In these limited circumstances, “a waiver of these requirements (42 CFR §483.35(d)) is still available and the aide may continue to work in the facility while continuing to attempt to become certified as soon as possible.” *Id.* 5.

A facility must notify the state agency about “capacity issues” and state agencies must report to their CMS Location (formerly known as Regional Office) “with information about the status of their NATCEPs.” *Id.*

CMS “acknowledge[s] that federal requirements allow states to use a variety of means to administer the curriculum (e.g., online, classroom, or onsite training)” but that “all programs must adequately provide the required training.” *Id.* If a state “observes trends in poor quality of care among certified nurse aides that were hired under the nurse aide training waiver, this could indicate that the NATCEP does not adequately address the components of the required curriculum specified at 42 CFR §483.152(b).” *Id.* CMS suggests, “In these cases, the state should re-evaluate the approved NATCEP to see if the components of the program need to be adjusted to ensure the regulatory requirements are met and avoid poor quality of care.” *Id.*

Additional waivers for nursing homes that CMS is lifting in 30 days (7 requirements)

- Resident groups, §483.10(f)(5): participation in-person in resident groups will be permitted
- Physician delegation of tasks in SNFs, §483.30(c)(4): physicians will not be allowed to delegate tasks that the regulations say the physician must perform personally

- Physician visits, §483.30(c)(3): physicians will be required to conduct visits personally; telehealth continues (Cara Smith, “CMS Clarifies Confusion Among Nursing Facilities Over Role Of Telehealth,” *Inside Health Policy’s Inside TeleHealth* (Apr. 25, 2022), <https://insidehealthpolicy.com/inside-telehealth-daily-news/cms-clarifies-confusion-among-nursing-facilities-over-role-telehealth>)
- Physician visits in skilled nursing facilities/nursing facilities, §483.30: physicians will be required to conduct visits personally; telehealth continues
- Quality assurance and performance improvement (QAPI), §483.75(b)-(d) and (e)(3): facilities must implement QAPI
- Detailed information sharing for discharge planning for long-term care (LTC) facilities, §483.21(c)1)(viii): facilities must “assist residents and their representatives in selecting a post-acute care provider using data, such as standardized patient assessment data, quality measures and resource use”
- Clinical records, §483.10(g)(2)(ii): facilities must provide residents with a copy of their records within two working days, when requested

Additional waivers for nursing homes that CMS is lifting in 60 days (7 requirements)

- Physical environment for SNF/NFs, §483.90: non-SNF buildings may no longer be used for isolation purposes
- Facility and medical equipment inspection, testing & maintenance (ITM) for SNFs (and other providers), §483.90: inspection, testing, and maintenance requirements are back in effect
- Life Safety Code (LSC) for SNFs (and other providers), §483.90(a)(1)(i) and (b): requirements are back in effect
- Outside windows and doors for SNFs/NFs (and other providers), §483.90(a)(7): every sleeping room must have an outside window or outside door
- Life Safety Code for SNFs/NFs (and other providers), §483.90(a): fire drills must be performed; temporary construction rules are in effect
- Paid feeding assistants for LTC facilities, §§483.60(h)(1)(i) and 483.160(a): eight hours of training are required
- In-service training for LTC facilities, §483.95(g)(1): nursing assistants must receive at least 12 hours of in-service training annually

“Update to COVID-19 Emergency Declaration Blanket Waivers for Specific Providers” is available at <https://www.cms.gov/files/document/qso-22-15-nh-nltc-lsc.pdf> and from the Center for Medicare Advocacy, on request.

2. CMS REVISES JANUARY 2022 GUIDANCE ON COVID-19 HEALTH CARE VACCINATIONS FOR STAFF

The Centers for Medicare & Medicaid Services (CMS) revises guidance issued on January 14, 2022 for all health care providers on COVID-19 health care staff vaccinations. CMS makes a single change in the memorandum, adding the following two sentences:

Surveying for staff vaccination requirements is not required on Life Safety Code (LSC)-only complaints, or LSC-only follow-up surveys. Surveyors may modify the staff vaccination compliance review if the provider/supplier was determined to be in substantial compliance with this requirement within the previous six weeks.

CMS, “*Revised* Guidance for the Interim Final Rule – Medicare and Medicaid Programs; Omnibus COVID-19 Health Care Staff Vaccination,” QSO-22-09-ALL (Jan. 14, 2022, rev. Apr. 5, 2022) (Memorandum from Karen L. Tritz, Director, Survey & Operations Group, and David R. Wright, Director, Quality, Safety & Oversight Group, to State Survey Agency Directors).

Attachment A, for long-term care facilities, with additional revisions, is linked through QSO-22-11-ALL (Jan. 20, 2022, rev. Apr. 5, 2022) (a revision made to apply the guidance to Texas). It is applicable to all nursing facilities, QSO-22-07-ALL-Revised, QSO-22-09-ALL-Revised, and QSO-22-11-ALL-Revised. New language is in red italics.

CMS redefines “temporarily delayed vaccination” to mean vaccinations temporarily deferred for reasons including a “*known COVID-19 infection until recovery from the acute illness (if symptoms were present) and criteria to discontinue isolation have been met.*” Appendix (unnumbered) 3.

When facilities are surveyed, “*Facility staff who have been suspended or are on extended leave e.g., Family and Medical Leave Act (FMLA) leave, or Worker’s Compensation Leave, would not count as unvaccinated staff for determining compliance with this requirement.*” *Id.* (unnumbered) 4.

Section 483.80(i)(3)(iii) discusses actions and job modifications for staff who are not yet fully vaccinated. CMS writes,

This requirement is not explicit and does not specify which actions must be taken. The examples above are not all inclusive and represent actions that can be implemented. However, facilities can choose other precautions that align with the intent of the regulation which is intended to “mitigate the transmission and spread of COVID-19 for all staff who are not fully vaccinated.

Id. (unnumbered) 6.

Discussing medical exemptions, CMS writes that CDC recommends a temporary delay in vaccination “*due to clinical considerations, including known COVID-19 infection until recovery from the acute illness (if symptoms were present) and criteria to discontinue isolation have been met.*” *Id.* (unnumbered) 8.

Discussing survey process updates, CMS allows facilities to use a list of vaccinated staff or the Staff Vaccine Matrix for sampling purposes. In addition,

Surveyors may modify the staff vaccination compliance review if the facility was determined to be in substantial compliance with this requirement within the previous six weeks. For Life Safety Code (LSC)-only complaint or LSC-only follow-up surveys, staff vaccination requirements are not required to be investigated.

Id. (unnumbered) 9. With respect to contract staff,

Failure of contract staff to provide evidence of vaccination status reflects noncompliance and should be cited at F888 under the requirement to have policies and procedures for ensuring that all staff are fully vaccinated, except for those staff who have been granted exemptions or a temporary delay at 483.80(i)(3)(ii).

Id. (unnumbered) 11.

Discussing “good-faith effort,” for purposes of lowering the scope and severity of a citation, CMS writes,

if the facility staff vaccination rate is 90% or more, there is no resident outbreak in the previous 4 weeks, and all policies and procedures were developed and implemented, per Table 1 this would be cited “D”. However, if the facility provides evidence that it has made a good faith effort by taking aggressive steps to get all staff vaccinated, surveyors may lower the citation to “A”.

Id. (unnumbered) 13. The table for Scope and Severity Grid add to Immediate Jeopardy that the facility “*has no policies and procedures developed or implemented.*” *Id.* (unnumbered 14).

“Revised Guidance for the Interim Final Rule – Medicare and Medicaid Programs; Omnibus COVID-19 Health Care Staff Vaccination” is available at <https://www.cms.gov/files/document/qso-22-09-all-revised.pdf>; Attachment A, at <https://www.cms.gov/files/document/attachment.pdf>. The memorandum and Attachment are available from the Center for Medicare Advocacy, on request.

3. CMS TO REDUCE FUNDING TO KANSAS BY NEARLY \$350,000 WHEN STATE REFUSES TO ENFORCE THE VACCINE MANDATE FOR NURSING HOME STAFF

The Kansas City Star reports that Jonathan Blum, Chief Operating Officer at the Centers for Medicare & Medicaid Services (CMS), advised the State of Kansas in a March 18, 2022 letter that CMS will reduce funding to the State by \$348,723 because of the State's violation of its Medicare agreement with CMS. Specifically, the State will not survey for compliance with, and therefore refuses to enforce, the federal mandate for vaccinations of nursing home staff. Katie Bernard, "Kansas loses federal money not enforcing vaccine mandates in hospitals, nursing homes," *The Kansas City Star* (Mar. 29, 2022).

"Kansas loses federal money not enforcing vaccine mandates in hospitals, nursing homes" is available at <https://www.kansascity.com/news/politics-government/article259913005.html> and from the Center for Medicare Advocacy, on request.

OTHER FEDERAL ISSUES

4. CONGRESSMAN BOBBY RUSH ASKS ENERGY & COMMERCE COMMITTEE TO HOLD HEARING ON PRIVATE EQUITY AND NURSING HOMES; *SKILLED NURSING NEWS* REPORTS REITS ARGUE PRIVATE OWNERS ARE OF GREATER CONCERN

In an April 1, 2022 letter, Congressman Bobby L. Rush (D, IL) asks Congresswoman Diana DeGette, Chair of the Oversight and Investigations Subcommittee of the House Energy and Commerce Committee, "to schedule a hearing on the failures of nursing homes during the pandemic, on the practices of REITs buying the operation of nursing homes, and on the real-life consequences for patients."

Citing the *USA Today* investigative report *Dying for Care*, which "shed a bright light on the horrific practices and pervasive failures by the nursing home industry, whose facilities are increasingly owned by Real Estate Investment Trusts (REITs)," the Congressman calls on the Committee to expose "the profiteering, cold-hearted nature of these corporations" and "to shine a bright light on the current practices, to reign them in, and to set and strictly enforce high standards for performance." He wants REITs to be prohibited from operating nursing homes: "if they own the real estate, then they should not be given the authority to operate the nursing homes and should not get one red cent of taxpayer money to operate these nursing homes."

Editor's Note: The *USA Today* report, *Dying for Care*, is discussed in *Enforcement*, Issue No. 266, pp. 18-19 (Mar. 2022).

Skilled Nursing Homes quotes REITs' and private equity companies' defense of their practices ("they want to improve the asset because they want to sell the real estate and get out of it") and blame of "owner/operators" about whom, they claim, there is little transparency. Alex Zorn, "Why Private Owner/Operators May Be Riskier for Nursing Homes than REITs, Private Equity," *Skilled Nursing News* (Apr. 19, 2022). As REITs and private equity companies have reduced their ownership, owning fewer facilities now than they owned five years ago, private buyers have

increased their purchases, accounting for \$4.2 billion of the \$4.7 billion in transactions in 2021, often with funding from the Department of Housing and Urban Development.

Skilled Nursing News compares the transparency of REITs with the opacity of Ephram Lahasky, a private owner recently profiled by *MarketWatch*.

Editor’s Note: *MarketWatch*’s article on Lahasky, “All you hear about is the bad stuff: Ephram Lahasky has a new investment model for America’s nursing homes. Regulators have questions,” is discussed in *Enforcement*, Issue No. 266, pp. 16-18 (Mar. 2022).

The letter is available at <https://www.documentcloud.org/documents/21579147-rep-rush-hearing-request-on-nursing-homes>; “Why Private Owner/Operators May Be Riskier for Nursing Homes than REITs, Private Equity,” at <https://skillednursingnews.com/2022/04/why-private-owner-operators-may-be-riskier-for-nursing-homes-than-reits-private-equity/>. The letter and article are available from the Center for Medicare Advocacy, on request.

REPORTS

5. HHS RELEASES FIRST-EVER REPORT ON CHANGE OF OWNERSHIP OF NURSING HOMES (AND HOSPITALS)

Health care providers, including nursing homes, are required to self-report information about changes in ownership, within 30 days, to the Centers for Medicare & Medicaid Services (CMS), using the Provider Enrollment, Chain, and Ownership System (PECOS). Although PECOS was established in 2002, CMS is now, for the first time, publicly releasing PECOS information on “mergers, acquisitions, consolidations, and changes of ownership from 2016-2022.” CMS, “HHS Releases New Data and Report on Hospital and Nursing Home Ownership” (Press Release, Apr. 20, 2022). The data for skilled nursing facilities (SNFs), which will be released quarterly, are available at <https://data.cms.gov/provider-characteristics/hospitals-and-other-facilities/skilled-nursing-facility-change-of-ownership>

In an analysis of PECOS data from 2016-2021, the Office of Health Policy, Assistant Secretary for Planning and Evaluation (ASPE), reports that 3,236 SNFs were sold in the five-year period (39.9 per 1,000 SNFs per year). W. Pete Welch, Joel Ruhter, Arielle Bosworth, Nancy De Lew, and Benjamin D. Somers, “Changes of Ownership of Hospital and Skilled Nursing Facilities: An Analysis of Newly-Released CMS Data,” *Data Point*, p. 3 (Apr. 20, 2022). Although most of the ASPE report discusses hospitals, the report finds that 62.3% of the SNFs have “a single organizational owner, while 18.2% have only individual owners.” Report 4.

ASPE suggests that the new dataset will allow analysis of many issues, including whether facilities with lower performance are more likely to be sold and whether performance improves or declines after sale. ASPE cautions that PECOS data are self-reported and “there is no centralized database to which CMS can compare the self-reported information.” *Id.* 7.

“HHS Releases New Data and Report on Hospital and Nursing Home Ownership” is available at <https://www.cms.gov/newsroom/press-releases/hhs-releases-new-data-and-report-hospital-and->

[nursing-home-ownership](#); “Changes of Ownership of Hospital and Skilled Nursing Facilities: An Analysis of Newly-Released CMS Data,” at <https://aspe.hhs.gov/sites/default/files/documents/4d960147d5fd8e2ea9af508f115ca7b7/aspe-datapoint-change-ownership-pecos.pdf>. The Press Release and ASPE’s analysis are available from the Center for Medicare Advocacy, on request.

6. NATIONAL CONSUMER VOICE FOR QUALITY LONG TERM CARE RELEASES DATA SHOWING THAT HIGHER STAFFING LEVELS MEAN LESS ABUSE OF RESIDENTS

Analyzing weekday staffing data from the Centers for Medicare & Medicaid Services (CMS), the National Consumer Voice for Quality Long-Term Care (Consumer Voice) shows that facilities with more staff also have higher health inspection ratings and overall ratings and that as staffing decreases, “so does a facility’s overall rating and performance in health inspections, and instances of abuse.” Consumer Voice, *Staffing Matters* p. 1 (2022). In facilities with the lowest staffing levels, “one half hour less of direct care each day doubles the likelihood that a nursing home has a history of abuse.” *Id.* 2.

A study prepared for CMS and released in 2001 identified .75 hours of care by registered nurse (RN) per resident per day as necessary. Consumer Voice finds that 10,000 nursing facilities (65.7% of the total) do not provide this recommended level of RN care to residents. *Id.* Consumer Voice finds that “A decrease of six minutes of resident care, from .7-.8 to .6-.7, results in a 31% increase in the likelihood that a nursing home has a history of abuse.” *Id.*

Staffing Matters is available at <https://theconsumervoice.org/uploads/files/issues/Staffing-Matters.pdf> and from the Center for Medicare Advocacy, on request.

