Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

In the Case of:	)	
	)	
North Carolina State Veterans Nursing Home, Salisbury, (CCN: 34-5531),	)	Date: October 20, 2008
	)	
Petitioner,	)	
	)	
- v. -	)	
	)	Docket No. C-06-670
Centers for Medicare & Medicaid Services.	)	Decision No. CR1855
	)	
	)	

DECISION

I sustain the determination of the Centers for Medicare & Medicaid Services (CMS) to impose a Civil Money Penalty (CMP) against Petitioner, North Carolina State Veterans Nursing Home, Salisbury, for failure to comply substantially with federal requirements governing participation of long-term care facilities in Medicare and State Medicaid programs. Therefore, I sustain the CMP of $6000 per day effective June 18, 2006 through June 23, 2006. I also sustain a CMP of $100 per day for the period of June 24, 2006 through July 20, 2006.

I. Background

This case came before me pursuant to a request for hearing filed by Petitioner on September 13, 2006. Petitioner is a long-term care provider located in Salisbury, North Carolina.

On July 27, 2006, CMS informed Petitioner that it was imposing the following remedies pursuant to a complaint investigation completed by the North Carolina State Survey Agency (State Survey Agency) on June 29, 2006:

- CMP of $6000 per day effective June 18, 2006, and continuing through June 23, 2006;

- CMP of $100 per day beginning June 24, 2006, and continuing until substantial compliance was achieved;

- Denial of payment for new admissions (DPNA) effective September 29, 2006; and

- Mandatory termination effective December 29, 2006.

CMS Ex. 23, at 1-4.

I held a hearing on March 4, 2008, in Winston Salem, North Carolina. At the hearing, CMS offered 38 exhibits, identified as CMS Exs. 1-38. I received CMS's exhibits into evidence without objection. Petitioner offered 67 exhibits, identified as P. Exs. 1-67. I received these exhibits into evidence without objection. Transcript (Tr.) at 3-4.

Subsequent to the hearing, the parties submitted post-hearing briefs (CMS Br. and P. Br.) and reply briefs. (P. Reply and CMS Reply).

Based on the testimony offered at the hearing, the documentary evidence, the arguments of the parties, and the applicable law and regulations, I find that Petitioner was not in substantial compliance on the dates determined by the State Survey Agency and CMS. I further find that CMS was authorized to impose a CMP of $6000 for noncompliance from June 18, 2006 through June 23, 2006, and a $100 per day CMP thereafter, until July 21, 2006.

II. Applicable Law and Regulations

Petitioner is a long-term care facility that participates in the Medicare and Medicaid programs. The statutory and regulatory requirements for participation by a long-term care facility are found at sections 1819 and 1919 of the Social Security Act (Act), and at 42 C.F.R. Part 483.

Sections 1819 and 1919 of the Act invest the Secretary of Health and Human Services with authority to impose remedies of CMPs and DPNA against a long-term care facility for failure to comply substantially with participation requirements.

Facilities that participate in Medicare may be surveyed on behalf of CMS by state survey agencies in order to determine whether the facilities are complying with federal participation requirements. 42 C.F.R. §§ 488.10- 488.28; 42 C.F.R. §§ 488.300 - 488.335. Pursuant to 42 C.F.R. Part 488, CMS may impose either a per day CMP or a per instance CMP against a long-term care facility when a state survey agency concludes that the facility is not complying substantially with federal participation requirements. 42

C.F.R. §§ 488.406, 488.408, and 488.430. The penalty may start accruing as early as the date that the facility was first out of compliance until the date substantial compliance is achieved or the provider agreement is terminated. 42 C.F.R. § 488.440.

The regulations specify that a per day CMP that is imposed against a facility will fall into one of two broad ranges of penalties. 42 C.F.R. §§ 488.408, 488.438. The upper range of CMPs, from $3050 per day to $10,000 per day, is reserved for deficiencies that constitute immediate jeopardy to a facility's residents, and in some circumstances, for repeated deficiencies. 42 C.F.R. §§ 488.438(a)(1), (d)(2). The lower range of CMPs, from $50 per day to $3000 per day, is reserved for deficiencies that do not constitute 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).

The regulations define the term "substantial compliance" to mean:

> [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 causing minimal harm.

42 C.F.R. § 488.301.

"Immediate jeopardy" is defined to mean:

> a situation in which 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.

Id.

The Act and regulations make a hearing available before an administrative law judge (ALJ) to a long-term facility against whom CMS has determined to impose a CMP. But the scope of such hearings is limited to whether an *initial determination* made by CMS is correct. Act, § 1128A(c)(2); 42 C.F.R. §§ 488.408(g), 498.3(b)(12) and (13). The hearing before an ALJ is a de novo proceeding. *Anesthesiologists Affiliated, et al*, DAB CR65 (1990), *aff'd* 941 F.2d 678 (8th Cir. 1991).

III. Issues

A. Whether the facility was complying substantially with federal participation requirements on the dates CMS determined to impose a CMP.

B. Whether CMS's determination of immediate jeopardy was clearly erroneous.

C. Whether the amount of the penalty imposed by CMS is reasonable, if noncompliance is established.

IV. Findings and Discussion

The findings of fact and conclusions of law noted below in bolded italics are followed by a discussion of each finding.

