Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Ridgecrest Healthcare,
(CCN: 03-5125),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-13-513

Decision No. CR3222

Date: May 06, 2014

DECISION

I sustain the determination of the Centers for Medicare & Medicaid Services (CMS) to impose civil money penalties against Petitioner, Ridgecrest Healthcare, consisting of the following:

- A per-diem civil money penalty of $5,000 for Petitioner's noncompliance with Medicare participation requirements on December 7, 2012;

- A per-diem civil money penalty of $7,200 for Petitioner's noncompliance with Medicare participation requirements on February 1, 2013; and

- A civil money penalty of $500 per day for Petitioner's noncompliance with Medicare participation requirements during a period that began on December 8, 2012 and that ran through April 4, 2013.

Additionally, I sustain CMS's determination to deny Petitioner Medicare payment for new admissions from February 2 through April 4, 2013.

CMS notified Petitioner of its intent to impose the remedies that I recite above and Petitioner requested a hearing before an administrative law judge. The case was assigned

originally to another administrative law judge and then reassigned to me. I held a hearing on February 24, 2014 by video teleconference. At the hearing I heard the cross-examination testimony of several witnesses whose direct testimony had been filed in writing. I received into evidence exhibits from the parties, including the witnesses' written direct testimony, which was identified as CMS Ex. 1 – CMS Ex. 37 and P. Ex. 1 – P. Ex. 45.

I. CMS's Allegations of Noncompliance

This case is based entirely on the care that Petitioner gave to one of its residents, identified in the parties' exhibits as Resident # 1. The facts are undisputed that Resident # 1 is a relatively young and physically healthy individual whose primary medical problems consist of a chronic schizoaffective disorder and a bipolar disorder. CMS Ex. 1 at 1-2; CMS Ex. 19 at 4. He resides in a locked unit in Petitioner's facility that is reserved for individuals with psychiatric and behavioral problems.

On November 22, 2012, there was an incident at Petitioner's facility involving Resident # 1 and three of Petitioner's certified nursing assistant employees. It is undisputed that a nursing assistant was escorting the resident from one of Petitioner's shower rooms when the resident became uncooperative. The incident included the resident grabbing the handles of two doors, effectively immobilizing himself. One of Petitioner's nursing assistants, Morris Sohn, used physical force to pry the resident's hand from a door and the resident sustained a broken finger.

Based on this incident and the events that ensued subsequently CMS alleges that Petitioner:

- Allowed Resident # 1 to be abused physically, in violation of the requirements of 42 C.F.R. §§ 483.13(b) and (c)(1)(i);

- Continued to employ an individual (Mr. Sohn) who had abused a resident, failed to report to appropriate authorities the incident that caused Resident # 1 to sustain a broken finger, and failed to protect the resident against possible additional abuse while an investigation into the November 22 incident was in progress, in violation of the requirements of 42 C.F.R. §§ 483.13(c)(1)(ii) and (c)(2) – (4);

- Failed to implement its written anti-abuse policies because it failed to complete a thorough and timely investigation of the November 22 incident, in violation of the requirements of 42 C.F.R. § 483.13(c); and

- Failed to provide Resident # 1 with necessary care and services to address the pain and swelling that the resident experienced from his broken finger, in violation of the requirements of 42 C.F.R. § 483.25.

CMS bases its noncompliance allegation on findings that were made at two surveys of Petitioner's facility, completed on December 8, 2012 (December survey) and on February 2, 2013 (February survey). CMS Ex. 1; CMS Ex. 27. Both of these surveys resulted in findings that Petitioner's alleged noncompliance with the requirements of 42 C.F.R. §§ 483.13(c)(1)(ii) and (c)(2) – (4) was so egregious as to constitute immediate jeopardy. That is the basis for the $5,000 and $7,200 civil money penalties that I cite in the opening paragraph of this decision. Other findings of alleged noncompliance were at a less egregious level of scope and severity than immediate jeopardy and all of the findings of noncompliance are the basis for the $500 daily civil money penalties and denial of payment for new admissions.

