Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Pine Meadows Health Care,
(CCN: 18-5215),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-12-1088

Decision No. CR2928

Date: September 23, 2013

DECISION

Petitioner, Pine Meadows Health Care (Petitioner or facility), is a long-term care facility located in Lexington, Kentucky, that participates in the Medicare program. This case centers around two disturbing events: 1) a nurse aide allegedly abused (verbally and physically) an anxious and demented resident; and 2) a nurse allegedly failed to suction – or even to assess – a distressed resident and then falsified the resident's medical records to indicate that he had responded appropriately.

Based on these and other findings from surveys completed April 28 and May 31, 2012, the Centers for Medicare & Medicaid Services (CMS) determined that the facility was not in substantial compliance with multiple Medicare program requirements and that its deficiencies posed immediate jeopardy to resident health and safety. CMS imposed civil money penalties (CMPs) of $3,550 per day for 87 days of immediate jeopardy and $100 per day for 10 days of substantial noncompliance that was not immediate jeopardy, for a total penalty of $309,850.

Petitioner appeals.

For the reasons set forth below, I find that the facility was not in substantial compliance with Medicare program requirements; that its deficiencies posed immediate jeopardy to resident health and safety; and that the penalties imposed are reasonable.

I. 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 complaint investigation survey completed April 28, 2012, CMS determined that the facility was not in substantial compliance with multiple program requirements, specifically:

- 42 C.F.R. §§ 483.13(b) and (c) (Tag F223 – resident behavior and facility practices/freedom from abuse) at scope and severity level J (isolated instance of immediate jeopardy);

- 42 C.F.R. § 483.13(c) (Tag F224 – resident behavior and facility practices/staff treatment of residents) at scope and severity level J;

- 42 C.F.R. § 483.13(c) (Tag F226 – resident behavior and facility practices/ policies to prohibit neglect and abuse) at scope and severity level J;

- 42 C.F.R. § 483.20(k)(3)(i) (Tag F281 – comprehensive care plans/professional standards of quality) at scope and severity level J;

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

- 42 C.F.R. § 483.75(l)(1) – Tag F514 (administration/clinical records) at scope and severity level J.

CMS Ex. 1.[1] CMS subsequently determined that the facility returned to substantial compliance on May 8, 2012. CMS Ex. 2 at 2.

CMS has imposed against the facility CMPs of $ 3,550 per day for 87 days of immediate jeopardy (February 1 through April 27, 2012) and $100 per day for 10 days of substantial noncompliance that was not immediate jeopardy (April 28 through May 7, 2012), for a total CMP of $ 309,850.

Petitioner timely requested a hearing.

On February 7, 2013, I convened a video hearing from the offices of the Departmental Appeals Board in Washington, D.C. Ms. Erin Shear and Mr. Donald J. Calder appeared on behalf of CMS and convened in Atlanta, Georgia. Mr. J. Guthrie True appeared on behalf of Petitioner. Mr. True and the witnesses convened in Lexington, Kentucky. I have admitted into evidence CMS Exhibits (CMS Exs.) 1-42 and Petitioner Exhibits (P. Exs.) 1-8. Summary of Prehearing Conference (January 16, 2013); Transcript (Tr.) at 6.

The parties have filed pre-hearing briefs (CMS Pre-hrg. Br.; P. Pre-hrg. Br.) and post-hearing briefs (CMS Post-hrg. Br.; P. Post-hrg. Br.). CMS filed a reply brief (CMS Reply).

II. Issues

The issues before me are:

1. From February 1 through May 7, 2012, was the facility in substantial compliance with Medicare program requirements;

2. If the facility was not in substantial compliance with program requirements from February 1 through April 27, 2012, did its deficiencies then pose immediate jeopardy to resident health and safety; and

3. Are the penalties imposed – $3,550 per day for 87 days of immediate jeopardy and $100 per day for 10 days of substantial noncompliance that was not immediate jeopardy – reasonable?

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[1] CMS also cites deficiencies under 42 C.F.R. § 483.20(g)-(j) (Tag F278 – accuracy of assessments/coordination/certification/falsification penalty). CMS Ex. 1 at 37. Because I find that the deficiencies cited under 42 C.F.R. §§ 483.13, 483.20(k)(3)(i), and 483.75(l)(1) more than justify the penalties imposed, I decline to address this additional deficiency. *See, e.g., Senior Rehab. & Skilled Nursing Ctr.*, DAB No. 2300 at 6 n.5 (2010), *aff'd, Senior Rehab. & Skilled Nursing Ctr. v. HHS*, 405 F. App'x 820 (5th Cir. 2010).

Summary of Prehearing Conference (January 16, 2013); Tr. at 5-6.

III. Discussion

A. The facility was not in substantial compliance with 42 C.F.R. §§ 483.13(b) and (c), because: a staff member abused a resident; two other staff members witnessed the abuse but failed to intervene to protect the resident; they delayed reporting or failed to report the incident; and facility management did not adequately investigate and did not adequately protect residents while an investigation was pending.[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 County 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. 42 C.F.R. § 483.13(c). Among other requirements, the facility 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).

Facility policies. Here, consistent with the regulation, the facility had in place written policies and procedures for reporting and investigating allegations of abuse. According to the policy, abuse includes "the willful infliction of injury . . . intimidation, punishment with resulting physical harm, pain or mental anguish. . . ." Verbal abuse involves "any use of oral . . . language that willfully includes disparaging and derogatory terms to residents . . . regardless of their age, ability to comprehend, or disability." Physical abuse includes hitting and slapping. Mental abuse includes humiliation. CMS Ex. 9 at 6.

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

The policy directs staff to report *immediately* to facility management any incident or suspected incident of resident abuse or neglect and sets forth detailed instructions to staff for protecting residents and investigating the incidents (discussed below). CMS Ex. 9.