7. NATIONAL ACADEMY OF SCIENCES, ENERGY AND MEDICINE’S COMMITTEE ON THE QUALITY OF CARE IN NURSING HOMES ISSUES REPORT CALLING FOR MAJOR REFORMS

Describing “the way in which the United States finances, delivers, and regulates care in nursing homes settings [as] ineffective, inefficient, fragmented, and unsustainable,” the National Academy of Sciences, Engineering, and Medicine’s Committee on the Quality of Care in Nursing Homes calls for “immediate action to initiate fundamental change.” The Committee released its report, *The National Imperative to Improve Nursing Home Quality; Honoring Our Commitment to Residents, Facility, and Staff*, and described its findings and recommendations at a webinar on April 6, 2022.

Editor’s Note: Many of the Committee’s findings and recommendations mirror President Biden’s nursing home reform agenda, which was described in a February 28 White House Fact Sheet and announced by the President in his State of the Union address on March 1. The White House Fact Sheet describing President Biden’s nursing home reform agenda is discussed in *Enforcement*, Issue No. 266, pp. 1-4 (Mar. 2022).

The 605-page report addresses concerns that advocates for residents have been raising for many years – inadequate staffing levels, failure to enforce standards of care, lack of requirements and accountability for how public reimbursement is spent, among others – and proposes specific solutions that advocates have urged. While the Committee recognizes that additional financial resources will likely be required to implement its recommendations, it cautions that

this investment should not be viewed as simply adding more resources to the nursing home sector as it currently operates, because that alone would not likely result in significant improvements. Rather, the committee calls for targeted investments that (combined with current funding) would be inextricably linked to requirements for transparency. Such transparency will enable stronger and more effective oversight to ensure resources are properly allocated to improving the quality of care.

Report 3-4. The Committee rejects industry arguments that Medicaid reimbursement is always inadequate, writing, “The lack of transparency or accountability in payment, funds flow, and nursing home finances make it extremely difficult to assess the adequacy of current Medicaid payments.” *Id.* 365.

Some of the recommendations included in the report’s seven broad goals are:

Workforce

- Registered nurse(RN) coverage 24 hours per day/seven days per week, “with additional RN coverage that reflects resident census, acuity, case mix, and the professional nursing needs for residents as determined by the residents’ assessments and care plans” (Recommendation 2B, p. 510)
- A study “to identify and rigorously test specific minimum and optimum staffing standards for direct-care staff,” with findings implemented in updated federal and state regulatory requirements (Recommendation 2C, p. 511)
- An increase in minimum training hours for certified nurse aides from 75 to 120 (Recommendation 2F, p. 514)

Transparency

- “HHS should collect, audit, and make publicly available detailed facility-level data on the finances, operations, and ownership of all nursing homes (e.g., through Medicare and Medicaid cost reports and data from Medicare’s Provider Enrollment, Chain, and Ownership System)” (Recommendation 3A, p. 518)
- “HHs should ensure that accurate and comprehensive data on the finances, operations, and ownership of all nursing homes are available in a real-time, readily usable, and searchable database so that consumers, payers, researchers, and federal and state regulators are able to use the data to:
 - “Evaluate and track the quality of care for facilities with common ownership or management company.
 - “Assess the impact of nursing home real estate ownership models and related party transactions on the quality of care.” (Recommendation 3B, p. 519)

Financing

- “[M]ove toward the establishment of a federal long-term care benefit that would expand access and advance equity for all adults who need long-term care” (Recommendation 4A, p. 520)
- Direct care ratios: “[R]equire a specific percentage of nursing home Medicare and Medicaid payments to be designated to pay for direct-care services for nursing home residents, including staffing (including both the number of staff and their wages and benefits), behavioral health, and clinical care” (Recommendation 4C, p. 522)

Survey and enforcement

- “CMS should ensure that state survey agencies have adequate capacity, organizational structure, and resources to fulfill their current nursing home oversight responsibilities for monitoring, investigation, and enforcement.” (Recommendation 5A, p. 526)
- “Greater use of enforcement remedies beyond civil monetary penalties, including chain-wide corporate integrity agreements, denial of admissions, directed plans of correction, temporary management, and termination from Medicare and Medicaid.” (Recommendation 5B, p. 527)
- “When data on the finances and ownership of nursing homes reveal a pattern of poor quality care across facilities with a common owner (including across state lines), federal and state oversight agencies (e.g., CMS, state licensure and survey agencies, the Department of Justice) should impose oversight and enforcement actions on the owner,” including “Denial of new or renewed licensure,” sanctions, “including the exclusion of individuals and entities from participation in Medicare and Medicaid,” and “strengthened oversight (e.g., through an improved and expanded special focus facilities program.” (Recommendation 5D, p. 529)

The National Imperative to Improve Nursing Home Quality; Honoring Our Commitment to Residents, Facility, and Staff can be downloaded through a link at

<https://nap.nationalacademies.org/catalog/26526/the-national-imperative-to-improve-nursing-home-quality-honoring-our>. It is also available from the Center for Medicare Advocacy, on request.

8. LONG TERM CARE COMMUNITY COALITION RELEASES POLICY BRIEF ON DIRECT CARE MINIMUM SPENDING LAWS

In a new Policy Brief, the Long Term Care Community Coalition (LTCCC), a New York-based national advocacy organization for nursing home residents, calls for enactment of direct care minimum spending laws that

- require nursing facilities to spend designated percentages of their revenues on direct resident care
- require facility reporting of spending and revenues
- authorize state audits of facility reports
- establish penalties for failure to meeting spending and reporting requirements, and
- authorize states to collect penalties and excess funds

LTCCC, *Direct Care Minimum Staffing Laws; A Critical Tool for Improving Care for Nursing Home Residents and Accountability for Taxpayer Funds* (2022).

The report begins with a discussion of COVID-19 deaths in nursing homes, the growth in private equity ownership of nursing homes, research showing declines in resident care following private equity's take-over of facilities, summaries of laws recently enacted in New Jersey, Massachusetts, and New York mandating direct care ratios for nursing facilities, and legislation pending in California and Connecticut. Report 3-5, 8-14.

The report discusses the key components of a direct care minimum staffing law, with recommendations for implementation of each of the five components. *Id.* 5-8.

Direct Care Minimum Staffing Laws is available at <https://nursinghome411.org/wp-content/uploads/2022/04/Policy-Brief-Direct-Care-Min.-Spending-Laws.pdf> and from the Center for Medicare Advocacy, on request.

9. TRELLA HEALTH REPORTS “DECREASE IN VOLUNTARY SKILLED NURSING” FACILITY ADMISSIONS

Trella Health, an Atlanta-based health analytics company founded in 2015 and rebranded as Trella in 2019, <https://www.trellahealth.com/about-us>, reports “The skilled nursing industry, already experiencing declining admissions before the pandemic, continues to struggle with no clear end in sight.” Trella Health, *Post-Acute Care Industry Trend Report, 2021*, p. 14. Between 2019 Quarter 1 (Q1) and 2021, Q3, admissions to skilled nursing facilities declined from 580,000 people to 436,000 people. Report 14. Trella Health reports:

The skilled nursing industry has suffered massively due to the ongoing pandemic. Staffing shortages continue to plague agencies to the point where, anecdotally, some facilities have been forced to turn patients away. Despite billions of dollars provided through the Public Relief Fund (PRF) to skilled nursing facilities, the decrease in admissions and increase in costs associated with the pandemic has left many agencies in precarious financial positions.

Id. Trella Health suggests, “To gain more admissions, the skilled nursing industry must rebuild its reputation of delivering safe and effective care while immediately targeting inpatient discharges with skilled nursing instructions to gain more admissions.” *Id.* 15.

The decrease in voluntary admissions to facilities could “indicate Medicare beneficiaries’ fears of COVID-19 outbreaks in SNFs.” *Id.* Trella Health suggests, “The industry must confront this issue by demonstrating its ability to deliver safe, effective care. In the meantime, however, SNFs must focus on patients discharged from an inpatient stay with skilled nursing discharge instructions.” *Id.* Trella Health found that 100,000 beneficiaries “discharged from an inpatient facility with instructions to enter skilled nursing care did not adhere to those instructions.” *Id.*

Post-Acute Care Industry Trend Report is available by completing a form at <https://www.trellahealth.com/2021-industry-trend-report-medicare-data-analytics/>. The report is also available from the Center for Medicare Advocacy, on request.

10. NATIONAL INVESTMENT CENTER REPORTS MORE MEDICARE-COVERED RESIDENTS IN NURSING HOMES DUE TO OMICRON

The National Investment Center (NIC) reports that occupancy rates at the beginning of 2022 were 75.8%, a decline from the December 2021 high of 76.1% and the pre-pandemic level (February 2020) of 86.1%. Bill Kauffman, “Skilled Nursing Medicare Mix Increased Significantly Due to Omicron,” *NIC Market Trends* (Mar. 31, 2022). The Omicron variant “seemingly stalled the occupancy recovery.”

Medicare revenue per patient day increased to \$585 in January 2022, from \$580 in December 2021. NIC attributes the increase to the Omicron variant. NIC anticipates that Medicare revenue will decline as COVID-19 cases decline.

The Medicare program paid for 25.2% of residents in January, which NIC attributes to the increase in COVID-19 cases and the waiver of the three-day inpatient rule. NIC anticipates that the Medicare revenue mix will decline as the number of COVID cases declines.

Medicare managed care was 10.5% in January, with Medicare managed care revenue of \$454 per patient day, a decline from \$468 a year earlier. NIC notes, “The persistent decline in managed Medicare revenue per patient day continues to result in an expanded reimbursement differential between Medicare fee-for-service and managed Medicare, which has accelerated during the pandemic.” The differential was \$130 per patient day in January 2022.

In January, Medicaid paid for 63.7% of resident days, at an average of \$245 per day. Medicaid revenue mix declined to 47.5%, which NIC attributes to the spike in Omicron cases in January and facilities’ use of Medicare for residents “as they required isolation and higher skilled care.”

“Skilled Nursing Medicare Mix Increased Significantly Due to Omicron” is available at <https://blog.nic.org/skilled-nursing-medicare-mix-increased-significantly-due-to-omicron> and from the Center for Medicare Advocacy, on request.

11. BUREAU OF LABOR STATISTICS REPORTS NURSING HOMES LOST 2,500 WORKERS IN MARCH 2022

Highlighting statistics reported by the federal Bureau of Labor Statistics (BLS), Employment Situation Summary (Apr. 1, 2022), Table B-1 (Employees on nonfarm payrolls by industry sector and selected industry detail), <https://www.bls.gov/news.release/empsit.t17.htm>, the American Health Care Association (AHCA) reports the loss of 2,500 jobs in March 2022, “deepening a historic labor shortage for the sector.” AHCA, “BLS March 2022 Jobs Report.” During the COVID-19 pandemic, the nursing home industry lost 241,000 workers, 15.2% of its

total workforce. The nursing home workforce declined from 1,584,800 in February 2020 to 1,343,800 in March 2022.

Citing BLS statistics, AHCA reports that home health, outpatient care, and physicians' offices have all increased their employment and now exceed February 2020 staffing levels. However, hospitals have experienced a 1.9% decline in employment and nursing homes, a 15.2% decline.

“BLS March 2022 Jobs Report” is available at <https://www.ahcancal.org/News-and-Communications/Fact-Sheets/FactSheets/BLS-MARCH2022-JOBS-REPORT.pdf> and from the Center for Medicare Advocacy, on request.

DEPARTMENTAL APPEALS BOARD

APPELLATE DIVISION

12. PANEL VACATES ALJ HUGHES’S 2019 SUMMARY JUDGMENT DECISION SUSTAINING FIVE IMMEDIATE JEOPARDY DEFICIENCIES CITED AT FLORIDA NURSING FACILITY; FINDS GENUINE FACTUAL DISPUTES; REMANDS CASE TO ALJ

The Rehabilitation Center at Hollywood Hills lost electric power to its central air conditioning system on September 10, 2017 during Hurricane Irma. The system did not work for 62 consecutive hours. The facility installed portable air conditioners. By September 13, eight residents at the Florida nursing facility who had serious pre-existing medical conditions and needed extensive staff help had died of heat stroke or heat exposure. The facility evacuated other residents to a nearby hospital on September 13. Following a survey by the state survey agency after the evacuation, the Centers for Medicare & Medicaid Services (CMS) cited five immediate jeopardy deficiencies – (1) safe and homelike environment (excessive heat), 42 C.F.R. §483.10(i); (2) neglect, §483.12; (3) quality of life, §483.24; (4) quality of care, §483.25; (5) administration, §483.70 – and imposed a per day civil money penalty (CMP) of \$20,965 and termination (effective October 13, 2017). The state also initiated a license revocation action. In a summary judgment decision, Administrative Law Judge (ALJ) Carolyn Cozad Hughes sustained the deficiencies and CMPs and termination. CR5232 (Jan. 16, 2019). Finding that CMS failed to meet its burden for summary judgment or that there were genuine factual disputes for each of the five deficiencies, an appellate panel vacates the ALJ’s decision and remands the case to the ALJ. *Rehabilitation Center at Hollywood Hills*, Docket No. A-19-64, Decision No. 3052 (Dec. 27, 2021).

Editor’s Note: The State of Florida revoked the facility’s license. The Florida Appellate Court’s upholding of the revocation was discussed in *Enforcement*, Issue No. 222, pp. 12-14 (Jun. 2018).

The Federal District Court’s dismissal of the facility’s lawsuit against the Department of Health and Human Services for excluding the facility from Medicare and Medicaid was discussed in *Enforcement*, Issue No. 257, p. 28 (Jun. 2021); the complaint was discussed in *Enforcement*, Issue No. 247, p. 34 (Jul. 2020).

Addressing four “subsidiary” issues, the panel first summarily affirms the ALJ’s denial of the facility’s motion to exclude certain exhibits when the facility does not dispute the ALJ’s ruling and the ALJ’s decision “on its face reflects no error of fact or law and is consistent with Board precedent.” Decision 12. Next, the panel finds it unnecessary to address whether the facility committed a violation of her pre-hearing order because the issue is moot when the panel rules that summary judgment was improper. *Id.* 12-13. The ALJ incorrectly stated that the facility had waived its right to rely on certain evidence that it had not cited in accordance with her pre-hearing order. The panel finds no waiver by the facility. *Id.* 13.

Third, the panel finds that the ALJ “based her decision in part on grounds not identified in CMS’s summary judgment motion, including alleged shortcomings in medical record-keeping and emergency preparedness planning, and an alleged failure to follow physician orders and plans of care.” *Id.* The panel notes Board decisions holding that ““an ALJ may not grant summary judgment on a ground not alleged by the moving party without providing adequate notice and an opportunity to show that a genuine dispute of material fact exists.” *Daniel H. Kinzie, IV, M.D., DAB No. 2341, at 6 (2010).*” *Id.*

Finally, “the Board was unable, using available media players, to open and play a substantial number of video (.mp4) files proffered by the parties, including files cited by CMS in support of its summary judgment motion.” *Id.* The panel finds,

The inaccessibility of some video files made it impossible for the Board to independently assess both CMS’s claim that Petitioner neglected certain residents during the evening of September 12 and early morning of September 13, 2017, and Petitioner’s rejoinder that the video was unreliable evidence of what care its staff provided on those (and other) days.

