Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

In the Case of:	)	
	)	
Singing River Rehabilitation &	)	
Nursing Center (CCN: 25-5174),	)	Date: September 2, 2008
	)	
Petitioner,	)	
	)	
- v. -	)	Docket No. C-07-595
	)	Decision No. CR1838
Centers for Medicare &	)	
Medicaid Services.	)	
	)	

DECISION

I find that Petitioner, Singing River Rehabilitation & Nursing Center complied substantially with a Medicare participation requirement that obligated it to protect its residents against abuse. Consequently, the Centers for Medicare & Medicaid Services (CMS) is not authorized to impose remedies for Petitioner's alleged noncompliance with this requirement.

I find also that Petitioner failed to comply substantially with a Medicare participation requirement mandating that it report to State authorities the results of an investigation into possible abuse of a resident by another resident. As a remedy for that noncompliance I impose a civil money penalty of $50 for each day of a period that began on April 14, 2007 and which ran through May 25, 2007.

I. Background

Petitioner is a skilled nursing facility doing business in Moss Point, Mississippi. It participates in the Medicare program. Its participation in Medicare is governed by sections 1819 and 1866 of the Social Security Act and by implementing regulations at 42 C.F.R. Parts 483 and 488. Its right to a hearing in this case is governed by regulations at 42 C.F.R. Part 498.

Petitioner was surveyed for compliance with Medicare participation requirements on April 26, 2007 (April survey). The surveyors concluded that Petitioner was deficient in two respects. First, they found that Petitioner had failed to protect residents of its facility from abuse by one of them. They found that this alleged deficiency was so egregious as to comprise immediate jeopardy for residents of Petitioner's facility. "Immediate jeopardy" is defined at 42 C.F.R. § 488.301 to mean noncompliance that causes or has the likelihood of causing serious injury, harm, impairment, or death to one or more residents of a facility. Second, they found that Petitioner had failed to comply with a Medicare requirement that obligated it to investigate thoroughly an allegation of abuse. The surveyors concluded that the scope and severity of this second instance of alleged noncompliance was minimal albeit substantial.

CMS accepted the surveyors' findings and determined to impose the following remedies:

- Civil money penalties of $3500 per day for each day of a period that began on April 14, 2007 and which ran through April 25, 2007; and

- Civil money penalties of $50 per day for each day of a period that began on April 26, 2007 and which ran through May 25, 2007.

Petitioner requested a hearing and the case was assigned to me for a hearing and a decision. I issued a pre-hearing order which directed the parties to file pre-hearing exchanges that included pre-hearing briefs addressing all of the issues of the case and all proposed exhibits. The exhibits that I directed the parties to file included the written direct testimony of all proposed witnesses.

The parties filed their exchanges and I scheduled the case for an in-person hearing. Prior to the hearing I held a pre-hearing conference by telephone. Shortly thereafter the parties advised me that neither party wished to cross-examine the other party's witnesses. Based on these representations I canceled the in-person hearing and directed the parties to submit final briefs. Petitioner then moved that I schedule an in-person hearing so that I could receive the *direct* testimony of its proposed witnesses (it did not retract its representation that it did not wish to cross-examine any of CMS's witnesses). I denied Petitioner's motion. Ruling Denying Petitioner's Motion to Present Direct Testimony of its Proposed Witnesses, June 9, 2008. I do not reiterate my ruling here but I incorporate it by reference and I discuss it where relevant below.

CMS then filed a final brief. On July 10, 2008 Petitioner filed a motion in which it moved to strike portions of CMS's final brief. Petitioner asserted that CMS had raised arguments in its final brief which it had not raised previously and which came as a surprise to Petitioner. Petitioner moved that it be permitted to submit additional evidence

to address CMS's allegedly new arguments, or, in the alternative, that it be granted an in-person hearing at which to present this evidence, and that it be allowed to file an additional brief addressing the merits of the allegedly new arguments. CMS opposed the motion. I rule on it at Part II of this decision.

CMS filed 23 proposed exhibits as part of its pre-hearing exchange which it identified as CMS Ex. 1 - CMS Ex. 23. Petitioner filed a total of nine proposed exhibits which it identified as P. Ex. 1 - P. Ex. 9. I receive all of the parties exhibits into the record of this case.

II. Ruling on Petitioner's motion

I agree with Petitioner that CMS raised arguments in its final brief which it had not made in its initial brief. I exclude those arguments from consideration.

