Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Belle Meade, A Rehabilitation Guest Care Facility
(CCN: 04-5170),

Petitioner

v.

Centers for Medicare and Medicaid Services.

Docket No. C-11-11

Decision No. CR2382

Date: June 10, 2011

DECISION

I grant the motion of the Centers for Medicare and Medicaid Services (CMS) for summary judgment against Petitioner, Belle Meade, A Rehabilitation Guest Care Facility. I sustain two per-instance civil money penalties against Petitioner, each in the amount of $4,500, as well as CMS's determination that Petitioner lose authority to conduct nurse aide training.

I. Background

Petitioner is a skilled nursing facility that does business in the State of Arkansas. It participates in the Medicare program. Petitioner's participation in Medicare is governed by sections 1819 and 1866 of the Social Security Act (Act), as well as by implementing regulations at 42 C.F.R. Parts 483 and 488. Petitioner's hearing rights are governed by regulations at 42 C.F.R. Part 498.

On July 24, 2010, Petitioner was surveyed for compliance with Medicare participation requirements, and the surveyors found that Petitioner was not complying substantially with several requirements. CMS concurred with the surveyors' findings and determined

to impose the civil money penalties that I discuss in the opening paragraph of this decision, based on Petitioner's alleged noncompliance with two of these requirements. The requirements, which I discuss in more detail below, are at 42 C.F.R. §§ 483.13(c)(2)-(4) and 483.13(c). Petitioner requested a hearing to challenge CMS's determination, and the case was assigned to me for a hearing and a decision.

Both parties filed pre-hearing exchanges that included their proposed exhibits (Ex.). CMS designated its proposed exhibits as CMS Ex. 1 – CMS Ex. 10. Petitioner designated its proposed exhibits as P. Ex. 1 – P. Ex. 25. CMS then moved for summary judgment, and Petitioner opposed the motion. I receive the parties' exhibits into the record of this case.

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 the requirements of 42 C.F.R. §§ 483.13(c)(2)-(4) and 483.13(c); and

2. CMS's remedy determinations are supported by the undisputed facts and the law.

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. §§ 483.13(c)(2)-(4) and 483.13(c).

In moving for summary judgment, CMS contends that it should prevail as a matter of law based on undisputed material facts. In discussing the facts of this case, I rely only on facts that are undisputed.

a. The undisputed material facts establish that Petitioner failed to comply substantially with the requirements of 42 C.F.R. § 483.13(c)(2)-(4).

In relevant part, the applicable regulation requires that a skilled nursing facility: ensure that all allegations of resident mistreatment, neglect, or abuse be reported immediately to the facility's administration; and protect its residents from possible further abuse while pending allegations of abuse are investigated and resolved. CMS alleges that Petitioner

failed to comply with the regulation's requirements in providing care to a single resident who is identified as Resident # 19. It contends that Petitioner's staff failed to report immediately to Petitioner's administrator the resident's allegations that she had been abused and mistreated by a member, or members, of the staff and failed to protect residents against possible additional abuse or mistreatment while the allegations remained unresolved.

The undisputed material facts support the allegations. The facts establish that Resident # 19 voiced complaints that she had been abused physically and/or mistreated by Petitioner's staff but that staff failed to report those complaints immediately to Petitioner's administrator. And, they establish that Petitioner implemented no measures to protect residents while Resident # 19's complaints remained unresolved.

It is undisputed that, shortly after 1:30 on the morning of June 17, 2010, Resident # 19 told a licensed practical nurse employed by Petitioner that another member of Petitioner's staff had mistreated her and hurt her arm. CMS Ex. 5 at 11. The allegation of abuse or mistreatment appears to relate to an incident that had occurred just prior to the resident's complaint, during which a member of Petitioner's staff directed the resident away from a restroom that was reserved for staff members. *Id.* at 13. It is undisputed also that the staff member who received the complaint from Resident # 19 failed to report the resident's allegations immediately to Petitioner's administrator. Petitioner's Response to CMS's Motion for Summary Judgment (Response) at 3 ¶ 4.

The undisputed facts establish also that the staff member – a certified nursing assistant (CNA) – who was the target of Resident # 19's allegations was approached by another staff member shortly after the alleged incident and asked whether someone had been "mean" to Resident # 19. CMS Ex. 5 at 13. The CNA then went to Resident # 19's room to apologize to the resident. *Id.* It is undisputed that the CNA failed to report immediately to Petitioner's administrator the allegation that she or someone else had been "mean" to Resident # 19. Response at 3 ¶ 6.