II. Issues, Findings of Fact and Conclusions of Law

A. Issues

The issues are whether: Petitioner failed to comply substantially with the participation requirements cited by CMS; CMS's determination that Petitioner's failure to comply with the requirements of 42 C.F.R. §§ 483.13(c)(1)(ii) and (c)(2) – (4) was clearly erroneous; and CMS's remedy determinations are reasonable.

B. Findings of Fact and Conclusions of Law

The evidence establishes overwhelmingly that Mr. Sohn not only used unreasonable force in attempting to gain control over Resident # 1 but that he should not have used force at all. The evidence also establishes that Petitioner breached its responsibility to investigate the November 22 incident thoroughly and completely and to report that incident to appropriate State authorities. These failures put Resident # 1 at immediate jeopardy because not only was he harmed but also there was a likelihood of additional harm to the resident due to Petitioner's failure to recognize its duties and its failure to protect the resident adequately. The fact that Petitioner allowed Mr. Sohn to continue to serve as a nursing assistant, without retraining him or without supervising his actions, in and of itself, put Resident # 1 and, potentially, other residents, at risk for serious harm.

The heart of this case – and not disputed – is that Mr. Sohn forcefully intervened to remove Resident # 1's hand from a door when the resident was resisting being moved from Petitioner's shower area. The parties agree that while the resident was being escorted from the shower he grabbed two door handles in an entryway and refused to move. It was at that point that Mr. Sohn applied pressure to the fingers of the resident's

left hand in order to pry that hand away from the door, and in the process of doing so he broke the resident's finger. CMS Ex. 34 at 3; Tr. at 172-73.

I see no justification for this use of force. At the moment that Mr. Sohn acted the resident was posing no threat to himself or to others. He could not have done so: he had immobilized himself by grabbing the two door handles. Tr. at 172-73. The nursing assistants who intervened were not confronting a resident who was violently acting out or who was in the process of engaging in something harmful.

Petitioner argues that the resident had a history of engaging in self-injurious conduct. Furthermore, according to Petitioner, at the time of the incident, Resident # 1 was actively attempting to grab potentially harmful items, such as shaving equipment, that were stored in "cubbies" that were immediately adjacent to the resident. The cubbies that Petitioner refers to are a kind of shelving in which residents store personal items such as shampoo and shaving equipment. It contends that Mr. Sohn was motivated to use force against the resident by his concern that the resident might seize an item from the cubbies and use it to harm himself. Petitioner's post-hearing brief at 5. Thus, according to Petitioner, and in the heat of the moment, its staff reacted to what they perceived to be a danger – that the resident might grab an object from the cubbies and harm himself – and reacted appropriately. *Id*. at 9.

The obvious flaw in this argument is that Resident # 1 *could not possibly have harmed himself* at the moment that Mr. Sohn decided to use force. He could not have done so because he had immobilized himself by grabbing door handles with both hands. Resident # 1 was not actively attempting to grab anything other than the door handles.

Petitioner's own witness, Gary Martin, PhD, recognized that the use of force against Resident # 1 was unnecessary:

> I did express concern . . . about the staff's technique of trying to remove the Resident's hands from the door handles (even before I learned that the Resident's finger had been injured). But my concern was for the technique used to intervene, and not from any concern about possible abuse. For instance, I recall inquiring why staff had to use that technique *rather than simply standing between the Resident and the cubbyholes and waiting for him to release the door handles, which I thought was likely to happen fairly soon given the Resident's short attention span.*

P. Ex. 40 at 7-8 (emphasis added).

Mr. Sohn could have prevented the resident from seizing items from the cubbies without using force against the resident. As Mr. Sohn admitted in his testimony, he was standing between the resident and the cubbies at the moment that he decided to intervene

forcefully to remove the resident's hand from the door handle. In that position, he was blocking the resident's access to the cubbies. Tr. at 171-72.

