Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Appellate Division

In the Case of:	DATE: May 2, 2008
Beverly Health Care Lumberton, CCN:34-5234, Petitioner,	Civil Remedies CR1626 App. Div. Docket No. A-08-74 Reconsideration of Decision No. 2156
- v. -	Ruling No. 2008-5
Centers for Medicare & Medicaid Services.	

DENIAL OF PETITION FOR REOPENING

On April 3, 2008, Beverly Health Care Lumberton (Lumberton) filed a petition to reopen and reconsider the decision of this Board in Beverly Health Care Lumberton, DAB No. 2156 (2008) (Board Decision) in order to address what Lumberton characterized as "two significant errors of law." Lumberton Petition to Reopen (Petition) at 1. Lumberton also requested oral argument on its Petition on the ground that the issues raised "are so significant." Id. Lumberton further requested that the time period for seeking judicial review of the Board Decision be extended pending resolution of the petition. Id.

The Board may reopen its decision, within 60 days of the date of notice of the decision, upon its own motion or the petition of either party. 42 C.F.R. § 498.100. The regulations do not specify a standard for granting a petition to reopen. Procedures applicable to other types of disputes provide that the Board may reconsider a decision when a party promptly alleges a clear error of fact or law. 45 C.F.R. § 16.13. This standard is reasonably applied here as well. Reopening a Board decision is not a routine step under the Part 498 procedures for Board review of an

ALJ decision. Rather, it is the means for the parties and the Board to point out and correct any errors that make the decision clearly wrong.

For the reasons explained below, Lumberton's assertions of legal error are without any merit. Oral argument on these contentions would serve no purpose. We therefore deny the Petition to reopen, deny oral argument, and decline to reconsider the Board Decision.

Analysis[1]

Although Lumberton asserts that it seeks reopening because of two alleged legal errors, in fact its Petition frames the issues addressed in the Board Decision erroneously before ever reaching those allegations. Below, we first address Lumberton's misrepresentation of the substantive issue presented to and resolved by the Board. We then consider the two specific legal issues that Lumberton raises. These issues are (1) whether the fact that an individual alleged to have abused a resident has not been excluded from providing care at other facilities (although Lumberton fired him) undercuts CMS's finding of noncompliance by Lumberton; and (2) whether a surveyor who was involved in citing that finding of noncompliance should have been disqualified as a witness because his sister was employed as a nurse by Lumberton (and, if so, whether considering his testimony denied due process to Lumberton).

1. The Board did not ignore the substantive issue before it.

Lumberton begins by misstating the "substantive issue" in the case as "whether the Board would sustain a citation for 'abuse' where two nurses involved in a late night incident in which a certified nursing assistant helped them subdue a dangerously combative resident denied such a concern." Petition at 1. While this scenario may have been one which Lumberton would have preferred to defend, the statement fails to reflect the facts found by the ALJ, distorts the evidence of record, and misunderstands the appellate review process.

The substantive issue actually before the Board was whether substantial evidence in the record as a whole supported the ALJ's finding that the facility failed to follow regulatory

[1] We do not repeat here the factual background or applicable legal standards because they are fully discussed in the Board Decision.

requirements, and its own policy for preventing abuse and dealing with allegations of abuse, where rough handling of a vulnerable resident resulting in actual injury was reported by a nurse to the Director of Nursing (DON) two days late, and the nurse aide was permitted to care for residents in the interim before the facility terminated him.

The situation depicted by evidence in the record was that a nurse aide, asked to help prevent an 87-year old man from falling while his soft waist restraint belt was refastened, became angry with the resident's uncooperative behavior and handled the resident so harshly that his wrists were bruised. One of the nurses on the scene was sufficiently concerned about the interaction between the nurse aide and the resident, as well as about the resident's distress on being returned to the nurses' station after the nurse aide had taken the resident to his room to change his diaper, that she wrote a three-page note to the DON describing the nurse aide's "rough handling" of and anger with the resident. The nurse, however, failed to deliver the note until the Monday after the Saturday night incident. The DON determined that the abuse was substantiated (according to her report to the state agency) and terminated the nurse aide.

In regard to this and other incidents, the ALJ found that Lumberton failed to follow its own policy and the regulatory requirements to have an environment free of abuse, to report concerns about abuse immediately first to the facility administrators and then to the state agency, and to investigate them thoroughly and protect the residents in the interim. 42 C.F.R. § 483.13; P. Ex. 11, at 6-7. The Board found ample evidence in the record supporting the ALJ's findings.

