Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Lee County Care and Rehabilitation Center
(CCN: 18-5337),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-13-923

Decision No. CR4546

Date: March 15, 2016

DECISION

In this case, we again consider a long-term-care facility's responsibility to prevent abuse and to report and investigate all allegations of it, while keeping its residents safe from any potential abuser.

Petitioner, Lee County Care and Rehabilitation Center, is a long-term-care facility, located in Beattyville, Kentucky, that participates in the Medicare program. Based on surveys completed from February through June 2013, the Centers for Medicare & Medicaid Services (CMS) determined that the facility was not in substantial compliance with Medicare program requirements and that its deficiencies posed immediate jeopardy to resident health and safety. CMS imposed civil money penalties (CMPs) of $5,050 per day for 59 days of immediate jeopardy (February 17 through April 16, 2013), followed by CMPs of $150 per day for 28 days (April 17 through May 14, 2013) and $250 dollars per day for 20 days (May 15 through June 3, 2013) of substantial noncompliance that was not immediate jeopardy.

Petitioner does not challenge CMS's finding that it was not in substantial compliance from April 17 through June 3, 2013, nor the penalties imposed for those days. It appeals

the deficiencies cited at the immediate jeopardy level (42 C.F.R. §§ 483.13(b) and(c), 483.75, and 483.75(o)(1)), the immediate jeopardy determination itself, and the amount of the CMP imposed for the 59 days of immediate jeopardy.

For the reasons set forth below, I find that, from February 17 through April 16, 2013, the facility was not in substantial compliance with 42 C.F.R. §§ 483.13(b) and (c), 483.75, and 483.75(o)(1); its deficiencies posed immediate jeopardy to resident health and safety; and the penalty imposed for that period is reasonable.

Background

The Social Security Act (Act) sets forth requirements for nursing facilities to participate in the Medicare program and authorizes the Secretary of Health and Human Services to promulgate regulations implementing those statutory provisions. Act § 1819. The Secretary's regulations are found at 42 C.F.R. Part 483. To participate in the Medicare program, a nursing facility must maintain substantial compliance with program requirements. To be in substantial compliance, a facility's deficiencies may pose no greater risk to resident health and safety than "the potential for causing minimal harm." 42 C.F.R. § 488.301.

The Secretary contracts with state survey agencies to survey skilled nursing facilities in order to determine whether they are in substantial compliance. Act § 1864(a); 42 C.F.R. § 488.20. Each facility must be surveyed annually, with no more than fifteen months elapsing between surveys, and must be surveyed more often, if necessary, to ensure that identified deficiencies are corrected. Act § 1819(g)(2)(A); 42 C.F.R. §§ 488.20(a); 488.308. The state agency must also investigate all complaints. Act § 1819(g)(4).

In this case, surveyors from the Kentucky Cabinet for Health and Family Services (state agency) completed a series of complaint investigations/surveys, which began in February and ended on June 19, 2013. CMS Exhibits (Exs.) 1, 2, 5-9. Based on their findings, CMS determined that the facility was not in substantial compliance with multiple program requirements. Petitioner Lee County limits its appeal to: 1) the deficiencies cited at the immediate jeopardy level of scope and severity during the survey ending April 9, 2013; 2) the immediate jeopardy finding itself; and 3) the resulting penalties. Based on that survey, CMS determined that the facility was not in substantial compliance with the following:

- 42 C.F.R. § 483.10(b)(11) (Tag F157) (resident rights – notice of rights and services) at scope and severity level D (isolated instance of substantial noncompliance that caused no actual harm with the potential for more than minimal harm);

- **42 C.F.R. § 483.13(b) and (c)(1)(i) (Tag F223) (abuse and staff treatment of residents) at scope and severity level J (isolated instance of noncompliance that posed immediate jeopardy to resident health and safety)**;[1]

- **42 C.F.R. § 483.13(c)(1)(ii)-(iii) and (c)(2)-(4) (Tag F225) (staff treatment of residents: investigate and report allegations of abuse) at scope and severity level K (pattern of noncompliance that posed immediate jeopardy to resident health and safety)**;

- **42 C.F.R. § 483.13(c) (Tag F226 – policies to prohibit abuse and neglect) at scope and severity level K**;

- 42 C.F.R. § 483.20(k)(3)(i) (Tag F281 – resident assessment: comprehensive care plans/professional standards of quality) at scope and severity level E (pattern of noncompliance that caused no actual harm with the potential for more than minimal harm);

- 42 C.F.R. § 483.20(k)(3)(ii) (Tag F282 – resident assessment: comprehensive care plans/services provided) at scope and severity level D;

- 42 C.F.R. § 483.25(m)(1) (Tag F332 – quality of care: medication errors) at scope and severity level E;

- 42 C.F.R. § 483.25(m)(2) (Tag F333 – quality of care: medication errors) at scope and severity level D;

- 42 C.F.R. § 483.35(i) (Tag F371 – dietary services: sanitary conditions) at scope and severity level D;

- 42 C.F.R. § 483.60(a) and (b) (Tag F425 – pharmacy services: procedures and consultation) at scope and severity level E;

- 42 C.F.R. § 483.60(b), (d), and (e) (Tag F431 – pharmacy services: consultation, drug labeling and storage) at scope and severity level E;

- 42 C.F.R. § 483.70(h)(4) (Tag F469 – physical environment: pest control) at scope and severity level D;

[1] The deficiencies that are the subject of this appeal are highlighted in bold. Although not challenged, the remaining deficiencies are relevant in determining whether the CMP is reasonable (see discussion below).

- **42 C.F.R. § 483.75 (Tag F490 – administration) at scope and severity level K**;

- 42 C.F.R. § 483.75 (*l*)(1) (Tag F514 – administration: clinical records) at scope and severity level E;

- 42 C.F.R. § 483.75(m)(2) (Tag F518 – administration: emergency preparedness) at scope and severity level D;

- **42 C.F.R. § 483.75(o)(1) (Tag F520 – administration: quality assessment and assurance) at scope and severity level K.**

CMS Ex. 1.

Surveyors revisited the facility on April 23, May 15, and June 19, 2013. CMS Exs. 6, 7, 8, 9. Following the June 19 survey, CMS determined that the facility finally returned to substantial compliance on June 4, 2013. CMS Ex. 9.

CMS imposed against the facility CMPs of $5,050 per day for 59 days of immediate jeopardy (February 17 through April 16), and $150 per day and $250 per day for the remaining days of substantial noncompliance that was not immediate jeopardy (April 17 through May 14 and May 15 through June 3), for penalties totaling $307,150 ($297,950 + $4,200 + $5,000). CMS Exs. 8, 9.

Petitioner timely requested review, challenging the deficiencies cited at the immediate jeopardy level – 42 C.F.R. §§ 483.13(b) and (c), 483.75, and 483.75(o)(1). Petitioner also challenges the immediate jeopardy determination itself and the amount of the CMP imposed for its 59 days of immediate jeopardy.

On September 10, 2014, I convened a hearing, via video conference, from the offices of the Departmental Appeals Board in Washington, D.C. Counsel and witnesses convened in Lexington, Kentucky. Ms. Sonia G. Burnett appeared on behalf of CMS, and Ms. Lisa English Hinkle appeared on behalf of Petitioner Lee County. Transcript (Tr.) 9.

The parties filed pre-hearing briefs (CMS Pre-hrg. Br.; P. Pre-hrg. Br.) and post-hearing briefs (CMS Post-hrg. Br.; P. Post-hrg. Br.). I admitted into evidence CMS Exs. 1-28, 30-39, 41, 43-45, 47-62, 65-66, and 70-85. I also admitted P. Exs. 1-40. Summary of Prehearing Conference and Order Establishing Procedure for Hearing at 2-5 (June 30, 2014); Tr. 12.