Id. 13-14. On remand, the ALJ must ensure that all video evidence is accessible. It may be necessary to permit the parties to resubmit files. *Id.* 14.

The panel then turns to the five deficiencies.

Comfortable and safe temperature levels, §483.10(i)

Since the record did not reflect whether the facility was certified for Medicare after October 1, 1990, “it is unclear whether Petitioner can be found noncompliant with section 483.10(i) solely based on whether temperatures in the resident environment ever exceeded the 81-degree threshold specified in the regulation.” *Id.* Nevertheless, the Administrator believed the facility was subject to a maximum temperature of 81°. *Id.*

The panel finds that the facility proffered evidence disputing CMS’s argument that it did not maintain safe temperatures for at least some residents, citing **affidavits** (the plant manager, administrator, and the overnight shift nursing supervisor) as well as **deposition testimony** (a former second-floor resident, a physician who visited the second floor, and a family member of a first-floor resident), who all described the facility’s temperature as in the 70s or as slightly

warmer than usual. *Id.* 14-16. In addition, **affidavits** (an engineer and climatologist) about temperatures in the facility provided facts challenging CMS’s argument. *Id.* 16. The panel concludes that “a reasonable trier of fact could find that Petitioner maintained temperatures in the facility within a range that the regulation deems – and that Petitioner’s staff reasonably thought was – comfortable and safe.” *Id.* On remand, the ALJ may find that the facility’s witnesses

are not credible or persuasive on this issue; that the weight of the evidence establishes that temperatures were not in fact comfortable and safe in some areas of the resident environment (such as residents’ rooms on the second floor); and that its staff knew or had reason to know of that circumstance.

Id. The panel finds that the ALJ “did not always view the record in the light most favorable to Petitioner,” as required in a summary judgment ruling. *Id.* 17. The ALJ also cited the facility’s “‘affirmative duty’ to measure’ temperatures in residents rooms and ‘to document its measurements,’” but no such requirement exists. *Id.*

Right to be free from neglect, §483.12

The panel accepts, for purposes of summary judgment, the facility’s “claim that it maintained temperatures at or below 81°F in all parts of the resident environment during the relevant period.” *Id.* 19. It finds that CMS “was not clear or precise [in its summary judgment motion] about what good and services, or interventions, it believed were ‘necessary’ to avoid harm to Petitioner’s residents following the loss of central air conditioning.” *Id.* CMS seemed to imply that the facility failed to keep residents hydrated and failed to check on them sufficiently or to provide necessary care.

The panel holds that the facility “proffered evidence sufficient to raise a genuine dispute about whether its staff neglected residents,” citing deposition testimony and affidavits about actions that staff took and expert testimony suggesting that “the nursing staff should not be faulted for failing to assess each resident’s susceptibility to heat-related illness because there are no ‘clear guidelines’ about how to perform such assessments.” *Id.* 19. The facility “questioned the reliability of security camera video cited by CMS to support its claim of neglect” and contended that testimony of the Hollywood Police Department detective “supports its view that the video cannot be considered reliable.” *Id.*

Quality of life, §483.24; quality of care, §483.25

The panel finds that “CMS’s summary judgment motion stated legally insufficient grounds for its claim that Petitioner violated sections 483.24 and 483.25” because “the motion failed to specify what CMS thought were the ‘necessary care and services’ for residents’ ‘quality of life’ that Petitioner failed to provide during the relevant period” and similarly “failed to indicate how Petitioner failed to provide, as section 483.25 requires, ‘treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the resident’s choices.’” *Id.* 21. Instead, “CMS merely suggested that any failure by Petitioner to meet its obligation under section 483.12 to keep residents free from neglect also constituted a violation of the requirements in sections 483.24 and 483.25.” *Id.*

The panel finds that CMS’s evidence about the facility’s failure to follow physician orders or care plans for Residents 3 and 4 was “inconclusive, . . . , or at least in dispute.” *Id.* It describes as similarly “inconclusive” the facility’s treatment and clinical records. *Id.* 21-22.

Facility administration, §483.70

Although an administration deficiency may be based on noncompliance with other requirements, the panel vacates the administration deficiency because it rejects the other deficiencies. *Id.* 22. It also finds that the administration deficiency “is inconsistent with the summary judgment standard” when the ALJ “apparently inferred from the nature and seriousness of other alleged deficiencies that they were the product of ineffective or inefficient governance or management.” *Id.* 23. Such inferences may not be made in a summary judgment ruling.

The ALJ also cited the facility’s “‘deficiencies in planning for the loss of air conditioning,’ including a failure to ‘plan for [residents’] ongoing care when the facility lost its air-conditioning’ and not having a ‘back-up plan in place to protect residents if temperatures exceeded safe levels.’” *Id.* The panel notes that it is “disinclined to sustain the remedies on that basis because CMS did not allege shortcomings in emergency-planning in its motion for summary judgment.” *Id.* Moreover, there was record evidence “including affidavits or deposition testimony of its administrator, plant manager, and others – sufficient to raise a genuine dispute about whether Petitioner’s pre-hurricane planning was adequate.” *Id.* The panel similarly cites “some evidence that its staff planned for the ‘ongoing care’ of residents after losing central air conditioning,” citing the Director of Nursing’s testimony. *Id.* 24.

Medical records, §483.70(i)(1)

Although the ALJ found that the facility’s medical records were “‘unreliable,’” “CMS’s summary judgment motion alleged no medical-recordkeeping deficiency.” *Id.* 24-25. Moreover, “intertwined” with the issue of “the completeness and accuracy of Petitioner’s medical records” is “the question of whether Petitioner actually provided residents with the nursing and other care it claimed to have provided after losing its central air conditioning.” *Id.* 25. For purposes of summary judgment, the panel “must accept, as true, testimony by Petitioner’s employees . . . that such care was provided.” *Id.* 26.

The panel concludes with a “final observation:”

The circumstances presented in this case are unquestionably tragic with the loss of multiple lives in the midst of the crisis created by the hurricane. We have concluded that summary judgment is not an appropriate vehicle here for resolving the questions about the facility’s actions/omissions in planning for and responding to the crisis or in providing care to its residents. That conclusion does not imply any opinion about how those questions should be resolved and in no way minimizes the severity of the situation. On the contrary, the seriousness of the events and its impact on residents calls for a thorough neutral exploration of all the facts and evidence without the constraints imposed by the use of summary judgment.

Id. The panel vacates the summary judgment to CMS and remands the case.

The 26-page decision is available at <https://www.hhs.gov/about/agencies/dab/decisions/board-decisions/2021/board-dab-3052/index.html> and from the Center for Medicare Advocacy, on request.

CIVIL REMEDIES DIVISION

13. DECIDING OHIO NURSING FACILITY’S APPEAL WITHOUT A HEARING, ALJ ROGALL SUSTAINS IMMEDIATE JEOPARDY DEFICIENCY FOR FAILURE TO PROVIDE BASIC LIFE SUPPORT TO FULL CODE RESIDENT, CITED AT NURSING FACILITY IN 2018; SUSTAINS PER INSTANCE CIVIL MONEY PENALTY OF \$19,500

Following a partial extended survey and complaint investigation by the Ohio state survey agency, completed March 26, 2018, the Centers for Medicare & Medicaid Services (CMS) cited failure to provide life support to a resident prior to the arrival of emergency personnel, 42 C.F.R. §483.24(a)(3), F678, made a determination of immediate jeopardy (level J), and imposed a per instance civil money penalty (CMP) of \$19,500. Deciding the facility’s appeal on the record, without a hearing, Administrative Law Judge (ALJ) Leslie C. Rogall sustained the deficiency and CMP. *Gardens of McGregor and Amasa Stone v. CMS*, Docket No. C-19-92, Decision No. CR5947 (Sep. 23, 2021).

Editor’s Note: As of April 19, 2022, the facility has three stars in health inspections, three stars in staffing, and four stars in quality measures. Its overall rating is three stars.

As of April 19, neither the March 2018 complaint survey nor the \$19,500 CMP is reported on *Care Compare*. A standard survey on September 21, 2017 is reported, but its related complaint surveys are for the period March 1, 2019-February 29, 2020. A standard survey is also reported for November 1, 2018, but its related complaint surveys are for the period March 1, 2020-February 28, 2021.

The deficiency was based on the care provided to Resident 202 (R202), who was admitted to the facility on February 23, 2018 as a full code resident. On February 28, 2018, at 2:00 a.m., the facility notified R202’s treating physician that the resident had low blood pressure. At 8:00 a.m., a state tested nurse aide (STNA) reported that R202 had a large amount of loose stool, her face was swollen, and she had a hive-like rash. R202 said she was not in pain but was itchy. Her physician gave orders to administer Benadryl and discontinue antibiotic treatment. At 8:10 a.m., the STNA reported to a nurse that something was wrong. The nurse administered a sternal rub, but R202 was not responsive to the rub. The nurse could not detect a pulse and initiated the facility’s code protocol at 8:15 a.m. A registered nurse documented the administration of oxygen via nasal cannula in R202’s nose. The EMS arrived at 8:23 a.m. and took responsibility for R202, performing chest compressions, ventilating her, and transporting her to the hospital, which reported to the facility at 9:00 a.m. that R202 had died of acute myocardial infarction. Decision 4-6.

A licensed practical nurse at the facility reported that there was “no ambu bag on crash cart.” *Id.* 6. Written testimony by a nurse surveyor indicated that the facility’s policy called for staff to ventilate a resident with an Ambu bag and that all crash carts should have Ambu bags. Written testimony by a professor at Harvard Medical School indicated that a full code resident should receive basic life support, or CPR, including ventilatory support with ambu bagging. He testified that R202 could have survived initial resuscitation, but that a good outcome for R202 was “extremely unlikely.” *Id.* 7.

The facility’s expert witness, a clinical professor at Ohio University Heritage College of Osteopathic Medicine and a Certified Medical Director, testified that an Ambu bag was brought to the resident when the first emergency cart did not include one. An unsworn statement from R202’s physician indicated that he “did not suspect that Resident # 202’s death was unusual” and that “he had ‘no information to indicate that respiratory resuscitation prior to her intubation would have changed the outcome of [her] death.’” *Id.*

Sustaining the deficiency, Judge Rogall cites §483.24(a)(3), which requires facilities to provide basic life support, including CPR, to a resident who requires emergency care prior to the arrival of emergency personnel and the facility’s policy, which, incorporating the American Heart Association’s (AHA’s) guidance for CPR for health care providers, required that the emergency cart on each floor include an Ambu bag. *Id.* The ALJ also quotes the State Operations Manual’s explanation of the requirement for CPR and cites AHA’s CPR guidelines, decisions of the Departmental Appeals Board, and the facility’s policies for Code Blue and Emergency Cart Maintenance. *Id.* 8-10.

Judge Rogall finds that the emergency cart on R202’s floor did not contain an Ambu bag and that staff could not obtain an Ambu bag “until eight minutes after it initiated CPR, and, as a result, it did not ventilate Resident #202 prior to EMS taking over care.” *Id.* 10. Both failures violated facility policy and the federal regulation. *Id.* 10. The ALJ finds that R202 “had been unresponsive for five minutes prior to its initiation of CPR” and, because of the lack of the Ambu bag, she was not ventilated R202 for eight minutes. *Id.* 11.

Judge Rogall rejects the facility’s contention that compression-only CPR was adequate, finding that AHA considers compression-only CPR appropriate only for an untrained rescuer, not health care providers. *Id.* She faults the facility for not maintaining a stocked emergency cart on R202’s floor. *Id.*

The substandard quality of care resulting in a partial extended survey led CMS to determine that the facility lost approval for a nurse aide training and competency evaluation program. Judge Rogall sustains the determination of jeopardy as not clearly erroneous, when the facility’s failure to ventilate the resident “thwarted the slim opportunity she had for prolonged survival.” *Id.* 13.

The ALJ sustains the CMP as reasonable, citing the severity of the deficiency and the facility’s history of recent noncompliance. *Id.* 14-15.

The 15-page decision is available at <https://www.hhs.gov/about/agencies/dab/decisions/alj-decisions/2021/alj-cr5947/index.html> and from the Center for Medicare Advocacy, on request.

14. ALJ ROGALL SUSTAINS TWO DEFICIENCIES CITED AT NEW JERSEY NURSING FACILITY IN 2018, INCLUDING IMMEDIATE JEOPARDY QUALITY OF CARE DEFICIENCY; SUSTAINS TWO PER INSTANCE CIVIL MONEY PENALTIES TOTALING \$25,405

Following a standard survey, completed by the New Jersey state survey agency at Morris View Healthcare Center on March 15, 2018, the Centers for Medicare & Medicaid Services (CMS) cited deficiencies – quality of care, 42 C.F.R. §483.25, F684, level L, and food storage, §483.160(i)(1), (2), F812, level F, and imposed two per instance civil money penalties (CMPs), \$20,405 and \$5,000, respectively, totaling \$25,405. Deciding the facility’s appeal based on the written submissions and statements, Administrative Law Judge (ALJ) Leslie C. Rogall sustains the deficiencies and CMPs. *Morris View Healthcare Center v. CMS*, Docket No. C-18-1136, Decision No. CR5942 (Sep. 20, 2021).

Editor’s Note: As of April 18, 2022, the facility has two stars in health inspections, three stars in staffing, and five stars in quality measures. Its overall rating is three stars. The facility’s five-star rating in quality measures boosted its overall rating from two stars, based on health inspections, to three stars.

A March 15, 2018 survey appears on *Care Compare*, <https://www.medicare.gov/care-compare/inspections/pdf/nursing-home/315303/health/standard?date=2018-03-15>, but it does not include either deficiency discussed in the ALJ’s decision. *Care Compare* also does not report the two per instance CMPs.

Resident 56 (R56) was admitted to the facility in October 2006 when she was 25 years old. She had cerebral palsy, dysphagia, convulsions, and microcephaly. A speech therapist determined that R56 was at risk for aspiration and was totally dependent on staff for eating. On September 8, 2017, she completed a Feeding Program Guide & Caregiver Training form indicating that R56 needed a diet of puree with honey-thickened liquids. The therapist identified specific requirements for feeding R56, including giving her small sips/bites and allowing time between mouthfuls. Speech therapy services were discontinued in October after caregiver education about feeding R56 was completed.

R56’s care plan included direction to ensure that nursing and dietary staff were responsible for R56’s eating, that R56’s head was properly positioned during meals, that R56 wore a soft cervical collar during meals, and other specific requirements for her complicated feeding regimen. Nevertheless, the surveyor observed (and it was undisputed that) a hospitality aide from the recreation/activities department fed R56 on March 2, 2018. The aide was enrolled in a nurse aide training and competency evaluation program (NATCEP) but had not passed the skills demonstration and oral/written examination. Decision 6.

A second resident, Resident 124 (R124), was also at risk for aspiration and totally dependent on staff for eating. The speech therapist “initiated a six-week course of treatment for ‘dysphagia management’” and completed the form setting out requirements for feeding R124. *Id.* R124’s MDS assessment on January 12, 2018 did not list dysphagia or report signs or symptoms of a

swallowing disorder. A surveyor saw a different hospitality aide, also enrolled in NATCEP, feeding R124. *Id.* 7.