Resident 1 (R1). R1 was an 89-year-old woman suffering from chronic renal insufficiency, Alzheimers disease, dementia, depression, history of urinary tract infections, and many other disorders. She could be extremely anxious and was on medication for her anxiety. She required extensive assistance with activities of daily living. She was also frequently incontinent of urine. CMS Ex. 11 at 1, 35-40.

The incident. The incident underlying the abuse citation occurred in the early morning hours of March 14, 2012. The facility's records manager, Bonnie Thompson, witnessed the event and, that same day, wrote two reports describing what she saw and heard. CMS Ex. 36 at 1-3. According to her reports:

At about 5:30 to 5:45 a.m. on March 14, 2012, she was walking past R1's room. The door was ajar. Two nurse aides, Marilyn "Becky" Miller and Rose Eno, were in the room. Manager Thompson "glanced in" and saw R1 standing up, asking for help. She heard R1 say, "Honey[,] help me please[.] I'm in a mess."

Nurse Aide Miller replied: "Set [sic] down, [R1][.] You will have to wait."

Manager Thompson observed Nurse Aide Miller turn to the other resident in the room. R1 got up and said: "Please, Honey. I don't know what to do!!"

Nurse Aide Miller replied: "[R1,] I told you to set [sic] down." She went over to R1, "firmly" put her back on her bed, and said, "Oh my God, look at this now. I have a bigger mess to clean up. You've wet yourself and the bed."

R1 replied: "Honey[,] I was trying to tell you I was in a mess." Nurse Aide Miller then began to undress the resident. Manager Thompson described the nurse aide as "very firm with her language and the force with her hands"; she frightened the resident, who was upset and began crying. When the resident put her hand on the bed's wet spot, Nurse Aide Miller "grabbed her hand and said, 'I told you not to put your hands over there.'" R1 became more agitated and again put her left hand on the wet bed. Nurse Aide Miller said, "God, [R1], how many times do I have to tell you." She grabbed the resident's left hand and slapped her on the wrist.

R1 said, "Honey, I'm sorry. I'm wet and I don't know why!" Nurse Aide Miller then grabbed some clean clothes, stood the resident up and "roughly" took her gown off. Because the door was open she exposed the partially-clad resident to view from the hall. As she pulled the resident back onto the bed in order to change her brief, Nurse Aide

Miller observed the records manager at the door. She told Nurse Aide Eno to shut the door.

According to Manager Thompson, Nurse Aide Eno saw all of this and "had to have heard." Yet, when Ms. Thompson asked the nurse aide, "Do you see what's going on in this room?" Nurse Aide Eno replied, "No, I had my back turned and that is not true." CMS Ex. 36 at 1-3.

Interviewed by Surveyor Sherry Harrison on March 23, 2012, Manager Thompson added that she left the resident alone with Nurse Aide Miller and reported the incident to the night supervisor, Licensed Practical Nurse (LPN) Teresa Kidd, and "Patty" (last name unknown). She acknowledged that she should have opened the door and asked Nurse Aide Miller to step out of the room. She also told the surveyor that a facility surveillance video showed her in the hall at the time, "very distraught." CMS Ex. 10 at 25.

For their parts, the nurse aides steadfastly deny that anything happened. CMS Ex. 36 at 4, 5; CMS Ex. 10 at 32, 33. Nurse Aide Miller initially did not admit to any contact with the resident; she wrote only that she asked R1 not to put her hand on the wet spot. CMS Ex. 36 at 4. She later told Surveyor Harrison that, when R1 reached for the wet spot, she "took her hand [and] placed it on her lap." CMS Ex. 10 at 32.

The investigation. LPN Teresa Kidd testified that Manager Thompson reported her "alleged" observations "immediately" and that LPN Kidd went "immediately" to the resident's room. She assessed the resident's hands and arms and found no marks except a small bruise from a past needle stick. P. Ex. 8 at 2 (Kidd Decl. ¶ 4). She then went "immediately" to Nurse Aide Miller, who denied striking or otherwise mistreating R1. She spoke to Nurse Aide Eno who, according to LPN Kidd, "indicated shock at the allegation" and said she had neither seen nor heard "any circumstance that would constitute abuse of [R1]." P. Ex. 8 at 2 (Kidd Decl. ¶ 5).

What LPN Kidd considers "immediately" is difficult to discern, because she did not document any time frames. No statement or report mentions when anyone was notified or when interviews took place. LPN Kidd's written declaration mentions no specific times. CMS Ex. 36; *see* P. Ex. 8 (Kidd Decl.).[3]

[3] Petitioner seems to fault the surveyors for not knowing how much time elapsed before Manager Thompson reported the incident to someone in authority. P. Post-hrg. Br. at 3-4. While I agree with Petitioner that the timing is "critical" information that should have been documented, I hold the *facility*, not CMS or the surveyors, responsible for the omission. LPN Kidd should have documented the time Manager Thompson reported the incident and the time she reported it to her superiors. The surveyors can hardly be faulted for not having information that was never reported or recorded.

LPN Kidd determined that "no abuse could be substantiated." P. Ex. 8 at 2 (Kidd Decl. ¶ 6). She allowed Nurse Aide Miller to complete her shift, which lasted about another hour, providing care to other residents, although – LPN Kidd claims – not to R1. Nurse Aide Miller was subsequently suspended "pending report of the alleged incident to the facility administrator and conclusion of any additional investigation [he] deemed appropriate." P. Ex. 8 at 2 (Kidd Decl. ¶ 6).