My principal purpose in ordering the parties to file pre-hearing briefs, along with their proposed evidence, was to eliminate the element of surprise from this case. I told the parties that:

> A pre-hearing brief must contain any argument that a party intends to make including *any* argument that is not explicitly stated in a notice document such as a hearing request or a survey report. *I may exclude an argument and evidence that relates to such argument if a party fails to address it in its pre-hearing brief.*

Acknowledgment and Initial Pre-Hearing Order, August 2, 2007, at 4, Paragraph 7 (emphasis added).

In its pre-hearing brief CMS addresses both Petitioner's alleged failure to protect its residents against abuse and its alleged failure to thoroughly investigate allegations of abuse. However, and as I explain below, CMS added additional allegations in its final brief that it had never made previously. And, in doing so, it substantially shifted the focus and emphasis of its allegations of noncompliance in a way that Petitioner could not have anticipated. CMS's final arguments about Petitioner's noncompliance are very different from those which it made initially. Those final arguments are not stated explicitly in the April survey report. I conclude that Petitioner was ambushed by those arguments.

The gravamen of CMS's contentions in its pre-hearing brief concerning Petitioner's alleged failure to protect its residents against abuse is that Petitioner failed to protect its residents adequately from one of its residents *after* an incident occurring on April 14,

2007 in which that resident, identified in the April survey report as Resident # 1, allegedly pulled a pocket knife out of his pocket and showed it to another resident, identified as Resident # 2, during the course of an argument between the two residents. CMS stated in its pre-hearing brief that Petitioner failed to comply with Medicare participation requirements:

> by failing to take actions to protect its resident population *following the incident* . . . .

CMS's pre-hearing brief at 3 (emphasis added). All of the allegations of fact and arguments which follow that assertion address what Petitioner's staff allegedly did or failed to do in the wake of the incident. *Id.* at 3-13.

In its pre-hearing brief CMS makes the following specific allegations about Petitioner's alleged noncompliance with participation requirements governing protection of residents against abuse:

> • After the April 14 incident the facility staff failed to document the results of searching Resident # 1's room, and the rooms of other residents, for weapons or dangerous items. CMS's pre-hearing brief at 3.
>
> • During a period after April 14 when facility staff performed routine checks of Resident # 1 at two hour intervals there was no documentation on the resident's flow sheet showing that the resident's behavior was monitored. *Id.*
>
> • There was no documentation of the resident's behavior on April 14, 2007, the day of the incident. *Id.*
>
> • Although the resident was sent to the hospital on April 16, 2007 for a psychiatric examination, his medical record does not show that his care plan was updated to include additional monitoring of the resident or searching his room for weapons. *Id.*
>
> • After the incident Petitioner's staff did not conduct a facility-wide search for inappropriate items until April 26, 2007. *Id.*
>
> • After April 14 Petitioner did not audit all residents for inappropriate behavior, and revise care plans appropriately to include measures to address inappropriate behavior. *Id.* at 3-4.

From these assertions CMS asserts that Petitioner's:

> failure to document results of searching Resident #1's room for weapons or dangerous items and to conduct a thorough search of the entire facility for evidence of any other potential weapons, and the failure to audit all residents for inappropriate behavior, and revise care plans appropriately constituted substantial noncompliance under the regulations and applicable case law. In particular, there was no reason for the staff to delay the search of other [residents'] rooms in the facility.

CMS's pre-hearing brief at 5.

In discussing Petitioner's alleged failure to comply with regulatory requirements governing abuse investigation, CMS claims in its pre-hearing brief that Petitioner was deficient "because it did not ensure that its written policy of abuse prevention was followed, and by failing to thoroughly investigate and report abuse." CMS's pre-hearing brief at 6. It makes the following fact allegations to support this contention:

> • Petitioner had a written policy regarding abuse prevention that allegedly was directly applicable to the incident of April 14. However, the facility staff failed to implement the policy "as it was written." CMS's pre-hearing brief at 6. CMS does not explain in its brief either what the relevant contents of the policy were or how Petitioner failed to implement it.
>
> • Petitioner failed to report the April 14 incident to the Mississippi State Department of Health "as is required by law and by the facility's policy and procedure" for investigating abuse. *Id.*
>
> • There was no documented evidence that residents of Petitioner's facility and staff members that were in the dining room at the time of the April 14 incident were interviewed. *Id.* at 6-7.
>
> • The facility's director of nursing (DON) failed to learn all of the facts relevant to the incident and, in particular, failed to interview eyewitnesses to the incident. *Id.* at 7.

