Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Merrimack County Nursing Home
(CCN: 305056),

Petitioner

v.

Centers for Medicare and Medicaid Services.

Docket No. C-11-34

Decision No. CR2352

Date: April 8, 2011

DECISION

I decide this case based on the written record. I sustain the imposition of a per-instance civil money penalty of $3,000 against Petitioner, Merrimack County Nursing Home.

I. Background

Petitioner is a skilled nursing facility that operates in Boscawen, New Hampshire. It participates in the Medicare program. Its participation in Medicare is governed by sections 1819 and 1866 of the Social Security Act (Act), along with implementing regulations at 42 C.F.R. Parts 483 and 488. Its hearing rights in this case are governed by regulations at 42 C.F.R. Part 498.

On September 15, 2010 Petitioner was surveyed for compliance with Medicare participation requirements. CMS concurred with noncompliance findings that were made at the survey and determined to impose a remedy against Petitioner consisting of a $6,000 per-instance civil money penalty. Petitioner requested a hearing, and the case was assigned to me for a hearing and a decision. CMS then moved for summary judgment, and Petitioner opposed the motion and cross-moved for summary judgment.

With its motion CMS filed five proposed exhibits (CMS Ex.) that are designated CMS Ex. 1 – CMS Ex. 5. Petitioner filed with its opposition to the motion ten proposed exhibits (P. Ex.) that are designated P. Ex. 1 – P. Ex. 10. I receive these exhibits into evidence.

The parties have styled their motions as motions for summary judgment. However, it is unnecessary that I apply the technical standards for summary judgment to the parties' arguments to decide this case based on the written record. Although Petitioner speaks vaguely of wanting an evidentiary hearing, neither party has presented me with any basis to conduct a hearing in person. Neither CMS nor Petitioner has offered the testimony of any witnesses nor has either party asserted that it requires a hearing to produce testimony. A hearing in this case, therefore, would consist of me receiving into evidence the parties' exhibits, something that I have done. Consequently, it is appropriate that I decide the case based on the parties' written submissions consisting of their exhibits. In this decision, I make evidentiary findings based on those exhibits.

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; and

2. CMS's remedy determination is reasonable.

B. Findings of Fact and Conclusions of Law

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. § 483.10(b)(4). The preponderance of the evidence establishes that Petitioner complied with the requirements of 42 C.F.R. § 483.13(b).

CMS alleges that Petitioner failed to comply substantially with two Medicare participation requirements. These consist of alleged failures to comply with: 42 C.F.R. § 483.10(b)(4), which, in relevant part, states that a resident of a skilled nursing facility has the right to refuse treatment; and 42 C.F.R. § 483.13(b), which states that a resident has the right to be free from abuse. CMS alleges that Petitioner, through the actions of

one of its employees, denied a resident, who is identified as Resident # 2, the right to refuse treatment and also physically abused Resident # 2.

As I discuss in detail, below, the facts plainly establish that Petitioner's staff denied Resident # 2 his right to refuse treatment. Consequently, Petitioner failed to comply substantially with the requirements of 42 C.F.R. § 483.10(b)(4). However, the preponderance of the evidence establishes that Petitioner's staff did not abuse Resident # 2. Therefore, I conclude that Petitioner complied substantially with the requirements of 42 C.F.R. § 483.13(b).

Resident # 2 is an individual who suffers from, among other things, Alzheimer's disease with behavioral disturbance and cognitive loss. CMS Ex. 2 at 1-2. The resident's behaviors include agitated and aggressive behavior, and the resident at times has resisted Petitioner's attempts to provide care to him. Beginning on August 10, 2010, Petitioner implemented a care plan for Resident # 2, providing that, should the resident resist the staff's efforts to care for him, the employee or employees caring for the resident should walk away from the resident and re-approach him after 10 to 15 minutes had elapsed. *Id.* at 2. The care plan recognized that the resident was prone to resist, sometimes violently, attempts to provide him with care.

On September 7, 2010, a licensed nurse's assistant employed by Petitioner attempted to lead Resident # 2 into his room for the purpose of toileting him. The resident resisted and pushed the staff member. CMS Ex. 2 at 1-2. The staff member then placed her hands on the resident and led him towards the room. She then put her hands on the resident's back and attempted to push him into the room. P. Br. at 3. The resident responded by grabbing the staff member by the arms, pushing her away from the doorway to the room, and ultimately causing the staff member to fall to the floor. *Id.* at 4; P. Ex. 10.

The attempt by the nurse's assistant to guide Resident # 2 into his room against his will plainly was a violation of the resident's right to refuse care and constituted substantial noncompliance with the requirements of 42 C.F.R. § 483.10(b)(4). Although he is demented, the resident nevertheless has an absolute right under this regulation to refuse treatment. Thus, even a well-meaning attempt by Petitioner's staff to guide the resident into his room against his will contravened that right and was a substantial violation of the regulation.

CMS also argues that the staff member's attempt to guide the resident into his room constituted physical abuse of the resident. It asserts that pushing or pulling the resident against his will constituted – at a minimum – intentional infliction of mental anguish.

I disagree. The evidence in this case does not support a finding of abuse. To be sure, the nurse's assistant disregarded the resident's plan of care in attempting to guide the resident

into his room against his will. But, there is nothing in the record to suggest that the staff member intentionally harmed the resident.