A. The facility was not in substantial compliance with federal participation requirements from June 18, 2006 through July 20, 2006.

1. Abuse (Tag F223): CMS established that the facility failed to provide an environment free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion as provided by 42 C.F.R. § 483.13(b) with respect to Resident 2 (immediate jeopardy).

Resident 2 (R2)

Based on record review and staff interviews, the state surveyors found that Petitioner failed to protect two of its residents R2 and R3 from physical abuse. CMS Ex. 1, at 1-20. R2 was admitted to the facility on May 5, 2005, with multiple diagnoses, which included dementia, Parkinson's disease, aphasia, and stroke. He had both long and short memory problems and severely impaired decision making skills. The Minimum Data Set (MDS) assessment indicated that the resident was cognitively impaired and totally dependent on staff for all of his care. CMS Ex. 1, at 2. According to the care plan the resident had a history of physically abusive behavior and resistance to care. The intervention to address this problem required staff to remove themselves from the situation whenever the resident became combative, and re-approach him after he had time to calm down. CMS Ex. 1, at 3.

A review of the nurse's notes revealed that R2 was found with physical injuries on June 18, 2006. The charge nurse reported that on June 18, 2006, at 11:10 a.m., she was called into the resident's room by the certified nurse aide (CNA or nurse aide) and that R2 had an abrasion to the tip of the right hand in two areas. R2 also exhibited multiple red marks

to both sides of the neck and three red spots on both sides of the inner groin area. Above the hairline, an indentation was noted to the left side of the head. Additionally, he had a red mark on the back of the head, an ulceration on the left side of the upper lip, and red scratch marks in the left abdominal area and right hip area. CMS Ex. 1, at 4; CMS Ex. 35, at 29.

A nurse's note dated June 18, 2006, at 11:20 a.m. indicated that the nurse supervisor who was on duty that morning had seen R2 after the charge nurse (Joanne Shedrick) called her. She assessed the resident and confirmed that he had physical injuries. She notified the Director of Nursing (DON), who in turn notified the administrator. The nurse supervisor also notified the resident's family and the physician assistant. She then sent the resident to a local hospital emergency room for treatment and evaluation. CMS Ex. 1, at 5.

A report from the local hospital emergency department, dated June 18, 2006, indicated that R2 was evaluated, treated, and discharged that same day. CMS Ex. 1, at 5; CMS Ex. 35, at 13.[1]

The police department was also called and two CNAs were arrested (referred to in this decision as CNAs # 1 and # 2). CMS Ex. 1, at 5-6.

On the day of the incident, at approximately 11:15 a.m., Ms. Shedrick was approached by Loretta Gray[2], the CNA in charge of R2's care on June 18, 2006, and she provided an account as to how the resident came to be injured. Ms. Gray stated that the resident had been combative and hit his lip with his own hand. When this happened, she observed blood on his lip, on the left side, and a cut on the top of the right hand. Tr. at 110.

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[1] The report of emergency treatment is reflected on a boiler plate summary that renders it useless in attempting to determine the precise findings and treatment rendered. Thus, although the surveyor stated that the report mentioned that sutures and steri-strips were used, such finding cannot be gleaned from the emergency room summary. For the most part, the discharge summary provides a list of instructions to be followed at home by the patient. Regarding sutures, the instructions tell the patient to keep the wound clean and dry *if sutures and steri-strips were used.* CMS Ex. 35, at 13. The discharge summary does not say that sutures or steri-strips were in fact used. The discharge summary does indicate, however, that R2 suffered extremity, face, trunk, scalp, and mouth wounds, albeit without elaboration.

[2] Loretta Gray was identified on the Statement of Deficiencies (SOD) as nurse aide # 3.

After Ms. Gray returned from lunch she again approached Ms. Shedrick and confessed that when she originally gave an account as to the manner in which R2 acquired the injuries observed on the morning of June 18, 2006, she had lied. Ms. Gray then related the following account:

> R2 "was in a mess" and she stuck her head out the resident's room and asked two girls who happened to be walking by for help in providing him with care. She needed assistance because the resident had been combative. She left the two nurse aides (CNA # 1 and CNA # 2 with the resident while she went out to get some linen. When she returned, she noticed that one of the nurse aides was holding R2 down while the other was punching him in the head and in the chest. Upon inquiry, Ms. Gray responded to the charge nurse that she did not yell out for help because she was frightened, inasmuch as the two nurse aides told her they knew where she lived and would get her if she said anything.

See Tr. at 113.

CMS contends that Petitioner acknowledged that the facility was required by regulatory mandate to provide an abuse-free environment, but that it failed to do so. The abuse occurred, asserts CMS, when R2 was severely beaten by two employees of the facility while a third employee witnessed all or part of the event. CMS Br. at 7.

Petitioner contends that the SOD does not identify any deficient practice on the part of the facility that may have contributed in any way to the abusive actions alleged against the three CNAs. Thus, reliance on the employment relationship alone as sufficient to implicate the facility in abusive conduct is completely inappropriate, both as a basis for citing the deficiency as well as assigning immediate jeopardy. Petitioner places reliance on the ALJ decision rendered in *Bryden Place, Inc.*, DAB CR1365 (2005).

