Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Senior Care Beltline
(CCN: 67-5822),

Petitioner,

v.

Centers for Medicare and Medicaid Services.

Docket No. C-11-291

Decision No. CR2592

Date: August 17, 2012

DECISION

Petitioner, Senior Care Beltline, did not violate 42 C.F.R. §§ 483.13(c); 483.13(c)(2), (3), and (4); or 483.75,[1] as alleged by the survey completed on November 22, 2010. Accordingly, Petitioner remained in substantial compliance with program participation requirements and there is no basis for the imposition of enforcement remedies.

I. Background

Petitioner is located in Garland, Texas, and participates in Medicare as a skilled nursing facility (SNF) and the state Medicaid program as a nursing facility (NF). Petitioner was subject to an annual recertification survey by the Texas Department of Aging and Disability Services (state agency) from November 16 through 22, 2010. The survey concluded that Petitioner was not in substantial compliance with program participation requirements. The Centers for Medicare and Medicaid Services (CMS) notified

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[1] References are to the version of the Code of Federal Regulations (C.F.R.) in effect at the time of the survey, unless otherwise indicated.

Petitioner by letter dated December 21, 2010, that it was imposing the following enforcement remedies: termination of Petitioner's provider agreement effective March 22, 2011, if Petitioner did not return to substantial compliance prior to that date; a denial of payment for new admissions (DPNA) effective January 5, 2011, if Petitioner did not return to substantial compliance before that date; and a civil money penalty (CMP) of $6,250 per day for the period November 6 through 22, 2010, and $900 per day effective November 23, 2010 and continuing until Petitioner returned to substantial compliance or was terminated. The letter also advised Petitioner that it was ineligible to conduct a nurse aide training and competency evaluation program (NATCEP) for a period of two years. CMS advised Petitioner by letter dated January 19, 2011, that the proposed termination, the DPNA, and the $900 per day CMP were rescinded due to Petitioner's return to substantial compliance. Joint Stipulation of Undisputed Facts (Jt. Stip.).

Petitioner requested a hearing before an administrative law judge (ALJ) on February 14, 2011. The case was assigned to me for hearing and decision on February 24, 2011, and an Acknowledgement and Prehearing Order was issued at my direction. On January 3, 2012, a hearing was convened in Dallas, Texas, and a transcript (Tr.) of the proceedings was prepared. CMS offered CMS exhibits (CMS Ex.) 1 through 19 that were admitted as evidence. Petitioner elected not to offer any documents as evidence, choosing to rely upon the documents offered by CMS. CMS called Surveyor Sharon O'Boyle, RN, as a witness. Petitioner called Jeffrey Merry, RN, Petitioner's Director of Nursing (DON), as a witness. The parties filed post-hearing briefs and post-hearing reply briefs.

II. Discussion

A. Issues

> Whether there is a basis for the imposition of an enforcement remedy; and,
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> 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. Part 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.[2] 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 has been less 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. § 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. Part 483, subpart 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

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[2] 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.

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).

Petitioner was notified in this case that it was ineligible to conduct a NATCEP for two years. Pursuant to sections 1819(b)(5) and 1919(b)(5) of the Act, SNFs and NFs may only use nurse aides who have completed a training and competency evaluation program. Pursuant to sections 1819(f)(2) and 1919(f)(2) of the Act, the Secretary was tasked to develop requirements for approval of NATCEPs and the process for review of those programs. Sections 1819(e) and 1919(e) of the Act impose upon the states the requirement to specify what NATCEPs they will approve that meet the requirements that the Secretary established and a process for reviewing and re-approving those programs using criteria the Secretary set. The Secretary promulgated regulations at 42 C.F.R. Part 483, subpart D. Pursuant to 42 C.F.R. § 483.151(b)(2) and (e)(1), a state may not approve and must withdraw any prior approval of a NATCEP offered by a SNF or NF that has been: (1) subject to an extended or partial extended survey under sections 1819(g)(2)(B)(i) or 1919(g)(2)(B)(i) of the Act; (2) assessed a CMP of not less than $5,000; or (3) subject to termination of its participation agreement, a DPNA, or the appointment of temporary management. Extended and partial extended surveys are triggered by a finding of "substandard quality of care" during a standard or abbreviated standard survey and involve evaluating additional participation requirements. "Substandard quality of care" is identified by the situation where surveyors identify one or more deficiencies related to participation requirements established by 42 C.F.R. § 483.13 (Resident Behavior and Facility Practices), § 483.15 (Quality of Life), or § 483.25 (Quality of Care) that are found to constitute either immediate jeopardy, a pattern of or widespread actual harm that does not amount to immediate jeopardy, or a widespread potential for more than minimal harm that does not amount to immediate jeopardy and there is no actual harm. 42 C.F.R. § 488.301.

