Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

The Lodge at Maplecreek
(CCN: 23-5458),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-09-516

Decision No. CR2110

Date: April 12, 2010

DECISION

I sustain the determination of the Centers for Medicare & Medicaid Services (CMS) to impose a civil money penalty of $5,250 against Petitioner, The Lodge at Maplecreek, to remedy Petitioner's noncompliance with Medicare participation requirements on April 6, 2009. Additionally, I incorporate into this decision my ruling of December 10, 2009, in which I granted partial summary disposition in favor of CMS. In that ruling, I authorized CMS to impose: civil money penalties of $200 per day against Petitioner for each day of a period that began on April 7, 2009 and ran through June 15, 2009; and a denial of payment for new admissions for each day of a period, which began on May 3, 2009 and ran through June 15, 2009.

I. Background

Petitioner is a skilled nursing facility in Grand Rapids, Michigan. 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.

Petitioner was surveyed for Medicare compliance on April 7, 2009 (April Survey) and on May 29, 2009 (May Survey). The surveyors found that Petitioner was deficient in several respects. The findings of noncompliance included a finding at the April Survey that Petitioner manifested an immediate jeopardy level failure to comply with the requirements of 42 C.F.R. § 483.13(c). CMS concurred with the surveyors' findings and determined to impose remedies against Petitioner consisting of those that I describe in the opening paragraph of this decision.

Petitioner requested a hearing to challenge CMS's determinations of noncompliance and to impose remedies and the case was assigned to me for a hearing and a decision. CMS filed a pre-hearing exchange that included a brief and proposed exhibits. With its exchange, CMS filed a motion for summary disposition as to all alleged noncompliance. Petitioner then opposed the motion and filed its own pre-hearing exchange.

On December 10, 2009, I issued a ruling granting in part and denying in part CMS's motion for summary disposition. I denied CMS's motion insofar as it requested summary disposition for the finding of immediate jeopardy level noncompliance and the $5,250 civil money penalty. I granted the motion insofar as it requested summary disposition for non-immediate jeopardy level deficiency findings that were made at the April and May surveys. I found that Petitioner had not opposed CMS's motion with respect to these deficiency findings. I also granted CMS's motion as to the remedies that were imposed to address the non-immediate jeopardy level deficiency findings.

I then scheduled an in-person hearing to address the issue of the immediate jeopardy level deficiency finding. However, the parties agreed that the case could be heard and decided based on their written exchanges. Each party submitted a final brief.

CMS filed a total of 55 proposed exhibits that it identified as CMS Ex. 1 – CMS Ex. 55. Petitioner filed a total of 17 proposed exhibits that it identified as P. Ex. 1 – P. Ex. 17. I receive all of the parties' proposed exhibits into evidence.

II. Issues, findings of fact and conclusions of law

A. Issues

The issues in this case are whether:

1. Petitioner failed to comply substantially with the requirements of 42 C.F.R. § 483.13(c);

2. CMS's determination of immediate jeopardy level noncompliance is clearly erroneous; and

3. CMS's determination to impose a civil money penalty of $5,250 against Petitioner is reasonable.

B. Findings of fact and conclusions of law

I make the following findings of fact and conclusions of law.

1. I incorporate my ruling of December 10, 2009 into this decision.

I incorporate into this decision my ruling of December 10, 2009 granting in part CMS's motion for summary disposition. CMS is thus authorized to impose civil money penalties of $200 per day against Petitioner for each day of a period that began on April 7, 2009 and continued through June 15, 2009. Additionally, CMS is authorized to impose against Petitioner a denial of payment for new Medicare admissions for each day of the period that began on May 3, 2009 and ran through June 15, 2009.