The victim in the deficiency under scrutiny here (R2), was a 74-year-old male (CMS Ex. 35, at 16). He had end-stage Alzheimer's disease and had suffered a stroke that left him without the use of the right side of his body, and he was unable to speak or sit up on his own. In fact, he relied on staff for all transfers and activities of daily living. Tr. at 104.

The facts surrounding the immediate jeopardy charge are set forth in the interview of Ms. Loretta Gray by the surveyor that took place on June 23, 2006. Ms. Gray stated that she began working at the facility on May 24, 2006, and received training on the abuse policy. During that orientation she was instructed to immediately intervene to prevent an abuse

from happening or immediately call for help to stop abuse if she could not intervene to prevent it. Although R2 had been cooperative on June 17, 2006, he was not so cooperative on the 18th. Thus, when Ms. Gray knocked on his door on the morning of June 18, 2006, and approached him to provide care, he seemed agitated and became combative. She left him alone and returned 30 minutes later, only to find him still agitated. However, rather than wait awhile longer to see if the resident would calm down, she enlisted the assistance of other staff members to provide care in spite of his resistance. In the company of nurse aides # 1 and # 2, she again knocked on R2's door and entered his room. Nurse aide # 1 positioned herself on the right side of the bed and nurse aide # 2 positioned herself on the left side. The two nurse aides who volunteered to help did not approach R2 with an introductory explanation as to what care they were about to provide. They just pulled the covers off him, unfastened his diaper, and shoved him instead of rolling him over. At this point, R2 raised his right [sic] leg to kick, at which time nurse aide # 2 grabbed his leg and pinned him down, and told him "you gonna get changed."[3] He had a bowel movement, and nurse aide # 1 was cleaning him roughly. At that point Ms. Gray was clearly in the presence of abuse upon a very vulnerable resident. R2 was at that moment a victim of rough handling, verbal intimidation, and physical abuse. Ms. Gray did not intervene to stop the abuse nor did she call for help, and had no excuse for failing to do so. In spite of the alleged abuse training she had received, she did not act as required by the facility policy to take immediate action to curb the abuse. Apparently undisturbed by what she had witnessed, Ms. Gray simply left the room to get wash cloths and a clean pad for the bed. Upon her return to the resident's room, the abuse had significantly escalated. When she entered the room she saw nurse aide # 1 smacking R2 on the side of the head. Nurse aide # 2 pushed the resident toward nurse aide # 1. R2 became angry and started to kick and move his hands [sic] and head.[4] Nurse aide # 2 took the resident's hand and pressed it down on him to protect herself from being bitten, and punched him in his leg. This made R2 angrier. Nurse aide # 2 then grabbed his hand and said "I'll break your fingers if you bite me," and shoved R2's fingers in his mouth causing a bad skin tear in his hand.[5] When nurse aide # 2 let the resident's hand go, he swung back, but she was able to land several blows to his head. After the previously

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[3] Ms. Gray stated that nurse aide # 2 who was positioned on R2's left side grabbed his leg and pinned him down to keep him from kicking. However, I find that inasmuch as the resident was paralyzed on the right side, he could not have raised his right leg. If he did raise a leg at all, it had to be his left leg. That would make more sense since nurse aide # 2 was on his left side.

[4] R2 was unable to move his right hand.

[5] The two nurse aides accompanied the assault on R2 with derogatory language.

described incident, Ms. Gray reported to the charge nurse that R2 had become combative and caused injuries to himself. She later recanted her story and admitted that she had lied about how the resident was injured. It was then that she revealed the abuse perpetrated by nurse aides # 1 and # 2. CMS Ex. 25 at 10-12; CMS Ex. 1 at 9-11.

Ms. Gray stated when interviewed by the surveyor that she did not intervene to prevent the abuse because she was afraid of nurse aides # 1 and # 2. She also stated that she did not do anything because she was in shock as she had never seen anything like that before.

Petitioner's account of the aforementioned described event can be summarized as follows:

> On the morning of June 18, 2006, CNA # 3 entered the room of R2 to provide care. She found him to be difficult, and uncooperative, so she left the room. She returned later with CNAs # 1 and # 2 who agreed to assist her. CNAs # 1 and # 2 began positioning the resident for care. CNA # 3 left the room to obtain some towels to clean the resident, and when she re-entered the room she saw that the other two CNAs were handling the resident in an abrupt and harsh manner. He immediately became combative, swinging his arms and legs about, and CNAs # 1 and # 2 responded by physically striking R2 repeatedly. CNA # 3 later told her supervisor that she was shocked by what she saw the other CNAs doing. Tr. at 113. The two CNAs told her they knew where she lived and would get her if she said anything.

