Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Honey Grove Nursing Center,
(CCN: 67-5066),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-12-825

Decision No. CR3039

Date: December 19, 2013

DECISION

Following a complaint investigation survey, the Texas Department of Aging and Disability Services (state agency) determined that Honey Grove Nursing Center (Petitioner or facility) was not in substantial compliance with Medicare participation requirements for long-term care facilities, relating to resident abuse and effective facility administration, and that its noncompliance posed immediate jeopardy to the health and safety of its residents. By two notices, dated April 2, 2012 and May 17, 2012, the Centers for Medicare & Medicaid Services (CMS) agreed with the state agency's determination and imposed a $5,550 per day civil money penalty (CMP) against Petitioner beginning March 3, 2012, and continuing through March 9, 2012. Petitioner now appeals.

As explained below, I find that Petitioner was not in substantial compliance with Medicare participation requirements during the cited period, CMS's determination of "immediate jeopardy" was not clearly erroneous, and the CMP of $5,550 per day beginning March 3, 2012, and continuing through March 9, 2012, is reasonable.

I. Case Background and Procedural History

Petitioner is a long-term care facility located in Honey Grove, Texas, that participates in the Medicare program as a skilled nursing facility and the Medicaid program as a nursing facility. The incident giving rise to this case involved a 77-year-old male resident in Petitioner's facility, referred to during the survey and these proceedings as "Resident 1." Resident 1 suffered from, among other medical conditions, Alzheimer's disease, psychosis, and anxiety. He had a history of refusing care and at times could be physically and verbally aggressive towards facility staff.

On March 8, 2012, Petitioner reported to the state agency an episode of possible resident abuse involving Resident 1. CMS Exhibit (Ex.) 20. The report stated that Resident 1 told the facility's administrator that a male certified nursing assistant (CNA), D.M., "hit [Resident 1] in his chest with his fists," which resulted in bruising and a skin tear. CMS Ex. 20, at 3. Petitioner's report prompted the state agency to conduct an investigation survey, which it completed on March 9, 2012.

Based on interviews and review of medical documents, the surveyor found that the facility permitted CNA D.M. to provide care to Resident 1 despite his physical aggression towards male staff and statements that he did not want male aides providing care to him. CMS Ex. 4, at 3-4. According to the surveyor, while CNA D.M. was providing incontinency care to him on March 8, 2012, Resident 1 became agitated and began to physically resist the care. CNA D.M. did not stop but forcefully continued providing the care. CMS Ex. 4, at 3-4. Resident 1 then told the administrator that CNA D.M. had assaulted him. CMS Ex. 4, at 7-8. He repeated that allegation to the surveyor during an interview. CMS Ex. 4, at 16-17. The administrator and other staff found bruises on Resident 1's arms and a skin tear on his right arm, which the surveyor later observed and photographed. CMS Ex. 19. The surveyor determined that the injuries to Resident 1's arms resulted from the altercation between Resident 1 and CNA D.M. over the forced incontinency care. As a result of the survey, the state agency determined that Petitioner was not in substantial compliance with the following Medicare participation standards:

- 42 C.F.R. § 483.13(b), (c)(1)(i) (Tag F-223)[1] — resident has the right to be free from and facility must not use verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion;

[1] The Statement of Deficiencies (SOD) cited "42 C.F.R. § 483.13(b)(1)(i)" as part of the abuse prohibition standard in Tag F-223, though no such regulatory provision exists. *See* CMS Ex. 4, at 2. However, the actual language of Tag F-223, which the state agency used in the SOD, is consistent with 42 C.F.R. § 483.13(*c*)(1)(i), which prohibits a facility from using abuse, corporal punishment and involuntary seclusion. Because the language used in the SOD was a correct statement of the regulatory provision, even though the

- 42 C.F.R. § 483.13(c) (Tag F-226) — facility must develop and implement written policies and procedures prohibiting mistreatment, neglect, and abuse of residents; and

- 42 C.F.R. § 483.75 (Tag F-490) — facility must be administered in a manner that enables it to use its resources to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.

The state agency also determined that Petitioner's noncompliance was at a scope and severity level "K," meaning the noncompliance was a pattern of immediate jeopardy between March 3, 2012 and March 9, 2012. At the end of the survey, the state agency found that the facility had not attained substantial compliance but that its noncompliance no longer posed immediate jeopardy. By letter dated April 2, 2012, CMS accepted the state agency's findings and imposed a $5,550 per day CMP from March 3, 2012 through March 9, 2012 (seven days) and a $900 per day CMP beginning March 10, 2012, and ending once Petitioner achieved substantial compliance. CMS Ex. 1. A later survey determined that Petitioner achieved substantial compliance on March 10, 2012. By letter dated May 17, 2012, CMS notified Petitioner that the $5,550 per day CMP for seven days would remain in effect, but all other proposed enforcement remedies had been rescinded. CMS Ex. 2.

