Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Leroy Manor,
(CCN: 145674/0047704),
Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-14-1383

Decision No. CR3512

Date: December 12, 2014

DECISION

I grant in part and deny in part the motion for summary judgment by the Centers for Medicare & Medicaid Services (CMS) and the cross-motion for summary judgment by Petitioner, Leroy Manor. I impose the following remedies against Petitioner:

- Civil money penalties of $7000 per day for each day of a period that began on February 23, 2014 and that continued through February 25, 2014.

- Civil money penalties of $200 per day for each day of a period that began on February 26, 2014 and that continued through March 6, 2014.

I. Introduction

CMS initially determined to impose per-diem civil money penalties of $10,000 against Petitioner, a skilled nursing facility doing business in Illinois, for the February 23 – 25 period and of $200 for the February 26 – March 6 period. CMS based its determination on its conclusion that as of February 23 Petitioner manifested three immediate jeopardy level deficiencies and two additional alleged deficiencies that were at less than the immediate jeopardy level of scope and severity.

CMS moved for summary judgment (CMS Br.). Petitioner opposed CMS's motion and cross-moved for summary judgment (P. Br.). CMS opposed Petitioner's cross-motion. With its motion CMS filed 23 proposed exhibits that it identified as CMS Ex. 1 – CMS Ex. 23. In opposing the motion Petitioner filed 17 proposed exhibits that it identified as P. Ex. 1 – P. Ex. 17. I receive the parties' exhibits into the record.

II. Issues, Findings of Fact and Conclusions of Law

A. Issues

The issues are whether: Petitioner was non-compliant with Medicare participation requirements; CMS's determination of immediate jeopardy was clearly erroneous; and, CMS's remedy determinations are reasonable.

In this decision I address only CMS's findings of immediate jeopardy level noncompliance. I find it unnecessary that I adjudicate the findings of non-immediate jeopardy level noncompliance for reasons that I explain below.

B. Findings of Fact and Conclusions of Law

In moving for summary judgment the parties acknowledge that there are no disputed issues of material fact in this case. But, even if there were facts in dispute, in moving for summary judgment each party effectively has acknowledged that it sees no need to cross-examine any of the witnesses whose written direct testimony was filed as an exhibit by its opponent. Consequently, there is no need for an in-person hearing in this case.

I agree with the parties that there are no material facts in dispute. The facts in this case are clear and uncontroverted.

The case revolves around the care that Petitioner gave to two of its residents, identified as Resident # 4 and Resident # 5. It is undisputed that at 1 a.m. on February 23, 2014, Resident # 4, who suffered from dementia, assaulted Resident # 5, a frail and demented woman who was 91 years old at the time (P. Exs. 9, 10), by lying on Resident # 5's body while she covered the resident's nose and mouth with her hands. CMS Ex. 14 at 16; CMS Ex. 15; CMS Ex. 20 at 1, 3, 7. CMS's allegations of noncompliance all relate to that assault.

CMS's allegations of immediate jeopardy level noncompliance are as follows.

First, it asserts that Petitioner failed to comply with the requirements of 42 C.F.R. § 483.13(b). This section provides, among other things, that every resident of a skilled nursing facility has the right to be free from physical abuse. CMS contends that Petitioner failed to comply with this section because it allowed Resident # 4 to abuse

physically Resident # 5. CMS Ex. 1 at 4-7. Elaborating on this assertion, CMS argues that Petitioner knew or should have known that Resident # 4 posed a threat to Resident # 5 and failed to do anything meaningful to address that threat. It argues, essentially, that the proximate cause of the assault that occurred on February 23 was the alleged failure by Petitioner to protect other residents from Resident # 4.

Second, CMS asserts that Petitioner failed to comply with the requirements of 42 C.F.R. § 483.13(c). In relevant part this regulation directs a skilled nursing facility to develop and implement policies to protect its residents against abuse. CMS claims that Petitioner did not comply with this regulation in that Petitioner's Administrator could not recall the specific requirements of Petitioner's abuse prevention policy when questioned about them. CMS Ex. 1 at 11, 14; CMS Br. at 17-18. CMS argues also that Petitioner violated its abuse prevention policy in that it failed to provide continuous (i.e. one-to-one) supervision of Resident # 4 in the period immediately following her assault on Resident # 5.

