Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Daughters of Israel Pleasant Valley Home
(CCN: 31-5029),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-14-538

Decision No. CR4259

Date: September 30, 2015

DECISION

Petitioner, Daughters of Israel Pleasant Valley Home, is a long-term care facility in West Orange, New Jersey, that participates in the Medicare program. Following a complaint investigation survey in February 2013, the New Jersey Department of Health and Senior Services (state agency) determined that Petitioner was not in substantial compliance with abuse prohibition regulations applicable to Medicare-participating long-term care facilities. The state agency also determined that Petitioner's noncompliance posed immediate jeopardy to the health and safety of its residents. The Centers for Medicare & Medicaid Services (CMS) accepted the state agency's findings and imposed a $5,300 per-day civil money penalty (CMP) from January 30 through February 11, 2013, for a total CMP of $68,900. Petitioner requested a hearing to challenge the survey findings and CMS's enforcement remedies. CMS now moves for summary judgment, which Petitioner opposes.

For the reasons set forth below, I grant summary judgment in favor of CMS. The undisputed material facts of this case establish that: Petitioner was not in substantial compliance with regulatory requirements during the cited period; CMS's immediate jeopardy determination was not clearly erroneous; and the CMP imposed is reasonable.

I. Case Background

In response to two facility-reported incidents of resident injury and abuse, the state agency conducted a survey of Petitioner's facility between February 11 and February 13, 2013. The state agency determined that, from January 30 through February 11, 2013, Petitioner was not in substantial compliance with:

1) 42 C.F.R. § 483(b), (c)(1) (Tag F-223) – requiring a facility to protect each resident's right to be free from verbal, sexual, physical, and mental abuse, corporeal punishment, and involuntary seclusion; and

2) 42 C.F.R. § 483.13(c) (Tag F-226) – requiring a facility to develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.

The state agency also determined that Petitioner's noncompliance posed immediate jeopardy to the health and safety of its residents for the duration of the cited period of noncompliance. Specifically, the state agency cited the noncompliance at a scope and severity level "J," meaning isolated immediate jeopardy. CMS Exhibits (Exs.) 1, 4; *see also* State Operations Manual, ch. 7, § 7400.5 (Sep. 10, 2010).

Three incidents of potential abuse and Petitioner's response to those incidents formed the basis of the state agency's noncompliance determination. First, according to the state agency's findings, on January 30, 2013, a resident with cognitive impairment, referred to as "Resident 1" in the related documentation, reported that nurse aides, including a certified nursing assistant (CNA) referred to as "CNA 5," wrapped her up in a sheet and left her in a bathroom for over two hours. The state agency asserted that Petitioner did not timely report or thoroughly investigate this allegation in violation of regulatory requirements. The second incident also involved Resident 1 and CNA 5 and occurred later in the day on January 30, 2013. Resident 1 showed a bruise on her wrist to a CNA on the evening shift and reported that CNA 5, who worked on the day shift, had grabbed her and caused the bruise. The state agency determined that Petitioner did not begin its investigation of this allegation until the following day, which violated regulatory requirements. The third incident, on February 3, 2013, involved a separate resident with dementia, referred to as "Resident 2," and consisted of a staff-witnessed incident of staff-to-resident abuse. According to the state agency's findings, three CNAs, referred to as "CNA 1," "CNA 2," and "CNA 3," were providing care to Resident 2 when the resident began to yell. CNA 2 then covered Resident 2's head with a pillow and pushed down. Afterwards, CNA 2 began poking near Resident 2's vagina, over her diaper, in an effort to stimulate the resident's habit of masturbating. Neither CNA 1 nor CNA 3 reported the incident until the following day, which, according to the state agency, did not comply with regulatory requirements. CMS Ex. 4

On July 10, 2013, CMS notified Petitioner that it accepted the state agency's findings and imposed a per-day CMP of $5,300 for one day, February 11, 2013. CMS Ex. 2. Petitioner requested a hearing before an administrative law judge. On November 13, 2013, CMS issued a "Notice of Reopening and Revision of Initial Determination," which stated that CMS reopened and revised its July 10, 2013 initial determination pursuant to 42 C.F.R. §§ 498.30 and 498.32(a). CMS Ex. 3. Similar to the initial determination, the revised determination accepted the state agency's findings from the February 2013 survey and imposed a $5,300 per-day CMP; however, it revised the effective date of the CMP from one day to 13 days, *i.e.*, from January 30, 2013 through February 11, 2013. CMS Ex. 3 at 1-2. On November 21, 2013, I dismissed Petitioner's hearing request related to CMS's July 10 initial determination because that determination was no longer operational, which, in turn, rendered Petitioner's hearing request moot. Petitioner then filed a request for hearing disputing the November 13 revised determination.

CMS subsequently moved for summary judgment and filed a supporting brief (CMS Br.) as well as 12 proposed exhibits (CMS Exs. 1-12). Petitioner opposed summary judgment and submitted a brief in opposition (P. Br.) as well as 21 proposed exhibits (P. Exs. 1-21). CMS filed a reply brief (CMS Reply). Neither party objected to any of the proposed exhibits, therefore, I admit all of the proposed exhibits into the record.