2. Petitioner failed to comply substantially with the requirements of 42 C.F.R. § 483.13(c).

The regulation that is at issue here requires a skilled nursing facility to implement policies and procedures to prohibit neglect, mistreatment, and abuse of residents. "Neglect" is defined at 42 C.F.R. § 488.301 to consist of a failure by a facility to provide its residents with goods and services that are necessary to avoid physical harm, mental anguish, or mental illness. Failure by a facility to protect its residents from another resident's aggressive or sexually inappropriate behavior may constitute failure to protect residents against neglect. *Martha & Mary Lutheran Servs.*, DAB No. 2147 (2008); *Barn Hill Care Ctr.*, DAB No. 1848 (2002).

CMS's allegations about Petitioner's alleged noncompliance all relate to a resident who is identified in the April Survey report as Resident # 30. At the time of the April Survey, the resident was an 82-year-old woman who was afflicted with medical conditions that included Alzheimer's disease. CMS Ex. 22 at 1, 6, 11. Her dementia caused her to experience behavioral disturbances. The resident suffered from paranoid delusions. *Id*. at 11, 32.

At times, Resident # 30's dementia caused her to become both physically and sexually aggressive towards other residents of Petitioner's facility and staff. There were occasions when the resident acted out violently.

Some of the resident's inappropriate behavior was linked to attempts by her treating physician to reduce, or eliminate, the resident's consumption of antipsychotic medication. The resident was prescribed the antipsychotic Lexapro in January 2007. CMS Ex. 22 at 11. In September of that year the resident's treating physician reduced the dosage, and,

in December, administration of the medication was discontinued. *Id*. However, in January 2008, the resident began manifesting increased inappropriate sexual comments and gestures, and so, her physician again prescribed Lexapro. *Id*. Another attempt to reduce the dosage of Lexapro began on February 1, 2008. However, in June 2008, the resident again exhibited episodes of inappropriate sexual behavior, this time directed towards her roommate. *Id*. at 31. Resident # 30 was moved to a different room in Petitioner's facility, and she underwent a psychiatric evaluation. *Id*. at 33-34.

In September 2008, it was again recommended that the resident's use of Lexapro be discontinued. CMS Ex. 22 at 11. The medication was discontinued on September 18, 2008. *Id*. at 11, 28.

However, the resident soon began exhibiting aggressive behavior. On November 12, 2008, Resident # 30, evidently suffering from a paranoid delusion, screamed at a member of Petitioner's staff. CMS Ex. 22 at 57. The next day the resident picked up a chair and threatened to do bodily harm to another resident. *Id*. at 16, 57. On November 15, 2008, again evidently suffering from a paranoid delusion, Resident # 30 attacked a staff member, scratching and pushing that individual. *Id*. at 57. Two days later, the resident, suffering from paranoia, yelled at a staff member. *Id*. at 58. The resident's verbally abusive and delusional behavior continued. On November 20, 2008, Resident # 30 struck another resident's family member. *Id*. at 24. The resident again began taking Lexapro on November 20, 2008. *Id*. at 24, 25.

But, on the following day, November 21, 2008, Resident # 30 committed an act of sexual aggression directed against another Resident, Resident # 31. Resident # 30 was discovered by Petitioner's staff standing nude at the end of Resident # 31's bed. CMS Ex. 22 at 6. Resident # 31's blanket had been removed, and her pants had been pulled down. *Id*. at 6, 11. Resident # 31 complained that Resident # 30 had entered Resident # 31's room, undressed, and climbed on top of Resident # 31. Resident # 31 complained that Resident # 30 kissed her and touched her over her incontinence brief and breast area. *Id*. Resident # 31 complained to Petitioner's social worker that she had suffered psychological distress as a result of the event. *Id*. at 11, 12.

