Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

In the Case of:	)	
	)	
New Horizon Rehabilitation Center (CNN: 10-5196),	)	Date: November 25, 2008
	)	
Petitioner,	)	
	)	
- v. -	)	Docket No. C-07-163
	)	Decision No. CR1868
Centers for Medicare & Medicaid Services,	)	
	)	
Respondent.	)	
	)	

DECISION

Petitioner, New Horizon Rehabilitation Center, failed to follow its own policies for investigating allegations of sexual abuse of one of its residents, putting it in noncompliance with program requirements and placing its residents in immediate jeopardy for a period of three days. Petitioner returned to substantial compliance when it resumed adhering to its policies regarding resident abuse.

I. BACKGROUND

Petitioner is a skilled nursing facility located in Ocala, Florida, dually certified to participate in both the Medicare and Medicaid programs. On November 7, 2006, the Florida Agency for Health Care Administration (state agency) conducted a complaint investigation at Petitioner's facility. The complaint investigation concerned events surrounding one of Petitioner's residents. The survey resulted in the citation of Petitioner for its failure to investigate and report violations involving alleged resident abuse as required by the regulations, with Petitioner being cited at the immediate jeopardy level.

CMS imposed a civil money penalty (CMP) of $7500 per day for the period of November 4 through November 6, 2006, and a $400 per day CMP beginning on November 7, 2006 and continuing until December 8, 2006, when the State agency made a re-visit to Petitioner's facility and determined that Petitioner had achieved substantial compliance.

This case was docketed and assigned to me for hearing and decision on December 28, 2006. The parties submitted pre-hearing briefs. I held a hearing in Ocala, Florida, on January 8 and 9, 2008. At the hearing, CMS offered 42 exhibits (CMS Exs. 1-42). Petitioner objected to parts of CMS Exs. 8 and 9, but I overruled the objections. Petitioner offered 23 exhibits (P. Exs 1-23), but withdrew its Ex. 19. CMS made no objection to Petitioner's exhibits. Accordingly, I admitted into the record CMS Exs. 1 - 42 and P. Exs. 1-18 and 20-23. Additionally, I admitted into the record ALJ Ex. 1, a portion of a deposition a CMS witness had given in a related matter. The parties then submitted post-hearing briefs and CMS a reply brief.

II. ISSUES

The issues presented in this case are:

1) Whether Petitioner failed to ensure that an allegation of resident abuse was immediately investigated and reported to the proper authorities.

2) Whether immediate jeopardy was present, and if so, was the amount of the CMP reasonable; and

3) When did Petitioner return to substantial compliance.

III. FINDINGS OF FACT AND CONCLUSIONS OF LAW

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

1. Petitioner failed to investigate and report immediately an allegation of sexual abuse of one of its residents.

A facility is required by regulation to ensure that its residents are free of mistreatment and abuse. Specifically, the facility must develop and implement written policies and procedures that prohibit the abuse of residents. 42 C.F.R. § 483.13(c). In addition,

> The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property are reported immediately to the administration of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).

42 C.F.R. § 483.13(c)(2).

Moreover, 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 psychosocial well-being of each resident.

42 C.F.R. § 483.75.

The survey report found deficiencies of the requirements of the provisions of 42 C.F.R. § 483.13(c) at Tags F225 and F226, at a scope and severity level of "L," indicating immediate jeopardy to resident health and safety. CMS Ex. 1, at 1-14. Additionally, the survey report also cited Petitioner for failure to meet the requirements of 42 C.F.R. § 483.75 at Tag F490, also at the "L" level, for Petitioner's administration of its facility. CMS Ex. 1, at 14-16. All of the alleged deficiencies arose from the same incident.

Shortly before noon on Saturday November 4, 2006, a housekeeping employee at the facility, JH, told a certified nursing assistant (CNA), TA, that he had seen another housekeeping employee, RV, in Resident 1's room and that RV had his hand down by Resident 1's groin area.[1] Resident 1, a 50-year-old female at the time of the incident, had diagnoses which included blindness, deafness, and muteness. TA told JH that he should report what he saw to the licensed practical nurse (LPN) on duty, DM, which he promptly did. DM told another nurse, DB, about the alleged abuse, and together they monitored RV, but did not notify the nurse supervisor of the incident.

