Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Rosewood Care Center of Swansea,
(CCN: 145620),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-15-194

Decision Number CR4408

Date: November 6, 2015

DECISION

I sustain the determination of the Centers for Medicare & Medicaid Services (CMS) to impose the following remedies against Petitioner, Rosewood Care Center of Swansea, a skilled nursing facility in the State of Illinois:

- Civil money penalties of $6050 for each day of a period that began on May 12, 2014 and that ran through May 21, 2014; and

- Civil money penalties of $200 for each day of a period that began on May 22, 2014 and that ran through June 16, 2014.

I. Background

Petitioner requested a hearing to challenge the remedy determinations that I cite in the opening paragraph of this decision. I scheduled an in-person hearing. However, the parties agreed that the case could be heard and decided based on their written filings. Therefore, I decide this case based on the written record.

CMS filed an opening brief, a final brief, and exhibits that are identified as CMS Ex. 1 – CMS Ex. 61. Petitioner filed an opening brief, a final brief, and exhibits that are identified as P. Ex. 1 – P Ex. 6. I receive the parties' exhibits into the record.

II. Issues, Findings of Fact and Conclusions of Law

A. Issues

The issues are whether: Petitioner failed to comply with Medicare participation requirements; that noncompliance was so egregious as to constitute immediate jeopardy for residents of Petitioner's facility; and, the civil money penalties that CMS determined to impose are reasonable. [1]

B. Findings of Fact and Conclusions of Law

CMS alleges that Petitioner failed to comply substantially with several Medicare participation requirements and that its noncompliance was so egregious as to put residents of Petitioner's facility in a state of immediate jeopardy. The term "immediate jeopardy" means noncompliance that is so serious as to cause, or to create a likelihood of causing, serious injury, harm, impairment, or death to a resident. 42 C.F.R. § 488.301. Specifically, CMS asserts that Petitioner's immediate jeopardy level noncompliance consists of the following:

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[1] It is unclear to me whether Petitioner is contending that it, in fact, complied with the regulations about which CMS is alleging immediate jeopardy level noncompliance or whether it is challenging only the level of noncompliance found by CMS. In its pre-hearing brief, Petitioner seems to argue that it was in compliance with at least some of the regulations that CMS contends that Petitioner violated at the immediate jeopardy level. However, in its closing brief, Petitioner states:

> the investigation conducted by . . . [Illinois Department of Public Health] surveyors do[es] not support the imposition of . . . [immediate jeopardy] deficiencies . . . [The administrative law judge] should reduce the scope and severity findings for . . . [the immediate jeopardy level deficiencies]. A corresponding reduction in the amount of the . . . [civil money penalties] is also warranted.

Petitioner's final brief at 1. Out of an abundance of caution I am addressing both the issues of Petitioner's compliance and the level of its noncompliance in this decision.

- Petitioner allowed a resident to be verbally and physically abused in violation of the requirements of 42 C.F.R. §§ 483.13(b) and (c)(1)(i). CMS argues additionally that, even if no actual abuse occurred, Petitioner allowed a climate to exist at its facility that made abuse likely.

- Petitioner contravened the requirements of 42 C.F.R. § 483.13(c)(3) because it failed to investigate allegations of abuse and to protect its residents while these allegations were being investigated.

- Petitioner did not comply substantially with the requirements of 42 C.F.R. § 483.13(c)(2) because it failed to report to appropriate authorities allegations of neglect, abuse, and misappropriation of resident property.

- Petitioner violated 42 C.F.R. § 483.13(c) because it failed to implement its own anti-abuse policies.

CMS also alleged that Petitioner manifested several additional deficiencies albeit not so egregious as to put residents at immediate jeopardy. I do not address those additional deficiencies here inasmuch as Petitioner has not offered evidence or argument addressing them. I find them to be administratively final.

The evidence of noncompliance in this case is mostly uncontroverted and strongly supports CMS's allegations. It establishes that Petitioner's staff both verbally and physically abused Resident # 34, a 92-year old individual who was mentally incapacitated due to advanced dementia. It establishes that Petitioner's staff and management failed to investigate thoroughly allegations of abuse raised by a family member of another resident, Resident # 6. The evidence establishes also that Petitioner failed to report those allegations or the results of its investigation to appropriate State authorities. These instances of noncompliance were also a failure by Petitioner to implement its own anti-abuse policies.