P. Br. at 4-5.

This account omits the fact that Ms. Gray witnessed nurse aides # 1 and # 2 abuse R2 as soon as they entered his room to assist with his care, and she did not intervene to stop the abuse. Ms. Gray condoned the abuse and simply stepped out of the room to retrieve supplies. When she returned, the beating perpetrated on the resident had escalated from shoving, pinning him down, and verbal abuse to an unrestrained beating. I infer that had Ms. Gray intervened when she first observed the abuse, the situation would not have gotten out of hand the way it did after she stepped out of the room to obtain supplies. Petitioner suggests that the two CNAs had blocked Ms. Gray's exit from R2's room, making it impossible for her to seek help. That is a distortion of the facts. After Ms. Gray first witnessed the abuse, she was able to leave the room without interference, and when she returned and saw the physical onslaught being perpetrated upon the resident, she could have easily turned around at the threshold. She chose not to intervene nor to seek help from a supervisor to protect a very vulnerable resident who was paralyzed on

one side of his body. Notwithstanding his very limited physical and cognitive capabilities, Petitioner asserts that R2 "immediately became combative, swinging his arms and legs about." P. Br. at 4. In truth, R2 became combative when he was victimized by the facility staff. Moreover, he was incapable of moving *arms* and *legs* because he was paralyzed on the right side. It is worthy of note that Ms. Shedrick had testified that when she cared for R2 and gave him his medication, she obtained his cooperation by being friendly. She would share a soda with him and toast in friendly gesture. Tr. at 109. Her approach was a far cry from the personnel who entered his room on the 18th of June 2006. In contrast, and without a polite introduction, they began to push him around with no regard for his compromised physical and mental conditions or dignity.

The statement given to the surveyor on June 23, 2006, by Ms. Gray is a more complete account of the June 18 incident than the version provided at the hearing by Ms. Shedrick or the summary provided by Petitioner in its brief. Ms. Shedrick's testimony is based on the undated summary of her discussion with Ms. Gray after the June 18 incident. P. Ex. 26, at 2-3. In this regard, it is worth noting that Ms. Shedrick refers to Ms. Gray's state of shock as to the physical assault she witnessed when returning to the resident's room after retrieving supplies, but did not mention the abuse she had already witnessed prior to exiting the room. It is not known whether the omission is attributable to Ms. Gray or Ms. Shedrick. Thus, it is fair to conclude that either one or the other, or both, did not consider the events that transpired prior to Ms. Gray leaving the room to obtain supplies to constitute abuse.

As pointed out earlier, Petitioner unconvincingly states that Ms. Gray did not get help to stop the assault on R2, because she was blocked from exiting the resident's room. Additionally, it maintains Ms. Gray feared retaliation and she "would have known that to yell for help would have been futile" (due to competing noise). P. Br. at 5. To say that she would have known that to yell for help would have been futile, is mere speculation. Moreover, it would be more acceptable if Ms. Gray had in fact yelled for help, and her voice had been drowned by competing noise. It is ludicrous, however, to excuse her failure to cry for help under the guise that such effort would have been futile.

Furthermore, if Ms. Gray was in fact threatened, that was not the case when she first witnessed the abuse of R2 and did nothing to intervene. If she was afterwards threatened, that still does not exonerate the facility from providing its residents with an environment free from abuse. At least, after realizing the gravity of her actions (or inactions), Ms. Gray admitted to the truth as to how R2 was abused.

Petitioner places emphasis on its allegation that the facility took immediate steps to to assure compliance with the regulations dealing with allegations of abuse. P. Br. at 6-8. However, the fact that the facility took prompt remedial action does not cancel the fact or the nature of the noncompliance. Not only did R2 suffer actual and severe harm, but other residents were exposed to the likelihood of harm.

Petitioner also argues that the SOD does not identify any deficient practice on the part of the facility that may have contributed in any way to the abusive actions alleged against the three CNAs. Thus, Petitioner maintains that reliance on the employment relationship alone is insufficient to implicate the facility in abusive conduct.

Petitioner's argument that the SOD does not identify any deficient practice on the part of the facility or that the employment relationship alone is insufficient to reach a finding of noncompliance is misplaced. This is not a situation where liability is being imputed to the facility simply because of the liability of its employees. The Departmental Appeals Board (Board) has held that:

> A facility that undertakes to receive federal funds for its services . . . commits to meet the applicable requirements to participate in Medicare and Medicaid. Such a facility can act only through its agents and employees who make and implement policies, provide care, and perform the various responsibilities called for by the federal programs to protect and ensure the welfare of residents. Therefore, a facility whose administration and staff have been found not to be substantially complying with federal requirements is itself subject to administrative enforcement remedies. The facility cannot avoid such remedies by merely attempting to disown the acts and omissions of its own staff and administration since the facility elected to rely on them to carry out its commitments.

Beverly Health Care Lumberton, Ruling No. 2008-5, at 6-7, Reconsideration of DAB No. 2156 (2008).

Petitioner also equivocates in alleging that the SOD does not identify any deficient practice on the part of the facility that contributed to the nurse aides' abusive conduct perpetrated against R2. Pertinent to this is Petitioner's assertion that the surveyor's work papers reflect that they inquired into the manner the facility hired its staff and verified their credentials and suitability for employment. In doing this, no deficiency was found. Additionally, Petitioner maintains that the surveyors ascertained that the staff understood

the facility's abuse reporting and investigating requirements. I find Petitioner's contention that in the absence of a deficient practice related to the illegal acts of its employees, it is improper to cite the facility for this deficiency, to be without merit.

In *Emerald Oaks*, the Board considered Petitioner's suggestion that the ALJ should have accepted its evidence that it could not fairly be held responsible for the nurse's actions because she had received proper training and yet had acted so far outside her duties that she lost her license. The Board did not find that suggestion persuasive inasmuch as it was clear from the uncontested findings that the nurse was acting within the scope of her employment responsibilities. Thus, her employer could not disown the consequences of the inadequacy of the care provided by the simple expedient of pointing the finger at her fault, since she was the agent of her employer empowered to make and carry out daily care decisions. Additionally, the Board considered that the deficient practice did not stem from the actions of a single nurse (as in the present case). *Emerald Oaks*, DAB No. 1800, at 7 n.3 (2001).

