Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Spring Creek Health Care,
(CCN: 18-5005),

Petitioner,

v.

Centers for Medicare & Medicaid Services

Docket No. C-14-1714

Decision No. CR4053

Date: July 21, 2015

DECISION

I find that the preponderance of the evidence establishes that Petitioner, Spring Creek Health Care, complied substantially with Medicare participation requirements. For that reason I impose no remedies against Petitioner.

I. Background

Petitioner is a skilled nursing facility in the State of Kentucky. The Centers for Medicare & Medicaid Services (CMS) determined that Petitioner failed to comply substantially with Medicare participation requirements relating to an allegation of resident abuse. It imposed remedies against Petitioner including civil money penalties totaling $61,850 and loss of a nurse aide training and competency evaluation program. Petitioner requested a hearing to challenge CMS's determination. I held a hearing on April 2, 2015. At that hearing I heard the cross-examination testimony of several witnesses. I received into evidence exhibits from CMS, identified as CMS Ex. 1 – CMS Ex. 20, and exhibits from Petitioner, identified as P. Ex. 1 – P. Ex. 13. The exhibits included the written direct testimony of those witnesses who were cross-examined at the hearing.

II. Issue, Findings of Fact and Conclusions of Law

A. Issue

The issue is whether Petitioner failed to comply substantially with two participation requirements.[1] These requirements are contained in 42 C.F.R. §§ 483.13(c) and 483.75. CMS alleges multiple instances of noncompliance with 42 C.F.R. § 483.13(c). Specifically, it contends that Petitioner failed to: thoroughly and appropriately investigate allegations of resident abuse; take necessary and immediate action to prevent further abuse while investigating allegations of abuse; and failed to implement its own anti-abuse policy. CMS alleges additionally that Petitioner's multiple instances of noncompliance with 42 C.F.R. § 483.13(c) and (c)(3) established a failure of management in contravention of 42 C.F.R. § 483.75.

B. Findings of Fact and Conclusions of Law

The multiple non-compliance allegations all center on an alleged incident of abuse involving a resident identified as Resident # 1. On April 17, 2014, at about 1:45 p.m., this resident complained to a supervisor on Petitioner's staff that unnamed individuals had abused her physically. She asserted that, in the course of being served lunch by these individuals they had hit her hand, pulled her arm, and slapped her face. She alleged that every time she reached for her food these unnamed persons would hit her hand. She averred that they had stuck an empty spoon in her mouth. Resident #1 stated she could not identify the individual(s) because they did not speak. CMS Ex. 10 at 15 – 19; P. Ex. 3. The licensed social worker on Petitioner's staff interviewed Resident # 1 shortly thereafter. During this interview the resident essentially repeated the allegations that she had made previously but added that the perpetrators would stick her hand with something. P. Ex. 7. In subsequent interviews the resident amplified her allegations, contending that the staff had pulled on her ear and hair and that the staff had stuck her hand with something that felt specifically like a needle. CMS Ex. 12 at 4, 6; P. Ex. 8.

As of April 17, 2014, Resident # 1 was 72 years old. She had resided at Petitioner's facility for about two years. Her medical diagnoses included diabetes, an unspecified paranoid disorder, short-term memory loss, and impaired decision making. She was legally blind and was hard of hearing. CMS Ex. 10 at 20 – 37. The resident had a history of threatening members of Petitioner's staff and being verbally aggressive towards the staff. For this reason Petitioner required that there be two staff members in the resident's room at all times when care was being given to the resident. *Id.*

[1] Had I found noncompliance I would have addressed additional issues including whether the noncompliance was so egregious as to comprise immediate jeopardy for Petitioner's residents and whether CMS's remedy determination is reasonable.