Seroquel, another antipsychotic medication, was ordered on November 23, 2008, to address Resident # 30's paranoia, delusions, and inappropriate and aggressive sexual behavior. *See* CMS Ex. 22 at 11. Notwithstanding, the resident continued to manifest behavior that included the following incidents:

- On January 7, 2009, she kissed another resident;
- On January 9, 2009, she was found in another resident's room;
- On January 23, 2009, she was found rubbing another resident's stomach;

- On January 28, 2009, she was observed holding on to another resident's arm;
- On January 29, 2009, she approached a male staff member in a sexually inappropriate way;
- On January 31, 2009, she wandered into another resident's room;
- On February 5, 2009, she struck a nurse three times;
- On February 11, 2009, she threw objects at a nurse;
- On February 15, 2009, she touched another resident and became combative with a nurse;
- On February 16, 2009, she made inappropriate comments of a sexual nature to a staff member;
- On February 19, 2009, she had a violent outburst;
- On February 20, 2009, she attempted to choke a staff member;
- On February 23, 2009, she was combative towards Petitioner's staff; and
- On March 11, 2009, she wandered into another resident's room.

CMS Ex. 22 at 35, 41-44, 46. The dosage of Resident # 30's Lexapro was increased on March 13, 2009. However, the resident remained combative. On March 30, 2009, the resident struck another resident, Resident # 34. *Id*. at 59.

CMS argues that the interventions implemented by Petitioner's staff – principally consisting of psychiatric consultations and adjustments of Resident # 30's antipsychotic medication – provided inadequate protection for the other residents of Petitioner's facility. It asserts that the resident's combative and sexually aggressive behavior, beginning with the series of incidents in November 2008 that I describe above, should have motivated Petitioner's staff to provide continuous supervision of Resident # 30 to ensure the resident's safety and to protect other residents from her.

I find CMS's arguments to be persuasive. The behavior manifested by Resident # 30 beginning in November 2008 was not only inappropriate, but it posed both physical and psychological threats to other residents in Petitioner's facility. It should have been obvious to Petitioner's staff beginning with the November incidents that Resident # 30's dementia caused her to be capable of causing harm to others. Moreover, her behavior

was unpredictable, ranging from violent to sexually aggressive. The fact that this behavior continued after November 2008, despite increases or resumed doses of antipsychotic medication, should have put Petitioner's staff on notice that much closer supervision of the resident was necessary as a protective measure.

I have considered Petitioner's several defenses, and I find them to be unpersuasive. First, Petitioner argues that many of the incidents cited by CMS were actually benign and cannot be considered fairly to be examples of aggressive or inappropriate sexual behavior by Resident # 30. It asserts that much of the resident's behavior actually was "normal behavior" manifested by a demented resident. Petitioner's Final Brief at 4.

I agree with Petitioner that some of the behavior manifested by Resident # 30 appears to be rather benign when viewed outside of the pattern of behavior that she demonstrated during the period from November 2008 until the April Survey. Holding on to another resident's arm or wandering into other residents' rooms, for example, may at least arguably be relatively benign episodes and might well be viewed as essentially harmless when exhibited by an individual who has shown no propensity to commit violent or sexually aggressive acts. But, that was not the case with Resident # 30. In her case, these relatively benign episodes are embedded in a series of episodes that are far from benign.

In the case of Resident # 30, the only reasonable interpretation that the staff could have made from her behavior, including the several instances of relatively benign but inappropriate acts, is that this was a dangerously unstable individual who could engage in injurious conduct at any moment. The evidence offered by CMS, and not rebutted by Petitioner, shows that the resident frequently was combative and was at times physically violent. The resident continued to perpetrate violence throughout the period between November 2008 and the April Survey. Her violent outbursts were not directed solely towards members of Petitioner's staff. The evidence shows that, as late as March 30, 2009, Resident # 30 struck another resident. CMS Ex. 22 at 59.

Petitioner also attempts to characterize CMS's case as essentially being an argument that Petitioner's staff should have watched Resident # 30 more closely on those occasions when the administration of antipsychotic medications to the resident was reduced or eliminated. Petitioner's Final Brief at 5-6. Petitioner then argues that, in fact, the behaviors exhibited by the resident on those occasions were "benign verbally inappropriate comments and gestures, none of which would have suggested that Petitioner should monitor for sexual assault." *Id*. at 6.