Similarly, in the case now before me, Petitioner cannot escape responsibility by arguing that the facility was diligent in its hiring practices and the staff understood the facility's abuse reporting and investigation requirements. Contrary to Petitioner's contention, I do not have to look for a deficient facility practice outside the actions of the staff entrusted to act on behalf of the facility. Consequently, the deficient facility practice, in this case, is unequivocally found in the improper conduct of those that the facility empowered to act on its behalf. The facility, as a business entity, exists only in contemplation of the law, and can only perform the functions of a long-term care provider through the employees it chooses and empowers to act on its behalf. Acceptance of Petitioner's argument as sufficient justification for a finding of substantial compliance would render the law and regulations applicable here, meaningless.

Petitioner's reliance on the ALJ decision rendered in *Bryden Place, Inc.* is unpersuasive. In that case, the ALJ found that noncompliance was not established where the prohibited conduct was displayed by a sole employee who was not acting within the scope of his responsibilities on behalf of the facility because the occasion on which he verbally abused a resident was his day off. Here, the conduct involved several employees who were acting on behalf of the facility in two separate instances.[6] Moreover, although the ALJ did not articulate his rationale, following my precise reasoning, that decision did not have the benefit of appellate scrutiny and is not binding. *Bryden Place, Inc.*, DAB CR1365 (2005)

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[6] The incident involving R3 will be discussed later on in my decision.

In the case now before me, nurse aides # 1 and # 2 caused actual harm to R2 by perpetrating a physical assault upon him that resulted in severe injuries. The act of abuse was committed by staff members in the process of providing care to a resident of Petitioner's facility. The perpetrators of the abuse had been entrusted by the facility to carry out its commitment as a participant in the Medicare and Medicaid programs. In the discharge of that trust, they failed to provide R2 with an environment free from abuse. Similarly, Ms. Gray, also acting on behalf of the facility, condoned the abusive acts of nurse aides # 1 and # 2 by not intervening in the abuse that occurred in her presence and by not reporting it immediately to her supervisor or other staff members who could help intervene to protect R2 from physical abuse. In view of the foregoing, it is my finding that CMS has established a prima facie case that Petitioner was in violation of Tag F223. Petitioner has not overcome that showing by a preponderance of the evidence.

> ***2. <u>Abuse (Tag F226)</u>: CMS established that the facility failed to develop and implement policies and procedures that prohibit mistreatment, neglect, and abuse of residents as provided by 42 C.F.R. § 483.13(c) (immediate jeopardy).***

Based on record review and staff interviews, the facility failed to follow its abuse policies and procedures related to providing an environment free from verbal, physical, and mental abuse. The discussion as to Tag F223 serves as basis for establishing that Petitioner failed to implement its abuse policies when one of its nurse aides did not prevent or stop the physical abuse on two of its residents (Residents 2 and 3). In fact, the nurse aide who incurred in such failure (Ms. Loretta Gray), was terminated from her employment at the facility because she did not follow the abuse and neglect policy. In the letter of dismissal dated June 24, 2006, Ms. Sally Davis, the administrator, told her the following:

> The policy clearly states that it is **your responsibility to inform your immediate supervisor immediately of any violations of the abuse and neglect policy**. You failed to follow the policy by not **immediately** reporting the witnessed act of alleged abuse to your immediate supervisor on June 18, 2006 as well as the witnessed act of alleged abuse on June 3, 2006.

P. Ex. 13 (emphasis in original).

Although the facility took prompt action to address the staff member's failure to implement its policies and procedures, it was not so diligent in ascertaining that the policies were actually implemented. Without question, the failure to actually implement

facility policy against abuse and neglect leaves the resident at real risk for serious harm. *See West Point Community Living Center*, DAB CR1473, at 8 (2006). The best articulated policies and procedures are of little value if not properly and timely implemented and understood by each staff member.

It is my finding that CMS has established a prima facie case that Petitioner was in violation of Tag 226. Petitioner has not overcome that showing by a preponderance of the evidence.

The deficiencies under Tags 223 and 226 regarding the abuse of Resident 2 constitute immediate jeopardy.

On June 24, 2006, the surveyors conducted interviews with nurses, nursing assistants, and administrative and support staff. It was revealed that the facility staff had received re-inservice training related to the protection of residents at all times, and the need for staff to report occurrences immediately and without fear of reprisal. Inservice records were reviewed, and it was determined that the immediate jeopardy was removed on June 24, 2006, at 5:00 p.m. However, the facility remained out of compliance with an isolated deficiency that constituted no actual harm with potential for more than minimal harm that is not immediate jeopardy. CMS Ex. 1, at 17-18.

> ***3. <u>Abuse (Tag F223)</u>: CMS established that the facility failed to provide an environment free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion as provided by 42 C.F.R. § 483.13(b) with respect to Resident 3 (less than immediate jeopardy).***

<u>Resident 3 (R3)</u>

R3 was admitted to Petitioner's facility on March 31, 2006, with diagnoses of Alzheimer's, dementia, hypertension, cerebrovascular accident, cancer, and seizure disorder. The MDS also indicated that R3 was hearing and vision impaired. The MDS had the additional indication that the resident had persistent anger with self and others, and that the displayed behavior was not easily altered. That behavior included verbal and physical abuse and resistance to care.