In its final brief, dated July 8, 2008 (CMS entitles this brief its "brief in lieu of hearing"), CMS makes a series of entirely new allegations. In addressing Petitioner's alleged failure to protect its residents against abuse CMS now contends that Resident # 1's behaviors leading up to and culminating with the altercation between Resident # 1 and Resident # 2 on April 14, 2007 constitute acts of abuse which Petitioner's staff should have anticipated

and prevented. Thus, the focus of the final brief shifts from what happened *after* the incident on April 14, 2007 to the *incident itself*, to behavior exhibited by Resident # 1 which predated that incident, and to Petitioner's overall policies for preventing abuse.

In its final brief, CMS focuses on allegedly abusive conduct by Resident # 1 which occurred prior to April 14, 2007 consisting of:

> • Socially inappropriate statements and disruptive behavior such as screaming and yelling at staff and other residents preceding the April 14 incident. CMS's final brief at 4.
>
> • Inappropriate sexual remarks by Resident # 1, made by him prior to April 14, which caused Petitioner to refer the resident to a psychologist in March 2007. *Id.*

According to CMS, this evidence establishes a long history of verbal abuse by the resident, signaling increased aggression. CMS's final brief at 7. In its final brief CMS contends that "Petitioner tolerated [these] repeated instances of verbal abuse . . . but never reported or investigated the abuse according to its abuse policy." *Id.* And, according to CMS, Petitioner was deficient because it allowed the resident's verbally abusive behavior to continue unabated *up to and until* it culminated in the April 14 incident. *Id.*

In addition, CMS contends in its final brief that Petitioner had inadequate written policies and procedures in place to protect residents against abuse. CMS's final brief at 10.[1] It concludes by asserting that:

> Given the facility's failure to take action to prevent verbal abuse and tolerating *repeated* episodes of verbal abuse, the facility cannot argue that it did all within its control to prevent abuse.

Id. (emphasis in original).

CMS also makes new allegations of noncompliance in its final brief concerning Petitioner's alleged failure to investigate thoroughly the April 14, 2007 incident. For the first time, CMS contends that Petitioner left its residents at risk because it failed to adhere

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[1] Here, CMS cites the April survey report as support for this contention. CMS's final brief at 10; *see* CMS Ex. 8, at 8. However, there is nothing on that page of the survey report that addresses the adequacy of Petitioner's abuse protection policies and procedures. Nor have I been able to find anything elsewhere in the report that explicitly recites CMS's allegation.

to its own policies regarding who should conduct abuse investigations. CMS contends that the investigation into the April 14 incident was conducted by Petitioner's director of nursing (DON). According to CMS the DON was not the appropriate individual to conduct such an investigation. CMS's final brief at 8. CMS goes from this assertion to contend in its final brief that Petitioner failed to follow its own abuse investigation protocol. *Id.* at 8-10.

These new arguments by CMS constitute much more than a shift in emphasis. Rather, they constitute a whole new set of allegations of noncompliance, allegations that CMS never made explicitly prior to filing its final brief. And, the April survey report does not make allegations that mirror those which CMS now makes. Although the survey report recites some of the facts that CMS now relies on to make its new allegations of noncompliance (for example, Resident # 1's history of disruptive behavior is discussed in the report) the report contains nothing that a reasonable person could construe as constituting an allegation that Petitioner failed to protect its residents against repeated episodes of verbal abuse which were perpetrated by Resident # 1 prior to April 14, 2007. CMS does not even allude to the survey report in its final brief as providing support for these new allegations with the exception of a single citation to the report that I discuss in n.1 of this decision.

As a general rule CMS is not bound by the language of a survey report in making allegations of noncompliance. It is free to clarify those allegations or even to amend them. But, it is bound by the letter and intent of the pre-hearing process that I establish in a case. CMS should have put the allegations that it now raises in its pre-hearing brief.[2] Had it done so I would have no reason to bar CMS from making them.

I exclude CMS's new arguments and allegations from consideration as a sanction against CMS for failing to make them timely but also because I would deny Petitioner due process if I allowed CMS to make them at this time. CMS ambushed Petitioner by making these new arguments and allegations at the 11th hour and 59th minute of this case.[3]

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[2] Or, if CMS contended that its new arguments and allegations were based on newly discovered evidence, it could have moved to reopen the pre-hearing process. However, CMS has not contended that anything it alleges in its final brief consists of information of which it was unaware previously.