On Sunday, November 5, 2006, LPN DM was again on duty, and again failed to notify any of her superiors about the incident. Meanwhile, RV continued to work at the facility, working shifts on Sunday and Monday.

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[1] I identify all of Petitioner's employees by their initials.

On November 6, 2006, at approximately 8:00 a.m., LPN DM informed the Director of Nursing (DON) about the incident. The DON informed the facility's administrator at 8:20 a.m. At around noon, Petitioner informed the State agency of the incident.

A surveyor from the state agency, Richard Brooker, arrived on November 7, 2006, to perform a complaint survey. After Mr. Brooker conferred with Petitioner's administrator, the administrator notified the police of the incident.

RV was suspended on November 6, pending an investigation of the incident. Petitioner also suspended DM for three days for her failure to report the incident, and subsequently, terminated DM on November 15, 2006. CMS Ex. 10. On November 8, 2006, police arrested RV and charged him with "lewd/lascivious molestation of elderly person." CMS Ex. 16. LPN DM was charged on November 14, 2006, with the failure to report abuse/neglect of a vulnerable adult. CMS Ex. 27.

The issue in this case is not about whether Resident 1 was sexually abused; that, while very disturbing, is not relevant to the basis for Petitioner's alleged noncompliance with program requirements. Nor is Resident 1's physical status as an individual who is blind, deaf, and mute relevant. To suggest otherwise would be to posit that a facility's duty of care to its residents is somehow dependent on the physical or mental status of each resident. The duty of care of a facility to prevent the abuse of its residents, be it physical or sexual, is absolute. No greater or lesser duty of care is owed because of a resident's particular frailties.

Rather, the dispositive issue before me is whether Petitioner adhered to the regulatory requirements and its own procedures in investigating and reporting this incident.

Petitioner maintains that it had policies and procedures in place to prevent, identify, and report resident abuse. It states that all employees received an in-depth orientation on resident abuse. All of its employees wore identification badges which had on their back instructions on how to report abuse. It placed numerous signs throughout the facility on how to report abuse of residents. All healthcare employees received continuing abuse identification and reporting training as part of their professional education.

Petitioner states that once the incident was reported on November 6, 2006, it immediately undertook a series of actions in accord with its established policies. RV was removed from the facility, suspended, and ultimately terminated. Petitioner's abuse coordinator arranged for a specialist from blind services to conduct an interview with Resident 1. The abuse coordinator also conducted a physical examination of Resident 1, and found no physical or psychological distress. Resident 1's family members were immediately notified. Petitioner interviewed all of the other female residents in the facility and found

no signs or symptoms of abuse. Petitioner immediately conducted in-service training of all its staff on abuse prevention, as well as on identification and reporting polices and procedures. Petitioner reported the incident to the Abuse Registry, Florida's Abuse Reporting Clearing House, around noon on November 6. Petitioner further notified the State agency on November 6, which sent in a surveyor to conduct a complaint investigation on November 7. Petitioner's department heads reviewed policies and procedures and directed that all vulnerable residents be assessed for indicators of abuse or neglect. It arranged for Resident 1's personal physician to schedule an examination which was completed several days later. The facility also ordered a psychiatric consult of Resident 1 to be conducted on November 6.

Petitioner maintains that it never before had a breakdown in its abuse reporting system and had no inkling that a breakdown would occur, and that LPN DM's failure to follow clear policy was beyond its control. Petitioner maintains that LPN DM's failure to follow policy was beyond its control. Petitioner argues that DM made a judgment call that was admittedly wrong, in that she should have notified immediately her superiors about the incident, but that this was an isolated technical violation of the regulations and not an indication of a systemic problem within the facility.