I find also that CMS's findings of immediate jeopardy level noncompliance were not clearly erroneous. The principal risk to residents – and the likelihood of harm – resulted from Petitioner's failure to comprehend the seriousness of the situation at its facility. It allowed escalating hostilities between feuding members of its own staff to jeopardize the safety of its residents. Its failure to investigate thoroughly allegations of abuse meant that potentially dangerous situations were going unexamined. State authorities were not brought into the matter timely, further exacerbating the risk of harm to residents of Petitioner's facility.

CMS's allegations of noncompliance center around the care that Petitioner gave to three of its residents, identified as Residents #s 34, 6, and 28. In May 2014 Resident # 34 was

92 years and suffered from end-stage dementia. CMS Ex. 1 at 3. By any measure he was utterly helpless. He was severely cognitively impaired and was totally dependent on Petitioner's staff for all activities of daily living including transfers to and from his bed and showers. He needed the assistance of two staff persons for such activities. *Id.* The resident could at times be difficult to care for. He resisted assistance at times, almost certainly as a consequence of his advanced dementia.

The evidence establishes that Resident # 34 was abused in some measure as a consequence of an unchecked and virulent feud between two members of Petitioner's staff. CMS Ex. 21 at 15; CMS Ex. 24 at 8. These two staff members were assigned to provide care to Resident # 34. During the evening of May 12, 2014, these staff members engaged in verbal altercations even while attempting to provide care to the resident. One of the staff members, a nursing assistant, cursed loudly as she attempted to shower Resident # 34. CMS Ex. 24 at 5; CMS Ex. 20 at 4. Later that evening the same nursing assistant treated the resident so roughly as she turned him in bed that the resident nearly rolled out of the bed and fell to the floor. CMS Ex. 24 at 4, 7, 8.

Staff reported the allegations of abuse on the evening of May 12 to a supervisor. CMS Ex. 24 at 8. The supervisor concluded that the allegations were merely an outgrowth of the feuding that typified the relationship between the two nursing assistants who provided care to Resident # 34. She discounted these allegations and failed either to report or to investigate them immediately. CMS Ex. 21 at 15; CMS Ex. 9 at ¶ 16. Nor did she relieve either of the feuding nursing assistants from their duties, but allowed them to continue working while the allegations of abuse went unexamined.

Petitioner's failures to protect Resident # 34 from abuse are apparent from the foregoing evidence. The cursing and verbal outbursts of the nursing assistant may not have been directed at the resident so much as they were an element of a verbal altercation between that nursing assistant and another nursing assistant. However, Resident # 34, who was severely cognitively impaired, was caught in the direct line of fire. Even more troubling is the physical abuse that the resident experienced incident to the ongoing feud between the nursing assistants. Finally, the failure of the nursing assistants' supervisor initially to take the allegations of abuse seriously not only meant that serious abuse episodes were not being investigated, but contributed to an ongoing climate in which more abuse could have easily occurred.

The evidence is equivocal as to whether Petitioner's staff abused Resident # 6. But, CMS isn't contending that the resident was abused. Rather, CMS's allegation is that Petitioner's management failed to investigate thoroughly and to report complaints that a member of Petitioner's staff abused the resident. The evidence is unequivocal as to these allegations.

Resident # 6's wife complained that a member of Petitioner's staff had abused the resident mentally. CMS Ex. 15 at 1. She alleged that a female staff member had kissed the resident more than once and told him that she loved him. She asserted that the kissing incident was not an expression of concern or care by a staff member, but was something that was entirely inappropriate. *Id.* She asserted also that she had complained to Petitioner's administrator, but that Petitioner's management had not immediately investigated her complaint. *Id.*

The evidence establishes that Petitioner belatedly investigated the allegations of abuse concerning Resident # 6. Petitioner's administrator conducted an investigation only after the Illinois Department of Public Health initiated a complaint survey of Petitioner's facility. CMS Ex. 23 at 1. The investigation was palpably incomplete. Petitioner's management interviewed several staff members – all of who denied seeing anyone kiss Resident # 6 – and management obtained statements from these staff members. *Id.* at 2 – 11. However, although management interviewed Resident # 6, it inexplicably did not obtain a statement from him. Nor did it obtain a statement from the resident's wife even though she had initiated the complaint of abuse.

