Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Leroy Manor
(CCN: 145674/0047704),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-17-2

Decision No. CR4749

Date: December 1, 2016

DECISION ON REMAND

I impose the following remedies against Petitioner, Leroy Manor, a skilled nursing facility:

- Civil money penalties of $7000 per day for each day of a period that began on February 23, 2014, and that continued through February 25, 2014.

- Civil money penalties of $200 per day for each day of a period that began on February 26, 2014, and that continued through March 6, 2014.

I base my remedy determination in part on my findings that Petitioner contravened two regulations governing its participation in the Medicare program at a level of noncompliance that was so egregious as to comprise immediate jeopardy for residents of Petitioner's facility from February 23 through February 25, 2014. I do not find that Petitioner failed to comply substantially with a third regulation, as is alleged by the Centers for Medicare & Medicaid Services (CMS). I also base my remedy determination

on my finding that Petitioner remained out of compliance with participation requirements, albeit at a level that is less egregious than immediate jeopardy, through March 6, 2014.

I. Background

I originally entered partial summary judgment in favor of CMS and partial summary judgment in favor of Petitioner, affirming the same findings of noncompliance and the same remedy determinations that I sustain in this decision. Petitioner appealed that decision to the appellate panel of the Departmental Appeals Board, which remanded the case to me based on evidence that Petitioner had not offered in the case before me.

On remand, I instructed the parties to file final briefs addressing all issues in the case. I denied Petitioner's motion to cross-examine Patricia Fountain, R.N., whose direct testimony is set forth in CMS Ex. 23.

I am receiving into evidence exhibits offered by CMS and identified as CMS Ex. 1-CMS Ex. 22. I do not receive CMS Ex. 23. As I explained in my ruling denying cross-examination of Ms. Fountain, her testimony is inadmissible because it consists of conclusions of law. I also receive into evidence Petitioner's exhibits identified as P. Ex. 1-P. Ex. 18. That includes the exhibit (P. Ex. 18) that Petitioner offered on appeal but did not offer originally.

II. Issues, Findings of Fact and Conclusions of Law

A. Issues

The issues are whether: Petitioner was noncompliant with Medicare participation requirements; CMS's determination of immediate jeopardy was clearly erroneous; and, CMS's remedy determinations are reasonable.

In this decision – as with my original decision in this case – I address only CMS's findings of immediate jeopardy level noncompliance. I find it unnecessary to adjudicate the findings of non-immediate jeopardy level noncompliance. Petitioner's immediate jeopardy level noncompliance and failure to abate completely that noncompliance for a period of days after immediate jeopardy was removed justify all of the remedies that I sustain.

B. Findings of Fact and Conclusions of Law

In my original decision I applied the well-known standards for issuing summary judgment, basing that decision entirely on facts that were undisputed and declining to draw inferences favorable to a party where other inferences, even if unlikely, could be

drawn from those facts. I am not bound by those standards here. I draw such inferences from the evidence as I find to be reasonable even if other and less likely inferences could be drawn from the same evidence.

As I noted in my original decision, the case revolves around the care that Petitioner gave to two of its residents, identified as Resident # 4 and Resident # 5. These two residents, both elderly and demented women, were roommates in Petitioner's facility. At about 1 a.m. on February 23, 2014, Resident # 4 assaulted Resident # 5, who was 91 years old at the time, by lying on Resident #5's body while she covered the resident's nose and mouth with her hands. CMS Ex. 14 at 16; CMS Ex. 15; CMS Ex. 20 at 1, 3, 7. All of CMS's allegations of noncompliance relate to that assault.

CMS makes the following allegations of immediate jeopardy level noncompliance.

First, CMS asserts that Petitioner failed to comply with the requirements of 42 C.F.R. § 483.13(b). This regulation provides, among other things, that every resident of a skilled nursing facility has the right to be free from physical abuse. CMS contends that Petitioner failed to comply with this section because it allowed Resident # 4 to assault Resident # 5. Elaborating on this assertion, CMS argues that Petitioner knew or should have known that Resident # 4 posed a threat to Resident # 5 and failed to take meaningful measures to address that threat. It argues, essentially, that the proximate cause of the February 23, 2014 assault was the alleged failure by Petitioner to protect other residents from Resident # 4.

Second, CMS asserts that Petitioner failed to comply with the requirements of 42 C.F.R. § 483.13(c). In relevant part this section directs a skilled nursing facility to develop and implement policies to protect its residents against abuse. CMS claims that Petitioner did not comply with this regulation in that Petitioner's Administrator could not recall the specific requirements of Petitioner's abuse prevention policy when questioned about them. CMS argues also that Petitioner violated its abuse prevention policy in that it failed to provide continuous supervision of Resident # 4 in the period immediately following her assault on Resident # 5.

