Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

In the Case of:	)	
	)	
Martha & Mary Lutheran Services, (CCN: 50-5474),	)	Date: May 10, 2007
	)	
Petitioner,	)	
	)	Docket No. C-06-575
- v. -	)	Decision No. CR1595
	)	
Centers for Medicare & Medicaid Services.	)	
	)	

DECISION

I sustain the determination of the Centers for Medicare & Medicaid Services (CMS) that Petitioner failed to comply with a Medicare participation requirement provided care that was at a substandard level. As a consequence Petitioner loses its authority to conduct a nurse aide competency and evaluation program (NATCEP) for a period of two years.

I. Background

Petitioner is a skilled nursing facility doing business in Poulsbo, Washington. It participates in Medicare. Its participation in that program is governed by sections 1866 and 1819 of the Social Security Act (Act) and by federal regulations at 42 C.F.R. Parts 483 and 488.

Petitioner was surveyed for compliance with Medicare participation requirements twice in May 2006. The first survey was an unannounced survey conducted by employees of the Washington State Department of Social and Health Services (DSHS) on May 2 and 4, 2006. At that survey the surveyors found that Petitioner provided care of a substandard quality. They then conducted a partial extended survey of Petitioner on May 15, 2006. Ultimately, the surveyors concluded that Petitioner failed to comply with two

participation requirements at a level of noncompliance that was substandard. CMS concurred with the surveyors' findings. The consequence of CMS's determination was that Petitioner lost its authority to conduct NATCEP for two years. CMS imposed no additional remedies.

Petitioner requested a hearing and the case was assigned to me for a hearing and a decision. The parties completed a pre-hearing exchange which included an exchange of proposed exhibits. I scheduled an in-person hearing in the case. However, the parties then agreed that the case could be heard and decided after a hearing by telephone. I conducted a hearing by telephone on March 8, 2007. I received into evidence exhibits from CMS which are identified as CMS Ex. 1-CMS Ex. 72, and exhibits from Petitioner which are identified as P. Ex. 1-P. Ex. 51.

II. Issue, findings of fact and conclusions of law

A. Issue

The issue in this case is whether, as of May 2006, Petitioner manifested one or more deficiencies at a level of care that was substandard.

B. Findings of fact and conclusions of law

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

At the outset I note that CMS alleges that, as of May 2006, Petitioner failed to comply substantially with two Medicare participation requirements at a substandard level of care. The deficiencies alleged by CMS are two distinct failures by Petitioner to comply with the requirements of 42 C.F.R. § 483.13(c). The regulation requires a facility to develop and implement policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of residents' property. First, CMS alleges that Petitioner failed to protect vulnerable residents residing in a secured dementia unit from aggressive physical, verbal, and mental abuse by a resident who Petitioner's staff knew or should have known was capable of aggressive and dangerous behavior. Second, CMS alleges that Petitioner failed to comply with its regulatory obligation to investigate incidents of abusive resident-on-resident behavior and to report them to the appropriate State authorities.

In this decision I address only the first of these two allegations of noncompliance. I find it unnecessary to address the second allegation because Petitioner clearly failed to protect its residents against abuse or neglect and because Petitioner did not disprove CMS's determination that the level of protection that Petitioner gave to its residents was substandard. That is sufficient for me to sustain Petitioner's loss of NATCEP because, as a matter of law, a facility that is found to provide a substandard quality of care is prohibited from conducting NATCEP. Act, section 1819(f)(2)(B)(iii) (citing section 1819(g)(2)(B)(i)).

1. Petitioner failed to comply with the requirements of 42 C.F.R. § 483.13(c) because it failed to protect its residents adequately against a verbally and physically aggressive resident.

The purpose of 42 C.F.R. § 483.13(c) is to assure that a skilled nursing facility protect its residents against mistreatment, abuse, and neglect. "Abuse" is defined at 42 C.F.R. § 488.301 to mean: "the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish." "Neglect" is defined by the same regulation to mean: "failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness." The definitions of these terms make it evident that the regulation is not only intended to protect residents against the willful infliction of harm but also against harm that is the consequence of indifference and or negligence. Harm resulting from poor planning to deal with exigent circumstances and from failure to supervise residents appropriately falls within the meaning of neglect.