Petitioner's complaints regarding the conduct of the hearing. Much of Petitioner's post-hearing brief addresses peripheral procedural issues rather than the merits of this case. Petitioner complains primarily about the conduct of the hearing, arguing that I abused my discretion and that my rulings were arbitrary and capricious and violated Petitioner's procedural and substantive due process rights. P. Post-hrg. Br. at 2-3, 5-6, 16-22.

The administrative law judge has broad authority to decide the conduct of the hearing. 42 C.F.R. 498.60(b)(2). In a pre-hearing order, dated June 24, 2013, I directed the parties to file pre-hearing exchanges, including, as proposed exhibits, "the complete written direct testimony of any proposed witness." I advised the parties that I would generally accept the written testimony as a statement in lieu of in-person testimony. Acknowledgment and Initial Pre-hearing Order (Pre-hearing Order) at 3 (¶ 4) (June 24, 2013); *see Premier Living & Rehab. Ctr.*, DAB No. 2146 at 27-28 (2008); *Lutheran Home at Trinity Oaks*, DAB No. 2111 at 22-25 (2007) (noting with approval the use of written direct testimony). I warned that I may impose sanctions pursuant to section 1128A(c)(4) of the Act for a party's failure to comply with my order. Pre-hearing Order at 4 (¶ 11). I also advised the parties that they might supplement their pre-hearing exchanges upon a showing of good cause. *Id.* at 2 (¶ 3).

Section 1128A(c)(4) authorizes a hearing official to sanction a party "for failing to comply with an order or procedure . . . or other misconduct as would interfere with the speedy, orderly, or fair conduct of the hearing." The sanction imposed should "reasonably relate to the severity and nature of the failure or misconduct." The sanctions include "prohibiting a party from introducing certain evidence or otherwise supporting a particular claim or defense." Act § 1128A(c)(4)(B).

During a prehearing conference, held June 27, 2014, Petitioner asked that I issue subpoenas to secure the testimony of certain witnesses. Petitioner represented that it could not provide written declarations from these witnesses because they refused to cooperate. I advised Petitioner that I would issue subpoenas in response to a written motion demonstrating compliance with 42 C.F.R. § 498.58, the regulation that governs issuance of subpoenas. Summary of Prehearing Conference and Order Establishing Procedure for Hearing at 5 (June 30, 2014).

In a motion dated July 23, 2014, Petitioner asked me to issue subpoenas for four witnesses: April Hagerman, Shane Marshall, Debra Ann Kidd, and Timothy Schade. Petitioner represented that three of these individuals (Hagerman, Marshall, and Schade) "no longer worked for Petitioner" and "failed to respond to any of Petitioner's attempts to contact and interview [him or her]." Motion Requesting Issuance of Subpoenas (Subpoena Request) at 3, 4, and 7. Petitioner represented that the remaining witness, Ms. Kidd, "failed to respond to any of Petitioner's attempts to contact and interview her" and that "the only means for obtaining [her] response and testimony" was by subpoena. *Id.* at

6. Based on Petitioner's representations, and, in the absence of any objections, I issued the subpoenas.[2]

But, at the hearing, Petitioner's first witness, Timothy Schade, testified that he continues to work at Lee County Care and that *no one asked him to supply a written declaration*. Tr. 16, 17, 19-20. Petitioner did not adequately explain why it had misrepresented Mr. Schade's employment or why it had claimed that he refused to cooperate, when he had not refused. Petitioner maintained that it "was not aware" that Mr. Schade and one other witness (Ms. Kidd) continued to work at the facility. Tr. 17. But Petitioner's counsel ultimately conceded that she learned of Witness Schade's employment and availability at least two weeks prior to the date of the hearing. Tr. 17-19. Yet, she made no effort to supplement the record with his written declaration. Because Petitioner did not submit a written declaration, as required by my pre-hearing order, and did not show good cause for failing to submit that declaration, I did not allow the witness to testify at the hearing. Tr. 19-20.

Petitioner's representations with respect to Witness Kidd's ongoing employment were inconsistent and confusing. In its request for subpoena, Petitioner represented that Ms. Kidd was "currently employed" by the facility as a registered nurse but claimed that she "failed to respond to any of Petitioner's attempts to contact and interview her." Subpoena Request at 5-6. In contrast, during the hearing, Counsel represented that "we came to find out two days ago" that Debra Kidd is a facility employee, "[a]nd we did not know her whereabouts until about two days ago." Tr. 20. In any event, following my ruling with respect to Witness Schade, Petitioner opted not to call Witness Kidd. Tr. 20.

Petitioner did not call Witness Hagerman, so I did not rule on whether she would be allowed to testify.[3]

The final witness, Shane Marshall, no longer works at the facility. He testified that facility staff have his contact information but no one contacted him to ask for a written declaration. Tr. 66-67. Counsel again conceded that she did not ask him to provide a written declaration. Tr. 67-68. I nevertheless allowed him to testify.

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[2] Initially, CMS did not object to my issuing these subpoenas because CMS counsel accepted Petitioner's representation that the witnesses were not willing to cooperate. Tr. 19. This turned out not be true, and, after learning that Petitioner had made essentially no effort to obtain written statements, CMS objected to their testimony. Tr. 67-68.

[3] Witness Hagerman is no longer employed at the facility, her employment having been terminated at the time of a February 17 incident, discussed below. Petitioner asserts, largely without support, that all of the individuals subpoenaed were adverse (*see, e.g.*, P. Post-hrg. Br. at 19). Witness Hagerman is the only one for whom there is evidence to support this claim.

Given Petitioner's admissions during the hearing, I find baffling its post-hearing insistence that the subpoenaed witnesses "did not respond to . . . repeated requests for cooperation." P. Post-hrg. Br. at 2, 19-20. Not only did two witnesses – one of whom was a facility employee – testify that no one contacted them about providing a written declaration (Tr. 16, 17, 19-20, 66-67), but Counsel admitted that she made no effort to contact them. Tr. 17-19, 68 ("Did you ask [Mr. Marshall] for [a written statement]? Your honor, I stated that I did not.").

I also reject Petitioner's claim that it was denied the opportunity to present its case. P. Post-hrg. Br. at 17. Petitioner was provided ample opportunity to present its case, including the testimony of the subpoenaed witnesses. It was, however, bound to follow the procedures set forth in my orders as to the manner by which I would receive that evidence. Petitioner knew or should have known that some of its witnesses continued to work at the facility, and Petitioner should not have represented that these individuals refused to cooperate when, in fact, *it had not contacted any of them*, not even those still working at the facility.[4] In at least one case (Mr. Schade), Petitioner might have salvaged the situation, when it realized that he was an employee, by asking leave to file his written testimony out-of-time, which would have been at least two weeks before the scheduled hearing. But Petitioner did not. It essentially ignored my order and misrepresented the status of its witnesses and its efforts to obtain their cooperation. Its actions interfered with the speedy, orderly, and fair conduct of the hearing, creating the type of situation for which section 1128A sanctions were designed.

In a separate complaint, Petitioner charges (without citation to the record) that, during her cross-examination of Surveyor Mary Dills, I ordered counsel to "'stop' questioning the witness." P. Post-hrg. Br. at 5. But Petitioner mischaracterizes this exchange. Tr. 55 - 61. Surveyor Dills testified about an allegation of sexual abuse. Counsel's cross-examination was interrupted only once, when *CMS counsel* appropriately objected to one of her questions: "So is it fair to say that the resident never reported to you that there was any kind of sexual gratification in terms of her own sexual gratification or the person who watched her gratification?" I sustained the objection. Tr. 56-57.