As a threshold matter, it appears that no facility manager knew how to respond to allegations of abuse and that the facility's response fell short in multiple respects, violating federal regulations and the facility's own policies. Thus, although CMS does not fault the facility's written policies, it argues that those policies were not implemented. I agree. Implementing a policy requires more than drafting and maintaining documents. Staff must understand and follow the policy. As the Departmental Appeals Board has long recognized, examples of neglect or abuse can demonstrate that the facility has not implemented its policies. *Barn Hill Care Ctr.*, DAB No. 1848 at 9-12 (2002); *Emerald Oaks*, DAB No. 1800 at 18 (2001); *see also The Cottage Extended Care Ctr.*, DAB No. 2145 at 4 n.4. (2008); *Liberty Commons Nursing & Rehab Ctr. – Johnston*, DAB No. 2031 at 7-17 (2006), *aff'd, Liberty Commons Nursing & Rehab Ctr. – Johnston v. Leavitt*, 241 F. App'x 76 (4th Cir. 2007); 59 Fed. Reg. 56,116, 56,130 (Nov. 10, 1994). Where, as here, no manager or administrator knew what the facility policies required, I can reasonably conclude that the facility was not in substantial compliance with 42 C.F.R. § 483.13(c).[4]

- First, and most important, the facility did not ensure that residents were protected. The facility's policy dictates that an employee accused of participating in abuse "be immediately reassigned to duties that *do not involve resident contact*" or that the employee be suspended until the administrator has reviewed the investigation findings. If assigned to other duties, the assignment cannot be in "any part of the building [where] the resident frequents." CMS Ex. 9 at 3. In violation of this policy, Nurse Aide Miller continued to provide resident care, and worked in the

[4] A separate line of cases establishes that facility staff must understand and follow facility policies because they reflect the facility's own judgment as to what it must do to protect its residents. *See Agape Rehab. of Rock Hill*, DAB No. 2411 at 7, 18 (2011); *Senior Rehab. & Skilled Nursing Ctr.*, DAB No. 2300 at 13 (*quoting Sheridan Health Care Ctr.*, DAB No. 2178 at 15 (2008)) and holding that the facility's protocol represents the facility's own judgment as to what must be done to attain or maintain its residents' highest practicable physical, mental and psychosocial well-being); *Spring Meadows Health Care Ctr.*, DAB No. 1966 at 18 (2005) (holding that "it is reasonable to presume that the facility's policy reflects professional standards of quality, absent convincing evidence to the contrary").

vicinity of R1's room. In fact, Nurse Aide Miller told the surveyors that she continued to care for R1, even after LPN Kidd questioned her about the abuse allegation: "So I finished [R1] [and] went about the rest of my shift." CMS Ex. 10 at 32.

Director of Nursing (DON) Yolanda Loveless, Social Services Director Kay Gaines, and Registered Nurse (RN) Patty Spicer, all acknowledged that the nurse aide should not have been allowed to continue providing resident care. CMS Ex. 10 at 24, 31, 37 ("They should have sent Becky home until investigation completed"); *but see* CMS Ex. 10 at 62 (in which the facility administrator, Chad Helton, "didn't see a problem" with it; P. Ex. 5 at 2 (Gosser Decl. ¶ 11)(claiming "no need" to suspend the nurse aide).

- Second, facility policy also mandates that the resident be monitored by nursing staff for 24 hours, but I see no suggestion that anyone monitored R1. CMS Ex. 9 at 1.

- Third, facility staff did not timely notify the facility administration of the allegations. Facility policy dictates that, if the suspected abuse occurs after hours, "the **administrator and director of nursing services must be called at home or must be paged and informed of such incident immediately**." CMS Ex. 9 at 6 (emphasis in original). Neither LPN Kidd nor DON Loveless mentions in her witness declaration when the administrators were notified. P. Exs. 4, 8. DON Loveless told Surveyor Harrison that she learned of the abuse allegation at about 7:15 that morning. CMS Ex. 10 at 36. Administrator Helton submitted no written declaration at all, but he told Surveyor Gae Vanlandingham that DON Loveless told him about the incident, so we know that he learned of it sometime after 7:15. CMS Ex. 10 at 61. Staff thus delayed at least an hour and a half before telling him of the allegations.

- Fourth, in selecting an investigator, the facility ignored its own policies. According to the facility policy, when an allegation of abuse is reported, the administrator or his designee "will appoint a member of management to investigate the alleged incident." CMS Ex. 9 at 5. But here, Administrator Helton did not appoint LPN Kidd to investigate the incident. She assumed that task herself and had essentially completed her somewhat abbreviated investigation before she even informed management of the allegation. P. Ex. 8 at 2 (Kidd Decl. ¶ 6) (declaring that Nurse Aide Miller was allowed to complete her shift and then suspended "pending report of the alleged incident to the facility administrator."); P. Ex. 5 at 2 (Gosser Decl. ¶ 11).

- Nor did LPN Kidd follow facility policies when she assessed the resident. According to the facility policy, the resident was supposed to have been examined

immediately "from head to toe," and her statement should have been obtained. CMS Ex. 9 at 1. But LPN Kidd does not claim to have performed any examination beyond assessing the resident's hands and arms. P. Ex. 8 at 2 (Kidd Decl. ¶ 4). She does not claim to have interviewed the resident. P. Ex. 8 (Kidd Decl.). Although she told Surveyor Harrison that she asked the resident if anyone hit her, nothing in her notes, her report, or her written declaration indicates that she asked that question. And, even assuming that she did, the record does not reflect the resident's response. CMS Ex. 10 at 30; P. Ex. 8.

- At most, LPN Kidd's investigation included just three of nine key elements called for in the facility's policies. "[A]s a minimum," the facility policy requires the investigator to:

  1. Review the completed resident abuse report form;
  2. Review the resident's medical record to determine the events leading up to the incident;
  3. Interview the person(s) reporting the incident;
  4. Interview any witnesses to the incident;
  5. Interview the resident (as medically appropriate);
  6. Interview the staff members (on all shifts) who have had contact with the resident during the period of the alleged incident;
  7. Interview the resident's roommate, family members, and visitors;
  8. Interview other residents to whom the accused employee provides care or services; and
  9. Review all events leading up to the incident.

