Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Antonia Malla a.k.a. Toni Malla
(OI File Number 9-09-40444-9),

Petitioner

v.

The Inspector General.

Docket No. C-11-23

Decision No. CR2312

Date: January 20, 2011

DECISION

I sustain the determination of the Inspector General (I.G.) to exclude Petitioner, Antonia Malla, a.k.a. Toni Malla, from participating in Medicare, Medicaid, and other federally funded health care programs for a minimum of five years.

I. Background

The I.G. determined to exclude Petitioner for a minimum of five years, alleging that she had been convicted of a criminal offense relating to the neglect or abuse of patients in connection with the delivery of a health care item or service, as described at section 1128(a)(2) of the Social Security Act (Act). Petitioner requested a hearing, and the case was assigned to me for a hearing and a decision.

The I.G. filed a brief and seven proposed exhibits, which are identified as I.G. Ex. 1 – I.G. Ex. 7. Petitioner filed a brief and no proposed exhibits. The I.G. filed a reply brief with seven proposed exhibits, which are identified as I.G. Ex. 8 – I.G. Ex. 14. Petitioner objected to my receiving into evidence I.G. Ex. 6 and I.G. Ex. 7. She objected to my receiving I.G. Ex. 6 primarily on the grounds that it contains evidence that is irrelevant to

the issues in this case and that it contains hearsay. She objected to my receiving I.G. Ex. 7 on the grounds that it is irrelevant and that it is not authenticated.

I sustain Petitioner's objections. I.G. Ex. 6 is a police report consisting mostly of interviews of individuals who were witnesses to the incident that underlies the criminal conviction that is at the heart of this case. The evidence contained in the report is hearsay, to be sure, but that does not in and of itself render it inadmissible in this proceeding. I routinely admit hearsay evidence, even if I may ultimately accord it little or no probative value. However, I do not find that I.G. Ex. 6 contains any evidence that is necessary to deciding the case. The exhibit essentially states facts that are subsumed in the criminal charges to which Petitioner pled guilty. I.G. Ex. 7 is purported to be a photograph of the individual who was injured in the incident. It also evidences no facts that are not established elsewhere in the record of this case, and I exclude it for that reason.

I also exclude I.G. Ex. 8 – I.G. Ex. 14. These are exhibits that the I.G. plainly could have filed with his initial exchange in this case. The I.G. has made no showing justifying filing these exhibits untimely.

I receive into evidence I.G. Ex. 1 – I.G. Ex. 5.

I note that the I.G.'s brief is entitled "The Inspector General's Motion for Summary Judgment on the Written Record." That is an inaccurate characterization of the process. Summary judgment is a process by which a case is decided based on undisputed material facts. *See* Fed. R. Civ. P. Rule 56. But, that is not what is before me. I directed the parties to file all of their proposed evidence along with their briefs and to tell me whether they desired an in-person hearing. Neither party expressed an interest in an in-person hearing, so this case is ripe for decision based on the written record, *even if* there are disputed issues of material fact. Thus, I decide the case without regard to the rules governing summary judgment but based on the evidence before me.

II. Issues, Findings of Fact, and Conclusions of Law

A. Issues

The issues in this case are whether:

1. Petitioner was convicted of a crime as is described at section 1128(a)(2) of the Act; and

2. An exclusion of at least five years is mandated by law.

B. Findings of Fact and Conclusions of Law

I find as follows:

1. Petitioner was convicted of a crime as is described at section 1128(a)(2) of the Act.

The necessary elements of a conviction that is described at section 1128(a)(2) of the Act are that: (1) the excluded individual must be convicted of a crime in a State or a federal court; (2) the crime must relate to abuse or neglect; and (3) the abuse or neglect must be of a patient and in connection with the delivery of a health care item or service. All three of those elements are met here.

First, it is undisputed that Petitioner was convicted of a crime. On April 2, 2009, Petitioner entered a guilty plea in a Washington State court to the crime of Failure to Report, a crime that is punishable by up to a year in prison. I.G. Ex. 2. On May 11, 2009, the court accepted Petitioner's plea, and a judgment of guilty was entered against her. I.G. Ex. 3 at 1.

Second, the evidence establishes that Petitioner's crime relates to neglect or abuse. Petitioner is the licensed owner of three adult family homes in the Seattle, Washington area. I.G. Ex. 5 at 1. One of these homes is known as the "TLC Adult Family Home, Thistle" (TLC). Under Washington law, an adult family home is a dwelling in which a person or persons provide personal care, special care, and room and board to more than one but not more than six adults who are not related by blood or marriage to the person or persons providing the services. *Id.*

One of the residents at TLC was an individual who I identify as AH. The resident suffered from a number of illnesses and disabilities. She had left-sided hemiplegia (weakness), connective disorder, emphysema, lupus, short-term memory problems, chronic obstructive pulmonary disease, and a bipolar disorder. AH was wheelchair bound. I.G. Ex. 5 at 2. AH also took a variety of medications that had a sedating effect. *Id.*

AH was a cigarette smoker who smoked a pack of cigarettes per day. She also was dependent on portable oxygen. AH was dependent on her care givers to administer and remove her oxygen and also provide her with cigarettes, to light them, and to supervise her while she smoked. I.G. Ex. 5 at 4. The State of Washington had warned homes like TLC of the dangers of residents smoking in the vicinity of oxygen. *Id.* The State advised these homes that a resident should not smoke within ten feet of an oxygen container and that a resident's oxygen supply should be turned off and the nasal cannula removed from the resident's face while the resident smoked. *Id.*

On March 10, 2007, AH was severely burned while smoking and simultaneously using oxygen. I.G. Ex. 5 at 2. The employee of TLC who had direct responsibility for providing care to AH, and who failed to protect AH against smoking while using oxygen, was charged with the crime of criminal mistreatment in the first degree. I.G. Ex. 4 at 1.

