Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

In the Case of:	)	
	)	
Beverly Health Care Lumberton,	)	Date: July 20, 2007
CCN: 34-5234	)	
Petitioner,	)	
	)	
- v. -	)	Docket No. C-06-20
Centers for Medicare & Medicaid	)	Decision No. CR1626
Services.	)	
	)	

DECISION

I sustain the determination of the Centers for Medicare and Medicaid Services (CMS) to impose a Civil Money Penalty (CMP) against Petitioner, Beverly Health Care Lumberton, for failure to comply substantially with federal requirements governing participation of long term care facilities in Medicare and State Medicaid programs. Therefore, I sustain the CMP of $3,050 per day but only for the period of April 9, 2005 through April 11, 2005. I also sustain a CMP of $1000 per day for the period of April 12, 2005 until August 4, 2005.

I. Background

This case came before me pursuant to a request for hearing filed by Petitioner on October 11, 2005. Petitioner is a long-term care provider located in Lumberton, North Carolina.

On August 17, 2005, the Centers for Medicare and Medicaid Services (CMS) informed Petitioner that it was imposing the following remedies pursuant to a complaint investigation completed on August 4, 2005, by the North Carolina State Survey Agency:

- CMP of $3,050 per day effective April 9, 2005, and continuing through April 14, 2005 (the surveyors found Petitioner out of compliance with three requirements, F Tags 223, 225, and 226, at the scope and severity level J, constituting immediate jeopardy).

- CMP of $1000 per day beginning April 15, 2005 through August 4, 2005.

- CMP of $50 per day effective August 5, 2005.[1]

- Denial of payment for new admissions (DPNA) effective November 4, 2005.

CMS Ex. 6.

I held a hearing on July 18, 2006, in Raleigh, North Carolina. At the hearing, CMS offered 15 exhibits, identified as CMS Exs. 1-15. I received CMS's exhibits into evidence without objection. Petitioner offered 23 exhibits, identified as P. Exs. 1-23. I received these exhibits into evidence without objection. Transcript (Tr.) at 10, 11.

Subsequent to the hearing, the parties submitted post-hearing briefs (CMS Br. and P. Br.). Petitioner filed a reply brief (P. Reply), but CMS did not .

Based on the testimony offered at the hearing, the documentary evidence, the arguments of the parties, and the applicable law and regulations, I find that Petitioner was not in substantial compliance on the dates determined by the State survey agency and CMS, subject to the exception noted below. I further find that CMS was authorized to impose a CMP of $3,050 for non compliance from April 9, 2005 through April 11, 2005, and a $1000 per day CMP thereafter until August 4, 2005.

II. Applicable Law and Regulations

Petitioner is a long-term care facility located in Lumberton, North Carolina that participates in the Medicare and Medicaid programs. The statutory and regulatory requirements for participation by a long-term care facility are found at sections 1819 and 1919 of the Social Security Act (Act), and at 42 C.F.R. Part 483.

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[1] As result of a revisit survey conducted on September 21, 2005, it was determined that the facility returned to substantial compliance on August 5, 2005. Thus, the $50 per day CMP and the DPNA were rescinded.

Sections 1819 and 1919 of the Act invest the Secretary of HHS with authority to impose remedies of CMPs and denial of payment for new admissions against a long-term care facility for failure to comply substantially with participation requirements.

Facilities that participate in Medicare may be surveyed on behalf of CMS by state survey agencies in order to determine whether the facilities are complying with federal participation requirements. 42 C.F.R §§ 488.10- 488.28; 42 C.F.R. §§ 488.300 - 488.335. Pursuant to 42 C.F.R. Part 488, CMS may impose either a per day CMP or a per instance CMP against a long-term care facility when a state survey agency concludes that the facility is not complying substantially with federal participation requirements. 42 C.F.R. §§ 488.406, 488.408, and 488.430. The penalty may start accruing as early as the date that the facility was first out of compliance until the date substantial compliance is achieved or the provider agreement is terminated. 42 C.F.R. § 488.440.

The regulations specify that a per day CMP that is imposed against a facility will fall into one of two broad ranges of penalties. 42 C.F.R. §§ 488.408, 488.438. The upper range of CMPs, of from $3,050 per day to $10,000 per day, is reserved for deficiencies that constitute immediate jeopardy to a facility's residents, and in some circumstances, for repeated deficiencies. 42 C.F.R. §§ 488.438(a)(1), (d)(2). The lower range of CMPs, of from $50 per day to $3,000 per day, is reserved for deficiencies that do not constitute immediate jeopardy, but either cause actual harm to residents, or cause no actual harm, but have the potential for causing more than minimal harm. 42 C.F.R. § 488.438(a)(1)(ii).

