Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Tulsa Jewish Community Retirement and Health Care Center,
(CCN: 37-5547),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-13-378

Decision No. CR3712

Date: March 31, 2015

DECISION

Petitioner, Tulsa Jewish Community Retirement and Health Care Center, was not in substantial compliance with program participation requirements from November 8, 2012 through January 15, 2013, due to violations of 42 C.F.R. §§ 483.13(c) and (c)(2), (3), and (4) and 483.75.[1] There is a basis for the imposition of enforcement remedies. The following enforcement remedies are reasonable: a civil money penalty (CMP) of $5,650 per day for November 8 and 9, 2012, and $1,050 per day from November 10, 2012 through January 15, 2013; and a discretionary denial of payments for new admissions (DPNA) from December 26, 2012 through January 15, 2013.

I. Background

Petitioner is located in Tulsa, Oklahoma, and participates in Medicare as a skilled nursing facility (SNF) and the state Medicaid program as a nursing facility (NF). Petitioner was

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[1] References are to the 2012 revision of the Code of Federal Regulations (C.F.R.), unless otherwise indicated.

subject to a recertification and licensure survey by the Oklahoma State Department of Health (state agency) from November 5 through 13, 2012. The state agency surveyors concluded that Petitioner was not in substantial compliance with program participation requirements due to fourteen deficiencies, three of which allegedly posed immediate jeopardy. Joint Stipulation of Facts (Jt. Stip.) ¶¶ 1-3; Centers for Medicare & Medicaid Services (CMS) Exhibit (Ex.) 2.

CMS notified Petitioner by letter dated January 2, 2013, that it was imposing the following enforcement remedies: termination of Petitioner's provider agreement and participation in Medicare effective May 13, 2013, if Petitioner did not return to substantial compliance prior to that date; a CMP of $10,000 per day for November 8 and 9, 2012; a CMP of $1,050 per day beginning November 10, 2012 and continuing until termination or Petitioner's return to substantial compliance; and a DPNA effective December 26, 2012. CMS Ex. 1 at 4-7; Jt. Stip. ¶ 4. CMS notified Petitioner by letter dated February 6, 2013, that Petitioner returned to substantial compliance on January 16, 2013. CMS modified the enforcement remedies as follows: a CMP of $5,650 per day for November 8 and 9, 2012; a CMP of $1,050 per day for the period November 10, 2012 through January 15, 2013; a DPNA effective December 26, 2012 through January 15, 2013. The letter advised that termination of Petitioner's provider agreement was rescinded. Jt. Stip. ¶ 5;[2] CMS Ex. 1 at 1-3.

Petitioner requested a hearing before an administrative law judge (ALJ) on January 31, 2013 (RFH). The case was assigned to me for hearing and decision on February 8, 2013, and an Acknowledgement and Prehearing Order was issued at my direction. On November 13 and 14, 2013, a hearing was convened by video teleconference and a transcript (Tr.) of the proceedings was prepared. CMS offered CMS Exs. 1 through 34 and Petitioner offered Petitioner exhibits (P. Exs.) 1 through 5. I admitted all the exhibits. Tr. 62-63. CMS called the following witnesses: Surveyor Allette Gregory, RN; Surveyor Sherry Reid, RN; and Surveyor Leslie Gay Thomas, RN. Petitioner called the following witnesses: Nancy Chigede, LPN; Alin Torianyk; and James (Jim) Jakubovitz, Petitioner's Administrator. Subsequent to the hearing, CMS offered CMS Ex. 35, which is admitted. Tr. 69-71. The parties filed post-hearing briefs.

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[2] The parties incorrectly stipulated that the February 6, 2013 notice advised Petitioner that the per-day CMP for November 8 and 9, 2012, was $10,000. Jt. Stip. ¶ 5. I do not treat that part of the stipulation as binding on the parties, but rather, I recognize that it was a clerical error.

II. Discussion

A. Issues

Whether there is a basis for the imposition of an enforcement remedy; and,

Whether the remedy imposed is reasonable.

B. Applicable Law

The statutory and regulatory requirements for participation of a SNF in Medicare are found at section 1819 of the Social Security Act (Act) and at 42 C.F.R. pt. 483. Section 1819(h)(2) of the Act authorizes the Secretary of Health and Human Services (Secretary) to impose enforcement remedies against a SNF for failure to comply substantially with the federal participation requirements established by sections 1819(b), (c), and (d) of the Act.[3] The Act requires that the Secretary terminate the Medicare participation of any SNF that does not return to substantial compliance with participation requirements within six months of being found not to be in substantial compliance. Act § 1819(h)(2)(C). The Act also requires that the Secretary deny payment of Medicare benefits for any beneficiary admitted to a SNF, if the SNF fails to return to substantial compliance with program participation requirements within three months of being found not to be in substantial compliance – commonly referred to as the mandatory or statutory DPNA. Act § 1819(h)(2)(D). The Act grants the Secretary discretionary authority to terminate a noncompliant SNF's participation in Medicare, even if there are fewer than 180 days of noncompliance. The Act also grants the Secretary authority to impose other enforcement remedies, including a discretionary DPNA, CMPs, appointment of temporary management, and other remedies such as a directed plan of correction. Act § 1819(h)(2)(B).

The Secretary has delegated to CMS and the states the authority to impose remedies against a long-term care facility that is not complying substantially with federal participation requirements. "*Substantial compliance* means 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.

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[3] Participation of a NF in Medicaid is governed by section 1919 of the Act. Section 1919(h)(2) of the Act gives enforcement authority to the states to ensure that NFs comply with their participation requirements established by sections 1919(b), (c), and (d) of the Act.

§ 488.301 (emphasis in original). A deficiency is a violation of a participation requirement established by sections 1819(b), (c), and (d) of the Act or the Secretary's regulations at 42 C.F.R. pt. 483, subpt. B. Noncompliance refers to any deficiency that causes a facility not to be in substantial compliance. 42 C.F.R. § 488.301. State survey agencies survey facilities that participate in Medicare on behalf of CMS to determine whether the facilities are complying with federal participation requirements. 42 C.F.R. §§ 488.10-.28, 488.300-.335. The regulations specify the enforcement remedies that CMS may impose if a facility is not in substantial compliance with Medicare requirements. 42 C.F.R. § 488.406.

The regulations specify that a CMP that is imposed against a facility on a per day basis will fall into one of two ranges of penalties. 42 C.F.R. §§ 488.408, 488.438. The upper range of a CMP, $3,050 per day to $10,000 per day, is reserved for deficiencies that pose immediate jeopardy to a facility's residents and, in some circumstances, for repeated deficiencies. 42 C.F.R. § 488.438(a)(1)(i), (d)(2). "*Immediate jeopardy* means 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." 42 C.F.R. § 488.301 (emphasis in original). The lower range of CMPs, $50 per day to $3,000 per day, is reserved for deficiencies that do not pose 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 Act and regulations make a hearing before an ALJ available to a long-term care facility against which CMS has determined to impose an enforcement remedy. Act §§ 1128A(c)(2), 1866(h); 42 C.F.R. §§ 488.408(g), 498.3(b)(13). A facility has a right to appeal a "certification of noncompliance leading to an enforcement remedy." 42 C.F.R. § 488.408(g)(1); 42 C.F.R. §§ 488.330(e), 498.3. However, the choice of remedies, or the factors CMS considered when choosing remedies, are not subject to review. 42 C.F.R. § 488.408(g)(2). A facility may only challenge the scope and severity level of noncompliance determined by CMS, if a successful challenge would affect the range of the CMP that may be imposed or impact the facility's authority to conduct a nurse aide training and competency evaluation program (NATCEP). 42 C.F.R. § 498.3(b)(14), (d)(10)(i). The CMS determination as to the level of noncompliance, including the finding of immediate jeopardy, "must be upheld unless it is clearly erroneous." 42 C.F.R. § 498.60(c)(2); *Woodstock Care Ctr.*, DAB No. 1726 at 9, 38 (2000), *aff'd*, 363 F.3d 583 (6th Cir. 2003). The Departmental Appeals Board (the Board) has long held that the net effect of the regulations is that a provider has no right to challenge the scope and severity level assigned to a noncompliance finding, except in the situation where that finding was the basis for an immediate jeopardy determination. *See, e.g.*, *Ridge Terrace*, DAB No. 1834 (2002); *Koester Pavilion*, DAB No. 1750 (2000). ALJ review of a CMP is subject to 42 C.F.R. § 488.438(e).

