Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Rockcastle Health and Rehabilitation Center,
(CCN: 18-5246)

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-14-1984

Decision No. CR4926

Date: August 17, 2017

DECISION

Rockcastle Health and Rehabilitation Center (Petitioner or "the facility") is a long-term-care facility located in Brodhead, Kentucky that participates in the Medicare program. Following a complaint survey completed June 27, 2014, the Centers for Medicare and Medicaid Services (CMS) determined that the facility was not in substantial compliance with Medicare program requirements and that its deficiencies posed immediate jeopardy to resident health and safety. CMS imposed civil money penalties (CMPs) of $5,300 per day for 30 days of immediate jeopardy and $100 per day for 36 days of substantial noncompliance that was not immediate jeopardy.

For the reasons discussed below, I find that from May 26 through June 24, 2014, the facility's deficiencies posed immediate jeopardy to resident health and safety, and that the facility was not in substantial compliance with Medicare program requirements from June 25 through July 30, 2014. The $162,600 penalty imposed is reasonable.

I. Background

The Social Security Act (Act) sets requirements for skilled nursing facility (SNF) participation in the Medicare program. The Act authorizes the Secretary of the United States Department of Health & Human Services (Secretary) to promulgate regulations implementing those statutory provisions. Act § 1819 (42 U.S.C. § 1395i-3). The Secretary's regulations are found at 42 C.F.R. part 483.

A facility must maintain substantial compliance with program requirements in order to participate in the program. To be in substantial compliance, a facility's deficiencies may pose no greater risk to resident health and safety than "the potential for causing minimal harm." 42 C.F.R. § 488.301.

The Secretary contracts with state agencies to conduct periodic surveys to determine whether SNFs are in substantial compliance with the participation requirements. Act § 1864(a) (42 U.S.C. § 1395aa(a)); 42 C.F.R. §§ 488.10, 488.20. The Act and its implementing regulations require that facilities be surveyed on average every twelve months, and more often if necessary, to ensure that identified deficiencies are corrected. Act § 1819(g)(2)(A) (42 U.S.C. § 1395i-3(g)(2)(A)); 42 C.F.R. §§ 488.20(a), 488.308.

Surveyors from the Kentucky Office of Inspector General, Division of Health Facilities and Services (State OIG), conducted an initial and extended survey of the facility as part of a complaint investigation that was completed on June 27, 2014. CMS Exhibits (Exs.) 1 at 1; 33 at 1. Based on the survey findings, CMS determined that, among other deficiencies, the facility was not in substantial compliance with the following participation requirements:

> 42 C.F.R. § 483.10(b)(4) (Tag 155, Right to Refuse Treatment) at the scope and severity level of J (isolated instance of substantial noncompliance that poses immediate jeopardy to resident health and safety);
>
> 42 C.F.R. §§ 483.13(b) and 483.13(c)(1)(i) (Tag F223, Abuse and staff treatment of residents) at the scope and severity level of J;
>
> 42 C.F.R. § 483.13(c)(2)-(4) (Tag F225, Investigate and report abuse) at the scope and severity level of J;
>
> 42 C.F.R. § 483.13(c) (Tag F226, Facility policies – abuse and neglect policies and procedures) at the scope and severity level of J;

42 C.F.R. § 483.75 (Tag F490, Administration) at scope and severity level of J[1];

CMS Ex. 1. After a revisit on September 10, 2014, CMS determined that the facility had returned to substantial compliance on July 31, 2014. CMS Ex. 3.

CMS imposed CMPs of $5,300 per day for 30 days of immediate jeopardy from May 26 to June 24, 2014, and CMPs of $100 per day for 36 days of substantial noncompliance that was not immediate jeopardy from June 25 to July 30, 2014. The total amount of penalties is $162,600. CMS Ex. 5 at 3.

Petitioner timely requested review on September 12, 2014. This case had been assigned to Administrative Law Judge Joseph Grow, and the Director of the Civil Remedies Division reassigned the case to me following Judge Grow's departure from the Departmental Appeals Board (DAB).