  Each interview is to be conducted separately and in a private location, its purpose and confidentiality explained to each person involved in the interview process. CMS Ex. 9 at 11. LPN Kidd told Surveyor Harrison that she walked R1 to the nurses' station, examined her "up to her elbows," and asked if anyone hit her. She placed R1 in a chair in front of the nurses' station (which does not sound like a private location). Nurse Aide Miller was "in day room in front of nurses' station." CMS Ex. 10 at 29-30.

  LPN Kidd interviewed Manager Thompson (the person reporting the incident), and she interviewed the nurse aides present (witnesses to the incident). She may have interviewed the resident, although that cannot be verified, because we have no record of any interview or any attempt to interview her. With respect to the other factors, nothing in the record suggests that she included any of them in her investigation.

Notwithstanding all of these shortcomings, the facility's administration defends its handling of the investigation. Demonstrating that he was unfamiliar with the facility's

policies, Administrator Helton told the surveyors that he thought LPN Kidd "did what she should have done." CMS Ex. 10 at 61. He also said that he "didn't see a problem" with Nurse Aide Miller finishing her shift. CMS Ex. 10 at 62.

According to Joni Gosser, RN, Director of Operations for the facility's management company, LPN Kidd appropriately allowed Nurse Aide Miller to continue working with residents, because she had completed her investigation and determined there had been no abuse "based on the fact" that Nurse Aides Miller and Eno "corroborated" that R1 had not been slapped. RN Gosser's opinion also reflects a fundamental misunderstanding of the facility's policies as well as of the underlying facts.

> Based on the fact that the employee interviews corroborated [R1] had not been slapped and no injuries occurred, the nursing supervisor determined no abuse occurred and allowed the employee to continue working. There was no need to suspend [the nurse aide] at this time as the investigation was completed. The facility policy states that reports of abuse, neglect and injuries of unknown origin shall be promptly and thoroughly investigated by facility management. In this instance, at 0530, the allegation of abuse was investigated by the facility Supervisor and a determination was made that no abuse occurred. Therefore, [Nurse Aide Miller] was allowed to return to work. [Nurse Aide Miller] was not permitted to provide any care to [R1] during the remainder of the shift. [Nurse Aide Miller] was suspended after the end of her shift pending report of the alleged incident to the facility administrator and conclusion of any additional investigation deemed appropriate by the administrator.

P. Ex. 5 at 2 (Gosser Decl. ¶ 11).

State reporting. The facility reported a version of the incident to the state agency as required, although its description of Manager Thompson's report differs substantially from what the records manager actually reported. Manager Thompson reported twice that Nurse Aide Miller "grabbed" the resident's left hand and "slapped" her on the wrist or hand. CMS Ex. 36 at 1, 3. But the facility reported that the resident "put her hand down on the bed in the wet area and [the nurse aide] swatted her hand away and told her not to put her hands in the wet area." CMS Ex. 37 at 2. The report to the state agency alludes to the nurse aide speaking in a "firm voice," but does not mention that she frightened the resident, who began crying. Nor did the facility report that the nurse aide "roughly" removed the resident's gown and exposed her to view from the hall – all part of Manager Thompson's reports. Based on the facility report, Manager Thompson might simply have misinterpreted reasonable actions; the manager's actual account leaves no room for such misinterpretation.

The poor investigation and failure to protect R1 and other residents are serious deficiencies. The inadequate investigation led to a premature – and erroneous –

conclusion. Based on the more reliable evidence, I find that the abuse described by Manager Thompson occurred.

First, Manager Thompson's description of the incident is graphic, and her statements are detailed, giving them the ring of truth. She freely admitted her own errors, which makes her more credible. Her statements have been consistent. On March 23, 2012, she told Surveyor Harrison a story consistent with her reports. CMS Ex. 10 at 25.

In contrast, the nurse aide versions are very general denials, containing no details as to what went on in that room. CMS Ex. 36 at 4, 5.[5] Nurse Aide Miller's written statement implies that she did not even touch the resident. She later admitted to Surveyor Harrison that she had touched the resident's hand. CMS Ex. 10 at 32. I find this a significant discrepancy that undermines her credibility.

Nurse Aide Eno's written statement contains even less detail. She says that Nurse Aide Miller was "talking" to the resident but describes neither the tone nor the content of the nurse aide's remarks. She claims that she did not "see Becky" hitting the resident. Ironically, in this regard, her statement is not inconsistent with that of Manager Thompson, who wrote that Nurse Aide Eno said that she had not seen anything because her back was turned. CMS Ex. 36 at 2. At a minimum, I'd have expected a competent investigator to ask whether the nurse aide was watching the other two people in the room or was turned away from them.

Neither nurse aide even mentions seeing the records manager in the hall.[6] Nurse Aide Eno neither admits nor denies having a short conversation with her.

The nurse aides' motives for denying the abuse are obvious. They are protecting their jobs and their futures. No one has suggested any reason why Manager Thompson would have exaggerated her observations. Petitioner does not claim that she had anything to gain by coming forward; in fact, she subjected herself to potential disciplinary action, because she admitted that she left the resident alone with an abuser.

Petitioner attempts to undermine Manager Thompson's allegation by claiming "a clear discrepancy" in how LPN Kidd learned of the allegation. P. Post-hrg. Br. at 3. Without citation to any authority, Petitioner asserts that "[a]ccording to Bonnie Thompson,

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[5] LPN Kidd insisted that Manager Thompson write a second statement, finding that her first one was "very vague." CMS Ex. 10 at 36. In fact, Manager Thompson's first statement is a relative goldmine of detail compared to the nurse aides' statements. Yet, LPN Kidd did not ask them to expand on their versions.

[6] We know she was there because of the surveillance video. Petitioner has not produced that video, but has not denied that she was there.