Finally, CMS asserts an additional immediate jeopardy level violation of 42 C.F.R. § 483.13(c) in that Petitioner allegedly failed – in contravention of its abuse prevention policy – to notify law enforcement officials immediately of the assault of Resident # 5 by Resident # 4. CMS Ex. 1 at 16.

The fact that a resident perpetrates an assault on another resident of a skilled nursing facility is not in and of itself sufficient to establish that a facility allowed its residents to be abused in violation of regulatory requirements. In order for the facility to be culpable, the abuse must be *foreseeable and preventable*. In other words, a facility has to know in advance or it should know that there is a risk of resident-against-resident abuse and there must be evidence that the facility ignored or failed adequately to deal with that risk, in order for it to be held liable for failure to comply with the requirements of 42 C.F.R. § 483.13(b). CMS acknowledges that this is the standard, which is why it asserts that Petitioner either knew or should have known that Resident # 4 posed a threat to other residents.

I find that the undisputed facts establish that Petitioner and its staff were on notice that Resident # 4 manifested homicidal ideation. That knowledge, coupled with the resident's behavior, put Petitioner and its staff on notice that the resident posed a potential danger to other residents of the facility. The assault that Resident # 4 perpetrated against Resident # 5 was, therefore, foreseeable and preventable, and Petitioner is liable for not protecting its residents against abuse in contravention of 42 C.F.R. § 483.13(b).

The undisputed material facts establish this. At the time of the February 23 assault, Resident # 4 was 75 years old. She had resided at Petitioner's facility beginning in January 2014. She had a number of impairments that included dementia. She exhibited anxiety, depression, and altered mental status. CMS Ex. 14; CMS Ex. 15; P. Ex. 3; *see* P.

Ex. 2 at 16. The clinical record for Resident # 4 does not describe any incidents of the resident assaulting other residents prior to February 23. But, and this is highly significant, Petitioner's medical director diagnosed Resident # 4 as manifesting homicidal ideation shortly after her admission to Petitioner's facility.[1] P. Ex. 3 at 1.

The medical director's diagnosis of the resident's homicidal ideation is a laconic comment, grouped with multiple other diagnoses, to a much lengthier mental status evaluation that the medical director conducted on January 8, 2014, around the date of the resident's admission to Petitioner's facility. There is no elaboration of this comment. P. Ex. 3 at 1. What the resident may have said that triggered the medical director's finding is, therefore, unknown. But, whether or not the resident articulated her ideation in detail, the fact that she harbored homicidal thoughts certainly was a sufficient basis for the facility to treat the resident as being potentially dangerous to others.

On February 12, 2014, 11 days prior to the assault on Resident # 5, Resident # 4 complained to Petitioner's nursing staff that Resident # 5 was disturbing her. At the time, Resident # 4 and Resident # 5 were roommates. Later on that same date Resident # 4 again complained to Petitioner's nursing staff, asserting with a raised voice that "she cannot take her roommate talking, [and] that she does not have to put up with it." CMS Ex. 14 at 13. Petitioner's staff responded to Resident # 4's complaints by removing Resident # 5 from her room. *Id.*[2]

The resident's vocalization and complaints prior to February 23 do not, in and of themselves, signify any propensity on Resident # 4's part for violent behavior. Standing alone, they show her merely to be argumentative and unreasonable. But, when coupled with her homicidal ideation, they were a flashing red warning light that should have put Petitioner's staff on notice that this resident potentially was dangerous to her co-residents.

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[1] CMS argues that there is additional evidence that put Petitioner on notice that Resident # 4 was a danger to others. That alleged additional evidence includes a psychiatric evaluation of the resident that found that the resident manifested homicidal ideation. CMS Ex. 21. Of course, this evidence would be very significant if I could infer from it that Petitioner knew or should have known prior to February 23, 2014, that Resident # 4 harbored homicidal thoughts. But, the evidence that CMS cites is a hospital evaluation made of Resident #4 *after the events of February 23*. That report was made in the wake of, and not prior to, Resident # 4's assault of Resident # 5.

[2] It is not clear from the undisputed facts whether Petitioner's staff assigned Resident # 5 to another room on February 12 or whether they simply removed the resident temporarily in order to placate Resident # 4.