Neither numerous measures Petitioner took to prevent the abuse of its residents and to ensure the reporting of suspected cases of abuse, nor the actions Petitioner took after it was notified of the incident are in dispute. All those measures, however, prove meaningless when Petitioner's employees fail to act on their training or Petitioner fails to effectively communicate and implement those procedures. Here, it was not just one, but at least three of its employees – CNA TA, LPN DM, and nurse DB – who failed to report the incident to higher authorities within the facility. Furthermore, even when Petitioner's administration was notified of the potential abuse of one of its residents on November 6, it was not until November 7 that it notified, at the prompting of the State agency surveyor, the police of the incident.

At the hearing CMS presented the expert testimony of Dr. Peter Lichtenberg, who was qualified as a clinical psychologist and a neuropsychologist, and also as an expert in interdisciplinary teamwork. Dr. Lichtenberg testified that LPN DM should have recognized the urgency of the situation when the incident was reported to her and that she should have acted according to the procedures formulated by Petitioner. Tr. at 112. Dr. Lichtenberg further testified that the failure to immediately suspend RV, instead of allowing RV to continue working at the facility throughout the weekend, did not meet the standard of care. Tr. at 39.

I reject Petitioner's position that it should not be punished because of the actions of one of its employees to follow its procedures on abuse reporting. First, Petitioner is responsible for the actions of its employees. Second, as noted above, three of the employees were aware of the incident throughout the weekend, and none sought to keep RV from access to residents for two days. The failure of multiple employees to alert Petitioner's administration of the incident indicates a systemic problem within the facility.

Moreover, there was evidence that RV was involved in an earlier incident involving alleged sexual harassment of one of his fellow employees for nearly three months from November 2005 through January 2006; these incidents were not reported until November 6, 2006. CMS Ex. 8. Petitioner did not write RV up for these incidents of sexual harassment until November 9, 2006, five days after the incident that is at the heart of this case. CMS Ex. 7. Dr. Lichtenberg testified that this raised questions about whether Petitioner effectively communicated the importance of professional boundaries to its staff, particularly in relation to sexual matters (Tr. at 58), and that this was evidence that RV was a "troubled employee" (Tr. at 115). Additionally, there was evidence that DM had been suspended for a three-day period just 10 days before the incident at issue. P. Ex. 4. Dr. Lichtenberg testified that this was an indication of a failure of DM's position as a role model for other staff in the facility. Tr. at 60. Dr. Lichtenberg testified that the prior suspension indicated that the relationship between DM and her supervisors was in "real trouble." Tr. at 115.

I therefore find that CMS has established a prima facie case that Petitioner, through its employees, did not follow its own policies in reporting and investigating allegations of resident abuse, and that Petitioner has failed to rebut this case.

2. Petitioner's failure to investigate and report the allegation of resident abuse put the residents of the facility in immediate jeopardy, justifying the amount of the CMP imposed.

CMS asserted that Petitioner's failure to immediately investigate an allegation of resident abuse constituted immediate jeopardy to all the residents in the facility. Petitioner was cited at a scope and severity level of "L," which means widespread immediate jeopardy to resident health and safety. According to the regulations, immediate jeopardy --

> means 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.

42 C.F.R. § 489.3. I note that the regulation does not require that actual harm to a resident occur in order for immediate jeopardy to apply, but only that there is a *likely potential* for harm to a resident.

Here, it is inconclusive whether Resident 1 suffered any actual injury or harm as a result of the alleged abuse. No convincing evidence of actual harm or injury has been presented. Nevertheless, even though Resident 1 may not have been actually harmed, there was certainly the potential for harm to her *and* to other residents as the allegation of sexual abuse went uninvestigated for nearly 48 hours, time during which the suspected abuser remained at work at the facility among other residents. There were 132 residents at the facility at the time of the incident, including 36 with dementia and two with mental retardation. CMS Ex. 23, at 1. Each of the residents was potentially at risk while a member of the cleaning staff, charged with a credible accusation of abuse, was among them. Consequently, I find that immediate jeopardy was present for the period November 4 through 6, 2006.

The amounts of a CMP for deficiencies constituting immediate jeopardy are set forth at 42 C.F.R. § 488.438(a)(1). The amounts range from $3,050 to $10,000 per day. Here CMS imposed a CMP of $7,500 per day for three days, a penalty toward the upper end of the range of possible CMPs.