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[4] Moreover, considering that these employees were witnesses to incidents resulting in serious allegations of abuse – indeed, some were charged with abuse – it seems incomprehensible that Petitioner did not know whether they continued to work at the facility. Competent management should be able to identify all of its employees, but especially those whose performance has been questioned. Where the administration is not aware that an alleged abuser continues to work at its facility, the facility is not administered "in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psycho-social well-being of each resident," as required by 42 C.F.R. § 483.75. *See* discussion below.

On re-cross, Petitioner's counsel asked Surveyor Dills if she were "aware whether the social worker concluded that the report . . . rose to the level of abuse." Tr. 63. But the witness had answered that question *just minutes before*. She had testified that "the social worker reported that she had conducted an investigation . . . and they had decided that abuse did not occur. . . ." Tr. 60. After counsel repeated the question, but before the witness answered it a second time, I asked whether we'd been through this. I asked counsel to stop talking because she was attempting to talk over me as I posed my question. Tr. 63. If two individuals speak at the same time, our videoconferencing equipment cancels out both speakers – nothing can be heard or recorded.

As the record shows, Petitioner had ample opportunity to cross-examine CMS's witnesses and its complaints about being cut off are without merit.

Issues

Based on the uncontested issues:

- The facility was not in substantial compliance with Medicare program requirements from April 17 through June 3, 2013, and the penalties imposed for that period – $150 per day for 28 days and $250 per day for 20 days – are reasonable;

- For the period from February 17 through April 16, 2013, the facility was not in substantial compliance with Medicare program requirements, and I must affirm a CMP of at least $50 per day for those days. 42 C.F.R. §§ 488.408(d)(1)(iii); 488.438(a)(1)(ii).

The remaining issues are:

1. From February 17 through April 16, 2013, was the facility in substantial compliance with: 42 C.F.R. §§ 483.13(b) and (c) (cited at Tags F223, F225, and F226); 483.75 (cited at Tag F490); and 483.75(o)(1) (cited at Tag F520);

2. If not, did those deficiencies pose immediate jeopardy to resident health and safety; and

3. Is the penalty imposed –$5,050 per day for 59 days of immediate jeopardy (total $297,950) – reasonable.

Discussion

1. Surveyor performance does not relieve the facility of its obligation to meet program requirements nor invalidate adequately documented deficiencies. 42 C.F.R. § 488.318(b).[5]

As a threshold matter, I note that Petitioner builds much of its case around purported surveyor errors. It faults the surveyors for not reviewing enough records; claims that they did not perform the appropriate analysis to determine if various incidents "rose to level of abuse"; and claims that they failed to interview the appropriate people. P. Post-hrg. Br. at 3-5, 8, 10, 11.

Survey performance does not relieve the facility of its obligation to meet all requirements for program participation nor does it invalidate adequately documented deficiencies. 42 C.F.R. § 488.318(b); *Mississippi Care Ctr. of Greenville*, DAB No. 2450 at 18 (2012), *aff'd, Mississippi Care Ctr. of Greenville v. U.S. Dept. of Health & Human Servs.*, 517 Fed. App'x. 209 (5th Cir. 2013).

Even if I agreed with Petitioner's claims regarding the quality of the survey (which I do not), I would still review *de novo* the evidence before me to determine whether the facility was in substantial compliance. By a long line of cases, the Departmental Appeals Board has observed that an administrative law judge "reviews de novo whether the evidence supports CMS's . . . determination of noncompliance. Any allegation that a state surveyor failed to follow the procedures set forth in the regulations is thus irrelevant so long as the objective evidence – such as a facility's own records – establishes noncompliance." *N.C. State Veterans Nursing Home, Salisbury*, DAB No. 2256 at 24 (2009); *see also Sunshine Haven Lordsburg*, DAB No. 2456 at 21-22 (2012); *Jewish Home of E. Pa.*, DAB No. 2380 at 7 n.3 (2011) (holding that the ALJ's "de novo evaluation of the evidence 'insulates a facility from the effect of any perceived disparate treatment or bias on the part of the state survey agency or CMS'"); *Manor of Wayne Skilled Nursing & Rehab.*, DAB No. 2249 at 12 (2009); *SunBridge Care & Rehab for Pembroke*, DAB No. 2170 at 26-27 (2008).

[5] My findings of fact and conclusions of law are set forth, in bold and italics, as captions in the discussion section of this decision.

2. Administration and staff did not follow the facility's policies and procedures for preventing abuse; they did not immediately report or thoroughly investigate instances of abuse or potential abuse; and they made inadequate efforts to prevent potential abuse while an investigation was pending. The facility was therefore not in substantial compliance with 42 C.F.R. §§ 483.13(b) and (c), 483.75, and 483.75(o)(1).

Program requirements. "Abuse" means the willful infliction of injury, unreasonable confinement, intimidation, or punishment, with resulting physical harm, pain, or mental anguish. 42 C.F.R. § 488.301.

Facility residents have the right to be free from verbal, sexual, physical, and mental abuse. 42 C.F.R. § 483.13(b). To this end, a facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents. 42 C.F.R. § 483.13(c). It must ensure that all alleged violations are reported *immediately* to the facility administrator and appropriate state officials. The facility must have evidence that all alleged violations are thoroughly investigated, and it must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator (or designated representative) and to the appropriate state officials within 5 working days of the incident. If the violation is verified, the facility must take appropriate action. 42 C.F.R. § 483.13(c)(2), (3), and (4).

Petitioner seems to think that it need not report incidents unless it determines that they constitute abuse. To the contrary, the regulations require the facility to report and investigate thoroughly *all alleged* violations. The reporting requirements are triggered by an *allegation* of abuse, whether or not it is recognized as such by the facility. *Illinois Knights Templar Home*, DAB No. 2369 at 11, 12 (2011). The pertinent question is not whether any abuse occurred or whether the facility had reasonable cause to believe that any abuse occurred, but whether there is an allegation that facility staff abused a resident. *Britthaven, Inc. d/b/a Britthaven of Smithfield*, DAB No. 2018 at 15 (2006) (citing *Cedar View Good Samaritan*, DAB No. 1897 at 11 (2003)). In *Illinois Knights Templar*, the Board, quoting ALJ Kessel's earlier opinion, noted good reasons for this reporting requirement: to authenticate an allegation of abuse is not in the facility's self-interest, which creates a potential conflict of interest for facility management. Requiring the facility to report the allegations "assures that a neutral third party (the state) will be apprised of the allegations and will be in a position to take protective action if necessary." *Illinois Knights Templar*, DAB No. 2369 at 12-13 (quoting DAB CR2203 at 10 (2010)).

Mischaracterizing the testimony of Surveyor Earl Thomas, Petitioner also maintains that "the regulations and guidance define 'immediate' to be within 24 hours." P. Post-hrg. Br. at 13. In fact, Surveyor Thomas testified that "immediately" is *not* defined as a 24-hour period. "Immediate is immediate." Tr. 50; *see Magnolia Estates Skilled Care*, DAB No. 2228 at 8 (2009) (finding that, in another "reporting" context, "immediately" means

"*without any intervening interval of time*" (emphasis added)). Moreover, I find no compelling support for Petitioner's position, particularly with respect to staff's reporting an incident to facility management, where delays could result in serious, ongoing abuse of vulnerable residents. In *Rolling Hills Rehab Center*, DAB No. 2119 (2007), for example, a nurse aide witnessed an incident of abuse but called another aide before reporting to the supervisory nurse. Although her delay could be measured in minutes, not hours, the Board found that she violated the regulatory requirement to report immediately. Similarly, the Board faulted the supervisory nurse, who, doubting the allegation, waited an additional 45 minutes before notifying the facility administrator. The Board noted that the nurse's first obligation was to ensure that the alleged victim and other residents were safe. Her second responsibility was to call the facility administrator immediately. *Rolling Hills*, DAB No. 2119 at 9-10.

