Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Illinois Knights Templar Home,
(CCN: 14-5449),

Petitioner,

v.

Centers for Medicare and Medicaid Services.

Docket No. C-09-774

Decision No. CR2203

Date: August 10, 2010

DECISION

I sustain the determination of the Centers for Medicare and Medicaid Services (CMS) to impose the following remedies against Petitioner, Illinois Knights Templar Home:

- Civil money penalties of $3,050 per day for each day of a period beginning on March 28, 2008 and continuing through April 3, 2008; and

- Civil money penalties of $300 per day for each day of a period beginning on April 4, 2008 and continuing through April 30, 2008.

I. Background

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

CMS determined to impose the remedies that I describe in the opening paragraph of this decision based on noncompliance findings that were made at a survey of Petitioner's facility conducted on April 14, 2008 (April survey). The April survey findings included findings that Petitioner manifested three deficiencies that were so egregious as to comprise immediate jeopardy for Petitioner's residents. An "immediate jeopardy" level deficiency is one that is so serious as to cause or to be likely to cause serious injury, harm, impairment, or death to a resident or residents of a facility. 42 C.F.R. § 488.301.

Petitioner requested a hearing and the case was assigned to me for a hearing and a decision. CMS moved for summary judgment and I issued a decision favorable to CMS. An appellate panel of the Departmental Appeals Board subsequently remanded the case to me because it found that there were disputed issues of fact. I then held a hearing in Chicago, Illinois on April 12, 2010. At the hearing I received into evidence from CMS exhibits that are identified as CMS Ex. 1 – 18, 21 – 27, and 29 – 70. I received into evidence from Petitioner exhibits that are identified as P. Ex. 1 – 18. I also heard the cross examination and redirect testimony of several witnesses whose direct testimony is in evidence as affidavits or declarations.

II. Issues, findings of fact and conclusions of law

A. Issues

The issues in this case are whether:

1. Petitioner failed to comply substantially with Medicare participation requirements;

2. CMS's determination of immediate jeopardy level noncompliance is clearly erroneous;

3. CMS's remedy determinations are reasonable.

B. Findings of fact and conclusions of law

In this decision I do not address all of the noncompliance findings that were made at the April survey. I address all of the findings of immediate jeopardy level noncompliance as well as one of the findings of non-immediate jeopardy level noncompliance. I do not address the other noncompliance findings because the findings that I do address and that I sustain are more than sufficient to justify CMS's remedy determinations. Making additional noncompliance findings is simply unnecessary to the outcome of this case.

The findings of noncompliance that I address consist of allegations that Petitioner failed to comply with the following regulations: 42 C.F.R. §§ 483.13(b)(1)(i); 483.13(c)(2) – (4); 483.13(c); and 483.75.

I make the following findings of fact and conclusions of law (Findings).

1. Petitioner failed to comply substantially with the requirements of 42 C.F.R. §§ 483.13(b) and (c)(1)(i).

The applicable regulation prohibits a facility from subjecting a resident to verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. In practice the regulation prohibits a facility from tolerating abusive behavior by facility staff against residents. "Abuse" is defined at 42 C.F.R. § 488.301 to mean:

> the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish.

The term "willful" has been interpreted on numerous occasions to mean "deliberate." Abuse can occur in the absence of a specific intent by a staff member of a facility to harm a resident. Malice is not a necessary element of abuse. The willfulness standard is satisfied where an employee of a facility deliberately does something which he or she knows or should know could cause a resident to suffer from physical harm, pain, or mental anguish.

CMS's allegation that Petitioner failed to comply with the requirements of 42 C.F.R. §§ 483.413(b) and (c)(1)(i) focuses primarily on the behavior of a certified nursing assistant on Petitioner's staff whom I refer to as "H." It is undisputed that very early on the morning of September 9, 2007, H and two other nursing assistants were in a room shared by two of Petitioner's residents who are identified as Resident # 4 and Resident # 17. The nursing assistants were providing care to Resident # 17 while Resident # 4, who is nearly blind, slept. While the three nursing assistants were in the room, H began repeatedly hitting his leg against Resident # 4's bed. The two nursing assistants who were with H at the time, Olha York and Kathy Arends, respectively described what H was doing as either "bouncing" the bed or "tapping" on it. CMS Ex. 41 at 1-2. These nursing assistants described H's behavior as joking. *Id.* However, H refused to cease his behavior when Resident # 17 and the two nursing assistants asked him to stop. *Id.* That refusal provoked a confrontation between H and the other nursing assistants. Ms. York raised her hand as if to indicate that she would push H away from Resident # 4's bed. *Id.* That gesture caused H to become angry and he threatened to harm Ms. York if she ever touched him. *Id.* at 1. H then became very agitated, began yelling, and left the room. *Id.*; CMS Ex. 16 at 22.