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 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, Woodstock Care Ctr. v. Thompson*, 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. *The Residence at Salem Woods*, DAB No. 2052 (2006); *Cal Turner Extended Care*, 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*, *Anesthesiologists Affiliated v. Sullivan*, 941 F.2d 678 (8th Cir. 1991). The standard of proof, or quantum of evidence required, 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. The Board has stated that CMS must come forward with "evidence related to disputed findings that is sufficient (together with any undisputed findings and relevant legal authority) to establish a prima facie case of noncompliance with a regulatory requirement." *Evergreene Nursing Care Ctr.*, DAB No. 2069, at 7 (2007); *Batavia Nursing and Convalescent Ctr.*, DAB No 1904 (2004). "Prima facie" means generally that the evidence is "[s]ufficient to establish a fact or raise a presumption unless disproved or rebutted." *Black's Law Dictionary* 1228 (8th ed. 2004). In *Hillman Rehab. Ctr.*, the Board described the elements of the CMS prima facie case in general terms as follows:

> HCFA [now known as CMS] must identify the legal criteria to which it seeks to hold a provider. Moreover, to the extent that a provider challenges HCFA's findings, HCFA must come forward with evidence of the basis for its determination, including the factual findings on which HCFA is relying and, if HCFA has determined that a condition of participation was not met, HCFA's evaluation that the deficiencies found meet the regulatory standard for a condition-level deficiency.

DAB No. 1611, at 11 (1997), *aff'd, Hillman Rehab. Ctr. v. United States,* No. 98-3789 (GEB), 1999 WL 34813783 (D.N.J. May 13, 1999). Thus, CMS has the initial burden of coming forward with sufficient evidence to show that its decision to impose an enforcement remedy is legally sufficient under the statute and regulations. The Act and regulations give Petitioner notice of the criteria or elements it must meet to comply with the program participation requirements. 5 U.S.C. §§ 551(4), 552(a)(1). To make a prima facie case that its decision was legally sufficient, CMS must: (1) identify the statute, regulation or other legal criteria that Petitioner violated; (2) come forward with evidence upon which it relies for its factual conclusions that are disputed by Petitioner; and (3)

show how the deficiencies it found amount to noncompliance that warrants an enforcement remedy, i.e., that there was a risk for more than minimal harm due to the violation of law. CMS makes a prima facie showing of noncompliance if the credible evidence CMS relies on is sufficient to support a decision in its favor absent an effective rebuttal.

The Board has long held that 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, Batavia Nursing & Convalescent Ctr. v. Thompson*, 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). However, only when CMS makes a prima facie showing of noncompliance, is the facility burdened to show, by a preponderance of the evidence on the record as a whole, that it was in substantial compliance or had an affirmative defense. *Evergreene Nursing Care Ctr.*, DAB No. 2069, at 7. A facility can overcome CMS's prima facie case either by rebutting the evidence upon which that case rests, or by proving facts that affirmatively show substantial compliance. "An effective rebuttal of CMS's prima facie case would mean that at the close of the evidence the facility had shown that the facts on which its case depended (that is, for which it had the burden of proof) were supported by a preponderance of the evidence." *Id.* at 7-8 (citations omitted).

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.[3] I also discuss any evidence that I find 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.

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[3] "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.