Depending on state timeframe requirements, the facility may have some flexibility with respect to when it reports to the state agency, but, under no circumstances, can the reporting delay exceed 24 hours. Tr. 50; *see* P. Ex. 5 at 1 ("Immediately means *as soon as possible* but ought not exceed 24 hours after discovery of the incident."); P. Ex. 11 at 2 (describing requirement that facilities submit an initial report followed by 5-day follow-up investigative report). Here, state rules require that an oral or written report "be made immediately" to the state agency "upon knowledge of suspected abuse." P. Ex. 11 at 7. Because the facility did not even meet a 24-hour deadline for reporting (see discussion below), I need not decide whether reporting to the state agency 24 hours after discovery of an incident ever satisfies the requirement to report immediately to the state officials.[6]

Finally, the facility must be governed in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. 42 C.F.R. § 483.75.

Facility policies. The facility had in place written policies and procedures for preventing abuse. Consistent with the regulations, the policies require that all *allegations* of abuse be reported *immediately* to the charge nurse or, if she is not available, to another licensed nurse or manager in the facility. (If the charge nurse (or other) does not respond, the reporting individual must notify the director of nursing (DON) or facility administrator.) The charge nurse must then *immediately* remove the suspected perpetrator from the resident care areas, obtain the staff member's witness statement, and *immediately* suspend the employee, pending the outcome of an investigation. The charge nurse must also *immediately* notify the facility administrator, the DON, and/or the facility abuse coordinator. Either the facility administrator or the DON immediately reports the

[6] It would be strange, perhaps unprecedented, to define differently the same word ("immediately") in the same regulation (483.13(c)) or set of regulations. *See* 42 C.F.R. § 483.10(b)(11).

incident to the state agency and other entities, as required. CMS Ex. 16 at 1, 3-4, 6, 10; CMS Ex. 17 at 3.

The person who observes an incident must *immediately* report it and provide a written statement that includes the name of the resident, the date and time of the incident, where the incident occurred, the staff involved, and a description of what occurred. CMS Ex. 16 at 4, 6; CMS Ex. 17 at 4.

The facility must *immediately* initiate a thorough investigation of all alleged incidents of abuse by staff members. CMS Ex. 16 at 6.

All allegations of abuse must be investigated and reported to the appropriate state agencies. CMS Ex. 17 at 3-4. The administrator or his designee must make reasonable efforts to investigate and address "all alleged reports, concerns, and grievances." CMS Ex. 17 at 4.

The policies specify that reports of abuse or mistreatment that result in "serious bodily injury," *which includes sexual abuse*, must be reported to the state agency within two hours. Incidents that do not meet the definition must be reported with 24 hours. CMS Ex. 16 at 5.[7]

In the meantime, the resident involved must "receive measures to ensure his or her immediate safety and wellbeing . . . during the investigation process." CMS Ex. 16 at 9. Employees accused of participating in the alleged abuse "will be immediately suspended until the findings of the investigation have been reviewed" by the administrator, DON, and human resources director. CMS Ex. 16 at 9.

Finally, social services must follow-up with the resident to monitor his/her emotional well-being. CMS Ex. 17 at 4.

Resident 1 (R1). R1 was a 75-year-old woman suffering the effects of a stroke. She was paralyzed on her right side, had a nutritional deficiency, a diaphragmatic hernia, and other ailments. CMS Ex. 77 at 1, 44, 129. She was totally dependent on staff for transfers, bed mobility, and her activities of daily living. CMS Ex. 77 at 18, 128. She relied on a wheelchair to get around. CMS Ex. 77 at 128.

Multiple staff members reported that, following breakfast on the morning of February 17, 2012, Licensed Practical Nurse (LPN) April Hagerman insisted that R1 remain sitting in a geri-chair by the nurses' station, even though the resident cried and complained, asking

[7] The facility did not satisfy this generous timeline for reporting allegations of abuse, so I need not address the issue here, but, as noted above, the plain language of the federal regulation and the state rule may undermine the validity of this provision.

to be taken to bed. In addressing the incident, Petitioner did not call as witnesses the housekeepers or the nurse aides who observed it. Although listed as a witness and subpoenaed, Petitioner did not call LPN Hagerman. Instead, Petitioner provided written declarations from individuals working in the facility's corporate offices, who reviewed documents and offer their opinions, but were not actual witnesses to the incident. I find their testimony – particularly their unsupported assertions – far less reliable than the contemporaneous witness statements and supporting documents.

Among the staff members' contemporaneous statements:

- Nurse Aide Virginia Combs reported that LPN Hagerman instructed her and another aide to leave R1 at the nurses' station, rather than returning her to her room. LPN Hagerman said that she was "going to teach her a lesson" for hollering in the dining room. LPN Hagerman finally allowed the aides to return the resident to her room at about 10:00 a.m. CMS Ex. 12 at 1.

- Another nurse aide, Jessica Caudell, wrote that she witnessed LPN Hagerman tell the resident that "she would sit up until she stopped crying. . . ." LPN Hagerman then turned up the radio. CMS Ex. 12 at 3.

- A housekeeping employee, Fannie Callahan, reported that R1 was "crying and wanting to go to bed." LPN Hagerman told the resident that "as long as she whined and cried . . . she was not going to bed," and she told the nurse aides not to take her there. LPN Hagerman also obtained a radio and "turned it up loud to drown out the resident crying." CMS Ex. 12 at 4.

- Yet another nurse aide, Timothy Schade, reported that R1 was in a chair by the nurses' station "hollering." He tried to calm her. Music was playing and "at one time the music was turned up." The resident complained that she was freezing and wanted to go to her room. For reasons he does not explain, the aide did not take her to her room but took her through the building and returned her to the nurses' station. CMS Ex. 12 at 7.

  Petitioner asserts that Nurse Aide Schade rolled the resident around in order to console her, suggesting that this was an intervention prescribed by her care plan. P. Post-hrg. Br. at 8. But the claim is not supported. Among the interventions listed as responses to R1's behaviors (which include "episodes of crying"), staff is instructed to encourage her to talk and express her feelings; to acknowledge the importance of individual space; to provide her with privacy during care and private time; to provide her with calm reassurance as needed; to "encourage" (not force) "out of room" activities[8]; to assist her to establish a "trusting relationship"

[8] I do not consider sitting in a geri-chair at the nurses' station an "activity."

with staff; to provide a "non-threatening" atmosphere; and to encourage (not compel) her to sit in social areas and talk to other residents. CMS Ex. 77 at 99-101. The plan does not mention wheeling her around the facility, ignoring her expressed wishes to return to her room, or forcing her, against her will, to remain where she does not want to be.

- A second housekeeping employee, Imogene Johnson, reported that LPN Hagerman "was talking to the resident in a way she shouldn't [have]." R1 had been crying in the dining room at breakfast. Because she was crying, LPN Hagerman would not allow the nurse aides to return her to her room but insisted that she be left at the nurses' station. Instead, LPN Hagerman got a radio and turned the volume up loud. CMS Ex. 12 at 8.

Although the reports do not include exact time frames, it seems that staff witnessed this behavior at about 7:35 a.m. on February 17. They did not immediately report it, but, between 11:30 a.m. and noon, the housekeepers attempted to contact Denise Lynch, the facility's social services director, who served as the abuse coordinator. When they were unable to reach her, they left a voice message, and, at about 11:40 a.m., they reported their observations to the staff development coordinator/nurse manager, Shannon Foster. CMS Ex. 1 at 40.