On May 31, 2012, Petitioner requested a hearing to challenge the noncompliance finding and enforcement remedy. Following my prehearing order, CMS submitted a prehearing brief and 27 proposed exhibits (CMS Exs. 1-27). Petitioner submitted a prehearing brief and four proposed exhibits (P. Exs. 1-4). On February 20, 2013, I convened a prehearing conference by telephone, and in the absence of objections, I admitted CMS Exs. 1-27 and P. Exs. 1-4 into the record. During the prehearing conference, the parties indicated that an in-person hearing would be necessary to cross-examine certain witnesses who had provided written direct testimony. I therefore scheduled a one-day hearing by video teleconference. Soon after, however, the parties agreed that an in-person hearing was no longer necessary. At my direction, each party submitted a closing brief on the written record (CMS Br. and P. Br.). CMS submitted a reply brief (CMS Reply Br.). Petitioner waived its opportunity to file a reply.

II. Issues Presented

This case presents the following issues:

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citation was wrong, Petitioner had adequate notice of the alleged deficiency. *See Illinois Knights Templar Home*, DAB No. 2369, at 2 n.2 (2011).

1. Whether Petitioner was in substantial compliance with Medicare participation requirements from March 3, 2012 through March 9, 2012;

2. If Petitioner was not in substantial compliance, whether CMS's determination that the noncompliance posed immediate jeopardy to the health and safety of residents was clearly erroneous; and

3. If Petitioner was not in substantial compliance, whether the enforcement remedy imposed, a $5,550 per day CMP for seven days, is reasonable.

III. Statutory and Regulatory Framework

The Social Security Act (Act) establishes the requirements that a long-term care facility must meet to participate in the Medicare and Medicaid programs and authorizes the Secretary of the U.S. Department of Health and Human Services (Secretary) to promulgate regulations implementing those statutory requirements. Act §§ 1819, 1919.[2] Specific Medicare participation requirements for long-term care facilities are found at 42 C.F.R. Part 483. A long-term care facility must remain in substantial compliance with program requirements to participate in Medicare. 42 C.F.R. § 483.1(b). "Substantial compliance" means "a level of compliance with the requirements of participation such that any identified deficiencies pose no greater risk to resident health or safety than the potential for minimal harm. 42 C.F.R. § 488.301. "Noncompliance" means "any deficiency that causes a facility not to be in substantial compliance." *Id.*

The Act authorizes the Secretary to impose enforcement remedies against a long-term care facility for failure to comply substantially with the federal participation requirements. The Secretary has delegated to CMS and the states the authority to impose remedies against a long-term care facility not in substantial compliance with program participation requirements. State agencies survey facilities on behalf of CMS to determine whether the facilities comply with federal participation requirements. 42 C.F.R. §§ 488.10-.28, 488.300-.335. The regulations specify the enforcement remedies that CMS may impose if a facility is not in substantial compliance with Medicare requirements. 42 C.F.R. § 488.406.

CMS may impose a per-day CMP for the number of days a facility is not in substantial compliance or a per-instance CMP for each instance of the facility's noncompliance. 42 C.F.R. § 488.430(a). A per day CMP, which CMS imposed in this case, may range from either $50 to $3,000 per day for less serious noncompliance or $3,050 to $10,000 per day for more serious noncompliance that poses immediate jeopardy to the health and safety of

[2] The Act, as amended, is available at http://www.ssa.gov/OP_Home/ssact/ssact.htm. On this website, each section of the Act contains a reference to the corresponding citation in the United States Code.

residents. 42 C.F.R. § 488.438(a)(2). "Immediate jeopardy" exists when "the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident." 42 C.F.R. § 488.301.

If CMS imposes one or more enforcement remedies against a long-term care facility based on a noncompliance determination, the facility may request a hearing before an administrative law judge to challenge the noncompliance finding and enforcement remedies. Act §§ 1128A(c)(2), 1866(h); 42 C.F.R. §§ 488.408(g), 498.3(b)(13).

IV. Findings of Fact and Conclusions of Law

1. *Petitioner was not in substantial compliance with participation requirements at 42 C.F.R. § 483.13(b) and (c)(1)(i) (Tag F-223) because it did not take reasonable steps to protect Resident 1 from abuse by a staff member.*

A 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). To that end, a facility is prohibited from using all forms of abuse, corporal punishment, or involuntary seclusion against a resident. *Id.* § 483.13(c)(1)(i). "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 Board has explained:

> The goal of section 483.13(b) is to keep residents free from abuse. This goal cannot be achieved if a facility could be found in compliance even though it failed to take reasonable steps to protect residents from potentially injurious acts which it knew or should have known might occur and which might be willful . . . .