H did not give the other nursing assistants an explanation for his striking Resident # 4's bed. However, an explanation that I accept as reasonable was offered by nursing assistant York, who observed that H had in the past picked on Resident # 17. She opined that H was disturbing Resident # 4's bed in order to "get at" Resident # 17, that is to say, to either annoy or intimidate the resident. CMS Ex. 16 at 21.

After H left the residents' room he went to Petitioner's nurse's station. He remained angry and upset. CMS Ex. 16 at 16. He told a registered nurse that he wanted to go on a break. CMS Ex. 16 at 16. When nursing assistant York approached the nurse's station H "jumped up from his seat and went outside, cussing and saying that he was going home." CMS Ex. 41 at 1. Nursing assistants York and Arends then reported to the nurse the events that had occurred in the residents' room. CMS Ex. 16 at 16. Shortly thereafter H called the nurse and advised her that he was leaving the premises.

Petitioner's director of nursing and administrator were advised about the incident on September 10, 2007. P. Ex. 7 at 4; P. Ex. 8 at 1. On that date the administrator spoke with H. He gave H a written warning and counseled H about Petitioner's code of ethics. The warning stated that H had engaged in "uncooperative behavior or acts that are in disregard of established personnel policies and procedures and that H had left his shift before it was completed. CMS Ex. 43 at 2. In a separate note the administrator circled a statement indicating that H had engaged in fighting or in threatening or intimidating activities. *Id.* at 3.

H continued to work at Petitioner's facility for several weeks after the events of September 9, 2007. Petitioner terminated H's employment on October 19, 2007. The termination was the consequence of a second incident involving H.

On October 18, 2007, Petitioner's activity director reported to the director of nursing and Petitioner's administrator that she had become aware of an allegation of abuse involving H. CMS Ex. 16 at 8; CMS Ex. 42 at 3, 9. A nursing assistant, Mandy Ebert, reported that she had witnessed H verbally abuse a resident identified as Resident # 13, a man aged 88 years, who was totally dependent on Petitioner's staff for assistance. According to Ms. Ebert, the resident had complained to H that he felt as if H was "breaking his arm" while H was transferring the resident via a device known as a hoyer lift. CMS Ex. 42 at 4. Ms. Ebert asserted that H had responded by saying: "if you keep that up, I'll roll you onto the floor." *Id.* Ms. Ebert also reported that she had witnessed H being rude to residents on other occasions. *Id.* Neither Ms. Ebert nor another nursing assistant, who had spoken with Ms. Ebert about the incident, immediately reported it to Petitioner's management. CMS Ex. 16 at 6, 8; CMS Ex. 42 at 5, 9; P. Ex. 7 at 8.

Petitioner's administrator spoke with H about the reports of abuse. CMS Ex. 42 at 6. H denied abusing residents but also became extremely confrontational. The administrator then terminated H's employment.

The evidence that I have discussed pertaining to H's conduct establishes abusive behavior by this employee. It also shows a failure on the part of Petitioner's management to recognize, and to respond appropriately, to this abuse. The behavior of H on the night of September 9, 2010 was clearly abusive. It was not simply an altercation between H and another nursing assistant. The evidence establishes that H deliberately and repeatedly

struck Resident # 4's bed, conduct which was found to be offensive by Resident # 17, and which had at least the potential for causing emotional distress to both Residents # 4 and # 17. It was not inadvertent as is evidenced by H's refusal to stop engaging in the conduct when asked to stop. The fact that the behavior was characterized as joking behavior by the two other nursing assistants who observed H on that evening does not detract at all from its abusive character. H may have intended his behavior to be funny but he was on notice that others considered it to be offensive and he refused to cease his behavior when he was asked to do so.