The facility's then administrator, Tom Rawlins, interviewed LPN Hagerman on February 21. She conceded that she told staff to leave R1 at the nurses' station but insisted that she wanted her there "so I could monitor her due to her crying." CMS Ex. 12 at 5. She also admitted that she told R1 "if you [are] going to cry, stay out here (by nurses' station)." CMS Ex. 12 at 5. She admitted that she asked "Imogene" in housekeeping to bring her a radio, but claimed that she turned it on "for the residents" and not to drown out R1. CMS Ex. 12 at 6.

Petitioner defends LPN Hagerman's actions. It describes R1 as a "moaner" and claims that the resident "incomprehensively moans on an almost continual basis" and that she "consistently indicates that she wishes to go to bed." P. Pre-hrg. Br. at 10; P. Ex. 3 at 6 (Hogan Decl. ¶¶ 6m and 6n). According to Petitioner, because R1's moans are incomprehensible, "it is impossible" for staff to determine whether R1 is in actual pain unless she is monitored. P. Pre-hrg. Br. at 4.

The problem with this claim is that R1's assessments, care plan, and nursing notes do not support it. A monthly assessment, dated January 6, 2013, describes R1's speech as unclear, but indicates that she is usually understood. It indicates no mood or behavior symptoms. CMS Ex. 77 at 128. R1's February 4, 2013 assessment describes her speech as "clear" with "distinct, intelligible words" and says that she is "usually" able to express her ideas and wants. CMS Ex. 77 at 12. It says specifically that she recently exhibited no crying, whining, gasping, moaning, or groaning. CMS Ex. 77 at 24.

A care plan entry dated February 5, 2013 describes "episodes of repetitive verbalizations, noises, [and] rambling conversations [with] self" and says that the resident moans *at times*." CMS Ex. 77 at 58; *see* CMS Ex. 77 at 65. The plan directs staff to ask the resident whether she is hurting, to monitor her facial expressions, and to "monitor less (sic) episodes of moaning if on one side or other." (Because R1 was paralyzed on one side, I assume this means that, when R1 was lying down, staff were supposed to monitor whether her level of pain varied depending on which side she lay.) CMS Ex. 77 at 58.

Significantly, the nursing notes for February 2013 describe a resident who is able to convey to staff her relatively infrequent complaints of pain. *See* CMS Ex. 77 at 116-121 (complaining of urinary pain at 4:00 a.m. on February 8).

A pain assessment, taken by the registered nurse at 11:45 a.m. on February 17 (not long after she was returned to her room), says that the resident "denied pain at present" and exhibited "no whining or crying." CMS Ex. 77 at 72. On the evening of February 17, she is described as "resting well in bed without [signs or symptoms] of distress. . . . No verbal or non-verbal indicators of pain expressed. . . ." CMS Ex. 77 at 119.

Citing to a page from her care plan, Petitioner also claims that R1 was required to sit up rather than lie down after meals. P. Pre-hrg. Br. at 11 (citing P. Ex. 16). But the care plan says nothing about the resident sitting up after meals. P. Ex. 16. Moreover, LPN Hagerman did not mention this as a reason she would not allow the resident to return to her room. CMS Ex. 12 at 5-6.

Petitioner attacks the credibility of the two housekeepers who observed and reported the incident. Petitioner gratuitously claims that the housekeepers disliked LPN Hagerman and wanted to get her into trouble. P. Ex. 4 at 3 (Henderson Decl. ¶ 6).[9] It alleges that their statements are inconsistent and that one of them recanted. P. Pre-hrg. Br. at 11. According to Corporate Nurse Executive, Annette Wenzler, Housekeeper Johnson had not even been in a position to observe the incident. P. Ex. 1 at 3 (Wenzler Decl. ¶ 3). But Housekeeper Johnson must have been in a very good position to observe because she took the radio to LPN Hagerman. CMS Ex. 12 at 6.

[9] Nurse Consultant Regina Henderson speculates that, because the housekeepers were "elderly," their perception of "loud music" might have differed from that of other staff members "in that the music could have been perceived as distasteful." P. Ex. 4 at 3 (Henderson Decl. ¶ 6). I accord no weight to this unsupported claim, which, in any event, does not help Petitioner's case. The facility residents are also (for the most part) *elderly*, and this would mean that the LPN was deliberately playing music that the residents would likely consider "loud" and "distasteful." *See* CMS Ex. 12 at 6 (claiming that the LPN turned the music on "for the residents").

Further, the housekeepers' statements are not only consistent with each other (CMS Ex. 12 at 4, 8), they are consistent with statements from the nurse aides who witnessed the incident. CMS Ex. 12 at 1, 3. They are even generally consistent with LPN Hagerman's own statement. LPN Hagerman admitted that she would not allow R1 to return to her room and that she told R1: "if you are going to cry, stay out here." CMS Ex. 12 at 6.

With respect to investigating and reporting, Petitioner concedes that the facility's housekeepers contacted Nurse Manager Foster at about 11:40 a.m. and that she arrived at the facility at about noon to begin an investigation and to ensure that LPN Hagerman "not have direct patient access." According to (current) Administrator Edward Hogan, Nurse Manager Foster "placed LPN [Hagerman] behind the nursing station," which, ironically, was about where the nurse was when the alleged abuse occurred. P. Ex. 3 at 2, 3 (Hogan Decl. ¶¶ 6b, 6c).

In an undated note titled "Reportable Occurrence," Social Services Director Lynch writes that LPN Hagerman was suspended "pending further investigation" and that a "final report [would] follow in five days." P. Ex. 12. A statement dated February 18 indicates that the facility's Quality-of-Life Director, Wayne Phillips, and Nurse Manager Foster met with LPN Hagerman at about 1:00 p.m. on February 17 and told her that she would be suspended pending a full investigation. P. Ex. 14; CMS Ex. 10 at 1 (advising the state agency that the LPN was "immediately suspended" pending the outcome of the investigation). But, according to Nurse Consultant Henderson, the facility did not suspend LPN Hagerman. It terminated her employment because she falsified medical records, signing off on treatment not provided. P. Ex. 4 at 2 (Henderson Decl. ¶ 5).[10] In fact, the termination notice is dated February 25; it alludes to the LPN having been "relieved by a nurse manager" at about 1:00 p.m. on February 17. CMS Ex. 49 at 1. So LPN Hagerman probably was suspended at the time and fired a week later.

Administrator Rawlins told the surveyors that he investigated the incident by reviewing the witness statements, consulting the regional staff, and interviewing LPN Hagerman. He concluded that staff "might have misinterpreted" the nurse's actions and he was therefore unable to determine whether the LPN abused R1. He took no further action. CMS Ex. 1 at 25; *see* P. Ex. 3 at 4 (Hogan Decl. ¶ 6e).

I find more than substantial evidence of resident abuse. The undisputed evidence establishes that R1, who was already upset and crying, wanted to return to her room but, against her express wishes, she was held at the nurses' station (or wheeled around the

[10] Falsifying medical records is a very serious offense, which the surveyors cited under the quality-of-care regulation, 42 C.F.R. § 483.10(k)(3). Among other examples, they noted that medications documented as "given" remained in the medication drawer. CMS Ex. 1 at 57.

facility) for about two and a half hours. And, consistent with the witness reports, the nurse responsible admitted that she told R1 that she would have to stay there if she were going to cry. CMS Ex. 12 at 5; *see* CMS Ex. 12 at 1, 3, 4, 8. The LPN willfully confined the resident to a geri-chair in a place the resident did not want to be. Her conduct was intimidating and caused the resident mental anguish as evidenced by her continued crying. The facility was therefore not in substantial compliance with 42 C.F.R. § 483.13(b).