However, and contrary to Petitioner's assertions, the behavior manifested by Resident # 30 on those occasions when her antipsychotic medication dosage was reduced or eliminated was not limited to benign verbally inappropriate comments and gestures. Resident # 30 perpetrated a sexual assault against Resident # 31 in November 2008,

immediately after one of the occasions when elimination of antipsychotic medication was attempted. On other occasions, the resident became physically combative, paranoid, and verbally abusive.

Furthermore, Petitioner mischaracterizes CMS's argument. The issue here is not whether Petitioner's staff should have supervised Resident # 30 more closely on those occasions when the resident's antipsychotic medication was administered in reduced doses, or eliminated altogether. Rather, it is CMS's contention, amply supported by the evidence, that Resident # 30 was so untrustworthy and her behavior so mercurial that she needed to be watched closely throughout her stay at Petitioner's facility, beginning with the incidents that occurred in November 2008. The evidence establishes numerous occasions of volatile behavior by Resident # 30, some of which included violence. These incidents were only in some respects linked to efforts to reduce, or eliminate, the resident's use of antipsychotic medications. The incidents that occurred in January and February, 2009, for example, appear to have nothing to do with an attempted dosage reduction during that period. The evidence shows, and I find, that this resident was capable of violence even when she was taking increased doses of antipsychotics.

Petitioner additionally characterizes CMS's argument as being that Petitioner should have done more to protect its residents from possible sexually aggressive behavior by Resident # 30. Petitioner's Final Brief at 11. That is also a mischaracterization of CMS's case against Petitioner and of the problems that Resident # 30 posed for other residents. It is true that Resident # 30 had on occasion manifested sexually aggressive behavior towards other residents. But, Resident # 30 also engaged in violent acts that were unrelated to sexual conduct. Petitioner had a duty to protect its residents not only against possibly sexually abusive behavior by Resident # 30, but also against Resident # 30's violent outbursts.

Petitioner also argues that the violent and sexually aggressive behavior that Resident # 30 manifested in November 2008 was likely due to the fact that the resident was suffering from a urinary tract infection at the time and taking an antibiotic. Petitioner's Final Brief at 8. Petitioner has not offered persuasive evidence showing why, or how, a urinary tract infection or the administration of antibiotics would have made the resident become violent and sexually aggressive. But, in fact, the precise cause of the resident's behavior is not relevant. What is relevant is that the resident became violent and sexually aggressive. That triggered an obligation by Petitioner to protect other residents from Resident # 30 and also to protect Resident # 30 from her own violent behavior.

Petitioner argues that it responded appropriately to the November incidents by: giving Resident # 30 psychiatric evaluations on November 20 and November 22, 2008; placing the resident on Seroquel in addition to her other antipsychotic medication, Lexapro; and moving the resident to a secure dementia unit where the resident was placed in a private

room. Petitioner's Final Brief at 9. The problem, however, is that these measures – as appropriate as they may have been – were quickly proven by subsequent events to be inadequate. Resident # 30's violent and inappropriate behavior continued after November 2008. She perpetrated, as I have discussed, a string of violent acts.

Petitioner argues also that the aggressive acts manifested by Resident # 30 after November 2008 were directed at Petitioner's staff and not at other residents. Petitioner's Final Brief at 10. From this it argues that, while staff may have been victims of the resident's violent outbursts, other residents were not in danger. I find this argument to be unpersuasive. Resident # 30's violence may have been directed mainly against Petitioner's staff. But, there was more than one instance in which the resident perpetrated violence against other residents, or a family member of another resident. The overall pattern of the resident's violent behavior leads me to infer that the resident was capable of violence and not just violence directed at a specific and narrow class of individuals.

Finally, Petitioner argues that, on March 30, 2009, when Resident # 30 struck Resident # 34, Resident # 30 was being supervised directly by a staff member. Petitioner's Final Brief at 11. The inference Petitioner evidently would have me draw from this assertion is that even direct supervision of Resident # 30 would have been inadequate to protect other residents.