Petitioner argues also that its staff was merely following a standard and widely accepted protocol when Mr. Sohn applied force to Resident # 1. It contends that its staff was trained in crisis prevention techniques including the proper use of physical interventions in appropriate circumstances to deescalate inappropriate resident behavior and to assure resident and staff safety. P. Ex. 45; CMS Ex. 15. But, nothing in the training that Petitioner refers to or in the crisis prevention techniques to which it refers suggests or allows the use of force against residents in circumstances where force is unnecessary. There was no need to use force here, consequently, Petitioner's assertion that it used appropriate techniques is unavailing.

Petitioner's staff abused Resident # 1 when Mr. Sohn forcefully removed the resident's hand from the door handle. Here, and by his own admission, Mr. Sohn deliberately used force against Resident # 1. That use of force was clearly inappropriate and it caused the resident to sustain an injury, a broken finger.[1] The inappropriate use of force in this case was thus abuse. A resident has a right to be free from physical abuse. 42 C.F.R. §§ 483.13(b), (c)(1)(i). "Abuse" constitutes the willful infliction of injury, among other things. 42 C.F.R. § 488.301. "Willful" means "deliberate." Abuse may occur where a staff member takes a deliberate action against a resident that causes the resident harm even if the staff did not intend to harm the resident. *Vandalia Park,* DAB No. 1939 (2004).

Furthermore, Petitioner's staff violated Petitioner's anti-abuse policy when Mr. Sohn applied inappropriate force to Resident # 1. CMS Ex. 14 at 19-20. Petitioner's policy explicitly prohibits its staff from "Twisting, squeezing or pinching any part of a resident's body with fingers or nails." *Id.* at 20. Mr. Sohn deliberately squeezed Resident # 1's fingers in his attempt to remove the resident's hand from the door.

Petitioner's management was informed about the incident and it also knew that the resident had sustained a fractured finger. Yet, management did virtually nothing to investigate the events of November 22. The sum total of Petitioner's "investigation" of the incident consists of a few sentence fragments jotted down on a single piece of paper

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[1] Petitioner argues that it is within the realm of reasonable possibility that Mr. Sohn's use of force was not the cause of Resident #1's broken finger. Petitioner's post-hearing brief at 6 n.5. Anything is possible, of course, but the overwhelming probability is that the use of force against the resident was the cause of the fracture. The resident had no complaints prior to the incident and complained of pain almost immediately afterward. However, whether or not the resident was injured is not necessary to my decision. The use of force against Resident # 1 would have been inappropriate and harmful even if the resident had sustained no injury as a consequence.

and dated November 27. CMS Ex. 24 at 1. These sentence fragments are notations of what the nursing assistants had to say about the November 22 incident. There is no summary of the events, no analysis of what happened, no reference to facility policies, no discussion of the Resident and his condition, and no conclusions as to whether the actions taken by staff were appropriate or not.

A skilled nursing facility has an obligation to investigate thoroughly any incident that might involve abuse. Even the remote possibility that a resident has suffered abuse triggers the duty to conduct a full and thorough investigation. The facility must report all possible incidents of abuse to appropriate State authorities and it must prevent further possible incidents of abuse while an incident is being investigated. 42 C.F.R. § 483.13(c)(2) – (4).

The cursory "investigation" that Petitioner's management conducted of the November 22 incident fell far short of what it was obligated to do and constituted a substantial violation of regulatory requirements. As I have discussed, management did nothing to investigate the incident aside from its supervisor making a few cursory notations of the staff's statements about what had occurred.

Petitioner argues that the notes in question are merely the tip of the iceberg, that in fact, its employee, Ms. Nicole Crothers, interviewed all of the staff members who were involved in the November 22 incident and determined, based on her interviews, that no abuse had occurred. Petitioner's post-hearing brief at 4. But, in the absence of any evidence that a thorough investigation took place speculating about what Ms. Crothers did or did not do is pointless. There is no evidence showing that Ms. Crothers or anyone else on Petitioner's staff thoroughly investigated the November 22 incident.