Nor did the facility comply with federal regulations or its own policies with respect to reporting the incident immediately and protecting residents pending the outcome of an investigation. Approximately four hours elapsed between the onset of the incident and the housekeepers' reporting, and, for a significant portion of that time, R1 was subjected to ongoing abuse.[11] The nurse aides who witnessed the incident did not report it at all. The facility was therefore not in substantial compliance with its own policies or federal regulations requiring that alleged violations be reported immediately to the facility administrator and that residents be protected until the facility has completed an investigation. 42 C.F.R. § 483.13(c)(2); CMS Ex. 16 at 4, 6, 10; CMS Ex. 17 at 3; *see Rolling Hills*, DAB No. 2119 at 9-12 (finding that a nurse aide's short delay in reporting – in order to consult another nurse aide – violated the requirement that allegations of abuse be reported immediately).

Finally, even Administrator Hogan does not claim that the facility was substantially compliant, as, indeed, it was not. He argues that the scope and severity of the deficiency should be reduced. P. Ex. 3 at 7 (Hogan Decl. ¶ 7). I discuss below why CMS's immediate jeopardy finding is not clearly erroneous.

Resident 4 (R4). R4 was a 74-year-old woman who was admitted to the facility from a psychiatric hospital. CMS Ex. 78 at 5. Her diagnoses included amnestic disorder, not otherwise specified (i.e., memory loss of unknown cause), dementia, coronary artery disease, seizure disorder, schizophrenia, and multiple other disorders. Her mental functioning varied. CMS Ex. 78 at 6, 80.

On March 24, 2013, R4 accused the night nurse of being "mean" to her. She told the nurse to stay out of her room. To her credit, the nurse assured R4 that someone else would assist her, and she subsequently asked others to do so. CMS Ex. 12 at 11; CMS Ex. 78 at 118. The night nurse must also have reported the complaint (although I see no evidence of a written report) because, on that same day, a nurse on the unit told the dietary manager about the incident, and someone reported it to the director of nursing (DON). CMS Ex. 12 at 10, 14. But no one reported the incident to the facility administrator.

[11] Management's response to the housekeepers' reporting – which has included attacking their motives – makes understandable an employee's reluctance to report.

Administrator Rawlins first learned about the allegation *three days later*, when, at 5:30 p.m., someone from the facility's corporate office called to ask him about it. He asked the interim DON, who told him that someone called her with the allegation on Sunday, March 24, but admitted that she "had forgotten about it" and was only then starting the investigation. CMS Ex. 12 at 10; *see* CMS Ex. 10 at 5.

It seems that the facility initially reported the charges to the state agency on March 28. CMS Ex. 10 at 6. In a letter dated April 1, more than a week after R4 made the allegation, Social Services Director Lynch advised the state agency that the allegations were "found to be unsubstantiated because of the resident's moderately impaired cognitive ability." CMS Ex. 10 at 8-9.

I have no problem with the facility's conclusion that abuse did not occur. I see no evidence that the night nurse behaved inappropriately. But the facility's response to an allegation of abuse fell far short. In violation of the regulations and the facility's own policies, staff did not immediately report the allegations to the facility administrator. The DON did not even begin to investigate until three days after R4 made the allegation. The facility waited four days before reporting the allegation to the state agency and did not report the results of its investigation within five days. These deficiencies put it out of substantial compliance with 42 C.F.R. § 483.13(c).

Resident 19 (R19). The record does not include much information about R19 except that she had memory problems, was unable to recall the seasons or where she was, and had severely impaired cognitive skills. CMS Ex. 12 at 41.

On April 4, 2013, a lab technician, with the assistance of two nurse aides, attempted to draw blood from R19. Each aide held one of the resident's arms. When stuck with the needle, R19 began kicking. The lab tech told her, "Honey, if you kick me, it's going to hurt you more than me because I have this needle in your arm." CMS Ex. 10 at 22; CMS Ex. 12 at 32, 34, 45. The nurse aides immediately reported the incident, complaining about the lab tech's remarks. CMS Ex. 10 at 21; CMS Ex. 12 at 32, 40.

Sometime thereafter, Corporate Nurse Wenzler, Nurse Consultant Henderson, and the facility's DON met with and attempted to interview the lab tech. The nurses' descriptions of the encounter are chilling. Nurse Consultant Henderson testified that, when she tried to speak to the lab tech, she was "loud, rude, and even yelled at me." When asked to leave the facility, the lab tech refused and ultimately had to be escorted out. P. Ex. 4 at 4 (Henderson Decl. ¶¶ 9, 11-13). Corporate Nurse Wenzler describes the lab tech as "uncooperative." She refused to give a statement regarding the incident, but "became emotional . . . was rude and yelled at us." P. Ex. 1 at 5 (Wenzler Decl. ¶¶ 7, 8).

The facility did not report the incident to the state agency until April 6. CMS Ex. 10 at 21. Later, in a letter to the state agency, dated April 8, Administrator Hogan reported "no negative findings related to [the lab tech] being rude or speaking inappropriately to any resident." He concluded that the allegations of abuse were unsubstantiated. P. Ex. 20 at 1.

Notwithstanding the facility's representations to the state agency, Petitioner now seems to concede that the lab tech's comments were at least rude. P. Post-hrg. Br. at 4; P. Ex. 1 at 6 (Wenzler Decl. ¶¶ 14, 19) ("I found the lab technician's statement to be rude"); P. Ex. 4 at 4, 5 (Henderson Decl. ¶¶ 8, 18). Nevertheless, Petitioner justifies its long delay in reporting the incident to the state agency by claiming that the lab tech's rude remarks did not constitute verbal abuse. P. Post-hrg. Br. at 4.

As discussed above, the facility must investigate and report all allegations of abuse, and this incident is no exception. The facility's failure to report timely to the state agency put it out of substantial compliance with 42 C.F.R. § 483.13(c).

But the facility managers also dismissed too lightly the allegation of abuse. I find this inexcusable, inasmuch as they had also been on the receiving end of the lab tech's abusive behavior. Why would they assume that the lab tech treated the resident any better than she treated them? These nurse managers held positions of authority; R19 was powerless. Further, the nurses understood that they were dealing with an irrational response and that they were in a position to defend themselves (which they did by having the lab tech escorted out of the facility). But R19 was severely cognitively impaired and virtually defenseless.

Even if I agreed that the lab tech's comments could have been benign (which I do not), it seems highly unlikely that they were well-intentioned, given the lab tech's unhinged response to simple (and legitimate) questions asked by the nurse managers. It seems far more likely that this personality would have reacted with anger to the prospect of being kicked by a resident. Telling an elderly and demented resident, who is restrained and likely frightened, that she is going to hurt even more sounds intimidating, even threatening, and therefore meets the definition of abuse.

Petitioner also suggests that it should not be responsible for the lab tech's actions because she was not one of its employees but worked for a company with which Petitioner contracted. P. Ex. 1 at 4-5. Federal regulations hold the facility as responsible for the actions of its contractors as it is for the actions of its own employees. 42 C.F.R. § 483.20(k)(3)(i) (requiring that services arranged by the facility meet professional standards of quality); 483.75(h) (2) (providing that arrangements for services furnished by outside resources must specify that the *facility assumes responsibility for* obtaining services that meet professional standards and principles that apply to professionals providing services in such facility).

Resident 29 (R29). R29 was a 66-year-old woman suffering from chronic obstructive pulmonary disease, sciatica, and other disorders. She had multiple compression fractures and was in chronic pain. CMS Ex. 80 at 1, 9, 25. Her gait and balance were unsteady, and she required assistance with turning and repositioning. CMS Ex. 80 at 38, 42.

On April 5, during the survey, R29 told one of the surveyors that, two or three months earlier, a staff member had abused her by grabbing her breast. CMS Ex. 10 at 26; CMS Ex. 80 at 19. Social Services Director Lynch interviewed R29 that day. R29 told her that she was afraid of one of the nurse aides because he had "made a pass at her" (grabbed her breast and hugged her) but that the prior administrator had resolved the problem by transferring the aide to another hall. R29 said that she reported the incident to her daughter, who called the facility. R29 also said that, a few months earlier, she told the social services director about the incident, and, in a note dated March 1, Social Services Director Lynch documented that conversation. CMS Ex. 12 at 52-55.