The hearing before an ALJ is a de novo proceeding, i.e., "a fresh look by a neutral decision-maker at the legal and factual basis for the deficiency findings underlying the remedies." *Life Care Ctr. of Bardstown*, DAB No. 2479 at 32 (2012) (citation omitted); *The Residence at Salem Woods*, DAB No. 2052 (2006); *Cal Turner Extended Care Pavilion*, DAB No. 2030 (2006); *Beechwood Sanitarium*, DAB No. 1906 (2004); *Emerald Oaks*, DAB No. 1800 at 11 (2001); *Anesthesiologists Affiliated*, DAB CR65 (1990), *aff'd*, 941 F.2d 678 (8th Cir. 1991). The Secretary's regulations do not address the allocation of the burden of proof or the standard of proof. However, the Board has addressed the allocation of the burden of proof in many decisions. The standard of proof is a preponderance of the evidence. CMS has the burden of coming forward with the evidence and making a prima facie showing of a basis for imposition of an enforcement remedy. Petitioner bears the burden of persuasion to show by a preponderance of the evidence that it was in substantial compliance with participation requirements or any affirmative defense. *Batavia Nursing & Convalescent Inn*, DAB No. 1911 (2004); *Batavia Nursing & Convalescent Ctr.*, DAB No. 1904 (2004), *aff'd*, 129 F. App'x 181 (6th Cir. 2005); *Emerald Oaks*, DAB No. 1800; *Cross Creek Health Care Ctr.*, DAB No. 1665 (1998); *Hillman Rehab. Ctr.*, DAB No. 1611 (1997), DAB CR500 (1997) (on remand), *rev'd*, DAB No. 1663 (1998), *aff'd*, *Hillman Rehab. Ctr. v. United States*, No. 98-3789 (GEB), 1999 WL 34813783 (D.N.J. May 13, 1999).

C. Findings of Fact, Conclusions of Law, and Analysis

My conclusions of law are set forth in bold text followed by my findings of fact and analysis. I have carefully considered all the evidence and the arguments of both parties, although not all may be specifically discussed in this decision. I discuss the credible evidence given the greatest weight in my decision-making.[4] I also discuss any evidence that I find is not credible or worthy of weight. The fact that evidence is not specifically discussed should not be considered sufficient to rebut the presumption that I considered all the evidence and assigned such weight or probative value to the credible evidence that I determined appropriate within my discretion as an ALJ. There is no requirement for me to discuss the weight given every piece of evidence considered in this case, nor would it be consistent with notions of judicial economy to do so. Charles H. Koch, Jr., *Admin. L. and Prac.* § 5:64 (3d ed. 2013).

The recertification and licensure survey that ended November 13, 2012, cited Petitioner for 14 deficiencies. A life safety code survey completed on November 7, 2012, cited

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[4] "Credible evidence" is evidence that is worthy of belief. *Black's Law Dictionary* 596 (18th ed. 2004). The "weight of evidence" is the persuasiveness of some evidence compared to other evidence. *Id*. at 1625.

Petitioner with three additional deficiencies, which were all violations of 42 C.F.R. § 483.70(a), but Petitioner did not specifically request review as to those deficiencies. RFH. Petitioner also stipulated in advance of hearing that it did not request my review of the following deficiency citations from the survey that ended on November 13, 2012: 42 C.F.R. § 483.10(a)(1) & (2) (Tag F151[5], scope and severity (s/s) level [6] E); 42 C.F.R. § 483.10(b)(11) (Tag F157, s/s level E); 42 C.F.R. § 483.13(a) (Tag F221, s/s level E); 42 C.F.R. § 483.20(k)(3)(ii) (Tag F282, s/s level E); 42 C.F.R. § 483.25 (Tag F309, s/s level E); 42 C.F.R. § 483.25(h) (Tag F323, s/s level G); 42 C.F.R. § 483.40(a) (Tag F385, s/s level E); 42 C.F.R. § 483.60(a), (b) (Tag F425, s/s level D); 42 C.F.R. § 483.65 (Tag F441, s/s level E); 42 C.F.R. § 483.75(j)(2)(i) (Tag F504, s/s level E); and 42 C.F.R. § 483.75(o)(1) (Tag F520, s/s level F). Jt. Stip. ¶¶ 7-9, 12-17, 19-20; RFH. Petitioner only requested review of the cited deficiencies alleged to have posed immediate jeopardy to Petitioner's residents: 42 C.F.R. § 483.13(c)(1)(ii)-(iii), (c)(2), (3), and (4) (Tag F225, s/s level K); 42 C.F.R. § 483.13(c) (Tag F226, s/s level L); and 42 C.F.R. § 483.75 (Tag F490, s/s level K). Jt. Stip. ¶¶ 10, 11, 18; RFH. At hearing, however, Petitioner's non-

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[5] This is a "Tag" designation as used in CMS Publication 100-07, State Operations Manual (SOM), app. PP – Guidance to Surveyors for Long Term Care Facilities (http://www.cms.hhs.gov/Manuals/IOM/list.asp). The "Tag" refers to the specific regulatory provision allegedly violated and CMS's policy guidance to surveyors. Although the SOM does not have the force and effect of law, the provisions of the Act and regulations interpreted clearly do have such force and effect. *Ind. Dep't. of Pub. Welfare v. Sullivan*, 934 F.2d 853 (7th Cir. 1991); *Nw. Tissue No. v. Shalala*, 1 F.3d 522 (7th Cir. 1993). Thus, while the Secretary may not seek to enforce the provisions of the SOM, she may seek to enforce the provisions of the Act or regulations as interpreted by the SOM.

[6] Scope and severity levels are used by CMS and a state when selecting remedies. The scope and severity level is designated by an alpha character, A through L, selected by CMS or the state agency from the scope and severity matrix published in the SOM, ch. 7, § 7400E. A scope and severity level of A, B, or C indicates a deficiency that presents no actual harm but has the potential for minimal harm, which is an insufficient basis for imposing an enforcement remedy. Facilities with deficiencies of a level no greater than C remain in substantial compliance. 42 C.F.R. § 488.301. A scope and severity level of D, E, or F indicates a deficiency that presents no actual harm but has the potential for more than minimal harm that does not amount to immediate jeopardy. A scope and severity level of G, H, or I indicates a deficiency that involves actual harm that does not amount to immediate jeopardy. Scope and severity levels J, K, and L are deficiencies that constitute immediate jeopardy to resident health or safety. The matrix, which is based on 42 C.F.R. § 488.408, specifies which remedies are required and optional at each level based upon the frequency of the deficiency.

attorney representative effectively withdrew from the stipulation, explaining that Petitioner contested all the alleged deficiencies, including the alleged life safety code violations, and the reasonableness of the enforcement remedies based on those alleged deficiencies. Out of an abundance of caution, I ruled that all deficiencies and the reasonableness of all remedies remained at issue. Tr. 23-46, 66-71.

I conclude that Petitioner violated 42 C.F.R. §§ 483.13(c) and (c)(2), (3), and (4) and 483.75. I further conclude that the declaration of immediate jeopardy as to the violations of 42 C.F.R. §§ 483.13(c) and (c)(2), (3), and (4) and 483.75 was not clearly erroneous. The noncompliance with 42 C.F.R. §§ 483.13(c) and (c)(2), (3), and (4) and 483.75 alone is a sufficient basis for the proposed enforcement remedies, which I conclude are reasonable. I conclude, in the interest of judicial economy, that it is not necessary to discuss all the alleged deficiencies. I enter no findings or conclusions as to any alleged deficiencies except 42 C.F.R. §§ 483.13(c) (Tag F226) and (c)(2), (3), and (4) (Tag F225) and 483.75 (Tag F490).

1. Petitioner violated 42 C.F.R. § 483.13(c)(2), (3), and (4) (Tag F225).

2. The violation of 42 C.F.R. § 483.13(c)(2), (3), and (4) (Tag F225) posed a risk for more than minimal harm.

3. Petitioner has not met its burden to show that the declaration of immediate jeopardy related to the noncompliance with 42 C.F.R. § 483.13(c)(2), (3), and (4) (Tag F225) was clearly erroneous.

4. Petitioner violated 42 C.F.R. § 483.13(c) (Tag F226).

5. The violation of 42 C.F.R. § 483.13(c) (Tag F226) posed a risk for more than minimal harm.

6. Petitioner has not met its burden to show that the declaration of immediate jeopardy related to the violation of 42 C.F.R. § 483.13(c) (Tag F226) was clearly erroneous.

a. Facts

The surveyors cited the violations of 42 C.F.R. § 483.13(c) and (c)(2), (3), and (4) (Tags F225 and F226) based on incidents involving Resident 9 and 19. CMS Ex. 2 at 16-59.