Regulations governing abuse investigations do not define what is meant by the duty to investigate thoroughly allegations of abuse. *See* 42 C.F.R. § 483.13(c)(3). But, the intent of the regulations is nevertheless evident. A "thorough" investigation is one that adequately explores all possible avenues of evidence concerning an incident or an allegation and one that is sufficient to assure that there are not potentially fruitful areas of evidence that are left unexamined. Here, the failure to obtain a statement from Resident # 6 is inexplicable. The resident was a primary witness to the abuse and the alleged subject of that abuse. His knowledge – or lack of it – of what was alleged to have occurred was absolutely essential to resolving the allegations. There is no evidence to show that the resident suffered from mental or cognitive impairments that would have prevented him from providing a statement of what had occurred. But, despite that, Petitioner's management failed to obtain a signed statement from the resident. Instead, the report of the investigation merely attributes a statement to the resident that the person who allegedly kissed him was not wearing white. CMS Ex. 23 at 13.

Similarly inexplicable is the failure to obtain a statement from the resident's wife. Her allegations were extremely explicit. How she came by them is unclear. It is possible that her allegations were unsupported, but how would Petitioner's management know that without carefully interviewing her and documenting the findings?

Petitioner asserts, baldly, that: "no interview of . . . [Resident # 6] or his wife would have yielded any information that would have furthered the investigation." Petitioner's final brief at 5. But, that is simply speculation on Petitioner's part.

The evidence also is clear that Petitioner was remiss in not reporting the resident's allegations of abuse to appropriate State authorities. Petitioner's administrator did not file a report of the investigation until May 14, 2014, twelve days after the incident allegedly occurred. CMS Ex. 23. The administrator filed a follow-up report two days later and a second follow-up report on May 26, 2014,when Petitioner's management learned that a staff member had in fact kissed Resident # 6 (although, the purported intent was benign). CMS Ex. 26. There is no legitimate reason for Petitioner to have delayed either its investigation or its report for more than three weeks.

Petitioner's explanation for delaying both its investigation and its report is that it never put much credence in the complaint that Resident # 6 was abused. That is a case of outcome-oriented reasoning and it is absolutely prohibited by the regulations. Obviously, skilled nursing facilities have incentive not to find abuse when allegations of abuse are made. Verified findings of abuse can damage a facility's reputation and they can lead to adverse legal and administrative consequences. So, it is in a facility's self-interest to see things through rose-tinted glasses when there are allegations of abuse. Concluding that allegations are not very credible prior to investigating them thoroughly is certainly in a facility's self-interest, but it does nothing to protect vulnerable residents from the possibility of abuse.

CMS's allegation of failure to report possible misappropriation of resident property stems from an incident involving Resident # 28. The facts are uncontroverted. On December 27, 2013, members of the resident's family reported that his rings were missing. However, staff delayed reporting those allegations to Petitioner's administrator until December 30, 2013, three days later. CMS Ex. 21 at 17. That is a clear violation of regulatory requirements that allegations of abuse and misappropriation of resident property be immediately reported and investigated.

As concerns Petitioner's failure to implement its anti-abuse policy, the evidence also is clear. Petitioner's anti-abuse policy tracks closely the operative language of the governing regulations. CMS Ex. 22. It says, for example, that its administrator's duty is to report "immediately" to appropriate State authorities all allegations of abuse and misappropriation of property. *Id.* at 1. There is nothing in this policy that gives Petitioner's management discretion to either delay reporting or to make judgments about which allegations are credible (and thus meriting reporting) and which are not (thereby not meriting reporting). Petitioner plainly violated its own policy – and, consequently, failed to implement it – by not reporting immediately the allegations that were made concerning Resident # 6. The failure by Petitioner's supervisor to report immediately to Petitioner's management the allegations made concerning Residents # 28 and 34 also violated Petitioner's internal anti-abuse policy.

Petitioner violated its policy in other ways. The failure to conduct a thorough investigation into the allegations concerning Resident # 6 violated the policy's injunction

that concerns expressed by a resident's family be documented. CMS Ex. 22 at 7. Moreover, the abuse directed at Resident # 34 by members of Petitioner's staff plainly violated Petitioner's policy's prohibition against abuse.

Petitioner has not controverted directly any of the evidence that I have discussed. It has offered no affirmative proof that it in fact complied with regulatory requirements. Rather, it devotes much energy to criticizing the quality of the Illinois Department of Public Health surveyors' investigation into the allegations of Petitioner's noncompliance. I find that Petitioner's arguments establish no defense to the noncompliance findings that I make in this decision. The quality of the survey conducted of Petitioner's facility does not provide a meaningful defense for two reasons. First, and as a matter of law, inadequate performance of a survey does not excuse a skilled nursing facility from its duty to comply with regulatory requirements. 42 C.F.R. § 488.318(b)(1), (2). Second, and more importantly, Petitioner has not shown how any alleged defects in the conduct of the survey of its facility undercut or impeach the evidence of noncompliance offered by CMS.