[3] I have considered the possibility of reopening the proceedings and allowing Petitioner to make an evidentiary filing to address CMS's new arguments and allegations. I decline to do that because it is not in the interest of efficient case management. This

Indeed, the requirement in the pre-hearing order that CMS present its entire case in its pre-hearing exchange, and my assumption that CMS had done so, were the principal reasons for my denying Petitioner's motion to present direct testimony of its proposed witnesses in person. Ruling Denying Petitioner's Motion to Present Direct Testimony of its Proposed Witnesses at 2. In its motion Petitioner argued that it needed to present direct testimony in order to respond to unanticipated shifts in position by CMS. I ruled that such shifts were ruled out by my pre-hearing order. I stated that:

> I would bar CMS from presenting any evidence that it had not filed pursuant to my pre-hearing order. Thus, Petitioner's assertion that something unanticipated might happen at the hearing ignores the contents of my pre-hearing order *as well as CMS's evidentiary submission and pre-hearing brief.*

Id. at 2 (emphasis added).

III. Issues, findings of fact, and conclusions of law

A. Issues

The issues in this case are whether:

1. Petitioner failed to comply substantially with Medicare participation requirements;

2. CMS's remedy determinations are reasonable.

B. Findings of fact and conclusions of law

I make findings of fact and conclusions of law (Findings) to support my decision in this case. I set forth each Finding below as a separate heading.

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case is the oldest case on my docket. I see no reason to prolong it as a consequence of CMS's failure to comply with my initial pre-hearing order.

1. Petitioner did not fail to comply substantially with the requirements of 42 C.F.R. §§ 483.13(b) and 483.13(c) governing protection of residents against abuse.

The regulatory sections at issue here provide in relevant part that a resident of a skilled nursing facility has the right to be free from verbal, sexual, physical, and mental abuse. They provide also that a facility must develop and implement procedures that prohibit mistreatment, neglect and abuse of residents and misappropriation of resident property.

The evidence offered by CMS establishes that Resident # 1 had been a long-term resident of Petitioner's facility prior to the April 14, 2007 incident. His illnesses included alcoholic dementia, anxiety, and psychosis. CMS Ex. 8, at 4; CMS Ex. 10, at 54-68. The resident had impaired memory and he was frequently disruptive. In March 2007 Petitioner's staff assessed the resident as displaying socially disruptive and inappropriate behavioral symptoms on a daily basis that were not easy to alter. CMS Ex. 8, at 4. In April the resident began to display signs and symptoms of anxiety and aggressive behavior. CMS Ex. 10, at 8. This behavior included episodes of arguments between the resident and Petitioner's staff. CMS Ex. 17, at 4.

On April 14, Resident # 1 became involved in an altercation with Resident # 2 while the two residents were in the main dining room of Petitioner's facility. According to other residents and certified nursing assistants who witnessed the incident, the two residents were arguing when Resident # 1 pulled a folding knife from his pocket and showed it to Resident # 2. There are conflicting accounts as to whether Resident # 1 actually opened the knife or showed the closed knife to Resident # 2, but he told Resident # 2 that he would cut off Resident # 2's head. CMS Ex. 8, at 9-12; P. Ex. 2, at 1, 8. A nursing assistant then observed Resident # 1 leave the dining room, go into the facility's shower room, and return shortly. The nursing assistant entered the shower room and found a six-inch knife in the bathroom's garbage can under some trash. *Id.* at 12.

Resident # 1's behavior on the 14th of April put Petitioner on notice that the resident jeopardized the safety and well-being of Petitioner's other residents. That knowledge imposed on Petitioner's staff the duty to take every reasonable measure to protect other residents. The evidence offered by CMS establishes that Petitioner implemented a variety of protective measures. The resident was immediately placed on observation at two-hour intervals and he was referred to a Behavior Health Program. On April 14, 2007, the day of the knife-brandishing incident, a physician signed an order directing that the resident's room be searched every shift for prohibited items. CMS Ex. 10, at 76. Resident # 1 was referred for a psychiatric evaluation on April 16, 2007. *Id.* at 73. Petitioner decided also that, given his behavior, Resident # 1 could no longer reside at Petitioner's facility and, on April 20, 2007, it determined to discharge the resident after 30 days. *Id*. at 6.

