**Department of Health and Human Services**

**DEPARTMENTAL APPEALS BOARD**

**Civil Remedies Division**

Rensselaer Care Center,
(CCN: 15-5287),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-12-423

Decision No. CR2784

Date: May 14, 2013

# DECISION

In this case, I consider whether a long-term care facility must timely investigate a demented resident's allegations of sexual abuse.

Petitioner, Rensselaer Care Center, is a long-term care facility, located in Rensselaer, Indiana, that participates in the Medicare program. Based on a complaint investigation survey, completed November 29, 2011, the Centers for Medicare and Medicaid Services (CMS) determined that the facility was not in substantial compliance with Medicare program requirements and that its deficiencies posed immediate jeopardy to resident health and safety. CMS imposed civil money penalties of $4,900 per day for six days of immediate jeopardy and $500 per day for 42 days of substantial noncompliance that was not immediate jeopardy. Petitioner here appeals the immediate jeopardy determination only.

For the reasons set forth below, I find that, from November 17 through 22, 2011, the facility was not in substantial compliance with 42 C.F.R. § 483.13(c) (aimed at prohibiting neglect and abuse), and that its substantial noncompliance posed immediate jeopardy to resident health and safety. The penalty imposed for that period is reasonable.

## I. Background

The Social Security Act (Act) sets forth requirements for nursing facility participation in the Medicare program, and authorizes the Secretary of Health and Human Services to promulgate regulations implementing those statutory provisions. Act §1819. The Secretary's regulations are found at 42 C.F.R. Part 483. To participate in the Medicare program, a nursing facility must maintain substantial compliance with program requirements. To be in substantial compliance, a facility's deficiencies may pose no greater risk to resident health and safety than "the potential for causing minimal harm." 42 C.F.R. § 488.301.

The Secretary contracts with state survey agencies to conduct periodic surveys to determine whether skilled nursing facilities are in substantial compliance. Act § 1864(a); 42 C.F.R. § 488.20. The regulations require that each facility be surveyed once every twelve months, and more often, if necessary, to ensure that identified deficiencies are corrected. Act § 1819(g)(2)(A); 42 C.F.R. §§ 488.20(a); 488.308. The state agency must also investigate all complaints. Act § 1819(g)(4).

In this case, surveyors from the Indiana State Department of Health (state agency) completed a complaint investigation/survey on November 29, 2011. Based on their findings, CMS determined that the facility was not in substantial compliance with multiple program requirements, specifically:

- 42 C.F.R. § 483.13(c) (Tag F224 –prohibit neglect), at scope and severity level G (isolated instance of actual harm that is not immediate jeopardy);

- 42 C.F.R. § 483.13(c) (Tags F225 and F226 – investigate/report allegations/develop/implement policies to prohibit neglect and abuse) at scope and severity level K (pattern of noncompliance that poses immediate jeopardy to resident health and safety);

- 42 C.F.R. § 483.15(a) (Tag F241 – quality of life – dignity) at scope and severity level G;

- 42 C.F.R. § 483.25(a)(3) (Tag F312 – quality of care: activities of daily living) at scope and severity level G;

- 42 C.F.R. § 483.25(h) (Tag F323 – quality of care: accident prevention) at scope and severity level G;

- 42 C.F.R. § 483.25(k) (Tag F328 – quality of care: special needs) at scope and severity level D (isolated instance of noncompliance that causes no actual harm with the potential for more than minimal harm);

- 42 C.F.R. § 483.30(a) (Tag F353 – nursing services/sufficient staff) at scope and severity level G;

- 42 C.F.R. § 483.35(d)(1)-(2) (Tag F364 – dietary services/food) at scope and severity level E (pattern of noncompliance that causes no actual harm with the potential for more than minimal harm).

CMS Ex. 2.

Surveyors returned to the facility and completed a follow-up survey on January 4, 2012. Following that survey, CMS determined that the facility returned to substantial compliance effective January 4. CMS Ex. 1 at 2.

CMS imposed against the facility CMPs of $4,900 per day for six days of immediate jeopardy (November 17-22, 2011) and $500 per day for 42 days of substantial noncompliance that was not immediate jeopardy (November 23, 2011 – January 3, 2012), for a total penalty of $50,400 ($29,400 + $21,000 = $50,400). CMS Ex. 1 at 2.