Thompson found and alerted Nurse Kidd. According to Nurse Kidd, she learned of the incident after encountering Thompson at the nurses' desk and inquiring as to why she was upset." *Id*. I see no such discrepancies. LPN Kidd writes in her declaration that Manager Thompson "immediately reported her alleged observations concerning [R1]." P. Ex. 8 at 2 (Kidd Decl. ¶ 4). She told Surveyor Harrison that she "came up to" the unit and noticed that the "medical records clerk" was upset. It took Ms. Thompson "a minute or two" to explain her concerns. CMS Ex. 10 at 29. Thus, to the extent there might be a discrepancy, it is between LPN Kidd's two statements and not anything Manager Thompson said. Manager Thompson's written report says simply "I walked away [from R1's room] and told Patti and Teresa." This general statement is consistent with both of LPN Kidd's versions. CMS Ex. 36 at 3.

Further, Petitioner concedes that something upset Manager Thompson on the morning of March 14, 2012. In addition to Petitioner's assertion that LPN Kidd asked the records manager why she was upset, video surveillance taken outside the resident's door at the time of the incident showed that she was "very distraught." CMS Ex. 10 at 25.

Petitioner did not present as witnesses any of the principals in this scenario. Manager Thompson did not come forward to withdraw any of her allegations, and the nurse aides did not come forward to deny them.

I therefore conclude that the facility was not in substantial compliance with 42 C.F.R. § 483.13(b), because staff willfully slapped and humiliated R1, likely causing physical pain and unquestionably causing mental anguish.

Even if Manager Thompson misinterpreted the situation (which I do not find), the facility's response to her allegations, establishes "wider systemic problems in the facility" that left its residents "at real risk for serious harm." *See Beverly Healthcare Lumberton v. Leavitt*, 338 F. App'x 307, 314 (4th Cir. 2009). No one knew how to respond to an allegation of abuse. They disregarded their policies, conducted a superficial investigation, ignored compelling evidence, and took no steps to protect residents from a potential abuser. The facility was therefore not in substantial compliance with 42 C.F.R. § 483.13(c).

B. The facility was not in substantial compliance with 42 C.F.R. §§ 483.13(c), 483.20(k)(3)(i), and 483.75(l)(1), because a nurse failed to assess or suction a distressed resident and then falsified the resident's medical records.

Program requirements. The regulation governing staff treatment of residents, 42 C.F.R. § 483.13(c), also mandates that facilities develop and implement written policies and procedures that prohibit neglect. "Neglect" means failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness. 42 C.F.R.

§ 488.301.

The drafters of the regulation deliberately rejected the suggestion that the regulations require evidence of a negative outcome to support the finding of neglect.

> We do not accept this comment because neglect may be determined even if no apparent negative outcome has occurred. The *potential* for negative outcome must be considered.

59 Fed. Reg. at 56,116, 56,130 (emphasis added).

The services provided or arranged by the facility must meet professional standards of quality. 42 C.F.R. § 483.20(k)(3)(i).

The facility must also be administered 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. To this end, the facility must, among other requirements, maintain clinical records on each resident in accordance with accepted professional standards and practices. Records must be complete, accurately documented, readily accessible, and systematically organized. 42 C.F.R. § 483.75(l)(1).

Facility policy. The facility's neglect policy adds that neglect might also be "giving little or no attention to a resident that requires attention." CMS Ex. 9 at 2.

The facility's emergency care policy instructs staff to "provide emergency care as necessary" and "[a]lways take, report and record vital signs when a resident's condition has changed." Documentation should include date and time. CMS Ex. 6.

Resident 2 (R2). R2 was a 92-year-old hospice patient, suffering from coronary artery disease, peripheral vascular disease, Alzheimer's disease, anxiety disorder, and depression. She was completely dependent on staff for her activities of daily living. CMS Ex. 14 at 49; CMS Ex. 15 at 4, 16, 19, 20, 52; CMS Ex. 16 at 6, 11, 13, 16, 17, 23, 24.

She also suffered respiratory difficulties for which she received oxygen therapy. CMS Ex. 15 at 30; CMS Ex. 16 at 25-26. She had difficulty swallowing, was unable to clear secretions, and was in danger of aspiration (drawing substances into her respiratory tract during inhalation), so she was on aspiration precautions, and her care plan directed staff to assist her if she started to choke. CMS Ex. 16 at 24; CMS Ex. 19 at 2; CMS Ex. 21 at 2; CMS Ex. 35 at 2; CMS Ex. 41 at 2 (Harrison Decl. ¶ 5). Her physician ordered oral suction as needed. CMS Ex. 14 at 1, 13, 20, 26, 32, 34, 36, 38, 40, 42, 44, 46, 48, 56. A suction machine was placed next to her bed, and nurses regularly suctioned her when she

sounded "gurgly." CMS Ex. 24 at 2-3; CMS Ex. 35 at 4, 11; CMS Ex. 41 at 2 (Harrison Decl. ¶ 5). In one instance (August 31, 2011), she became cyanotic (bluish discoloration of skin and mucous membranes due to lack of oxygen in the blood) and unresponsive, emitting a large amount of white foam from her mouth. Staff suctioned her, obtaining copious secretions; her color returned, she was sent to the emergency room, and recovered from the acute episode. CMS Ex. 18 at 3-5; CMS Ex. 24 at 2-3.