Petitioner reacted to the resident's allegations by investigating them immediately. The staff conducted a skin assessment of Resident # 1. There was no evidence that the resident had suffered any physical injury. CMS Ex. 10 at 15 – 19; P. Ex. 3. Petitioner's management identified three certified nursing assistants who had attended to Resident # 1 during the time period covered by the resident's abuse allegations. All three of the assistants were interviewed. Each of them averred that the resident had become volatile and rude towards Petitioner's staff during her lunch period and that she had cursed at one of them for speaking too loudly. P. Exs. 3, 4, 5, 6. All of the assistants denied abusing the resident or witnessing any inappropriate behavior toward Resident #1. *Id.*

A registered nurse and Petitioner's director of nursing met with Resident # 1 beginning at about 2:35 p.m. on April 17, and this meeting lasted about 45 minutes. The resident was unable to identify the perpetrator(s) of the alleged abuse. Nor could she recall whether her alleged abuser(s) were male or female. CMS Ex. 12 at 6; P. Ex. 8. Petitioner also interviewed all other staff that worked in the vicinity of the resident's room. None of them recalled hearing anything unusual coming from the room during the period when the resident had been served lunch. *Id.*; P. Ex. 3. Petitioner's staff also reviewed the care that had been provided to other residents who lived in Resident # 1's unit on April 17 and nothing unusual was observed. P. Ex. 3.

The regulations governing a skilled nursing facility's responsibility to deal with abuse allegations require a facility to develop and to implement written policies and procedures that prohibit mistreatment, neglect and abuse of residents. 42 C.F.R. § 483.13(c). Additionally, these regulations require a facility to assure that all allegations of abuse are thoroughly investigated and that the facility protect its residents from abuse while allegations of abuse are being investigated. 42 C.F.R. § 483.13(c)(3). The regulations are not specific as to what precisely a facility must say in its anti-abuse policy nor do they prescribe the specific measures that a facility must take in order to investigate abuse allegations or to protect its residents from abuse while an investigation is pending. The regulations thus repose considerable discretion in the facility to develop and implement anti-abuse policies. *See Somerset Nursing & Rehab. Facility*, DAB No. 2353, at 23 (2010).

That said, it is implicit in the regulations that whatever a facility does, those actions must be effective in protecting residents against abuse. The regulations do not give facilities carte blanche to develop and implement inadequate policies, to conduct slipshod investigations into abuse allegations, or to take halfhearted measures to protect their residents.

Here, the case turns on the specific actions that Petitioner took in the wake of Resident # 1's allegations. CMS identifies the following alleged failures by Petitioner to comply with regulatory requirements.

- Petitioner did not suspend, pending its investigation into abuse allegations, the three nursing assistants whom it identified as having provided care to Resident # 1. CMS points to Petitioner's anti-abuse policy which, at the time of the alleged incident, stated that supervisory personnel "should ask the person in which the allegation was made against to leave the facility immediately pending an investigation . . ." and argues that Petitioner plainly failed to comply with this policy in not suspending the three nursing assistants while it investigated the resident's complaints. Thus, according to CMS, the three assistants were allowed to continue to provide care and, potentially, to put residents at risk, while Petitioner investigated the allegations of abuse.

- Petitioner failed to protect Resident # 1 against additional abuse because it did not place her under close observation or otherwise ensure that she was insulated from the three alleged miscreants.

- Petitioner did not adequately investigate the allegations of abuse, because its management interviewed only Resident # 1 and the three nursing assistants who allegedly perpetrated the abuse. Other residents were not systematically interviewed nor were they examined to determine whether they had been abused.

Petitioner acknowledges that the three nursing assistants were not suspended pending the outcome of the investigation into Resident # 1's allegations. It argues that it was not obligated to do so because the language of its anti-abuse policy did not, at the time of the incident, require suspension but said only that the facility "should" suspend individuals who are alleged to have committed abuse. Petitioner contends that it made a legitimate discretionary determination that made sense given the facts surrounding Resident # 1's allegations.

It is obvious that Petitioner's decision not to suspend the three nursing assistants was deliberate. That is made apparent by the fact that on April 17, 2014, the same day that Resident # 1 made her allegations of abuse, Petitioner amended its anti-abuse policy to clarify that the facility administration had discretion to suspend or not suspend an employee who is the target of an abuse allegation. CMS Ex. 2 at 8. Clearly, Petitioner implemented that change in order to buttress its decision not to suspend the employees.

I conclude that Petitioner – either by virtue of its policy or pursuant to regulatory requirements – was not obligated to suspend the three nursing assistants while it investigated Resident # 1's allegations. Petitioner's original anti-abuse policy did not mandate suspension. "Should" does not necessarily mean "must." The policy vested discretion in Petitioner's management as to what to do with a staff member who is the target of an abuse allegation. Furthermore, there is no requirement at all in governing regulations that mandates suspension of an employee who is accused of engaging in abuse.