On August 18, 2016, I convened a hearing, via video teleconference, from the offices of the DAB in Washington, D.C. for the purpose of allowing counsel for Petitioner the opportunity to cross-examine a CMS witness, Kimberly Brock.[2] Counsel for CMS appeared from Atlanta, Georgia, the witness appeared from London, Kentucky, and counsel for Petitioner appeared in Washington, DC. Transcript (Tr.) at 4.

CMS filed a pre-hearing brief (CMS Br.), and Petitioner filed a motion for summary judgment[3] and pre-hearing brief. (P. Br.). Both parties filed post-hearing briefs (CMS

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[1] Federal nursing home regulations substantially changed effective October 4, 2016. Based on the date of the survey, which preceded the regulatory revisions, I refer to the regulations that were in effect at the time of the survey.

[2] CMS did not request an opportunity to cross-examine the following witnesses who submitted written direct testimony: Ramona Barker, R.N. (Petitioner (P.) Ex. 59); Rachel Martin, L.P.N. (P. Ex. 60), Alicia Bullock, R.N. (P. Ex. 61), Steven Cook (P. Ex. 62), Lakia Sneed, L.P.N. (P. Ex. 63), and Beverly Lowery, R.N. (P. Ex. 64).

[3] Petitioner appended a copy of the state ALJ's Findings of Fact, Conclusions of Law, and Final Order to its motion of summary judgment and argued that summary judgment was warranted based on the state ALJ's determinations. The state ALJ determined that because Petitioner had handled certain incidents as grievances, it was not required to report those same incidents as allegations of abuse to the State OIG, explaining that "[c]ertainly the OIG does not want to assume the role of exercising this initial judgment" and "[d]oing so would result in every facility contacting OIG to ask whether it was appropriate to utilize the grievance the [sic] process or begin an abuse investigation." Motion for Summary Judgment, Exhibit A (Conclusions of Law, ¶ 5). Further, the state ALJ stated "this tribunal concluded that even if the facility failed to have an effective

Post-Hearing Br.; P. Post-Hearing Br.) and post-hearing reply briefs (CMS Post-Hearing Reply and P. Post-Hearing Reply). On August 1, 2016, I issued an Order ruling on the admissibility of evidence, at which time I excluded P. Exs. 1, 2, 3, and 7a, and admitted P. Exs. 4-7 despite CMS's objections. *See* Tr. at 8.

II. Issues

The issues before me are:

1. From May 26 through July 30, 2014, was the facility in substantial compliance with Medicare program requirements;

2. If, from May 26 through June 24, 2014, the facility was not in substantial compliance with program requirements, did its deficiencies then pose immediate jeopardy to resident health and safety; and

3. If the facility was not in substantial compliance, are the penalties imposed of $5,300 per day for 30 days of immediate jeopardy and $100 per day for 36 days of substantial compliance that was not immediate jeopardy reasonable?[4]

III. Discussion

1. The facility had written policies and procedures in effect between May 15, 2013 and June 11, 2014, to include separate policies addressing the administration of medications and abuse, neglect, and misappropriation.

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system to identify and prevent and prevent abuse, and abuse allegations were not thoroughly investigated, and appropriate State agencies were not notified, there is no proof in the record that establishes that the incidents in question presented an imminent danger and created substantial risk that death or serious mental or physical harm to a resident could occur." Motion for Summary Judgment, Exhibit A (Conclusions of Law, ¶ 6). Judge Grow denied Petitioner's motion for summary judgment on March 30, 2016.

[4] Petitioner challenges only the immediate jeopardy deficiencies and does not challenge the two non-immediate jeopardy deficiencies. To the extent that Petitioner does not challenge the deficiencies cited as 42 C.F.R. § 483.10(a)(1)-(2) (Tag F151 – right to exercise rights) and 42 C.F.R. § 483.75(l)(1) (Tag F514 – accurate clinical records), both cited at the D level of scope and severity, Petitioner does not challenge the CMPs associated with those deficiencies. Therefore, Petitioner does not challenge the $100 per day CMP for the 36-day period from June 25 to July 30, 2014.

Facility policies: The facility had a written policy in place for medication administration. (CMS Ex. 32 at 1-5). The facility's policy, dated December 2010, states, in pertinent part:

> **Important:** If the resident refuses medication, indicate failure to administer medication on administration record and nurse's clinical notes.
>
> Counsel the resident on the potential dangers to him/herself if medication is refused. In nurse's clinical notes, document refusal, reason and counseling. Notify the physician timely of refusal as medication indicates.