Petitioner claims that this August 31 incident was the only time the suctioning equipment had been used prior to the resident's death, suggesting that choking was not a persistent problem for R2, and "there was no reason to believe that chocking [sic] was the cause of the resident's death." P. Post-hrg. Br. at 6. As discussed below, the actual cause of R2's death is probably unknowable at this point but is not material to finding that facility staff violated the regulations. In fact, the evidence establishes that R2 often required suctioning. LPN Anyekeze Biame told the surveyor that he had "suctioned her more than once." CMS Ex. 35 at 4. Assistant Director of Nursing (ADON) Debbie Huston told Surveyor Harrison that staff "suctioned her off and on, if she sounded gurgly." CMS Ex. 35 at 11.[7] According to the nursing notes, a nurse suctioned R2 on September 7, 2011, because she had accumulated sputum in the back of her mouth that she was unable to spit. After suctioning, she was fine. CMS Ex. 18 at 9. She was suctioned again on November 6, 2011. CMS Ex. 18 at 13. On November 16, she was suctioned related to "audible congestion and visible mucous." CMS Ex. 18 at 14. On November 26, she was suctioned twice because of increased secretions. CMS Ex. 18 at 14. A note dated November 29 says "suctioned prn (as needed)." CMS Ex. 18 at 17.

The incident. We may never really know the truth regarding R2's death. However, the following facts are undisputed:

On the morning of February 1, 2012, at 8:02 a.m., LPN Biame entered R2's room, apparently to check on her roommate. According to surveillance video, he left the room after only five or six seconds (8:02:33 to 8:02:39). CMS Ex. 2 at 35; CMS Ex. 39; CMS Ex. 41 at 3 (Harrison Decl. ¶ 9). He returned to the room less than a minute later (8:03:15) and closed the door behind him. CMS Ex. 39. He was in the room for about 12 seconds before he opened the door (8:03:27). After about 15 additional seconds (8:03:45), he left the room again, having remained there for less than 30 seconds. CMS Ex. 2 at 35; CMS Ex. 39; CMS Ex. 41 at 3 (Harrison Decl. ¶ 9).

[7] In her written declaration, ADON Huston asserts that "the only instance of *serious* need for suctioning occurred on August 31, 2011." P. Ex. 7 at 1-2 (Huston Decl. ¶ 3) (emphasis added). I find this statement somewhat disingenuous. ADON Huston well-knew that R2 regularly required suctioning. That her condition only once deteriorated to the point of requiring an emergency room visit does not mean that these other instances were not serious, or likely to become serious, had staff not timely provided the suctioning.

At about 8:06:01, he returned to close the door, without entering the room, and left again. CMS Ex. 39; CMS Ex. 41 at 3 (Harrison Decl. ¶ 9). At 8:06:26, a nurse aide entered the room, but she left immediately. CMS Ex. 39; CMS Ex. 41 at 3 (Harrison Decl. ¶ 10). At around 8:06:52 two nurse aides entered R2's room. The first nurse aide exited at 8:07:22 and the other at 8:07:33. The nurse aides told Surveyor Harrison that they did not provide care to R2 during this time. CMS Ex. 39; CMS Ex. 41 at 3 (Harrison Decl. ¶ 10). Minutes later, at about 8:09:10, LPN Biame returned to the room, accompanied by ADON Huston. CMS Ex. 2 at 35; CMS Ex. 39; *see* CMS Ex. 41 at 4 (Harrison Decl. ¶ 11).

What transpired in R2's room during this time is difficult to ascertain, in large part because LPN Biame wrote an obviously inaccurate account in the nursing notes and thereafter told inconsistent stories. Surveyor Harrison interviewed him four times. He told her that he thought that R2 was supposed to be up, but, when he first entered the room, he saw the resident dressed but lying in bed, her head elevated. He apparently noticed nothing amiss, so he left to look for the nurse aide assigned to her, to ask why she had been left in bed. CMS Ex. 35 at 1.[8] When he returned to the room, he turned on the light and noticed that R1 was paler than normal. He approached her and noticed that she wasn't breathing. He did not touch her. She had secretions coming out of her mouth, but he did not suction her. He stepped out of the room to look for the ADON. He went to the office and then to a different unit, before he found her. They returned to the room together. According to LPN Biame, they then discovered that the resident had no pulse. She had foamy secretions about the mouth, and the ADON suctioned her. CMS Ex. 35 at 1-2; CMS Ex. 41 at 4 (Harrison Decl. ¶ 11); Tr. 69-71.

LPN Biame did not explain why he left the resident alone, without performing an assessment. Standard nursing practice and the facility policy required him to assess immediately for signs of life by checking for a pulse and auscultating (listening) for lung sounds. CMS Ex. 6; *see* CMS Ex. 35 at 5-6, 11; CMS Ex. 41 at 4 (Harrison Decl. ¶ 16); Tr. 59-61. He told the surveyor that he needed someone in the room in order to perform the assessment and that it did not occur to him to use the call light to summon help. He did not want to be in the room by himself. He did not listen to her lungs because he had no stethoscope. CMS Ex. 35 at 2, 3.

[8] In a separate interview, Nurse Aide Adolphe Jackson told Surveyor Harrison that he dressed R2 that morning and left her in bed, as he had been instructed. The next shift was supposed to give her breakfast, which would have been about the time his shift ended, 7:00 a.m. Everything was "good" when he last saw her at 6:15 to 6:30 a.m. CMS Ex. 35 at 10. Review of the facility's surveillance video confirms that a staff member left the resident's room at 6:10, which is generally consistent with Nurse Aide Jackson's statement. CMS Ex. 39.

ADON Huston's initial account was consistent with this. She told Surveyor Harrison that LPN Biame approached her to say that R2 needed her assistance. She accompanied the LPN to R2's room and found R2 in bed with foamy secretion in her mouth. ADON Huston began to suction R2's mouth. She raised the head of the resident's bed and "performed a sweep of the resident's mouth." She assessed the resident, who had no pulse and no respirations but was warm to the touch. Following the assessment, she determined that R2 was deceased. CMS Ex. 2 at 35; CMS Ex. 41 at 3 (Harrison Decl. ¶ 11).