Furthermore, H's explosive reaction to the other nursing assistants' requests that he cease his abusive behavior, in the presence of residents, was abusive in its own right. He subjected residents who are by definition individuals who are frail and ill to his outburst and this behavior clearly had the likelihood of causing the residents to suffer from anguish.

A skilled nursing facility is not simply an extension of a hospital or a sick bay for frail and ill individuals. It is, in fact, the residents' home, the place where they live. Residents of a facility are entitled to be treated with dignity and to be protected against abusive conduct such as that engaged in by H. Petitioner failed to provide its residents with this protection when it failed to remove H immediately from resident care when his behavior on the morning of September 9, 2007 was brought to the attention of Petitioner's management. Either his employment should have been terminated or H should have been suspended from resident care pending a full and thorough investigation of the circumstances of the September 9 event.

Petitioner's policy governing investigation of suspected incidents of abuse states that:

> Employees alleged to have been involved in the abuse, neglect, involuntary seclusion or misappropriation of resident property will immediately be suspended pending the outcome of the investigation.

CMS Ex. 40 at 2. Petitioner plainly failed to follow its policy in the case of the September 9, 2007 incident involving H.

I do not fault the actions of Petitioner's management in removing H from employment on October 19, 2007. That was appropriate given what management had learned about H. But, the fact that H was allowed to remain in his job for more than a month after the September 9, 2007 incident – during which he continued to provide care to residents – proves failure by Petitioner's management to appreciate the seriousness of the September 9 incident.

I have considered the evidence and arguments that Petitioner offers in defense of its handling of H and I do not find them to be persuasive.

Petitioner argues that H's repeated hitting of Resident # 4's bed on the night of September 9, 2007 was not forceful because the resident slept through the entire event. Petitioner's post-hearing brief at 4. There is no evidence in the record that describes with any particularity how vigorously H hit the resident's bed. However, it was not the force with which H engaged in this action that the other nursing assistants and Resident # 17 found to be offensive; rather, it was the inappropriateness of H's behavior coupled with his refusal to cease doing it when asked.

Petitioner also asserts that H's conduct on the evening of September 9 was benign because it was characterized as "joking" by the two nursing assistants who witnessed his conduct. I have discussed that above. Whatever H's intent was, he also knew that both of the nursing assistants and Resident # 17 found his conduct to be offensive, because they asked that he cease engaging in it and he refused.

Petitioner argues also that the events of September 9 did not constitute "even an allegation of abuse." Petitioner's post-hearing brief at 4. The premise for this assertion is that Resident # 17 would have filed a claim of abuse had she believed that H's conduct was abusive. This assertion is speculative and, so, I find it to be without merit. Furthermore, Petitioner's management knew that there was an allegation of abuse because the two nursing assistants who were witnesses to H's conduct had reported it in terms that described abuse by any objective measure. CMS Ex. 41 at 1-2.

I note, moreover, that there is no evidence that anyone on Petitioner's staff interviewed Resident # 17 in the hours or days following the incident. Consequently, the resident's take on what occurred in the immediate aftermath of the incident is simply unknown. In its post-hearing brief Petitioner asserts that its management interviewed "the resident who witnessed the event," meaning I assume, Resident # 17, as part of its investigation of the September 9 incident. Petitioner's post-hearing brief at 5. However, Petitioner has cited to nothing in evidence to support that assertion and I can find no supporting documentation in the record. Petitioner took statements from the two nursing assistants who witnessed the event, but there is no record of a statement taken from Resident # 17 during Petitioner's investigation of the September 9 incident. *See* CMS Ex. 42.

Resident # 17 was interviewed by a surveyor during the April survey. The resident, however, was unable to remember the event of September 9 and therefore, contributed no meaningful evidence concerning that event. Petitioner asserts that Resident # 17 felt intimidated when she was interviewed by surveyors during the April survey and it attempts to characterize the interview as an episode of abuse. This allegation is irrelevant.