Petitioner argues also that no one on its staff actually thought that anything abusive had occurred on November 22. Rather, Petitioner's management concluded that the incident was merely a "behavioral incident" that didn't rise to the level of abuse. Petitioner's post-hearing brief at 14-15. From this assertion Petitioner apparently believes that its staff had no duty to conduct more of an investigation than the cursory interviews that the staff conducted. Petitioner would have me find that its staff's conclusion that there was no abuse justified not investigating the possibility of abuse.

This is plainly circular reasoning. There was overwhelming evidence that suggested more than the remote possibility that abuse had occurred on November 22. That included the staff's admission that there had been a physical confrontation with Resident # 1 and also the fact that the resident had sustained a serious injury caused by that confrontation. There also was a surveillance video that showed the confrontation and it is apparent that

the video revealed a physical altercation between the staff and the resident.[2] That Petitioner's management could have misjudged this evidence and formed the implausible belief that there was no possibility of abuse doesn't excuse it from investigating the possibility of abuse.

Petitioner did not notify appropriate State officials of the November 22 incident.[3] This failure, coupled with the failure to investigate promptly and thoroughly the November 22 incident comprised immediate jeopardy level noncompliance. "Immediate jeopardy" is defined at 42 C.F.R. § 488.301 to mean a situation where noncompliance has caused or is likely to cause serious injury, impairment, harm, or death to a resident. Here, there was a high probability of harm, not only to Resident # 1, but to all of Petitioner's residents, because in not investigating the November 22 incident, Petitioner's management blinded itself to the probability that further abusive conduct would occur. How could management trust its staff to do the right thing in the next confrontation with a resident if management did not fully investigate and assess the November 22 incident? How could management be assured that further confrontations and inappropriate uses of force would not occur? The answers to these questions are that management could not have known whether staff would act inappropriately without conducting an investigation. Moreover, and as I discuss below, it turns out that Mr. Sohn – and probably other staff members as well – were laboring under a highly inappropriate misunderstanding of when force could be used against residents. By not investigating the November 22 incident management tolerated this misunderstanding and greatly increased the likelihood that residents would be harmed.

Petitioner did nothing to protect Resident # 1 or other residents from the possibility that Mr. Sohn might engage in additional abusive conduct. In fact, it continued to permit Mr. Sohn to provide care to residents without substantial re-training, not only during the days following November 22, but also during the period between the December and February surveys. CMS's determination to impose a second immediate jeopardy level civil money penalty against Petitioner on February 1, 2013 is based on Petitioner's continued employment of Mr. Sohn without addressing his abusive act.

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[2] Petitioner destroyed the surveillance video. I find that the best evidence of what that video showed is the testimony of Katrina Huff, a State Agency surveyor, who saw the video. CMS Ex. 34. Ms. Huff testified that she saw three of Petitioner's staff attempting to remove the resident's right hand from a door handle and the resident physically resisting. *Id.* at 2-3; Tr. at 25-26.

[3] Petitioner subsequently investigated the November 22 incident, but only after the December survey and only after it had been cited for not investigating or reporting the November 22 incident.

I am not suggesting that Mr. Sohn acted out of malice when he broke the resident's finger. To the contrary, I conclude from the testimony that Mr. Sohn gave at the hearing that he believed – and still believes – that he acted appropriately during the November 22 incident. Tr. at 168-86. What was evident from Mr. Sohn's testimony is that he lacks any comprehension of why his use of force against Resident # 1 was inappropriate and abusive. He asserted that he was merely implementing the techniques that he had been trained to use against residents who are engaging in obstructive or dangerous conduct. Tr. at 177. What Mr. Sohn so obviously failed to comprehend is that the techniques that he had been trained to use and that he used – which definitely involve the application of force – are reserved only for those circumstances where the use of force is appropriate, such as a situation where a staff member is assaulted physically by a resident and the staff member is unable to retreat. *See* CMS Ex. 15.

Petitioner allowed Mr. Sohn to continue working while under the misapprehension that he could use physical force to confront a resident, as with the case of Resident # 1, in a circumstance where physical force would never be appropriate. That is a clear regulatory violation.