Petitioner timely requested review, but limits its appeal to the immediate jeopardy finding. P. Br. at 1-2. The facility therefore was not in substantial compliance with Medicare program requirements from November 17, 2011 through January 3, 2012 and is subject to a penalty of at least $500 per day for that period.

The parties agree that no material facts are in dispute and that the case can be decided based on the written record. Order Summarizing Prehearing Conference at 2 (August 31, 2012).

The parties have filed briefs (CMS Br.; P. Br.) and CMS filed a reply brief (CMS Reply). Petitioner submitted six proposed exhibits (P. Exs. 1-6). CMS initially submitted 24 exhibits (CMS Exs. 1-24) but subsequently withdrew CMS Exs. 13-16, 22, and 24. CMS Reply at 4. I therefore admit into evidence P. Exs. 1-6 and CMS Exs. 1- 12, 17-21, and 23.

## II. Issues

The issues before me are:

1. From November 17-22, 2011, did the facility's deficiencies cited under 42 C.F.R. § 483.13(c) pose immediate jeopardy to resident health and safety; and

2. Is the penalty imposed for that period ($4,900 per day) reasonable.

## III. Discussion

### *A. CMS's determination that, from November 17 through 22, 2011, the facility's deficiencies under 42 C.F.R. § 483.13(c) posed immediate jeopardy to resident health and safety is not clearly erroneous.*[1]

Immediate jeopardy. Immediate jeopardy exists if a facility's noncompliance has caused or is likely to cause "serious injury, harm, impairment, or death to a resident." 42 C.F.R. § 488.301. CMS's determination as to the level of a facility's noncompliance (which would include an immediate jeopardy finding) must be upheld unless it is "clearly erroneous." 42 C.F.R. § 498.60(c). The Departmental Appeals Board has observed repeatedly that the "clearly erroneous" standard imposes on facilities a "heavy burden" to show no immediate jeopardy, and has sustained determinations of immediate jeopardy where CMS presented evidence "from which '[o]ne could reasonably conclude' that immediate jeopardy exists." *Barbourville Nursing Home*, DAB No. 1931 at 27-28 (2004), *citing Koester Pavilion*, DAB No. 1750 (2000); *Daughters of Miriam Center*, DAB No. 2067 at 7, 9 (2007).

Program requirements. Facilities must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents. 42 C.F.R. § 483.13(c). Among other requirements, the facility must ensure that all alleged violations are reported immediately to the facility administrator and appropriate state officials. The facility must have evidence that all alleged violations are thoroughly investigated, and it must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator (or designated representative) and to the appropriate state officials within 5 working days of the incident. If the violation is verified, the facility must take appropriate action. 42 C.F.R. § 483.13(c)(2), (3), and (4).

The drafters of the regulation deliberately rejected the suggestion that the regulations require evidence of a negative outcome to support the finding of neglect.

> We do not accept this comment because neglect may be determined even if no apparent negative outcome has occurred. The *potential* for negative outcome must be considered.

[1] My findings of fact and conclusions of law are set forth, in bold and italics, as captions in the discussion section of this decision.

59 Fed. Reg. 56,116, 56,130 (Nov. 10, 1994)(emphasis added).

Facility policies. Here, consistent with the regulation, the facility had in place written policies and procedures for reporting and investigating allegations of abuse. The policy directs all personnel to report immediately to his/her immediate supervisor and/or charge nurse "any alleged, actual or suspected" incident of resident abuse or neglect. CMS Ex. 17 at 1, 3.

The supervisor or charge nurse is then directed to illicit specific facts, such as resident name; the date, time, and location of the incident(s); names of witnesses and others involved; and other pertinent information. CMS Ex. 17 at 1. The charge nurse must assess the resident immediately and document her findings. She must complete and sign an incident report and notify the resident's doctor and responsible party. The incident must be reported immediately to the facility administrator or his designee. The administrator, director of nursing (DON), or a designee is then required to investigate the incident and prepare a written summary of the findings no later than five working days after the reported occurrence. Finally, the administrator must designate a resident advocate to support the resident and coordinate all necessary interventions. CMS Ex. 17 at 2.