In this respect the reach of 42 C.F.R. § 483.13(c) is very similar to that of another regulation, 42 C.F.R. § 483.25(h)(2). The latter regulation requires a facility to provide each of its residents with adequate supervision and assistance devices to prevent accidents. The regulation has been interpreted to require a facility to implement all reasonable efforts to protect residents against adverse events that are reasonably foreseeable. A practically identical duty is prescribed by 42 C.F.R. § 483.13(c). Failure by a facility to protect a resident against a known or foreseeable hazard – including the possibility that a resident might be physically abused or assaulted by another resident whose aggressive behavior has become known to a facility's staff – is a failure by a facility to provide services that are necessary to prevent physical harm or mental anguish and is, thus, neglect.

Here, CMS presented evidence that Petitioner failed to fulfill its obligation to protect several demented residents against the abusive and assaultive acts committed by a resident who is identified by CMS as Resident # 1. The evidence is strong prima facie proof, which I find that Petitioner did not rebut, that Petitioner neglected the needs of its residents in contravention of 42 C.F.R. § 483.13(c).

The evidence offered by CMS shows that, over a period of about six weeks, Resident # 1 engaged in a series of abuses and physical assaults directed against residents in Petitioner's secured dementia unit. Although Petitioner's staff was aware of the resident's propensities, their efforts to protect residents against Resident # 1's behavior were ineffective. His abusive and assaultive behavior continued, essentially unchecked, culminating with an incident in which he pushed another resident, causing her to fall and to break her wrist.

Resident # 1's abusive and assaultive behavior played out with a series of incidents, all of which were known to Petitioner's staff. On March 9, 2006, Resident # 1 put his hand around the head of a resident who is identified as Resident # 2, and covered her mouth, causing the victim of this behavior to scream for help. CMS Ex. 25, at 1. On March 15, 2006, Resident # 1 again assaulted Resident # 2, slapping her. CMS Ex. 27. On March 24, 2006, Resident # 1 blocked the path of Resident # 3, yelled at her, and waved a newspaper at her. CMS Ex. 29, at 1. Later on that same day, in separate incidents, Resident # 1 kicked Resident # 4 and pulled on the wheelchair of Resident # 5. CMS Ex. 31, at 1; CMS Ex. 33, at 1.

Resident # 1's behavior became progressively more violent. On April 2, 2006, he struck Resident # 6 after she resisted his attempts to "get fresh," causing the resident to sustain a bruise to her forehead. CMS Ex. 37, at 1. On April 12, 2006, he slapped Resident # 7. CMS Ex. 39, at 1. On April 13, 2006, Resident # 1 seized Resident # 8 by the wrists. CMS Ex. 70, at 1. And, on April 22 he pushed Resident # 9, causing her to break her wrist. CMS Ex. 37, at 1-5.

The evidence offered by CMS describes a pattern of mounting abuse and violence by Resident # 1 directed at other residents. I agree with CMS that Petitioner's staff was put on notice by these behaviors that Resident # 1 was dangerously out of control and that other residents needed to be protected from him by all reasonable means. I infer from the unchecked violence that Resident # 1 directed at other residents over a period of more than a month that Petitioner's staff failed to do what was reasonable and necessary.

Petitioner's response to CMS's allegations is to argue that it not only recognized Resident # 1's propensities, but that it took numerous actions that were designed to address them. Petitioner argues that it properly identified the risks posed by Resident # 1, developed implementation strategies to address those risks, monitored the resident, and reassessed interventions when those that were implemented proved to be unsuccessful. At bottom, Petitioner's argument is that its efforts should not be judged by the behaviors manifested by Resident # 1, but by the staff's recognition of those behaviors and its attempts to address them. It contends that it should not be held accountable for its failure to protect other residents from Resident # 1 because it took all steps that it reasonably could have taken to protect them.