Nurse Aide Shane Marshall conceded that, as he was starting his shift one afternoon, he saw R29 sitting at the bottom of the ramp way and hugged her. Tr. 70-72. He also testified that the resident was "rather hateful" and that he "always had a feeling that she had disliked me." Tr. 72. He opined that she disliked him because of his sexual preference. Tr. 73. He admitted that, as far as he knew, the facility had no policies about staff hugging residents and that, until this incident, it had not occurred to him that some people would not welcome that level of intimacy. Tr. 74.

Petitioner claims that, "ultimately," I refused to consider the nurse aide's testimony or evidence to support Petitioner's allegations involving R29. P. Post-hrg. Br. at 6. Petitioner misunderstands the issues here. I think the nurse aide's conduct was inappropriate, his judgment questionable, and I fault the facility for failing to train its staff to respect resident boundaries. I am nevertheless satisfied that Nurse Aide Marshall did not intend to abuse R29. Although misguided, he thought he was being kind by showing her some affection, and his conduct does not meet the definition of abuse. 42 C.F.R. § 488.301.

But the real problem in this instance was the facility's response to an allegation of abuse. In late February or early March, a resident charged that a staff member grabbed her breast. Under anyone's definition, this is an allegation of sex abuse. On March 1, Social Services Director Lynch spoke to the resident, her daughter, the accused nurse aide, and some other staff (although I see no investigative report in the record). CMS Ex. 12 at 48-52; P. Exs. 21, 22. Yet, the facility did not report the complaint to the state agency until April, when the resident complained to a surveyor. Again, this put the facility out of substantial compliance with 42 C.F.R. § 483.13(c).

The facility suspended the employee on April 5, over a month after the allegation was made and, ironically, after the facility determined that abuse had not occurred.

Resident 30 (R30). On March 22, 2013, R30 complained to the facility social worker that he was mistreated during and after a shower. He reported that two nurse aides prepared him for the shower. When one of the aides left, the other sprayed him with cold water. He complained that the water was cold but she sprayed him "two or three" times. He also complained that she wrapped a sheet tightly around his neck. When the aides returned him to his bed, using a lift, they "bumped" him against the lift's bar "between [his] legs." CMS Ex. 12 at 56-59.

Two days later, on March 24, he reported the incident to one of the facility nurses, who suggested that the nurse aide was just adjusting the water temperature. But R30 was adamant that she did it on purpose. "I just know. I would tell her it was too warm then she would turn it back to real cold." CMS Ex. 12 at 60.

The nurse questioned the nurse aide about the accusation and told her that she would have to "clock out." The accused nurse aide admitted that she had adjusted the water several times but claimed that the problem was with the water, which "had messed up before." CMS Ex. 12 at 60-61.

The facility's DON spoke to R30 on March 25. According to her report, R30 said that he and the accused had been "playin around" prior to his shower. While showering, he complained that the water was too cold, "so she turned it back." According to the DON's report, R30 claimed that the aide knew that the sheet was too tight around his neck. He also said that he hit his leg on the lift but, when pressed, conceded that he didn't know if it had been an accident, replying, "I guess." He became agitated by the questions and accused the DON of treating him "like a confused resident."[12] Ultimately, he said that he wasn't hurt. CMS Ex. 12 at 64. According to the DON's report, the facility administrator walked in at that point, and R30 repeated that he had not been hurt. CMS Ex. 12 at 64; *see* CMS Ex. 12 at 66.

In a written statement, the accused nurse aide claimed that, when she began R30's shower, he said that the water was ok. When he said it was getting too hot, she pulled it back to cool it down. When he said it was too cold, she adjusted it to be warmer. She said that she loosely wrapped the sheet around his neck and, with the other aide, took him to his room. CMS Ex. 12 at 63.

[12] I am concerned that R30 ended up on the defensive. If abuse complaints are not taken seriously, or, worse, those who report feel attacked and demeaned (see footnotes 9 and 11), people will be reluctant to report abuse. Here, the reports suggest that R30 was definite during his interview with the first nurse, even when challenged. By the time the DON completed her interview, though obviously angry, he seems to have given up.

In a written statement dated March 25, the other nurse aide described R30 as "laughing and cutting up" with the aides as they took him to the shower. After adjusting the water temperature, she left the shower room for about ten minutes. R30 seemed fine when she returned, according to the aide. They covered him with a sheet and returned him to his room. In transferring him to bed by means of the lift, the nurse aide claimed that she put her arm in front of his knees "as I always do" so that he would not be hit "in the private area." CMS Ex. 12 at 62.

The facility administrator reported the complaint to the state agency two weeks later, in a letter dated April 9, 2013. He told the state agency that the nurse aide involved would be suspended and not allowed to return to work until an investigation was completed and she was cleared. CMS Ex. 12 at 67.

Regardless of whether the nurse aides abused R30, the facility was not in substantial compliance with section 483.13(c) because it delayed so long in reporting the allegation of abuse.

Resident 31 (R31). Sometime in March 2013, R31 complained that two nurse aides handled her with excessive force. Sometime thereafter, R31's daughter reported that her mother had been "slammed down." Under any definition, that is an allegation of abuse and warranted immediate investigation and reporting.

DON Cathy Dennis apparently investigated, albeit belatedly. In an April 4, 2013 witness statement, a nurse aide reported that, while she and another aide were caring for a standing R31, R31 began to lean more of her weight than the aide could bear. To prevent a fall, the aides quickly lowered the resident on to her chair, and she "did sit down a little hard." CMS Ex. 12 at 69; *see* CMS Ex. 12 at 70. Administrator Hogan did not learn until April 9 that R31 had complained that a nurse aide "pushed her down in a chair." P. Ex. 35. He suspended the nurse aides involved and reported the allegation to the state agency. P. Exs. 35-37.

In an April 13 letter to the state agency, DON Dennis conceded that, three weeks earlier, R31 told her daughter that a nurse aide "slammed her down in a chair, saying 'Stand up, you can stand up.'" The daughter reported the incident to Social Services Director Lynch (who was apparently no longer social services director on April 13). DON Dennis acknowledged that the resident reported pain, but she minimized that complaint, quoting the resident as saying that it hurt for "a little while," and then "just for some minutes." Notwithstanding R31's complaints and the nurse aides' acknowledgment that they sat her down "a little hard," DON Dennis reported "no negative findings." P. Ex. 39.

At a minimum, the nurse aides should immediately have reported the incident, and staff should have immediately assessed the resident for injuries (even if this were a quality-of-

care problem rather than abuse). When R31's daughter complained that her mother had been "slammed down," Social Services Director Lynch should have reported the allegation of abuse, and the facility should have investigated immediately.

Because the allegation was not investigated or reported until long after the resident lodged her complaint, the facility was again not in substantial compliance with 42 C.F.R. § 483.13(c).

Administration. A finding of substantial noncompliance in the facility's administration may derive from findings of substantial noncompliance in other areas.

> [W]here a facility has been shown to be so out of compliance with program requirements that its residents have been placed in immediate jeopardy, the facility was not administered in a manner that used its resources effectively to attain the highest practicable physical, mental, and psychosocial well-being of each resident.

Asbury Center at Johnson City, DAB No. 1815 at 11 (2002); *Odd Fellow and Rebekah Health Care Facility*, DAB No. 1839 at 7 (2002); *Stone County Nursing and Rehab. Ctr.*, DAB No. 2276 at 15-16 (2009). As discussed below, I find that the facility's deficiencies posed immediate jeopardy to resident health and safety, which, by itself, justifies the finding that the facility was not in substantial compliance with 42 C.F.R. § 483.75.