(i) Resident 9

Resident 9, a female, was 81 years old at the time of the survey in November 2012. Her diagnoses included, among other things, hypothyroidism, dementia and delirium, atrial

fibrillation, diabetes mellitus, osteoporosis, a history of transient ischemic attacks, and hypertension. CMS Ex. 13 at 5, 7-9, 12. Resident 9 was prescribed several medications, including aspirin and the generic form of Plavix® as anticoagulant therapy to address her vascular dementia. CMS Ex. 13 at 12. There is no dispute that a resident taking Plavix® and aspirin is subject to easy bruising. Tr. 139, 303, 321; P. Ex. 1. Resident 9's care plans reflect that she was very limited cognitively and physically. She required extensive assistance with all activities of daily living and she had difficulty understanding others and being understood. CMS Ex. 13 at 6.

In the case of Resident 9, the surveyors cite ten instances of bruising and one instance of the resident being struck by a private sitter. CMS Ex. 2 at 22-26, 28-29. The surveyors concluded that Petitioner failed: to investigate the cause of the resident's bruising and the spanking incident; to protect Resident 9 from potential abuse during the investigation; to implement measures to prevent possible future abuse; and to report allegations of abuse to the appropriate state agency. CMS Ex. 2 at 20-30, 41-51.

Review of the evidence obtained by the surveyors from Petitioner's clinical records reveals the following:

> On February 5, 2012, staff observed multiple small areas of "ecchymosis" on the right inner thigh, the right hand, and abdomen of Resident 9. An Incident/Accident Report dated February 6, 2012 documents the observations; states that staff notified Resident 9's physician and Ms. Alin Torianyk, who was Resident 9's private sitter/caregiver; and states Resident 9 was not seen by a physician. The report lists the following interventions to prevent recurrence: Resident 9's diaper should be changed, she should be rotated, and wear protective sleeves on her hands. CMS Ex. 13 at 108.
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> On February 25, 2012, staff observed that Resident 9 had a bruise on the outside of her left foot and she was assessed as having no pain in the area. The Incident/Accident Report dated February 27, 2012, states that the bruising may have been the result of the resident hitting her left foot on her wheelchair. The report states that staff notified Resident 9's physician and Ms. Torianyk, the sitter. Resident 9 was not seen by a physician and no first aid was administered. As an intervention to prevent recurrence, the report states that the resident should be pushed in her wheelchair. CMS Ex. 13 at 109.
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> On March 3, 2012, staff noted a bruise on Resident 9's right breast above the areola. An Incident/Accident Report dated March 5, 2012, states that staff notified Resident 9's physician and Ms. Torianyk. Resident 9 was not seen by a physician and no first aid was administered. The report states that staff should use extra care when touching Resident 9's skin due to

fragility. CMS Ex. 13 at 110.[7] A nursing progress note dated March 3, 2012, states that "ecchymosis" persisted on the resident's left foot; the resident's sitter asked the nurse to look at the bruise on the resident's breast; the nurse recorded that she observed a small ecchymosis above the resident's right areola. CMS Ex. 13 at 41, 42. A nursing progress note dated March 3, 2012, at 11:00 p.m., documents that Resident 9 received a head to toe assessment from nursing staff. The note states that the resident did not have any new "bruising," and she needed a pillow between her legs to help prevent bone to bone pressure and her left lower extremity was elevated. CMS Ex. 13 at 41, 42. A March 4, 2012 nursing progress note states that nursing staff performed another complete head to toe skin assessment of Resident 9 in the morning. The note states that "ecchymosis" persisted on her left breast, both legs, on her legs in the groin area (inner groin), and the outside of her left foot. CMS Ex. 13 at 41, 42. Nursing progress notes for March 4 through 6, 2012, record that there was no new bruising. A note on March 5 states that the resident was sleeping with her lower extremities elevated and with a pillow between her legs to prevent bruising, but the resident kept kicking her feet, causing the pillow not to be correctly positioned. CMS Ex. 13 at 40.

An Incident/Accident Report and a nursing progress note dated April 17, 2012, record that Resident 9's sitter found a bruise on the resident's right knee. The note states that the origin of the bruise is unknown. The note states that the resident's physician was notified. CMS Ex. 13 at 3, 38. The Incident/Accident Report lists as an intervention that the certified nursing assistants (CNAs) and sitter were told to be gentle when caring for and transferring Resident 9 because she had fragile skin. CMS Ex. 13 at 3. Nursing notes from April 18 through 20, 2012, show that Resident 9 was subject to continuous charting due to the right knee bruise which improved during that period. CMS Ex. 13 at 38.

An Incident/Accident Report and a nursing progress note dated May 4, 2012, show that Resident 9's sitter discovered bruising on Resident 9's right inner thigh. The physician and Petitioner's Director of Nursing (DON) were notified. CMS Ex. 13 at 4, 35, 37. The Incident/Accident Report states that CNAs were to be instructed about safety and repositioning while providing the resident care. CMS Ex. 13 at 4.

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[7] The March 5, 2012 Incident/Accident Report lists the date of the incident as "3/3/13." CMS Ex. 13 at 110. The year is obviously a clerical error as that date was after the survey.

Petitioner's staff monitored the bruise from May 4 through 6, 2012. CMS Ex. 13 at 35, 37.

A nursing progress note dated May 6, 2012 and an Incident/Accident Report dated May 7, 2012, document that on May 6, 2012, a small "eccymosis" was discovered over Resident 9's left eye. The report states that staff notified Resident 9's physician and her sitter, Ms. Torianyk. Resident 9 was not seen by a physician, and no first aid was administered. CMS Ex. 13 at 35, 37, 111. The Incident/Accident Report states that the resident may possibly benefit from wearing mitts when she sleeps. CMS Ex. 13 at 111. A nursing note dated May 6, 1012 at 9:00 p.m. characterizes the blue area at the left eyebrow as being a bruise. CMS Ex. 13 at 36. Nursing notes dated May 6 and 7, 2012, show that Petitioner's staff monitored the "bruise" above Resident 9's left eye and on her right thigh. CMS Ex. 13 at 36. According to a May 7 note, the bruising to the resident's left eyebrow was "barely noticeable." CMS Ex. 13 at 36.

A nursing progress note dated May 13, 2012 and an Incident/Accident Report dated May 14, 2012, show that a new bluish area characterized as ecchymosis was discovered above Resident 9's left eye by the sitter on May 13, 2012 around 2:00 p.m. CMS Ex. 13 at 36, 112. The Incident/Accident Report states that Resident 9 "may benefit from bilateral hand mitts." CMS Ex. 13 at 112. A subsequent nursing note on May 13, 2012 at 4:00 p.m. characterizes that bluish area above the left eye as a bruise. CMS Ex. 13 at 34. A nursing progress note dated May 8, 2012 at 4:00 p.m. shows that Dr. Finer, Resident 9's physician, called the facility about the report of a bruise above the resident's eye. Dr. Finer asked if the resident was on blood thinners. The note indicates that Dr. Finer ordered a complete blood count to be done on May 14, 2012. CMS Ex. 13 at 34. Nursing progress notes from May 13 through 16, 2012, show that staff continued to monitor the "bruise" above the resident's left eye. The notes do not reflect a change in the order for the resident's dose of aspirin or generic Plavix®. CMS Ex. 13 at 33-34.

An Incident/Accident Report dated June 10, 2012, records that a CNA reported that she had observed one of Resident 9's sitters spanking the resident on the buttocks the previous day. No bruising was observed. The report states that the DON was notified. CMS Ex. 13 at 62, 113; P. Ex. 3. An unsworn, unsigned, handwritten statement of the CNA states that she saw the sitter hit Resident 9 on both the shoulder and the buttocks. CMS Ex. 13 at 114; P. Ex. 4 at 8. This incident is discussed in greater detail hereafter.

> Nursing progress notes from June 10, 2012 and an Incident/Accident Report dated June 10, 2012, document that on that date it was discovered while Resident 9 was being showered that she had a bruise on her right wrist. CMS Ex. 13 at 32-33, 63. The Incident/Accident Report states that staff notified Resident 9's physician and sitter, and states that the resident may benefit from arm protectors. CMS Ex. 13 at 63. Nursing notes dated June 10 and 11, 2012, document continued monitoring of the right wrist bruise. CMS Ex. 13 at 32-33.
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> Nursing progress notes dated July 4, 2012, and an undated Incident/Accident Report record that a bruise was found on Resident 9's right knee. The resident was noted to have pain with movement of her leg. Resident 9 was unable to explain what happened. Her physician and sitter were notified. Resident 9 was not seen by a physician and no first aid was administered. CMS Ex. 13 at 30, 64. The Incident/Accident Report recommended that staff be reminded to be gentle when transferring the resident. CMS Ex. 13 at 64. A July 4, 2012 nursing progress note states that the CNA was counseled to be gentle when transferring Resident 9. CMS Ex. 13 at 30.
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> On July 5, 2012, Petitioner's records show that Resident 9's sitter reported finding a bruise above the resident's right eye. Resident 9's physician was notified, but Resident 9 was not seen by a physician. The resident was to be monitored for bruises. CMS Ex. 13 at 29, 65. Nursing notes for July 6 through 8, 2012, note that bruising was still present to Resident 9's right knee and right eye, but she had no visible signs of pain or distress. Nursing notes on July 7 and 8, refer to "ecchymosis" and "bruising" persisting above the right eye and right knee. CMS Ex. 13 at 28-29.