The evidentiary record includes a surveillance video of the events that are the basis for CMS's allegations. P. Ex. 10. That video does not support a finding of intentional infliction of harm. It shows the nurse's assistant attempting to guide the resident into his room, an act that might have been entirely appropriate but for the resident's demented state and his tendency to react violently when assisted by Petitioner's staff. There is no suggestion in the video that the nurse's assistant was doing anything other than attempting to assist the resident, albeit inappropriately, given the unique circumstances of his mental condition.

The regulatory definition of "abuse" is:

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

42 C.F.R. § 488.301. The elements of abuse defined by the regulation are not present here. The nurse's assistant plainly committed an error of judgment, but that does not rise to the level of abuse. The evidence establishes that the nurse's assistant contravened the resident's plan of care by attempting to guide him into his room against his will. But, that error is not axiomatically abuse. What is lacking here is the element of intent. Nothing about the nurse's assistant's conduct suggests that she intended to inflict injury or harm. Indeed, her actions would have been entirely appropriate but for Resident # 2's unique demented state.

I have considered Petitioner's arguments that it should not be held liable for abridging Resident # 2's right to refuse treatment, and I find them to be without merit. Petitioner's primary argument is that it should not be held responsible for the actions of its staff member. It contends that it: has policies in place that are intended to prevent abridgement of residents' rights; trained all of its staff in these policies; and had no reason to assume that the staff member in question would violate these policies and disregard her training in managing Resident # 2.

I disagree with this argument. A facility is responsible for the acts of its employees. Put simply, all of the care provided by a skilled nursing facility is provided by employees on its staff. The staff's performance of their duties is the measure of whether a facility complies with regulatory requirements. Consequently, a facility bears responsibility for the actions of each of its staff members. *Gateway Nursing Ctr.*, DAB No. 2283 (2009). Asserting that a staff member violated facility policy or engaged in an action that is not reflected by that staff member's employment history is, therefore, no defense to a finding of noncompliance emanating from that staff member's performance.

This is not, as Petitioner contends, a rule of strict liability. Rather, it is simply an expression of the reality that a skilled nursing facility provides care only to the extent that the individual members of its staff provide it. A facility would be immune from nearly all liability for noncompliance with regulatory requirements, if it were excused from noncompliance on the ground that it was an issue of staff performance.

Additionally, Petitioner argues that CMS inappropriately determined that the scope and severity of Petitioner's noncompliance was such that it caused actual harm to Resident # 2. It contends that I should reduce the scope and severity of its noncompliance so that, if noncompliance occurred, it was insubstantial.

Petitioner's argument is incorrect for two reasons. First, Resident # 2 was harmed. That harm was in the form of emotional distress. That is made manifest by the resident's violent reaction to the nurse's assistant's attempt to guide him into his room. That this level of emotional distress might not have been present in the case of a non-demented resident is no defense to the fact that this resident suffered emotional distress as a result of the nurse's assistant's inappropriate act. Second, I do not have the authority to address the scope and severity of CMS's noncompliance determination aside from deciding whether the facility's noncompliance was substantial. I have the authority to decide the appropriateness of a scope and severity determination only in limited circumstances, these being: (1) where the range of a civil money penalty (immediate versus non-immediate jeopardy) is at issue; and (2) where there is a finding of substandard quality of care leading to a loss of the facility's authority to conduct nurse aide training. 42 C.F.R. § 498.3(b)(14),(16); (d)(10)(i). Here, there is no issue of immediate jeopardy versus non-immediate jeopardy compliance. The presence of immediate jeopardy is not a necessary factor to the imposition of a per-instance civil money penalty as was determined to be imposed by CMS. 42 C.F.R. § 488.438(a)(2). Nor is there an issue of a finding of substandard quality of care.

2. A per-instance civil money penalty of $3,000 is reasonable.

A per-instance civil money penalty may fall within a range of from $1,000 to $10,000. 42 C.F.R. § 483.438(a)(2). There are regulatory criteria that must be used in deciding where within that range a per-instance penalty should fall. These factors include: the seriousness of a facility's noncompliance; its compliance history; its culpability; and its financial condition. 42 C.F.R. §§ 488.438(f)(1) – (4); 488.404 (incorporated by reference into 42 C.F.R. § 488.438(f)(3)).

CMS determined to impose a per-instance penalty of $6,000, based on Petitioner's alleged noncompliance with two regulations governing residents' rights and abuse. However, the evidence in this case establishes only one failure by Petitioner to comply substantially with regulatory requirements. That Petitioner contravened only one and not

two regulations, in the context of this case's evidence, reduces the seriousness of its noncompliance.

However, the noncompliance that occurred was serious and merits a per-instance penalty, even if less than $6,000. I find that a per-instance penalty of $3,000 is supported by the seriousness of Petitioner's noncompliance. Residents in skilled nursing facilities are by definition individuals who are incapable of caring for themselves. Residents often suffer from grievous physical infirmities. Many are at risk for injuries from accidents and falls. Use of force against a nursing home resident is axiomatically an act that would put that resident at risk for harm.

In this case, the risk to Resident # 2 was more than theoretical. The resident was identified by Petitioner's staff as being at risk from falls. P. Ex. 8 at 5. Attempting to guide the resident into his room against his will and in light of his uniquely demented state clearly exacerbated this resident's risk of falling and posed a risk for causing that resident to suffer from severe physical harm.

/s/
Steven T. Kessel
Administrative Law Judge