Moreover, as the above discussion establishes, the failures here were directly attributable to administrative, as well as staff, failures. The facility's administration disregarded facility policies in failing to investigate and report timely allegations of resident abuse. It also fell short in protecting residents from a potential abuser. There is also no evidence that Petitioner's equivalent of a Quality Assurance (QA) Committee addressed or actually developed effective corrective actions after the repeated abuse allegations during February and March 2013. Even if a QA Committee met, which is speculative at best, there is no documentation supporting that it developed any strategies to address the pervasive abuse allegations. The facility was therefore not administered in a manner that used its resources effectively to attain or maintain the highest practicable physical, mental, and psychosocial well-being of its residents and was not in substantial compliance with 42 C.F.R. § 483.75, and 483.75(o)(1).

3. CMS's determination that the facility's substantial noncompliance posed immediate jeopardy to resident health and safety is not clearly erroneous.

Immediate jeopardy. Immediate jeopardy exists if a facility's noncompliance has caused or is likely to cause "serious injury, harm, impairment, or death to a resident." 42 C.F.R. § 488.301. CMS's determination as to the level of a facility's noncompliance (which

would include an immediate jeopardy finding) must be upheld unless it is "clearly erroneous." 42 C.F.R. § 498.60(c). The Board has observed repeatedly that the "clearly erroneous" standard imposes on facilities a "heavy burden" to show no immediate jeopardy and has sustained determinations of immediate jeopardy where CMS presented evidence "from which '[o]ne could reasonably conclude' that immediate jeopardy exists." *Barbourville Nursing Home*, DAB No. 1931 at 27-28 (2004) (citing *Koester Pavilion*, DAB No. 1750 (2000)); *Daughters of Miriam Center*, DAB No. 2067 at 7, 9 (2007).

Petitioner argues that no resident was "harmed, injured, or suffered any emotional or physical harm or was at risk thereof." P. Pre-hrg. Br. at 22; P. Post-hrg. Br. at 15. But I need not find that the facility's noncompliance caused actual harm or injury to a resident. So long as the deficiencies are likely to cause serious injury or harm, they pose immediate jeopardy. Here, the evidence shows that at least one, and maybe as many as three, residents suffered actual harm. Even if they had not, these are the types of incidents likely to cause serious injury or harm:

- R1, already visibly upset, was forced to remain where she did not want to be, and, according to the evidence, cried for hours until returned to her room.

- The lab tech menaced R19, who was demented, frightened, and restrained, with a needle in her arm.

- A male aide inappropriately and without R29's consent, hugged R29 in what she believed even one month later to be an act of sexual abuse against her.

- Staff caused or allowed R31 to hit a chair with excessive force, and she complained that it hurt.

Petitioner also asserts that the cited deficiencies were isolated and did not constitute systemic failures. P. Pre-hrg. Br. at 22; P. Post-hrg. Br. at 15. In fact, multiple facility employees – including the employees specifically charged with implementing the facility's abuse policies – repeatedly disregarded those policies in critical respects: reporting, protecting the residents, and investigating. Such disregard for the policies in place to protect residents from abuse puts those residents at risk, and the situation is likely to cause serious harm. CMS's determination that the deficiencies posed immediate jeopardy to resident health and safety is therefore not clearly erroneous.

4. The penalty is reasonable.

To determine whether the CMPs are reasonable, I apply the factors listed in 42 C.F.R. § 488.438(f): 1) the facility's history of noncompliance; 2) the facility's financial condition; 3) factors specified in 42 C.F.R. § 488.404; and 4) the facility's degree of

culpability, which includes neglect, indifference, or disregard for resident care, comfort or safety. The absence of culpability is not a mitigating factor. The factors in 42 C.F.R. § 488.404 include: 1) the scope and severity of the deficiency; 2) the relationship of the deficiency to other deficiencies resulting in noncompliance; and 3) the facility's prior history of noncompliance in general and specifically with reference to the cited deficiencies.

I consider whether the evidence supports a finding that the amount of the CMP is at a level reasonably related to an effort to produce corrective action by a provider with the kind of deficiencies found, and in light of the above factors. I am neither bound to defer to CMS's factual assertions, nor free to make a wholly independent choice of remedies without regard for CMS's discretion. *Barn Hill Care Ctr.*, DAB No. 1848 at 21 (2002); *Community Nursing Home*, DAB No. 1807 at 22 *et seq.* (2002); *Emerald Oaks*, DAB No. 1800 at 9 (2001); *CarePlex of Silver Spring*, DAB No. 1638 at 8 (1999).

Here, CMS imposed a penalty of $5,050 per day for each day of immediate jeopardy, which is at the low end of the range for a per day CMP ($3,050-$10,000). 42 C.F.R. §§ 488.408(e)(1)(iii); 488.438(a)(1)(i).

The facility has a poor compliance history. It was not in substantial compliance during the three surveys immediately preceding this one: August 2010; July 2011; and June 2012. The deficiencies cited during the July 2011 survey posed immediate jeopardy to resident health and safety. Many of the deficiencies cited during those earlier surveys, including those that posed immediate jeopardy, were also found during this survey.

Specifically:

- During the survey immediately prior to this one, completed in June 2012, the facility was not in substantial compliance with, among other requirements, 42 C.F.R. § 483.20(k)(3)(i) (Tag F281 – resident assessment: comprehensive care plans/professional standards of quality). The facility did not subsequently maintain substantial compliance with this requirement because it was again not in substantial compliance with section 483.20(k)(3)(i) during this survey, at an even higher level of scope and severity (level E, worse than the level D cited in 2012);

- For the survey completed in July 2011, the facility was also not in substantial compliance with 42 C.F.R. § 483.20(k)(3)(i);

  Even more significant, the facility was then, as now, not in substantial compliance with 42 C.F.R. § 483.75 (Tag F490 – administration), cited at the immediate jeopardy level;

- For the survey completed in August 2010, the facility was not in substantial compliance with, among other requirements, 42 C.F.R. § 483.35(i) (Tag F371 – dietary services: sanitary conditions), a deficiency repeated during this survey.

CMS Ex. 3. Thus, the facility's history, by itself, justifies a penalty significantly higher than the $3,050 minimum.

Petitioner does not claim that its financial condition affects its ability to pay the CMP.

With respect to the remaining factors, not only was the facility not in substantial compliance with sections 483.13(b) and (c), it was not in substantial compliance with eleven additional program requirements, several of which were repeat deficiencies. CMS Exs. 1, 3. Moreover, the immediate jeopardy-level violations indicate that facility staff did not take seriously the facility's policies for preventing abuse and protecting the residents. From the facility administration on down, staff members repeatedly disregarded policies; they declined to investigate and report allegations of abuse; and alleged abusers continued, for indefinite periods, to provide direct care to residents. The facility is culpable for these failings.

Finally, I reject Petitioner's argument that its commitment to achieving compliance should be considered a mitigating factor in reducing the CMP. P. Pre-hrg. Br. at 23. A facility's efforts to stop violating federal regulations is hardly a mitigating factor. Facilities are supposed to maintain substantial compliance at all times.

For these reasons, I find that the CMP is reasonable.

Conclusion

The parties agree that, from February 17 through April 16, 2013, the facility was not in substantial compliance with Medicare participation requirements.

I find that, from February 17 through April 16, 2013, it was not in substantial compliance with 42 C.F.R. §§ 483.13(b) and (c), 483.75, and 483.75(o)(1), and that those deficiencies posed immediate jeopardy to resident health and safety. The penalty imposed for the period of immediate jeopardy – $5,050 per day for 59 days – is reasonable.

/s/
Carolyn Cozad Hughes
Administrative Law Judge