CMS Ex. 32 at 2 (emphasis in original).

The facility also had a policy for abuse, neglect and misappropriation. CMS Ex. 32 at 6-9. While the policy directs that staff will receive orientation and training on "[w]hat constitutes abuse, neglect and misappropriation of resident property," the facility's policy does not contain a definition of how the facility defines the term "abuse."[5] CMS Ex. 32 at 8. The facility's abuse, neglect and misappropriation policy, effective April 2013, states:

> **POLICY**
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> A. Verbal, sexual, physical, and mental abuse, corporal punishment, neglect and involuntary seclusion of the resident, resident exploitation as well as misappropriation of resident property are prohibited.
>
> B. All allegations of abuse involving abuse along with injuries of unknown origin are reported immediately to the charge nurse and/or administrator

[5] The facility policy did not define abuse for purposes of the policy. The definition provided in 42 C.F.R. § 488.301 states:

> *Abuse* is the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology. *Willful,* as used in this definition of abuse, means the individual must have acted deliberately, not that the individual must have intended to inflict injury or harm.

of the facility along with other officials in accordance with State law through established guidelines.

C. Individuals are not hired when a history of abuse is known.

D. Retribution against residents, staff or visitors who file reports of abuse is prohibited.

E. Each facility must designate an Abuse Prevention Coordinator.

CMS Ex. 32 at 6 (emphasis in original). The abuse, neglect and misappropriation policy further states:

V. Protection of the Resident

A. All allegations of abuse are to be reported immediately to charge nurse. If the charge nurse is the suspected perpetrator the allegation will be reported to another licensed nurse and/or manager in the facility, or via phone to Administrator and/or DON.

B. If the person reporting the abuse believes there is a lack of response from the charge nurse the person will then notify the [Director of Nursing] and/or Administrator. If DON/Administrator are not in the facility staff will notify them via phone.

C. The charge nurse will immediately remove the suspected perpetrator from resident care areas, obtain the staff members witness statement and immediately suspend the employee pending the outcome of the investigation.

D. The charge nurse will immediately notify the Administrator, DON and/or Abuse Coordinator as appropriate.

E. The Administrator and/or DON will notify state agencies according to their reporting guidelines.

CMS Ex. 32 at 8 (emphasis in original). The facility's policy states that "[a]ll allegations of abuse will be investigated and reported to the appropriate agencies"[6] and that "[t]he

[6] The Director of Nursing testified that "Kentucky requires that allegations of abuse must be reported on a specific form to the survey agency (known in Kentucky as the Office of Inspector General or 'OIG'), to Adult Protective Services, and to the local Ombudsman." P. Ex. 59 at 5; *see also* P. Ex. 64 at 3 (testimony of Beverly Lowery, R.N. (Vice President

Administrator/designee will make all reasonable efforts to investigate and address alleged reports, concerns, and grievances." CMS Ex. 32 at 8-9. The policy also states that "[a]ll allegations are to be reported within the timeframe allotted by state agency." CMS Ex. 32 at 9.

> ***2. Over the course of more than twelve months, the facility received at least five allegations of staff abuse of residents. The facility initially processed three of those five allegations of abuse as grievances and did not report these three allegations of abuse to the State OIG, Adult Protective Services, and the Ombudsman within five days. Petitioner belatedly reported these three allegations of abuse to the State OIG[7], but reported that its investigation did not substantiate abuse had occurred in any of these three instances. The facility later reported, upon re-investigation of two of those allegations that had originally been processed as grievances, that abuse had been substantiated. Two other allegations of abuse were initially processed as allegations of abuse by Petitioner and reported to the State OIG, but Petitioner reported to the State OIG that abuse had not been substantiated. Upon re-investigation of both allegations of abuse, Petitioner later substantiated that abuse had occurred.***

Summary of relevant allegations of abuse:

May 15, 2013

A facility employee recorded a grievance from Resident # 2 on May 16, 2013, at which time the resident reported that Medication Aide 1 (MA #1) was "rough" with her when she put her back to bed on May 15, 2013. CMS Ex. 16 at 3. The grievance explained that "[Resident # 2] did not feel like [MA # 1] was intentionally rough with her," but that MA # 1 "hoisted her into bed with more force than was necessary" and that the nurse aide was "overzealous."[8] CMS Ex. 16 at 1. The resident did not allege that she was injured

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of Regulatory Compliance and Quality Assurance for Signature Healthcare, the facility's operator).