These measures were clearly appropriate given Resident # 1's behavior and CMS does not deny that. However, according to CMS, Petitioner failed to implement these measures and failed to take other measures which, CMS contends, Petitioner should have taken to protect its residents.

However, the preponderance of the evidence plainly establishes that Petitioner implemented all of the measures that it determined to take. I find that it was unnecessary that Petitioner take the other measures that CMS contends it should have taken to protect its residents.

CMS makes a series of allegations in its pre-hearing brief about the alleged deficient actions that Petitioner and its staff took to protect its residents after the April 14 incident. I address each one of them below and I find that these allegations are either incorrect or do not describe a substantial failure by Petitioner to comply with participation requirements. But, there is an overall weakness in CMS's allegations which is not captured by a point-by-point discussion of them. It is apparent that, from the moment of the incident on April 14, Petitioner and its staff were concerned with protecting the well-being of the residents of the facility. The protective measures that Petitioner took were not only thorough but they reflected accurately the potential for harm (or lack thereof) posed by Resident # 1's continued presence at the facility until his date of discharge. The evidence which establishes what Petitioner and its staff did shows that they were diligent in protecting other residents from even the possibility that Resident # 1 might pose a threat.

Moreover, CMS fails to address in its allegations the conclusion reached by a psychiatrist who evaluated Resident # 1 on April 16, 2007 and found him to be essentially harmless. The psychiatrist who evaluated the resident found that the resident:

> has a normal mental status now. He is alert, appropriate and cooperative. He is not delusional or hallucinating, and very pleasant to interview.

CMS Ex. 10, at 74. The psychiatrist concluded that:

> I feel like he is not a harm to himself or to others . . . .

Id. I am by no means suggesting that Petitioner should have ignored this resident after the April 14 incident. But, the measures that Petitioner took appear to be quite reasonable

in light of the mental status examination made on the 16th of April.[4] More draconian measures which CMS claims that Petitioner should have taken – especially regularly searching all of the residents' rooms in Petitioner's facility for dangerous objects and weapons and assessing other residents as potential threats – are not warranted by the facts of this case.

a. Petitioner adequately documented that it searched for weapons or other dangerous items in Resident # 1's room.

As a principal contention CMS asserts that Petitioner failed to document that it searched Resident # 1's room, and the rooms of other residents, after the April 14 episode. To support this contention CMS cites to the report of the April survey. CMS Ex. 8, at 5.

The allegation has two components. First, CMS contends that Petitioner failed to search Resident # 1's room for weapons. That allegation is simply incorrect. Petitioner's records show that the resident's room was searched once per nursing shift beginning on April 14, 2007 and continuing thereafter. CMS Ex. 10, at 71.

Second, CMS asserts that Petitioner failed to document that it had searched the rooms of other residents for weapons. As to that contention I find that CMS made no prima facie showing that such a facility-wide search was necessary. There is no evidence in this case that residents other than Resident # 1 engaged in aggressive conduct. Petitioner would have had no reason to conclude from the facts relating to Resident # 1 that other residents had concealed weapons in their rooms. Nor has CMS cited any evidence showing that Resident # 1 had a penchant for invading other residents' rooms and concealing objects there. The only credible evidence proves that the incident of April 14 was limited to Resident # 1 and that the knife that he produced on that occasion was a pocket knife that the resident confessed that he had possessed for years. Given that, Petitioner would have had no reason to conduct a facility-wide search in the wake of the incident.

b. Petitioner adequately documented that it monitored Resident # 1's behavior after the April 14, 2007 incident.

CMS contends, without citing any supporting evidence, that there was no documentation on Resident # 1's flow sheet showing that the resident's behavior after the April 14 incident was being monitored by Petitioner's staff. I am not sure what a "flow sheet" is inasmuch as CMS did not define that term in its pre-hearing brief. In any event, the

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[4] Resident # 1 was also seen by his treating physician on the 14th of April and this physician also did not find that the resident posed a threat to himself or to others.

allegation that Petitioner failed to document that it monitored the resident's behavior is incorrect. Petitioner's records show that, after the incident, Petitioner's staff routinely documented the resident's behavior on a behavior monitoring form. CMS Ex. 10, at 84, 86. And, for the first 72 hours after the incident, the staff made written reports about their observations of the resident. CMS Ex. 10, at 85.