I find Petitioner's arguments to be unpersuasive. I have no doubt from the evidence that Petitioner introduced that its staff recognized Resident # 1 to be a threat to other residents. It is apparent, also, from that evidence, that Petitioner's staff made efforts to address the resident's behavior and to protect other residents from him. But, these efforts were inadequate. Resident # 1's unchecked abusive and violent behavior, particularly after April 1, 2006, put the staff on notice that *all* of the preventive measures that they had implemented to protect residents from Resident # 1 were failing. Given that, Petitioner's staff owed the other residents a duty of taking additional necessary measures – including segregating Resident # 1 from the remainder of the resident population, or discharging the resident – in order to protect them.[1] The actions taken by the staff were simply inadequate given the dangers to other residents posed by Resident # 1.

The actions taken in March and April 2006 by Petitioner's staff included:

- informing the resident's physician on numerous occasions of the resident's behavioral problems and care. P. Ex. 21, at 2, 4, 5, 6, 7, 8, 11, 13, 15, 16;

- referring the resident to a mental health provider and implementing that provider's recommendations. P. Ex. 21, at 7; P. Ex. 28, at 1; P. Ex. 10, at 16;

[1] Petitioner discharged Resident # 1 on April 23, 2006, after the resident had committed the assaults that I describe in this decision.

- referring the resident to a local hospital more than once for consultation, consulting with a nurse practitioner, and implementing recommendations for adjustment of the resident's medications. P. Ex. 27, at 1; P. Ex. 31, at 1; P. Ex. 32, at 1; P. Ex. 25, at 1; P. Ex. 21, at 9; P. Ex. 10, at 1, 7 - 8; and

- implementing increased monitoring of the resident.

Petitioner asserts that the monitoring that it implemented during March and April 2006 was "near[ly] constant." P. Ex. 49, at 2. It contends that the monitoring was generally one-on-one or line-of-sight. P. Ex. 48, at 2; P. Ex. 49, at 3.

But, obviously, the psychiatric interventions, the medication adjustments, and the enhanced monitoring were inadequate to protect other residents from Resident # 1's violent outbursts. Petitioner's staff should have recognized that their efforts simply were inadequate to protect other residents and, well before the incident of April 22, 2006, the staff should have done whatever was necessary to keep Resident # 1 apart from those vulnerable residents. The undisputed evidence in this case is that, after April 1, 2006, Resident # 1 assaulted other residents physically four times within a three-week period. That level of violence is simply intolerable in a facility, such as Petitioner's facility, that houses elderly, frail, demented, and essentially helpless individuals living together in close proximity with each other.

2. Petitioner did not disprove CMS's determination that the care that Petitioner gave to its residents was of a substandard quality.

A substandard quality of care deficiency will consist of a failure by a facility to comply with the requirements of 42 C.F.R. § 483.13 at a level of noncompliance that either poses immediate jeopardy for a facility's residents or which constitutes a pattern of actual harm to residents. Here, CMS determined that the compliance that I discuss at Finding 1 constituted a pattern of actual harm but not immediate jeopardy. CMS Ex. 8, at 1. I must sustain that finding unless Petitioner proves that it is incorrect.

Petitioner failed to do so. It argued that its care of its residents did not consist of failure to implement its anti-abuse and neglect policies. I found that argument to be unpersuasive at Finding 1. But, it did not argue, nor did it offer evidence to support a contention that, *if* it was deficient, its noncompliance was at a scope and severity that is less than that which CMS determined to exist. Consequently, I must sustain CMS's determination of scope and severity.

Although CMS has no additional burden to prove scope and severity beyond establishing the presence of a deficiency, I conclude that the evidence offered by CMS in this case strongly supports a finding of a pattern of actual harm. Resident # 1 repeatedly assaulted other residents and some of those assaults caused injuries. The evidence offered by CMS made it plain that the efforts of Petitioner's staff to protect other residents from Resident # 1 were ineffective and that the resident was a menace to other residents so long as he resided in Petitioner's facility and was not physically separated from the resident population.

/s/

Steven T. Kessel
Administrative Law Judge