II. Issues

The issues before me are:

1. Whether summary judgment is appropriate;

2. Whether Petitioner was in substantial compliance with the participation requirements in 42 C.F.R. § 483.13(b), (c)(1) (Tag F-223) and 42 C.F.R. § 483.13(c) (Tag F-226) from January 30 through February 11, 2013;

3. If Petitioner was not in substantial compliance, whether Petitioner's noncompliance posed immediate jeopardy to resident health and safety; and

4. If Petitioner was not in substantial compliance, whether the CMP imposed is reasonable.

III. Discussion

The Social Security Act establishes the requirements for long-term care facilities that participate in the Medicare and Medicaid programs. *See generally* 42 U.S.C. §§ 1395i-3, 1396r. The statute authorizes the Secretary of Health and Human Services (Secretary) to issue regulations that implement those statutory requirements. *Id.* The Secretary established by regulation the Medicare participation requirements for long-term care

facilities, which are currently set forth in 42 C.F.R. Part 483. A long-term care facility must remain in substantial compliance with program requirements to participate in Medicare. *See* 42 C.F.R. § 483.1(b). "Substantial compliance" means "a level of compliance with the requirements of participation such that any identified deficiencies pose no greater risk to resident health or safety than the potential for minimal harm." 42 C.F.R. § 488.301. "Noncompliance," in contrast, means "any deficiency that causes a facility not to be in substantial compliance." *Id.*

The Social Security Act also authorizes the Secretary to impose enforcement remedies against a long-term care facility that does not comply with the federal participation requirements. 42 U.S.C. § 1395i-3(h)(2). The Secretary delegated to CMS and the states the authority to impose remedies against a long-term care facility not in substantial compliance. State agencies survey facilities on behalf of CMS to determine whether the facilities comply with federal participation requirements. 42 C.F.R. §§ 488.10-.28, 488.300-.335.

The regulations specify the enforcement remedies that CMS may impose if a facility is not in substantial compliance with Medicare requirements. 42 C.F.R. § 488.406. Among other enforcement remedies, CMS may impose a per-day CMP for the number of days a facility is not in substantial compliance or a per-instance CMP for each instance of the facility's noncompliance. 42 C.F.R. § 488.430(a). A per day CMP, which CMS imposed in this case, may range from either $50 to $3,000 per day for less serious noncompliance, or $3,050 to $10,000 per day for more serious noncompliance that poses immediate jeopardy to the health and safety of residents. 42 C.F.R. § 488.438(a)(1). "Immediate jeopardy" exists when "the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident." 42 C.F.R. § 488.301.

If CMS imposes a CMP on a long-term care facility based on a noncompliance determination, then the facility may request a hearing before an administrative law judge to challenge the noncompliance finding and enforcement remedy. 42 U.S.C. §§ 1320a-7a(c)(2), 1395i(h)(2)(B); 42 C.F.R. §§ 488.408(g), 498.3(b)(13).

1. Summary judgment is appropriate.[1]

Summary judgment is appropriate in cases where 42 C.F.R. Part 498 applies if there is no genuine dispute of any material fact and the moving party is entitled to judgment as a matter of law. *Crestview Parke Care Ctr. v. Thompson*, 373 F.3d 743, 750 (6th Cir.

[1] My numbered conclusions of law are set forth in bold and italics. I decide this case on summary judgment, so I do not make any formal factual findings. As discussed in detail below, the material facts are undisputed.

2004); CRDP § 7 (eff. July 6, 2009), *accord* CRDP § 19(a) (eff. Jan. 1, 2015). To defeat a well-pleaded motion for summary judgment, the non-moving party must come forward with some evidence of a dispute concerning a material fact; mere denials in its pleadings are not sufficient. *Senior Rehab. & Skilled Nursing Ctr.*, DAB No. 2300, at 3 (2010). A dispute is "genuine" if "the evidence is such that a reasonable [trier of fact] could return a verdict for the nonmoving party." *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 248 (1986). Moreover, a factual dispute cannot reach a trier of fact if there is no "probative evidence tending to support the complaint." *Id.* (citing *First Nat. Bank of Ariz. v. Cities Serv. Co.*, 391 U.S. 253, 290 (1968)). As explained below, CMS has presented evidence in support of its motion for summary judgment that establishes abusive conduct by Petitioner's staff, abuse allegations by a resident, and the steps Petitioner's staff took in response to these incidents. In response to CMS's evidence, Petitioner offered no evidence that raises a genuine dispute of any material fact; its witnesses repeatedly cite incorrect facts or draw inferences that have no record support. No reasonable trier of fact could find in favor of Petitioner based on those incorrect factual claims.

a. First Abuse Allegation by Resident 1 on January 30, 2013.

Resident 1, an 87-year-old female resident with moderately impaired cognitive ability, reported to the "7-3 LPN" after breakfast on January 30, 2013, that three other staff members wrapped her in a sheet and left her in the bathroom for two hours. CMS Ex. 7 at 8, 44, 68; CMS Ex. 10 at 5, 8, 16. Petitioner does not dispute that Resident 1 made this allegation. P. Br. at 5. Resident 1 had a history of "complaining" and "episodes of outbursts mostly when . . . she does not understand what is being said," but there is no evidence that she previously accused staff of abusive conduct. CMS Ex. 7 at 26-27, 47; *see also* CMS Ex. 7 at 42-44, 48-55.

