Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Talmadge Park, Inc.,
(CCN: 07-5294),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-13-1033

Decision No. CR4603

Date: May 6, 2016

DECISION

In this case we consider a long-term-care facility's accountability for the conduct of an employee who abuses a facility resident.

Petitioner, Talmadge Park, Inc., is a long-term care facility, located in East Haven, Connecticut, that participates in the Medicare program. Following a survey completed on April 25, 2013, the Centers for Medicare & Medicaid Services (CMS) determined that the facility was not in substantial compliance with Medicare program requirements, including 42 C.F.R.§ 483.13(b) and (c), which protect facility residents from abuse. CMS imposed a per instance civil money penalty (CMP) of $1,800 for the deficiencies cited under section 483.13.

Petitioner appeals, challenging the finding of substantial noncompliance.

For the reasons set forth below, I find that the facility was not in substantial compliance with 42 C.F.R. § 483.13(b) and (c).

Background

The Social Security Act (Act) sets forth requirements for nursing facility participation 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 conduct periodic surveys to determine whether skilled nursing facilities are in substantial compliance. Act § 1864(a); 42 C.F.R. § 488.20. The regulations require that each facility be surveyed once every twelve months, and 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.

Here, following a survey completed April 25, 2013, CMS determined that the facility was not in substantial compliance with program requirements, including 42 C.F.R. § 483.13(b) and (c) (Tag F223 – resident behavior and facility practices/freedom from abuse). CMS Exs. 1, 2. Based solely on that deficiency, CMS imposed against the facility a per instance CMP of $1,800. Petitioner timely requested a hearing.

The parties agree that an in-person hearing would serve no purpose and that my decision can be based on the written record. I have admitted into evidence CMS Exhibits (CMS Exs.) 1-9 and Petitioner's Exhibits (P. Exs.) 1-13. Summary of Prehearing Conference (May 8, 2015).[1]

Issue

The sole issue before me is whether the facility was in substantial compliance with 42 C.F.R. § 483.13(b) and (c). Except to argue that it was in substantial compliance with program requirements and is not subject to any penalty, Petitioner has not challenged the amount of the CMP.

[1] P. Exs. 1-9 are duplicates of CMS Exs. 1-9.

Discussion

The facility was not in substantial compliance with 42 C.F.R. § 483.13 (b) and (c) because one of its staff members abused a resident.[2]

Program requirements. The regulation governing resident behavior and facility practices mandates that each resident "has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion." 42 C.F.R. § 483.13(b). Abuse is defined as "the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish." 42 C.F.R. § 488.301. The phrase "willful infliction" means that the actor must have acted deliberately, not that the actor must have intended to inflict injury or harm. *Merrimack Cnty. Nursing Home*, DAB No. 2424 at 4 (2011); *Britthaven, Inc., d/b/a Britthaven of Smithfield*, DAB No. 2018 at 4 (2006).

In order to keep residents free from abuse, facilities must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents. Among other requirements, the facility must ensure that all alleged violations are reported immediately to the facility administrator and appropriate state officials. 42 C.F.R. § 483.13(c).

The abuse. The parties do not dispute the basic facts of this case. Resident 89 (R89) was a 90-year old man suffering from advanced dementia and depression. His cognition was severely impaired. He required extensive to total assistance with activities of daily living. He had behavior problems "characterized by ineffective coping." CMS Ex. 4 at 12, 13; CMS Ex. 5 at 1; CMS Ex. 9 at 1. To address his ineffective coping, agitation, and frustration, his care plan directed staff to redirect and counsel him "in a quiet manner." CMS Ex. 4 at 12. The resident was "to sit quietly for 10 min[utes] upon request." If his behavior became disruptive or unacceptable, staff were to remove him from the public area, talk to him "in a low pitch, calm voice" to decrease the undesired behavior, and provide him with a "diversional activity." CMS Ex. 4 at 12.