Third, CMS asserts an additional immediate jeopardy level violation of 42 C.F.R. § 483.13(c) in that Petitioner allegedly failed – in contravention of its own abuse policy – to notify law enforcement officials immediately of the assault of Resident # 5 by Resident # 4.

In my original decision I held and I reaffirm here that the fact that a resident perpetrates an assault on another resident of a skilled nursing facility is not in and of itself sufficient to establish that the facility allowed its residents to be abused in violation of regulatory

requirements. In order for a facility to be culpable, the abuse must be *foreseeable and preventable*. In other words, a facility has to know in advance or it should know that there is a risk of resident-against-resident abuse and there must be evidence that the facility ignored or failed adequately to deal with that risk, in order for it to be held liable for failure to protect its residents against abuse.

In my original decision I held that Petitioner knew that Resident # 4 posed a potential threat to other residents because its medical director diagnosed the resident to be suffering from homicidal ideation shortly after her admission to the facility. On appeal, Petitioner offered P. Ex. 18, which shows that the medical director did not make a diagnosis of homicidal ideation until February 23, 2014, after Resident # 4 perpetrated her assault against Resident # 5. That new evidence rebuts the argument that the facility was put on notice by a medical diagnosis of homicidal ideation made prior to the assault.

But, that evidence aside, there is ample additional evidence showing that Petitioner should have known that Resident # 4 posed a danger to other residents. I find from that additional evidence that Petitioner should have been aware of the danger associated with housing Residents #s 4 and 5 together as roommates. Its failure to provide adequate protection to Resident # 5 in advance of the February 23 assault is proof that Petitioner failed to protect this resident against the likelihood of abuse.

Petitioner's staff knew that Resident # 4 manifested severe behavioral problems almost from the inception of her stay at Petitioner's facility on January 8, 2014. CMS Ex. 14 at 1, 2, and 5. She had been diagnosed to have very poor judgment as a consequence of her dementia. P. Ex. 2 at 11. On January 11, 2014, her physician noted that the resident's confusion was worsening and that she manifested anxiety, depression, and behavioral problems. CMS Ex. 14 at 2.

Petitioner's staff assessed the resident during the first week of her stay and found that her behavioral issues included threatening, screaming, and cursing at other individuals. P. Ex. 4 at 10-11. A dementia care plan for the resident developed by Petitioner's staff found that her poor judgment could pose a risk to herself and to others. P Ex. 6 at 4.

This evidence establishes that well before February 23, 2014, Petitioner's staff knew that Resident # 4 was a confused and demented individual whose dementia triggered angry outbursts that included threatening, screaming, and cursing at other individuals. That behavior was a warning to Petitioner's staff that the resident was at least potentially dangerous, particularly in light of the fact that she was housed with other individuals who

were similarly demented and who were enfeebled by physical impairments and the vicissitudes of age.[1] But, more than that, Petitioner's staff knew not only that the resident was potentially dangerous, but that by mid-February 2014, she was engaging in behavior suggesting that she *was* dangerous to others.

Petitioner's staff documented several incidents of escalating anger and verbal aggression by Resident # 4 between her admission and her February 23, 2014 attack on Resident # 5. From January 10 through February 18, 2014, Resident # 4 engaged in several incidents of severe verbal aggression directed towards other individuals. P. Ex. 5. On January 16, 2014, the resident engaged in severe verbal aggression directed against her roommate at the time. P. Ex. 5 at 1. On February 12, 2014, the resident approached Petitioner's nurse's station and complained about her roommate, asserting that her roommate was talking and disturbing her. CMS Ex. 14 at 13. Within minutes Resident # 4 returned to the nurse's station, asserting in a raised voice that she could not take her roommate talking and that she did not have to put up with it. *Id.*

Resident # 4 manifested not only verbally aggressive behavior but behavior that evidenced a severe or at least heightened level of confusion. On February 21, 2014, a nurse found the resident in her room, crawling on her hands and knees. CMS Ex. 14 at 15. On the following day a nurse found the resident in her room squatting over the side of her bed and urinating. *Id.* The resident was found on that same day yelling at a nonexistent person ("Angie") and telling her to put away her clothing. CMS Ex. 20 at 7. On that same date, Resident # 4 was found to be in her roommate's (Resident # 5's) bed on two occasions. CMS Ex. 18 at 11, 14.