I am not persuaded by this argument. There may be instances where even direct and one-on-one supervision of a resident by staff will not be sufficient to protect other residents from that resident's violent acts. And, it may be that there are times when the staff is doing all that one could reasonably expect them to do, and violence occurs notwithstanding. But, the fact is that, in this case, Petitioner's staff did not supply Resident # 30 with continuous supervision. Many of the incidents that I have documented occurred at times when the resident was not being closely supervised by Petitioner's staff. Thus, one cannot say that more supervision would have been futile.

3. CMS's determination of immediate jeopardy level noncompliance is not clearly erroneous.

"Immediate jeopardy" is noncompliance that is so egregious as to cause, or to be likely to cause, serious injury, harm, impairment, or death to one or more residents of a skilled nursing facility. 42 C.F.R. § 488.301. The evidence that CMS offered in this case strongly supports its determination of immediate jeopardy level noncompliance. Petitioner has offered no affirmative evidence to show that CMS's determination is clearly erroneous.

Resident # 30 could at times be dangerously violent. She struck other individuals, threw objects at them, threatened to strike a resident with a chair, and, on one occasion, attempted to choke a staff member. She suffered from paranoid delusions that clearly provoked her into becoming enraged at times. Her sexual assault caused one resident to assert that she had experienced psychological trauma as a result. Some of the individuals who were the object of Resident # 30's rage and outbursts were individuals who were themselves frail and extremely vulnerable. In a situation such as that which prevailed at Petitioner's facility, the likelihood of – at a minimum – serious harm resulting from Resident # 30's conduct was very high.

That likelihood was not diminished by the way in which Petitioner dealt with Resident # 30. As I discuss above, at Finding 2, the failure to supervise Resident # 30 created opportunities for the resident to do violence to others.

4. CMS's civil money penalty determination is reasonable.

I find that a civil money penalty of $5,250 for one day of immediate jeopardy is a reasonable remedy. It is justified by the seriousness of Petitioner's noncompliance. Moreover, it constitutes just a tiny fraction of the penalty amount that CMS could have imposed, given the duration of Petitioner's noncompliance.

Immediate jeopardy level civil money penalties, such as the one under consideration here, must fall within a range of $3,050 to $10,000 per day. 42 C.F.R. § 488.438(a)(1)(i). The criteria for deciding where within that range a penalty should fall are established by 42 C.F.R. §§ 488.438(f)(1) – (4) and 488.404 (incorporated by reference into 42 C.F.R. § 488.438(f)(3)). They may include the seriousness of a facility's noncompliance, its culpability, its compliance history, and its financial condition.

Here, the civil money penalty that CMS determined to impose falls more or less at the middle of the range of penalties that may be imposed for immediate jeopardy level noncompliance. It is, however, a very small penalty when measured against the duration of Petitioner's noncompliance. The persuasive evidence offered by CMS establishes that Petitioner's immediate jeopardy level noncompliance began in November 2008 when Resident # 30 engaged in a series of violent outbursts and sexually assaulted another resident, Resident # 31. CMS could have – but elected not to – imposed a civil money penalty of at least $3,050 per day for each day of the period beginning in November 2008 and continuing through the April Survey. That penalty would have dwarfed the amount that CMS determined to impose here, a penalty of $5,250 for a single day of immediate jeopardy level noncompliance.

The penalty of $5,250 is more than justified by the seriousness of Petitioner's noncompliance. As I have described, Resident # 30's behavior jeopardized the health and safety of other residents of Petitioner's facility and created the likelihood that, inevitably, someone would be seriously injured at a minimum.

Petitioner has offered no evidence to challenge the penalty amount and offered no argument to show that the penalty is unreasonable. Therefore, I sustain it.

/s/
Steven T. Kessel
Administrative Law Judge