For example, Petitioner asserts that the survey findings are defective because: "the surveyors failed to interview the staff they claim abused residents even though the facility investigation gave the surveyors the identity of the alleged perpetrators." Petitioner's final brief at 3. That may be so, but that fact, standing alone, provides no benefit to Petitioner. Petitioner has not alleged that any of these staff members possess information that would change the outcome of this case if disclosed. Nor has Petitioner shown that the reports of what these staff members said and did are inaccurate.

Petitioner's assertion of allegedly inadequate investigation into its deficiencies is plainly an attempt to escape its regulatory responsibilities. It is not CMS's or the Illinois Department of Public Health's responsibility to prove beyond peradventure that Petitioner was noncompliant. CMS's burden in this case is to come forward with sufficient evidence to prove, prima facie, that Petitioner was noncompliant. To the extent that surveyors find prima facie evidence of failure by Petitioner to discharge its responsibilities – as was plainly found in this case – it is Petitioner's obligation to defend against such evidence. Here, the surveyors found enough evidence to prove that Petitioner violated regulatory requirements. Neither the surveyors nor CMS had any obligation to probe further or to adduce additional evidence beyond what was necessary to prove a prima facie case of noncompliance.

Petitioner contends that the evidence relating to the abuse of Resident # 34 is equivocal and insufficient to establish that abuse actually occurred. It asserts that the two nursing assistants who were involved in the resident's care tell different versions of what happened on the evening of May 12, 2014, that these versions are contradictory, and that CMS has simply picked one side of the story without justification. Petitioner's final brief at 7.

But, there is corroboration for allegations that Resident # 34 was abused and that corroboration is, in my judgment, sufficient to make more credible the assertions that: a nursing assistant perpetrated verbal abuse by cursing and shouting in the resident's presence; and, the same nursing assistant handled the resident so roughly as to endanger him. That corroboration comes in the form of a statement by the resident's roommate that she heard loud talking and yelling when the resident was being showered. CMS Ex. 20 at 4. It also is contained in the statement of the nursing assistant's supervisor, who witnessed the assistant cursing and shouting on the evening of May 12, 2014. CMS Ex. 24 at 8.

It is true that there is no third-party witness to the rough treatment of Resident # 34 nor did the roommate hear actual cursing when she overheard yelling coming from the shower, but nonetheless, the corroboration that I have cited is sufficient evidence for me to infer that the remaining allegations are true. Thus, the evidence concerning the abuse of Resident # 34 is not equivocal.

As I have stated, there is ample basis to conclude that Petitioner's non-compliance was so egregious as to place residents of Petitioner's facility in a state of immediate jeopardy. It is apparent that Petitioner's management did not comprehend the seriousness of the allegations of abuse and so; its response to them was lethargic and half-hearted. That had the consequence of leaving residents unprotected against additional instances of abuse, an extremely dangerous situation for the frail and vulnerable individuals who resided at Petitioner's facility.

I find the amount of the penalties – $6050 per day for the period of immediate jeopardy and $200 per day for subsequent days of noncompliance – to be entirely reasonable. Daily civil money penalties for immediate jeopardy compliance fall within a range of between $3050 and $10,000 depending on factors that include the seriousness of a facility's noncompliance. 42 C.F.R. §§ 488.438(a)(1)(i); 488.438(f). The penalties determined by CMS are slightly less than one-half the maximum permissible amount and are modest given the seriousness of Petitioner's noncompliance. The $200 daily penalties for non-immediate jeopardy level deficiencies are at the low end of the permissible range for such penalties of from $50 to $3000 per day. 42 C.F.R. § 488.438(a)(1)(ii). I note that Petitioner did not challenge multiple findings of non-immediate jeopardy level noncompliance and these findings are more than adequate to justify penalties of $200 per day.

Furthermore, Petitioner did not challenge CMS's findings as to the duration of its noncompliance. It did not contend that, if it was deficient at an immediate jeopardy level, it abated that noncompliance at an earlier date than that which was determined by CMS.

Nor did it contend that it abated the remaining non-immediate jeopardy level deficiencies at a date that was earlier than CMS's determination of the date when Petitioner attained substantial compliance with all participation requirements.

/s/
Steven T. Kessel
Administrative Law Judge