Petitioner's clinical records are confusing because in some of the records, the nurses who signed the records refer to ecchymosis in certain locations on Resident 9, while other records describe bruising in those same locations. A hemorrhage is the escape of blood from the blood vessels, with a small hemorrhage being referred to as a petechia and a larger hemorrhage being referred to as an ecchymosis. *Dorland's Illustrated Medical Dictionary* 750 (28th ed. 1994).[8] "Ecchymosis" is a "small hemorrhagic spot, larger than

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[8] I concluded that it was unnecessary to provide the parties advance notice that I would take administrative notice of definitions in a medical dictionary which is in common use among medical professionals, attorneys, and other professionals who deal regularly with the medical profession. Further, while the definitions provided may not be common knowledge among most lay people, these terms are commonly used and known among

(Footnote continued next page.)

a petechia, in the skin or mucous membrane forming a nonelevated, rounded or irregular, blue or purplish patch." *Dorland's* 524. A bruise or contusion, however, is "a superficial injury produced by impact without a laceration." *Dorland's* 233. The distinction between a bluish or purplish spot of skin being diagnosed as ecchymosis or a bruise can be important because bruising is caused by a trauma or impact injury, while ecchymosis is not. Based on the records of Resident 9 that I have summarized, I conclude that the use of the term ecchymosis versus the term bruising is not based on any diagnostic distinction, but rather simply the preference of the writer. While one staff member describes a bluish or purplish area as ecchymosis, another describes the same area as a bruise. The term "bruise" is the much more common and frequently used characterization of the blue or purplish areas observed on Resident 9 as described in Petitioner's clinical records. Resident 9's physician also uses the term bruising to refer to the injuries suffered by Resident 9. P. Ex. 1. Accordingly, I find that in each instance described above, there was bruising rather than ecchymosis, despite the staff's characterization. I do not find that the use of the term ecchymosis by Petitioner's staff establishes a medical diagnosis that the bruising suffered by Resident 9 was spontaneous, that is, without trauma or an impact.

Petitioner has failed to present competent medical testimony to show that any of the bluish or purplish areas did not involve a trauma or impact injury. Admitted as P. Ex. 1, with no objection by CMS, was the unsworn statement of Resident 9's physician, Jan Finer, M.D., dated February 15, 2013. Generally, witnesses must testify under oath or affirmation and submit to cross-examination. 42 C.F.R. § 498.62. Furthermore, I am allowed to admit and consider hearsay statements in this administrative hearing even if such statements would be inadmissible under the rules of evidence applicable to court proceedings. 42 C.F.R. § 498.61; *Florence Park Care Ctr.*, DAB No. 1931 (2004). The Board has recognized that hearsay statements "may be accorded appropriate weight, if supported by adequate indicia of reliability." *Omni Manor Nursing Home*, DAB No. 1920 at 16 (2004). The weight an ALJ accords hearsay is "determined by the degree of reliability, based on relevant indicia of reliability and whether the hearsay is corroborated by other evidence in the record as a whole." *Id*. at 17. Because CMS did not object to my consideration of the unsworn testimony of Dr. Finer, I am at liberty to consider the content of her letter. I do not discount the probative value of the letter because it is unsworn and Dr. Finer was not subject to cross-examination. Dr. Finer states that she has been Resident 9's physician for ten years. Dr. Finer states that Resident 9 was on anticoagulant therapy, using aspirin and Plavix® to address her vascular dementia and risk for stroke. Dr. Finer opined that the anticoagulant therapy and Resident 9's thin skin

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(Footnote continued.)

medical professionals and those who deal regularly with the medical profession. These definitions are also not subject to dispute.

made her susceptible to "easy bruising." Dr. Finer opined that Resident 9 experienced spontaneous bruising and skin tears not due to the way she was handled or cared for. She opined that Resident 9's caregivers exercised utmost care. I cannot accept as weighty, Dr. Finer's opinion that Resident 9 experienced spontaneous bruising and skin tears. Dr. Finer did not see Resident 9 every day or every week. Dr. Finer states that she saw Resident 9 at most monthly or bimonthly. The contemporaneous nursing progress notes and Incident/Accident Reports in evidence show that Dr. Finer was advised of the incidents of bruising, but they also show that she did not examine Resident 9 in connection with the reported incidents of bruising. There is no evidence that Petitioner or Dr. Finer conducted any root cause analysis or investigation to identify causes for the trauma that caused the bruising. Therefore, whatever information Dr. Finer had was provided to her by Petitioner's staff, all of whom assumed that Resident 9's bruising was attributable only to her anticoagulant therapy. I accept Dr. Finer's opinion that Resident 9 was susceptible to easy bruising due to her anticoagulant therapy. However, I cannot accept as credible or weighty Dr. Finer's opinion that the bruising was spontaneous as that opinion is purely speculative with no basis other than assumptions by Dr. Finer and Petitioner's staff. I also cannot accept as weighty Dr. Finer's opinion that staff exercised utmost care when caring for Resident 9 in light of her limited opportunity to observe the delivery of care. Petitioner had admitted as evidence a prescription pad sheet for Dr. Finer dated November 28, 2012, which is after the survey, on which Dr. Finer opined that Resident 9's bruising was "spontaneous . . . secondary to being on Plavix® and aspirin" and states that she saw no reason to report the bruises to the state agency. P. Ex. 4 at 17. I find the opinions expressed by Dr. Finer on the prescription pad are not weighty for the same reasons already discussed.

LPN Nancy Chigede was called as a witness by Petitioner. She testified that Resident 9 was taking aspirin and Plavix® and that bruising is a common side effect of Plavix®. Tr. 321. LPN Chigede testified that a resident with Resident 9's diagnosis and drug regimen would be expected to bruise easily and that the resident's physician had also expressed this opinion. Tr. 303, 311. She did not believe Resident 9's bruises to be "suspicious or abusive in any way." Tr. 303. Even though she believed that the bruises were "incidental," she still documented them in incident reports because that is required of staff. Tr. 303-04. In response to my questioning as to how the facility responded whenever a new bruise on Resident 9 was discovered, LPN Chigede could only state generally, that "we do have interventions that we come up with depending where the bruise happened or what we think might have caused the bruise, so the interventions would vary, depending." Tr. 232-24. LPN Chigede recalled a time when she found a bruise on Resident 9's heel, and stated that staff put a pillow between the resident's legs to prevent friction because she crossed her legs while sleeping. Tr. 324.

Petitioner also called Resident 9's regular private sitter/caregiver, Alin Torianyk, to testify. Ms. Torianyk testified that she worked as a sitter for Resident 9 and had been with the resident's family for nine years. She testified that Resident 9's son had given

her full authority to make care decisions for Resident 9. Tr. 330-31, 346, 347-48. With respect to Resident 9's bruising, Ms. Torianyk testified that the facility "did anything in their power to protect [Resident 9] from being bruised" and discussed possible interventions with her. Tr. 335-36. She stated that Petitioner's staff called her "right away" every time Resident 9 had a bruise, and she would go to the facility and check the resident. Tr. 335-37, 344. According to Ms. Torianyk, the bruises did not have the appearance of bruises, but were a "very light blue." Tr. 344. Ms. Torianyk testified that she discussed Resident 9's bruising with her physician, and medication was changed in an attempt to minimize bruising. She testified that Resident 9's son was aware of the problem. Tr. 336, 344-45. Ms. Torianyk testified that neither she nor Resident 9's physician and family believed that the resident's bruises were caused by anything other than incidental contact. Tr. 336. She stated that Resident 9's bruises did not give her cause for concern because she knew that the resident bruised easily, despite their efforts to prevent the bruising. Tr. 336-37. Ms. Torianyk admitted in response to my questions that she was not a trained medical professional. Tr. 347. She was not even permitted to bathe or change Resident 9; she could only feed her and then only after she had completed a certification course. Tr. 350-51. Due to her lack of medical training, I give Ms. Torianyk's opinions regarding the cause of Resident 9's bruising and the quality of medical care and treatment no weight.