Petitioner argues that H's conduct on September 9, 2007 was not abuse because it was not specifically directed against a resident. Petitioner's post-hearing brief at 5-7. Petitioner characterizes the events of September 9 as constituting merely a dispute between staff members which cannot rise to the level of abuse. I disagree with this

assertion on two counts. First, H's conduct was directed both at Resident # 4 and Resident # 17. It was directed against Resident # 4 because H repeatedly struck the resident's bed while she lay in it. It was directed against Resident # 17 because the plausible explanation for H's conduct was that he was attempting to annoy or anger the resident. CMS Ex. 16 at 21. Second, H's conduct was abusive towards residents even if it was specifically directed at the two other nursing assistants who were in the room with him on September 9. H knew or should have known that his striking Resident # 4's bed and his subsequent outburst of temper when confronted by one of the nursing assistants had the likelihood of being viewed as offensive and intimidating by the residents.

Petitioner argues that the testimony of the surveyors who conducted the April survey is not credible. It premises this argument on the assertion that the demeanor of the surveyor who interviewed the nursing assistants about the September 9 incident was evasive. Petitioner's brief at 7. I disagree. I find nothing evasive in this witness' testimony. The premise for Petitioner's characterization is that the surveyor was unable to remember some of the findings that she made at the April survey without consulting her notes or exhibits in evidence. I find that to be understandable given that the in-person hearing took place about three years after the survey was completed. The surveyor's memory lapses are certainly no basis to impeach the notes and reports that she made contemporaneously with the survey.

Petitioner argues also that its witnesses' testimony is inherently more credible than that of CMS's witnesses. It contends that I must assume all of its witnesses' written direct testimony to be credible inasmuch as CMS counsel declined to cross examine these witnesses. I do not find this argument to be persuasive. Petitioner seems to assert that the only way in which a witness' credibility may be assessed is by observing his or her demeanor as that person testifies in person and under oath. That is simply incorrect. Credibility may be based on many factors other than demeanor. Testimony that is not supported by the record or that is inconsistent with other evidence may be found to be not credible even if the affiant does not testify in person.

Petitioner has not pointed to any specific element of its witnesses' testimony that calls into question the veracity of the evidence that I have discussed in this decision. *See* Petitioner's post-hearing brief at 7. However, I have reviewed the written direct testimony of Petitioner's witnesses and I find it not to be credible in significant respects. There are statements that are unsupported by any other evidence in the record and that are, for this reason, not credible. Other statements are simply opinions which I find not to be supported by the evidence.

In her affidavit Kathryn L. Swan, Petitioner's administrator recites her version of the September 9 incident involving H. P. Ex. 7 at 3-4. She characterizes the entire incident as lasting less than a minute. About H's actions, she says:

> [H] was observed shaking his knee – like a nervous tic. In the process . . . [H's] knee tapped R4's foot board . . . R4's roommate asked . . . [H] to stop. . . [H's] nervous tic continued.

Id. These statements clearly are aimed at having me infer that the September 9 incident was of very brief duration and involved no voluntary action by H. But, there is simply nothing in the record to support them. Ms. Swan was not a witness to the September 9 incident. Neither of the nursing assistants who were witnesses and who were interviewed after the incident characterized H's actions as a "nervous tic" nor did they describe the incident as lasting less than a minute. CMS Ex. 41 at 1-2.

Similarly, Ms. Swan characterizes the September 9 incident as follows:

> The alleged actions of . . . [H] did not constitute abuse or an allegation of abuse. His nervous energy was not willful, and did not inflict injury, confinement, intimidation, or punishment to R4 or any other residents in the facility. . . . The facility did not fail to recognize abuse because no abuse occurred.

P. Ex. 7 at 3.

Ms. Swan offers no foundation for this assertion and I find it to be an unsupported conclusion. I have explained why H's actions on September 9 satisfy the definition of "abuse" and why Petitioner should have treated the allegations of the two nursing assistants who were present during the incident as allegations of abuse.

Petitioner's director of nursing, Carol A. Langley, avers in her affidavit that no abuse occurred on September 9, 2007. P. Ex. 8 at 1. Ms. Langley cites to no facts other than those that I have addressed in this decision as support for her opinion. She bases her opinion on "my conversations with . . . [H and the other two nursing assistants] as well as my knowledge of R4 and R17 . . . ." *Id.* She asserts also that she agrees with Ms. Swan's opinion about the events of September 9. I have explained why I disagree with Petitioner's characterization of the events of September 9 and the allegations that were made about those events and it is unnecessary for me to revisit that analysis here except to say that I disagree with this witness' conclusions.