In her written declaration, ADON Huston modifies this account in a subtle, but significant way, declaring that "Anye Biame, LPN notified me of [R2's] death on the morning of February 1, 2012." P. Ex. 7 at 2 (Huston Decl. ¶ 4). She does not mention when he told her this. Based on the LPN's statements to the surveyor, ADON Huston's own earlier statement, and the LPN's nursing notes, which say that the ADON was notified of the resident's "change in condition," I find it questionable that LPN Biame announced the resident's death rather than telling the ADON that the resident needed her assistance. CMS Ex. 18 at 27.[9]

In his written declaration, LPN Biame repeats that he entered the room at about 8:00 a.m., and saw R2 dressed and lying in bed. When he returned, he noticed no signs of breathing, i.e., her chest was not rising and falling, her pupils were dilated, her mouth gaping open, and her color was pale. He saw white, frothy substance around her mouth. P. Ex. 6 at 1-2 (Biame Meh Decl. ¶ 3). He now claims that he took her pulse and that the surveyor "misunderstood" his comments during the interview. P. Ex. 6 at 2 (Biame Meh Decl. ¶ 4). I find this impossible to believe. Surveyor Harrison took careful notes. Tr. 41. According to these notes:

- At 2:07 p.m. on March 26, LPN Biame told Surveyor Harrison that he "approached" the resident, realized she wasn't breathing, and immediately stepped out of the room. CMS Ex. 35 at 1. This is consistent with the surveillance video. CMS Ex. 39.

- At 11:10 a.m. on March 27, he told Surveyor Harrison that he did not "completely go in the room" the first time (the surveillance video shows that he did). The second time "I did not touch her." CMS Ex. 35 at 2; CMS Ex. 39.

- At 4:45 p.m. on March 28, the surveyor quotes him as saying twice: "I did not physically touch that woman" and "I'm telling you that I did not touch that woman by myself." CMS Ex. 35 at 3.

[9]I recognize that death may be categorized as a "change in condition," but cannot imagine that anyone would announce a death by saying that the person underwent a "change in condition." People do not speak that way.

- At 9:20 a.m. on March 29, the surveyor quotes him as saying: "I'm human, I'm trained, there are times you don't [sic] I was uncomfortable, I needed someone to assist me. I did not touch her." When asked about suctioning, he said, "It never occurred to me." CMS Ex. 35 at 4.

He also now claims that he notified ADON Huston of the resident's death after instructing a nurse aide to clean and prepare the resident's body for family viewing or transport to the funeral home. P. Ex. 6 at 2 (Biame Meh Decl. ¶ 5). I find this assertion questionable. No witness testimony or other evidence corroborates that he gave these instructions. Moreover, even if true, it does not help Petitioner's case. Until ADON Huston arrived in the room, no one had taken any vital signs, much less determined that the resident was dead. According to the surveillance video, nurse aides entered the room shortly before LPN Biame and ADON Huston arrived, but they left immediately. Obviously, they did not clean and prepare the body in the limited time that they were there. CMS Ex. 39; CMS Ex. 41 at 3 (Harrison Decl. ¶ 10).

CMS also points out that, under state law, an LPN is not authorized to pronounce death. Kentucky law authorizes RNs, but not LPNs, to determine and pronounce death. Ky. Rev. Stat. § 314.181(4).

Nursing Notes. On February 1, LPN Biame drafted nursing notes that were plainly inaccurate. His first note is dated February 1 at 7:45 a.m. He wrote that the resident was in bed, cleaned up, with oxygen canula in place and oxygen running, ready to be gotten up for breakfast. As he walked in to provide care for her roommate, he noticed that she "had a pale looking color and had no respirations." He said that lung sounds were auscultated and no lung sounds were heard. He wrote that she had no pulse, and he could not obtain a blood pressure. He said that her head was inclined at 30°, and she was suctioned using the suction machine by her bed. CMS Ex. 18 at 27. This note is untruthful. LPN Biame did not listen for lung sounds; he did not take the resident's pulse or blood pressure. He certainly did not suction her.

In the next note, labeled 7:50 a.m., he wrote that the ADON was notified of the change in the resident's condition and that she came into the room, suctioned the resident, and performed a complete assessment of the resident's vital signs but could obtain none. CMS Ex. 18 at 27.

LPN Biame justifies the deceptive nursing notes by claiming: "I created a block nursing note for the events of February 1, 2012. My note included the nursing measures I undertook as well as those undertaken by Debbie Huston, RN. Since I had to chart these activities after-the-fact, I estimated the time at 7:45 a.m." P. Ex. 6 at 2 (Biame Meh Decl. ¶ 7). In fact, he did not "block chart," which involves writing one note to describe events

that span a significant period of time, such as an entire shift.[10] He wrote two very specific notes describing separate events that purportedly occurred five minutes apart. In doing so, he falsely claimed that both he and ADON Huston independently took vital signs and provided emergency care, when, in fact, he had not done so.

We do not know when R2 died, nor do we know the exact cause of her death. We know that she was alive, clean, dressed, and ready for breakfast by 6:30 a.m. She should have been given her breakfast shortly thereafter, probably by 7:00. Yet, no evidence suggests that, between 6:30 and 8:00 a.m., anyone gave her a meal. We can tell from surveillance video that two employees entered her room at 6:58 a.m., but they left 20 to 30 seconds later. An employee entered the room at 7:48 a.m., but left after about 20 seconds. CMS Ex. 39. We have no idea who these individuals were or what they found.[11] In the meantime, R2 began emitting white frothy substance from her mouth, from which I can reasonably infer that she was unable to clear secretions and that she required suctioning, as ordered by her physician. When the LPN found her at 8:00 a.m., he did nothing for her. Notwithstanding the facility policy, he took no vital signs. Notwithstanding the physician order, he did not suction her. Instead, he left her alone.