Petitioner's staff also knew that Resident # 4 manifested severe problems getting along with other individuals, especially her roommates. In the few weeks between the resident's admission and her attack on Resident # 5, Resident # 4 had been housed with three roommates other than Resident # 5. P. Ex. 15 at 3-4. Petitioner's decision to house Resident # 4 with Resident # 5 may have been a last resort on Petitioner's part in that it had run out of other candidates to serve as roommates for Resident # 4.

But, Resident # 5 – the victim of Resident # 4's attack – was an individual whose behaviors might be interpreted as provocative by an individual as demented and hostile as

[1] In my original decision I held that the resident's verbal aggressiveness, standing alone, was insufficient to put Petitioner on notice that she was capable of assaulting others. I do not alter that finding. But, that is not to suggest that this verbal aggression was meaningless. I find that the resident's verbal aggressiveness – coupled with her other documented behaviors and her advanced dementia – create a picture of an unstable individual who was capable of physically abusive behavior.

was Resident # 4. Resident # 5 suffered from severe dementia and psychosis. P. Ex. 9 at 1; P. Ex. 10 at 2; P. Ex. 12 at 5; *see* P. Ex. 16 at 3-4. She was severely impaired physically and incapable of caring for herself. CMS Ex. 1 at 21. However, she was also combative and was physically and verbally aggressive at times. Within the nine months prior to being attacked on February 23, 2014, Resident # 5 had injured herself on three occasions during which she was physically aggressive towards Petitioner's staff. P. Ex. 12 at 12, 27, and 31.

The evidence thus establishes that Petitioner housed Resident # 4 – an individual who the staff knew was a confused, combative, and at times irrationally angry person who often made her roommates the targets of her aggression – with Resident # 5, another highly confused and combative individual. I find that was a recipe for an explosion. The attack that occurred on February 23, 2014, was both foreseeable and preventable. Petitioner is liable for the physical abuse that occurred on that date.

Respondent argues that the evidence shows neither a foreseeable nor a preventable likelihood of abuse. Essentially, it contends that it could not have known that Resident # 4 presented a threat towards other individuals prior to February 23, 2014. It centers its case on the fact that Resident # 4 was not physically aggressive towards her roommates prior to February 23. Petitioner contends also that there is no evidence that Resident # 4 manifested hostility towards Resident # 5 prior to the February 23, 2014 attack. Indeed, Petitioner contends that Resident # 4 did not manifest hostility towards any of her roommates prior to February 23.

I do not find credible Petitioner's assertion that Resident # 4 was not hostile towards her roommates. In the six weeks prior to February 23, Resident # 4 was housed with four different roommates due to the resident's hostility and anger. On February 12, 2014, Resident # 4 was openly hostile towards her roommate, albeit outside of her presence, and she stated in a raised voice that she did not have to put up with her roommate's behavior. Moreover, even if the resident was not hostile towards specific individuals, Petitioner's staff remarked on her general level of hostility on numerous occasions. That hostility and verbal aggression easily could morph into physical aggression given the resident's level of confusion and her at times bizarre behavior.

Petitioner asserts that prior to February 23, 2014, Resident # 4 never experienced an episode consisting of a hallucination or one that involved confusing the identity of her roommate with another person. I do not find that assertion to be persuasive: the resident's berating of "Angie" on the 22nd of February appears to have been a hallucination and she may indeed have confused her roommate with "Angie" on the day of her attack. Apparently, Resident # 4 thought that Resident # 5 was "Angie." CMS Ex. 14 at 16. But, whether or not the resident was experiencing hallucinations does not gainsay the fact that she clearly was a highly confused and aggressive individual and that the staff knew that well before February 23.

In my original decision I found that the facts strongly supported CMS's finding that Petitioner's noncompliance with 42 C.F.R. § 483.13 posed immediate jeopardy to Petitioner's residents. I find no reason to change that conclusion. The evidence overwhelmingly supports the conclusion that Resident # 4 was capable of perpetrating great harm to other individuals. On February 23, she assaulted Resident # 5 by covering the resident's nose and mouth with her hands while lying on top of her. She easily could have suffocated the resident, a physically helpless person. I find that Petitioner's failure to perceive the likelihood that Resident # 4 could cause harm to other individuals created a high probability of harm, injury, or death to others.