Western Care Mgmt. Corp. d/b/a Rehab Specialties Inn, DAB No. 1921, at 14 (2004). Thus, the Board has held that actual abuse need not occur for a facility to violate 42 C.F.R. § 483.13(b) and (c)(1)(i). *See also Holy Cross Vill. at Notre Dame, Inc.*, DAB No. 2291, at 7 (2009) (citation omitted). "It is sufficient for CMS to show that that the facility failed to protect residents from reasonably foreseeable risks of abuse." *Id.* (citing *Western Care Mgmt.*, DAB No. 1921, at 15). However, the Board has also noted that "considerations of foreseeability are inapposite when *staff abuse* has occurred," and a facility acts through its staff and cannot disown the consequence of the actions of its employees. *Gateway Nursing Ctr.*, DAB No. 2283, at 8 (2009) (emphasis added).

a. Petitioner's staff knew, or should have known, on March 3, 2012 that there was a potential for abuse or neglect involving Resident 1.

Petitioner's facility administrator learned through a phone call from a supervisory nurse on March 3, 2012, that Resident 1 did not want to receive care from male aides. CMS

Ex. 10, at 4-5. The following day, the administrator instructed two supervisory staff members (including the nurse who notified the administrator about Resident 1's preference) over the phone that only female aides were to provide care for Resident 1 to ensure that he received necessary care. CMS Ex. 10, at 4. However, she did not take steps to memorialize the female-only directive in Resident 1's care plan or other medical records. CMS Ex. 10, at 4-5. A resident's gender preference of care providers and an administrator's failure to document that preference, when taken alone, are not sufficient to show a reasonable risk of abuse or neglect. However, considering those facts in light of Resident 1's well-documented aggressive behavior, the risk of potential neglect or abuse should have been evident to Petitioner.

There is no dispute that Resident 1 was ill-tempered and posed a challenge to staff members who provided his care. Resident 1 routinely used profanity, tried on several occasions to hit and kick staff members, and repeatedly refused care. CMS Ex. 17, at 1-6; *see also* P. Br. at 9-11. His care plan from August 2011 addressed his aggression and agitation (which describes Resident 1 as being "verbally abusive" and "physically abusive" to staff), providing that if he became agitated during care, staff was to "stop and return later to allow resident to calm down." CMS Ex. 14, at 2-3.

Resident 1's behavior issues appear to have been escalating in late 2011 and early 2012. Earlier care plan entries from May 2011 did not include Resident 1's aggressive behavior as a problem area. CMS Ex. 14, at 5-12. Later nursing notes from January 2012 document four instances of Resident 1 refusing care, while notes from February 2012 document nine such instances, most at the end of the month. *See* CMS Ex. 17, at 1-6. Even before the facility administrator was aware of Resident 1's preference for care from female aides, other staff members recognized that Resident 1 was more likely to accept care from female staff members. Male staff members told surveyors that they often switched with female staff members to provide care to Resident 1. CMS Ex. 22, at 3-6.

On March 3, 2012, when the facility administrator learned of Resident 1's preference for care from female aides, it was reasonably foreseeable that Resident 1 could thereafter be subjected to abuse or neglect if this preference was ignored. The administrator learned of a factor — care by male staff members — that was a likely trigger for at least some of Resident 1's apoplexy and behavioral problems. It was foreseeable that allowing male staff members to provide care to Resident 1, who in turn was likely to refuse care from male aides, may have created prolonged periods where Resident 1 did not receive necessary care and was thus neglected. *See, e.g.*, CMS Ex. 17, at 5 (clinical note by male CNA on February 20, 2012, stating that Resident 1 refused needed incontinent care three times over four hours). In addition, it was foreseeable that Resident 1's already-escalating behavior problems and outbursts of physical aggression might increase upon receiving care from male aides. *See, e.g.*, CMS Ex. 17, at 4 (clinical note on February 2, 2012, stating that Resident 1 was "prone to hit and curse" staff member when providing care); *see also* CMS Ex. 22, at 3 (male staff member stating to surveyor that Resident 1

"would be aggressive" with male aides). Such a foreseeable outburst would likely put staff and Resident 1 at risk of physical injury and could — and did — lead to a physical altercation.

The administrator's response to learning of Resident 1's gender preference for his care providers demonstrates that she must have recognized the potential for abuse or neglect. Specifically, she decided that only female aides would provide care to Resident 1 although, as discussed below, that decision was not effectively disseminated to staff members caring for Resident 1 and therefore not sufficient to prevent future abuse or neglect. CMS Ex. 10, at 4. Nothing in the record suggests that male and female aides provided differing levels of care to Resident 1 that would affect his overall well-being. Rather, Resident 1 was more likely to refuse care and be combative with male aides. CMS Ex. 22, at 3. Thus, the administrator had no reason to require female-only care be provided to Resident 1 unless she believed that his preference and past history of aggression and refusal of care created a potential for abuse or neglect if male aides continued to provide care to Resident 1. *See, e.g.*, *Cedar View Good Samaritan*, DAB No. 1897, at 17 (2003) (finding that a facility's response to an episode of possible sexual abuse, when the facility directed that female staff members accompany male staff caring for female residents and that a male staff member be monitored, demonstrated that it was aware of the future potential for abuse). Accordingly, when the administrator learned of Resident 1's preference for care from female aides, she knew or should have known of the risk of abuse and neglect, yet she did not take the reasonable steps to expeditiously implement the new rule.

b. Petitioner did not take the reasonable steps to formalize Resident 1's new care approach and prevent potential abuse or neglect after March 3, 2012.