A third resident, Resident 222 (R222) had a history of choking at mealtimes. The speech therapist determined that R222 had dysphagia, was at risk for aspiration, and needed to be fed. A surveyor observed the first hospitality aide feeding R222. *Id.* 7-8.

Judge Rogall finds that hospitality aides report to the Recreation Director and, under facility policy and procedure, may not feed residents or thicken resident's beverages. Facility policy provides that only certified feeding assistants may feed residents. The ALJ finds that at the time of the survey, New Jersey did not have a state-approved training program for feeding assistants. Nevertheless, the facility allowed hospitality aides to feed three residents who had complicated feeding problems. *Id.* 8-10.

The ALJ cites the September 26, 2003 rules that allowed facilities to use paid feeding assistants who “‘would not handle complicated feeding cases,’ with the stated intent of the newly authorized feeding assistant position ‘[being] to provide more residents with help in eating and drinking and reduce the incidence of unplanned weight loss and dehydration.’” *Id.* 10, citing 68 Fed. Reg. 55,528, 55,529 (Sep. 26, 2003). Judge Rogall notes that “‘CMS expected that ‘facilities would be free . . . to use persons who have a lesser level of training to assist residents who have no feeding issues that require specialized attention.’ 68 Fed. Reg. 55,531.” *Id.* 10-11. Nurse aides, according to CMS, would feed residents with complicated feeding problems. *Id.* 11.

The facility's hospitality aide position prohibited aides from feeding residents or thickening residents' beverages. Their tasks included delivering trays to residents who ate independently, opening containers for residents, observing resident intake, requesting nurses to provide food substitutes, and transporting residents to activities and the dining room. *Id.* 12.

Gail Rader, RN, MSN, CALA, owner of Care Perspectives, testified that she reviewed the records and found there was no immediate jeopardy when hospitality aides fed residents, stating, without evidence, that hospitality aides were directly supervised by licensed nurses when feeding residents. *Id.* 13. She also “‘relies on the absence of, or her inability to identify, care planning for dysphagia as a basis to support her conclusions, *id.*, misreading the residents' records and failing to address how hospitality aides had the training and competency to feed residents, *id.* 13-14.

Even though New Jersey did not have a paid feeding assistant program, the facility reported for the fourth quarter of 2017 “‘1,415 staff hours performed by 27 ‘Feeding Assistants.’” *Id.* The speech therapist had not trained, or been asked to train, the hospitality aides. The Director of Nursing told a surveyor that hospitality aides were part of the recreation department, not the nursing department. The Unit Manager reported that “‘for safety,’ she would redirect or replace hospitality aides whose ‘technique feeding could be more efficient.’” *Id.* 13.

Judge Rogall sustains the quality of care deficiency for failure to ensure that residents receive treatment according to professional standards of practice and residents' care plans, citing multiple decisions of the Departmental Appeals Board that failure to follow a resident's care plan

may support a quality of care deficiency. *Id.* 15. She finds that the hospitality aides had not passed the CNA skills demonstration or the oral/written examination and rejects the facility’s contention that hospitality aides had successfully completed an eight-hour feeding assistant program. *Id.* 16-17. Judge Rogall concludes, “By permitting its hospitality aides to feed residents, particularly residents with complicated feeding problems, Petitioner placed dysphagic residents at risk for aspiration when it disregarded its own policy setting the parameters for hospitality aide duties.” *Id.* 17,

Judge Rogall holds that the facility may not challenge the determination of immediate jeopardy because CMS imposed per instance CMPs. *Id.* 18-19.

The facility did not dispute the surveyor’s observations that its food storage, preparation, distribution, and service violated professional standards for food safety, but argued, unsuccessfully, that it corrected the problems immediately in front of the surveyor. *Id.* 19-20.

The ALJ sustains the \$20,405 CMP as reasonable when the facility’s noncompliance was “serious, repeated, ongoing, and widespread.” *Id.* 21. She also sustains the \$5,000 CMP “for a deficiency involving multiple failures to adhere to the facility’s food storage policy.” *Id.*

The 23-page decision is available at <https://www.hhs.gov/about/agencies/dab/decisions/alj-decisions/2021/alj-cr5942/index.html> and from the Center for Medicare Advocacy, on request.

15. FOLLOWING A HEARING BY VIDEOCONFERENCE, ALJ THOMAS SUSTAINS IMMEDIATE JEOPARDY ABUSE DEFICIENCIES, CAPTURED ON HIDDEN CAMERA PLACED IN RESIDENTS’ ROOMS BY STATE ATTORNEY GENERAL AND CITED AT OHIO NURSING FACILITY IN 2016; SUSTAINS PER DAY CIVIL MONEY PENALTIES TOTALING \$74,053

In April 2016, the Ohio Attorney General’s (Ohio AG) Healthcare Fraud Section placed a hidden camera in the room of Resident 13 (R13) at Union City Care Center, “after receiving allegations of abuse against the facility.” *Union City Care Center v. CMS*, Docket No. C-17-258, Decision No. CR5939, p. 1 (Sep. 14, 2021). On June 3, “Ohio AG investigators showed still frames from the hidden camera video to the facility’s administrator and the facility’s director of nursing,” which demonstrated staff abuse toward R13 on April 5 and April 24. Decision 1. Following a complaint survey on June 23, 2016, conducted by the state survey agency, the Centers for Medicare & Medicaid Services (CMS) cited three abuse deficiencies – 42 C.F.R. §13(b), (c)(1)(i), F223, level J; §483.13(c)(1)(ii)-(iii), (c)(2)-(4), level K; and §483.13(c), level K – made a determination of immediate jeopardy for all three deficiencies, and imposed per day civil money penalties (CMPs) – \$13,841, June 3-7, 2016; \$303, June 8-23, 2016 – totaling \$74,053. The facility was barred from operating a nurse aide training and competency evaluation program for two years. Administrative Law Judge (ALJ) Bill Thomas held a videoconference on January 29, 2019. He sustains the deficiencies and CMPs.

Editor’s Note: As of April 18, 2022, Union city Care Center has two stars in health inspections, three stars in staffing, and five stars in quality measures on *Care Compare*.

Its overall rating is three stars. The facility's five-star rating in quality measures boosted its overall rating from two stars, based on health inspections, to three stars.

The 2016 survey and CMPs are not reported on *Care Compare*, as of April 18, 2022; they are too old.

Judge Thomas provides a lengthy discussion of the parties' dispute, before and after the hearing, over the admissibility of the Ohio AG's tape and exhibits. *Id.* 3-7.

The deficiencies are based on incidents involving Resident 13 (R13), a 43-year old man who sustained traumatic brain injury in a car crash. He required total care from staff for activities of daily living, "exhibited memory problems, impaired decision-making, resistance to care, sexual aggressiveness, and daily sexual impropriety," *id.* 10, and demonstrated severe cognitive impairment. The video camera showed that on April 5, a hospitality aide pinched R13's ear after he grabbed her breast while the aide and state tested nursing assistant (STNA) were providing him with incontinence care. On April 24, the video camera showed another STNA pulled R13's hair after two STNAs transferred R13 into his wheelchair. CMS alleged that both incidents indicated abuse; the facility denied its staff abused R13 and alleged that staff engaged in self-defense in both incidents from R13's sexually inappropriate conduct. *Id.* 11.

Reviewing the video, Judge Thomas finds that the hospitality aide abused R13. *Id.* 12. Moreover, the aide told the surveyor she had pinched R13's ear in reaction to his grabbing her breast and a facility incident summary, dated June 3, recorded the aide's admission of tugging R13's hair. *Id.* 12-13. The facility argued that the ALJ should give no weight to the hospitality aide's admissions, because they were inconsistent. Judge Thomas was "unpersuaded" that the discrepancies required dismissal of the evidence, since either admission constituted abuse. *Id.* 13-14. He finds that the STNA's "blanket denial of abuse . . . is simply insufficient" and "otherwise inconsistent" with the hospitality aide's admissions. *Id.* 14, 15.

The ALJ is also unpersuaded by R13's alleged denial of abuse to the Director of Nursing (DON) on June 3, citing the resident's "extreme cognitive impairment" and "significant memory problems" and the two-month delay in the alleged denial. *Id.* 15. He also dismisses R13's father's denial of abuse, since he was not in R13's room "during the incident and would only have known what Resident 13 was able to remember and convey to him." *Id.* Judge Thomas concludes "Petitioner cannot rely on the failure of a cognitively limited individual with brain trauma and a host of mental issues to know when to signal possible abuse to his care providers. That burden does not rest on the resident." *Id.* 16.

The facility also argued that the aide's contact with R13 was not abusive and that the pinch or tweak "could serve as a redirecting cue to distract 'children or child-like persons' or alert them to discontinue a certain activity." *Id.* It also relied on the administrator's and DON's testimony that no abuse occurred. Judge Thomas rejects both arguments. He describes the administrator's and DON's testimony as "incredible and self-serving" and gives them no weight. *Id.* Moreover, the facility's report to the state "indicated suspected abuse and resulted in the firing" of both the hospitality aide and the STNA. *Id.*

In addition, the facility's own abuse policy, mirroring federal policy in the State Operations Manual, "defines such contact as abuse without regard for intent or the degree of harm caused." *Id.* 17. The DON confirmed that pinching and hair pulling were not condoned by the facility as appropriate staff interventions. R13's care plan called for staff to calm down before continuing care. *Id.*

Judge Thomas also rejects the facility's claim that the hospitality aide was engaging in self-defense, noting that the state placed the hospitality aide on a registry to ensure she could not work in long-term care facilities and state authorities criminally charged her with felonies of abuse and neglect (which were resolved by pleas to a lesser charge). *Id.* 17-19.

The ALJ sustains the second, April 24 incident of abuse of R13, citing the video tape and rejecting the STNA's denial that she abused the resident and a second STNA's and R13's denial that abuse occurred. *Id.* 19-21. He also rejects the facility's argument of self-defense and lack of actual harm. *Id.* 21. Noting that the facility suspended the STNA and later terminated her, Judge Thomas writes, "Petitioner has offered no evidence that it ever considered STNA #100's actions to amount to self-defense until it became expedient to do so in the course of litigation." *Id.* 22. The state charged STNA 100 with felony patient abuse; she pleaded to a lesser charge. *Id.*

Judge Thomas gives no weight to a state hearing officer's conclusion, in a hearing on the aide's license, that the state had not presented sufficient evidence of abuse, writing that the state hearing officer's conclusions are not binding on him and are based on state law, which requires the causing of harm to cite abuse. *Id.* 22. In addition, the state hearing officer's conclusions were not based on all the evidence before the ALJ and were inconsistent with the evidence. The state hearing officer seemed concerned about the defective notice of the hearing that was given to the STNA. *Id.* 23.

The ALJ sustains the deficiency at §483.13(c)(1)(ii)-(iii), (c)(2)-(4), which is also a violation of facility policy, for failure to immediately report the abuse of R13 to the state survey agency. *Id.* 23-24. He suggests that the incidents would never have been identified, but for the state's videocamera.

Judge Thomas sustains the deficiency at §483.13(c) for failure to implement the facility's abuse prevention policies and procedures, citing the abuse of R13 by two staff members and the STNA's failure to intervene in both incidents and to report the abuse. *Id.* 24-25.

The ALJ holds that CMS's determination of immediate jeopardy was not clearly erroneous. *Id.* 25-27. He sustains the amount and duration of the CMP as reasonable, citing the facility's compliance history and culpability. *Id.* 27-29.

The 30-page decision is available at <https://www.hhs.gov/about/agencies/dab/decisions/alj-decisions/2021/alj-cr5939/index.html> and from the Center for Medicare Advocacy, on request.

16. DECIDING ARKANSAS NURSING FACILITY’S APPEAL ON THE PARTIES’ WRITTEN EXCHANGES, ALJ KESSEL SUSTAINS DEFICIENCY CITED AT NURSING FACILITY FOR SAFE, SANITARY, AND COMFORTABLE ENVIRONMENT (INFECTION CONTROL) CITED IN 2020; SUSTAINS PER INSTANCE CIVIL MONEY PENALTY OF \$5,000

On August 31, 2020, a state surveyor observed a registered nurse at Shiloh Nursing and Rehab not wearing her face mask snugly over her nose and chin. She told the surveyor how the face mask should be worn, but said hers had slipped. On September 1, 2020, a surveyor observed a nursing assistant wearing a mask that did not cover her nose. She also claimed the mask had slipped. Administrative Law Judge (ALJ) Steven T. Kessel describes the incidents as “absolute proof that members of Petitioner’s staff were not following Petitioner’s policy, or CDC guidelines, about wearing masks.” *Shiloh Nursing and Rehab, LLC v. CMS*, Docket No. C-21-284, Decision No. CR5940, p. 3 (Sep. 13, 2021). He sustains an infection control deficiency and a per instance civil money penalty (CMP) of \$5,000 imposed by the Centers for Medicare & Medicaid Services (CMS).

Editor’s Note: Although Judge Kessel does not identify the state, it appears to be an Arkansas nursing facility. As of April 13, the facility has four stars in health inspections, two stars in staffing, and five stars in quality measures. Its overall rating is five stars. Its five-star rating in quality measures boosted its overall rating from four stars, based on health inspections, to five stars.

As of April 13, 2022, *Care Compare* reports the deficiency (in a complaint survey, <https://www.medicare.gov/care-compare/inspections/pdf/nursing-home/045427/health/infection-control?date=2020-09-04>) and a CMP of \$5,000 imposed on September 4, 2020.

In response to the facility’s claim that CMS was imposing a strict liability standard, the ALJ writes, “But in this case, strict compliance isn’t an arbitrarily harsh measurement of compliance, it is absolutely necessary. The well-known infectiousness of Covid makes strict compliance with mask wearing requirements essential, indeed, ‘critical.’” Decision 3. He distinguishes this case from others that hold that strict liability is “an inappropriate standard for measuring a skilled nursing facility’s performance.” *Id.* Although facilities are responsible for protecting residents only from foreseeable accidents,

Here, however, it is entirely foreseeable that failure to wear a face mask properly potentially exposes residents of a facility and other staff members to Covid particles. Thus, holding a facility strictly accountable for enforcing an infection control requirement, such as a requirement that staff wear masks, is in no way equivalent to a hypothetical strict liability requirement in an accident case.

Id. The facility relied on testimony by Dr. Stillwell that staff members seen by the surveyors were not actually providing care to residents when they were observed. Judge Kessel finds it reasonable to infer that the RN was providing care because she was seen leaving a resident’s room. Moreover, the fact that both staff members “knew they were wearing their masks improperly, but nevertheless wore them that way” supported the ALJ’s “inference that these staff

members were generally nonchalant about mask wearing requirements.” *Id.* 4. Since “Nonchalant mask wearing can eventually lead to transmission of disease,” Judge Kessel concludes, “That is enough to establish noncompliance.” *Id.*

A second basis for the infection control deficiency was “improper decontamination measures employed by a member of Petitioner’s staff in caring for an incontinent resident” – specifically, a staff member’s failure to wash her hands after she touched some of a resident’s stool. *Id.* 4, 5. The staff member changed her gloves, but failed to wash her hands before putting on the clean gloves. She said she was nervous and forgot. *Id.* 5.