1. Petitioner did not violate 42 C.F.R. § 483.13(c)(2), (3), and (4) (Tag F225).[4]

2. Petitioner did not violate 42 C.F.R. § 483.13(c) (Tag F226).

CMS alleges based upon the survey that ended on November 22, 2010, that Petitioner was not in substantial compliance with program participation requirements from November 6 through 22, 2010, based upon violations of 42 C.F.R. §§ 483.13(c) (Tag F226); (c)(2), (3), and (4) (Tag F225); and 483.75 (Tag F490). All the alleged deficiencies in this case relate to an incident involving Resident 15 that occurred on November 6, 2010.

a. Facts

The following facts are supported by the weight of the credible evidence and generally not in dispute. Tr. at 6.

Between 5:15 a.m. and 5:30 a.m. on Saturday, November 6, 2010, CNA Momoh alerted RN Kornegay that Resident 15's breathing was irregular. CMS Ex. 9, at 22. RN Kornegay assessed the resident and found his vital signs acceptable. The two elevated his head and applied oxygen. CMS Ex. 9, at 22, 23; CMS Ex. 10, at 58; CMS Ex. 19, at 2. DON Merry testified that the vital signs recorded in the progress notes were acceptable, though the resident's respirations of 14 at 5:15 a.m. were lower than his normal. Tr. at 146-50. RN Kornegay exited the resident's room. CMS Ex. 9, at 22, 23. CNA Momoh was concerned and did not leave but continued to observe the resident. CMS Ex. 9, at 22. CNA Momoh became concerned that the resident was not breathing and she again called for RN Kornegay. RN Kornegay returned to the resident's room. CMS Ex. 9, at 23. According to the progress notes, RN Kornegay assessed the resident as not breathing and she went to call emergency services. CMS Ex. 10, at 58; CMS Ex.

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[4] The SOD also alleges under Tag F225 that Petitioner also violated 42 C.F.R. § 483.13(c)(1)(ii) and (iii). CMS Ex. 2, at 1-2. Subsection 483.13(c)(1)(ii) provides that a facility may not employ individuals who have either been found guilty of abusing, neglecting, or mistreating residents, or who have been listed on a state nurse aide registry for abuse, neglect, mistreatment of residents, or misappropriation of resident property. Subsection 483.13(c)(1)(iii) requires that a facility report to the state nurse aide registry or licensing authority any knowledge the facility has of court actions against an employee that indicates unfitness for service as a nurse aide or other facility staff. The SOD alleges no facts showing a potential violation of 42 C.F.R. § 483.13(c)(1)(ii) or (iii). I conclude that citation to those subsections of the regulation was clerical error, and I do not discuss those subsections further.

19, at 2; Tr. 138-39. Another nurse and CNA entered Resident 15's room and began cardiopulmonary resuscitation (CPR). CMS Ex. 9, at 22, 23; Tr. 152. The resident was transported to the hospital where he was declared dead. CMS Ex. 10, at 59; CMS Ex. 19, at 155.

There is no dispute that on November 6, 2010, following the incident with Resident 15, CNA Momoh placed a handwritten statement under the doors of the Assistant DON and the DON. The content of the note is set forth here due to its significance to the alleged deficiencies:

> I Isatu Momoh on the of 6th of November at 5:20 a.m. I walked in to [Resident 15's room] to [illegible] my finale round after asking the other aid Jean to help me pull up [Resident 15] up the bed. I noticed he was bearly breathing. I immediately stop ran out to get my nurse Ellen to a check on him she did come in and she saw him and told me that oh honey he will be fine. Sleep apena and he will start breathing again. So she came back in and I think did his blood pressure and said that he had a perfect blood pressure and that to put his oxygen in pull his head up and she ask me for a pillow to slide under his head, so we did all that then she left the room closed the door behind me but I didn't leave the room cos I wanted to make sure he will start breathing again, so I was in there for another 3-4 minutes. Looking at him but he still wasn't breathing, so I came back to tell her but she still continuing told me that he was fine. I noticed he was changing colors, so I called a co-worker to come help see if he was fine. she came but her nurse Niquedra Smith followed her so she rushed in and started C.P.R. and also Cathy joined her while Ellen was sitting at station 1 nurses station on the fone, so it was Niquedra and Cathy that was doing CPR on him but he didn't survived.

CMS Ex. 2, at 8-9; CMS Ex. 9, at 22.