The facility administrator told only two other staff members by telephone of her decision to have only female aides provide care to Resident 1, and then she relied on word-of-mouth to make sure that no males provided care to him. CMS Ex. 10, at 4-5. CNA D.M. acknowledged that another staff member told him that male aides were not supposed to provide care to Resident 1. CMS Ex. 22, at 5. However, prior to March 8, 2012, Resident 1's care plan did not limit male aides from providing care nor was such an approach documented anywhere else, so there was no indication that this was more than an informal suggestion rather than a formal approach that staff had to follow.

The administrator's decision to have only female aides provide care to Resident 1, after March 3, 2012, was a reasonable step to prevent potential neglect or abuse against him. The approach was likely to have mitigated a foreseeable triggering factor for Resident 1's resistance of care and physical aggression towards staff. But even a reasonable decision that is kept between only a few staff members does not ensure the prevention of future abuse or neglect. The administrator's reliance on word-of-mouth to implement a

significant decision such as female-only care providers for a resident was ineffective, and, even if the later abuse had not occurred, was a deficient means of preventing potential abuse or neglect.

c. CNA D.M. abused Resident 1 on March 8, 2012.

On March 8, 2012, Resident 1 told the facility administrator that CNA D.M. had assaulted him earlier that morning. CMS Ex. 10, at 3. He said that CNA D.M. beat him with his fists at the direction of the facility administrator. CMS Ex. 10, at 3. Resident 1's roommate told the administrator that CNA D.M. came in to "clean" Resident 1 early in the morning and that Resident 1 began to "fight" CNA D.M. CMS Ex. 10, at 3. Staff found significant new bruising on Resident 1's arms and a new skin tear on his right wrist. The facility administrator described the skin tear as "fresh." CMS Ex. 10, at 3. There were no documented falls or other intervening incidents that reasonably explained the new bruises and fresh skin tear.

CNA D.M. acknowledged during the facility's investigation as well as in an interview with the surveyor that he provided incontinency care to Resident 1 on the morning of March 8, 2012, but he denied hitting or holding down Resident 1. CMS Ex. 27, at 19; CMS Ex. 22, at 6. He said that Resident 1 went "haywire" while receiving the incontinency care, which he described as "crazy, swinging his right hand, calling me names." CMS Ex. 22, at 6. CNA D.M. told the surveyor that the facility administrator ordered staff to change Resident 1 "no matter what." CMS Ex. 22, at 6. He said that he completed the care and left the room. CMS Ex. 22, at 6. CNA D.M. reported that he believed it would have been abuse not to provide incontinency care to Resident 1 and to allow him to sit in his own feces. CMS Ex. 22, at 6.

The evidence supports the finding that CNA D.M. abused Resident 1. CNA D.M. admitted to providing incontinency care to Resident 1 on March 8, 2012, that Resident 1 went "haywire" during that care, but he completed the care anyway. Resident 1's care plan required CNA D.M. to "stop and return later" when Resident 1 was agitated during care, but, by continuing to provide the care that Resident 1 was resisting, CNA D.M. clearly did not follow this approach. CMS Ex. 14, at 2-3. Resident 1 reported the abuse and identified CNA D.M. as the perpetrator.[3] Resident 1's roommate confirmed that Resident 1 began to "fight" with CNA D.M. Staff members found new bruises on Resident 1's arms with no reasonable explanation for their cause but for the intervening

[3] Petitioner argues that Resident 1 "changed his story" because he first reported that CNA D.M. hit him with his fists but later said CNA D.M. hit him with his elbow. *See* P. Br. at 15-16. The discrepancy between these statements is not significant enough to discredit the entire allegation. Resident 1 never varied from substance of his claim that CNA D.M. assaulted him while providing incontinency care.

abuse by CNA D.M. Staff also found a fresh skin tear on Resident 1's right wrist, which is the same hand that CNA D.M. said Resident 1 was swinging.[4] In its brief, CMS provided an accurate assessment of the situation: "in order for CNA [D.M.] to continue giving incontinent care to a resident who was going 'haywire,' he had to exert more physical force against the resident than the resident was exerting to escape the situation." CMS Br. at 10. In exerting that force, CNA D.M. caused injury, thus abusing him.

d. Petitioner's omissions to reasonably prevent potential abuse or neglect after March 3, 2012, and the March 8, 2012 abuse against Resident 1 by CNA D.M. violates 42 C.F.R. § 483.13(b) and (c)(1)(i).