The common and ordinary meaning of "neglect" is the failure to attend to the needs of an individual in the circumstance where the party who is charged with neglect has the duty to provide care to that individual. *Summit Health Ltd., dba Marina Convalescent Hosp.*, DAB No. 1173 at 8 (1990). The employee who facilitated AH's smoking in the presence of oxygen was charged with recklessly causing great bodily harm to AH by withholding from her the basic necessities of life. That crime is a crime of neglect of an individual because it is based on a failure to attend to AH's needs by a person who had the duty to care for AH. That duty of care had been assumed by TLC, when it accepted AH as its resident, and the employee had the direct responsibility for discharging that duty.

Petitioner's crime was that she failed to report the incident of March 10, 2007, as is required by Washington State law. It plainly is a crime that was *related to* neglect of AH. Under State law, she had the duty to report the incident of neglect that caused AH to be burned. But for that neglect she would have had no duty to make a report.

Third, Petitioner's conviction relates to the neglect of a patient in connection with the delivery of a health care item or service. Portable oxygen – such as the oxygen that AH received – is a health care item or service. I take notice that oxygen is prescribed by a physician to treat respiratory illnesses, such as AH's chronic obstructive pulmonary disease and emphysema. TLC was directly responsible for providing AH with access to portable oxygen. Its staff administered oxygen to the resident, ensured that she had access to oxygen, and was responsible for protecting her against the risks associated with using oxygen. Thus, TLC, through its staff, was administering a health care item or service to AH.

AH was a "patient." She was a patient of the physician who prescribed the oxygen to her. But, she was also a patient of TLC. Petitioner argues that TLC was not a health care facility, but merely a place of residence for individuals such as AH. That assertion is overwhelmingly refuted by the evidence. TLC was not a simple rooming house or boarding facility. It was a licensed provider of health care, subject to the authority of State law. It may not have met the criteria for Medicare reimbursement for its services as a skilled nursing facility, but it provided health care items or services nonetheless. It was required, pursuant to Washington law, to perform resident assessments, which, among other things, documented the residents' requirements for special care. I.G. Ex. 5 at 3. It was required to administer care to its residents consistent with their documented needs. And, its staff was required to administer medical items or services to residents such as the oxygen that they administered to AH.

Nothing in section 1128(a)(2) suggests that the word "patient" should be defined so narrowly as to exclude the relationship that TLC maintained with its residents. The term clearly subsumes the kind of relationship that existed between TLC and AH, a relationship that was regulated by State law and which required TLC's staff to assess the needs of its residents, including their needs for special care, and to meet those needs by providing care that included care prescribed by and delivered under the general control of a physician.

Petitioner argues that *she* had no relationship with AH that made AH her patient. She describes herself essentially as a passive owner of TLC and the other residences that she owned and not responsible for providing care to any of the residents of these facilities. Consequently, according to Petitioner, there is no nexus between her ownership of TLC and any act of neglect that may have occurred in providing care to AH.

Petitioner misreads section 1128(a)(2). The section does not apply solely to individuals who have a direct relationship with patients who are under their personal care. It has a much broader reach than that. It applies to any individual who is convicted of a crime relating to abuse or neglect of a patient in connection with the delivery of a health care item or services. The term "relating to" sweeps in crimes in which the relationship between the perpetrator and the victim is indirect, as well as those crimes committed by caregivers in the course of providing care.

Furthermore, and Petitioner's assertions notwithstanding, she did have a care giver's relationship with AH. Petitioner was not simply a passive owner of TLC, she bore a direct and personal responsibility for assuring that TLC was operated in a manner that was consistent with State law. As TLC's owner, Petitioner bore ultimate responsibility for assuring that AH received the care that she had contracted to receive. In a brochure that Petitioner published, she described her primary responsibility as ensuring that TLC is run according to the requirements of law. I.G. Ex. 5 at 1.

Finally, Petitioner argues that there are equitable considerations that operate in her behalf. She contends that her crime had no personal impact on AH and could not have harmed her. Consequently, she asserts, it is unfair to make her liable for the events that led to AH's injuries.

Section 1128(a)(2) does not allow for equitable exceptions. There is nothing in the Act that excuses an individual from liability based on fairness grounds. Moreover, I disagree with Petitioner that it would be inequitable or unfair to exclude Petitioner. As I have stated, Petitioner was not simply a passive equity owner of TLC. As owner of TLC, she bore direct and personal responsibility for assuring that each resident was treated consistent with State requirements.

2. An exclusion of at least five years is mandated by law.

An individual who is excluded pursuant to section 1128(a)(2) must be excluded for at least five years. Act § 1128(c)(3)(B). The exclusion that the I.G. imposed against Petitioner – at least five years – is thus for the statutory minimum period and is reasonable as a matter of law.

/s/
Steven T. Kessel
Administrative Law Judge