The regulations define the term "substantial compliance" to mean:

> [A] level of compliance with the requirements of participation such that any identified deficiencies pose no greater risk to resident health or safety than the potential for causing minimal harm.

42 C.F.R § 488.301.

"Immediate jeopardy" is defined to mean:

> a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident.

The Act and regulations make a hearing available before an administrative law judge (ALJ) to a long-term facility against whom CMS has determined to impose a CMP. But the scope of such hearings is limited to whether an *initial determination* made by CMS is correct. Act, section 1128A(c)(2); 42 C.F.R. §§ 488.408(g), 498.3(b)(12) and (13). The hearing before an administrative law judge is a de novo proceeding. *Anesthesiologists Affiliated, et al*, DAB CR65 (1990), aff'd 941 F2d. 678 (8th Cir. 1991).

III. Issues

A. Whether the facility was complying substantially with federal participation requirements on the dates CMS determined to impose a CMP.

B. Whether CMS's determination of immediate jeopardy was clearly erroneous.

C. Whether the amount of the penalty imposed by CMS is reasonable, if noncompliance is established

IV. Findings and Discussion

The findings of fact and conclusions of law noted below in bolded italics are followed by a discussion of each finding.

> ***A. The facility was not in substantial compliance with federal participation requirements from April 9, 2005 through August 4, 2005.***
>
> ***B. Abuse (Tag F223) CMS established that the facility failed to provide an environment free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion as provided by 42 C.F.R. §* 483.13(b).**

Based on record review and staff interviews, the state surveyors found that Petitioner failed to protect one of its residents [Resident 2 (R2)] from physical abuse. CMS Ex. 1, at 1-2. R2 was admitted to the facility on December 3, 2004, with diagnoses of dementia and history of hip fracture. He had both long and short memory problems and impaired decision making skills. The care plan dated December 21, 2004, noted that R2 was at risk for behavioral decline related to dementia. When interviewed on August 4, 2005, Nurse 1 (Marylyn Marino) stated that on April 9, 2005, at approximately midnight, Nursing Assistant 1(NA 1) (Charles Robinson) helped her and Nurse 2 (Octavia Taylor) control R2 to keep him from falling after he removed a soft belt restraint and stood up in front of his wheelchair. NA 1 held R2 by his arms while the nurses attempted to take the belt away from R2. After the belt was taken away from R2, one of the nurses suggested that

NA 1 take the resident to bed. NA 1 took R2 to his room and cleaned him up because he was soiled, and then wheeled him back to the nurses' station. At that time, it was noted that R2 had red areas on his wrists and he was upset with tears in his eyes. On the morning of April 10, 2005, the morning shift nurse reported that R2 had bruises on his wrists. CMS Ex. 1, at 1.

When interviewed by the state surveyor on August 4, 2005, Nurse 2 stated that when R2 came out of his room after being cleaned by NA 1 on the night of April 9, 2005, he was mad. CMS Ex. 1, at 2. When she saw the red marks on R2's arm she spoke with NA 1 and he said that R2 was fighting with him. NA 1 was suspended on April 11, 2005, and terminated on April 14, 2005.

Discussion

42 C.F.R. § 483.13(b) provides that a long-term care facility must ensure that each resident be free from verbal, sexual, physical and mental abuse, corporal punishment, and involuntary seclusion. Abuse is defined as the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. 42 C.F.R. § 488.301.

CMS contends that "physical abuse" (which includes controlling behavior through corporal punishment), is the most applicable of the regulatory prohibitions to the situation in the present case. Specifically, CMS posits that NA 1 reacted to the resident's combative behavior by forcibly restraining him, as opposed to speaking to him calmly and gently in order to remove the restraint belt from his grasp. CMS Br. at xii.

Petitioner, on the other hand, maintains that CMS does not appear to allege that NA 1 hit, slapped, pinched, kicked, or inflicted "Corporal punishment" on the resident, and the evidence would not seem to support any finding of fact to that effect. Petitioner further alleges that witnesses for both parties agreed that the incident involving R2 does not fall into any of the categories of "physical abuse" (mentioned above) described in the State Operations Manual (SOM) nor in Petitioner's policy. P. Br at 14.