Residents B and C. Resident C was an 83-year-old woman suffering from dementia, psychosis, depression, and other impairments. CMS Ex. 11 at 1, 5, 53-55. Her roommate, Resident B, was a 90-year-old woman, also suffering from dementia. CMS Ex. 10 at 1, 61. The facility recognized that, because of her cognitive impairments, Resident B was at risk for abuse, neglect, and exploitation. CMS Ex. 10 at 9. Both residents resided in the facility's "special care unit," where the facility housed residents suffering from dementia who required a secure setting. P. Ex. 5 at 1 (Hershman Decl. ¶ 4).

On November 17, 2011, Resident B suddenly lost consciousness for a few seconds, and facility staff sent her to the hospital. CMS Ex. 10 at 5-8. In the emergency room, she told a nurse that "a large, tall gentleman . . . sneaked into my room at night and fondled my neighbor." Emergency Room staff called the facility and reported the statement to Licensed Practical Nurse (LPN) Missy Lockhard, who is identified as LPN #2 in survey documents. CMS Ex. 7 at 4; CMS Ex.10 at 7.

Surveyor notes dated November 21, 2011, indicate that, during the survey, LPN Lockhard confirmed that she had received the ER nurse's report on November 17. She said that she reported the allegation to LPN Lori Simmons, the unit manager, but prepared no written statement. CMS Ex. 8 at 19; CMS Ex. 9 at 17. She subsequently wrote a statement, which is dated November 21, in which she says that, on November 17, the ER nurse reported that Resident B said: "a tall dark man comes into [my] room [and] goes over to [my] roommate [and] touches her . . . ." The ER nurse said that Resident B

made a hand gesture indicating the peri area. The ER nurse reported the remarks to the physician on call, and LPN Lockhard reported them to the residents' unit manager, according to the written statement. CMS Ex. 18.

LPN Lockhard also told the survey team that "a lot of people" wander around the unit, and she identified a tall male resident who wanders into the residents' rooms. CMS Ex. 9 at 17.

LPN Simmons prepared her written statement on November 21. She confirmed that Resident B told emergency room staff that a "tall dark man" came into her room at night and "touched her roommate's private parts." LPN Simmons noted that Resident B is continent and takes herself to the bathroom with assistance, but that her roommate is "check [and] change [and] staff changes her [and] provides pericare." LPN Simmons also wrote that she reported the allegation to the Assistant Director of Nurses and to Social Services. CMS Ex. 20.

In another statement, also written on November 21, 2011, Social Services Director, Jessica Bach, wrote that, on November 17, the special care unit manager notified her "that charge nurse Missy Lockard (sic) was informed by nurse at [Jasper County Hospital] that [Resident B] reported a tall dark man had entered [the resident's] room at night. [Executive Director] notified immediately on 11/17/11."[2] In an obviously different ink (suggesting that she may have written it at a different time), she added "[O]n 11/21/11 writer [and Executive Director] notified by unit manager that [Resident B] alleged her roommate was touched in peri-area. I was not aware of peri-area allegation until 11/21/11." CMS Ex. 19.

The facility's administrator, Jason Eastlund, initially told the surveyors that, on November 17, staff told him that Resident B said someone comes in the middle of the night and checks private parts, but he did not then consider this an allegation of abuse, because staff checked residents for incontinence at night. CMS Ex. 8 at 19; *see* CMS Ex. 2 at 9. About 40 minutes later, however, he told the surveyors that, until the day of the survey, no one said anything to him about the peri area and that he thought that Resident B was referring to a man she saw at the hospital. CMS Ex. 8 at 11; CMS Ex. 9 at 14; *see* CMS Ex. 2 at 9. He admitted that the facility had not investigated the allegation of abuse. CMS Ex. 9 at 14. When he finally completed an incident report, he wrote that "originally it was not reported to writer that any touching occurred, only that someone came into the room at night time." P. Ex. 3 at 1.

According to Surveyor Regina Sanders, the facility did not complete any investigation until November 23, 2011. CMS Ex. 3 at 2 (Sanders Decl. ¶ 10). Petitioner submits an undated document labeled "Facility Incident Reporting Form." P. Ex. 3. The statements

[2] The facility administrator apparently held the title of executive director.

attached to it, which appear to comprise the facility's investigation, are dated November 21, 22, and 23; they confirm that the investigation could not have been completed prior to November 23. *Id.* In any event, Petitioner does not claim to have completed its investigation any earlier.