An alert and fully oriented resident reported that, at about 5:30 or 6:00 p.m. on December 15, 2012, R89 was agitated and stood up from his wheelchair, interfering with a conversation between two nurse aides. The reporting resident saw one of the nurse aides grab R89 by the arms and "forcefully slam him down" into his chair. CMS Ex. 7 at 1, 3, 4. R89 suffered bruising on his arm. CMS Ex. 5 at 2. In her own statement, the accused nurse aide conceded that, when the resident stood up, she "pulled him back into his wheelchair and reclined it further back." She pulled his chair away from the table and left him. CMS Ex. 7 at 6. She did not counsel him "in a quiet manner"; she did not

[2] I make this one finding of fact/conclusion of law.

remove him from the public area; she did not divert him with an activity. In short, she disregarded all his care plan instructions.

The facility determined that the nurse aide had "forcefully slammed" R89 into his chair, and it fired her for providing "rough care." CMS Ex. 5 at 4; CMS Ex. 8. But the facility declined to characterize the treatment as abusive and, in a letter dated January 17, 2013, advised the state agency that the abuse allegation was not substantiated. CMS Ex. 5 at 3.

I find that the nurse aide abused R89. By any standard, grabbing, "slamming down," and bruising a resident constitutes abuse. That the victim was a demented 90-year-old man makes the abuse even worse, because he was so confused, defenseless, and vulnerable.

Petitioner, however, argues that it should not be held accountable for the nurse aide's conduct because the facility "properly trained and supported its staff to ensure that [they] interacted appropriately with residents." In Petitioner's view, the facility did "everything it was required to do" and should not be cited for abuse "simply because an abusive act allegedly occurred." P. Br. at 4, 6. According to Petitioner, a facility should be cited only if it lacks policies to prevent abuse or fails to train the abuser. P. Br. at 6.

Petitioner's argument fails for several reasons. Most dispositive, section 483.13(b) is unequivocal and means exactly what it says: *each* resident *must* be free from physical abuse. A single instance of abuse puts the facility out of substantial compliance with 42 C.F.R. § 483.13(b).[3] The fact of the abuse, by itself, puts the facility out of substantial compliance and justifies the relatively low CMP imposed here.

Moreover, while the parties agree that the facility had in place written policies prohibiting abuse (CMS Ex. 6), Petitioner has not established that it adequately implemented those policies. In fact, the evidence suggests otherwise. The facility policy requires staff to report *immediately* any signs of abuse. CMS Ex. 6 at 6, 10. At least one other nurse aide (the one speaking to the abuser) was in the dining room and witnessed the incident. Yet no staff member reported the incident.

Nor has Petitioner established that it adequately trained its employees (which its policies also require). CMS Ex. 6 at 1, 9. A nurse aide abused a resident; another nurse aide

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[3] No comparable provision precludes neglect. The sole anti-neglect provision – section 483.13(c) – is not as straightforward as section 483.13(b), raising questions as to whether a single instance of neglect supports a finding of substantial noncompliance. Because of the way section 483.13(c) is written, the Departmental Appeals Board instructs us to consider whether the facts show an "underlying breakdown in the facility's implementation of its anti-neglect policy." *Avalon Place Kirbyville*, DAB No. 2569 at 12 (2014). *But see* 59 Fed. Reg. 56,130 (November 10, 1994) (declaring that the requirement that each resident be free from neglect is "inherent in section 483.13(c).").

witnessed the abuse but took no action to prevent or report it. Both nurse aides were faced with an agitated resident whose care plan included specific instructions for addressing his problem behavior. Yet neither nurse aide implemented any of the interventions called for.

The Departmental Appeals Board has rejected the proposition that a facility complies with section 483.13(c) so long as it has policies in place and trains its employees, observing that:

> [s]anctions on facilities for failing to implement policies and procedures to prohibit neglect or abuse through their staff serve the obvious goal of encouraging facilities to maintain hiring, training, and supervision practices that protect residents.

Life Care Ctr. of Gwinnett, DAB No. 2240 at 13 (2009).

Because Petitioner has not established that it properly implemented its anti-abuse policies, it was not in substantial compliance with section 483.13(c).

Conclusion

The facility was not in substantial compliance with 42 C.F.R. § 483.13(b) and (c), and the penalty imposed, which Petitioner has not challenged, is reasonable.

/s/
Carolyn Cozad Hughes
Administrative Law Judge