Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

In the Case of:	)	
	)	
Illinois Knights Templar Home,	)	Date: January 6, 2009
	)	
Petitioner,	)	
	)	
- v. -	)	Docket No. C-08-537
	)	Decision No. CR1879
Centers for Medicare & Medicaid Services.	)	
	)	

DECISION GRANTING MOTION FOR SUMMARY JUDGMENT

I grant the motion of the Centers for Medicare & Medicaid Services (CMS) for summary judgment against Petitioner, Illinois Knights Templar Home. I find that the undisputed material facts of this case establish that Petitioner failed to protect its residents against abuse, in violation of the requirements of 42 C.F.R. § 483.13(a) and (b).[1] Based on that I sustain CMS's determination to impose civil money penalties against Petitioner consisting of the following:

- $3050 per day for each day of a period that began on March 28, 2008 and which continued through April 3, 2008; and

- $300 per day for each day of a period that began on April 4, 2008 and which continued through April 30, 2008.

[1] CMS made additional allegations of noncompliance and moved for summary judgment with respect to some of them. I find it unnecessary to address these additional allegations in order to sustain CMS's remedy determinations.

I. Background

Petitioner is a skilled nursing facility doing business in the State of Illinois. It participates in the Medicare program. Its participation in Medicare is governed by sections 1819 and 1866 of the Social Security Act and by regulations at 42 C.F.R. Parts 483 and 488. Its right to a hearing in this case is governed by regulations at 42 C.F.R. Part 498.

CMS determined to impose the remedies that I describe above based on noncompliance findings that were made at a survey of Petitioner's facility on April 14, 2008 (April survey). Petitioner requested a hearing and the case was assigned to me for a hearing and a decision. CMS moved for summary judgment and Petitioner opposed the motion.[2]

II. Issues, findings of fact and conclusions of law

A. Issues

The issues in this case are whether the undisputed material facts support findings that:

1. Petitioner failed to protect its residents against abuse;

2. CMS's determination of immediate jeopardy level noncompliance is not clearly erroneous; and

3. CMS's remedy determinations are reasonable.

B. Findings of fact and conclusions of law

I make findings of fact and conclusions of law (Findings) to support my decision in this case. I set forth each Finding below as a separate heading and I discuss it in detail.

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[2] CMS filed 70 proposed exhibits which it identifies as CMS Ex. 1 - CMS Ex. 70. Petitioner filed 18 proposed exhibits which it identifies as P. Ex. 1 - P. Ex. 18. I am receiving all of these proposed exhibits into the record of this case and I cite to some of them in this decision for purposes of illustration. However, I make no evidentiary findings based on the exhibits. My fact findings in this decision are based solely on the undisputed material facts as averred by the parties in CMS's motion and Petitioner's opposition to it.

1. The undisputed material facts establish that Petitioner failed to protect its residents against abuse .

The regulation that is at issue here provides that a resident of a skilled nursing facility has the right to be free from verbal, sexual, physical, and mental abuse. "Abuse" is defined at 42 C.F.R. § 488.301 to mean "the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish." The regulation provides further that a facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents.

CMS's noncompliance allegations with this regulation center around the performance of a certified nursing assistant (CNA) on Petitioner's staff who I identify as "H" for purposes of this decision. CMS contends that Petitioner was aware that H had demonstrated an explosive temper in his interactions with residents and other staff but, nevertheless, failed to take decisive action to address that conduct.

CMS's allegations encompass two incidents involving H and residents. CMS contends that, on September 9, 2007, H and two other CNAs entered a room shared by two residents in order to provide care to them. While he was in the room, H was witnessed by other staff members to be repeatedly bumping or hitting his knee against the footboard of a resident's (identified as Resident # 4) bed. Resident # 4 is a 90-year old individual who is blind. An altercation between H and two other CNAs ensued when one of them asked H to cease this behavior and H did not do so. During the course of this altercation, H allegedly threatened one of the other CNAs. This altercation was punctuated by yelling among H and the other CNAs. H allegedly became very agitated and then left Petitioner's premises before completing his shift. CMS Ex. 16, at 2; CMS Ex. 41, at 1-2. Before leaving, H told a registered nurse that he was too angry to work and felt that he could not control himself. CMS Ex. 16, at 22.

H subsequently received a written warning concerning his behavior which stated that he had engaged in "uncooperative behaviors or acts that are in disregard of established personnel policies or procedures." CMS Ex. 43, at 2.