Petitioner offered affidavits by other witnesses. P. Ex. 9 – P. Ex. 14. None of these affidavits provide any evidence concerning the events of September 9, 2007 other than that which I have previously addressed. Of the affiants, only Ms. York was an actual witness to the September 9 events. P. Ex. 12. In her affidavit Ms. York affirms that what she said previously about the September 9 incident is true. *Id.*; CMS Ex. 41 at 1. She adds that "I don't think . . . [H] was trying to be mean to R4. He only seemed to be angry with me." That statement adds nothing to what Ms. York previously said about the incident. Moreover, and as I have explained, it is not necessary that I find that H was

trying to harm Resident # 4 by striking her bed in order that I conclude that his conduct on September 9 was abusive.

2. Petitioner failed to comply substantially with the requirements of 42 C.F.R. § 483.13(c)(2) – (4).

The applicable regulation mandates in relevant part that a skilled nursing facility must ensure that all allegations of abuse are reported immediately to the facility's administrator and to relevant State officials in accordance with established procedures. It requires that all allegations of abuse be thoroughly investigated. And, it requires that the results of all investigations be reported to the administrator and to relevant State officials within five working days of the incident.

CMS alleges that Petitioner failed to treat the September 9, 2007 incident as an abuse allegation. Thus, according to CMS, the incident was not immediately reported to Petitioner's administrator, H was not prohibited from providing resident care pending the outcome of an investigation into the incident, and the incident was not reported to State officials. CMS also alleges that Petitioner delayed in investigating the allegations arising from the October incident because the nursing assistant who made these allegations failed to comply with facility policy and report them immediately.

The evidence overwhelmingly supports CMS's allegations. It establishes that Petitioner's staff did not report the September 9 incident to Petitioner's administrator until the next day, a full day after the incident occurred. It establishes also that H was allowed to continue to provide care to residents after the incident and was not relieved from his duties of providing such care until after the subsequent allegation of abuse in October 2007. The evidence establishes that Petitioner's staff failed to interview either Resident # 4 or Resident # 17 about the incident. Finally, the incident was never reported to State officials. The evidence also substantiates CMS's assertion that the nursing assistant who reported the October allegations delayed more than a week in making them.

Petitioner's defense to CMS's allegations and to the supporting evidence is that "there were no allegations of resident abuse with respect to the September 9, 2007 event." Petitioner's post-hearing brief at 12. Additionally, Petitioner asserts that the allegations pertaining to the subsequent incident involving H that took place in October 2007 were "fabricated" by the nursing assistant who made them. *Id.* Consequently, according to Petitioner, it is absolved from any duty to investigate the allegations relating to the September and October 2007 incidents, was not required to suspend H after the September incident, and was not required to report the September allegations to State officials.

I disagree. First, and as I have held above, the allegations that the other two nursing assistants made about H's conduct on September 9, 2007 clearly described abusive conduct. Those allegations obligated Petitioner to comply with all of the regulatory

requirements pertaining to investigation of abuse allegations. Similarly, the allegations made concerning the October 2007 incident were, by any measure, allegations of abuse and they also triggered the regulatory investigation and reporting requirements. Petitioner may not evade its responsibility for reporting the September 2007 incident to State officials by now claiming that no abuse actually occurred. The allegations that the two nursing assistants made about that incident plainly described abuse. The regulation requires that all *allegations* of abuse be investigated and reported even if they subsequently turn out to be invalid. It is, therefore, no defense to argue in retrospect that the investigation and reporting requirements were not triggered because the allegations ultimately were not sustained.

There is an obvious reason for the requirement that all abuse allegations be reported to State officials. When a facility's management receives an allegation of resident abuse it is placed in situation where, potentially, there is a conflict of interest. It is not in a facility's self-interest to authenticate allegations of resident abuse because, at the very least, the facility's reputation may be damaged. Moreover, such allegations, if proven, may lead to the imposition of remedies against the facility. Thus, a facility has motivation not to find abuse on its premises. On the other hand, the facility has an absolute duty to protect the welfare and safety of its residents.

The requirement that abuse allegations be thoroughly investigated and reported to State officials assures that this potential conflict of interest does not adversely affect the outcome of investigations into such allegations. It assures that a neutral third party (the State) will be apprised of the allegations and will be in a position to take protective action if necessary. It also assures that the facility will do all that is needed to protect the safety and well-being of its residents.