The evidence clearly supports a finding that Resident 9 was subject to easy bruising due to her anticoagulant therapy. However, Petitioner's clinical records in evidence do not show for any of the instances that I have summarized that Petitioner undertook any root cause analysis or investigation to identify what trauma caused the multiple bruises reported. The traumas that caused the bruises were not witnessed. The records show no investigation to determine the actual source of the bruising. The records show that nursing staff generally assumed that the bruising was due to rough handling, and the CNAs and sitters were repeatedly reminded to handle Resident 9 with care. In the case of the bruises above the left and right eye, the recommended intervention to apply hand mitts shows that nursing staff assumed that the resident hit herself. In the case of the bruising around the inner groin, an assumption was made that the resident bruised herself and the intervention was to place a pillow between her legs. In the case of the wrist bruise, the intervention to use arm protectors indicates that an assumption was made that Resident 9 injured herself by striking her wrist on some object. In one instance, it was assumed that the resident hit her left foot on her wheelchair. These interventions evidence that Petitioner's staff did not believe many of the bruises were spontaneous, but, rather, that the bruises were caused by some trauma.

The surveyors also cite the incident described above, involving Resident 9 on June 9, 2012, at about 10:00 p.m. CMS Ex. 2 at 24. Petitioner's Incident/Accident Report dated

June 10, 2012, records that on June 9, 2012[9], a CNA reported that she observed the resident's private weekend sitter spank the resident on her buttocks. The report states that no bruising was observed. The report suggested that the resident's regular sitter was advised to address the issue with the weekend sitter who allegedly spanked the resident. The report also states that the matter was reported to the DON. CMS Ex. 13 at 62, 113; P. Ex. 3. The unsworn and unsigned statement of the CNA offered by both parties as evidence without objections states that the CNA also saw the sitter hit the resident on the shoulder and that she had seen the sitter hit Resident 9 before. CMS Ex. 13 at 114; P. Ex. 4 at 8. The evidence shows that the CNA did not immediately report the incident to her supervisor, the DON, or the administrator. Rather, the CNA reported it the next day, June 10, 2012, when questioned by the LPN. The resident's regular sitter was notified on June 10, 2012, and the physician was not notified until June 12, 2012. CMS Ex. 13 at 113. LPN Nancy Chigede states in her unsworn statement dated June 14, 2012, that the resident's regular sitter came to the facility on June 10, 2012. The CNA who made the allegation was interviewed by LPN Chigede and the regular sitter. The regular sitter then called the weekend sitter, who admitted to patting the resident on the buttocks to make her stand up. CMS Ex. 13 at 115; P. Ex. 4 at 7. Petitioner filed an initial report with the state agency on June 12, 2012, checking the box for "Certain Injuries" rather than the box for "Allegations of Abuse/Mistreatment." The report indicates that local police were notified on June 12, 2012. The initial report is undated. However, a facsimile transmission report shows that a two-page document was sent at 3:58 p.m. on June 12, 2012. CMS Ex. 13 at 20-21, 24; P. Ex. 4 at 2-4; Tr. 107. Petitioner offered and had admitted as P. Ex. 4 at 15, a document addressed to Petitioner's Administrator or DON, dated September 18, 2012, from the state agency. The document states that the incident report related to the incident on June 9, 2012, was incomplete as no final report had been received. A handwritten note indicates that the state agency was contacted on September 18, 2012, the report was located at the state agency, and that Petitioner need take no further action. P. Ex. 4 at 15; P. Ex. 5; Tr. 357. Also in evidence is a state agency report that is undated that is marked as a "Final" report. The documentary evidence does not show when this final report was submitted. However, the report clearly states in two places that the investigation was ongoing at the time of the report, which shows that the

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[9] Some copies of Petitioner's Incident/Accident Report admitted as evidence record that the incident occurred in 2010. The 2010 date is clearly a clerical error. Copies of the report admitted as CMS Ex. 13 at 62 and P. Ex. 3 have the date "6-9-10" in the "Date of incident/accident" block. On a copy of the same document marked and admitted as CMS Ex. 13 at 113, the "10" in "6-9-10" has a single strike-through and the number "12" is written above the "10" stricken. Other contemporaneous records also state that the incident occurred on June 9, 2012. P. Ex. 4 at 2, 5, 8, 14; CMS Ex. 13 at 20, 114. The incident on June 9, 2012, was not reported in the nursing progress notes in evidence. CMS Ex. 13 at 32-33.

report was likely not final. The report is also marked to indicate that the incident involved "Certain Injuries" rather than "Allegations of Abuse/Mistreatment." CMS Ex. 13 at 22-23; P. Ex. 4 at 5-6.

LPN Chigede testified that she first heard of the alleged spanking of Resident 9 on Sunday, June 10, 2012. The incident was not reported to her, but rather she overheard the CNA in the break room telling another CNA about the incident. The CNA said she saw the weekend sitter spank Resident 9. At that point, LNP Chigede took the CNA aside and inquired as to what had happened. LPN Chigede then examined the resident and found no signs of bruising on her buttocks. At hearing, LPN Chigede opined that the absence of bruising was inconsistent with the CNA's allegation because the resident bruised so easily. After hearing the allegation of the CNA, LPN Chigede called Resident 9's regular sitter, Ms. Torianyk, who came to the facility and both then examined the resident and found no sign of bruising. Both then interviewed the CNA, who persisted in her allegation that she saw the weekend sitter spank Resident 9. The regular sitter then called the weekend sitter using the speaker phone. The weekend sitter denied spanking the resident but admitted to patting her to get her to stand up. LPN Chigede testified that after hearing the weekend sitter, she did not believe the CNA's report and neither did the regular sitter. LPN Chigede testified that the weekend sitter did not return to the facility on Sunday, June 10, 2012, because she only worked on Saturdays, and she never subsequently returned because she was fired. LPN Chigede testified that after examining the resident, she contacted both the DON and Administrator. Tr. 297-303, 307, 309-10, 313-14. She testified that she believed the CNA did not report the incident to anyone on June 9, 2012. She admitted on cross-examination that the weekend sitter completed her shift on Saturday, June 9, 2012. Tr. 310-11. She testified that an investigation of the incident was conducted and she was interviewed, the CNA was interviewed, Resident 9's physician was informed, Resident 9's regular sitter was involved, the police were contacted, and she opined that the investigation was thorough. Tr. 306-07. LPN Chegede testified in response to my questions that she recognized that the CNA had made an allegation that Resident 9 was abused by her weekend sitter. Tr. 314.

Resident 9's regular sitter, Ms. Torianyk, testified that after LPN Chigede called her on June 10, 2012, and informed her of the incident involving Resident 9 and her weekend sitter, she went to the facility the same day. Tr. 331-32. Ms. Torianyk testified that she and LPN Chigede went to Resident 9's room and checked her "from head to toe," including her buttocks. She did not see any bruising consistent with an assault or a spanking. Tr. 332. Ms. Torianyk called the weekend sitter, who stated she only tapped Resident 9 softly on the shoulder but never spanked her. Tr. 333-34. Ms. Torianyk stated that she believed the sitter. She testified that the weekend sitter did not work on Sundays. She testified that she informed the weekend sitter on Monday that she could not enter the facility anymore. Tr. 33-35.

Petitioner's Administrator, James Jakubovitz, testified that the facility took every measure to keep Resident 9 safe, that the facility fully investigated the allegation, the facility immediately notified the family, and the facility also notified the police. Tr. 356-57. The Administrator's opinion is not credible or entitled to weight because the Administrator did not acknowledge that the alleged incident was witnessed by a CNA who did not immediately report the incident. Therefore, the Administrator also failed to acknowledge that there was a period between the incident and its discovery when the resident was not protected from the weekend sitter who was permitted to complete her shift sitting for Resident 9 on Saturday, June 9, 2012. The Administrator's opinion fails to acknowledge that the CNA did not actually report the incident as she was required to do under the applicable federal regulations, but rather LPN Chigede accidentally overheard the CNA in the break room and then inquired further. The Administrator also fails to acknowledge that the incident was not reported to the physician or family for a day and to the police for three days.

There is no dispute that the CNA alleged potential abuse when she alleged that the weekend sitter spanked Resident 9 and hit her on the shoulder. The CNA did not, however, immediately report the incident, but was accidentally overhead discussing the incident by LPN Chigede. Due to the CNA's failure to immediately report the allegation to the DON or Petitioner's Administrator, the weekend sitter remained at the facility with Resident 9. Thus, for a period on Saturday, June 9, 2012, Resident 9 was not protected from potential abuse by the weekend sitter. LPN Chigede learned of the incident on June 10, 2012, and reported it to the DON and Administrator. However, the incident was not reported to the state agency and police until June 12, 2012.

ii. Resident 19

Resident 19 was 74 years old at the time of the survey. He suffered from, among other things, dementia and Parkinson's, and was completely dependent on staff for assistance with his activities of daily living, including eating his meals. He was assessed as having difficulty understanding and being understood, and he was described as being non-verbal. CMS Ex. 19 at 12, 48, 62, 66, 68, 70, 72.