In response to Resident 1's allegation, the 7-3 LPN asked Resident 1 when the incident happened, to which she replied "the 31st," even though it was January 30. P. Ex. 5 at 1. As CNA 5 passed by, Resident 1 pointed at her and stated that "she was one of them." P. Ex. 5 at 1. The 7-3 LPN tried to contact Petitioner's social worker by telephone.[2] P. Ex. 5 at 2. The social worker did not answer, and the 7-3 LPN did not leave a message or follow-up with the social worker at a later time. P. Ex. 5 at 2. The 7-3 LPN did not notify a nursing supervisor, the director of nursing, or the facility administrator of Resident 1's allegation until 2:00 p.m., when she called the nursing supervisor to report a separate incident involving Resident 1 and CNA 5. P. Ex. 5 at 2; P. Ex. 6 at 1. "Later," the 7-3 LPN spoke with CNA 5, although the 7-3 LPN did not question her about the

[2] It is not clear whether the 7-3 LPN attempted to contact the social worker to report Resident 1's allegation or because Resident 1 insisted that she had a meeting with the social worker that morning. *See* P. Ex. 5. For summary judgment, I accept that the 7-3 LPN was attempting to report the abuse allegation to the social worker.

alleged incident of leaving Resident 1 in the bathroom for two hours that morning. Instead, she inquired about whether CNA 5 had additional staff assistance when transferring Resident 1 to and from the shower. P. Ex. 5.

Petitioner now asserts that the abuse that Resident 1 alleged could not have happened; she had a shower at 8:30 a.m., was examined in her room at 8:46 a.m., and was then taken to the dining area to eat breakfast. P. Br. at 5-6; P. Ex. 19 at 5-7. Petitioner also claims that the 7-3 LPN "interviewed the aide, and asked the aide who assisted her with the resident in the shower." P. Br. at 6. In response, CNA 5 said that CNA R.L.[3] assisted her that morning. According to Petitioner, CNA R.L. "denied wrapping the resident up in a sheet and leaving her in the shower room." P. Br. at 6-7 (citing P. Ex. 5, P. Ex. 6). Also according to Petitioner, the 7-3 LPN called the nursing supervisor to the room to be a "second witness" to Resident 1's allegation of being left in the bathroom. P. Br. at 7. Petitioner further asserts that the 7-3 LPN overstayed the end of her shift "in an attempt to continue the investigation of Resident 1's earlier allegation." P. Br. at 7.

Petitioner's claims about the 7-3 LPN's investigative actions are incorrect characterizations of the evidence. The 7-3 LPN's interview of CNA 5 only addressed how many people assisted Resident 1 to and from the shower.[4] Specifically, the 7-3 LPN "asked [CNA 5] later how many did she use to transfer [Resident 1] while [in the] shower room, [CNA 5] said 2 persons, I asked who she said [CNA R.L.] in shower room, not quite sure who assisted her in room." P. Ex. 5 at 1-2. CNA R.L. provided an undated written statement that made no reference to the allegation, merely that Resident 1 did not appear agitated after her shower. P. Ex. 4. CNA R.L.'s statement does not comport with Petitioner's claim that she "denied wrapping the resident up in a sheet and leaving her in the shower." P. Br. at 6-7. There is simply no evidence in CNA R.L.'s written statement to support Petitioner's claim about what she said.[5] Also, despite ample opportunity on

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[3] Surveyors did not assign this specific CNA a numerical identifier. Therefore, I refer to her by her title and initials.

[4] Despite no other record support, I accept for purposes of summary judgment the reasonable inference that the 7-3 LPN may have questioned CNA 5 to help the 7-3 LPN establish a timeline of Resident 1's whereabouts during the morning of January 30, 2013. *See* P. Br. at 6. However, the 7-3 LPN never documented her findings or established a timeline of events for Resident 1 that morning.

[5] It is not reasonable to infer that CNA R.L. meant to say that she did not wrap up the resident or leave her in the shower. Her statement about Resident 1's demeanor after the shower has no correlation to CNA R.L.'s actions at that time. Therefore, Petitioner's incorrect recitation of what CNA R.L. said cannot be construed as a reasonable inference that would preclude summary judgment.

January 30, Petitioner's staff made no attempt until the following day to get a formal statement from CNA 5 about the allegation. The 7-3 LPN stated that she "forgot" to ask CNA 5 for a statement before she left for the day. P. Ex. 5 at 2.

Petitioner's claim that the 7-3 LPN overstayed the end of her shift that day "in an attempt to continue the investigation of Resident 1's earlier allegation" (P. Br. at 7) is also unreasonable and unsupported.[6] Indeed, the 7-3 LPN admitted to the surveyor that she did not investigate the allegation. CMS Ex. 12 at ¶ 19. The evidence corroborates this. In her written statement, the 7-3 LPN made no assertions about why she stayed late on January 30. She wrote that she "was still on the unit working at approximately 3:15 pm when CNA from 3-11 shift came and asked me what happened to [Resident 1's] hand." P. Ex. 5 at 2. Moreover, Petitioner does not address the fact that the results of the supposed investigation into the shower incident were not included in the facility's final report to the state agency about another January 30 allegation. If, as Petitioner claims, the 7-3 LPN had spent over six hours investigating the allegation, it is untenable that the report to the state agency (and the rest of the record in this case) is devoid of any conclusions from that specific investigation. *See* P. Ex. 2 at 1 (discussing Resident 1's allegation about the shower, but not discussing any investigation into the allegation or results of an investigation).

Petitioner's additional claim that the 7-3 LPN called the nurse supervisor as part of her investigation into the shower incident is disingenuous. P. Br. at 7 ("The supervisor, Lydia S. was called as a witness or a second person to hear Resident 1's complaint . . . . The LPN promptly called the same nursing supervisor *that was contacted earlier about the shower allegation*." (emphasis added)). The nurse supervisor wrote in her investigation statement that she received a single phone call, at 2:00 p.m., which reported a later scratching incident as well as the shower incident that had occurred earlier in the day. P. Ex. 6 at 1. Also, the 7-3 LPN stated that she first called the supervisor after the report that Resident 1 scratched the aide, at approximately 2:00 p.m. P. Ex. 5 at 2. Thus, the assertion that the 7-3 LPN called the supervisor as a witness to Resident 1's shower allegation omits that she did so much later in the day and as part of her reporting a second incident involving Resident 1 and CNA 5. Petitioner's implication that there were two calls to the supervisor (P. Br. at 7) has no evidentiary support.