Similarly, it is no defense to assert that the allegations relating to the October incident may have been "fabricated" or that they were false. The regulation requires that all allegations of abuse – true or not – be investigated immediately and reported. Arguing after the fact – as Petitioner does here – that the allegations turned out not to establish abuse is a way of justifying in retrospect a failure to comply with regulatory responsibilities.

3. *Petitioner failed to comply substantially with the requirements of 42 C.F.R. § 483.13(c).*

The applicable regulation requires in relevant part that a facility develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents. CMS alleges that Petitioner failed to comply with its own abuse policies in dealing with the allegations of abuse that were made in September and October 2007. Specifically, CMS asserts that Petitioner violated its abuse policy by failing to suspend H or to relieve him of his responsibilities of providing direct care to residents while it investigated the allegations made concerning the September incident. Also, CMS asserts

that the failure by the nursing assistant to report immediately her allegations of H's abusive behavior in October 2007 is a violation of Petitioner's abuse policy.

The evidence overwhelmingly supports these allegations. There is no dispute that Petitioner's management failed to suspend H or to relieve him from resident care after it learned about the September incident. Nor is there any dispute that the nursing assistant who reported the October incident waited about a week before reporting her allegations.

Petitioner did not address CMS's allegations in its post-hearing brief. I assume that it contends that the suspension and reporting requirements were not contravened because the allegations of abuse turned out – in Petitioner's view – to be unsubstantiated. That argument, although not made explicitly, is consistent with what Petitioner argues elsewhere. But, if that is Petitioner's position, it is without merit. Petitioner's policies are predicated on allegations of abuse and in that respect they mirror regulatory requirements. It is no defense to argue, that when viewed with hindsight, allegations of abuse turn out to be unproven.

4. *Petitioner failed to comply substantially with the requirements of 42 C.F.R. § 483.75*

The regulation at issue requires that a skilled nursing facility 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.

CMS alleges that Petitioner failed to comply substantially with the requirements of this regulation based on Petitioner's alleged multiple systemic failures to comply with other regulatory requirements. More specifically, however, CMS rests its case on Petitioner's failures to comply with the requirements that I address in Findings 1 and 2 of this decision.

The evidence in this case plainly establishes a systemic failure by Petitioner's management to apply its policies to protect residents against abuse. What is evident in this case is that Petitioner's management failed to implement policies that assured that allegations of abuse be promptly and thoroughly investigated, that they be reported to appropriate State officials, and that residents are protected pending the outcome of such investigations. The failures by Petitioner to implement its policies were not confined to errors surrounding the September 9, 2007 incident. There was a subsequent failure evidenced by the delayed reporting of allegations pertaining to the October incident.

Ultimately, the responsibility for implementing and enforcing a facility's policies lies with management. Petitioner's policies concerning abuse were not self-implementing. Management had to take affirmative steps in order to apply the policies when abuse allegations were brought to its attention. The failure to treat the allegations concerning the September 9, 2007 incident as abuse allegations and to implement the full panoply of

abuse policies to deal with that incident evidences a fundamental misunderstanding on Petitioner's management's part about what constitutes abuse and how to deal with allegations of abuse.

CMS predicated its allegations of noncompliance with 42 C.F.R. § 483.75 on the full range of deficiencies that it alleged. However, the core of CMS's allegations relates to Petitioner's noncompliance with the regulations governing abuse and which I have addressed in detail in this decision. I find it unnecessary to make findings about other alleged deficiencies in order to find that Petitioner failed to comply with the requirements of 42 C.F.R. § 483.75. Evidence that Petitioner's management failed to implement the facility's policy concerning investigation of and protecting against abuse is sufficient to sustain CMS's allegations of noncompliance with the requirements of 42 C.F.R. § 483.75.

5. CMS's findings of immediate jeopardy level noncompliance are not clearly erroneous.

CMS found immediate jeopardy level noncompliance with respect to three of the deficiencies that I address in this decision. These deficiencies are Petitioner's failures to comply with the requirements of 42 C.F.R. §§ 483.13(b), 483.13(c)(1)(i), 483.13(c)(2) – (4), and 483.75 (Findings 1, 2, and 4).

The evidence amply supports CMS's determinations of immediate jeopardy. As I have discussed, there was a fundamental misunderstanding on Petitioner's part of its obligation to recognize and respond appropriately to abusive behavior by its staff. That basic failure created the likelihood that residents would be subjected to serious injury or harm.