On the morning of November 8, 2010, DON Jeffrey Merry found the note from CNA Momoh under the door of his office. Tr. 111, 136, 155. Although Surveyor O'Boyle testified that Petitioner's staff told her that they contacted DON Merry the day that Resident 15 died (Tr. 52-53), DON Merry testified that he never received a phone call regarding the incident involving Resident 15. Tr. 111-12. I find DON Merry's testimony more credible on this point than the hearsay statements of staff related by Surveyor O'Boyle. RN Kornegay also wrote a statement describing the incident involving Resident 15. CMS Ex. 9, at 23.

There is no dispute that Petitioner had issued a written policy and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property as required by 42 C.F.R. § 483.13(c). Petitioner's policy was titled "Senior Care Policy to Prohibit the Mistreatment, Neglect, and Abuse of Residents and the Misappropriation of Resident Property." CMS Ex. 16, at 41-45. Petitioner had a separate section within the policy titled "Abuse/Neglect Prohibition Policy" that made the DON "responsible for coordination of the abuse prohibition task" and addressed reporting suspected abuse or neglect. CMS Ex. 16, at 45. Petitioner's policy provides that "[a]ll employees are to report suspected abuse or neglect at any time it is identified." CMS Ex. 16, at 45. It provides further that the person must report to their immediate supervisor, if not the charge nurse, who in turn will report to the charge nurse responsible for the particular resident. The charge nurse is then required to either directly contact the DON or the Administrator or immediately report the alleged abuse/neglect to the on-call nurse, who will report to the DON or the Administrator. CMS Ex. 16, at 45. Petitioner's policy provides further that the administrator or his/her designee will report the alleged abuse/neglect to the state agency and/or other appropriate agency, including law enforcement, per regulation. CMS Ex. 16, at 45. Petitioner was not cited for not having the required policy or because the policy was inadequate in some respect and CMS does not make such allegations before me. Tr. 81-82.

Surveyor O'Brien wrote the Statement of Deficiencies (SOD). Tr. 47. There is no dispute that when Surveyor O'Brien advised Petitioner that she believed CNA Momoh alleged neglect in her note, Petitioner immediately notified the state; conducted the required investigation; protected residents during the investigation; reported to the state the result of the investigation that no negligence was found; retained copies of the report; and, thereby, satisfied all requirements of 42 C.F.R. § 483.13(c)(2)-(4). Surveyor O'Brien did not cite Petitioner for neglecting Resident 15 or failure to deliver necessary care and services. Tr. 56, 66, 81-82, 123-24. There is no dispute that, prior to Surveyor O'Brien advising DON Merry and the Administrator that she believed CNA Momoh's note alleged neglect by RN Kornegay, there was no report of an allegation of neglect to the state; there was no investigation as required by 42 C.F.R. § 483.13(c); and there were no measures implemented to protect residents during the investigation. Tr. 66, 137.

b. Analysis

It is alleged under Tag F225 in the SOD that Petitioner violated 42 C.F.R. § 483.13(c)(2)-(4) because Petitioner failed to ensure that an allegation of neglect relating to Resident 15 was reviewed, reported to the State agency, and thoroughly investigated. The SOD alleges further that Petitioner failed to ensure that its residents were protected from the potential of further abuse/neglect. CMS Ex. 2, at 3. The SOD alleges that Petitioner failed to immediately report the allegation of neglect to its Administrator and did not investigate the allegation until four days after it had been made. The SOD alleges that

interviews were not conducted with staff until the surveyor intervened. The SOD states that the alleged perpetrator of the neglect continued to provide nursing care to the residents. CMS Ex. 2, at 3-4.

It is alleged under Tag F226 in the SOD that Petitioner violated 42 C.F.R. § 483.13(c) because Petitioner failed to implement its "written Abuse Policies and Procedures" when an allegation of neglect was made relating to Resident 15. CMS Ex. 2, at 29. The alleged deficiency is based on the same facts that are the bases for the alleged deficiency under Tag F225. CMS Ex. 2, at 29-30.