Judge Kessel rejects the facility’s defense that the infractions were ““minor,”” reiterating “the extreme contagiousness of Covid” and the need for facilities to be “extraordinarily rigorous in its infection control efforts in order to combat the entry and spread of this disease into its premises.” *Id.*

The ALJ describes as a red herring the facility’s argument that CMS’s failure to identify the staff members who violated its infection control policy made it impossible to provide additional in-service training to them. *Id.* 6. He also rejects the facility’s claims that it took many actions to implement its infection control policy and that CMS was using a new interpretation of infection control requirements in citing the deficiency. *Id.*

The ALJ sustains the CMP as modest. *Id.* 7. He also cites the facility’s compliance history – its June 2020 deficiency in infection control. *Id.*

The seven-page decision is available at <https://www.hhs.gov/about/agencies/dab/decisions/alj-decisions/2021/alj-cr5940/index.html> and from the Center for Medicare Advocacy, on request.

17. IN SUMMARY JUDGMENT DECISION, ALJ HUGHES SUSTAINS QUALITY OF CARE DEFICIENCY CITED AT TEXAS NURSING FACILITY IN 2019; SUSTAINS PER INSTANCE CIVIL MONEY PENALTY OF \$21,393

Following a complaint survey at Wells LTC Partners, completed by the Texas state survey agency on February 14, 2019, the Centers for Medicare & Medicaid Services (CMS) cited two immediate jeopardy (level J) deficiencies – consultation with resident’s physician following a significant change in condition, 42 C.F.R. §483.10(g)(14) and (15), F580; and quality of care, §483.25(c), F684 – and imposed a per instance civil money penalty (CMP) of \$21,393, but solely for the quality of care deficiency. In a summary judgment decision, Administrative Law Judge (ALJ) Carolyn Cozad Hughes sustains the deficiency and the CMP. *Wells LTC Partners, Inc. v. CMS*, Docket No. C-19-873, Decision No. CR5935 (Sep. 2, 2021).

Editor’s Note: As of April 12, 2022, the facility has four stars in health inspections, two stars in staffing, and two stars in quality measures on *Care Compare*. Its overall rating is four stars.

Neither the complaint survey nor the CMP is reported on *Care Compare*, as of April 12, 2022. *Care Compare* reports that the facility has not had a deficiency cited as a result of a complaint survey in three years.

Judge Hughes discusses at length the facility's policies on physician notification, investigating and reporting accidents, signs and symptoms of abuse and neglect, reporting resident abuse, preventing abuse, and preventing resident accidents and incidents. Decision 9-13.

The quality of care deficiency was based on the care provided to Resident 1 (R1), "an exceptionally impaired and combative resident" who was 48 years old and had been the victim of traumatic brain injury. *Id.* 1, 13. She was severely cognitively impaired, resisted care, and could be extremely aggressive with staff. R1's care plan directed staff to monitor injuries, notify the charge nurse of new bruises or skin tears, notify the physician of abnormal findings, and "administer treatments as ordered." *Id.* 14.

On January 29, 2019, a nurse aide employed by a staffing agency reported to the charge nurse, a licensed vocational nurse (LVN) employed by a staffing agency, that R1 indicated, by yelling and pointing, that something was wrong with her right leg. The LVN did not record R1's sudden onset of significant pain in R1's medical record. A different LVN recorded R1's changes many hours later, but she did not consult with R1's physician or notify her family. The aide completed a witness statement more than a week later. *Id.* 14-15.

Rejecting the facility's argument that R1 had previously had problems with her leg and that her symptoms were not new, Judge Hughes cites "undisputed evidence" that R1's condition had significantly changed. She cites reports by an aide and LVNs of R1's experiencing significant pain and her knee looking different (bent), as well as red and swollen. *Id.* 15-17. An LVN gave R1 Tylenol, but did not record it on the medication administration record.

The ALJ discusses the discrepancy between the LVN's claim that she gave R1 Tylenol and the medication administration record, which does not show that medication was given, noting that both statements cannot be accurate and that neither inference she might draw (that the LVN did not provide medication to the resident from 11:30 a.m. to 10:27 p.m. or that the medication records are not accurate) "is particularly favorable to Petitioner." *Id.* 17.

Judge Hughes accepts, for purposes of summary judgment, the Director of Nursing's (DON) statement that the aide who reported to her that R1 was yelling did not indicate anything was wrong with R1. *Id.* 18.

A pain assessment on January 30 indicated a pain intensity of 10, the highest level. X-rays taken January 31 showed "diffuse demineralization (loss of bone mineral density)" and bursitis on the knee. R1's care plan was amended to reflect the resident's new diagnoses. *Id.* 19.

Judge Hughes concludes that undisputed evidence established that staff identified something wrong with R1 on January 29 – a significant change in her condition – but that staff did not immediately consult R1's physician, inform R1's family, or record the information in R1's

record. *Id.* She rejects the facility’s gratuitous attack on the agency aide, who did what was required and reported R1’s condition to the DON. *Id.*

Between January 30 and February 3, “R1 continued to experience redness, swelling, and pain in her right knee, which staff treated with the low dose Tylenol.” *Id.* On February 3, an LVN faxed R1’s physician that R1’s right hip was swollen, but he did not respond – the ALJ notes that sending a fax to the physician’s order is not required “consultation” – and the physician did not learn of R1’s changed condition for many hours. *Id.* 19-20.

Sometime on February 6, R1 was inconsolable and an aide identified a bruise on R1’s inner thigh, which was not reported to R1’s physician. *Id.* 21. Finally, on February 7, R1 had x-rays taken, which showed that R1 had “an acute right hip fracture.” *Id.* 22. R1 was sent to the hospital.

Judge Hughes rejects the facility’s argument that five categories of factual dispute precluded summary judgment. *Id.* 22-23. She concludes:

The undisputed evidence establishes that facility staff repeatedly failed to follow facility policies and the instructions in the resident’s care plan when they failed to consult immediately the resident’s physician and failed to notify her family or representative of changes in her condition. On all three occasions, the resident was in considerable pain for many hours before staff acted. LVN Willett did not record changes in the resident’s medical record. She either failed to administer pain medication or she administered it and failed to record it. The facility delayed reporting and investigating the bruise on R1’s thigh.

Any one of these failings puts the facility out of substantial compliance with section 483.25.

Id. 24.

Judge Hughes sustains the penalty as reasonable, describing the CMP as modest and the facility’s “less-than-stellar history” (multiple deficiencies cited in 2017 and 2018). *Id.* 24-26.

The 26-page decision is available at <https://www.hhs.gov/about/agencies/dab/decisions/alj-decisions/2021/alj-cr5935/index.html> and from the Center for Medicare Advocacy, on request.

18. DECIDING INDIANA NURSING FACILITY’S APPEAL ON THE WRITTEN RECORD, ALJ ANDERSON SUSTAINS IMMEDIATE JEOPARDY ABUSE DEFICIENCIES CITED AT FACILITY IN 2019; SUSTAINS PER DAY CIVIL MONEY PENALTIES TOTALING \$19,124

At 10:32 p.m. on January 8, 2019, Resident B texted the activity director at Lindberg Crossing Senior Living that a female facility employee, a housekeeper, performed an oral sexual act on him. The activity director reported the incident to the administrator the next morning. The administrator conducted an investigation, concluded that the sexual contact was consensual, and

fired the employee. She did not report the incident or the results of her investigation to the state survey agency. A complaint filed with the Indiana state survey agency led to a complaint survey on January 24-25, 2019. The survey agency notified the facility of its determination of immediate jeopardy. The Centers for Medicare & Medicaid Services (CMS) cited two abuse related deficiencies – failure to protect a resident from abuse, 42 C.F.R. §483.12(a)(1), F600; failure to report allegations, §483.12(c)(1), (4), F609 – and imposed per day civil money penalties (CMPs) – \$16,044, January 24, 2019; \$110, January 25-February 21, 2019 – totaling \$19,124 and denial of payment for new admissions (DPNA) (effective March 3, 2019). Another complaint survey, conducted February 12-13, 2019, resulted in three level D deficiencies – reporting alleged violations, §483.12(c)(1), (4), F609; investigating alleged violation, §483.12(c)(2)-(4), F610; and transfer and discharge requirements, §483.15(c)(1)(i)(ii)(2)(i)-(iii), F622. After the facility requested informal dispute resolution, the state changed the effective date of DPNA to March 26, 2019 and deleted a deficiency, cited January 2, 2019, for unnecessary psychotropic medications/PRN use, §483.45, F758. Administrative Law Judge (ALJ) Scott Anderson decided the facility’s appeal on the written record and sustains the abuse deficiencies and CMPs. *Lindberg Crossing Senior Living v. CMS*, Docket No. C-19-836, Decision No. CR5930 (Aug. 19, 2021).

Editor’s Note: As of April 11, 2022, the facility (now called Envive of Anderson) has three stars in health inspections, two stars in staffing, and one star in quality measures. Its overall rating is two stars. The one-star rating in quality measures reduced the facility’s overall rating from three stars, based on health inspections, to two stars.

Envive is owned by the county. Its legal business name is Witham Memorial Hospital.

As of April 11, 2022, *Care Compare* does not report either the January 24-25, 2019 complaint survey or the CMP of \$19,124.

Judge Anderson did not address the February deficiencies, finding that the facility did not appeal them. Decision 11.

The administrator told the activity director that she should have immediately reported Resident B’s text, “even though he had indicated he was joking, due to the need to initiate an investigation into possible inappropriate conduct by an employee. *Id.* 12. During her investigation of the incident on January 9, the administrator interviewed Resident B, who confirmed the incident and appeared happy about it. The housekeeper admitted that she sent nude pictures of herself to the resident while she was off-duty and intoxicated, but denied performing oral sex on the resident. The administrator terminated the housekeeper’s employment. The social services director called Resident B’s mother, his guardian, who said he was “not innocent in all of this.” *Id.* 13. In a second call on January 9, the social services director asked Resident B’s mother if she wanted to press criminal charges. She said no, describing her son as a “willing participant” in whatever had happened. *Id.* The facility notified the police of the incident, but the officer who went to the facility “declined to investigate or file a report because the officer did not believe that Resident B had alleged abuse and Resident B’s legal guardian did not want to pursue an investigation.”

The administrator did not believe that the housekeeper had conducted a sexual act on Resident B; the resident signed a declaration that the housekeeper had sent him nude photographs of herself and performed oral sex on him; and the activity director stated in her declaration that she did not believe that Resident B alleged sexual abuse. *Id.* 14.

The ALJ sustains the abuse deficiency, §483.12(c)(1), (4), finding that the activity director failed to report the allegation to the administration within two hours and the administrator did not report the allegation to the state survey agency either when she learned of it or after she completed her investigation. *Id.* 16-23. He cites the language of the federal regulations, state regulations, and the facility's policy. *Id.* 16-17.

Judge Anderson rejects the facility's primary defense, which he describes as that "as a matter of law, there was no sexual abuse because sexual abuse is only non-consensual sexual contact." *Id.* 17. The ALJ quotes the facility's abuse prohibition, reporting and investigation policy, which defines abuse to include any sexual contact between residents and staff. *Id.*

The facility cited the mother's statement, that Resident B makes his own decisions about personal relationships, *id.* 18, and the activity director's declaration that he thought Resident B was joking, *id.* 18-19. It also argued that its definition of any sexual contact between a resident and staff member as abuse is more stringent than the federal or state regulations, so that "holding Petitioner to a higher standard than required by any federal regulation is contrary to public policy," *id.* 19.

Judge Anderson finds that the evidence supports the finding that the sexual act occurred, but finds that even if it had not occurred, Resident B's text to the activity director alleged sexual abuse, as defined by the state agency and the facility's policy, and should have been reported immediately to the administrator. *Id.* 19-20. The ALJ also finds that the administrator failed to report the incident to the state agency both immediately, or after her investigation, as required. *Id.* 21. Moreover, the nude photographs that the housekeeper sent to resident B "alone constituted sufficient evidence of alleged sexual abuse to require reporting." *Id.*

The ALJ rejects the facility's arguments that Resident B consented. *Id.* 22. He focuses on the failures of the activity director and administrator. He does not address the facility's argument that it is not responsible for the actions of the housekeeper when she was acting outside the scope of her employment when he had sexual contact with Resident B and sent him nude photographs of herself. *Id.* 23.

Judge Anderson sustains CMS's determination of immediate jeopardy as not clearly erroneous. *Id.* 23-25. He also sustains the CMPs, citing the facility's extensive history of noncompliance (with six G-level and two J-level deficiencies cited, going back to 2006) and culpability. *Id.* 26-28.

The 29-page decision is available at <https://www.hhs.gov/about/agencies/dab/decisions/alj-decisions/2021/alj-cr5930/index.html> and from the Center for Medicare Advocacy, on request.

19. FOLLOWING VIDEO TELECONFERENCE, ALJ WEYN SUSTAINS HARM-LEVEL ACCIDENT HAZARDS/SUPERVISION DEFICIENCIES CITED AT ILLINOIS NURSING FACILITY IN 2017; SUSTAINS PER DAY CIVIL MONEY PENALTIES TOTALING \$37,875

On December 30, 2016, Symphony at 87th Street, a Chicago nursing facility, self-reported to the state survey agency that Resident 1A had experienced a fall with serious physical injury. Following a survey by the state survey agency on January 6, the Centers for Medicare & Medicaid Services (CMS) cited a deficiency in supervision, 42 C.F.R. §483.25(d)(1)(2), (n)(1)-(3), F323, level G, and imposed a \$500 per day civil money penalty (CMPs) beginning January 6, denial of payment for new admissions, beginning April 6, and termination, if the facility did not achieve substantial compliance by July 6.

On February 27, 2017, the facility self-reported a second incident of fall with serious physical injury that occurred on February 26. The survey completed by the state survey agency on March 7 found that the facility remained out of substantial compliance. The facility returned to substantial compliance as of March 22, 2017. CMS imposed a CMP, January 6-March 21, 2017, totaling \$37,875.

Administrative Law Judge (ALJ) Leslie A. Weyn held a video teleconference for the consolidated appeals on November 29, 2018. She sustains the deficiency and CMP. *Symphony at 87th Street v. CMS*, Docket No. C-17-837, Decision No. CR5927 (Aug. 18, 2021).

Editor’s Note: As of April 8, 2022, *Care Compare* reports that the facility has two stars in health inspections, one star in staffing, and five stars in quality measures. Its overall rating is two stars. The reduction of one star because of the low staffing rating is offset by the five-star rating in quality measures, which added one star.

The 2017 surveys and CMPs are not reported on *Care Compare*, as of April 8. They are beyond the three-year window.