I do not base this conclusion solely on the consequences of H's behavior during the September and October 2007 incidents. Petitioner argues that there is no proof that residents sustained actual harm as a result of these incidents and I agree with that contention. But, there was a *likelihood* of harm to residents that existed at Petitioner's facility by virtue of Petitioner's failure to comprehend the need to enforce vigorously its policies concerning abuse. The failure to suspend H, for example, after the September 9, 2007 incident, meant that an employee who demonstrated more than the potential for committing abusive acts was allowed to continue to provide direct resident care. The failure to report the September 9 incident to State officials meant that Petitioner's management had stripped residents of a protection that was guaranteed to them by law and, as a consequence, left them vulnerable to the possibility that Petitioner would not treat abuse allegations with the seriousness that they merited.

Petitioner did not prove CMS's findings of immediate jeopardy to be clearly erroneous. Essentially, Petitioner rests its case on its assertion that the September and October 2007 incidents did not constitute abuse of residents. But, even if that were true, it did not relieve Petitioner's management of its obligation to treat the *allegations of abuse*

seriously under its policies protecting residents against abuse and pursuant to governing law and regulations. The failure of management to do so created jeopardy for Petitioner's residents even if the allegations that were made concerning the September and October 2007 incidents were ultimately disproved. Moreover, I have found that the September incident – H's actions on that night – was abuse.

6. CMS's remedy determinations are reasonable.

a. CMS's determinations as to duration of noncompliance are reasonable.

CMS determined that Petitioner manifested immediate jeopardy level noncompliance during a period that began on March 28 and that continued through April 3, 2008 and non-immediate jeopardy level noncompliance during a period that began on April 4, 2008 and that continued through April 30, 2008. The premise of CMS's duration determination is that Petitioner did not rectify its failure to comprehend and to implement its obligation to protect against, investigate and report abuse during the entire period of noncompliance but that its failure was particularly egregious (at the immediate jeopardy level) during the March 28 – April 3 portion of the period.

Petitioner disputes these duration determinations. The basis for Petitioner's opposition is its continued insistence that it was complying with all participation requirements throughout the period and that CMS's allegations of noncompliance are baseless. I have dealt with Petitioner's objections previously and I will not revisit them here. Petitioner has offered no evidence to prove that it corrected its deficiencies on dates earlier than CMS found them to be corrected. Consequently, I sustain CMS's determinations as to duration.

b. The immediate jeopardy level civil money penalties are reasonable as a matter of law.

Civil money penalties to address immediate jeopardy level noncompliance must fall within a range of from $3,050 to $10,000 per day. 42 C.F.R. § 488.438(a)(1)(i). CMS determined to impose penalties of $3,050 per day for Petitioner's immediate jeopardy level noncompliance. That is the minimum immediate jeopardy level penalty amount and is, consequently, reasonable as a matter of law.

c. Civil money penalties of $300 per day are reasonable to address Petitioner's non-immediate jeopardy level noncompliance.

Penalties to remedy non-immediate jeopardy level noncompliance must fall within a range of from $50 to $3,000 per day. 42 C.F.R. § 488.438(a)(1)(ii). Regulations establish the criteria that must be used for deciding where within that range a penalty amount ought to fall. 42 C.F.R. §§ 488.438(f)(1) – (4); 488.404 (incorporated by

reference into 42 C.F.R. § 488.438(f)(3)). The factors may include a facility's compliance history, the seriousness of its noncompliance, its culpability, and its financial condition.

Penalties of $300 per day for non-immediate jeopardy level noncompliance are at the low end of the non-immediate jeopardy penalty range, comprising only ten percent of the allowable maximum. I find that the seriousness of Petitioner's noncompliance is sufficient to sustain penalties of at this very low level. The failure to completely correct noncompliance with regulations governing prevention, investigation and reporting of abuse meant that the facility's residents were still at a risk for harm even after immediate jeopardy was removed.

I note, furthermore, that Petitioner did not challenge the reasonableness of the amount of CMS's penalty determinations in its post-hearing brief. It has not offered any argument showing that the penalty amount of $300 per day is unreasonable.

/s/

Steven T. Kessel
Administrative Law Judge