At about 6:15 on the morning of June 17, 2010, the licensed practical nurse who had originally heard the allegation of abuse or mistreatment advised another member of Petitioner's staff – another licensed practical nurse – that Resident # 19 had complained of being mistreated or abused. The account that was relayed to this employee was that Resident # 19 had claimed that someone had hurt her arm. CMS Ex. 5 at 15. It is undisputed that no one on Petitioner's staff immediately reported these allegations to Petitioner's administrator. Response at 4 ¶ 9.

Sometime later during the morning of June 17, Resident # 19 complained to a physical therapist who is not a member of Petitioner's staff, but who works at Petitioner's facility, that, during the night, a nurse had grabbed her forcefully in the area of her ribs and told her in a hateful manner that she could not use the staff's bathroom. CMS Ex. 5 at 14.

The physical therapist related this complaint to Petitioner's social worker but did not personally report the complaint immediately to Petitioner's administrator.

The complaints of abuse were finally reported to Petitioner's administrator during a staff meeting on the morning of June 17, 2010. P Ex. 23 at 1; P. Ex. 25 at 1. In response, the administrator suspended the CNA who was the target of Resident # 19's allegations and determined to discipline the licensed practical nurse who originally heard resident's complaint.

On the morning of June 20, 2010, Resident # 19 again complained that she had been abused or mistreated. On that date, the resident approached the licensed professional nurse to whom she had originally complained on June 17, and stated:

> It's bad enough that the other nurse hurt my arm the other night, but then she tried to choke me.

CMS Ex. 4 at 18. It is undisputed that the licensed practical nurse failed to report immediately this complaint of abuse or mistreatment to Petitioner's administrator. Response at 5 ¶ 22. Rather, she made a note of the complaint and slipped a copy of that note under Petitioner's administrator's door the following morning along with a note expressing her concern about the impact of the resident's complaints on the staff's job security. CMS Ex. 4 at 23.

The undisputed facts establish also that Petitioner failed to take any measures to protect either Resident # 19 or its other residents from the possibility that an "other nurse" may have been capable of committing abuse against residents in the facility. Petitioner's administrator, by her own admission, simply assumed that the complaint voiced by Resident # 19 on June 20, 2010 was a reiteration of her June 17 complaint and made no attempt to investigate it. P. Ex. 23 at 3-4. Consequently, the possibility that a threat to residents, in addition to that which was alleged on June 17, went uninvestigated, and no protections were implemented by Petitioner.

Petitioner's defense to CMS's allegations of failure to report complaints of abuse and mistreatment is that Resident # 19 made no actionable allegations. Petitioner acknowledges that the allegations made by Resident # 19 were, on their face, allegations of abuse or mistreatment. However, Petitioner asserts that the resident's allegations do not actually describe abuse or mistreatment when viewed in their "factual context." Response at 9-14. Petitioner thus contends that the regulation's reporting requirement was never triggered.

Essentially, Petitioner is asserting that, when the events surrounding the resident's complaints are viewed in hindsight, the complaints were not credible or were fanciful.

Therefore, according to Petitioner, there was never any real abuse or mistreatment, and the failure to report the resident's complaints is excused.

However, the regulation does not condone a failure to report when viewed in hindsight, nor does it allow a facility's staff to exercise discretion whether to report or not report a complaint of abuse or mistreatment. The regulation requires a facility to assume that every complaint of abuse or mistreatment is legitimate until disproved. Whether abuse or mistreatment actually occurred is irrelevant at the moment that a complaint is voiced. The implicit premise of the regulation is that residents in skilled nursing facilities, being among the most vulnerable members of our society, must be protected at all costs from even the potential of abusive conduct. Consequently, when a resident voices a complaint of abuse or mistreatment, the facility and its staff may not discount that complaint until it is thoroughly investigated and either verified or found to be without support. Furthermore, a subsequent conclusion that the initial complaint was without merit never excuses a facility's staff from failing to discharge their duties to report.

Here, Resident # 19 voiced explicit complaints that she had been physically abused or mistreated by unidentified members of Petitioner's staff. That triggered an immediate duty on the part of those staff members who heard those complaints to report them to the facility's administrator. The regulation afforded the staff no discretion. They were obligated to report immediately exactly what they had been told.

Petitioner asserts that it did take steps to protect Resident # 19 and other residents from the possibility of further abuse in the wake of the resident's June 20, 2010 complaint. Response at 13-14. However, Petitioner has identified no measures that it took to protect the residents. Rather, it asserts that the facility's administrator's conclusion that the resident's June 20, 2010 complaint was part and parcel of the resident's June 17 complaint excused Petitioner from having to take any additional measures to protect its residents.