Lumberton made the same sort of attempts to recharacterize the evidence of record in its appeal to the Board as it does in this Petition. Far from ignoring these issues, as Lumberton now suggests, the Board expressly rejected Lumberton's arguments after full discussion of the evidence of record. In one example of its multiple misstatements, Lumberton implies that the Board sustained the deficiency finding <u>despite</u> two nurses who were present having denied that abuse occurred. In fact, Lumberton failed to present testimony from either eyewitness nurse, even though it placed both on the final witness list and did not suggest they were unavailable. In such circumstances, an inference may be drawn that the testimony would not have supported Lumberton's account. The Board therefore concluded that the ALJ could reasonably decide not to credit the DON's self-serving report of a conversation with the nurse who wrote the three-page note in which that nurse supposedly stated that

she did not mean her note to be taken as an allegation of abuse. Board Decision at 7-8.

From its mistaken premises, Lumberton then speculates in its Petition that "a nurse or administrator might even conclude that she may not even touch an agitated or combative resident, even in an emergency, no matter what danger his condition and behavior poses to the resident or others, lest a surveyor or ALJ second guess her decision." Petitioner at 2. No rational nurse or administrator could draw so farfetched a conclusion from an actual reading of the Board Decision. The counterfactual scenario proposed by Lumberton bears no resemblance to the facts of the incident from which Lumberton seeks to draw this conclusion.

First, no evidence was presented that this elderly, wheelchair-bound resident endangered or threatened anyone. Rather, the only danger identified in the record evidence relating to the resident's removal of his lap restraint and attempt to stand was that he might fall and hurt himself. Lumberton speculates at various points that diminutive female nurses sought help from the male nurse aide because the former were afraid of the resident, but, as mentioned, Lumberton did not present either nurse to substantiate this speculation nor does Lumberton point out any documentation that the 87-year-old resident was "dangerous," even though he was at times combative or uncooperative. The only concern expressed in the nurse's contemporaneous note went to the need for assistance to protect the resident rather any need for protection from the resident.

Second, the allegations did not involve an aide merely "touching" the resident but handling him so roughly as to leave bruises and result in tears, causing a professional nurse to write up the incident. Third, nothing in the Board Decision addresses what measures might be appropriate in an emergency situation, because no one argued that the situation here was an emergency. Finally, the ALJ did not secondguess the evaluation of the nurse on the scene, but accepted her contemporaranous description of the incident over any secondhand report retracting or minimizing it.

Furthermore, Lumberton's repeated suggestions that the DON never considered the events described to her in the nurse's note as alleged or potential abuse are contrary to evidence in the record. Cf. Petition at 5. It was hardly "completely illogical" for the Board to note that the DON's actions showed that she read the note as alleging abuse since her actions included suspending and then firing the nurse aide, signing a verification of "alleged physical abuse," notifying the resident's family and

physician, and noting on a 5-day follow-up form that the abuse allegations were substantiated. See Board Decision at 8, and record citations therein. Contrary to Lumberton's assertions, it was permissible for the ALJ to give more weight to the content of the contemporaneous note and the implications of the DON's responsive actions than to belated attempts to reinterpret the note in the context of a survey and resulting litigation. Cf. Petition at 9-10.

We therefore do not find any reason to reopen our decision based on Lumberton's misstatements of both the substantive issue and the relevant evidence.

2. It is irrelevant to Lumberton's failure to properly handle an allegation of abuse whether the alleged abuse was ultimately found to be substantiated by the state agency determining whether the nurse aide involved was eligible for further employment.

Lumberton alleges in its Petition (as it did previously) that the nurse aide involved in the incident discussed above still works in other nursing facilities, and that this result constitutes "agency inconsistency" and even "cuts to the heart of the integrity of the nursing facility enforcement process." Petition at 3. Lumberton has proffered no evidence of the employment of this nurse aide after he was terminated by Lumberton, but it is not disputed that the state agency component reviewing the abuse allegation against the nurse aide was unable to substantiate the abuse charges eventually reported to it. The state agency reached that conclusion under state law standards for different purposes (e.g., licensure of nurse aides or registry of offenders) based on potentially different evidence than that evaluated in the federal proceeding for the purpose of evaluating facility compliance with federal standards for reporting and investigating abuse allegations.