The second incident involving H allegedly occurred in October 2007. On October 18, 2007 a CNA reported to her supervisor that, one and one-half weeks previously, she had witnessed an incident involving H and a Resident who is identified as Resident # 13, an 88 year old individual. The CNA reported that she had observed H preparing to lift the resident mechanically. According to the CNA, Resident # 13 complained about the

manner in which he was being handled by H. Reportedly, H threatened to roll the resident onto the floor if he kept complaining. CMS Ex. 16, at 6; CMS Ex. 42, at 9. The CNA reported, additionally, that she had witnessed H being rude to other residents. CMS Ex. 42, at 3.

Petitioner terminated H's employment on October 19, 2007, based on the two incidents that I have described and on other reports of rude and angry behavior by H.

The facts offered by CMS, if not rebutted, provide a strong basis to conclude that Petitioner failed to prevent residents from being abused. H's behavior on September 9, 2007 should have been cause for his immediate termination as an employee. Residents of nursing homes are the most vulnerable individuals in our society. They are persons who are, by definition, incapable of caring for themselves, and they are literally at the mercy of the nursing facility staff who are assigned to care for them. On September 9, H engaged in conduct that jeopardized the physical and emotional well-being of at least two of Petitioner's residents. He repeatedly struck the bed of a 90-year old blind resident. He refused to cease striking the bed when another member of Petitioner's staff requested that he stop. He engaged in a loud altercation with other staff in which he uttered threats, in the intimate presence of two of Petitioner's residents. Neither of these residents had the wherewithal to defend themselves against H's conduct.

The facts as offered by CMS show that Petitioner's response to the September 9 incident was inappropriate. H received no discipline from Petitioner other than a written warning. Petitioner did not suspend H nor did it terminate his employment based on that incident. No efforts were made by Petitioner to assure that either of the two residents who were at a minimum the indirect victims of H's temper were provided heightened protection.

The failure by Petitioner to treat H's September 9 outburst with appropriate gravity establishes a misunderstanding – at least – by Petitioner of its obligations to protect residents against abuse. Petitioner knew that it had on its staff an individual who demonstrated a proclivity for an explosive temper. That knowledge should have triggered an immediate response by Petitioner's management. Management should have taken steps, as soon as it was apprised of the incident, to sever its relationship with H and to protect residents from him. In fact, its response – consisting only of a warning to H – was tepid and ineffective.

The subsequent incident that occurred in October is confirmation that H's employment should have been terminated at an earlier date. But, more than that, it evidences a failure on Petitioner's part to educate its staff as to the necessity for reporting immediately all

episodes of possible abuse.[3] There is no reasonable justification for the CNA who reported H's October conduct to have waited more than a week before doing so. An incident such as that which was described by the CNA should have been reported immediately.

I find to be unpersuasive Petitioner's arguments in opposition to CMS's motion. Petitioner asserts, first, that "the only undisputed fact [about the September 9 event] is that the resident allegedly abused, . . . [Resident # 4], slept through the entire event." Petitioner's response to CMS's motion at 2. That assertion is simply incorrect. Petitioner has produced no evidence to contradict the events that were reported by the two other CNAs who were in the residents' room with H on the night of September 9. There is nothing in the record to contradict CMS's contentions that: H struck Resident # 4's bed board repeatedly; that an altercation ensued between H and two other CNAs while they were in the residents' room that was punctuated by yelling; and that during the course of this altercation H threatened one of the two CNAs who were in the room with him.

In opposing CMS's motion, Petitioner offers the affidavit of Katheryn L. Swan, Petitioner's administrator. P. Ex. 7. Ms. Swan was not present at the events of September 9, but, in performing her duties as administrator she subsequently interviewed H and the other CNAs involved in the incident, along with the residents. Ms. Swan characterizes the striking of Resident # 4's bed board by H as "unintentional tapping" and as a "nervous tic." For purposes of my decision I am accepting these characterizations as accurate. But, even if H did not strike the resident's bed board as a demonstration of his anger or in order to intimidate the residents, failure to stop doing it when asked and his subsequent outburst when confronted by the other CNAs about his conduct was utterly unacceptable. Ms. Swan does not deny that the episode of September 9 culminated in an angry confrontation between H and the two other CNAs in the presence of the two residents.