I find no basis or support for Petitioner's arguments. When Petitioner alleges that physical abuse did not occur in this case because there was no hitting, slapping, pinching, or kicking, it overlooks the mandate of the applicable federal regulations. It is clear from the federal regulation cited above that "abuse" is not limited to physical abuse such as willful hitting, slapping, pinching, or kicking. Therefore, intentional actions such as forceful grabbing and rough handling of a resident also constitute abuse. Moreover, Petitioner misconstrues its own abuse policy. The facility policy defines abuse as the

"willful infraction (sic) of injury, unreasonable confinement, intimidation or punishment that results in physical harm, pain or mental anguish." The policy adds that physical abuse includes hitting, slapping, pinching and kicking. It also includes controlling behavior through corporal punishment. P. Ex. 7, at 7. Clearly, the actions by NA 1 to R2 would constitute "abuse" under any reading of the facility's policy.

For my determination as to whether the forceful or rough handling of R2 as alleged by CMS constitutes abuse under 42 C.F.R. § 483.13(b), I rely largely on the statement of Marilyn Marino (Nurse 1), given to the Director of Nursing (DON), Roxanne Thompson, on April 11, 2005. I find that contemporaneous statement to be the most complete and reliable account concerning the incident with R2 on the night of April 9, 2005. *See also* 42 C.F.R. § 483.13(c)(1)(i); CMS Ex. 3, at 5-7. The statement was provided to the DON in the form of nurses notes. Nurse Marino begins her account by stating that while she and two other staff members (Nurse 2 and NA 1) were at the nurses station they observed R2 nearby in his wheelchair, as he was in the process of removing his soft waist restraint. Immediately, the three approached R2 to prevent him from falling or trying to get up out of his wheelchair. NA 1 grabbed R2's right arm while he attempted to get the restraint out of his left hand. R2 pulled away, but NA 1 grabbed him again. At that point, Nurse 1, Marilyn Marino, who was on the left side of the wheelchair instructed NA 1 to "just let go" of the resident while she persuaded him to give up the belt. R2 let her have the belt when she assured him that it was his belt, but she would hold it for him. The two female nurses proceeded to reapply the belt, and NA 1 grabbed both of the resident's arms in a manner described by Nurse Marino as "roughly." After the two female nurses placed the soft waist restraint around the resident's waist and behind the wheelchair, NA 1 released his hold and fastened the restraint. However, R2 reached around with his right hand and unfastened the belt. When NA 1 attempted to grab R2's arms again, R2 started swinging at him. NA 1 was able to grab both of the resident's wrists and would not let go. At that moment, Nurse Marino suggested that maybe R2 needed to go to bed because it was past midnight. NA 1 angrily responded: "he's not going to bed," and proceeded to wheel R2 to his room on his own initiative. NA 1 re-emerged from R2's room about 10 minutes later after having cleaned R2 up and put his gown on, and placed R2 by the nurses' station. Nurse Marino noted the resident to be upset, eyes watery, and his lips quivering. He looked at her, raised his arms and pointed to his wrist with his left hand. Marilyn noticed redness and edema on the right wrist that stretched for approximately 3 to 4 inches up the forearm. His hand was also red and scratches were visible on the forearm. After showing Ms. Marino the marks on his upper extremities, R2 uttered the following words: "you broke my heart!" Nurse Marino did not notice marks on the resident's upper extremities nor did she describe him as shaken up until he re-emerged from his room with NA 1. I infer that the substance of R2's statements indicate he felt betrayed by Nurse Marino because she allowed NA 1 to take him to his room alone and unobserved by

others. The angry demeanor and rough handling observed by Nurse Marino is sufficient to establish a prima facie case that the facility failed to provide R2 an environment that was free from abuse.

The DON testified that she obtained a more complete explanation of the incident from Nurse Marino by telephone several months after the incident occurred and, in that explanation, Nurse Marino indicated that she did not believe that R2 had been the victim of abuse.[2] Tr. at 111. Other than the DON's brief testimony, there is no record or evidence of this much later alleged conversation. Additionally, Nurse Marino was not presented as a witness during the hearing, nor does the record reflect any attempt to summon her as a witness. Consequently, I find that the statement made by Nurse Marino contemporaneously with the incident (*see* CMS Ex. 3, at 5-7, Nurse Marino's written nurses notes dated April 9, 2005) is the most complete and reliable account of the incident. It is also worthy of note that the other staff member (Nurse 2) that could shed additional light as to what occurred on the night of April 9, 2005, with respect to R2, also was not called as a witness. I conclude, therefore, that the April 9, 2005, report of the incident submitted to the DON on the afternoon of April 11, 2005, remains unrebutted and unequivocally demonstrates that R2 was denied an environment free from abuse.