During an interview on June 22, 2006, Ms. Gray stated that she had been employed at the facility for about a month, and had been a nurse aide for about eight years. She stated that the first weekend that she worked at North Carolina Veterans Nursing Home she was assigned to work with nurse aide # 4, who was training her.

On May 28, 2006, the nursing assistants from an earlier shift (11-7) reported that R3 was combative the previous night. Therefore, Ms. Gray asked nurse aide # 4 to help her with R3. When they entered his room, the resident began to fight. In response, nurse aide # 4 grabbed R3's knee and pressed it up against his chest. Ms. Gray thought that the nurse aide was rough with the resident when he pinned him down. Ms. Gray told the supervisor that the incident should have been reported, but she had not done so because she feared what nurse aide # 4 would do to her if she told. Ms. Gray revealed the abuse four days after she witnessed the abuse of R2 on June 18, 2006, by nursing assistants # 1 and # 2.

Petitioner alleges that when Ms. Gray belatedly reported the abuse she witnessed of R3, the facility immediately launched an investigation and no corroborating evidence was found that such incident occurred. In this regard, Joan Russell, a surveyor testified that she reviewed the facility records and found no entry that provided an indication that R3 had been abused on May 28, 2006. She attempted to reach the CNA who had been mentioned as the person who engaged in the abusive conduct, and he could not be reached. Tr. at 63.

Dorothy Moody-Hunt, the DON, testified that she spoke to the resident and employees, and reviewed the medical record and could not come up with substantiation for the alleged abuse. The resident was unable to provide information due to his dementia and Alzheimer's disease. Tr. at 162, 163. Of course, it is not surprising that no documentation was found to confirm the incident, because the people involved had chosen not to make it known. Additionally, the employees who had knowledge of the abuse were Ms. Gray and CNA # 4. Consequently, corroboration could only come from Ms. Gray and/or CNA # 4. Ms. Gray had already confessed that she witnessed the abuse. She was willing to do this although she was now aware that she had already incurred in a serious violation of facility policy in a similar matter.[7] Thus, she made a confession knowing that such revelation would place her in a greater negative light than was already the case.

The other person that could assist in corroborating the alleged abuse was the perpetrator, CNA # 4. The DON testified that she contacted him but he refused to go to the facility to discuss the matter. Tr. at 162. Sally Fielding Davis, the administrator, also contacted CNA # 4, and he preferred to discontinue employment at the facility rather than go in to discuss the matter of the alleged abuse. The administrator stated that his response to the request to discuss the abuse of R3 was an indication to her that he may very well have been guilty of the alleged abuse. Tr. at 227-232. In fact, the failure of Ms. Gray to

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[7] On the 18th of June 2006, she had been reprimanded for not immediately reporting the abuse she had witnessed of R2.

immediately report this allegation of abuse to her supervisor was one of the reasons that supported her termination of employment with the facility.[8] P. Ex. 13. At one point in her testimony, the administrator testified that the reason Ms. Gray was terminated from employment at the facility was because of her failure to immediately report the abuse of R3. Tr. at 234-235. As stated earlier, the dismissal letter mentions Ms. Gray's failure to immediately report the abuse of R2 as well as R3, as the reason for termination.

I find that CMS has established a prima facie case of noncompliance with Tag F223 relative to the abuse of R3. Petitioner has not overcome that showing by a preponderance of the evidence.

> ***4. <u>Staff treatment of residents (Tag F225)</u>: CMS established that the facility failed to immediately report the physical abuse of Resident 3. 42 C.F.R. §* 483.13(c)(2).**

Based on record review and staff interviews, a nurse aide (Ms. Gray), witnessed and failed to immediately report abuse on R3. Ms. Gray witnessed the abuse on R3 on May 28, 2006, but did not reveal the incident until June 22, 2006, when she was interviewed by a surveyor. CMS Ex. 1, at 19.

Petitioner alleges that inasmuch as the facility was not guilty of any deficient practice in regard to R3, the incident should not have been cited as an act of noncompliance. Furthermore, Petitioner maintains that there is an absence of corroborating evidence that the incident in fact occurred. Petitioner speculates that Ms. Gray may have concocted the story regarding R3's abuse by CNA # 4 because she was resentful after being reprimanded for failure to immediately report the witnessed abuse of R2 on June 18, 2006. P. Br. at 23.

In speculating as to the motives behind Ms. Gray's revelation, Petitioner fails to address whether she was of the belief that the revelation would in fact point to the guilt of the facility rather than to her own guilt. If Petitioner argues (erroneously), that the actions of the employees are not attributable to the facility, why would it expect Ms. Gray to believe otherwise. Thus, following Petitioner's own reasoning, I would have to conclude that Ms. Gray revealed the occurrence of the incident with the knowledge that it would be self-incriminating.

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[8] Although the letter references June 3, 2006, as the occasion when Ms. Gray failed to report an abuse of R3, the correct date is May 28, 2006.