[6] Even if this is a factual inference, the 7-3 LPN did not document her supposed ongoing investigation, which alone violates the regulatory requirements. *See* 42 C.F.R. § 483.13(c)(3) ("The facility *must have evidence* that all alleged violations are thoroughly investigated . . . ." (emphasis added)). I do not consider a factual inference of conduct that violates the regulations to be a reasonable one that can defeat summary judgment.

Despite Petitioner's attempt to color certain facts of this case, the material facts of what happened after Resident 1's allegation — the 7-3 LPN's single question of the resident, the 7-3 LPN's failed attempt to contact the social worker, the questioning of CNA 5 regarding the number of staff assisting Resident 1, and a statement from CNA R.L. that Resident 1 did not seem agitated after her shower — remain undisputed.

b. Scratching Incident and Second Abuse Allegation by Resident 1 on January 30, 2013.

Soon after lunch on January 30, 2013, at approximately 2:00 p.m., CNA 5 reported to the 7-3 LPN that Resident 1 scratched her. CMS Ex. 7 at 44. CNA 5 also reported that Resident 1 had accused her and the 7-3 LPN of being "liars." P. Ex. 3 at 2; P. Ex. 5 at 2. The 7-3 LPN reported the scratching incident to the nursing supervisor. P. Ex. 5 at 2. At that time, she also reported Resident 1's earlier allegation of being wrapped up and left in the bathroom. CMS Ex. 10 at 12. The supervisor did not come to the unit to assess Resident 1's behavior or question CNA 5, but told the staff that she was "taking care of something on another unit" and would be there when she finished. P. Ex. 6 at 1. Later that afternoon, at approximately 3:15 p.m., a staff member found a large contusion (8cm x 11cm) on Resident 1's left posterior hand. Resident 1 said that a staff member, CNA 5, said "I'll show you what I can do" and twisted Resident 1's arm after she refused to eat lunch. CMS Ex. 10 at 3, 5, 8, 13, 17.

CNA 4, who discovered the contusion on Resident 1's hand, immediately left the room and notified the 7-3 LPN, who had overstayed her shift. CMS Ex. 10 at 5, 14, 17. The 7-3 LPN assessed the contusion and notified the nursing supervisor, who then came to Resident 1's room, assessed the contusion, and questioned the resident. CMS Ex. 10 at 12, 17. Neither the supervisor nor the 7-3 LPN attempted to question CNA 5 that day. *See* CMS Ex. 18 (statement from CNA 5 dated January 31, 2013). While it is undisputed that Petitioner's staff psychologist assessed Resident 1 later that day for "more behavioral issues," there are no documented investigative measures related to the contusion for the remainder of January 30, 2013. *See* CMS Ex. 7 at 56.[7] A staff member, the 7-3 LPN, made a written statement about the contusion the following day, January 31, 2013. In addition, the staff performed an x-ray of Resident 1's hand and wrist and her physician

[7] The psychologist notes "more behavior issues," but the Behavior Progress Notes do not record any behavior problems involving altercations with staff. *See* CMS Ex. 7 at 56. The record does not include evidence of any related behavior problems prior to January 30, 2013. Petitioner does not argue that the "more" behavior issues refers to Resident 1's earlier allegation on January 30, nor would that inference be a reasonable one as there is no evidence in the record that such a referral was made after the first allegation.

evaluated her for further injury. CMS Ex. 10 at 16 (statement dated January 31, 2013); CMS Ex. 10 at 8 (referring to x-ray and physician assessment, which occurred on January 31). The physician concluded that Resident 1's bruise was "self-injury by patient."[8] P. Ex. 13 at 1. Staff also completed an undated "Accident Report." CMS Ex. 10 at 8.

Petitioner asserts that the nursing supervisor "promptly proceeded to the resident's room to assess the resident, interviewed the resident, and completed an incident report. . . . *The supervisor then took statements of all involved* . . . . The next day the resident was further assessed by the attending physician . . . ." P. Br. at 7-8 (emphasis added). Petitioner's description of events implies that the supervisor took several statements on January 30, because the physician evaluation, "the next day," was undisputedly on January 31, 2013. *See* P. Ex. 13 at 1. But there is only *one* witness statement other than that of the supervisor in the record about the bruise on Resident 1's hand. That witness statement, which Petitioner alleges was made the day of the incident, is actually dated January 31, 2013. *See* P. Ex. 5. So, the record belies Petitioner's summary of the facts and the supposed investigative actions. There is no record of a statement from Resident 1, the victim of possible abuse. There is also no evidentiary support that the nursing supervisor completed the Accident Report. She stated that "*the nurse* went back to measure the bruise and complete the incident report." CMS Ex. 10 at 13 (emphasis added). Overall, Petitioner has not presented evidence to establish a genuine dispute about the actions of its staff after Resident 1's second abuse allegation on January 30.

c. Staff abuse of Resident 2 on February 3, 2013.