Indeed, the Petitioner concedes that the allegation of abuse "traveled through several staff members before it reached the facility Administrator . . . a couple of days later . . . ." By then, "there was some confusion as to the nature of the comment made by Resident #B." P. Br. at 3. By the facility's own admission, staff did not begin to investigate the allegation until November 21, 2011. At that time, the facility apparently suspended the two males working on the unit, a nurse aide and an LPN. P. Ex. 3 at 4, 7.

The facility thus unquestionably violated the regulation. Executive Director Eastlund has not been entirely consistent as to when he learned that Resident B alleged abuse. Either staff accurately reported the allegation of abuse to him on November 17, and he took no action, or staff misreported the allegation, and he took no action. Under either circumstance, no investigation ensued until the time of the survey; the facility did not complete an investigation within five days; and no efforts were made to protect the residents until at least four days after the allegation had been made. All of this establishes that the "system" the facility had in place for reporting and investigating allegations of abuse did not effectively protect its residents.

Petitioner nevertheless defends its inaction by arguing that no evidence establishes that sexual abuse occurred and no resident was at risk for sexual abuse during the period of the delay (November 17-22), because no male employees happened to be working on the unit during that time. P. Ex. 4; P. Ex. 5 at 2 (Hershman Decl. ¶¶ 7, 8); P. Br. at 4. In Petitioner's view, a facility is deficient only if the allegations of abuse are ultimately substantiated. The Departmental Appeals Board has consistently rejected this argument. *Illinois Knights Templar Home*, DAB No. 2369 (2011); *Beverly Health Care Lumberton*, DAB No. 2156 (2008); *aff'd*, *Beverly Health Care Lumberton v. Leavitt*, 338 Fed. App. 307, 315 (4th Cir. 2009); *Cedar View Good Samaritan*, DAB No. 1897 (2003).

In *Beverly*, for example, the facility argued that its late reporting of an incident of alleged abuse did not violate the regulation because the allegation was ultimately unsubstantiated. In upholding a determination of immediate jeopardy, the Board found that the allegation of abuse must be reported immediately and investigated thoroughly "without prejudging its merits."

> If the system does not function properly in response to an allegation that is subsequently found not to constitute abuse . . . then it is reasonable to conclude . . . that the system is broken and residents who may experience serious abuse cannot rely on that system to protect them.

*Beverly Health Care Lumberton*, DAB No. 2156 at 15.

In affirming the Board's decision, the Court of Appeals for the Fourth Circuit agreed that the facility's failures to implement its policies for reporting and investigating abuse "indicated a wider systemic problem in the facility" and left its residents "at real risk for serious harm." *Beverly Health Care Lumberton v. Leavitt*, 338 Fed. App. at 14-15.

Similarly, in *Illinois Knights Templar Home*, the Board ruled that is was "no defense to assert that the allegations [of abuse] may have been 'fabricated' or that they were false. The regulation requires that all allegations of abuse – true or not – be investigated immediately and reported." *Illinois Knights Templar*, DAB No. 2369 at 12. The facility's subsequent investigation – even if immediate and thorough – does not excuse its failure to insure that the allegation of abuse was reported immediately to its administrator. *Illinois Knights Templar*, DAB No. 2369 at 13. Finally, the Board found no authority for the proposition that the facility's failure to report does not establish a violation where the employee at issue, has been trained in abuse prevention, is a good employee, and has no history of engaging in such behavior. *Id.*

Nor did the facility here take necessary steps to protect its residents pending the outcome of the investigation. It did nothing at all for the first four days. No evidence suggests that the administrator ever designated a resident advocate, as called for in the facility's policy. It eventually suspended the special care unit's two male employees but took no steps to protect the residents from anyone else, including a male resident who wandered the halls at night and was known to enter resident rooms.