But, even though suspension of the employees wasn't mandatory, there still remains the issue of whether Petitioner should have suspended them pending the outcome of its investigation. Whether Petitioner ought to have done so depends on the credibility of the allegations and the potential risk that keeping the employees on duty posed for Petitioner's residents. There certainly will be instances where suspension of an alleged abuser is not only appropriate, but in fact, necessary. For example, where the abuse has been witnessed, where there is corroborating physical evidence such as bruising, where the allegations of abuse are credible, suspension is imperative.

None of those factors were present here. To begin with, Resident # 1 was not a credible accuser. She suffered from paranoia and impaired memory and judgment. She was hard of hearing, refused to wear a hearing aid, and legally blind. She had a history of behaving aggressively towards Petitioner's staff, so much so that Petitioner's management had ordered that staff members should not interact with the resident without assistance. At the very least, this history suggests that the resident would be an unreliable witness. More than that, it suggests that the resident might make fanciful or malicious allegations about Petitioner's staff.

Resident # 1's complaints were suspect on their face given the resident's medical conditions and her history of hostility towards staff. Even so, the fact that the resident was not a reliable reporter does not give Petitioner the excuse to ignore her complaints. I would not be sympathetic had Petitioner's management simply brushed them off. But, that is not the case here. The staff, including supervisory personnel, interviewed the resident multiple times on April 17, 2014, including an interview by a licensed social worker and one by the director of nursing that lasted for about 45 minutes, attempting to determine the truth of the resident's allegations. Despite the lengthy interviews, the resident never came up with anything more than vague accusations about the people who allegedly perpetrated the abuse which became more fanciful with each interview.[2]

Second, there was no evidence that corroborated anything that the resident alleged. She asserted that she'd been slapped and hit by someone and that unnamed individuals had stuck her hand with a sharp object. However, the resident displayed no signs whatsoever of physical abuse. Her skin was intact and there was no bruising. P. Ex. 3 at 2. She alleged that staff placed an empty spoon in her mouth, yet there was no evidence that staff offered cutlery to the resident based on her long-term preference to eat only with her hands. P. Exs. 3 – 6. Additionally, the contemporaneous interviews indicated that during lunch, Resident #1 was agitated and complained that staff was speaking too quietly and then too loudly. Finally, no staff member – including the three employees who were

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[2] Instead, the social worker found Resident #1's allegations consistent with her history of paranoia. P. Ex. 7 at 4.

alleged to have committed abuse – heard or saw anything remarkable on the day in question. *Id.*

So, what the allegations of abuse boil down to is uncorroborated and not credible assertions made by an unreliable witness. Given that, Petitioner's management did not act unreasonably in deciding not to suspend the three nursing assistants who provided care to Resident # 1. There simply is no evidence that would militate in favor of suspension.

Petitioner's efforts to investigate Resident # 1's allegations support my conclusion that it thoroughly investigated the allegations of abuse consistent with regulatory requirements. As I have discussed, there is no instruction in the regulations as to what is a thorough investigation. What is needed to get to the bottom of abuse allegations will depend on the circumstances: the strength of the allegations, the presence of witnesses, and supporting evidence.

Here, Petitioner's staff was confronted with allegations made by an unreliable witness who, based on her past behavior, was motivated to bring false charges against Petitioner's staff. Nonetheless, these allegations were treated seriously. Multiple members of Petitioner's staff and management interviewed Resident # 1 at length. Management identified the three nursing assistants who provided care to the resident at the time of the alleged incident, and it interviewed all of them. Each of these employees denied witnessing or perpetrating abuse.[3] Eight additional staff members – employees who were in the vicinity of the resident's room when the abuse allegedly occurred – were also interviewed.[4] The resident's skin was assessed for signs of physical injury. None of this investigation turned up any evidence that the resident had been abused.