There are 17 nursing facilities in Illinois with the name Symphony:

Facility	Overall rating	Health inspection rating	Staffing rating	Quality measure rating	Penalties
87 th Street (Chicago)	2	2	1	5	2 CMPs totaling \$35,650: Feb. 8, 2021: \$650; Aug. 18, 2020: \$35,000 Denial of payment for new admissions (DPNA), Aug. 18, 2020
Midway (Chicago)	1	2	1	4	6 CMPs totaling \$57,937: Jun. 21, 2021: \$1,625; Nov. 9, 2020: \$1,625; Oct. 26, 2020: \$975; Aug. 11, 2020: \$3,250; Jun. 8, 2020: \$650; Dec. 10, 2019:

					\$9,812
At the Tillers (Oswego)	2	2	3	4	1 CMP: Jun. 10, 2021: \$31,154
Encore (Chicago)	2	1	2	5	6 CMPs totaling \$68,815: Jun. 28, 2021: \$1,310; Jun. 21, 2021: \$983; Feb. 8, 2021: \$650; Jan. 20, 2021: \$20,000; Aug. 25, 2020: \$35,000; Mar. 22, 2019: \$11,873
Evanston Healthcare (Evanston)	4	4	2	4	N/A
Maple Crest (Belvidere)	3	3	2	2	N/A
Northwoods (Belvidere)	5	4	2	5	N/A
Bronzeville (Chicago)	1 Abuse icon	1	1	2	9 CMPs totaling \$314,971: Aug. 16, 2021: \$1,300; Jul. 30, 2021: \$56,575; Jun. 7, 2020: \$53,215; Feb. 22, 2021: \$983; Feb. 5, 2021: \$158,620; Dec. 14, 2020: 4650; Oct. 18, 2020: \$5,000; Aug. 4, 2020: \$25,245; Mar. 12, 2020: \$13,383 DPNA, Feb. 5, 2021
Buffalo Grove (Buffalo Grove)	3	3	3	4	3 CMPs totaling \$110,050: Jun. 23, 2021: \$95,460; Feb. 5, 2020: \$7,296; Sep. 19, 2019: \$7,296
Chicago West (Chicago)	2	1	1	5	7 CMPs totaling \$309,781: Jun. 28, 2021: \$983; Mar. 26, 2021: \$194,910; Mar. 26, 2021: \$20,000; Jan. 29, 2021: \$9,750; Jan. 25, 2021: \$650; Sep. 1, 2020: \$20,000; May 31, 2019: \$63,488, DNPA, Mar. 26, 2021
Crestwood (Crestwood)	2	2	2	2	1 CMP totaling \$5,000: Dec. 18, 2020: \$5,000
Hanover Park (Hanover Park)	5	4	2	5	3 CMPs totaling \$30,650: Jul. 29, 2021: \$15,000; Apr. 12, 2021: \$650; Jan. 21, 2021: \$15,000
Morgan Park (Chicago)	1	2	1	4	4 CMPs totaling \$46,625: Aug. 19, 2021: \$20,000; Jun. 21, 2021: \$975; Jun. 21, 2021: \$650; Aug. 14, 2020: \$15,000

					DPNA, Feb. 26, 2021
Orchard Valley (Aurora)	2	2	3	3	N/A
South Shore (Chicago)	1	1	2	4	7 CMPs totaling \$71,903: Aug. 13, 2021: \$26,760; Jul. 5, 2021: \$1,300; Jun. 28, 2021: \$983; Jun. 21, 2021: \$650; Feb. 25, 2021: \$15,000; Nov. 19, 2020: \$20,000; Jun. 20, 2019: \$7,210, DPNA, Nov. 19, 2020
Palos Park (Palos Park)	2	3	1	2	2 CMPs totaling \$1,625: Jun. 28, 2021: \$975; Dec. 7, 2020: \$650

As shown below, there are some significant differences between the seven Chicago and nine non-Chicago facilities, although none of the 16 facilities has a staffing rating above three stars and 13 facilities have staffing ratings of one or two stars.

- Chicago facilities are all one or two stars in health rating, staffing, and overall rating, but six of the seven facilities have four or five stars in quality measures. All seven facilities have had CMPs imposed, which total \$907,317.
- Non-Chicago facilities have some threes and fours in health ratings and slightly higher staffing ratings (three facilities have three stars). Five of the nine facilities have four or five stars in quality measures. Four of the nine facilities have had CMPs imposed, which total \$176,844.

Facility	Number of facilities, Overall rating	Number of facilities, Health rating	Number of facilities, Staffing rating	Number of facilities, Quality measure rating	Total CMPs
Chicago 7 facilities	1-star: 5 2-stars: 2	1-star: 4 2-stars: 3	1-star: 5 2-stars: 2	2-stars: 1 4-stars: 3 5-stars: 3	\$907,317
Non-Chicago 9 facilities	2-stars: 4 3-stars: 2 4-stars: 3	2-stars: 3 3-stars: 3 4-stars: 3	1-star: 1 2-stars: 5 3-stars: 3	2-stars: 3 3-stars: 1 4-stars: 3 5-stars: 2	\$176,844

The deficiency discussed in the ALJ's decision was based on the care provided to the two residents.

The facility assessed Resident 1A as at risk for falls when she was admitted on February 25, 2013. Her June 13, 2016 care plan noted her potential for falls and identified various interventions, including checking on her frequently and keeping her area clutter-free. Her December 12, 2016 quarterly assessment described Resident 1A as completely relying on staff for activities of daily living, although alert and oriented. Decision 6-8. The resident rated making choices about dressing and bathing as important to her; she also wanted to be able to use the phone in private. *Id.* 8.

On December 29, 2016, Resident 1A fell out of her bed. The facility informed the resident's family and physician of her fall, found a small abrasion on the right side of her head, and sent her to the emergency room when she complained of pain to her right shoulder. The hospital diagnosed Resident 1A with a right clavicle fracture. *Id.* 9.

The facility "completed a post-fall 'huddle' form, dated December 29, 2016," but did not propose new interventions. *Id.* The facility self-reported the incident to the Illinois Department of Public Health (IDPH) on December 30 and sent a follow-up report on January 3, 2017, describing the ongoing investigation and actions being taken. *Id.* 9-10.

The state's investigation on January 6, 2017 included interviews with the certified nurse assistant (CNA), who described leaving the resident to get a nurse to change the resident's soiled wound dressing, and with the Director of Nursing (DON), who said that the resident needs two staff members for assistance and that she instructed staff to make sure residents were properly positioned in bed. *Id.* 10, 11.

Resident 1B was admitted to the facility on February 16, 2017. The 85-year old man had multiple medical conditions and was severely cognitively impaired and non-ambulatory. His care plan of February 16 indicated that he was at risk of injury from falls. The care plan of February 20 noted that he refused meals and medications and was not compliant with his care plan. From February 17-25, Resident 1B's blood sugar fluctuated from 73 mg/dL and 150 mg/dL. A late entry dated February 25 documented a blood sugar reading of 50. The facility notified the physician, who ordered a glucagon injection. Forty minutes later, the resident's blood sugar was 240. *Id.* 11-13.

On February 26, the resident fell out of his wheelchair in the dining room. The facility notified the physician and family and sent Resident 1B to the hospital, where a CT scan reveals "nondisplaced fractures," but no acute fractures. *Id.* 13.

The facility did an internal investigation, which identified an episode of hypoglycemia (a longstanding problem that preceded his nursing home residency) as the cause of the resident's fall, and faxed an initial report to IDPH on February 27. *Id.* 14.

The state's March 7 investigation included an interview with the CNA who attempted to stop the resident's fall, but could not get to him in time, as she was the only staff member in the small side of the dining room; another CNA, who said that Resident 1B had been attempting to get out of his wheelchair "multiple times that morning and should have been more closely monitored," *id.* 15; the DON, who said that "at mealtimes, all staff, including licensed nurses (7-10 additional

people) should be in the dining room assisting,” *id.*; and a licensed practical nurse (LPN), who completed the incident report and described Resident 1B as “always agitated, angry” and that she was not surprised that he fell, *id.* 16.

Sustaining the deficiency at §483.25(d)(1), (2), Judge Rogall cites Departmental Appeals Board decisions interpreting the regulatory requirement and finds that the facility failed to provide appropriate supervision and assistance to both residents. *Id.* 16-24.

The ALJ rejects the facility’s arguments that it could not have foreseen that Resident 1A would fall, citing the June 2016 care plan identifying the resident as at risk for falls, the resident’s inability to reposition herself, and the resident’s concern with privacy and autonomy. *Id.* 18-19.

She also rejects the facility’s argument that the MDS was not a care plan, noting that although an MDS and care plan have different purposes, the MDS indicated that the resident needed a two-person assist. *Id.* 19. While Resident 1A’s service plan indicated that the resident needed one-person assistance for bed mobility, it indicated that she needed two-person assistance for toileting. At the time of her fall, only one CNA was assisting Resident 1A. *Id.* 19-20.

Third, the resident’s care plan was “largely generic” and did not identify all interventions that Resident 1A needed. *Id.* 20. Fourth, the surveyor’s thought process, criticized by the facility, is immaterial when the ALJ reviews the evidence *de novo*. *Id.* Finally, the facility’s argument that it could not keep the resident safe was a “straw man,” when the facility could have provided two-person assistance during toileting. The aide should not have left the resident alone to get a nurse; she could have used a call bell. *Id.* 21.

The ALJ makes a similar detailed analysis for Resident 1B. *Id.* 21-24. She rejects the facility’s claim that the resident’s fall was unforeseeable because he did not have a history of falls, noting that the resident had experienced falls prior to his admission. The facility should have anticipated that Resident 1B could experience an episode of hypoglycemia at any time, as he had in his prior hospital stay just before his admission to the facility. Staff failed to monitor Resident 1B’s blood sugar levels as frequently or consistently as ordered by the physician. There were too few staff in the dining room and the CNA who tried to prevent the resident from falling did not know the resident.

Judge Rogall sustains the CMP as reasonable in amount and duration. *Id.* 24-26.

The 27-page decision is available at <https://www.hhs.gov/about/agencies/dab/decisions/alj-decisions/2021/alj-cr5927/index.html> and from the Center for Medicare Advocacy, on request.

20. DECIDING INDIANA NURSING FACILITY’S APPEAL ON THE RECORD, ALJ ROGALL SUSTAINS THREE ABUSE-RELATED DEFICIENCIES AND CARE PLAN DEFICIENCY CITED AT THE FACILITY IN 2017; SUSTAINS PER DAY CIVIL MONEY PENALTIES TOTALING \$99,990

Following a survey at Alexandria Care Center by the Indiana state survey agency, completed September 1, 2017, the Centers for Medicare & Medicaid Services (CMS) cited three-abuse

related deficiencies – (1) freedom from abuse, 42 C.F.R. §483.12(a)(1), F223, level G; (2) investigate/report alleged violations, §§483.12(a)(3)-(4) and 483.12(c)(1)-(4), F225, level D; and (3) develop/implement abuse/neglect policies, §483.95(c)(1)-(3), F226, level D – and a comprehensive care planning deficiency, §§483.20(d) and 483.21(b)(1), F279, level D, and imposed per day civil money penalties (CMPs) – \$505, March 11, 2017-September 24, 2017 – totaling \$99,990. Deciding the facility’s appeal on the record, Administrative Law Judge (ALJ) Leslie C. Rogall sustains the four deficiencies and the CMPs. *Alexandria Care Center v. CMS*, Docket No. C-18-951, Decision No. CR5924 (Aug. 17, 2021).

Editor’s Note: As of April 7, 2022, the facility has three stars in health inspections, two stars in staffing, and three stars in quality measures on *Care Compare*. Its overall rating is three stars.

The 2017 survey and CMPs are more than three years old, so they are not reported on *Care Compare* as of April 7, 2022.

On March 11, 2017, the facility cited an incident in which Resident H was verbally aggressive, made negative statements to his wife, who was his roommate, Resident M, and exhibited agitation. Resident M was crying. On March 20, the Social Services Director (SSD) documented “numerous complaints” by Resident M that she becomes upset when her husband becomes agitated. Decision 6. The SSD “educated” Resident H about the “effect [his] behavior has on wife,” but did not revise Resident H’s care plan. *Id.* 7.

Judge Rogall discusses at length the federal abuse regulations, State Operations Manual, and decisions of the Departmental Appeals Board about abuse. *Id.* 7-8. She also discusses the facility’s abuse prevention policy, which, unlike the federal definition, does not require that a victim suffer mental anguish from verbal abuse and which defines abuse as “Oral, written and/or gestured language that willfully includes disparaging and/or derogatory terms to residents or their families, or within their hearing distance, regardless of their age, ability to comprehend, or disability.” *Id.* 9. The facility’s policy requires thorough investigations and immediate reports of allegations of abuse to the administrator. *Id.*

The ALJ finds that, beginning March 11, 2017, the facility did not protect Resident M’s right to be free from abuse, in violation of §483.12(a)(1). *Id.* Although the facility argued that Resident M said there was no verbal abuse, Judge Rogall notes that Resident M testified, and only after Resident H’s death, that “his ‘*use of profanity*’ never upset [her] and never caused ‘her any distress’ and that she ‘never considered [Resident H’s] *use of profanity* during the time that we were both residents at Alexandria Care Center to be abusive to [her] [*italics in original.*]” The ALJ notes that use of profanity was not at issue. *Id.* 10-11.

Judge Rogall observes that “a victim may deny that abuse has occurred.” *Id.* 11. She was not persuaded by the Resident M’s daughter’s testimony that her mother did not find Resident H abusive, noting that Resident M did not state that she was not abused and that, in any case, Resident M’s view is not “dispositive.” *Id.* The administrator’s testimony that the residents wanted to be together in the same room does not support the absence of abuse. *Id.* 12. The ALJ concludes, “Verbal aggressiveness and negative statements directed at a resident that cause that

resident to cry raises, at a minimum, an allegation of abuse that requires action to ensure that Resident M remains free of abuse.” *Id.* The facility failed to investigate the incident, and its failures included failing to document the incident, obtain witness statements, notify Resident M’s physician, and monitor the resident.

Following the March 2017 incident, the facility continued to document Resident H’s verbal behavioral symptoms but not to take action to protect Resident M. *Id.* 13-14.

The facility did not report allegations of abuse to the administrator or state survey agency, in violation of §483.12(c)(1)-(4). *Id.* 15-16. By failing to investigate allegations of abuse, the facility also failed to implement its abuse policy, as required by §§483.12(b)(1)-(3), 483.95(c)(1)-(3). *Id.* 16-17.

Judge Rogall sustains CMS’s determination that the facility remained out of compliance from March 12, 2017 through September 24, 2017, the completion date for the facility’s plan of correction for the deficiencies. *Id.* 17. She rejects the facility’s contention that the survey was flawed because surveyors did not interview Resident M, noting both that Resident M’s denial (which was related solely to profanity) is immaterial to the deficiency and that even a flawed survey does not invalidate deficiencies. She also rejects the facility’s argument that the deficiency “somehow infringe[d] on the right of a husband and wife to live together in the facility.” *Id.* 18.

The assessment deficiency, §§483.20(d), 483.21(b)(1), was based on the failure to do appropriate care planning for a resident with a history of sexually inappropriate behavior. *Id.* 19-20.

Judge Rogall sustains the CMP as reasonable for “multiple deficiencies involving repeated failures.” *Id.* 21.

The 22-page decision is available at <https://www.hhs.gov/about/agencies/dab/decisions/alj-decisions/2021/alj-cr5924/index.html> and from the Center for Medicare Advocacy, on request.

21. DECIDING MISSOURI NURSING FACILITY’S APPEAL ON THE WRITTEN RECORD, ALJ KESSEL SUSTAINS FIVE DEFICIENCIES CITED AT NURSING FACILITY IN 2019; SUSTAINS PER DAY CIVIL MONEY PENALTIES TOTALING \$101,000

Deciding Riverside Nursing and Rehabilitation Center’ appeal on the written record, Administrative Law Judge (ALJ) Steven T. Kessel sustains five deficiencies cited at Missouri nursing facility and per day civil money penalties (CMPs) – \$2,200, December 17, 2019-February 4, 2020 – totaling \$101,000. *Riverside Nursing and Rehabilitation Center v. CMS*, Docket No. C-21-144, Decision No. CR5921, p. 4 (Aug. 13, 2021). The decision does not identify the date of the survey by the state survey agency.