Petitioner justifies such limited intervention by referring to a November 17, 2011 physician note and arguing that no male resident could possibly have been implicated. The physician wrote that Resident B was awake and conversant; she thought she was at the hospital because a male worker at the facility accosted a resident a month ago. P. Ex. 2; P. Br. at 4. I see no evidence that the investigating staff were even aware of this report; it is not made part of the investigation and no testimony suggests that anyone relied on it. *See* P. Ex. 3. In any event, such reliance would have been misplaced. No evidence establishes that Resident B made this remark directly to the physician. Inasmuch as the ER nurse reported the remarks to the physician on call, it is more likely that the physician was repeating (and embellishing) the ER nurse's report to him. Her initial report to LPN Lockhard mentioned nothing about a facility employee.

Apparently, Social Services Director Bach interviewed Resident B on November 21, but her initial report does not refer to any allegation of abuse. P. Ex. 3 at 13. In a second report, dated November 22, she writes that she and the activity director, Karen Allen, interviewed the resident. Whether this report describes the November 21 interview or an additional interview is not clear. According to the report, Resident B again described "a

man who came into our room at night and pulled her covers off [and] went like that" (moving her fingers to describe "went like that"). He was "a very tall man." According to the report, "Res. did state is (sic) was a staff member but was not certain of time it occurred." P. Ex. 3 at 14. Neither Social Services Director Bach nor Activity Director Allen testified, so the record includes no further details of Resident B's remarks.

I find reliance on these remarks a tenuous justification for limiting efforts to protect residents pending the outcome of the investigation. As Petitioner points out, Resident B's cognitive status was limited. P. Br. at 3. According to LPN Lockhard "a lot of people" wandered around the unit. Whether Resident B could distinguish an employee from anyone else is far from certain. As to the tall male resident known to wander the halls in the evening, Petitioner points out that he was on a "continuous monitoring plan" (apparently, to prevent his elopement) during the month of November and submits documents to show that staff checked him every 15 minutes. In fact, these documents establish that, consistent with LPN Lockhard's remarks, this resident spent many evenings walking the halls of the unit. P. Ex. 6. Whether checking his location every 15 minutes was sufficient to protect residents from his entering their rooms is questionable, and, in any event, no evidence establishes that the facility even considered that issue.

Thus, the facility violated the anti-abuse regulation and its own abuse-prevention policies, because its staff did not timely investigate allegations of abuse and did not take steps necessary to protect its residents pending the outcome of its investigation. [3]

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[3] Contrast this facility's actions to another facility's far more appropriate response in *Westview Manor*. There, as here, a demented resident's allegations of sexual abuse were ultimately unsubstantiated. But there, a facility nurse overheard a demented resident's telephone conversation, during which the resident reported that a male nurse had raped her. Within ten minutes, the nurse notified the house supervisor, the on-call administrator, and the on-call physician. She immediately transferred out of the resident's unit the only male staff member working there, and, shortly thereafter, he was suspended. She called an ambulance and sent the resident to the emergency room. The on-call administrator reported the incident to the facility administrator and called the police. The administrator went to the facility that evening and questioned key staff. He went to the hospital, where he met and interviewed the resident and her family. That same evening, he obtained written statements from all relevant staff and reported the incident to the state agency. Within 4 days, the facility social worker was conducting in-service training programs on the signs and symptoms of abuse and reporting abuse. All male staff were assigned to work with female staff and instructed not to enter any female resident's room unless accompanied. The facility specifically considered the possibility that an outsider might have entered the facility, and took steps to secure the unit. The DON and Assistant DONs performed physical assessments and interviews of all female residents. The administrator timely prepared and submitted to the state agency his comprehensive written report. *Westview Manor*, DAB CR1308 (2005).

These failures establish "wider systemic problems in the facility" that left its residents "at real risk for serious harm." *See Beverly Health Care Lumberton v. Leavitt*, 338 Fed. App. at 14-15. The facility was therefore not in substantial compliance with 42 C.F.R. § 483.13(c), and its deficiencies posed immediate jeopardy to resident health and safety.

### *B. The penalty imposed for the period of immediate jeopardy – $4,900 per day – is reasonable.*

To determine whether the CMPs are reasonable, I apply the factors listed in 42 C.F.R. § 488.438(f): 1) the facility's history of noncompliance; 2) the facility's financial condition; 3) factors specified in 42 C.F.R. § 488.404; and 4) the facility's degree of culpability, which includes neglect, indifference, or disregard for resident care, comfort or safety. The absence of culpability is not a mitigating factor. The factors in 42 C.F.R. § 488.404 include: 1) the scope and severity of the deficiency; 2) the relationship of the deficiency to other deficiencies resulting in noncompliance; and 3) the facility's prior history of noncompliance in general and specifically with reference to the cited deficiencies.