Petitioner justifies staff inaction by pointing out that the resident had an advance directive of "do not resuscitate (DNR)," which prohibits staff from initiating cardiopulmonary resuscitation or taking other heroic measures. I find this irrelevant to the questions of whether facility staff properly assessed and suctioned the resident. Complying with the physician order, facility policy, and standards of nursing practice – as called for here – in no way violates the resident's DNR.

I conclude that R2 was neglected, in violation of 42 C.F.R. § 483.13(b), and consider this additional evidence of the facility's failure to implement its policies preventing abuse and neglect. 42 C.F.R. § 483.13(c).

I also find that the facility's services failed to meet professional standards of quality, in violation of 42 C.F.R. § 483.20(k)(3)(i). *See Life Care Ctr. at Tullahoma*, DAB No. 2304 at 31 (2010) (and cases cited therein) (holding that nursing staff's failure to carry out a physician's order may constitute a failure to meet professional standards of quality); *Agape Rehab. of Rock Hill*, DAB No. 2411 at 7, 18 (and cases cited therein) (holding that, in failing to follow its own policies, the facility failed to meet professional standards of quality because its policies represent its own judgment as to what must be done to

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[10] Block charting is considered poor nursing practice. *See* Lippincott Williams & Wilkins, Lippincott's Nursing Procedures 52 (5th Ed. 2009).

[11] I have no evidence that the facility investigated what went on between 6:30 a.m. and 8:00 a.m., and CMS has not pursued this question in any meaningful way. I am deeply troubled that the parties seem to have disregarded this critical period.

attain or maintain its residents highest practicable physical, mental and psychosocial well-being).

Because its staff falsely documented in the nursing notes that the LPN had taken vital signs and suctioned R2, the facility records were not accurate and therefore not consistent with accepted standards and practices. This puts the facility out of substantial compliance with 42 C.F.R. § 483.75(l)(1).

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

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 Departmental Appeals 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. 1962 at 11 (2005), *aff'd, Barbourville Nursing Home v. U.S. Dep't of Health & Human Servs.*, 174 F. App'x 932 (6th Cir. 2006), citing *Florence Park Care Ctr.*, DAB No. 1931 at 27-28 (2004), citing *Koester Pavilion*, DAB No. 1750 (2000); *Daughters of Miriam Ctr.*, DAB No. 2067 at 7, 9 (2007).

Here, R1 was subjected to physical and mental abuse. A slap is inevitably physically painful. Perhaps even more serious, an anxious and confused woman was subjected to rough handling and verbal abuse from a nurse aide who frightened her and reduced to her to tears. Her treatment at the hands of someone upon whom she was greatly dependent caused serious actual harm.

That management did not know how to respond appropriately to an allegation of abuse is likely to cause serious harm to residents, particularly because a potential abuser was allowed to continue providing care to vulnerable residents.

A facility nurse left R2 alone, even after he observed secretions coming out of her mouth, which is a symptom that she required suctioning in order to avoid choking or aspiration. He took no vital signs and subsequently wrote a note falsely claiming that he had followed her physician order to suction and the facility policy to assess. These failures likely caused R2 serious injury.

I therefore conclude that CMS's immediate jeopardy determination is not clearly erroneous.

Petitioner suggests that, so long as a deficiency is "isolated," it cannot pose immediate jeopardy. If this were true, the "J" level deficiency – defined as an isolated instance of immediate jeopardy – could not exist. But federal regulations direct CMS to determine the scope and severity of a facility's deficiencies, and provide for findings of isolated deficiencies that pose immediate jeopardy. 42 C.F.R. § 488.404; State Operations Manual (SOM) App. P, § IV; *see Brian Ctr. Health & Rehab./Goldsboro*, DAB No. 2336 at 2 (2010). Moreover, the situations involving R1 and R2 illustrate how an isolated deficiency can pose immediate jeopardy to resident health and safety.

D. The penalties imposed are reasonable.

To determine whether a CMP is 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 section 488.438(f) 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); *Cmty. Nursing Home*, DAB No. 1807 at 22 *et seq*. (2002); *Emerald Oaks*, DAB No. 1800 at 9 (2001); *CarePlex of Silver Spring*, DAB No. 1683 at 8 (1999).

CMS imposes a penalty of $3,550 per day for the days of immediate jeopardy, which is at the very low end of the penalty range for deficiencies posing immediate jeopardy ($3,050 to $10,000 per day). 42 C.F.R. §§ 488.408(e)(iii); 488.438(a)(1)(i). For the period of substantial noncompliance that was not immediate jeopardy, CMS imposes a penalty – $100 per day – that is also at the very low end of the applicable penalty range ($50 to $3,000). 42 C.F.R. §§ 488.408(d)(1)(iii); 488.438(a)(1)(ii). Considering the relevant factors, the penalties are modest.

First, as CMS points out, the facility has a history of substantial noncompliance, including noncompliance with 42 C.F.R. § 483.13(c) (Tag F224), which was cited in February 2011. The facility was also not in substantial compliance based on surveys conducted in December 2008 and March 2010. CMS Ex. 5 at 1.

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

With respect to the remaining factors, I find that one staff member physically and mentally abused a resident, while a second staff member failed to report it and took no steps to protect her. A third staff member reported the abuse, but also left the resident in the care of her abuser. Facility management allowed the potential abuser to continue providing resident care. In a separate incident, a facility nurse failed to assess or provide treatment to a resident who was obviously in difficulty. For all of these failures, the facility is highly culpable.

IV. Conclusion

From February 1 through May 7, 2012, the facility was not in substantial compliance with Medicare participation requirements; its deficiencies posed immediate jeopardy to resident health and safety from February 1 through April 27, 2012.

I affirm as reasonable the penalties imposed – $3,550 a day for 87 days of immediate jeopardy and $100 per day for 10 days of substantial compliance that was not immediate jeopardy.

/s/
Carolyn Cozad Hughes
Administrative Law Judge