It is undisputed that on February 3, 2013, CNA 1, CNA 2, and CNA 3 provided care to Resident 2, a 93-year-old female resident with severely impaired decision-making skills. P. Ex. 10. Resident 2 began to yell out during her care. CMS Ex. 9 at 6-8. CNA 1 and CNA 3 then watched CNA 2 place a pillow over the face of Resident 2. CNA 1 removed the pillow, but CNA 2 put it back and pushed down in an effort to muffle the resident's yelling. Before the care was complete, CNA 1 and CNA 3 also observed CNA 2 poke Resident 2's vaginal area (over her diaper) in an attempt to stimulate Resident 2's habit of masturbating. CMS Ex. 9 at 6-7. CNA 3 attempted to report the incidents to her supervisor, "but found her door closed." P. Ex. 17 at 4. She did not attempt to locate another supervisor, and neither CNA 1 nor CNA 3 reported the abusive incident that day. CNA 3 reported the incident to Petitioner's nursing educator the following day, February 4, 2013. CMS Ex. 9 at 4, 6, 8.

[8] There is evidence that suggests the bruise may not have been "self-injury." *See, e.g.*, CMS Ex. 12 at 5 (statement of surveyor describing her interview with Resident 1, who had maintained for over 11 days that CNA 5 grabbed her, causing the bruise). For the purposes of summary judgment, however, I accept that Resident 1's bruise was the result of "self-injury."

Petitioner's staff obtained statements from CNA 1 and CNA 3 and reviewed surveillance footage of the area at the time of the incident. CMS Ex. 9 at 6-7. In their statements, both CNA 1 and CNA 3 stated that the "3-11" LPN walked in during the incident, but did not say anything to CNA 2. Instead, the 3-11 LPN told CNA 2 that she had another resident to change.[9] CMS Ex. 9 at 7. The staff also reported the incident to the local police, Resident 2's family, and her physician. The physician conducted an evaluation and assessment of Resident 2. P. Ex. 7. Petitioner terminated CNA 2's employment, although it did not obtain a statement from her. Petitioner's investigation concluded that abuse was suspected. P. Ex. 7.

Petitioner does not dispute CMS's description of the incident, nor has it presented any evidence to demonstrate that the incident did not happen the way CMS's evidence shows it did. Instead, Petitioner presents evidence that the CNA had good references prior to the facility's hiring her, indicating her abuse of a resident was not foreseeable, but those facts are not material to the outcome here. *See* P. Ex. 8 at 2. A facility cannot disown the consequences of its employee's abusive actions, even if those actions were not foreseeable. *See Gateway Nursing Ctr.*, DAB No. 2283, at 8 (2009). Therefore, the CNA's prior positive employment record, though not disputed, is not a material fact in this case.

Ultimately, Petitioner's coloring of the facts does not raise a genuine dispute of the material facts. *See Liberty Lobby*, 477 U.S. at 249-250 ("If the evidence is merely colorable . . . or is not significantly probative . . . summary judgment may be granted."). Petitioner's factual assertions are not reasonable inferences of evidence in the record. Therefore, Petitioner has not raised a genuine dispute of a material fact, and summary judgment is appropriate.

2. Petitioner was not in substantial compliance with 42 C.F.R. § 483.13(b) and (c)(1), cited under Tag F-223, because one of Petitioner's staff members abused a resident, and because Petitioner did not take steps to ensure that another resident was free from abuse after the potential for abuse arose.

A resident of a long-term care facility "has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion." 42 C.F.R. § 483.13(b). To protect that right, a facility cannot use any form of abuse, corporal punishment, or involuntary seclusion when caring for a resident. *Id.* § 483.13(c)(1)(i). "Abuse" is defined as "the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish." 42 C.F.R. § 488.301. "Protecting and promoting a resident's right to be free from abuse necessarily obligates the facility to take reasonable steps to prevent abusive acts,

[9] The 3-11 LPN told the surveyor that she did not observe the abuse, which I accept as true for purposes of summary judgment. *See* CMS Ex. 12.

regardless of their source." *Pinehurst Healthcare & Rehab. Ctr.*, DAB No. 2246, at 6 (2009) (quoting *Western Care Mgmt. Corp., d/b/a Rehab Specialties Inn*, DAB No. 1921, at 12 (2004)) (internal quotation marks omitted). Actual abuse need not occur for a facility to violate 42 C.F.R. § 483.13(b) and (c)(1)(i). *See Holy Cross Vill. at Notre Dame, Inc.*, DAB No. 2291, at 7 (2009) (citation omitted). "It is sufficient for CMS to show that that the facility failed to protect residents from reasonably foreseeable risks of abuse." *Id.* (citing *Western Care Mgmt.*, DAB No. 1921, at 15). However, "considerations of foreseeability are inapposite when *staff abuse* has occurred," and a facility, which acts through its staff, cannot disown the consequence of the actions of its employees. *Gateway Nursing Ctr.*, DAB No. 2283, at 8 (emphasis added).

It is undisputed that, on February 3, 2013, CNA 2 held a pillow down over Resident 2's face after the resident began yelling out during care. CMS Ex. 9, at 4, 6, 7; P. Br. at 9. According to CNA 3, who witnessed the event, CNA 2 held down the pillow over Resident 2's face because "she didn't want to he[a]r [Resident 2] scream." P. Ex. 10. But CNA 2 did not stop there. She began poking Resident 2's vaginal area in an attempt to stimulate the resident's habit of masturbating. CMS Ex. 9 at 6-8. CNA 2 explained to CNA 1, who was new to the facility, about Resident 2's habit, and stated that she was "getting her started." P. Ex. 10. CNA 1 also observed CNA 2's abuse of Resident 2. According to CNA 1's statement during Petitioner's internal investigation, CNA 2 poked Resident's vaginal area and was "asking her if she likes that." CMS Ex. 9 at 7.