I have already concluded that CMS has established a prima facie case as to the deficiency under Tag F223 regarding R3, and that Petitioner has not overcome that showing by a preponderance of the evidence. In arriving at that conclusion, one of the factors that I considered is the fact that the administrator testified that the evidence in the case pointed to the finding that it was very likely that CNA # 4 did in fact abuse R3. In fact, the administrator testified that she terminated Ms. Gray's employment with the facility based on the finding that she witnessed CNA # 4 abuse R3 and did not report it immediately.

Thus, it is my finding that CMS has established a prima facie case that Petitioner was not in compliance as to the deficiency under Tag 225 at the less than immediate jeopardy level.

> ***5. <u>Abuse (Tag F226)</u>: CMS established that the facility failed to develop and implement policies and procedures that prohibit mistreatment, neglect, and abuse of residents as provided by 42 C.F.R. § 483.139(c) at the less than immediate jeopardy level.***

The discussion above regarding Petitioner's noncompliance as to Tag F223 regarding R3 and Tag F226 regarding R2 and R3 is incorporated here by reference. No additional discussion is necessary in support of my finding that CMS has established a prima facie case that Petitioner was in noncompliance with Tag F226 at the less than immediate jeopardy level. Petitioner has not overcome that finding by a preponderance of the evidence.

> ***6. <u>Activities F248</u>: CMS established that the facility failed to provide an ongoing program of activities designed to meet, in accordance with the comprehensive assessment, the interests and the physical, mental, and psychosocial well-being of each resident.***

Based on observations, group interviews, staff interviews and review of the resident council minutes, the facility failed to provide meaningful activities to meet the needs and interests of residents during the evenings and weekends.

Several residents stated that they were interested in engaging in age-appropriate activities, field trips, sports, gardening, fishing, crafts, table games, music appreciation, etc., but the facility met their requests with excuses. The residents were told at times that the requested activity was too expensive, that they lacked the transportation capability, or did not have the needed volunteers. CMS Ex. 1, at 42-68.

Petitioner argues that the activities program met at all times. However, the facility is not charged with failing to have activity program meetings. What CMS found is that the facility failed to provide the meaningful activities requested by the residents at those meetings.

Additionally, Petitioner argues that assuming that the activities program was deficient during the time of the survey, those deficiencies were corrected after the June 2006 survey, but earlier than July 21, 2006, the correction date assigned by the State Survey Agency. However, the facility reported that the completion date for the deficiency at Tag F248 was July 21, 2006. Petitioner has presented no new evidence of probative value that the facility returned to substantial compliance at any time earlier than July 21, 2006. CMS Ex. 2, at 59.

In view of the foregoing, I find that CMS has established a prima facie case that Petitioner was not in substantial compliance with Tag F248 at the less than immediate jeopardy level. Petitioner has not overcome that showing by a preponderance of the evidence.

7. Other Issues

Petitioner also contends that CMS attempted to improperly introduce new evidence of an additional deficiency just as the case was ready to go to hearing. Regarding this additional incident of abuse, I had already ruled that I would not allow the introduction of a new deficiency, nor allow CMS to argue in favor of additional remedies as a result of such incident. Furthermore, I have not considered the alleged incident in arriving at any of the findings in this case.[9]

Finally, Petitioner has raised allegations that challenge the validity of the survey process that are beyond my adjudicative authority. Consequently, I will not address those challenges. P. Br. at 26-30.

B. CMS's finding of immediate jeopardy was not clearly erroneous.

I have already found that CMS has established a prima facie case that Petitioner was not in substantial compliance with federal requirements for skilled nursing facilities participating in the Medicare and Medicaid programs regarding Tags F223 and F226.

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[9] The alleged incident occurred on May 10, 2008, and involved R2. P. Br. at 15-16.

Furthermore, I sustain CMS's finding that Petitioner's level of noncompliance for each of these two deficiencies constitutes immediate jeopardy.

The regulations define immediate jeopardy as a situation in which a 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. A finding of immediate jeopardy does not require "a finding of present harm, but also encompasses a situation that is [likely to cause] harm." *Britthaven, Inc. d/b/a Britthaven of Smithfield*, DAB No. 2018 (2006) (quoting *Hermina Traeye Memorial Nursing Home*, DAB No. 1810 (2002)). CMS's determination of immediate jeopardy must be upheld unless it is clearly erroneous. 42 C.F.R. § 498.60(c)(2). The burden rests on the provider to prove that CMS's determination of immediate jeopardy is clearly erroneous. Petitioner has not met that burden here.

Petitioner contends that the immediate jeopardy is not warranted because there is no evidence of facility culpability. P. Br. at 15.

As I have discussed earlier, Petitioner caused actual physical and emotional harm to one of its residents (R2). When that occurred, nothing was done to immediately protect the harmed resident as well as other residents from similar harmful conduct. As I have already discussed, one staff member stood by while two others physically assaulted one of its residents. Ms. Shedrick, who was the charge nurse at the time of the incident testified that she admonished Ms. Gray that she should have yelled at the DON for help. Tr. at 121. In fact, as previously stated, Ms. Gray was terminated from employment at the facility because of her failure to immediately notify her supervisor of the abuse that she witnessed.