In my original decision I found no basis to conclude that Petitioner violated its abuse prevention policy in contravention of 42 C.F.R. § 483.13(c) by failing to place Resident # 4 under continuous supervision after she assaulted Resident # 5. I found that it was true, as CMS contended, that the facility did not place the resident under continuous supervision. Rather, Petitioner's staff moved the resident to a vacant resident room on a different hallway in Petitioner's facility from the hallway containing the room in which Resident # 4 had committed the assault. I found this action to be consistent with Petitioner's abuse policy which offered the staff the option of segregating a suspected assailant from other residents or imposing continuous supervision. CMS Ex. 22 at 14. I found also that Petitioner's staff had placed Resident # 4 under a regime of bed checks every 15 minutes and had placed the resident under continuous supervision after Resident # 4 returned from the hospital where she had been sent for psychiatric evaluation shortly after the assault.

Neither CMS nor Petitioner offered new evidence that would alter my original finding. P. Ex. 18 is irrelevant to that finding. I find again that Petitioner's actions concerning supervision of Resident # 4 after the February 23 assault were consistent with Petitioner's own policy and regulatory requirements and I find no violation.

CMS now argues that there is another section of Petitioner's anti-abuse policy – one not addressed by me in my original decision – that Petitioner contravened. The relevant language, according to CMS, states:

> If the incident involves alleged abuse and substantiated evidence indicates that another resident of the facility is the perpetrator of the abuse, then the Administrator shall take all steps necessary to protect all residents in the facility from abuse until the alleged perpetrator can be evaluated.

CMS Ex. 22 at 13; CMS Final Brief at 20. CMS argues that the "reasonable" step that Petitioner should have taken in the immediate wake of Resident # 4's assault on Resident # 5 was round-the-clock supervision of the resident.

I am not persuaded that this step was necessary in light of the precautionary action actually taken by Petitioner. Its staff removed Resident # 4 from her room, segregated her in another part of the facility, and observed her at 15-minute intervals until she was sent to a hospital for psychiatric evaluation about 10 hours after she perpetrated the attack. I find these actions to be sufficient to protect other residents from Resident # 4. There is nothing in the record to suggest that during the 10-hour period Resident # 4 would have been in a position to assault additional residents.

In my original decision I found that Petitioner contravened its abuse policies and the requirements of 42 C.F.R. § 483.13(c) by failing to notify law enforcement authorities of Resident # 4's attack on Resident # 5 immediately after the attack occurred. I found there that Petitioner's administrator admitted the error but that Petitioner contended that the error was minimally harmful. I disagreed, finding that there was not only a potential for more than minimal harm in that failure but that there was a likelihood of serious harm, injury, or death to residents resulting from Petitioner's failure to comply with its policy on future occasions. I thus sustained an immediate jeopardy level finding of noncompliance.

The parties offered nothing to change my analysis. I reaffirm the findings that I made in my original decision.

Petitioner continues to characterize its failure to notify authorities immediately after the February 23 assault as being, at worst, a "minor delay" that did not cause any actual harm to residents. I find that the delay was anything but minor for the reasons that I stated in my original decision. Moreover, the issue here is not whether that delay caused actual harm but whether it created a likelihood of serious injury, harm, or death to a resident. As I found in my original decision, Petitioner's unawareness of its obligation to notify law enforcement officials immediately after the February 23 assault supported a finding that it would be unaware of its mandate in other cases involving other residents. And, as I found there, and reiterate here, the requirement for immediate notification of law enforcement authorities after an assault serves multiple important purposes. It protects residents against the possibility of additional assaults, particularly in the case where the assailant is unknown. It facilitates investigation of the event while the evidence is fresh. And, it enables law enforcement authorities to preserve evidence that might otherwise be destroyed.

In my original decision I found that CMS's proposed civil money penalties of $10,000 per day for the period from February 23 through 25, 2014, were unreasonable because they were predicated on CMS's findings of three immediate jeopardy level deficiencies. I reiterate that finding here. I again impose civil money penalties of $7000 per day for the February 23-25 period based on the presence of two immediate jeopardy level deficiencies during that period.

In my original decision I sustained penalties of $200 per day for the period running from February 26 through March 6, 2014, predicated on my conclusion that Petitioner did not establish that it had completely rectified the two immediate jeopardy level deficiencies (continuing at a non-immediate jeopardy level of scope and severity after February 25) that I had found. Nothing offered by the parties in their most recent arguments is a basis for me to change that conclusion. I again conclude that it is unnecessary that I address the additional non-immediate jeopardy level deficiencies found by CMS because the $200 per day penalties are amply supported by Petitioner's non-immediate jeopardy level noncompliance with the two regulatory requirements that I discuss in this decision.

_____/s/_____
Steven T. Kessel
Administrative Law Judge