These undisputed facts establish that CNA 2 abused Resident 2 on February 3, 2013. Holding a pillow over a resident's head as retaliation for that resident's screaming is injurious, life-threatening, and is punishment that results in physical harm, pain, and mental anguish. In addition, while CNA 2 was pressing on Resident 2's vaginal area, CNA 2 described to CNA 1 that she was "getting her started," and asked Resident 2, who was non-verbal, whether she "likes that," a question that can only be understood as mocking Resident 2's incoherence and habit of masturbating. Thus, the only reasonable inference from CNA 2's behavior and contemporaneous comments is that she intended to humiliate Resident 2, which, regardless of Resident 2's cognitive status, may be deemed likely to cause her mental anguish. *See* 59 Fed. Reg. 56,116, 56,130 (Nov. 10, 1994) ("Our obligation is to protect the health and safety of every resident, including those that are incapable of perception or are unable to express themselves. This presumes that instances of abuse of any resident, whether cognizant or not, cause physical harm, pain, or mental anguish."). CNA 2's abuse of Resident 2 violates the regulatory requirement to protect a resident's right to be free from abuse and to prohibit staff abuse of residents. 42 C.F.R. § 483.13(b), (c)(1). As noted above, whether the abuse was foreseeable through prior work history or behavior is not relevant when a staff member perpetrates the abuse. *Gateway Nursing Ctr.*, DAB No. 2283, at 8.

With regard to Resident 1, Petitioner's staff should have known that there was a potential for abuse after she made the first allegation of abuse against CNA 5 and after the incident at lunchtime when she accused staff members of being liars and then scratched CNA 5. At that point, staff should have recognized the escalating tension between Resident 1 and CNA 5, but nothing was done to address it. The escalating tension resulted in a potential for abuse because it could have caused more physical altercations if Resident 1 continued to believe that CNA 5 abused her and then lied about it. She had already demonstrated aggressive behavior and refused to eat when CNA 5 brought her lunch. Petitioner should have taken reasonable steps following Resident 1's altercation with CNA 5 to address this growing potential for abuse. However, staff ignored the issue until Resident 1 presented with a large bruise on her hand. While the facility later determined that the injury to Resident 1's hand was self-inflicted, Resident 1 immediately and consistently blamed CNA 5. Staff did not interview CNA 5 that day, nor did staff obtain a statement or any additional information about the alleged incidents from Resident 1.

In *Honey Grove Nursing Center*, DAB No. 2570 (2014), a noncompliance was affirmed when the facility took no steps to address a resident's escalating behavioral problems. *See* DAB No. 2570, at 5-6. Ultimately, a male staff member engaged in a physical altercation with the resident, who had previously shown aggression towards male staff members. *Honey Grove Nursing Center* upheld the administrative law judge's finding that the omission of any steps to address that escalating tension between the resident and male staff members demonstrated a violation of the regulatory standard. DAB No. 2570, at 5. Similarly, Petitioner overlooked the escalating tension between Resident 1 and CNA 5, which included a physical altercation, but took no steps to address it. Thus, Petitioner did not comply with the regulatory requirement to keep residents free from abuse because it did not take any meaningful steps to protect Resident 1 (for example, by removing CNA 5 from her care to avoid confrontation) after she alleged that CNA 5 had left her in the bathroom that morning and after Resident 1 scratched CNA 5 following an altercation over her lunch. *See Western Care Mgmt.*, DAB No. 1921 (2004) ("The goal of section 483.13(b) is to keep residents free from abuse. This goal cannot be achieved if a facility could be found in compliance even though it failed to take reasonable steps to protect residents from potentially injurious acts which it knew or should have known might occur and which might be willful . . . .").

3. Petitioner was not in substantial compliance with 42 C.F.R. § 483.13(c), cited under Tag F-226, because Petitioner did not implement its written policies and procedures that prohibit mistreatment, neglect, and abuse of residents.

A facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. 42 C.F.R. § 483.13(c). One instance of abuse or neglect is generally not sufficient to establish that the facility did not implement its anti-abuse policy. The goal of section 483.13(c) is to ensure a facility adopts effective anti-abuse and anti-neglect policies, "not

targeting isolated events." *Emerald Oaks*, DAB No. 1800, at 18 (2001). However, multiple instances of abuse, or other examples where a facility's staff did not carry out its anti-abuse policy "support a reasonable inference that a facility failed to develop or implement policies and procedures" that prohibit abuse. *See Dumas Nursing & Rehab., L.P.*, DAB No. 2347, at 15 (2010) (discussing facility anti-neglect policies under 42 C.F.R. § 483.13(c)). A facility does not implement its anti-abuse policy if the circumstances surrounding each instance of abuse or alleged abuse demonstrate an "underlying breakdown" of the implementation of that anti-abuse policy. *See Oceanside Nursing & Rehab. Ctr.*, DAB No. 2382, at 11 (2011) (citing *Columbus Nursing & Rehab. Ctr.*, DAB No. 2247, at 27 (2009)).

Here, the facility has two relevant policies: "Abuse Prohibition" and "Recognizing and Reporting Signs and Symptoms of Abuse/Neglect." CMS does not argue that the substance of the policies is improper, but that Petitioner did not implement those policies. Petitioner's Abuse Prohibition policy states, in relevant part: "This facility will do everything in its control to prevent occurrences, and will conduct thorough investigations for all cases of alleged abuse." P. Ex. 1 at 19. The policy does not define a "thorough investigation." Section 5 of the policy states that Petitioner will "investigate different types of incidents [and] identify the staff member responsible for the initial reporting, investigation of alleged violations[,] and reporting of results to the proper authorities." P. Ex. 1 at 20. In addition, Petitioner's Recognizing and Reporting Signs and Symptoms of Abuse/Neglect policy provides, in relevant part, that "all personnel are to report any signs and symptoms of abuse/neglect to their supervisor, the director of Nursing Services[,] or an Administrator immediately." P. Ex. 1 at 22.