Clearly, the conduct displayed by NA 1 constitutes "abuse" as defined in 42 C.F.R § 488.301 and violates 42 C.F.R. § 483.13(b). The angry manner in which this staff member handled R2 was not accidental nor necessary in providing care and services to the resident. In fact, it was intentional and retaliatory. Nurse Marino described the incident unequivocally as abuse. Her statement surrounding the incident does not lend itself to any other reasonable interpretation. Roughly handling in anger an 87 year-old, fragile resident cannot be considered a mere inappropriate care technique, as suggested by Petitioner. P. Br. at 7, 16. R2 was not merely humiliated; he was physically and emotionally harmed. As was noted earlier, when NA 1 emerged from R2's room, wheeling R2 back to the nurses station, the resident was quivering, teary-eyed, and exhibiting scratches, redness and edema on his hands and arms. What the resident felt after being *put in his place* by NA 1, he himself best summed up when he exploded with resonating emotion: "*you broke my heart*!" Moreover, the DON and the administrator acted correctly at the time of the incident by suspending and eventually dismissing the

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[2] The Administrator and the DON acted correctly in suspending and eventually dismissing NA 1 for having handled R2 roughly and in anger as a response to the resident's combativeness. I am puzzled by the DON's as well as the Administrator's change of heart, however, during this proceeding.

perpetrator of the abuse. That action was based on the facility's finding and recognition that abuse of a resident took place. P. Ex. 14. I cannot give credence to the version of the event devised by Petitioner for hearing purposes over its own contemporaneous account provided when litigation was not contemplated. Consequently, it is my finding that CMS has established a prima facie case that Petitioner was in violation of Tag F223. Petitioner has not overcome that showing by a preponderance of the evidence.

C. Staff treatment of residents (Tag F225) CMS established that the facility failed to report all violations involving mistreatment, neglect or abuse. 42 C.F.R. § 483.13(c).

Section 483.13 (c)(2) of 42 C.F.R. provides that all alleged violations of mistreatment, neglect or abuse must be immediately reported to the facility administrator and to other officials in accordance with State law, including the State survey and certification agency.

Section 483.13 (c)(4) of 42 C.F.R. provides that the results of all investigations into allegations of abuse must be reported to the Administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified, appropriate corrective action must be taken.

Based on record review and staff interviews, the surveyors found that the facility failed to immediately notify the facility administrator of an abuse allegation for 1 of 5 residents. (Resident 2 (R2)); the facility failed to report 2 of 3 staff-to-resident abuse allegations to the State Agency within 24 hours of discovery; and failed to report the investigative findings in 2 of 5 staff-to-resident abuse allegations to the State Agency within 5 workings days of discovery (Residents 1 (R1) and 3 (R3)). CMS Ex. 1, at 2-5

Discussion

R2

Petitioner acknowledges that there is a regulatory requirement for facility staff to immediately report to the administrator and to other officials in accordance with state law, including the State survey and certification agency, all alleged violations of mistreatment, neglect or abuse of a long term care resident. Petitioner also asserts that its abuse reporting policy provides that "any associate (employee) who suspects that a resident has been abused must immediately notify the executive director (administrator) and appropriate state agencies in accordance with law." P. Br. at 21-23.

Petitioner maintains that the premise and plain language of the regulation is that *someone* must actually believe, and articulate, that abuse has occurred, as the trigger for investigation and reporting obligations.

The Departmental Appeals Board (Board) has held that "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.48843-48844 (Sept. 26, 1991).

I have already determined that based on a staff report describing an allegation of abuse in great detail, the facility DON and the Executive Director found that the abuse was substantiated, and in keeping with its policy, the facility suspended and eventually dismissed the perpetrator of the abuse.