CMS argues that DON Merry should have recognized that CNA Momoh's note as set forth above was an allegation that RN Kornegay neglected Resident 15. CMS argues Petitioner should have complied with 42 C.F.R. § 483.13(c)(2)-(4) and its policy by reporting, investigating, and protecting its residents. CMS Br. at 7-10. CMS argues that Petitioner's failure to follow its policy prohibiting abuse and neglect in this instance, establishes that Petitioner has failed to implement its policy, a deficiency under Tag F226. CMS Br. at 13-17. Petitioner argues that CNA Momoh's note does not allege that RN Kornegay neglected Resident 15. Petitioner argues that the note did not contain any "trigger words" such as "neglect" nor did it explicitly state that any needed services were denied to Resident 15. Petitioner contends that the DON compared CNA Momoh's statement to the nurse's progress notes and found them to be consistent in their description of the incident involving Resident 15. Petitioner contends that it was not required to conduct any investigation into an allegation of neglect because "none was objectively made." P. Br. at 11; see also P. Br. at 2.

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 facility must "[n]ot use verbal, mental, sexual, or physical abuse, corporal punishment or involuntary seclusion." 42 C.F.R. § 483.13(c)(1)(i). The facility "must ensure that all alleged violations involving mistreatment, neglect, or abuse . . . are reported immediately to the administrator of the facility and to other officials in accordance with State law." 42 C.F.R. § 483.13(c)(2). The facility "must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse" during the investigation. 42 C.F.R. § 483.13(c)(3). The facility must ensure that the results of all investigations are "reported to the administrator or his designated representative and to

other officials in accordance with State law . . . within 5 working days of the incident." 42 C.F.R. § 483.13(c)(4).

"Abuse" is "the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish." 42 C.F.R. § 488.301. The regulatory definition of "neglect" includes two elements: (1) any "failure to provide goods and services" and (2) the goods and service are "necessary to avoid physical harm, mental anguish, or mental illness." 42 C.F.R. § 488.301. The definition of neglect does not include an element of knowledge or notice, and the definition of neglect may be satisfied whether or not staff was aware that the resident was in need of goods and services to avoid physical harm, mental anguish, or mental illness. The definition of neglect does not consider the intent of Petitioner's staff. Neglect may occur even if the failure to deliver necessary goods and services was unintended. Under a strict application of the definition of neglect, neglect is complete the instant that staff fails to deliver care or services necessary to avoid physical harm, mental anguish, or mental illness. The definition of neglect does not specifically permit a period for a facility to assess and intervene to meet the need for goods and services. However, it has been noted by the Board in a number of different SNF enforcement cases that SNFs are generally not treated as being "strictly liable" for violations of statutory and regulatory requirements for participation. *See e.g. Tri-County Extended Care Ctr.*, DAB No. 1936, at 7 (2004), *aff'd*, *Tri-County Extended Care Ctr. v. Leavitt*, No. 04-04199 (6th Cir. Dec. 14, 2005); *Cherrywood Nursing and Living Ctr.*, DAB No. 1845 (2002). A limited number of defenses have been recognized for specific noncompliance, such as unavoidability, unforeseeability, and reasonableness. The Board has recognized, based mostly on interpretation of the regulations, that SNFs are not subject to enforcement remedies for unavoidable negative outcomes, or unforeseen or unpreventable circumstances that produce a risk for or an actual negative outcome. *Tri-County Extended Care Ctr.*, DAB No. 1936, at 7; *Woodstock Care Ctr.*, DAB No. 1726, at 21, 25, 40. Furthermore, not all regulatory or statutory violations, including instances of neglect, are subject to the imposition of enforcement remedies by CMS. Noncompliance occurs and CMS is authorized to impose an enforcement remedy, only if a statutory or regulatory violation poses a risk for more than minimal harm. 42 C.F.R. §§ 488.301, 488.402(b).