It is apparent from the undisputed facts that Petitioner did not take into consideration prior to February 23, 2014, the resident's homicidal ideation nor did its staff evaluate the resident's behavior in light of the mental status evaluation in which homicidal ideation was found. Indeed, Petitioner took no special precautions whatsoever prior to February 23 to protect other residents from potentially assaultive behavior by Resident # 4. I find it to be evident that the staff simply disregarded the medical director's assessment of the resident as having homicidal ideation. That failure to act and to protect other residents from Resident # 4 put those residents at risk for serious harm or worse. Resident # 4's assault on Resident # 5 was entirely foreseeable and Petitioner's failure to take reasonable preventive measures prior to February 23 is a violation of the regulations.

Petitioner's medical director submitted a declaration in which he asserts that there was nothing about Resident # 4's behavior that would have put Petitioner's staff on notice that she posed a threat to other residents. P. Ex. 17. I agree that the resident's behavior between January 8 and February 23, 2014, when considered in isolation, did not suggest that she was prone to assault other residents. But, the medical director failed to discuss his own finding, that he made on January 8, 2014, that the resident voiced homicidal ideation. That omission is significant. As I have discussed, everything Resident # 4 said and did after January 8 should have been viewed by Petitioner through the lens of that resident's homicidal thoughts.

The undisputed facts strongly support CMS's finding that Petitioner's noncompliance with 42 C.F.R. § 483.13(b) was at the immediate jeopardy level. Petitioner's staff knew, or it should have known, that Resident # 4 posed a significant threat to the safety and well being of other residents. The staff's failure to guard against the possibility that Resident # 4 might assault others plainly created a likelihood of serious injury, harm, or death to other residents.

I find no basis to conclude that Petitioner violated its abuse prevention policy, in contravention of 42 C.F.R. § 483.13(c), by failing to place Resident # 4 under continuous supervision immediately after she assaulted Resident # 5. It is true, as CMS contends, that Petitioner did not place Resident # 4 under continuous supervision in the hours following her assault on Resident # 5. Rather, the staff moved Resident # 4 to a vacant resident room on a different hallway in Petitioner's facility from the hallway containing the room in which Resident # 4 had committed the assault. Petitioner's staff initiated bed checks of Resident # 4 at 15-minute intervals in order to monitor her condition. P. Ex. 7 at 6; CMS Ex. 18 at 15, 17; CMS Ex. 20 at 4, 6.[3]

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[3] Petitioner subsequently placed Resident # 4 on continuous monitoring after she had been sent to a hospital and returned to Petitioner's facility and pending her transfer out of the facility. P. Ex. 7 at 7.

Petitioner's abuse prevention policy contains language for dealing with a resident who is suspected of assaulting, or known to have assaulted, another resident:

> If another resident is the suspected perpetrator of the abuse, then the suspected resident shall be supervised 1:1 or kept physically separate from all other residents until further orders.

CMS Ex. 22 at 14. CMS relies on the language calling for continuous supervision, in conjunction with the undisputed facts, to argue that Petitioner violated its abuse prevention policy. Stated simply, CMS argues that Petitioner assumed a responsibility to monitor Resident # 4 continuously in the hours immediately after the assault but failed to do so.

However, the policy is written in the disjunctive. That policy gave Petitioner's staff an option: either to supervise continuously or to sequester a resident who is suspected of, or who has committed, an assault.

Petitioner chose to do the latter. Putting Resident # 4 in an unoccupied room in a different part of the facility from Resident # 5 is entirely consistent with Petitioner's abuse prevention policy. Petitioner provided the added security of monitoring the resident at 15-minute intervals while the resident slept. These actions suggest no violation of regulatory requirements.

CMS argues that the reason that Petitioner opted, initially, not to put Resident # 4 under continuous supervision had to do with Petitioner's staffing. But, even if that is so, Petitioner had the option of doing what it did, sequestering the resident.

The fact that the Administrator may have not known the specifics of Petitioner's abuse prevention policy when asked about them is not proof of a violation. The issue is not whether a member of Petitioner's management could recite the provisions of the abuse prevention policy when quizzed about them but whether the policy had been implemented. The undisputed facts show that it was implemented in the case of Resident # 4 and CMS has offered no evidence to show that the policy was not implemented generally.