In a nursing progress note dated October 10, 2012, at 12:20 p.m., a LPN reported that she observed an aide who was feeding Resident 19 shaking him to wake him. She stated that the shaking appeared to be abusive. She also stated in the note that she reported the incident to the DON who advised her that she would take care of it. CMS Ex. 19 at 60. The record contains the DON's undated, unsworn, signed statement concerning the October 10, 2012 incident. CMS Ex. 21 at 13. Although the DON did not testify at the hearing subject to cross-examination, CMS offered the statement as evidence and Petitioner did not object to the admission of this statement or dispute its contents or authorship. The description of the October 10, 2012 incident in the DON's out-of-court statement is generally consistent with that of the LPN in her nursing note at CMS Ex. 19

at 60. Therefore, I find that the DON's statement contains sufficient indicia of reliability and I give it weight in my determination. According to the DON's statement, the LPN, who was the charge nurse, reported the incident to her on October 10, 2012. The DON's statement indicates that the LPN informed her that the CNA was talking loudly to the resident and being rough with him. The LPN related that a certified medication aide (CMA) had been an eyewitness to the event. The LPN reported to the DON that the CNA was removed from the table with Resident 19. The DON stated that she spoke to the CMA, who said that the CNA was not being that rough with Resident 19. The DON also described her conversation with the CNA. She recorded that she counseled the CNA that her behavior could be interpreted to be abusive. The DON suspended the CNA for two days without pay and terminated the CNA on November 12, 2012, based on the incident involving Resident 19. CMS Ex. 21 at 13.

Surveyor Sherry Reid, R.N., testified that the DON informed her during the survey that she did not report the incident to the state agency or the resident's family, but the Administrator was aware of the incident. Tr. 193; CMS Ex. 19 at 46; CMS Ex. 2 at 34. The DON told Surveyor Reid that she had talked to the CNA, LPN, and the CMA, but had not written anything down. Tr. 194. The DON admitted to Surveyor Reid that she did not interview any other staff or residents regarding the incident. Tr. 194.

Administrator Jakubovitz testified that he believed that the facility conducted a thorough investigation of the incident involving Resident 19. He testified that immediate action was taken to remove the CNA from Resident 19 and the CNA was reprimanded and suspended. He opined that Resident 19 was kept safe. Tr. 361-63. Administrator Jakubovitz testified that he was notified of the incident involving Resident 19 and the CNA in the dining room, but he could not remember exactly when. He testified he did not consider the incident abuse. He testified that one of the resident's family members told him that she also speaks loudly to the resident and shakes him. He testified that the incident was not reported to the state because he did not consider the incident abuse. Tr. 365-67, 369.

Petitioner had policies and procedures regarding the prohibition of resident abuse, neglect, mistreatment, injuries of unknown source, and misappropriation of resident property that existed before the November 2012 survey titled "Abuse Prevention Program Overview" and "Elder Abuse Recognition and Response." CMS Ex. 26 at 1-2, 5-6.

b. Analysis

Section 1819(c)(1)(A)(ii) of the Act requires that a SNF protect its residents and promote their "right to be free from physical or mental abuse, corporal punishment, involuntary seclusion, and any physical or chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms." The Secretary has provided by regulation that a "resident has the right to be free from verbal, sexual,

physical, and mental abuse, corporal punishment, and involuntary seclusion." 42 C.F.R. § 483.13(b). The regulations require that a facility develop and implement written policies and procedures prohibiting mistreatment, neglect, and abuse of residents and the misappropriation of residents' property. 42 C.F.R. § 483.13(c). The surveyors allege in the SOD that Petitioner violated 42 C.F.R. § 483.13(c)(1)(ii) and (iii) and (c)(2), (3), and (4). CMS Ex. 2 at 16-17. Subsection 483.13(c)(1)(ii) prohibits a SNF from hiring an individual who has been found guilty of abusing, neglecting, or mistreating a resident or who has a finding of abuse, neglect, mistreatment, or misappropriation of resident property entered on the state's nurse aide registry. Subsection 483.13(c)(1)(iii) requires that a SNF report certain court actions against employees to the state nurse aide registry or licensing authority. There is no evidence that Petitioner violated 42 C.F.R. § 483.13(c)(1)(ii) and (iii), and CMS does not allege before me that Petitioner violated those subsections. Therefore, I conclude that the citation of those subsections is merely a clerical error.

The allegations of the surveyors and CMS are that Petitioner violated 42 C.F.R. § 483.13(c)(2), (3), and (4), because Petitioner failed to thoroughly investigate, protect, and report related to the incidents described above involving Resident 9 and Resident 19. CMS Ex. 2 at 16-38. The gist of the CMS position is not that abuse actually occurred but that there was evidence or an allegation of abuse or neglect to which Petitioner failed to react as required by the regulations. The requirements of 42 C.F.R. § 483.13(c)(2), (3), and (4) are:

> (2) The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).
>
> (3) The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.
>
> (4) The results of all investigations 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.

I conclude that the evidence of Resident 9's bruising and the allegation that she was spanked triggered the requirements of 42 C.F.R. § 483.13(c)(2), (3), and (4), and Petitioner violated those requirements. I also conclude that Petitioner violated 42 C.F.R. § 483.13(c)(2), (3), and (4) in the example of Resident 19.

The federal regulation requires that all allegations of mistreatment, neglect, or abuse, including injuries of unknown source such as Resident 9's bruises, be immediately reported to the administrator and other officials in accordance with state law. 42 C.F.R. § 483.13(c)(2). The terms "abuse," "mistreatment," and "neglect" are not defined in 42 C.F.R. § 483.13. Definitions for abuse and neglect are found in 42 C.F.R. § 488.301. 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. Neglect is "failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness." 42 C.F.R. § 488.301. Mistreatment is not defined in the SNF regulations, and I construe the term to have its common meaning. CMS policy is that "immediately" means as soon as possible but not more than 24 hours after discovery of the allegation. Injuries of unknown source are those that are unwitnessed by staff; cannot be explained by the resident; and are unusual due to their nature, location, or frequency. SOM, app. PP, Tag F225. The applicable Oklahoma state law and regulations are not inconsistent with the Act and the Secretary's regulations. The Oklahoma Nursing Home Care Act defines "abuse" as "the willful infliction of injury, unreasonable confinement, intimidation or punishment, with resulting physical harm, impairment or mental anguish." Okla. Stat. Ann. Tit. 63, § 1-1902(1). Neglect is the "failure to provide goods and/or services necessary to avoid physical harm, mental anguish, or mental illness." Okla. Stat. Ann. Tit. 63, § 1-1902(15). The Oklahoma statute provides, in relevant part, that "[e]very resident shall be free from mental and physical abuse and neglect." Okla. Stat. Ann. Tit. 63, § 1-1918(B)(12). Under the Oklahoma Administrative Code, a facility must report an allegation or incident of resident abuse, neglect, or misappropriation of resident property to the state agency by telephone or facsimile within 24 hours of the reportable allegation or incident. The facility is then required to mail or fax a follow-up report to the state agency within five business days and complete a full-investigation and file a final report within ten days of the allegation or incident. Okla. Admin. Code §§ 310:675-7-5.1(a)-(b).

The evidence shows that between February 5, 2012 and July 5, 2012, Petitioner's staff discovered and reported that Resident 9 suffered at least ten instances of bruising. Bruising was identified on her right inner thigh, right hand, abdomen, left foot, right breast, left breast, inner groin, right knee, right wrist, and above her left eye and right eye. There is no factual dispute that Resident 9 was on anticoagulant therapy and was subject to easy bruising. However, the fact that Resident 9 was subject to easy bruising due to her anticoagulant therapy does not address the cause of the trauma that caused the multiple bruises she suffered. The assumption that her bruising was all spontaneous does not comport with the various interventions listed in Petitioner's clinical records for

Resident 9, which show that staff believed that bruising was due, at least in part, to impact with her wheelchair, the resident striking herself with her hands or on hard objects, and staff not handling the resident carefully and gently. The law requires that residents be free from abuse, neglect, and mistreatment. Even if one assumed that there was no abuse because there was no intentional bruising of Resident 9, that does not rule out the possibility that staff neglected to exercise necessary care in handling Resident 9 or mistreated her by rough handling. Petitioner never recognized that Resident 9's repeated bruising, particularly in highly suspect areas such as her groin and breasts, may have been the result of abuse, neglect, or mistreatment. Petitioner assumed that the bruising was due to the anticoagulant therapy, and took no action to investigate whether abuse, neglect, or mistreatment might have been the cause of the impacts that caused the bruises. Petitioner's own policy specifies that it will conduct an investigation in the event of suspicious bruising, but not even the breast and groin bruises suffered by Resident 9 were treated as suspicious by Petitioner's staff. No suspicion of neglect or mistreatment was triggered despite the fact when bruising was reported, it was deemed necessary to repeatedly advise staff to be more cautious and gentle when handling Resident 9. Because Petitioner never recognized Resident 9's repeated bruising as potential abuse, neglect, or mistreatment, Petitioner never complied with the requirements to protect the resident, investigate, report, and retain documents reflecting the investigation, protection, and reporting. Therefore, Petitioner violated 42 C.F.R. § 483.13(c)(2), (3), and (4). I conclude that the violation posed a risk for more than minimal harm due to the potential for further bruising or more significant injuries to Resident 9, who was unable to communicate or protect herself.