Nurse Marino, who observed the abusive conduct, failed to immediately notify the Executive Director or the DON. The incident here under scrutiny unequivocally involves an allegation of abuse that required immediate reporting according to the regulation as well as the facility policy. P. Ex. 11, at 1. A review of the pertinent facts reveals this clearly. Nurse Marino was aware that R2 would be responsive if approached in a calm way. That is why she instructed NA 1 to let go of the resident when she noticed that he was grabbing his "arms roughly." In fact, when she told the resident: "I know that's your belt, I just want to hold it for you," R2 gave her the belt. CMS Ex. 3, at 5. The DON, who was familiar with the resident, confirmed the nurse's action at that moment to be the proper approach. That is evident from the surveyor's interview of the DON on July 27, 2005. At that time, in reference to R2, she stated: "if you approach him in a calm way, he is nice." CMS Ex. 1, at 3. "If you are aggressive with him, he is combative." *Id.* It is, thus, surprising that when the resident removed the belt again and held on to it, the nurse allowed NA 1 to grab the resident's wrists again (and would not let go), instead of making use of the approach known to her to be effective with R2. Nonetheless, to defuse the situation, Nurse Marino suggested that maybe the resident needed to go to bed, because it was past midnight. To her suggestion, NA 1 retorted angrily, "he's not going to bed," and pushed R2's chair into his room. The question remains, if NA 1 was not taking the resident to bed, what was he going to do with him? It was noted that R2 was soiled, but the response did not seem to address the need to be cleaned up. No doubt, NA 1 was angry because R2 had taken swings at him. Even in the presence of two nurses, he treated R2 roughly and did not conceal his anger. Yet, he was allowed to be alone with the resident when he told the nurses that he was taking R2 to his room, but not to put him to bed. It is worthy of note here that NA 1 indicated in his statement that when he took R2 back to his room, the resident was still combative, and struck him several times. CMS

Ex. 3, at 8. It takes no stretch of the imagination to infer that this made NA 1 even angrier. That may explain Nurse Marino's description of R2 when he emerged from his room in the company of the NA 1. With quivering lips and watery eyes, he exhibited his bruises, and scratches. She examined his arm and he complained of pain when she touched the radial aspect. CMS Ex. 3, at 6.

Ms. Marino's description of R2 exhibiting the visible result of the rough manner in which he was handled, telling the nurse that it was "bad," and adding, that his heart had been broken, leaves no room for doubt that she was making an allegation of abuse that required immediate reporting. Moreover, there were two other staff members involved who also should have known that facility policy required that they report the incident immediately. However, no report was made and the perpetrator of the abuse was allowed to continue working and caring for the resident.

The following day, R2 re-emphasized his complaint of ill treatment by telling Nurse Marino, in reference to NA 1 that he was a "bad, bad man." Here, Nurse Marino passed up another opportunity to report the allegation of abuse. And nothing was done; NA 1 was allowed to continue caring for residents. The DON asserted that had she been informed of the situation when it occurred, she would have sent NA 1 home. CMS Ex. 1, at 3. However, what is obvious is that staff members who should have been aware of a duty to report, failed to do so.

Nurse Marino began to draft the report of abuse after the incident occurred and completed it on Sunday April 10, 2005. However, she did not deliver it to the DON until April 11, 2005 at 3:00 p.m, when she slipped it under the DON's door. She was aware that an abuse upon a resident had occurred in her presence, but failed to provide the immediate notification to the facility administrator, as required by the regulations and the facility policy. As has been previously stated, when the DON and the Executive Director[3] read her account they concluded that abuse had been substantiated. Although notification to State authorities may not have been possible on the weekend, nothing prevented reporting the matter to the Executive Director who is available any day of the week for such matters.

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[3] Executive Director is the title employed by the facility to refer to its administrator.

R1 and R3

According to the SOD, a facility grievance dated March 22, 2005, noted that a family member of R1called to report that another resident reported that staff had been verbally abusive to R1. The report indicated that a nursing assistant (NA 3) told the resident: "she better not turn the call light back on" again because they were short and there were only two of them. CMS Ex 1, at 17.

Surveyor Patrick Campbell testified that in the case of R1, although the facility was required to submit to the State Agency a report of the investigation within five business days, a report was not submitted until two months had elapsed. Tr. at 46, 47. A review of the facility records revealed an undated 24-hour report of an allegation of verbal abuse against R 3. Although the incident was noted to occur on April 8, 2005, the report of investigation was not submitted to the State Agency until April 19, 2005, well over 5 business days after the occurrence of the incident. CMS Ex. 1, at 4. It was also noted that the alleged perpetrator of the abuse (NA 2) was terminated by the facility on April 14, 2005.[4]

Petitioner's defense for the failure to timely file a report of the investigation of these allegations of abuse is that they were later determined to be unsubstantiated. However, as I have stated earlier, consistent with the Board's clear expression on the matter, what triggers the reporting requirement is not whether an allegation of abuse is substantiated, but whether such an allegation exists. With respect to R1 and R3, Petitioner failed to provide the results of the investigation regarding allegations of abuse to the State survey and certification agency within five working days of the incident as required by 42 C.F.R. § 483.13(c)(4).