As explained above, the regulations require that a facility take reasonable steps to prevent potential abuse or neglect of a resident. 42 C.F.R. § 483.13(b). Here, as of March 3, 2012, the facility administrator knew of the risk of potential neglect and abuse against Resident 1 and, in response, devised a reasonable step to prevent that potential abuse or neglect. However, despite devising that reasonable step, the administrator did not ensure that it was implemented or explained to all staff members who directly cared for Resident 1. That omission meant that the facility did not actually *execute* the reasonable step it foresaw to prevent abuse or neglect. Ultimately, the risk of abuse to Resident 1 coupled with the facility's failure to implement the reasonable steps to prevent it posed a potential for more than minimal harm to Resident 1. Thus, the facility was not in substantial compliance with 42 C.F.R. § 483.13(b) from at least March 3, 2012, when the administrator knew of the risk.[5] Moreover, a staff member actually abused Resident 1 on March 8, 2012, a clear violation of the plain language in 42 C.F.R. § 483.13(c)(1)(i) prohibiting staff from using any form of abuse against a resident.

[4] Petitioner suggests that Resident 1's bruises and skin tear were from a fall or "self-inflicted during the non-compliant episode" on March 8, 2012. P. Br. at 15. But the suggestion of a fall on or before March 8, 2012 is unpersuasive. Petitioner cites no evidence showing Resident 1 fell at any point on or before March 8, 2012, let alone a fall that would have resulted in bruising on both of his arms.

[5] It is certainly possible that Petitioner's noncompliance may have begun earlier than March 3, 2012, because it was widely-known among staff members before that time Resident 1 would refuse and resist care from male aides. As a result of that knowledge, there was an informal practice among staff members to switch-off male aides for female aides caring for Resident 1 to address his preference. *See* CMS Ex. 22, at 3. However, Petitioner was only cited for noncompliance beginning March 3, 2012, so the parties did not address an earlier date of noncompliance, and the record has not been developed on that issue.

e. Petitioner's employment discrimination arguments are without merit in these proceedings.

Petitioner suggests that it would be improper (and illegal) to require its staff to adhere to Resident 1's gender preference for his care providers. Petitioner offers two arguments: (1) this case is about "competing rights," the right of the resident to choose his care providers and the right of the male staff member to be free from gender discrimination while at work; and (2) strict adherence to a resident's discriminatory preference of who his care providers are cannot be a regulatory requirement as it is not afforded any constitutional protections. P. Br., *passim*.

First, despite Petitioner's claim, the "right" of a resident to choose the gender of his care providers in a long-term care facility is not at issue. Rather, the risk of abuse and neglect raised by Resident 1's preference and the facility's response are most relevant. Also, whether the facility took improperly discriminated against CNA D.M. because of his gender is beyond the scope of this review. Nevertheless, it is curious that Petitioner, the alleged discriminator, now seeks to advance the rights of CNA D.M., the alleged victim. Further, despite all of its argument about gender discrimination in health care settings, and the need for CMS to require a gender-neutral way for Petitioner to provide care to Resident 1, Petitioner has not demonstrated that it has actually developed a gender-neutral way of addressing Resident 1's preference for care from female aides. Overall, Petitioner's claim that this case is about "competing rights" is misplaced considering *Petitioner* actually developed and later implemented the alleged discriminatory practice.

Second, whether the regulations *require* a facility to implement gender-discriminatory approaches if a resident prefers female care providers also misstates the issue before me. The regulations require that a facility take reasonable steps to ensure that a resident is not neglected or abused. The exact steps a facility must take are left to the facility's discretion so long as they are reasonable. *See Woodstock Care Ctr. v. Thompson*, 363 F.3d 583, 586 (6th Cir. 2003). If a resident is aggressive with male aides, then limiting his contact with male aides is certainly a reasonable step to prevent future altercations and protect both staff and the resident. One of the cases that Petitioner cites as support for its position actually suggests that limiting a resident's contact with one gender is permissible by law:

> Just as the law tolerates same-sex restrooms or same-sex dressing rooms, but not white-only rooms, to accommodate privacy needs, *Title VII allows an employer to respect a preference for same-sex health providers*, but not same-race providers.

Chaney v. Plainfield Healthcare Ctr., 612 F.3d 908, 913 (7th Cir. 2010) (emphasis added). Thus, aside from mischaracterizing the issue in general, Petitioner did not demonstrate that the action it took to achieve substantial compliance — preventing male

aides from providing care to Resident 1 based on his preference and the likelihood of abuse or neglect — was even prohibited gender discrimination.

2. *Petitioner was not in substantial compliance with the participation requirement at 42 C.F.R. § 483.13(c) (Tag F-226) because there was a "systemic breakdown" in the implementation of Petitioner's anti-abuse policy*.