The undisputed facts of this case demonstrate that Petitioner's staff members did not implement the relevant facility policies because staff members: (1) did not conduct a thorough investigation of the alleged abuse against Resident 1 that occurred in the shower on January 30, 2013; (2) did not identify an individual who would be responsible for investigating that allegation of abuse; (3) did not immediately notify a supervisor of the first abuse allegation; and (4) did not immediately notify a supervisor of the abuse by a staff member against Resident 2. All of these instances demonstrate a systemic breakdown in the implementation of Petitioner's abuse prohibition and prevention policies.

The 7-3 LPN admitted that she did not investigate Resident 1's allegation of being left in the bathroom on January 30, 2013. CMS Ex. 12 at ¶ 19. Even absent this admission, the evidence shows that there was no investigation, let alone a thorough one, into the alleged abuse and neglect against Resident 1 in a bathroom. Despite having the opportunity to do so, the 7-3 LPN did not directly ask the alleged perpetrator, CNA 5, about the incident. The 7-3 LPN did not assess Resident 1 physically or ask her follow-up questions other than what day the incident occurred. Indeed, the 7-3 LPN admitted that she could not understand what Resident 1 was saying, yet there is no evidence that shows she took any

effective steps to clarify what Resident 1 had alleged. *See* CMS Ex. 10 at 12. It is unclear why the 7-3 LPN only asked Resident 1 about the date and ceased further inquiry when she responded "the 31st." Petitioner's policy does not vest any staff member with the discretion to move forward with an investigation into alleged abuse or not. All such incidents must be investigated and reported immediately. P. Ex. 1 at 20. The 7-3 LPN did not document any findings or conclusions about the incident, contrary to a separate regulatory requirement. *See* 42 C.F.R. § 483.13(c)(3). There is no evidence that the 7-3 LPN tried to report the incident to a supervisor after being unable to reach the social worker. The 7-3 LPN did not successfully report the abuse allegation until 2:00 p.m., nearly five hours after the allegation, and that report was only made in tandem with a report of a separate incident that involved a physical altercation. Neither the nursing supervisor nor the 7-3 LPN assessed or interviewed Resident 1 at that time, neither made any finding about the incident, and neither obtained any additional information about the allegation. Petitioner's staff did not identify either the 7-3 LPN or the nursing supervisor as the individual responsible for reporting the incident, investigating it, or reporting the findings to the appropriate authorities. Petitioner now argues that the 7-3 LPN was responsible for investigating the incident (*see* P. Br. at 13-14), yet there is no contemporaneous documentation identifying the 7-3 LPN as such. Most importantly, there were no formal findings about the abuse allegation, which renders any claim of a thorough investigation to be unreasonable. Thus, with regard to the first instance of alleged abuse on January 30, staff did not implement the Abuse Prohibition policy to identify the individual responsible for investigating the allegation and investigate the allegation thoroughly. Certainly, an investigation that lacks contemporaneous statements from the alleged perpetrator, contains no contemporaneous assessment of the alleged victim, has no witness statements that specifically address the allegation, and has no formal conclusion, is not a thorough one. Staff also did not implement the Recognizing and Reporting Signs and Symptoms of Abuse/Neglect policy to report the allegation immediately to a supervisor, nursing supervisor, or administrator. In the nearly five hours after the incident, the 7-3 LPN only once attempted to contact the social worker, who was not identified as a supervisor.

In addition, the nursing staff who observed CNA 2 hold a pillow over Resident 2's face waited until the following day to report the abuse. The fact that the staff members were recently hired or threatened by CNA 2 has no relevance – they were still required to comply with the facility's policy to report the incident *immediately*. P. Ex. 1 at 22. Neither CNA did so. Accepting as true that CNA 3 attempted to report the incident to her supervisor but found her door closed, that single attempt does not explain why CNA 3 did not immediately report the abuse to the nursing supervisor or facility administrator, which the facility policy requires. Petitioner points out that CNA 1 and CNA 3 ended their shifts only 15 minutes after the incident. But Petitioner's policy does not carve out an end-of-shift exception to reporting abuse immediately. Even if I accept that it was reasonable for CNA 1 and CNA 3 to ignore facility policy because their shifts ended, Petitioner overlooks that only CNA 3 reported the incident; CNA 1 did not. Instead,

Petitioner's staff approached CNA 1 about it. CNA 1's failure to report the incident is yet another example of the failure to implement the facility's policies. Moreover, CNA 3's comfort level with reporting abuse and whether she felt threatened by the perpetrator of abuse is irrelevant to whether she followed facility written policies about reporting abuse. Protecting residents from abuse cannot happen if those required to report abusive behavior are too intimidated or too inconvenienced to do so.

The undisputed evidence shows repeated instances of facility staff not implementing the facility's policies, which, in turn, sufficiently demonstrates a systemic breakdown of the implementation of the relevant abuse prohibition policies and procedures. Petitioner, therefore, had not effectively implemented those policies and was not in substantial compliance with 42 C.F.R. § 483.13(c).