Petitioner argues that at most the CMP imposed should be a one-time per instance CMP or, in the alternative, that the CMP imposed should be in the lower range of available CMPs from November 4 through November 6.

I find that the CMP of $7,500 is reasonable in the light of the circumstances. First, the scope and severity of the deficiencies were placed at the "L" level, the highest possible level in the matrix of the seriousness of deficiencies. CMS's determination as to the level of noncompliance must be upheld unless it is clearly erroneous. 42 C.F.R. § 498.60(c)(2). Moreover, one of the factors to be considered in determining the amount of a CMP is the facility's degree of culpability, which includes "neglect, indifference, or disregard of resident care, comfort, or safety." 42 C.F.R. § 488.438(f)(4). Here, Petitioner's culpability must be considered high, as several of its employees failed to report an incident of suspected abuse to higher authorities, and, once it was reported, Petitioner's administration failed to notify the police until prompted by the State agency surveyor. Thus, I find nothing erroneous about the level at which CMS set the CMP.

As for Petitioner's argument that a per-instance, rather than a daily, CMP should have been imposed, I do not have the authority to review CMS's choice of the type of CMP it decides to impose. 42 C.F.R. § 488.438(e).

I therefore find that Petitioner's noncompliance placed its residents in immediate jeopardy and that a daily CMP of $7,500 was reasonable under the circumstances.

3. Petitioner returned to substantial compliance on November 7, 2006, and no further CMP should have been imposed on or after that date.

In addition to the CMP imposed for the immediate jeopardy citation, CMS also imposed a CMP of $400 per day for the period November 7 through December 8, 2006. CMS offered no argument for the duration of this CMP other than that it was not until December 8, 2006, that a surveyor from the State agency revisited the facility for a follow-up survey and determined that Petitioner was in substantial compliance. That State agency surveyor, Mr. Brooker, was the same surveyor who visited the facility for the complaint investigation on November 7, 2006. During its examination of Mr. Brooker at the hearing, CMS suggested that since Petitioner in its plan of correction to the deficiencies identified during the November 7 complaint survey indicated that it planned to have all the cited deficiencies corrected by November 16, 2006[2], it was illogical to assume that Petitioner had achieved substantial compliance prior to that date. Tr. at 213.

Petitioner established in its cross-examination of Mr. Brooker that it was, in fact, in substantial compliance after his initial visit on November 7, 2006. Mr. Brooker responded affirmatively to all the actions Petition had taken once it had become informed of the incident on November 6. Those actions included: an in-house investigation; the suspension of involved staff; in-service training for staff; the interviewing of all female residents; the examination of Resident 1 and a care plan team meeting to address her needs; and the reporting of the incident to the abuse registry. Tr. at 204-07. Mr. Brooker further testified that Petitioner was not in substantial compliance with the reporting requirements when he entered the facility on November 7 because of Petitioner's failure to report the incident to the police. However, Mr. Brooker's testimony established that Petitioner was in compliance when he left the facility later that day as Petitioner had prepared and implemented a plan of corrective measures. Tr. at 209. Mr. Brooker also testified that he did not know why a CMP was imposed for the 30-day period afer November 7. Tr. at 210. In short, Mr. Brooker testified that Petitioner had returned to substantial compliance by the end of November 7, 2006.

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[2] Petitioner's plan of correction seems to indicate that it would correct all the deficiencies and return to compliance by November 9, 2006. *See* CMS Ex. 1, at 1, 5, 8, 11, and 14.

Contrary to CMS's assertions, Petitioner has sustained its burden of establishing that it returned to substantial compliance on November 7, 2006. Accordingly, I conclude that no CMP should have been imposed after November 6, 2006.

IV. CONCLUSION

Based on my review of all of the evidence and testimony presented in this case, I sustain the imposition of a CMP of $7,500 per day for the period of November 4 through November 6, 2006. I also find that the evidence in this case established that Petitioner returned to substantial compliance on November 7, 2006. Therefore, no additional CMP should be imposed after November 6, 2006.

/s/
Alfonso J. Montano
Administrative Law Judge