Furthermore, as we explained in the Board Decision, the noncompliance findings against the facility here were not premised on the occurrence of abuse but rather on the facility's failure to implement requirements to timely report and investigate all allegations of abuse. Thus, we stated:

> [A] finding that actual abuse occurred is not necessary to conclude that the facility was not in compliance with the requirement that it develop and implement policies and procedures to prohibit abuse. 42 C.F.R. § 483.13. As the Board held in a prior case, "the salient question is not whether any abuse in fact occurred or whether [a facility] had reasonable cause to believe that any abuse

> occurred, but whether there was an allegation that facility staff had abused a resident." Cedar View Good Samaritan, DAB No. 1897, at 11 (2003), citing 56 Fed. Reg. 48,843-844 (Sept. 26, 1991); see also Beverly Health and Rehabilitation Center – Williamsburg, DAB No. 1748 (2000).

Board Decision at 12-13.

Lumberton also makes a rather cryptic claim that the Board erred by imputing liability to Lumberton "even in the absence of any underlying liability," apparently in relation to the absence of state action against the nurse aide personally. Petition at 3. According to Lumberton, the Board in the past has held facilities "strictly liable" for their employees' acts and has now somehow gone even further. Id. This argument appears to arise partly from the misconception that tort concepts such as "imputed liability" and "strict liability" are relevant to federal administrative enforcement proceedings against noncompliant nursing homes.

The Board has made clear that a strict liability standard is not being applied simply because a facility is held to "standards enunciated in the relevant participation requirement and its own policies[.]" Tri-County Extended Care Center, DAB No. 2060, at 5 (2007); see also Martha & Mary Lutheran Services, DAB No. 2147 (2008); Lake Mary Health Care, DAB No. 2081 (2007). Thus, neither the ALJ nor the Board here applied a strict liability standard in concluding that Lumberton affirmatively failed to comply substantially with specific requirements. For example, the Board found that substantial evidence in the record as a whole supported the ALJ's finding of a "pervasive failure of Lumberton's staff to implement the facility's policy calling for immediate action to remove the suspected abuser and alert the administration," and that Lumberton's delayed response to several complaints or observations of alleged abuse violated regulatory requirements for timely and thorough reports and investigations. Board Decision at 13; 42 C.F.R. § 483.13(b) and (c).

Similarly, the Board has not "imputed liability" to a long-term care facility based on the liability of an employee or agent in this or in prior cases, contrary to Lumberton's argument. A facility that undertakes to receive federal funds for its services, as Lumberton did, commits to meet the applicable requirements to participate in Medicare and Medicaid. Such a facility can act only through its agents and employees who make and implement policies, provide care, and perform the various responsibilities called for by the federal programs to protect

and ensure the welfare of residents. Therefore, a facility whose administration and staff have been found not to be substantially complying with federal requirements is itself subject to administrative enforcement remedies. The facility cannot avoid such remedies merely by attempting to disown the acts and omissions of its own staff and administration since the facility elected to rely on them to carry out its commitments. See, e.g., Cal Turner Extended Care Pavilion, DAB No. 2030, at 15 (2006), citing Emerald Oaks, DAB No. 1800, at 7, n.3 (2001), Cherrywood Nursing and Living Center, DAB No. 1845 (2002), and Ridge Terrace, DAB No. 1834 (2002).

That the state agency governing nurse aide registries, applying state law, did not find the allegation of abuse by the nurse aide substantiated on whatever evidence was before it does not change the responsibilities of the facility and its staff in properly handling an allegation of abuse under governing federal law. It is the responsibility of a nursing facility to create an abuse-free environment. 42 C.F.R. § 483.13(b) and (c). Under both the regulations and Lumberton's own policies implementing the regulatory requirements, nursing staff confronted with suspected abuse must act to immediately remove any potential hazard to residents and notify appropriate persons and to promptly investigate the circumstances, e.g., preserving evidence and collecting statements, and make timely reports to state officials. 42 C.F.R. § 483.13(b)(2)-(4); P. Ex. 7.

These are the very measures by which Lumberton fell short. Whether or not a particular instance of abuse was substantiated against a particular staff person by a state agency is irrelevant to CMS's authority to impose remedies on Lumberton for its failure to meet these standards. We fully explained this point in the Board Decision and do not find any error in that discussion. See Board Decision at 9-10.