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[3] Petitioner contends that there is a dispute as to whether the October incident actually occurred because both H and the resident who was allegedly the subject of H's threats denied that it had happened. Thus, according to Petitioner, the October incident was a "fabricated allegation of abuse" rather than an episode of abuse. Petitioner's response to CMS's motion at 4. But, assuming for the purposes of this decision that Petitioner's characterization of the facts is accurate, it does not justify the CNA who reported the allegations delaying for more than one week communicating to Petitioner's management what she claimed to have observed. Thus, there was a failure in Petitioner's abuse prevention policies even if, as Petitioner contends, no abuse actually occurred in October 2007.

Petitioner argues also that, even if the facts as alleged by CMS are true, they do not establish any basis for finding that Petitioner failed to protect its residents against abuse. The heart of Petitioner's argument is that H's conduct on September 9 and thereafter cannot be characterized as abusive because H did not intentionally seek to harm a resident and, because no resident was actually harmed by H's conduct.

Petitioner's argument rests on its contention that there cannot be abuse without evidence of actual injury being inflicted. Petitioner asserts that neither Resident # 4 nor Resident # 17 were injured by H on the night of September 9. Indeed, according to Petitioner, Resident # 4, the resident whose bed was struck by H, slept through the incident.

But, it is not necessary for me to find that H actually harmed either of the two residents or even that he intended to harm these two individuals. What is evident here is that, on the night of September 9, 2007, H demonstrated beyond peradventure that he had a clear inability to control his temper while in the presence of residents and while providing care to them. The risk to Petitioner's residents was H's inability to suppress his anger. That danger was made apparent by H's conduct on September 9 whether or not he actually abused the two residents during the incident. The September 9 event put Petitioner on notice of an urgent need to protect its residents from H's explosive temper. Its failure to take immediate measures to do so and the failure of Petitioner's management to understand the risks inherent to its residents from having a person like H on Petitioner's staff comprises Petitioner's noncompliance in this case. 42 C.F.R. § 483.13(b).

There is no question that abuse occurs when an employee of a skilled nursing facility intentionally harms a resident. But, that does not suggest that a facility's obligations are satisfied when no one is hurt in a particular event. The regulation squarely imposes on a facility the duty to take notice of potential abuse and to take all reasonable measures to assure that negative outcomes do not occur. Here, Petitioner knew that it had on its staff an individual with an explosive temper. Even H acknowledged that his anger on the night of September 9 was so intense that he was afraid that he could not control it. CMS Ex. 16, at 22. That knowledge imposed on Petitioner the duty to take all reasonable measures to protect its residents against a possibly abusive outburst from H. It also imposed on Petitioner the duty to make certain that its management and staff were thoroughly trained and educated to be able to identify potentially dangerous situations and to avert them. The undisputed material facts establish that Petitioner satisfied neither of these obligations.

2. CMS's finding of immediate jeopardy level noncompliance was not clearly erroneous.

The undisputed material facts of this case establish that Petitioner failed to comprehend how H's continued presence on its staff posed grave risks for residents of the facility. There is ample reason to conclude that Petitioner's failure to understand its obligations put residents of the facility at immediate jeopardy.

"Immediate jeopardy" is defined as a situation in which 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. It is apparent from the plain language of the regulation that immediate jeopardy may exist at a facility even where actual injury, harm, impairment, or death has not occurred. What is frequently determinative in establishing immediate jeopardy is whether a *likelihood* of adverse consequences is demonstrated by a facility's noncompliance.

Here, the likelihood of eventual serious injury, harm, impairment, or death to a resident was made apparent not only by Petitioner's failure to terminate immediately an employee with an uncontrollable temper but, more importantly, by its failure to comprehend why keeping this individual on its staff posed great danger to residents. Petitioner simply failed to understand that having an employee with anger management problems dealing with aged, sick, and highly vulnerable residents was a recipe for disaster.

Petitioner has not proven CMS's determination to be clearly erroneous. It has offered no fact to prove that, for example, that H's temper was any less explosive that CMS depicts it to be. Nor has it demonstrated how it implemented measures to protect its residents from future harm associated with having other employees with anger management problems.

Petitioner contends that, by the April survey, it was sensitized to the possibility of abuse because it opened an abuse investigation based on assertions by residents that they had been intimidated by questions asked of them by the surveyors who conducted the April survey. I find this argument to be self-serving but, it also misses entirely the point of CMS's findings of noncompliance. Petitioner has simply offered no facts to show that it learned from its experience with H at any time prior to the April survey and implemented policies designed to avoid a repeat of the kinds of anger outbursts that this former employee demonstrated.