I consider whether the evidence supports a finding that the amount of the CMP is at a level reasonably related to an effort to produce corrective action by a provider with the kind of deficiencies found, and in light of the above factors. I am neither bound to defer to CMS's factual assertions, nor free to make a wholly independent choice of remedies without regard for CMS's discretion. *Barn Hill Care Center*, DAB No. 1848 at 21 (2002); *Community Nursing Home*, DAB No. 1807 at 22 *et seq*. (2002); *Emerald Oaks*, DAB No. 1800 at 9 (2001); *CarePlex of Silver Spring*, DAB No. 1638 at 8 (1999).

Here, CMS imposed a penalty of $4,900 per day, which is at the low end of the per-day penalty range for situations of immediate jeopardy ($3,050-$10,000). 42 C.F.R. §§ 488.408(e)(1)(iii); 488.438(a)(1)(i).

The facility has a history of substantial noncompliance:

- In 2009, the facility was not in substantial compliance with the quality-of-care requirements for prevention and treatment of pressure sores (42 C.F.R. § 483.25(c) –Tag F314); care of naso-gastric tubes (42 C.F.R. § 483.25(g)(2) – Tag F322); and accident prevention (42 C.F.R. § 483.25(h) – Tag F323) at the G levels of scope and severity, which means the deficiencies caused actual harm;

- In 2010, the facility was not in substantial compliance with requirements for comprehensive care plans (42 C.F.R. § 483.20(k)(3)(ii) – Tag F282); quality of care/accident prevention; and insuring nurse aide competency (42 C.F.R. § 483.75(h) – Tag F498) at scope and severity levels G and E.

CMS Ex. 22 at 3. This history alone justifies significantly increasing the penalty.

Petitioner does not claim that its financial condition affects its ability to pay the CMP. With respect to the remaining factors, the facility must also be considered culpable for its failure to investigate promptly the abuse allegation.

Further, I consider *all* of the facility's deficiencies, including those that Petitioner does not contest. These include multiple G-level deficiencies, one of which – accident prevention – had been cited at that level in 2009 and 2010. It was cited during this survey because, among other deficiencies, a nurse aide attempted to transfer a resident by means of a Hoyer lift. The resident's care plan called for a two-person assist, but the aide attempted the move without assistance. The resident fell from the sling, hit her head, and required stitches. CMS Ex. 2 at 37-38.

The facility was also not in substantial compliance with the neglect and dignity regulations because, among other problems, staff did not timely answer call lights or take residents to the bathroom when they asked. In one particularly egregious situation, a significantly impaired resident asked the staff development coordinator to take her to the bathroom. The development coordinator told the resident that she would get help, but, instead, she went back to passing food trays, then went to the nurse's desk, and finally left the unit without getting the resident any assistance. Twenty minutes later, a second nurse answered the resident's call light and arranged for staff to assist her to the bathroom. The resident tearfully told the surveyor that she has been incontinent because she has to wait so long for assistance. CMS Ex. 2 at 2-4. Other residents and their family members complained that they often waited a long time (up to an hour) before staff took them to the bathroom. CMS Ex. 2 at 4-5. I find especially cruel this blatant "indifference to the resident's care and comfort."

The facility did not meet its residents' special needs because staff failed to ensure that two residents were administered the oxygen that they required. CMS Ex. 2 at 44.

The facility did not have sufficient nursing staff in place to provide the residents necessary assistance in eating and toileting. CMS Ex. 2 at 48-57. Residents were served food that was unpalatable because the meals were cold. CMS Ex. 2 at 57-59.

These are also serious deficiencies, for which the facility is culpable, and they too justify a significant increase above the minimum penalty.

For these reasons, I find that the $4,900 per-day CMP is reasonable.

## IV. Conclusion

The facility's substantial noncompliance with 42 C.F.R. § 483.13(c) posed immediate jeopardy to resident health and safety. The penalty imposed –$4,900 per day – is reasonable.

/s/
Carolyn Cozad Hughes
Administrative Law Judge