The undisputed material facts do show, however, that Petitioner failed to comply with its own abuse prevention policy in another respect. The policy directs Petitioner's management and staff to notify law enforcement immediately in the event of abuse. CMS Ex. 22 at 12. Petitioner failed to comply with its policy in dealing with Resident # 4 after she assaulted Resident # 5. It is undisputed that Petitioner's staff did not notify

law enforcement authorities about Resident # 4 for several hours after she assaulted Resident # 5. CMS Ex. 21; P. Br. at 23. In fact, Petitioner only notified law enforcement authorities at the point when its staff determined to transport the resident to a hospital for evaluation. *See* P. Ex. 7 at 6; P. Br. at 23.

Petitioner concedes that it violated its policy but asserts that there was no significant harm as a result of its error. It argues, therefore, that its noncompliance was minimal at worst and certainly was not an immediate jeopardy level deficiency. It reasons that Resident # 4 posed no threat to other residents because she was sequestered during the period of time between her assault on Resident # 5 and her transport to a hospital and she was under continuous observation afterwards.

What Petitioner contends is undeniably true and I agree with Petitioner that the measures it took after the assault protected other residents from additional harm being perpetrated by Resident # 4.

However, I disagree with Petitioner's argument that its noncompliance with its abuse prevention policy was minimally harmful. Failure by the staff to notify law enforcement authorities immediately betrays ignorance by the staff of the facility's policy and also of the dangers posed by noncompliance. The requirement for immediate notification of law enforcement authorities after an assault serves multiple important purposes. It protects residents against the possibility of additional assaults, particularly in the case where the assailant is unknown. It facilitates investigation of the event while the evidence is fresh. And, it enables law enforcement authorities to preserve evidence that might otherwise be destroyed.

If Petitioner's staff was unaware that it was mandated to notify law enforcement officials in this case, then the probability is that it would be unaware of its mandate in other cases of assault and that certainly would lead to residents being placed in jeopardy. I find CMS's determination of immediate jeopardy level noncompliance not to be clearly erroneous for this reason.

CMS determined to impose civil money penalties of $10,000 per day for the three-day period of Petitioner's immediate jeopardy level noncompliance. That is the maximum daily penalty amount for immediate jeopardy level noncompliance. CMS plainly predicated this penalty on its determination that Petitioner manifested three immediate jeopardy level deficiencies between February 23 and 25, 2014.

I find the penalty amount of $10,000 per day to be unreasonable because Petitioner manifested two, and not three, immediate jeopardy level deficiencies. Put simply, Petitioner's noncompliance, although serious, was less egregious than CMS determined it to be. I find that civil money penalties of $7000 per day reasonably reflect the presence of two immediate jeopardy level deficiencies.

CMS also imposed civil money penalties of $200 per day for the period beginning February 26, 2014 that continued through March 6, 2014. These penalties were based on CMS's determination that Petitioner remained out of compliance, albeit not at the immediate jeopardy level, during this period and that it did not abate its noncompliance completely until March 7.

Petitioner does not contend that it abated its deficiencies – assuming that it was deficient – at a date that is earlier than March 7. Consequently, duration of noncompliance is not at issue in this case.

A per-diem civil money penalty of $200 is a minimal amount. It comprises only slightly more than six percent of the maximum daily penalty amount that CMS may impose for non-immediate jeopardy level deficiencies. 42 C.F.R. § 488.438(a)(1)(ii). Petitioner's non-immediate jeopardy level noncompliance with the requirements of 42 C.F.R. § 483.13(c) after February 25 is, in and of itself, sufficient to justify a minimal penalty amount of $200 per day.

As I discuss above, CMS alleged the presence of two non-immediate jeopardy level deficiencies in addition to the alleged deficiencies that I have addressed in this decision. I find it unnecessary that I discuss these additional alleged deficiencies. Their potential presence would not serve as a basis for increasing the immediate jeopardy level penalties that I sustain. Nor would it serve as a necessary basis for the $200 per day non-immediate jeopardy level penalties that I sustain, because the deficiencies that I have sustained are sufficient, in and of themselves, to justify $200 per day after February 25, 2014.

/s/

Steven T. Kessel
Administrative Law Judge