Additionally, CMS contends that Petitioner failed to update the resident's care plan to include additional monitoring of his behavior or searching his room for weapons. That is correct. However, in this instance I find the oversight by Petitioner to be insubstantial. This is not a situation in which the staff was unaware of what had been ordered for Resident # 1. Petitioner's records show that the staff was well aware that additional monitoring of the resident had been ordered along with once per shift searches of the resident's room for dangerous items. CMS Ex. 10, at 71, 84-86. There is no evidence in this instance that failure to update the resident's care plan interfered with the staff's carrying out of instructions or even had the potential for such interference.

c. Petitioner's staff documented Resident # 1's behavior on April 14, 2007.

In its pre-hearing brief CMS asserts that Petitioner's staff failed to document Resident # 1's behavior on April 14, 2007. It cites to nothing in the record of this case in support of its allegation. In fact, the record establishes that Petitioner documented the resident's behavior on that date in an exception report, on a behavior monitoring form, and in a document that is entitled "72-hour report." CMS Ex. 10, at 69, 84-86.

d. CMS failed to make a prima facie showing that Petitioner needed to audit other residents for inappropriate behavior or to revise the care plans of other residents to address inappropriate behavior.

In its pre-hearing brief CMS accuses Petitioner of failing to audit other residents after April 14, 2007 to determine whether they were engaging in inappropriate behavior and failing to revise the care plans of other residents as may have been appropriate. CMS cites to nothing to support this allegation. I find it to be perplexing. There is no evidence in this case to show that any member of Petitioner's resident population, aside from Resident # 1, was manifesting behavioral problems. The fact that Resident # 1 acted out did not, logically, suggest that other residents should be audited and their care plans revised.

e. CMS failed to make a prima facie showing that Petitioner failed to implement its abuse protection policy "as it was written."

CMS alleges in its pre-hearing brief that Petitioner failed to implement its abuse protection policy "as it was written." CMS's pre-hearing brief at 6. CMS doesn't explain what it means by this allegation and does not cite to any language in the policy except the following statement:

> The definition of Verbal Abuse in the facility Abuse Policy defines abuse as "saying things to frighten a resident."

Id.; *see* CMS Ex. 21. But this excerpt from the policy is simply a *definition* of what might constitute abuse. CMS has pointed to nothing in the policy itself that Petitioner allegedly contravened. I will not guess at the meaning of CMS's assertion.

2. Petitioner failed to comply with the requirements of 42 C.F.R. § 483.13(c) governing reporting of findings of abuse investigations.

There are two regulatory requirements governing investigation of abuse allegations that are implicated here. First, where there is actual or suspected abuse of a resident:

> The facility must have evidence that all alleged violations are thoroughly investigated, ...

Second:

> 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 the State survey and certification agency) within 5 working days of the incident . . . .

42 C.F.R. §§ 483.13(c)(3), (4).

CMS alleges that Petitioner failed to comply with both of these requirements. I do not agree with CMS's contention that Petitioner failed thoroughly to investigate the incident involving Resident # 1. However, although I find that Petitioner conducted a thorough internal investigation into the incident involving Resident # 1, I conclude that Petitioner should have reported the results of its investigation to appropriate Mississippi authorities.

The requirement that a facility thoroughly investigate an allegation of abuse does not specify precisely what steps a facility must take in order to comply. Certainly, however, the regulation imposes on a facility a duty to investigate a possible incident of abuse sufficiently so that it and its staff are apprised of all of the facts necessary to form a reasoned conclusion as to what happened so as to be able to protect residents from additional abuse.

The evidence in this case establishes that, immediately after the April 14, 2007 incident, Petitioner's DON personally conducted an investigation. P. Ex. 2. That investigation included interviewing and taking statements from Resident # 1, Resident # 2, and the certified nursing assistant who reported the incident. The investigation established that: there had been an altercation between Resident # 1 and Resident # 2; that during the course of the altercation Resident # 1 pulled a pocket knife out of his pocket and showed it to Resident # 2; that he may or may not have opened the knife; that Resident # 1 then walked out of the dining room and into Petitioner's shower room; and that, subsequently, the nursing assistant retrieved the knife from the trash. *Id*. at 1-8.

This investigation certainly was thorough in that it provided Petitioner's management and staff with all the information that they needed to take appropriate actions to protect the residents. Indeed, although CMS contends that the investigation was insufficiently thorough, it has not identified any facts in addition to those that I discuss above which Petitioner should have learned, or would have learned, had the investigation been "more thorough."