Petitioner argues that CMS's basis for finding that immediate jeopardy continued until February 1, 2013 is that in continuing to utilize Mr. Sohn as a care-giver Petitioner contravened the requirements of 42 C.F.R. § 483.13(c)(1)(ii)(A) and (B). This subsection essentially prohibits a facility from employing an individual who has been convicted of conduct amounting to abuse by a court of law or who has had a finding of abuse entered against him or her in a State nursing registry. Petitioner asserts that nothing of the kind had been issued against Mr. Sohn and consequently there is no basis in the regulations for finding that Petitioner contravened regulatory requirements in continuing to employ Mr. Sohn after the December survey. Petitioner's post-hearing brief at 18-19.

I agree with Petitioner that noncompliance in this case cannot be based on a violation of 42 C.F.R. § 483.13(c)(1)(ii)(A) and (B). As Petitioner correctly notes, Mr. Sohn was not convicted of abuse nor was an abuse finding entered against him in the State nursing registry. However, the continued employment of Mr. Sohn was nevertheless a regulatory violation. Petitioner is not culpable because it employed an individual who was convicted of abuse. It is culpable because it continued to employ Mr. Sohn as a caregiver without assuring that he understood why his conduct on November 22 was inappropriate and abusive. In doing so Petitioner ran the risk that Mr. Sohn, laboring under the mistaken belief that he'd acted appropriately on November 22, might engage in similar abusive conduct towards Resident # 1 or some other resident. That violated the provisions of 42 C.F.R. § 483.13(c)(1) barring facility abuse of residents, because there remained a high likelihood of continuing abuse so long as Mr. Sohn remained employed as a caregiver without correcting his faulty understanding of when it might be appropriate to use force.

The continued employment of Mr. Sohn without retraining him put both Resident # 1 and other residents at immediate jeopardy. That Mr. Sohn, and other staff members as well, did not understand the circumstances when force could be used against a resident put Resident # 1 and all other residents at Petitioner's facility at a likelihood for harm, at the very least. CMS's determination of immediate jeopardy was not clearly erroneous. Rather, it was entirely supported by the evidence.

Petitioner's failure to investigate timely and thoroughly the November 22 incident not only contravened regulatory requirements that it conduct such an investigation but it contravened Petitioner's own policy governing abuse. CMS Ex. 14; 42 C.F.R. § 483.13(c). Petitioner has not offered a specific defense here except to argue that it was not obligated to conduct the type of abuse investigation mandated by the regulations and its own policy because the November 22 incident was merely a "behavioral incident." I have explained why the incident of November 22 clearly constituted abuse and why Petitioner's management should have recognized that.

I find it unnecessary to address CMS's remaining allegation that Petitioner's staff failed adequately to deal with Resident # 1's complaints resulting from his broken finger. The other deficiency findings that I have sustained are more than adequate to support the remedies that CMS imposed against Petitioner.

The two immediate jeopardy level civil money penalties of $5,000 and $7,200 are based on the findings of immediate jeopardy level noncompliance that I have sustained. In any case where CMS imposes a per-diem immediate jeopardy level civil money penalty of more than $3,050 there potentially arises an issue of whether the penalty amount is reasonable. However, Petitioner has offered no argument here challenging the penalty amounts. I therefore find it unnecessary to address CMS's rationale for the penalty amounts in question.

Similarly, Petitioner has not disputed the $500 per day penalty amounts for non-immediate jeopardy level noncompliance between December 8, 2012 and April 4, 2013. Petitioner has not argued that, if it was noncompliant it cured its noncompliance at an earlier date than the date of substantial compliance determined by CMS. Nor does it argue that $500 per day for non-immediate jeopardy level noncompliance is unreasonable. Therefore, I find it unnecessary to address the duration and amount of the $500 per day penalties.

Finally, I find it unnecessary to address whether denial of payment for Medicare admissions is a permissible remedy in this case. As a matter of law such remedy is permissible whenever CMS finds noncompliance that is substantial. Petitioner has not

challenged the imposition of the remedy except to argue that no remedy should be imposed against it on the ground that it was at all times compliant with participation requirements. I have addressed those arguments.

/s/
Steven T. Kessel
Administrative Law Judge