3. The undisputed material facts establish that CMS's remedy determinations are reasonable.

There are two remedies that are at issue here. First, CMS determined to impose civil money penalties of $3050 per day against Petitioner for each day of a seven-day period beginning on March 28 and continuing through April 3, 2008. This remedy addresses Petitioner's immediate jeopardy level noncompliance and its duration reflects the period when CMS determined that immediate jeopardy continued at Petitioner's facility. Second, CMS determined to impose civil money penalties of $300 per day against Petitioner for each day of a 27-day period beginning on April 4 and continuing through April 30, 2008. This latter remedy addresses a period when, according to CMS, Petitioner remained noncompliant albeit at a level that is less than immediate jeopardy.

I find these remedies to be reasonable, both in duration and amount.

As to duration, CMS reasonably determined that immediate jeopardy persisted until Petitioner implemented an immediate jeopardy removal plan on April 3, 2008. The elements of that plan included revising Petitioner's employee handbook and abuse policies, developing an employee conduct review committee, in-servicing staff, re-educating Petitioner's administrator and assistant administrator on abuse policies, and replacing the administrator as the facility abuse coordinator. CMS reasonably determined that non-immediate jeopardy level noncompliance persisted until all additional steps that are described in Petitioner's corrective action plan were implemented. CMS Ex. 66, at 6-16, 32.

Petitioner asserts, incorrectly, that: "CMS argues only that the amount of the . . . [civil money penalties] are reasonable, without addressing whether the duration is reasonable." In fact, and as I discuss above, CMS clearly predicated its duration determination on the corrective action measures taken by Petitioner. There is nothing at all to suggest that CMS's determinations as to duration were arbitrary.

Moreover, it is Petitioner's burden to overcome the presumptions that its immediate jeopardy level noncompliance and its subsequent non-immediate jeopardy level noncompliance persisted until CMS determined that appropriate corrective actions had been taken. However, Petitioner has offered no facts to contradict CMS's asserted basis for its duration determinations.

Civil money penalty amounts are governed by regulations. Penalties for immediate jeopardy level deficiencies may range from $3050 to $10,000 per day. 42 C.F.R. § 488.438(a)(1)(i). There are regulatory factors that may be used to determine where within this range a civil money penalty amount may fall. 42 C.F.R. §§ 488.483(f)(1) -

(4); 488.404 (incorporated by reference into 42 C.F.R. § 488.438(f)(3). These factors include the seriousness of the deficiency; a facility's compliance history; and, its financial condition. However, these regulatory factors do not apply to deciding whether CMS's determination to impose penalties of $3050 per day to remedy Petitioner's immediate jeopardy level noncompliance is reasonable. That determination is reasonable as a matter of law inasmuch as the $3050 daily penalty amount is the minimum allowed by the regulations.

Civil money penalties to remedy non-immediate jeopardy level deficiencies may fall within a range of from $50 to $3000 per day. 42 C.F.R. § 488.438(a)(1)(ii). The same regulatory factors that apply to determining where within the allowable range an immediate jeopardy level penalty amount may fall apply to determining the amount of a non-immediate jeopardy level penalty.

The undisputed material facts support penalty amounts of $300 per day to remedy Petitioner's non-immediate jeopardy level deficiencies. $300 per day is at the low end of the permissible range for non-immediate jeopardy level deficiencies, comprising only ten percent of the allowable maximum amount. The $300 per day penalties CMS determined to impose are, therefore, quite modest. Moreover, Petitioner's noncompliance was serious. As I have discussed above, Petitioner's residents were at risk of abuse so long as Petitioner failed to comprehend the need for, and to implement effectively and fully, policies that were designed to protect its residents against potentially abusive employees.

Petitioner argues that there was no reason to assume that any of its residents were at risk inasmuch as it demonstrated its sensitivity to possible abuse allegations by immediately investigating the possibility that surveyors may have intimidated residents while conducting the April survey. To be sure, expeditiously investigating residents' complaints of possibly abusive statements is one element of an effective abuse prevention and protection plan. But, it is not the only element. As is demonstrated by Petitioner's own plan of correction, there were many other steps that Petitioner needed to take in order to protect its residents adequately.

/s/
Steven T. Kessel
Administrative Law Judge