4. The determination that Petitioner's noncompliance posed immediate jeopardy was not clearly erroneous.

A determination of "immediate jeopardy" must be affirmed unless Petitioner shows that it is clearly erroneous. 42 C.F.R. § 498.60(c)(2). The Board directs 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." *See Barbourville Nursing Home*, DAB No. 1962, at 11 (2005) (citing *Florence Park Care Ctr.*, DAB No. 1931, at 27-28 (2004)). The regulation does not require that a resident actually be harmed. *See Lakeport Skilled Nursing Ctr.*, DAB No. 2435, at 8 (2012). As noted above, "immediate jeopardy" is "a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident." 42 C.F.R. § 488.301.

Here, the facility did not respond in any meaningful way to Resident 1's initial abuse allegation on January 30, 2013. Staff did not immediately report the allegation to the nursing supervisor or administrator, nor did staff take steps to investigate the allegation further, contrary to facility policy. Even if staff believed that the allegation was false, they needed to follow Petitioner's written policies by beginning an investigation and making a formal conclusion. P. Ex. 1 at 19-20. By not following its own policies in reporting or investigating a serious abuse allegation, one may reasonably conclude that the facility was likely to cause serious injury to a resident by failing to protect residents from abusive situations. In addition, the staff took no steps to address the apparent problem that Resident 1 was having with CNA 5, and ignored the issue until Resident 1 appeared with a bruise on her hand. While the bruise was possibly self-inflicted, the fact that Resident 1 had to sustain an actual injury before the facility initiated any type of investigation amply supports an immediate jeopardy finding.

In addition, there is little doubt that holding a pillow over a resident's head and assaulting her by poking her vaginal area posed immediate jeopardy to resident health and safety. It likely caused serious injury – physically and mentally – to Resident 2 to have to endure a staff member punishing her for yelling out during care. Moreover, it is beyond dispute that holding a pillow down over an elderly woman's head is more than likely to cause serious injury or death.

Petitioner argues that any noncompliance did not pose immediate jeopardy because its staff's conduct did not result in actual harm. P. Br. at 20, 22. Petitioner also points out that the evidence shows that Resident 1's first abuse allegation could not have happened. P. Br. at 21. As already noted, actual harm to a resident is not required to establish immediate jeopardy. Further, Petitioner does not address how its failure to report or investigate an abuse allegation immediately and thoroughly was unlikely to cause serious injury to a resident, especially when a resident had incurred physical and emotional abuse at the hands of an employee and another resident had become more physically aggressive with a specific CNA over the course of a day. Petitioner's has not met its "heavy burden" of showing that the immediate jeopardy determination was clearly erroneous.

5. The CMP imposed is reasonable in duration and amount.

An administrative law judge must consider several factors de novo when determining if the amount of a CMP is reasonable: (1) the facility's history of noncompliance; (2) the facility's financial condition, *i.e.*, its ability to pay the CMP; (3) the severity and scope of the noncompliance, the "relationship of the one deficiency to other deficiencies resulting in noncompliance," and the facility's prior history of noncompliance; and (4) the facility's degree of culpability, which includes neglect, indifference, or disregard for resident care, comfort or safety. 42 C.F.R. §§ 488.438(f), 488.404(b), (c). Unless a facility contends that a particular regulatory factor does not support the CMP amount, the administrative law judge must sustain it. *Coquina Ctr.*, DAB No. 1860, at 32 (2002).

CMS imposed a $5,300 per day CMP from January 30, 2013 through February 11, 2013, for a total CMP of $68,900. CMS may impose an enforcement remedy against a facility for as long as the facility is not in substantial compliance with participation requirements. 42 C.F.R. § 488.430(a). Petitioner bears the burden of persuasion with regard to the duration of its noncompliance. *Owensboro Place & Rehab. Ctr.*, DAB No. 2397 at 12-13 (2011). Petitioner was not in substantial compliance with participation requirements beginning on January 30, 2013, after staff did not investigate Resident 1's first allegation of abuse, and ending February 12, 2013, when Petitioner implemented an acceptable plan of correction. Petitioner has not offered any evidence or argument that the period of noncompliance was shorter than what CMS cited. Accordingly, I find the duration of the CMP is reasonable.

CMS has not offered any evidence of Petitioner's history of noncompliance. Petitioner has not offered any financial information. The noncompliance here posed immediate jeopardy to the health and safety of residents, and included appalling conduct against an elderly and dependent resident. Accordingly, a middle-range CMP is justified based on the severity of the noncompliance. The facility was highly culpable, as well. Its own staff member seriously abused a resident, and other staff appeared ill-informed about how to respond properly to an abuse allegation. Petitioner is responsible for the acts of its employees and cannot escape its significant culpability by blaming a single, rogue employee. *See Gateway Nursing Ctr.*, DAB No. 2283, at 8. Moreover, while Petitioner points to training sessions it held for its staff, it cannot disown or disavow the conduct of its staff merely because it reflects poorly on Petitioner as a whole. Who Petitioner hires as its staff and places in direct contact with its residents reflects the overall care and services it provides. *See Life Care Ctr. of Gwinnett*, DAB No. 2240, at 13 n.9 (2009). Thus, the middle-range CMP imposed here is very reasonable in light of the seriousness of the noncompliance and Petitioner's high culpability.

IV. Conclusion

For the foregoing reasons, the undisputed material facts establish that Petitioner was not in substantial compliance with 42 C.F.R. § 483.13(b), (c), and (c)(1), the state agency's determination of immediate jeopardy is not clearly erroneous, and the penalty imposed is reasonable. Therefore, I grant summary judgment in favor of CMS.

/s/
Scott Anderson
Administrative Law Judge