In view of the foregoing, I find that CMS has established a prima facie case that the facility staff failed to notify its administrator of the existence of an allegation of abuse regarding R2. CMS has also established that the facility failed to submit a report to the State survey and certification agency of the results of the investigations into allegations of abuse as to R1 and R3 within 5 working days of the incident. Petitioner has not overcome CMS's showing by a preponderance of the evidence.

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[4] In both circumstances here, there is no evidence that the DON "immediately" notified the facility administrator of the incidents in addition to the failure to timely report the incidents to the State agency.

D. Staff Treatment of Residents (Tag F226) CMS established that the facility failed to develop and implement policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. 42 C.F.R. § 483.13(c).

Based on record review and staff interviews, the surveyors found that the facility failed to follow the facility abuse policies and procedures related to immediately reporting to the administrator and providing protection for 1 of 1 resident who was physically abused (R2) and it also failed to follow its abuse policies and procedures related to investigating and reporting to the State Agency abuse allegations for 2 of 5 residents (R1 and R3). CMS Ex. 1, at 19-30.

Every facility is required to develop and implement policies and procedures that prohibit mistreatment, neglect, and abuse of residents. But the facts of this case show that the facility staff from the Administrator and DON down to the nurses and nursing assistants were aware of particular events and allegations of abuse but failed to immediately report them or to take appropriate action as required by the policies. In previous cases, it has been determined that whether actual abuse occurred is not necessarily relevant to citations under Tag 225. Rather under this citation, an allegation of abuse is enough to require immediate action by all staff under the facility's policies and a failure to do so can illustrate a systemic problem in the facility. *West Point Community Living Center,* DAB CR1473, at 7 (2006); *Cedar View Good Samaritan*, DAB CR997 (2003); *see also Beverly Health and Rehabilitation Center - Williamsburg*, DAB No. 1748 (2000). The preponderance of the evidence here indicates a failure by Petitioner's staff on every level to recognize potentially abusive situations and allegations of abuse, and to appropriately and immediately investigate and report them as required to the Executive Director of the facility. CMS Ex. 1, at 6-7.

The discussion as to Tag F225, above, serves as a basis for establishing that Petitioner failed to implement its abuse policies by failing to immediately report alleged abuse to the facility administrator and to other officials in accordance with State law, including the State survey and certification agency and by failing to provide the State survey and certification agency the results of all investigations into allegations of abuse in two instances, within five business days of the incident, as required by 42 C.F.R. § 483.13 (c)(2). There is certainly no question that Nurse 1 and Nurse 2 should have recognized NA 1's actions towards R2 as abuse. Yet they failed to immediately report the incident. As for the two incidents of suspected verbal abuse, while a grievance was filed on March 22, 2005

with respect to suspected abuse towards R1, no action was taken at all by the facility until April 8th and the 5-day report was not sent to the State until May 24, 2005. In the situation with R3, the incident occurred on April 8, 2005 which was promptly reported to the Assistant DON. The DON indicates, however, that she was made aware of the incident on April 11, 2005, but the 5-day report to the State was not filed until April 19, 2005. *Id.* Petitioner's lax implementation of the facility policy for investigating and reporting abuse indicates a wider systemic problem in the facility. Moreover, it shows a real lack of understanding as to the reasons for not only developing policies but also the requirement for making sure those policies are actually implemented. The failure to actually implement facility policy against abuse and neglect leaves the residents at real risk for serious harm. *See West Point Community Living Center,* DAB CR1473, at 8 (2006). However, the "best policies and procedures are worthless if they are not being implemented and understood by each and every employee." *Id.*

Therefore, I find that Petitioner has not overcome CMS's prima facie showing of a violation of the deficiency under this Tag by a preponderance of the evidence.

E. CMS's finding of immediate jeopardy was not clearly erroneous.

I have already found that CMS has established a *prima facie* case that Petitioner was not in substantial compliance with federal requirements for skilled nursing facilities participating in the Medicare/Medicaid programs regarding Tag F-223, 255, and 226. Petitioner has not overcome CMS's showing by a preponderance of the evidence. Furthermore, I sustain CMS's finding that Petitioner's level of non-compliance for each of these three deficiencies constitutes immediate jeopardy.