Editor’s Note: As of April 6, 2022, *Care Compare* identifies the facility as a Special Focus Facility, so it has no star ratings.

Care Compare does not appear to include the survey and deficiencies that the ALJ discusses. The relevant survey period would seem to be the standard survey conducted November 22, 2019 and complaints for the period March 1, 2019-February 29, 2020. There is one only complaint survey in that complaint period, dated July 10, 2019, which is too early soon to include the deficiencies discussed here. The more recent standard survey, dated March 26, 2021, with the related complaints for the period March 1, 2020-February 28, 2021, does not report any complaint surveys.

Resident 1 (R1) was a 49 year old man who was readmitted to Riverside Nursing and Rehabilitation Center on December 10, 2019. In a previous admission to the facility, R1 had received hospice care. When he was readmitted to the Missouri nursing facility, following surgery on his amputation wounds, he returned for palliative care, not hospice care. The ALJ finds that the parties incorrectly used hospice and palliative care interchangeably. Palliative care, while not specifically defined in the federal regulations, was defined in R1's consent form with the facility to include nursing, dietary, and social services that are "necessary for the resident to be in a safe comfortable environment." Decision 4. Judge Kessel writes:

By any measure, Resident 1's stay at Petitioner's facility beginning with December 5, 2019, was an abject failure to promote improvement of, much less recovery from, the resident's surgical wounds. That stay ended on January 7, 2020, when the resident was readmitted to a hospital. On that date, the hospital staff found that the resident had a: "horrific wound on his [left] leg with necrotic femur protruding through necrotic surrounding tissue."

Decision 4. Sustaining deficiencies cited at 42 C.F.R. §§483.12 (neglect) and 483.25 (quality of care), Judge Kessel writes that R1 deteriorated during the month and "The deterioration was neither subtle nor hidden," described in nurses' notes on December 16 (when R1's wounds showed signs of infection), 20, 22, 26, 29 (describing exposed bone). *Id.* 5. R1 was uncooperative with his care and the ALJ had "no doubt that his behavior contributed to the dramatic deterioration of his surgical wound." *Id.* Judge Kessel also infers that R1 picked at his wounds because he was in pain, noting that R1 told a staff member that he was in pain on December 11.

R1 did not see a physician as his "leg wound dramatically deteriorated." *Id.* Staff cancelled scheduled appointments with a wound specialist because, the Director of Nursing (DON) told the surveyor, R1 was receiving palliative care. *Id.* 6. In a later written declaration, the DON stated that R1 made and cancelled his own appointments with physicians. Although the evidence about who cancelled appointments with the wound specialist and oncologist were contradictory, Judge Kessel finds that "The weight of the evidence supports the conclusion that Resident 1 canceled his physicians' appointments or that he asked Petitioner's staff to cancel the appointments." *Id.* However, he finds that the evidence also supports the conclusion that staff did not encourage R1 to keep his appointments because he was receiving palliative care. He finds, "For Petitioner's staff, palliative care was a shorthand for trying to keep the resident comfortable and not doing much else for him." *Id.* 7.

Judge Kessel finds that the facility should have (1) provided R1 with actual palliative care, including providing assistance to relieve symptoms, including pain, (2) assessed why R1 was uncooperative, and (3) sought “expert advice [from the wound specialist] concerning how to halt or reverse the decline.” *Id.* The nurse practitioner’s visit on December 30, which included an order for antibiotics, was “too little and too late.” *Id.*

The ALJ rejects the facility’s defenses – that R1 was, in the ALJ’s words, “the victim of his own choices” and that R1 received his prescribed treatments between December 30 and January 7 – as “without merit.” *Id.* 8. He describes R1’s care in January as “inadequate by any measure and Petitioner’s staff should have seen that it was” when R1’s “condition declined catastrophically” and staff did not seek any additional consultation. *Id.*

Sustaining the deficiency for a comprehensive written plan of care, §483.21(b)(1), based on the facility’s failure to satisfy care planning requirements for four residents, Judge Kessel first discusses the facility’s failures to refer to palliative care in R1’s care plan, to reassess R1 as he deteriorated, and to consider revising his care plan. *Id.* 9. The care plan for Resident 4 did not address the hospice services the resident was receiving and whether those services were appropriate. *Id.* Residents 8 and 9 were served foods that were prohibited by their therapeutic diets. *Id.* 9-10.

Section 483.70(o)(1)-(2) requires a written agreement between facilities and hospice providers that includes descriptions of which services the facility and hospice will each provide and that requires facilities to immediately inform the hospice of a significant change in the resident’s condition that might require a change in the resident’s care plan. The ALJ sustains the deficiency, but based on the care provided to only one of the four residents identified by CMS in the deficiency – Resident 7, who did not have the capacity, due to his dementia, to consent to hospice services. *Id.* 10-11.

The ALJ finds that the facility’s providing foods to Residents 8 and 9 that were prohibited by their therapeutic diets supported the deficiency cited at §483.60(d)(4)-(5). *Id.* 11-12.

Judge Kessel sustains the CMPs as reasonable in amount and duration for the non-jeopardy deficiencies, citing the seriousness of the deficiencies and the facility’s compliance history (four actual harm deficiencies three years earlier). *Id.* 12. He finds that the facility “deprived [R1] of a reasonable chance of recovery” due to neglect. *Id.* 13.

The 13-page decision is available at <https://www.hhs.gov/about/agencies/dab/decisions/alj-decisions/2021/alj-cr5921/index.html> and from the Center for Medicare Advocacy, on request.

FEDERAL LITIGATION

22. FEDERAL DISTRICT COURT IN NEW YORK APPROVES CLASS ACTION SETTLEMENT OF LAWSUIT BY FILIPINO NURSES CHARGING NURSING EMPLOYMENT AGENCY AND OTHERS WITH VIOLATIONS OF FEDERAL TRAFFICKING VICTIMS PROTECTION ACT; PLAINTIFF NURSES TO RECEIVE \$3,211,305.06

In 2017, Filipino nurses sued Prompt Nursing Employment Agency, Sentosacare, Sentosa Nursing Recruitment Agency, various individuals, and two nursing facilities, alleging that they violated the federal Trafficking Victims Protection Act (TVPA), 18 U.S.C. §§1589 *et seq.*, by recruiting them in the Philippines, employing them in the United States and then changing the terms of employment, and getting the nurses criminally prosecuted after they quit their jobs. The federal district court found that defendants were “liable under TVPA §1590(a) for recruiting, providing, or obtaining persons for labor in violation of the TVPA, and under TVPA §1594(b) for conspiracy to violate TVPA §§1589 and 1590.” *Paguirigan v. Prompt Nursing Home Employment Agency LLC d/b/a Sentosa Services, et al.*, No. 1:17-cv-01302-NG-CLP, page 4 (E.D.N.Y. Apr. 7, 2022).

The federal district court for the Eastern District of New York

- denied the motion to dismiss, 286 F.Supp.3d 430 (E.D.N.Y. 2017)
- certified the class, 2018 WL 4347799 (E.D.N.Y., Sep. 12, 2018)
- granted summary judgment to plaintiff class on liability, 2019 WL 4647648 (E.D.N.Y. Sep. 24, 2019), *aff'd in part, appeal dismissed in part*, 827 F.App'x 116 (2d Cir. 2020)
- granted summary judgment on compensatory damages, 2021 WL 2206738 (E.D.N.Y. Jun. 1, 2021)

Judge Nina Gershon approved the Settlement Agreement which requires defendants to pay \$3,000,000, increased (after a Fairness Hearing) to \$3,155,360.91 to reflect seven additional individuals included in the Settlement, *id.* 7, and then increased to \$3,211,305.06, *id.* 8, to reflect an additional class member, within 30 days. Each class member will receive “the full amount of compensatory damages awarded to them in my Damages Order, plus 9% annual interest.” Settlement 5. Named plaintiff Rose Paguirigan will receive an incentive fee of \$10,000. An award of attorneys’ fees may not exceed \$656,432.43. *Id.* 5.

Judge Gershon approved the Settlement as fair, reasonable, and adequate. *Id.* 9-13. She vacates only the portion of the Partial Judgment that found violation of TVPA and findings related to piercing of the corporate veil. “Punitive damages remain to be determined.” *Id.* 16.

Editor’s Note: The judge’s summary judgment decision is discussed in *Enforcement*, Issue No. 226, pp. 22-23 (Oct. 2019). Her denial of defendants’ motion to dismiss and certification of the class are discussed in *Enforcement*, Issue No. 228, pp. 13-15 (Dec. 2018). The complaint is discussed in *Enforcement*, Issue No. 209, pp. 23-24 (Mar. 2017).

The 17-page decision is available from the Center for Medicare Advocacy, on request.

STATE NEWS

23. NEW YORK ATTORNEY GENERAL LETITIA JAMES IS INVESTIGATING NURSING FACILITY WHERE SEVEN RESIDENTS DIED

As part of an investigation initiated in 2017 into abuse and neglect at Van Duyn Center for Rehabilitation and Nursing, including the deaths of seven residents, New York State Attorney General Letitia James has asked the Onondaga County state Supreme Court to require the nursing facility to comply with 22 subpoenas. James T. Mulder, “NY Attorney General investigating 7 deaths, financial fraud at Syracuse nursing home,” *The Post-Standard* (Mar. 29, 2022). The Syracuse newspaper has been investigating suspicious resident deaths, understaffing, and complaints at the nursing facility for a year. *The Post-Standard* reports that “A web of companies controlled by one of the owners of Van Duyn nursing home charged the troubled facility about \$60 million to provide food, management and other services from 2016 through 2020.” James T. Mulder, “How troubled Syracuse nursing home fed \$60 million into its owner’s corporate web,” *The Post-Standard* (Apr. 25, 2022).

The facility contends that it is not required to produce the subpoenaed documents because they are part of its quality assurance and performance improvement program.

Editor’s Note: In *State ex rel. Boone Retirement Center, Inc. v. Hamilton*, 946 S.W.2d 740 (1997), the Missouri Supreme Court, en banc, held that the privilege against providing documents is narrow and applies only to the quality assurance committee’s “own records, its minutes, or internal working papers or statements of conclusions from discovery.” The privilege “does not extend to records and materials generated or created by persons or entities operating outside the quality assurance committee. The grand jury may subpoena such records and material and may require Boone to produce them.”

<https://law.justia.com/cases/missouri/supreme-court/1997/79728-0.html>

Boone was about the quality assessment and assurance committee, now replaced in the federal regulations, by the term quality assurance and performance improvement. The same interpretation of privilege may apply.

Van Duyn Center for Rehabilitation and Nursing

The most recent data for Van Duyn Center for Rehabilitation and Nursing (*Care Compare* website visited Mar. 30, 2022) indicate five no-harm health deficiencies – 4 D and 1 E – at the facility for the most recent standard survey (which was also a complaint survey) on June 21, 2021. Three additional complaint surveys between March 1, 2021 and February 28, 2022 cited five health deficiencies, including one actual harm deficiency (in bold font):

May 11, 2021: **1 G**

Aug. 13, 2021: 2 D

Oct. 19, 2021: 2 D

As of March 30, 2022, the facility had one star in health surveys, two stars in staffing, and three stars in quality measures (four stars for short-stay residents, three stars for long-stay residents) on *Care Compare*. Its overall rating is one star.

Editor's Note: It is not clear why the facility received four stars for short-stay residents in its quality measure rating, when it had worse performance on three of the five categories for short-stay residents.

Care Compare indicates that four civil money penalties (Jun. 17, 2021: \$983; May 11, 2021: \$20,368; Dec. 7, 2020: \$655; and Feb. 18, 2020: \$13,380) totaling \$35,386, and no denials of payment for new admissions were imposed against the facility in the prior three years. Eleven complaint surveys or facility-reported incident surveys in the prior three years resulted in 29 health deficiencies, including two actual harm deficiencies (in bold font):

Aug. 27, 2019: 2 D
Oct. 4, 2019: 1 D

Feb. 18, 2020: 2 D, **1 G**
Oct. 30, 2020: 4 D
Nov. 19, 2020: 1 D, 1 E
Dec. 9, 2020: 1 D

Jan. 5, 2021: 2 D
May 11, 2021: **1 G**
Jun. 21, 2021: 6 D, 3 E
Aug. 13, 2021: 2 D
Oct. 19, 2021: 2 D

Four quality measures reflect influenza vaccinations. The facility reported worse performance on all four measures.

Of the other quality measures used to calculate the quality measure star rating, the facility reported better performance on six measures and worse performance on eight measures. **Van Duyn Center for Rehabilitation and Nursing reports that 2.3% of its short-stay residents took antipsychotic drugs, compared to the statewide average of 1.6%. It also reports that 20.1% of its long-stay residents took antipsychotic drugs, compared to the statewide average of 11.6%.**

Staffing

Van Duyn Center for Rehabilitation and Nursing reports considerably lower RN hours, considerably lower LPN hours, and considerably lower CNA hours, compared to statewide averages.

Van Duyn Center for Rehabilitation and Nursing reports considerably lower weekend RN coverage and considerably lower total weekend nurse staff coverage, compared to statewide averages.

Van Duyn Center for Rehabilitation and Nursing reports considerably higher RN turnover, considerably higher nursing staff turnover, and considerably higher administrator turnover, compared to state averages.

	Van Duyn Center for Rehabilitation and Nursing	State average in New York	National average
RN hours	28 minutes [sic]	42 minutes	42 minutes
LPN/LVN hours	37 minutes [sic]	47 minutes	53 minutes
CNA hours	1 hour 18 minutes [sic]	2 hours 1 minute	2 hours 11 minutes
Total nurse staff hours	2 hours 23 minutes	3 hours 29 minutes	3 hours 46 minutes
Physical therapy staff hours per resident per day	3 minutes	7 minutes	4 minutes
NEW	NEW	NEW	NEW
Weekend, RN staff	15 minutes [sic]	26 minutes	29 minutes
Weekend, total nurse staff	1 hour 58 minutes [sic]	2 hours 59 minutes	3 hours 16 minutes
Turnover RN	62.5%	46.2%	49.8%
Turnover, total nursing staff	54.9%	44.1%	51.6%
Turnover, Administrator	4	0.7	1.1

“NY Attorney General investigating 7 deaths, financial fraud at Syracuse nursing home” and “How troubled Syracuse nursing home fed \$60 million into its owner’s corporate web” are available from the Center for Medicare Advocacy, on request.

STATE ENFORCEMENT NEWS

CRIMINAL ENFORCEMENT

24. ILLINOIS NURSE PLEADS GUILTY TO RECKLESS MISCONDUCT FOR FAILING TO ASSESS NURSING HOME RESIDENT AND PROVIDE CPR

On August 1, 2017, the administrator of the Collinsville Rehabilitation and Healthcare Center “notified the Illinois State Police Medicaid Fraud Control Bureau of an allegation that [Christy] McCall neglected to provide proper care to a resident leading to the death of the resident.” Devese Ursery, “Belleville nurse convicted after the death of Collinsville nursing home resident,” *Belleville-News Democrat* (Apr. 14, 2022). The licensed practical nurse, originally

charged with criminal neglect of a resident resulting in injury and death for failure to administer live saving measures to Eunice Vancil, a resident, pleaded guilty to a misdemeanor of reckless conduct. McCall was sentenced to a year's probation "and ordered to pay fines and fees of \$1,039."