Although R2 was known to resist care and become combative at times, the abuse incident of June 18, 2006, was sparked by the rough treatment received by R2 at the hands of two members of the facility staff whose harsh treatment provoked the resident to anger. The facility should have foreseen that serious injury, harm, impairment, or death was likely to come to R2, whose physical and mental condition was severely compromised, if treated harshly, and forcefully given care. Petitioner should have also foreseen that if staff did not immediately intervene to stop the abuse, serious harm or injury was likely to come to R2. Other residents were also placed at risk of suffering serious injury, harm, impairment, or death.

Also, a requirement for a facility to develop and implement a policy against abuse and neglect is not a mere formality. The requirement has multiple purposes: it provides specific notice to facility employees regarding what is considered "abuse and neglect" and that "abuse and neglect" will not be tolerated; it informs and directs all employees of

their obligation to report any suspicion of abuse that they might witness or become aware of; it directs the facility to initially and continually train all employees to recognize abuse and how to take appropriate action to report it; and it protects residents from potential harm, especially because they may not be able to protect themselves from abuse and to ensure that residents feel safe and secure. Petitioner's failure to implement its policies against abuse as evidenced by the incidents with R2 and R3 also caused or was likely to cause serious injury or harm to these residents.

C. The amount of the penalty imposed by CMS is reasonable.

Petitioner contends that the CMP is unreasonable because even if the acts of the CNAs are attributable to the facility, their culpability is not. However, Petitioner offers no legal support for the proposition that liability, but not culpability, may be attributed to the facility based on the acts of its employees. Petitioner's assertion that surveyor Joan Russell testified that the facility bore no responsibility for the acts of its nursing assistants is misplaced (*See* Tr. at 52 and 58). The reference to pages 52 and 58 of the transcript lends no support to Petitioner's theory. Contrary to Petitioner's assertion, the surveyor testified that the facility documentation reflected their culpability. Moreover, Petitioner's responsibility for the actions of its employees is a legal issue for me to decide and not a matter to be resolved on the basis of the surveyor's testimony.

I have already addressed the basis for a finding of noncompliance and sustained CMS's finding that Petitioner's level of noncompliance for each of the two deficiencies at Tags F223 and F226 constituted immediate jeopardy.

I conclude that Petitioner has not met its burden of showing that CMS's determinations of immediate jeopardy were "clearly erroneous" for the period June 18, 2006 through June 23, 2006. The imposition of a CMP of $6000 per day for this period, imposed for noncompliance at the immediate jeopardy level, is reasonable in view of the gross failure to provide an environment for its residents that is free from abuse. In this case, where two CNAs so abusively assaulted a bedridden resident while a third staff member witnessed the shameful beating without intervening to stop it or seek the assistance of a supervisor, a CMP of $6000 per day is not unreasonable. That same CNA had witnessed a prior incident of abuse a month earlier, and failed to immediately report the incident. In both instances, the CNA asserted that she did not do anything to protect the residents or report the abuse for fear of retaliation. The facility's culpability cannot find sanctuary in such lame excuse. I find that the failure of Petitioner to implement its policies and procedures against abuse demonstrates a systemic problem within the facility.

The burden is on the facility to prove that it has resumed complying with program requirements, not on CMS to prove that the deficiencies continued to exist after they were discovered. *Hermina Traeye Memorial Nursing Home*, DAB No. 1810 (2002). In this case, CMS determined that the immediate jeopardy was abated on June 23, 2006, based on the facility's plan of correction showing that on that date it completed a physical assessment on all residents and did not identify any injuries of unknown origin. CMS Ex. 2, at 6.

It is true that other conditions in the facility still created a status of noncompliance. However, CMS deemed those lingering violations to be at the less than immediate jeopardy level. It is my finding, therefore, that the period of noncompliance at the less than immediate jeopardy level commenced on June 24, 2006, and ended on July 20, 2006.

Concerning the CMP of $100 per day for the deficiencies that are less than immediate jeopardy, I note that such penalty is at the lower end of the maximum permissible amount of $3000. I find that the penalty is appropriate and within a reasonable range. The onus is on Petitioner to come forward with evidence, consistent with 42 C.F.R. § 488.404, to show that the amount of the CMP is unreasonable. Petitioner has failed to do so.

Based on a revisit survey conducted in August 2006, CMS correctly determined that the facility returned to substantial compliance when the facility reached out to local civic and volunteer organizations, purchased new activity equipment, inserviced staff members regarding the new activity program, etc. *See* CMS Ex. 2, at 62. July 21, 2006, is the date the facility noted as the completion date of corrections concerning the deficiency under Tag F248. CMS Ex. 2, at 59. Petitioner has not satisfied its burden of showing that it eliminated the noncompliance on any date prior to July 21, 2006. Thus, a per day CMP of $100 for the less than immediate jeopardy deficiencies is appropriate through July 20, 2006.

V. Conclusion

Based on the testimony offered at the hearing, the documentary evidence, the arguments of the parties, and the applicable law and regulations, I find that Petitioner was not in substantial compliance with program participation requirements for the period of June 18, 2006 through July 20, 2006.

Petitioner was not in compliance with program participation requirements at the immediate jeopardy level from June 18, 2006 through June 23, 2006, and the imposition of a $6000 per day CMP for the period of the immediate jeopardy is reasonable.

I also sustain the CMP of $100 per day for the period of June 24, 2006, through July 20, 2006.

/s/
José A. Anglada
Administrative Law Judge