The regulations define immediate jeopardy as a situation in which a provider's non-compliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident. 42 C.F.R. § 488.301. A finding of immediate jeopardy does not require "a finding of present harm, but also encompasses a situation that is [likely to cause] harm." *Britthaven*, DAB No. CR1259 (quoting *Hermina Traeye Memorial Nursing Home*, DAB No. 1810 (2002)). CMS's determination of immediate jeopardy must be upheld unless it is clearly erroneous. 42 C.F.R. § 498.60(c)(2). The burden rests on the provider to prove that CMS's determination of immediate jeopardy is clearly erroneous. Petitioner has not met that burden here.

Petitioner contends that the immediate jeopardy is not warranted because there is no reliable evidence to support the conclusion that its actions caused or were likely to cause serious harm to one or more of its residents. P. Br. at 30. As I have discussed earlier, Petitioner caused actual physical and emotional harm to one of its residents (R2). When that occurred, nothing was done to immediately protect the harmed resident as well as other residents from similar harmful conduct. The abuse was so unequivocal that the DON stated to the surveyor that had she been notified immediately, she would have sent the perpetrator home at that very moment. CMS Ex. 1, at 3. Moreover, when she received the report of the allegation of abuse, the wrongdoer was immediately suspended and eventually terminated. Unfortunately, he was allowed to tend to R2 and other residents after the occurrence of the abuse incident. From a careful reading of Nurse Marino's report of abuse (CMS Ex. 3), it is clear that the nurses knew how to care for R2 in a calm and dignified manner, but allowed NA 1 to insert himself in the situation.[5] In the first instance he was allowed to unnecessarily intervene when the nurses were taking the lap belt from the resident and secondly, when he was allowed to determine what would be done with the resident after the belt was taken from him. Petitioner knew that R2 was responsive to care when treated calmly and spoken to gently, and that he would become combative when treated roughly. Furthermore, Petitioner should have foreseen that serious harm could come to R2, who was frail and elderly, if forcefully subdued.

Also, a requirement for a facility to develop and implement a policy against abuse and neglect it not a mere formality. The requirement has multiple purposes: it provides specific notice to facility employees regarding what is considered "abuse and neglect" and that "abuse and neglect" will not be tolerated; it informs and directs all employees of their obligation to report any suspicion of abuse that they might witness or become aware of; it directs the facility to initially and continually train all employees to recognize abuse and how to take appropriate action to report it; it protects residents from potential harm, especially because they may not be able to protect themselves from abuse and to ensure that residents feel safe and secure. Petitioner's failure to implement its policies against abuse as evidenced by the incidents with R1, R2, and R3 also caused or was likely to cause serious injury or harm to these residents.

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[5] Contrary to Petitioner's assertion. P. Br. at 30. When the resident was observed to be removing the soft waist restraint, Charles immediately joined the two other nurses and began to subdue the resident without being asked to intervene in order to overpower a frail, 87 year old resident. CMS Ex. 3, at 5.

F. The amount of the penalty imposed by CMS is unreasonable.

Petitioner contends that CMS failed to specifically provide any basis for a finding of immediate jeopardy that justifies the imposition of a $3,050 penalty from April 9, 2005 through April 14, 2005. I agree, as more amply discussed below.

I have already addressed the basis for a finding of noncompliance and sustained CMS's finding that Petitioner's level of noncompliance for each of the three deficiencies, Tag F223, Tag F225, and Tag F226, constituted immediate jeopardy. Although the state survey agency recommended that the CMP at the immediate jeopardy level be imposed until August 4, 2005, based on the facility's submission of a credible allegation of compliance, CMS determined to assess the facility at the immediate jeopardy level only until April 14, 2005. Tr. at 68-71; CMS Ex. 1, at 1; CMS Ex. 6, at 2. Petitioner maintains that CMS's evidence is conspicuously bare of any rationale as to why "immediate jeopardy began, and, [more] notably, when it ended." Petitioner adds that even if I were to find that it committed some "immediate jeopardy," on April 9, 2005, there is nothing in the record to show that severe noncompliance was abated six days later. P. Br. at 30.

I conclude that Petitioner has not met its burden of showing that CMS's determinations of immediate jeopardy were "clearly erroneous" for the period April 9, 2005 through April 11, 2005. The imposition of a CMP of $3050 per day for this period, imposed for noncompliance at the immediate jeopardy level, is the minimum permissible monetary penalty, and is therefore reasonable. I find that the failure of Petitioner to implement its procedures and policies against abuse demonstrates a systemic problem within the facility. The Board has stated that the burden is on the facility to prove that it has resumed complying with program requirements, not on CMS to prove that the deficiencies continued to exist after they were discovered. *Hermina Traeye Memorial Nursing Home*, DAB No. 1810 (2002).