A facility must "develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property." 42 C.F.R. § 483.13(c). Consistent with this requirement, Petitioner had two policies to address the recognition, reporting, and investigation of possible abuse of residents. *See* CMS Exs. 24-25. A policy titled "Senior Care Policy to Prohibit the Mistreatment, Neglect, and Abuse of Residents and the Misappropriation of Resident Property" states, among other things, that "Residents will not be subjected to abuse by anyone, including, but not limited to, staff . . . ." CMS Ex. 24, at 1. The policy also states that staff "is required to be trained in issues related to abuse prohibition practices," including "what constitutes abuse, neglect, and misappropriation of resident property." CMS Ex. 24, at 2. A separate policy titled "Resident Abuse Policy" states in relevant part:

> In the event [of] any evidence or cause to believe that a resident has suffered any of the above abuses [including physical abuse], the employee . . . [is] requested to report all allegations, suspicions, or incidents to the administrator of the facility, or to state officials as posted in the facility.
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> * * *
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> A person, including an owner or employee of an institution, who has cause to believe that the physical or mental health or welfare of a resident has been or may be adversely affected by abuse or neglect caused by another person shall report the abuse or neglect . . . .

CMS Ex. 25, at 1. CMS has not argued that the substance of Petitioner's abuse policy violates the regulation. Rather, CMS claims that Petitioner did not implement its anti-abuse policies because CNA D.M. abused Resident 1, the facility "failed to recognize the potential for catastrophic reactions and implement appropriate interventions to prevent the incident on March 8, 2012," and another CNA heard CNA D.M. admit to threatening Resident 1 and using profanity before the March 8, 2012 incident yet the CNA did not report CNA D.M. to the facility administrator. *See* CMS Br. at 13-14.

One instance of abuse is generally not sufficient to establish that the facility did not implement its anti-abuse policy. The Board has explained that section 483.13(c) "addresses adopting effective anti-neglect and abuse policies, not targeting isolated

events." *Emerald Oaks*, DAB No. 1800, at 18 (2001). However, multiple instances of abuse or other examples where facility staff did not carry out its anti-abuse policy "support a reasonable inference that a facility failed to develop or implement policies and procedures" that prohibit abuse. *See Dumas Nursing & Rehab., L.P.*, DAB No. 2347, at 15 (2010) (discussing facility anti-neglect policies under 42 C.F.R. § 483.13(c)). A facility does not implement its anti-abuse policy if the circumstances surrounding each instance of abuse demonstrate an "underlying breakdown" of the implementation of that anti-abuse policy. *See Oceanside Nursing & Rehab. Ctr.*, DAB No. 2382, at 11 (2011) (citing *Columbus Nursing & Rehab. Ctr.*, DAB No. 2247, at 27 (2009)).

I find the abuse against Resident 1 on March 8, 2012, violated the facility's anti-abuse policy. A staff member abused a resident in direct contravention of the policy stating that each resident will be free from abuse by staff. CMS Ex. 24, at 1. In addition, other members of the facility's staff did not report earlier episodes of potential abuse by CNA D.M. against Resident 1 despite the facility's abuse policy requiring staff to report all suspected abuse. One CNA, G.P., wrote that he worked the night shift on February 20, 2012, during which Resident 1 refused incontinent care from any of the male nurse aides. CMS Ex. 10, at 1-2. CNA D.M. also worked that shift. According to the statement from CNA G.P., soon after the February 20 shift, CNA D.M. announced to CNA G.P. and two other staff members that he "told [Resident 1] he was gonna have to be changed whether he liked it or not, so turn your ass over."[6] CMS Ex. 10, at 1. During a later interview with the facility administrator, another CNA reported that CNA D.M. confided on March 7, 2012, that CNA D.M. said to Resident 1 "You can get changed the easy way or the hard way." CMS Ex. 22, at 7. In a separate interview, yet another CNA reported that CNA D.M. earlier told him that he said to Resident 1, "I have to change you whether you like it or not." CMS Ex. 22, at 7. The use of profanity and statements such as "You can get changed the easy way or the hard way" while providing care to a resident amounts to abuse because it serves no purpose other than to intimidate the resident so he acquiesces to the care, and it is likely to cause abusive mental anguish in a resident who does not want the receive that care. Had the facility staff been properly trained to recognize signs of possible abuse, as its anti-abuse policy states they were (CMS Ex. 24, at 2), they would have recognized all of CNA D.M's statements to them as professing potentially-abusive conduct against a resident. That recognition of potential abuse, in turn, should have prompted a report to the facility administrator. CMS Ex. 25, at 1. CNA G.P. did not deny that he recognized the statement as being an episode of potential abuse but acknowledged that he did not report the statement to the facility administrator because CNA D.M. "used bad language and there were [other] staff around at the time." CMS Ex. 10, at 2. Apparently, the other staff members who heard CNA D.M. announce his

[6] During the facility's internal investigation, the two other staff members allegedly present when CNA D.M. made his statement to CNA G.P. denied that they actually overheard it. CMS Ex. 10, at 5.

abusive behavior against Resident 1 did not report the incidents, either. Based on the lack of any staff report to the facility administrator about CNA D.M.'s statements, it is reasonable to infer that multiple staff members who heard the statements either did not recognize potential abuse, which violated of the facility's anti-abuse policy, or they recognized the potential abuse by CNA D.M. but did not report it, which also violated the facility's anti-abuse policy. CMS Ex. 24, at 2; CMS Ex. 25, at 1.