The alleged spanking incident involving Resident 9 also reflects a regulatory violation. The CNA who allegedly witnessed the event did not immediately report to the Administrator as required by 42 C.F.R. § 483.13(c)(2), which prevented a timely report to the state agency. The CNA's failure to report also prevented protecting Resident 9 from further potential abuse on June 9, 2012, because the weekend sitter who did the alleged spanking was permitted to complete her shift that day. Tr. 310-11. The failure to protect Resident 9 constitutes a violation of 42 C.F.R. § 483.13(c)(3). Although not specifically alleged by the surveyors, I further note that Petitioner's records in evidence do not show that the investigation was ever completed or that corrective action was taken, which constitutes a violation of 42 C.F.R. § 483.13(c)(4). Both reports in evidence indicate that the investigation was on-going at the time of the report. Neither report reflects that an allegation of abuse or mistreatment was involved. Neither report states the corrective action taken. P. Ex. 4 at 2-3, 5-6.

I conclude that the evidence shows that Petitioner violated 42 C.F.R. § 483.13(c)(2), (3), and (4) in the example of Resident 19. Petitioner's Administrator admitted that the incident involving Resident 19 was not reported to the state agency as an incident of abuse, neglect, or mistreatment. Administrator Jakubovitz testified that he did not believe that an allegation of abuse had been made even though the nursing progress note

clearly states that the LPN who made the note thought that the action of the CNA was abusive. CMS Ex. 19 at 60. Administrator Jakubovitz failed to recognize the allegation of abuse even though the DON had counseled the CNA involved that her action could be interpreted to be abusive and the DON deemed the incident serious enough to terminate the CNA's employment. CMS Ex. 21 at 13. Administrator Jakubovitz was unwilling to acknowledge in testimony that his own opinion as to whether or not the incident was abuse was not the issue. The regulation clearly requires that an allegation of abuse be reported to the state. Administrator Jakubovitz's position that there was no allegation of abuse is inconsistent with the nursing note and the statement of the DON and is simply not credible. I conclude that the violation of 42 C.F.R. § 483.13(c)(2), (3), and (4) in the example of Resident 19 posed a risk for more than minimal harm to Resident 19. The evidence shows that Resident 19 was unable to communicate or defend himself from abuse, neglect, or mistreatment.

Petitioner argues that the incident involving Resident 19 was not abuse and that it followed "acceptable protocol." P. Br. at 4. Administrator Jakubovitz testified that he thought that a thorough investigation was done. Tr. 361, 367. However, Petitioner has presented no documentary evidence to show that the alleged abuse of Resident 19 was thoroughly investigated as required by 42 C.F.R. § 483.13(c)(3). After learning of the incident involving the CNA and Resident 19, the DON spoke with the LPN who made the report, the CMA who was the other eyewitness, and the CNA who was the alleged abuser, but did not write anything down. The DON admitted that she did not interview any other staff or residents regarding the incident. Tr. 194. The DON's cursory investigation does not constitute the thorough investigation as required by 42 C.F.R. § 483.13(c)(3). Petitioner's own abuse prohibition policy states that, in addition to the completion of an Incident Report within 24 hours, a thorough investigation will be conducted and specifies that signed statements are to be obtained from witnesses as well as from the individual suspected of the abuse as quickly as possible. Petitioner's staff did not complete an Incident Report and failed to gather written statements from the LPN, the CMA, the CNA, and anyone else who may have had knowledge of the incident involving Resident 19. Petitioner offered no contemporaneous documentation that an investigation was performed, and the absence of any evidence supports the conclusion that Petitioner's staff failed to conduct a thorough investigation of the alleged abuse of Resident 19. Petitioner has not rebutted CMS's prima facie showing that it was not in compliance with 42 C.F.R. § 483.13(c)(2), (3), and (4) or established any affirmative defense.

The surveyors also allege on the foregoing facts that Petitioner violated 42 C.F.R. § 483.13(c) because Petitioner failed to implement written policies and procedures prohibiting abuse, neglect, and mistreatment of residents and the misappropriation of resident property. The violation is cited under Tag F226 and is alleged to have posed immediate jeopardy. CMS Ex. 2 at 38-59. The SOD shows that Petitioner had the required written policy and procedures. Although the surveyors required certain revisions to the policy, they did not cite Petitioner for not having the required written

policies and procedures. CMS Ex. 2 at 39-43; CMS Ex. 26 at 1-2, 5-6. Rather, the surveyors cited Petitioner for failure to implement its policy and procedures. CMS Ex. 2 at 41.

In examining whether a facility has implemented policies and procedures prohibiting abuse, neglect, mistreatment, and misappropriation, the Board has held that the issue under 42 C.F.R. § 483.13(c) is "whether the circumstances presented, viewed as a whole, demonstrate a systemic problem in implementing policies and procedures" to prevent abuse. *Columbus Nursing & Rehab. Ctr.*, DAB No. 2247 at 27 (2009) (citing *Liberty Nursing and Rehab Ctr.–Johnston*, DAB No. 2031 at 14 (2031), *aff'd*, *Liberty Commons Nursing & Rehab Ctr.–Johnston v. Leavitt*, 241 F. App'x 76 (4th Cir. 2007). I conclude that the facts I have found related to the examples of Residents 9 and 19 clearly show that Petitioner had a systemic failure in implementing the policies and procedures required by 42 C.F.R. § 483.13(c). The facts show that staff failed to report alleged abuse, neglect, or mistreatment; the DON failed to follow Petitioner's policies and procedures and the federal and state regulations related to alleged abuse, neglect, or mistreatment; and the Administrator also failed to follow policies, procedures, and federal and state regulations, and, more significantly, failed to recognize an allegation of abuse. I conclude that Petitioner's failure to implement its policies and procedures posed a risk for more than minimal harm due to abuse, neglect, and mistreatment for Residents 9 and 19 and all Petitioner's other residents.

The surveyors alleged in the SOD and CMS argues before me that the noncompliance under Tags F225 and F226 posed immediate jeopardy. The CMS determination of immediate jeopardy must be upheld, unless Petitioner shows the declaration of immediate jeopardy to be clearly erroneous. 42 C.F.R. § 498.60(c)(2). CMS's determination of immediate jeopardy is presumed to be correct, and Petitioner has a heavy burden to demonstrate clear error in that determination. *Yakima Valley Sch.*, DAB No. 2422 at 8-9 (2011); *Cal Turner Extended Care Pavilion*, DAB No. 2384 at 14 (2011); *Brian Ctr. Health and Rehab./Goldsboro,* DAB No. 2336 at 9 (2010) (*citing Barbourville Nursing Home*, DAB No. 1962 at 11 (2005)), *aff'd, Barbourville Nursing Home v. U.S. Dep't of Health & Human Srvs.*,174 F. App'x 932 (6th Cir. 2006); *Maysville Nursing & Rehab. Facility*, DAB No. 2317 at 11 (2010); *Liberty Commons Nursing and Rehab Ctr.–Johnston*, DAB No. 2031 at 18-19 (2006), *aff'd*, *Liberty Commons Nursing & Rehab. Ctr.–Johnson v. Leavitt*, 241 F. App'x 76 (4th Cir. 2007). Once CMS presents evidence supporting a finding of noncompliance, CMS does not need to offer evidence to support its determination that the noncompliance constitutes immediate jeopardy. Rather, the burden is on the facility to show that that determination is clearly erroneous. *Cal Turner Extended Care Pavilion*, DAB No. 2384 at 14-15; *Liberty Commons Nursing & Rehab. Ctr.–Johnston*, 241 F. App'x 76 at 3-4.

"*Immediate jeopardy"* as used in the regulations refers to "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." 42 C.F.R. §§ 488.301, 489.3 (emphasis in original). In the context of survey, certification, and enforcement related to SNFs and NFs under the regulations, a conclusion by the state agency and CMS that noncompliance with program participation requirements poses immediate jeopardy to the facility residents, triggers specific regulatory provisions that require enhanced enforcement remedies, including authority for CMS to impose a larger CMP than may be imposed when there is no declaration of immediate jeopardy. 42 C.F.R. §§ 488.408(e), 488.438(a)(1)(i), (c), and (d). The regulations also require termination of the facility's provider agreement on an expedited basis or the removal of the immediate jeopardy through appointment of temporary management. 42 C.F.R. §§ 488.410, 488.440(g), 488.456, 489.53(d)(2)(B)(ii).