The issue to be resolved in this case is whether or not CNA Momoh's note, as set forth above, amounted to an allegation of neglect that triggered the requirements of 42 C.F.R. § 483.13(c) to report, protect, and investigate. The Board has addressed the standard to be applied to determine whether an allegation amounts to an allegation of abuse or neglect that triggers the requirements of 42 C.F.R. § 483.13(c)(2)-(4). The Board has stated that it is not necessary for a person who reports an incident or situation to specifically characterize the incident as being abuse or neglect. Rather, the test to be applied is whether a reasonable person would regard the allegations as involving neglect or abuse or, alternatively, whether one could reasonably conclude that the alleged facts involved neglect or abuse. *Illinois Knights Templar Home*, DAB No. 2369, at 11 (2011)

(*citing Grace Healthcare of Benton*, DAB No. 2189, at 6 (2008), *rev'd on other grounds, Grace Healthcare of Benton v. U.S. Dep't of Health & Human Servs., Ctrs. for Medicare & Medicaid Servs.*, 589 F.3d 926 (8th Cir. 2009), *modified on reh'g*, 603 F.3d 412 (8th Cir. 2010) (the "broad language" of section 483.13(c) "encompasses not only a direct allegation that the resident has been abused, but also an allegation of facts from which one could reasonably conclude that the resident has been abused.")); *Dumas Nursing and Rehab., L.P.*, DAB No. 2347, at 13 (2010) ("allegations that a reasonable person would regard as involving possible neglect"). The Board has not adopted a reasonable surveyor or reasonable administrator/DON test for determining whether an allegation is an allegation of neglect or abuse for purposes of triggering the requirements of 42 C.F.R. § 483.13(c)(2)-(4). Thus, the standard or test to apply to CNA Momoh's note is whether a reasonable person would read the note as alleging neglect or abuse of Resident 15.

Surveyor O'Brien alleged in the SOD that the note CNA Momoh placed under DON Merry's door on November 6, 2010, contained an allegation of neglect that should have triggered reporting an investigation under Petitioner's policy and 42 C.F.R. § 483.13(c)(2)-(4). CMS Ex. 2, at 3. However, Surveyor O'Brien testified that CNA Momoh's note raised questions about RN Kornegay's actions that should have prompted further inquiry by the DON. Tr. 51-64, 97-99. I do not find that Surveyor O'Brien's opinion that CNA Momoh's note contained an allegation of neglect is determinative or controlling. Surveyor O'Brien's testimony reflects that she reviewed the note not as a reasonable person, but rather as a surveyor looking for any evidence of noncompliance.

DON Merry testified that he did not read CNA Momoh's note as alleging neglect. He read CNA Momoh's note as simply reporting what happened. Tr. 111, 115-16, 119-20, 127, 134-35, 158, 162. DON Merry testified that he never spoke with CNA Momoh about her statement until the surveyors were on site at the facility. Tr. 118-20. DON Merry's review of other evidence related to the incident involving Resident 15 also did not cause him to believe that CNA Momoh's note amounted to an allegation of neglect. He testified that he read RN Kornegay's statement, reviewed the progress notes, discussed the matter with RN Kornegay and concluded that the emergency with Resident 15 was handled appropriately. Tr. 112-13, 115-16, 127, 155, 158, 160, 162. I find DON Merry's testimony credible. However, his testimony is also not determinative. The question is whether a reasonable person would read CNA Momoh's note as an allegation of neglect.

I conclude based on my review of CNA Momoh's note from the perspective of a reasonable person that the note does not contain or amount to an allegation that RN Kornegay neglected Resident 15. Rather the note simply reports CNA Momoh's actions related to Resident 15 and his death. The note states that CNA Momoh and another aide pulled Resident 15 up in his bed and CNA Momoh noted that the resident was barely breathing. She requested that RN Kornegay check the resident. RN Kornegay assessed the resident's vital signs and found them acceptable. RN Kornegay advised CNA

Momoh that the resident was experiencing apnea, which is temporary suspension of breathing; oxygen was applied; and his head was elevated. The note states that RN Kornegay then left the room closing the door behind her. CNA Momoh states in her note that she did not leave the room because she wanted to "make sure he will start breathing again." CMS Ex. 9, at 22. CNA Momoh's statement must be understood to be that she wanted to see if his breathing would return to normal as the resident was clearly breathing when RN Kornegay assessed his vital signs and applied oxygen. CNA Momoh's note states that she watched the resident for another three or four minutes and he was still not breathing so she again advised RN Kornegay, who told her Resident 15 would be fine. CNA Momoh's note states that she then noticed that Resident 15 was changing colors but she does not state that she advised RN Kornegay of this fact. Rather, the note states that CNA Momoh called another CNA and requested assistance. The CNA and her nurse came to the room and began CPR while RN Kornegay was on the telephone. CNA Momoh does not allege in her note that RN Kornegay was doing anything inappropriate by being on the telephone. CMS Ex. 9, at 22.