The essence of CMS's arguments about the alleged lack of thoroughness of the DON's investigation is that the DON failed to interview *all* of the potential and actual witnesses to the April 14, 2007 incident. CMS contends that there was one other resident (identified as Resident # 5) and a second nursing assistant who witnessed the incident and the DON failed to interview these individuals.

CMS's argument exalts form over substance. I do not find that Petitioner was noncompliant simply because the DON failed to interview every witness to the April 14 incident. The evidence in this case clearly establishes that the DON learned all that she needed to know from the investigation she conducted.

CMS points to nothing that these individuals witnessed that changed materially the picture of what happened on April 14. In effect, these two witnesses' stories simply corroborate that which the DON learned by interviewing the principals to the incident and the nursing assistant who reported it.[5]

Although Petitioner's investigation was thorough I conclude that Petitioner erred by not reporting the investigation's results to appropriate Mississippi authorities. Petitioner argues, essentially, that it was not obligated to report the findings of its investigation because Resident # 1's conduct on the 14th of April did not constitute "abuse" as that term is defined by Mississippi law. Under Mississippi law, abuse reporting requirements are triggered only where there is "willful or nonaccidental infliction of physical pain, injury, or mental anguish on a vulnerable adult . . . ." Miss. Code Section 43-47-5. According to Petitioner, its DON believed reasonably that the conduct of Resident # 1 on April 14, 2007 was not willful, given his demented state, and that, therefore, there was no need for her to report the results of her investigation.

However, "willful" clearly can mean more than intelligently planned harmful conduct. The common and ordinary meaning of "willful" is that an action is deliberate. Even a demented individual, such as Resident # 1, can take deliberate action in the sense that he or she intends his or her acts to have consequences. All of the facts obtained by Petitioner's DON from her investigation of the April 14 incident support a conclusion that Resident # 1's actions on that date were deliberate. He plainly intended to intimidate Resident # 2. Therefore, Petitioner should have reported its investigation's findings to State authorities.

3. Civil money penalties of $50 per day are a reasonable remedy for Petitioner's noncompliance.

Petitioner's noncompliance with the investigation reporting requirement was at the non-immediate jeopardy range of scope and severity. Regulations governing civil money penalty amounts provide that penalties for deficiencies in this range may be from $50 to $3000 per day. 42 C.F.R. § 488.438(a)(1)(ii).

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[5] The one additional piece of information that was obtained from the statements of those individuals that the DON did not interview consisted of the assertion by Resident # 5 that Resident # 1, in producing the knife, threatened Resident # 2 by saying that he would cut him. But, Resident # 5 did not aver that Resident # 1 brandished the knife in a threatening way. And, this reported statement loses considerable significance in light of the fact that, two days after the incident, a psychiatrist found that Resident # 1 posed no threat to himself or to others.

There are regulatory criteria for deciding the daily amount of a civil money penalty that falls within this range. The factors that may be considered include: the seriousness of a facility's noncompliance; its culpability; its compliance history; and its financial condition. 42 C.F.R. §§ 488.438(f)(1) - (4); 488.404 (incorporated by reference into 42 C.F.R. § 488.438(f)(3)).

There is no evidence in this case showing that Petitioner has a poor compliance history. Nor is there evidence pertaining to its financial condition. As to its culpability, the evidence does not support a finding of a high degree of culpability. Petitioner's DON made a judgment error, nothing more, in deciding not to report the results of her investigation to State authorities.

As for the seriousness of Petitioner's noncompliance I find it to be at a very low level, as did the surveyors who conducted the April survey. The potential for harm here lay not in the specific facts pertaining to Petitioner's relationship with Resident # 1 but in the faulty judgment of the DON in misunderstanding the reporting requirements. There was no risk, based on the weight of the evidence, that failure to report the findings of the investigation into the April 14, 2007 incident put Petitioner's residents at risk for harm. The only risk was the possibility that the DON might misjudge her reporting obligation in some future instance of abuse. That risk was, at best, hypothetical, and posed only the most minimal possibility of potential harm for Petitioner's residents.

In light of that, civil money penalties of $50 per day are reasonable. They adequately remedy the extremely low level deficiency that is present here. Petitioner did not offer arguments or evidence concerning the duration of its noncompliance. Therefore, I conclude that the period of noncompliance for which $50 daily penalties is a reasonable remedy runs from April 14 through May 25, 2007, the date on which CMS determined that Petitioner attained compliance with all participation requirements.

/s/
Steven T. Kessel
Administrative Law Judge