This argument is essentially identical to Petitioner's contention that the "factual context" of Resident # 19's complaints excused its staff from reporting those complaints. And, it fails for the same reason that Petitioner's argument relating to reporting fails. On June 20, 2010, the resident voiced a very explicit complaint that differed in significant respects from the complaints that she voiced on June 17. None of the resident's complaints on June 17 suggested that she had been choked, whereas, on June 20, the resident explicitly stated that she had been choked. And, on June 20, the resident referred to an "other nurse" suggesting plainly that a different individual had been involved than the unnamed alleged assailant that the resident described on June 17.

It may have been ultimately reasonable – after an investigation was completed – for the administrator to conclude that the June 20 complaint by Resident # 19 was merely a restatement of what she had voiced on June 17. But, what the administrator concluded,

either on June 20 or subsequently, did not excuse her from taking immediate action to protect Resident # 19 and other facility residents when she received the complaint. As is the case with the reporting requirement, the regulation does not allow for discretion by a facility or its staff in the face of a complaint of abuse or mistreatment. The duty is plain. A facility and its staff must treat every complaint as valid until proven otherwise. Assuming that the June 20 complaint by Resident # 19 was simply a restatement of a complaint made previously is not a legitimate basis for failing to take protective action.

b. The undisputed material facts establish that Petitioner failed to comply with the requirements of 42 C.F.R. § 483.13(c).

In relevant part, the regulation requires that a facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents. CMS alleges – and the undisputed facts establish – that Petitioner failed to implement its own policy as respects the complaints that were voiced by Resident # 19.

Petitioner's abuse policy explicitly requires that all incidents of alleged resident mistreatment, neglect, or abuse must immediately be reported to Petitioner's administrator. CMS Ex. 6 at 8. The multiple failures by Petitioner's staff to report the complaints of abuse and/or mistreatment voiced by Resident # 19 constituted an obvious violation of this policy.

Petitioner's defense to CMS's assertion, and the undisputed facts that support it, is essentially the same defense that it asserts in response to allegations that its staff failed to report allegations of abuse and/or mistreatment. Petitioner contends that the staff did, in fact, comply with its policy because they reasonably believed that Resident # 19's complaints were unsubstantiated. Response at 16.

I find this defense to be without merit. It is premised on the unstated contention that, when faced with allegations by a resident that she had been abused, Petitioner's staff had discretion to evaluate those allegations and to decline to report them if they concluded that the allegations were baseless. Nothing in Petitioner's policy gives the staff that discretion. The policy language is mandatory. The facility staff *must* report *every* allegation of abuse or mistreatment to the facility's administrator, without exception, and without prejudging the merits of the allegation. Indeed, the policy, on its face, tracks the language of 42 C.F.R. § 483.13(c)(2), which I have stated allows no discretion in deciding whether to report an allegation of abuse.

Petitioner's abuse policy also explicitly requires that its administrator immediately investigate all allegations of abuse as they are brought to her attention. CMS Ex. 6 at 10-11. CMS contends, and the undisputed facts establish, that Petitioner's administrator failed to comply with this policy when confronted with the allegations of abuse that Resident # 19 voiced on June 20, 2010. Rather than investigate those allegations the

administrator concluded that these allegations were merely a restatement of allegations previously made.

Petitioner argues that the administrator concluded that the June 20 allegations were part of a "continuing investigation into the June 17, 2010 statement." Response at 17. Petitioner then describes the administrator's interpretation of the Resident's June 20 complaint, contending that these constituted reasonable inferences that the June 20 complaint merely reiterated complaints previously voiced by the resident. *Id.*

The problem with this assertion is that Petitioner's administrator would have been in no position to make the judgments she made without first investigating the allegations made by Resident # 19 on June 20. For example, Petitioner asserts that the administrator interpreted the resident's June 20 claim that she had been choked as merely describing the position of the CNA's hands as she guided the resident away from the staff restroom on June 17. For purposes of this decision, I will accept as true Petitioner's description of what the administrator thought the June 20 complaint meant. But, that does not condone a failure to investigate because the administrator had no way of knowing with certainty what Resident # 19 meant by her June 20 complaint without investigating it. How could the administrator possibly have known what Resident # 19 meant – assuming any ambiguity in her complaint – without, at a minimum, interviewing the resident?

2. CMS's remedy determinations are supported by the undisputed facts and the law.

a. Per instance civil money penalties of $4,500 are reasonable.

At issue here are two civil money penalties, each in the amount of $4,500, that CMS determined to impose as remedies for Petitioner's noncompliance with the requirements of 42 C.F.R. §§ 483.13(c)(2)-(4) and 483.13(c). I find these penalties to be reasonable.