Collinsville Rehabilitation and Healthcare Center

The most recent data for Collinsville Rehabilitation and Healthcare Center (*Care Compare* website visited Apr. 14, 2022) indicate 16 no-harm and substantial compliance health deficiencies – 1 B, 5 D, 7 E, and 3 F – at the facility for the most recent standard survey (which was also a complaint survey) on September 14, 2021. Three additional complaint surveys between March 1, 2021 and February 28, 2022 cited seven no-harm health deficiencies:

Apr. 29, 2021: 2 D, 1 E, 2 F

Jul. 29, 2021: 1 D

Feb. 8, 2022: 1 F

As of April 14, 2022, the facility had one star in health surveys, one star in staffing, and two stars in quality measures (one star for short-stay residents, five stars for long-stay residents) on *Care Compare*. Its overall rating is one star.

Editor's Note: It is not clear why the facility received five stars for long-stay residents in its quality measure rating, when it had worse performance on four of the nine categories for long-stay residents.

Care Compare indicates that three civil money penalties (Apr. 29, 2021: \$13,000; Jun. 24, 2020: \$27,510; and Jan. 8, 2020: \$86,450) totaling \$126,960, and one denial of payment for new admissions (Jun. 24, 2020) were imposed against the facility in the prior three years. Nine complaint surveys or facility-reported incident surveys in the prior three years resulted in 26 health deficiencies, including three actual harm deficiencies (in bold font):

Mar. 5, 2019: 1 D

Mar. 21, 2019: 1 E

Sep. 12, 2019: 4 E

Jan. 8, 2020: 1 D, 3 E, 2 F, **3 G**

Jul. 2, 2020: 3 D

Nov. 9, 2020: 1 D

Feb. 26, 2021: 1 D

Apr. 29, 2021: 2 D, 1 E, 2 F

Jul. 29, 2021: 1 D

Four quality measures reflect influenza vaccinations. The facility reported better performance on all four measures.

Of the other quality measures used to calculate the quality measure star rating, the facility reported better performance on six measures, worse performance on seven measures, and information not available on one measure. **Collinsville Rehabilitation and Healthcare Center reports that 25.3% of its long-stay residents took antipsychotic drugs, compared to the statewide average of 18.7%.**

Staffing

Collinsville Rehabilitation and Healthcare Center reports considerably lower RN hours, considerably higher LPN hours, and higher CNA hours, compared to statewide averages.

Collinsville Rehabilitation and Healthcare Center reports considerably lower weekend RN coverage and lower total weekend nurse staff coverage, compared to statewide averages.

Collinsville Rehabilitation and Healthcare Center’s RN turnover and total nursing staff turnover rates are not available. The facility reports less administrator turnover, compared to state averages.

	Collinsville Rehabilitation and Healthcare Center	State average in Illinois	National average
RN hours	9 minutes [sic]	46 minutes	42 minutes
LPN/LVN hours	58 minutes [sic]	38 minutes	53 minutes
CNA hours	2 hours 3 minutes [sic]	1 hour 50 minutes	2 hours 11 minutes
Total nurse staff hours	3 hours 10 minutes	3 hours 14 minutes	3 hours 46 minutes
Physical therapy staff hours per resident per day	1 minute	4 minutes	4 minutes
NEW	NEW	NEW	NEW
Weekend, RN staff	11 minutes [sic]	33 minutes	29 minutes
Weekend, total nurse staff	2 hours 40 minutes [sic]	2 hours 47 minutes	3 hours 16 minutes
Turnover RN	NA	46.7%	49.8%
Turnover, total nursing staff	NA	50.6%	51.6%
Turnover, Administrator	1	1.8	1.1

“Belleville nurse convicted after the death of Collinsville nursing home resident” is available at <https://www.bnd.com/news/local/crime/article259696445.html> and from the Center for Medicare Advocacy, on request.

VOLUNTARY CLOSURE

25. SOUTH DAKOTA NURSING FACILITY TO CLOSE

Avantara Ipswich, one of 13 South Dakota nursing facilities owned by the Illinois company Legacy Health Care, has announced it will close on May 31, 2022, citing staffing shortages and challenges related to COVID-19. In April 2021, the state survey agency cited 13 deficiencies, in a 104-page survey report, at the 40-bed facility with 28 residents. Bart Pfankuch, “Pending closure and poor care at Ipswich nursing home latest outcomes of staffing crisis,” *South Dakota News Watch* (Apr. 17, 2022). Deficiencies included lack of staffing; significant weight loss (one resident lost 19 pounds in three weeks; another lost 18 pounds in three weeks); inadequate care for incontinence (residents were found soaked in urine); “and one elderly man had catheter problems that caused his penis to begin ‘eroding away.’” Surveyors cited failures to develop care plans for all residents, to implement toileting plans, and to document skin conditions and other issues. Unsafe or unsanitary conditions were cited. The clinical care coordinator was serving as interim director of nursing and as the person in charge of infection control.

Editor’s Note: As discussed below, *Care Compare* suggests that Avantara has 17 facilities in South Dakota. The company’s website reports 19 South Dakota nursing facilities. Legacy Health Care, <https://www.legacyhc.com/>, reports 61 nursing facilities in three states – Illinois (40 facilities), South Dakota (19 facilities), and Montana (2 facilities). The company website lists 300 available jobs, some with sign-on bonuses, <https://legacyhc.com/careers/>

South Dakota News Watch quotes the South Dakota Health Care Association’s director, Mark Deak, as describing the staffing problem that preceded the pandemic. Deak said that the industry may look to immigrants to hire, suggesting that “perhaps immigrants from Ukraine, fleeing the war in their country, could help fill employment gaps at South Dakota nursing homes.”

Nurse aides represent one of the most difficult positions for nursing homes to fill. In 2021, the average aide wage was \$14 an hour, or \$29,000 a year. *South Dakota News Watch* reports, “Many fast-food workers are being hired for higher pay in the current employment market, and they don’t have to manage elderly residents, provide them food, bathing and bathroom assistance, or go through the extensive training required of CNAs.” Training requirements, in South Dakota, are 75 hours of classroom and clinical instruction and completion of a competency evaluation, including “performing at least five nursing tasks on a live person.”

South Dakota News Watch reports that nursing homes lose more than \$50 per day for each Medicaid resident. In 2022, the Legislature allocated \$30 million to one-time funding for nursing homes, which “equals about a 20% bump in annual state funding to nursing homes, according to a legislative budget memo.” The Joint Committee on Appropriations encourages facilities to use the money, which they will receive by June 30, 2022, “for one-time expenses such as construction, debt payment or retention bonuses.” Deak described the \$30 million as “just a Band-Aid.”

In the past five years, South Dakota has seen “a handful of nursing home closures, mostly in rural areas.”

There are 17 nursing facilities with the Avantara name in South Dakota, which has 104 facilities:

Facility	Overall star rating	Health inspection star rating	Staffing star rating	Quality measure star rating	Civil Money Penalties (CMPs)
Arlington	3	2	4	4	N/A
Armour	3	2	4	2	2 CMPs: \$9,750, Sep. 15, 2021; \$3,250, Apr. 23, 2021, totaling \$13,000
Arrowhead	3	2	3	5	1 CMP: \$9,750, Jun. 9, 2020
Clark City	3	3	2	3	N/A
Groton	1	1	1	4	5 CMPs: \$30,628, Nov. 4, 2021; \$1,310, Jul. 5, 2021; \$983, Jun. 28, 2021; \$655, Jun. 21, 2021; \$20,111, Nov. 13, 2020, totaling \$53,687
Huron	2	2	3	3	1 CMP: \$3,250, May 13, 2021
Ipswich	1	1	3	1	2 CMPs: \$655, Jun. 28, 2021; \$59,543, Apr. 9, 2021; totaling \$60,098
Lake Norden	5	5	4	3	N/A
Milbank	4	4	2	4	N/A
Mountain View	3	3	3	3	2 CMPs: \$650, Aug. 18, 2021; \$9,750, Dec. 22, 2020; totaling \$10,400
North	2	3	3	1	1 CMP: \$655, Jun. 8, 2020
Norton	2	1	4	2	3 CMPs: \$3,250, Sep. 30, 2021; \$72,065, Sep. 30, 2021; \$46,654, Oct. 17, 2017; totaling \$121,969; Denial of

					payment for new admissions (DPNA), Sep. 30, 2021
Pierre	2	1	2	5	2 CMPs: \$3,250, Aug. 17, 2021; \$41,408, Jul, 10, 2019; totaling \$44,658
Redfield	3	3	3	2	N/A
Saint Cloud	2 Abuse icon	1	3	5	4 CMPs: \$9,750, Nov. 2, 2021; \$9,750, Dec. 16, 2020; \$3,250, Jul. 7, 2020; \$19,321, Sep. 19, 2019; totaling \$42,071; DPNA, Nov. 2, 2021
Salem	1	2	1	4	2 CMPs: \$18,200, Oct. 21, 2021; \$655, Aug. 23, 2021; totaling \$18,855
Watertown	4	4	4	4	N/A

Avantara Ipswich

The most recent data for Avantara Ipswich (*Care Compare* website visited Apr. 18, 2022) indicate 13 health deficiencies, including two actual harm deficiencies (in bold font) – 3 D, 4 E, 4 F, **1 G**, and **1 H** – at the facility for the most recent standard survey on April 9, 2021. There were no complaint surveys between March 1, 2021 and February 28, 2022.

As of April 18, 2022, the facility had one star in health surveys, three stars in staffing, and one star in quality measures (one star for short-stay residents, one star for long-stay residents) on *Care Compare*. Its overall rating is one star.

Care Compare indicates that two civil money penalties (\$655, June 28, 2021; \$59,543, Apr. 9, 2021) totaling \$60,198, and no denials of payment for new admissions were imposed against the facility in the prior three years. No complaint surveys or facility-reported incident surveys in the prior three years resulted in any health deficiencies.

Four quality measures reflect influenza vaccinations. The facility reported better performance on two measures and worse performance on two measures.

Of the other quality measures used to calculate the quality measure star rating, the facility reported better performance on five measures and worse performance on nine measures. **Avantara Ipswich reports that 11.5% of its short-stay residents took antipsychotic drugs,**

compared to the statewide average of 2.3%. It also reports that 44.1% [sic] of its long-stay residents took antipsychotic drugs, compared to the statewide average of 18.4%.

Staffing

Avantara Ipswich reports slightly lower RN hours, considerably higher LPN hours, and considerably lower CNA hours, compared to statewide averages.

Avantara Ipswich reports lower weekend RN coverage and considerably lower total weekend nurse staff coverage, compared to statewide averages.

Avantara Ipswich reports considerably higher RN turnover and considerably higher total nursing staff turnover rates, compared to statewide averages. The facility reports higher administrator turnover, compared to state averages.

	Avantara Ipswich	State average in South Dakota	National average
RN hours	45 minutes [sic]	50 minutes	42 minutes
LPN/LVN hours	42 minutes [sic]	27 minutes	53 minutes
CNA hours	1 hour 43 minutes [sic]	2 hours 16 minutes	2 hours 11 minutes
Total nurse staff hours	3 hours 10 minutes	3 hours 32 minutes	3 hours 46 minutes
Physical therapy staff hours per resident per day	0 minute	2 minutes	4 minutes
NEW	NEW	NEW	NEW
Weekend, RN staff	30 minutes [sic]	34 minutes	29 minutes
Weekend, total nurse staff	2 hours 32 minutes [sic]	3 hours 1 minute	3 hours 16 minutes
Turnover RN	66.7%	37.1%	49.8%
Turnover, total nursing staff	76.1%	53.0%	51.6%
Turnover, Administrator	1	0.7	1.1

“Pending closure and poor care at Ipswich nursing home latest outcomes of staffing crisis” is available at <https://www.keloland.com/news/local-news/pending-closure-and-poor-care-at-ipswich-nursing-home-latest-outcomes-of-staffing-crisis/> and from the Center for Medicare Advocacy, on request.

NURSING HOME INDUSTRY NEWS

26. IGNITE MEDICAL RESORTS EXPANDS INTO TEXAS WITH FOUR FACILITIES

McKnight’s Senior Living reports that Chicago-based Ignite Medical Resorts has expanded into Texas, leasing four facilities (Bridgemoor Transitional Care) from LTC Properties, a real estate

investment trust based in California. James M. Berkman, “Ignite Medical Resorts expands into Texas with 4 Bridgemoor facilities,” *McKnight’s Senior Living* (Apr. 4, 2022).

Ignite is a five-year old company that now operates 14 facilities in Illinois, Kansas, Missouri, Oklahoma, and Wisconsin. *McKnight’s* reports that Ignite “says its branded LuxeRehab model combines ‘uncompromising luxury and rapid rehabilitation,’” with “the amenities and décor of a fine hotel, as well as clinical programming for orthopedics, stroke, cardiac and respiratory care.” The company “specializes in short-term rehabilitation and nursing care, offering varied clinical specialty programs, including bedside dialysis and enhanced services in what is described as a five-star medical resort environment.”

“Ignite Medical Resorts expands into Texas with 4 Bridgemoor facilities” is available at <https://www.mcknightsseniorliving.com/home/news/business-daily-news/ignite-medical-resorts-acquires-4-bridgemoor-facilities-expands-into-texas/> and from the Center for Medicare Advocacy, on request.

27. STRAWBERRY FIELDS REAL ESTATE INVESTMENT TRUST PLANS TO GO PUBLIC, INCREASE ITS PORTFOLIO

The “self-administered real estate investment trust” Strawberry Fields, whose portfolio includes 74 skilled nursing facilities (SNFs), four “dual-purpose facilities, used as both SNFs and long-term acute hospitals (LTACs), and three assisted living facilities,” filed documents with the U.S. Securities and Exchange Commission (SEC) indicating that it intends to become a public company. Alex Zorn, “Strawberry Fields REIT Plans to Go Public, Grow its SNF Footprint in 2022,” *Skilled Nursing News* (Mar. 28, 2022). The facilities are located in Illinois, Indiana, Kentucky, Michigan, Ohio, Oklahoma, Tennessee, and Texas.

Strawberry Fields’s filing with the SEC explains its plan to invest in real estate:

“We believe these facilities have the potential to provide higher risk-adjusted returns compared to other forms of net-leased real estate assets due to the specialized expertise necessary to acquire, own, finance and manage these properties, which are factors that tend to limit competition among investors, owners, operators and finance companies.”

Strawberry Fields’ leases are on a triple-net basis, which means “the tenant pays the cost of real estate taxes, insurance and other operating costs of the facility.” The leases are generally 10 to 20 years, with two five-year extensions and annual rent escalators of 1% to 3% each year.

In August 2021, Strawberry acquired six SNFs in Kentucky and Tennessee for \$81 million. It has bought 51 properties since January 2015.

“Strawberry Fields REIT Plans to Go Public, Grow its SNF Footprint in 2022” is available at https://skillednursingnews.com/2022/03/strawberry-fields-reit-plans-to-go-public-grow-its-snf-footprint-in-2022/?itm_source=parsely-api and from the Center for Medicare Advocacy, on request.