The breakdown in the implementation of Petitioner's anti-abuse policies was not limited to one staff member on one occasion. Instead, multiple staff members heard CNA D.M. recount his abusive behavior yet none of those staff members reported the incident per the facility's anti-abuse policy. Soon after, CNA D.M. abused Resident 1 in a way that inflicted serious physical injury. *See* CMS Ex. 19, at 3-4. Thus, within a short period, multiple staff members violated Petitioner's anti-abuse policies on separate occasions, which establish an underlying breakdown of Petitioner's anti-abuse policies. The facility, therefore, had not effectively implemented those policies. Accordingly, Petitioner was not in substantial compliance with 42 C.F.R. § 483.13(c).

3. *Petitioner was not in substantial compliance with the participation requirement at 42 C.F.R. § 483.75 (Tag F-490) because, by not protecting against resident abuse, it did not administer its facility in a manner that ensured the highest practicable well-being for all residents.*

A facility must 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 psycho-social well-being of each resident. 42 C.F.R. § 483.75. A violation of this participation requirement is typically derivative of other deficiencies. *Cedar View Good Samaritan*, DAB No. 1897, at 23-24; *Asbury Ctr. at Johnson City*, DAB No. 1815, at 11 (2002). Here, Petitioner's noncompliance with 42 C.F.R. § 483.13(b), (c), and (c)(1)(i) establish that Petitioner did not administer its facility in a manner that prevented abuse of a resident, let alone in a manner that ensured the highest practicable well-being for residents. The administrator did not effectively communicate and execute an essential approach to address Resident 1's preference for care from female aides and, in turn, did not protect Resident 1 from potential abuse or neglect.

4. *Petitioner has not demonstrated that CMS's determination of "immediate jeopardy" was clearly erroneous*.

The state agency and CMS assert that Petitioner's noncompliance constituted a pattern of immediate jeopardy (level "K") from March 3, 2013 through March 9, 2012 (seven days). "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. The regulation does not require that a resident actually be harmed, *see Lakeport Skilled Nursing Ctr.*, DAB No. 2435, at 8 (2012), although here the evidence shows Resident 1

sustained actual injury and harm. By regulation, an immediate jeopardy determination must be upheld unless it is "clearly erroneous." 42 C.F.R. § 498.60(c). The Board directs 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." *See Barbourville Nursing Home*, DAB No. 1962, at 11 (2005) (citing *Florence Park Care Ctr.*, DAB No. 1931, at 27-28 (2004)).

Petitioner generally states that Resident 1's "bruises, even if avoidable, cannot sustain [a] finding of immediate and serious harm." P. Br. at 20. However, Petitioner has offered no evidence or specific argument that the immediate jeopardy determination was clearly erroneous. I do not find CMS's determination of immediate jeopardy clearly erroneous. Staff at first did not recognize or report possible abuse by CNA D.M. prior to March 8, 2012, which was likely to cause (or sustain) serious harm to residents because that abuse could continue unchecked. *See* CMS Ex. 10, at 1, CMS Ex. 22, at 7. The administrator's failure to effectively implement her female-only directive was also likely to cause serious injury or harm because male aides could continue to provide care to Resident 1 and provoke his agitation and physical resistance. Resident 1 had significant bruising and a skin tear as a result of the abuse that Petitioner did not take the reasonable steps to prevent. The bruises on Resident 1's arms were substantial in number and size and therefore serious. *See* CMS Ex. 19. Moreover, Resident 1 was on a blood-thinning regiment, which made his bruising and skin tear even more serious because of the danger in stopping any bleeding. CMS Ex. 12, at 2; P. Br. at 15. Overall, the record contains unrequited evidence that supports CMS's and the state agency's determination that Petitioner's noncompliance posed immediate jeopardy. To the contrary, there is no evidence or argument that effectively challenges that determination as clearly erroneous.

5. *The $5,550 per day CMP imposed is reasonable in amount and duration.*

CMS must consider several factors when determining the amount of a CMP, which an administrative law judge considers de novo when evaluating the reasonableness of the CMP that CMS imposed: (1) the facility's history of noncompliance; (2) the facility's financial condition, *i.e.*, its ability to pay the CMP; (3) the severity and scope of the noncompliance, the "relationship of the one deficiency to other deficiencies resulting in noncompliance," and the facility's prior history of noncompliance; and (4) the facility's degree of culpability, which includes neglect, indifference, or disregard for resident care, comfort or safety. 42 C.F.R. §§ 488.438(f), 488.404(b), (c).