Per-instance civil money penalties are authorized by 42 C.F.R. § 488.438(a)(2). The regulation allows for a penalty ranging from $1,000 to $10,000 for each instance of noncompliance. The penalties that CMS determined to impose thus fall more or less at the midpoint of that range.

Regulatory factors for deciding what is reasonable are set forth at 42 C.F.R. §§ 488.438(f)(1)-(4) and 488.404 (incorporated by reference into 42 C.F.R. § 488.438(f)(3)). These factors include: the seriousness of a facility's noncompliance; its compliance history; its culpability; and its financial condition.

The deficiencies at issue here were determined by CMS to be immediate jeopardy level deficiencies. The term "immediate jeopardy" is defined at 42 C.F.R. § 488.301 to mean noncompliance that is so severe as to cause or to pose a likelihood of causing serious

injury, harm, impairment, or death to a resident. It is not, strictly speaking, necessary that I find the presence of immediate jeopardy in evaluating the reasonableness of the penalties that are at issue here because the presence of immediate jeopardy is not a regulatory prerequisite for imposing a per-instance penalty of any amount.

Nevertheless, the deficiencies that are at issue here were very serious. That, coupled with Petitioner's prior history of citations for very similar deficiencies, is ample basis for me to find that the penalties that CMS determined to impose are reasonable.

The undisputed facts establish that Petitioner's staff ignored allegations that described staff misconduct at least bordering on criminal assault. Resident # 19 variously contended that she had been mistreated by staff, that staff had injured her arm, that a nurse had come up from behind her and grabbed her rib, and that an "other" nurse had tried to choke her. Petitioner's staff had no way of verifying or rejecting the resident's allegations without reporting and, then, investigating them.

That the underlying complaints may not have been true is irrelevant. The failure of Petitioner's staff and administrator to follow internal policy and to comply with regulatory requirements in the face of these complaints demonstrates a wholesale breakdown in a system that was designed to protect vulnerable individuals from abuse and mistreatment. That breakdown put residents at risk of great harm because it meant that serious allegations – which might have been true – were going unreported and uninvestigated. That in turn meant that residents were left unprotected against potential abuse and mistreatment.

Petitioner argues that its noncompliance was not serious because the allegations that were made by Resident # 19 were at bottom not credible. That argument – as with Petitioner's other arguments in this vein – is not persuasive because it rests on the faulty premise that Petitioner's staff had the discretion to discount and ignore the resident's complaints based on their on-the-spot judgments that the complaints were not credible. The purpose of both the governing regulation and Petitioner's own policy was to assure that allegations of abuse not be subject to the whim and discretion of Petitioner's staff, but rather, to guarantee that all allegations be reported and thoroughly investigated either to verify them or to find them to be unsubstantiated. Petitioner consistently argues that its staff was free to short circuit this process based on their intuition and judgment. That is simply incorrect.

It may well be that the staff correctly assumed that Resident # 19 was exaggerating or even deliberately misstating what happened to her. But, the staff should not be permitted to interpose their judgments on an objective process that is designed to protect residents. For one thing, Petitioner's staff had a clear and obvious conflict of interest. It was in their interest that the resident's allegations of abuse and mistreatment be found not credible. That is precisely why the regulations require immediate reporting of all

complaints and a thorough and impartial investigation of them. Furthermore, even if a facility's staff operates in good faith and discounts allegations of abuse, that impermissible exercise of discretion could have catastrophic effects for residents if the staff's judgment turns out to be incorrect.

The undisputed facts establish also that Petitioner has a previous history of noncompliance involving deficiencies that are similar in character to those that are at issue here. A few months prior to the incident that is at the heart of this case, Petitioner was cited for other instances of failing to report an allegation of abuse immediately to its administrator, failing to investigate thoroughly allegations of abuse, and failing to implement its internal abuse policy. CMS Ex. 1 at 20-29. Petitioner attempts to distinguish these previous deficiencies by arguing that they involved a bruise of unknown origin and verbal abuse of a resident and not the kind of alleged abuse that is at issue here. Response at 20. I find this purported distinction to be meaningless.

b. Loss of authority to conduct nurse aide training is authorized as a matter of law.

As a matter of law, loss of authority to conduct nurse aide training is mandatory where aggregate civil money penalties exceed $5,000, or where there is a finding of care of a substandard quality. 42 C.F.R. § 483.151(b)(2) and (3). Both of these criteria are met in this case. Petitioner has made no argument to challenge CMS's determination.

/s/
Steven T. Kessel
Administrative Law Judge