Because CNA Momoh's note does not amount to an allegation that RN Kornegay neglected Resident 15, the procedures of 42 C.F.R. § 483.13(c)(2)-(4) and Petitioner's policy were not triggered.

If a reasonable person also considered RN Kornegay's progress notes (CMS Ex. 10, at 58-59) and the statements DON Merry received from RN Kornegay on November 9, 2010 and Licensed Vocational Nurses (LVN) Smith and Ostrom on November 11, 2010 (CMS Ex. 9, at 23-25), the reasonable person would also conclude that there was no allegation that RN Kornegay neglected Resident 15 as the documents show that she was directing other nurses to the room of Resident 15 to assist with CPR and she was on the telephone notifying emergency services. CMS Ex. 9, at 23-25. CNA Momoh's note, RN Kornegay's progress notes, the statement of RN Kornegay, the statement of LVN Smith, and the statement of LVN Ostrom, are not inconsistent in their description of the incident. Rather, each statement includes additional details based on the different perspectives of the various authors.

I conclude that Petitioner did not violate 42 C.F.R. § 483.13(c)(2)-(4) as there was no allegation of neglect that triggered the requirements of the regulation.

I also conclude that Petitioner did not violate 42 C.F.R. § 483.13(c). There was no allegation of neglect in this case that required Petitioner to apply its policy prohibiting abuse and neglect. Therefore, the example cited by the survey related to Resident 15 is not a sufficient basis to conclude that Petitioner failed to implement its policy.

3. Petitioner did not violate 42 C.F.R. § 483.75 (Tag F490).

The surveyor alleges in the SOD that Petitioner violated 42 C.F.R. § 483.75 because the DON failed to manage facility resources effectively and efficiently and implement the facility's policies and procedures to prevent neglect when an allegation of neglect was made for Resident 15. The surveyor alleges that the DON failed to: report the allegation of neglect to the State agency; immediately and thoroughly investigate the allegation; and ensure that residents were protected from the potential of further neglect by not suspending the alleged perpetrator per the facility's policy and procedures for abuse/neglect. CMS Ex. 2, at 54-55. CMS relies on the same facts that are the bases for the alleged deficiencies under Tags F225 and F226.

Petitioner is obliged to 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 previously recognized that a violation of 42 C.F.R. § 483.75 may be derivative of findings of other deficiencies. *Cedar View Good Samaritan*, DAB No. 1897, at 23-24 (2003); *Asbury Ctr. at Johnson City*, DAB No. 1815, at 11 (2002).

I have concluded that Petitioner did not violate 42 C.F.R. § 483.13(c)(2)-(4) and 42 C.F.R. § 483.13(c). Accordingly, there is no derivative violation of 42 C.F.R. § 483.75 (Tag F490).

4. The declaration of immediate jeopardy was clearly erroneous.

5. Petitioner remained in substantial compliance.

6. There is no basis for the imposition of an enforcement remedy.

I have concluded that Petitioner did not violate 42 C.F.R. §§ 483.13(c), 483.13(c)(2)-(4), or 483.75. Accordingly, I conclude that the declaration that violation of those regulations posed immediate jeopardy was clearly erroneous.

I also conclude that Petitioner remained in substantial compliance with program participation requirements as there were no regulatory violations. Accordingly, I conclude that there is no basis for the imposition of an enforcement remedy.

III. Conclusion

For the foregoing reasons, I conclude that Petitioner did not violate 42 C.F.R. §§ 483.13(c), 483.13(c)(2), (3), and (4), and 483.75; the declaration of immediate jeopardy was clearly erroneous; and there is no basis for the imposition of an enforcement remedy.

/s/

Keith W. Sickendick
Administrative Law Judge