I find, however, that the record shows that immediate jeopardy was abated on April 12, 2005, not on April 14, 2005. Therefore, I conclude that CMS's determination of immediate jeopardy was clearly erroneous for the period April 12, 2005 through April 14, 2005.

A close look at the evidence of record shows that the incident relied upon by CMS to conclude that abatement of the immediate jeopardy was the termination of NA 1 (Charles Robinsón) on April 14, 2005. It is unequivocal that CMS reasoned that it was as of that date that the abuser had no access to R2 as well as other residents with whom he may come in contact in the process of providing care. I note, however, that NA 1 was suspended and removed from the facility premises on April 12, 2005, pending the outcome of the investigation that resulted in his termination on April 14. P. Ex. 15, at 1; P. Ex. 14, at 3. Thus, in accordance with CMS's reasoning, the residents were no longer exposed to abuse by NA 1 as of April 12, 2005, when he was suspended, and not as of April 14, when he was terminated. That is, the residents were no less protected on April 12, when NA 1 was suspended than they were on April 14, when he was terminated. Abatement of the immediate jeopardy, therefore, took place on April 12. Consequently, it was clearly erroneous to extend the immediate jeopardy period until April 14, 2005. It is true that other conditions in the facility still created a status of non compliance. However, CMS deemed those lingering violations to be at the less than immediate jeopardy level. It is my finding, therefore, that the period of non compliance at the less than immediate jeopardy level commenced on April 12, 2005, and ended on August 4, 2005.

Petitioner also maintains that CMS has offered no evidence regarding the regulatory factors to be considered in establishing the amount of the CMP (42 C.F.R. §§ 488.404 and 488.438(f) and that such penalty would not have the effect of deterring deficient conduct on the part of the facility. Petitioner also asserts that CMS has offered no rationale for its choice of remedies. P. Br. at 32. Petitioner's arguments have no support in the law or regulations.

The regulations clearly establish that "*[a] facility may not appeal the choice of remedy, including the factors considered by CMS or the State in selecting the remedy, specified in § 488.404.*" 42 C.F.R. § 488.408(g)(2). Furthermore, the onus is upon Petitioner to offer evidence concerning the reasonableness of the CMP even in the absence of such evidence in CMS's presentation of its *prima facie* case. *Coquina Center,* at 32-33, DAB 1860 (2002). Petitioner makes a broad, but unsubstantiated challenge, to the CMP imposed by CMS. Thus, it is my finding that the CMP in this case is reasonable.

As stated above, there is no discussion needed regarding the CMP of $3,050 for the immediate jeopardy violation, inasmuch as that is the lowest permissible penalty for a deficiency at that level of scope and severity. Concerning the CMP of $ 1,000 per day for the deficiencies that are less than immediate jeopardy, I note that such penalty is at the lower end of the maximum permissible amount of $3,000. I find that the penalty is appropriate and within a reasonable range, given the circumstances of this case, where Petitioner's systemic failure to implement its policies and procedures against abuse placed its residents' health and safety at risk. I further find that it served the purpose of driving the facility back into compliance. Had the facility taken no action at all, the per day penalty would have continued for a greater number of days, resulting in a higher dollar amount.

CMS correctly determined that the facility returned to substantial compliance after all staff, including the DON and Nurse 2, were inserviced on August 3 and 4, 2005. Additionally, all grievances from January 1, 2005 through August 4, 2005, were reviewed to verify that all allegations of abuse had been reported and investigated. Petitioner has not satisfied its burden of showing that it eliminated the non-compliance on any date prior to August 4, 2005. Thus, a per day CMP of $ 1,000 for the less than immediate jeopardy deficiencies is appropriate through August 4, 2005.

V. Conclusion

Based on the testimony offered at the hearing, the documentary evidence, the arguments of the parties, and the applicable law and regulations, I find that Petitioner was not in substantial compliance for the period of April 9 through August 4, 2005. I also find that Petitioner was not in compliance at the immediate jeopardy level from April 9, 2005 through April 11, 2005, and that the imposition of a $ 3,050 per day CMP for the period of the immediate jeopardy is reasonable. I also sustain the CMP of $1,000 per day for the period of April 12, 2005, until August 4, 2005.

/s/

Jose A. Anglada
Administrative Law Judge