For these reasons, we deny Lumberton's request to reopen the Board Decision based on the assertions that allegations of abuse by a particular nurse aide were not substantiated by the state agency or that the aide may still be working in other facilities.

3. Lumberton's assertion that the noncompliance findings should be overturned on the grounds that a surveyor should have been disqualified is without merit.

Lumberton points out in its Petition that the surveyor who prepared the Statement of Deficiencies on the noncompliance at issue here had a sister employed at Lumberton. Lumberton asserts that it discovered this connection with its staff member only the

night before the hearing and that the ALJ should have been more concerned about the information. Petition at 6. Lumberton goes further to suggest that the "Medicare Act" somehow compels the Board to rule in its favor because the surveyor should have been "disqualified." Id. at 6-7.

Lumberton relies on Section 1919(g)(E)(ii) of the Social Security Act[2] which provides as follows:

> A State may not use as a member of a survey team under this subsection an individual who is serving (or has served within the previous 2 years) as a member of the staff of, or as a consultant to, the facility surveyed respecting compliance with the requirements of subsections (b), (c), and (d) of this section, or who has a personal or familial financial interest in the facility being surveyed.

The regulations extend the disqualification of a surveyor to situations where an immediate family member is employed by the facility. 42 C.F.R. § 488.314(a)(4)(iii).

Lumberton argues that the "obvious" reason for these provisions is to protect regulated facilities from deprivation of property rights to participate in Medicare and Medicaid resulting from questionable findings by such surveyors. Petition at 7. Lumberton concludes that due process therefore requires that the surveyor should have been disqualified as a witness. Id. at 8. According to Lumberton, the Board instead said "all of this is OK." Id.

Lumberton's argument ignores several important facts. Notably, these provisions impose requirements on states that choose to partner with the federal government as to how the state is to carry out surveys. The interests being protected, therefore, appear to be those of the federal fisc and the intended recipients of services rather than the financial interests of providers of services. Certainly, the federal program may reasonably object if state surveyors are associated with the facilities they are meant to investigate. Indeed, the

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[2] The current version of the Social Security Act can be found at www.ssa.gov/OP_Home/ssact/comp-ssa.htm. Each section of the Act on that website contains a reference to the corresponding United States Code chapter and section. Also, a cross reference table for the Act and the United States Code can be found at 42 U.S.C.A. Ch. 7, Disp Table.

regulations go on to provide sanctions for states which fail to follow these and other federal requirements for conducting surveys. See 42 C.F.R. §§ 488.318(a)(1)(iii) and 488.320.

The regulations expressly provide, however, that inadequate survey performance by a state does not –

> (1) Relieve a [facility] of its obligation to meet all requirements for program participation; or
>
> (2) Invalidate adequately documented deficiencies.

42 C.F.R. § 488.318(b).

Neither the Board nor the ALJ opined that it was "OK" for the surveyor to have continued to participate in the survey after realizing that his sister was employed at Lumberton. The issue of whether any action might be appropriate against the surveyor or the state agency was not presented in this proceeding.

The Board concluded, for reasons explained in its decision, that Lumberton failed to make any factual showing of bias to justify disregarding the surveyor's testimony. Furthermore, the Board found that the noncompliance at issue was adequately supported in the record independent of any reliance on the surveyor's testimony. In fact, the noncompliance is documented largely in Lumberton's own records. Under such circumstances, it would be inappropriate to shield a facility from remedies intended to bring it into compliance and hence to protect its residents, merely because the state survey agency did not disqualify a surveyor who participated in the survey that disclosed the noncompliance.

Conclusion

As Lumberton has shown no error of law, and has neither alleged nor shown any clear error of fact, its Petition to reopen the Board Decision is denied.

Judicial Review

Section 498.95 of 42 C.F.R. provides that an affected party that is dissatisfied with a Board decision and is entitled to judicial review must commence civil action within 60 days from receipt of the notice of the Board's decision, unless the party files a request for extension with the Board in writing before the 60-day period ends and the Board extends the time for good cause shown.

Lumberton requested that the Board extend the time for judicial review pending resolution of this matter.

We have determined that there is good cause for extending the time for judicial review as requested. Accordingly, the time for requesting judicial review runs from Lumberton's receipt of notice of this ruling.

_____/s/_____
Judith A. Ballard

_____/s/_____
Sheila Ann Hegy

_____/s/_____
Leslie A. Sussan
Presiding Board Member