Pursuant to 42 C.F.R. § 498.3(d)(10), a finding by CMS that deficiencies pose immediate jeopardy to the health or safety of a facility's residents is not an initial determination that triggers a right to request a hearing by an ALJ or that is subject to review. Rather, a finding of noncompliance that results in the imposition of an enforcement remedy, except the remedy of monitoring by the state, does trigger a right to request a hearing and is subject to review. 42 C.F.R. §§ 488.408(g); 498.3(b)(8) and (13). Furthermore, the level of noncompliance, i.e. scope and severity, is subject to review only if a successful challenge would: (1) affect the amount of CMP that may be imposed, i.e. the higher range of CMP authorized for immediate jeopardy; or (2) affect a finding of substandard quality of care that rendered the facility ineligible to conduct a NATCEP. 42 C.F.R. § 498.3(b)(14) and (16). Pursuant to 42 C.F.R. § 498.60(c)(2), in reviewing a CMP, the ALJ must uphold the CMS determination of the level of noncompliance (i.e., the scope and severity), unless it is clearly erroneous.

Applying the clearly erroneous standard to the record before me related to the noncompliance I have found based on the violation of 42 C.F.R. § 483.13(c) and (c)(2), (3), and (4), I have no definite and firm conviction that an error has been committed in the determination that immediate jeopardy existed. Petitioner's DON and Administrator failed to recognize possible abuse, neglect, or mistreatment of two residents who were unable to communicate and unable to defend themselves. Staff, the DON, and the Administrator failed to respond appropriately by reporting and investigating and protecting the residents. While the evidence does not show actual harm, Petitioner's failures clearly created a situation that had the likelihood of further abuse and serious injury or harm to residents. Petitioner's failure to immediately report the abuse allegation prevented the state agency from conducting an independent investigation and taking any action necessary to protect the residents. Petitioner has failed to show that there was no likelihood for serious injury, harm, impairment, or death on account of its violations. Accordingly, I conclude that Petitioner failed to show that the declaration of immediate jeopardy based on the violations of 42 C.F.R. §§ 483.13(c) and (c)(2), (3), and (4) was clearly erroneous.

7. Petitioner violated 42 C.F.R. § 483.75 (Tag F490).

8. The violation of 42 C.F.R. § 483.75 (Tag F490) posed a risk for more than minimal harm.

9. Petitioner has not met its burden to show that the declaration of immediate jeopardy related to the noncompliance with 42 C.F.R. § 483.75 (Tag F490) was clearly erroneous.

The surveyors allege in the SOD that Petitioner violated 42 C.F.R. § 483.75 (Tag F490), based on the noncompliance under Tags F225 and F226 based on violations of 42 C.F.R. §§ 483.13(c) and (c)(2), (3), and (4) that posed immediate jeopardy. CMS Ex. 2 at 90-95.

The regulation requires that Petitioner administer its facility in "a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident." 42 C.F.R. § 483.75. The Board has held that a determination that a SNF failed to comply substantially with section 483.75 may be derived from findings that the SNF was not in substantial compliance with other participation requirements. *Stone Cnty. Nursing & Rehab. Ctr.*, DAB No. 2276 at 15 (2009); *Life Care Ctr. at Bardstown*, DAB No. 2233 at 28 (2009); *Britthaven, Inc.*, DAB No. 2018 at 22 (2006).

I have concluded that Petitioner violated 42 C.F.R. § 483.13(c), which amounted to noncompliance under Tags F225 and F226 that posed immediate jeopardy for Petitioner's residents. I conclude that the noncompliance under Tags F225 and F226 establishes that Petitioner failed to administer its facility effectively to ensure residents attained and maintained their highest practicable physical, mental, and psychosocial well-being. I further conclude that Petitioner has failed to show that the declaration of immediate jeopardy as to Tag F490 was clearly erroneous for the same reasons Petitioner failed to meet its burden with respect to Tags F225 and F226.

10. A CMP of $5,650 per day for November 8 and 9, 2012; a CMP of $1,050 per day from November 10, 2012 through January 15, 2013; and a DPNA from December 26, 2012 through January 15, 2013, are reasonable enforcement remedies.

I have concluded that Petitioner violated 42 C.F.R. §§ 483.13(c) and (c)(2), (3), and (4) and 483.75 (Tags F225, F226, and 490) and that the violations posed a risk for more than minimal harm to one or more facility residents. When a facility is not in substantial compliance with program requirements, CMS has the authority to impose one or more of the enforcement remedies listed in 42 C.F.R. § 488.406, including a CMP. CMS may impose a per day CMP for the number of days that the facility is not in compliance or for

each instance that a facility is not in substantial compliance, whether or not the deficiencies pose immediate jeopardy. 42 C.F.R. § 488.430(a).

If I conclude, as I have in this case, that there is a basis for the imposition of an enforcement remedy and the remedy proposed is a CMP, my authority to review the reasonableness of the CMP is limited by 42 C.F.R. § 488.438(e). The limitations are, I may: (1) not set the CMP at zero or reduce it to zero; (2) not review the exercise of discretion by CMS in selecting to impose a CMP; and (3) only consider the factors specified by 42 C.F.R. § 488.438(f) when determining the reasonableness of the CMP amount. In determining whether the amount of a CMP is reasonable, the following factors specified at 42 C.F.R. § 488.438(f) must be considered: (1) the facility's history of non-compliance, including repeated deficiencies; (2) the facility's financial condition; (3) the seriousness of the deficiencies as set forth at 42 C.F.R. § 488.404(b), the same factors CMS and/or the state were to consider when setting the CMP amount; and (4) the facility's degree of culpability, including, but not limited to, the facility's neglect, indifference, or disregard for resident care, comfort, and safety and the absence of culpability is not a mitigating factor. The factors that CMS and the state were required to consider when setting the CMP amount and that I am required to consider when assessing the reasonableness of the amount are set forth in 42 C.F.R. § 488.404(b): (1) whether the deficiencies caused no actual harm but had the potential for minimal harm, no actual harm with the potential for more than minimal harm, but not immediate jeopardy, actual harm that is not immediate jeopardy, or immediate jeopardy to resident health and safety; and (2) whether the deficiencies are isolated, constitute a pattern, or are widespread. My review of the reasonableness of the CMP is de novo and based upon the evidence in the record before me. I am not bound to defer to the CMS determination of the reasonable amount of the CMP to impose but my authority is limited by regulation as already explained. I am to determine whether the amount of any CMP proposed is within reasonable bounds considering the purpose of the Act and regulations. *Emerald Oaks*, DAB No. 1800 at 10 (2001); *CarePlex of Silver Spring*, DAB No. 1683 at 14-16 (1999); *Capitol Hill Comty. Rehab. and Specty. Care Ctr*, DAB No. 1629 (1997).

I have received no evidence that Petitioner had a history of noncompliance prior to the survey at issue. Petitioner has not argued that its financial condition affects its ability to pay the proposed CMP. I conclude that Petitioner's deficiencies are serious and that Petitioner was culpable. By failing to act in accordance with the law and its policy and procedure, Petitioner thereby risked the physical, emotional, and mental health of all of its residents.

A CMP that is imposed against a facility on a per day basis will fall into one of two ranges of penalties. 42 C.F.R. §§ 488.408, 488.438. The upper range of a CMP, $3,050 per day to $10,000 per day, is reserved for deficiencies that pose immediate jeopardy to a facility's residents and, in some circumstances, for repeated deficiencies. 42 C.F.R. § 488.438(a)(1)(i), (d)(2). The CMP of $5,650 per day proposed by CMS for the two

days of immediate jeopardy is in the middle of the authorized range, and I conclude it is reasonable based on my consideration of the regulatory factors. The lower range of CMPs, $50 per day to $3,000 per day, is reserved for deficiencies that do not pose 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). I conclude that the $1,050 per day CMP proposed for the period of noncompliance from November 10, 2012 through January 15, 2013, is reasonable. I also conclude that CMS was authorized to impose a DPNA from December 26, 2012 through January 15, 2013, and that the DPNA is a reasonable enforcement remedy.

III. Conclusion

For the foregoing reasons, I conclude that Petitioner was not in substantial compliance with program participation requirements from November 8, 2012 through January 15, 2013, due to violations of 42 C.F.R. §§ 483.13(c) and (c)(2), (3), and (4) and 483.75. I further conclude that a CMP of $5,650 per day for November 8 and 9, 2012, and $1,050 per day from November 10, 2012 through January 15, 2013; and a discretionary DPNA from December 26, 2012 through January 15, 2013, are reasonable enforcement remedies in this case.

/s/
Keith W. Sickendick
Administrative Law Judge