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[3] CMS suggests that the three employees colluded in producing exculpatory statements. It claims that the employees – contrary to Petitioner's representations that they were interviewed separately and separately prepared and signed statements – actually prepared their statements collectively, citing the hearing testimony of one of the three nursing assistants. *See* Tr. at 83. I have reviewed that portion of the transcript and I find nothing there to support CMS's assertion. The employee testified only that she prepared and signed a statement in the office of Jennifer Fannin, a supervisor at Petitioner's facility. That is entirely consistent with Petitioner's representation of how the statements were obtained and suggests absolutely nothing sinister.

[4] CMS challenges the credibility of Petitioner's assertion that its management spoke with the eight employees, asserting that the discussions were not cited in the report that Petitioner prepared of its investigation. The fact that Petitioner did not specifically refer to those discussions in its report does not mean that they did not occur. I find that the testimony of Ms. Fannin, the employee who was a party to these discussions, is credible. P. Ex. 3.

I find it entirely reasonable that Petitioner concluded that the investigation it conducted was sufficient to establish that Resident # 1's allegations were without foundation. There was simply no evidence produced by the primary sources of information – the resident and the three nursing assistants – to suggest that any abuse had occurred. Indeed, the evidence obtained by the facility suggests otherwise. The resident's complaints amount to an accusation that she was assaulted by one or more nursing assistants. As I have noted, there is no physical evidence to support that claim. Furthermore, none of the staff in the vicinity of the resident's room reported hearing or observing something unusual on the day and time in question. One would have expected that the staff would have heard something emanating from the resident's room if, in fact, she was being assaulted by staff. In light of that, pursuing additional avenues of inquiry strikes me as pointless.

CMS asserts that Petitioner should have conducted a more intensive investigation. It argues that Petitioner should have interviewed all of the residents whose rooms were on the same wing as Resident # 1's room in order to determine whether they'd witnessed any abuse. I do not agree with this assertion. Nothing in the regulations explicitly requires that degree of intensity. Furthermore, in this case none of the primary sources of evidence had produced even a shred of evidence to suggest that the resident had been abused. Digging more deeply, under the circumstances, was unnecessary.

CMS argues also that Petitioner's staff should have done skin assessments immediately of every resident whose room was in proximity to that of Resident # 1 in order to determine whether residents had been serially abused. But, there was no credible evidence of any abuse based on the allegations of Resident # 1, and she showed no signs of physical abuse whatsoever. In light of that, I do not understand why Petitioner would have had to assume that there was serial abuse of other residents. Nonetheless, Petitioner conducted assessments of a number of residents in the same unit, finding no irregularities. P. Ex. 3 at 3, 5.

CMS argues also that Resident # 1 should have been kept under close observation for several days after the alleged abuse – or at least until Petitioner sent its report of its investigation to the Kentucky State Agency – in order to protect her against the possibility of additional abuse. As with other assertions made by CMS about what Petitioner should have done there is no regulatory requirement that Petitioner maintain that degree of surveillance of the resident. Resident # 1 was closely monitored throughout the nursing shift during which she made her abuse allegations. This is sufficient given the absence of any evidence to support them. Moreover, the evidence demonstrates that the resident's bed was in a high traffic area and that Petitioner reported the event to the state ombudsman, adult protective services, and the office of inspector general, within three hours of the resident's complaint. P. Ex. 7 at 5.

At bottom, I find CMS's assertions of what Petitioner ought to have done to be unnecessarily rigid given the reality of what occurred. Petitioner acted reasonably and appropriately in the face of allegations of abuse that turned out to have no evidentiary support. A resident such as Resident # 1 – with her history of paranoia, her deficient short-term memory, and her repeated hostility towards Petitioner's staff – has the capacity to engage in highly disruptive behavior. The resident would have had the ability to hold Petitioner and its staff hostage to her allegations of abuse if Petitioner had to react to what were so evidently baseless allegations with the urgency that CMS demands. That demanded level of response was simply unrealistic in the context of the resident's allegations.[5]

/s/

Steven T. Kessel
Administrative Law Judge

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[5] CMS's allegation that Petitioner was not efficiently managed and that it thus contravened the requirements of 42 C.F.R. § 483.75 derives entirely from the other allegations that CMS made and that I have discussed in this decision. I find no basis for the mismanagement allegation in light of my findings that Petitioner was in compliance with the other regulatory requirements that are at issue here.