A CMP that is imposed against a facility on a per day basis will fall into one of two ranges of penalties. 42 C.F.R. §§ 488.408; 488.438. The upper range of a CMP, $3,050 per day to $10,000 per day, is reserved for deficiencies that pose immediate jeopardy to the health and safety of a facility's residents and, in some circumstances, for repeated deficiencies. 42 C.F.R. § 488.438(a)(1)(i); 488.438(d)(2). The lower range of CMP,

$50 to $3,000 per day, is reserved for deficiencies that do not pose immediate jeopardy, but either cause actual harm to residents, or cause no actual harm but have the potential for causing more than minimal harm. 42 C.F.R. § 488.438(a)(1)(ii). In assessing the reasonableness of a CMP amount, an administrative law judge looks at the per day amount, rather than the total accrual. *Kenton Healthcare, LLC*, DAB No. 2186, at 28 (2008). The regulations leave the decision regarding the choice of remedy to CMS and the amount of the remedy to CMS and the ALJ, requiring only that the regulatory factors at 42 C.F.R. §§ 488.438(f) and 488.404 be considered when determining the amount of a CMP within a particular range. 42 C.F.R. §§ 488.408; 488.408(g)(2); 498.3(d)(11); *see also* 42 C.F.R. § 488.438(e)(2); *Alexandria Place*, DAB No. 2245, at 27 (2009); *Kenton Healthcare, LLC*, DAB No. 2186, at 28-29.

Unless a facility contends that a particular regulatory factor does not support the CMP amount that CMS imposed, the ALJ must sustain it. *Coquina Ctr.*, DAB No. 1860, at 32 (2002). CMS determined to impose a per day CMP in this case. I found immediate jeopardy level noncompliance not to be clearly erroneous here. Thus, the minimum CMP I am required to sustain is $3,050 per day. The $5,550 per day CMP that CMS imposed is in the low-to-middle range for immediate jeopardy level noncompliance.

a. The duration of the CMP is reasonable.

CMS may impose an enforcement remedy against a facility for as long as the facility is not in substantial compliance with participation requirements. 42 C.F.R. § 488.430(a). The burden of persuasion regarding the duration of noncompliance is Petitioner's. In *Owensboro Place and Rehabilitation Center*, DAB No. 2397 (2011), the Board stated:

> The burden of persuasion is on the facility. The Board has made it clear that the facility bears the burden of showing that it returned to substantial compliance on a date earlier than that determined by CMS and has rejected the idea that CMS must establish a lack of substantial compliance during each day in which a remedy remains in effect . . . .

DAB No. 2397, at 12-13 (citations omitted). Petitioner was not in substantial compliance with participation requirements beginning on March 3, 2012, when the facility administrator learned of Resident 1's preference for care from female aides, and ending March 9, 2012, when the facility finally implemented an approach to address the likelihood of abuse and neglect that Resident 1's preference created. Petitioner has not offered any evidence or argument that the period of noncompliance was shorter than cited. Accordingly, I find the duration of the CMP is reasonable.

b. The amount of the CMP is reasonable.

CMS has presented evidence of Petitioner's history of noncompliance (CMS Ex. 21), which shows that in April 2010, Petitioner was cited for widespread immediate jeopardy posed by deficiencies with abuse (Tag F-223), neglect (Tag F-224), developing and implementing abuse and neglect prohibition policies (Tag F-226), and administration (Tag F-490), three of which are the same bases of the instant case. CMS fined Petitioner $61,000 for that noncompliance. CMS Ex. 21, at 2. The similarity in citations as well as the scope and severity of the noncompliance just two years prior to the instant case is remarkable and supports a higher CMP. Further, Petitioner's noncompliance posed immediate jeopardy to the health and safety of its residents, meaning it was the most severe noncompliance for a long-term care facility. Accordingly, a significant CMP is justified.

With regard to culpability, Petitioner was highly responsible for its noncompliance. The altercation was likely triggered by Resident 1's resistance, but it was Petitioner's own staff member who then abused Resident 1 rather than diffusing the situation by stopping the immediate care and following Resident 1's plan of care. Petitioner is responsible for the acts of its employees and cannot escape its significant culpability by blaming a rogue employee. *See Gateway Nursing Ctr.*, DAB No. 2283, at 8. In addition, it was Petitioner's administrator — an individual tasked with much responsibility over the day-to-day functioning of the facility — who failed to ensure reasonable steps were taken to prevent abuse and neglect of Resident 1. Accordingly, Petitioner was highly culpable for its overall noncompliance, and this supports a moderate to high CMP.

Petitioner offers no direct challenge to the amount or duration of the CMP imposed other than "any CMP endorses affirmative protection of discrimination." P. Br. at 23. Thus, there is no evidence to suggest that Petitioner is unable to pay the total CMP imposed. In light of all of the factors discussed, the moderate $5,550 per day CMP from March 3, 2012 through March 8, 2012 (seven days) is reasonable in amount and duration.

V. Conclusion

For all of the reasons stated above, I conclude that Petitioner was not in substantial compliance with Medicare participation requirements for the period cited, CMS's determinations of immediate jeopardy are not clearly erroneous, and the CMP imposed is reasonable.

/s/
Joseph Grow
Administrative Law Judge