[7] When I refer to a report to the State OIG, I also encompass Petitioner's reports of the same information to Adult Protective Services and the Ombudsman.

[8] Although it does not appear in any of the written investigation reports, Petitioner's witness explained that Resident # 2 told her that MA # 1 "had put her to bed in a quicker fashion and used more 'oomph' than the other aides." P. Ex. 60 at 2. It appears that the nurse used the word "oomph" to refer to the amount of forced used by MA # 1. *See* Merriam-Webster Dictionary (online edition) *https://www.merriam-*

by the facility employee. The facility performed a routine "Weekly Skin Rounds" examination of the resident's skin on May 17, 2013, two days after the resident reported she had been treated rough and a day after she made the report. CMS Ex. 16 at 13.

The facility counseled MA # 1 two days after Resident # 2 filed the grievance on May 18, 2013. The counseling statement directed that "[w]hile transferring Res[ident with] the use of the lift make sure you approach the Res[ident] in a slow manner [and] don't rush when putting the sling underneath her. Also explain what you are doing as you are transferring." CMS Ex. 16 at 2. The grievance report indicates that a nurse asked all residents "who were alert [and] oriented [with] BIM Score [above] 7 if they had any issues with said employee or anyone else in the facility" and "no one interviewed had any issues or felt afraid." CMS Ex. 16 at 1. The record does not show whether any of the residents who were questioned required a lift for transfers or if any of these residents had been assisted by MA # 1. CMS Ex. 16 at 1; *see* CMS Ex. 28 at 1-2.

In conjunction with the complaint survey by the State OIG in June 2014, the facility first reported this incident as an allegation of abuse more than a year later, on June 16, 2014.[9] CMS Ex. 16 at 3-5. The facility did not substantiate abuse in its initial report. CMS Ex. 16 at 4-5.

After the facility submitted its initial report of alleged abuse, additional personnel interviewed the resident, to include two nurse consultants from Petitioner's "home office" and the facility's Ombudsman, who conducted separate interviews on June 19, 2014. CMS Ex. 16 at 7-8; *see* P. Ex. 64 at 1. The two regional nurse consultants interviewed Resident # 2 together, at which time Resident # 2 recalled that MA # 1 "threw her legs into the bed like it was a sack of dog food." CMS Ex. 16 at 7. The same nurse consultants interviewed Resident # 2's roommate, Resident # 1, and Resident # 1 had a consistent recollection of the incident. CMS Ex. 16 at 7. Another interview conducted by the Ombudsman elicited that Resident # 2 was not injured by MA # 1, but that she did not like how MA # 1 had put her feet in bed "like slinging a sack of dog food." CMS Ex. 16 at 8. In a subsequent report to the State OIG, Steven Cook, NHA, reported that the allegation of abuse had been substantiated, stating: "Please consider this an amended reported [sic] substantiating this allegation which has been filed to the OIG, APS, and

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webster.com/dictionary/oomph (last visited July 24, 2017) (providing definitions of "punch, vitality" and "power or energy").

[9] Melissa McIntosh, the facility's abuse coordinator, submitted the initial report to the State OIG. *See* P. Ex. 60 at 2 (identifying Ms. McIntosh as the facility's abuse coordinator and social service director). Petitioner did not offer Ms. McIntosh as a witness.

Ombudsman."[10] CMS Ex. 16 at 6-9. While the parties have not submitted notes documenting an interview of Resident # 2's roommate at the time of the incident, Mr. Cook made a point to single out Resident # 2's roommate for her "marked difference" in her "story from May 2013 until now . . . ." CMS Ex. 16 at 8; *see* CMS Ex. 28 at 1-2; P. Ex. 62 at 7.

May 19, 2014

The facility accepted a grievance from the daughter of Resident # 4. CMS Ex. 21 at 1. The grievance reported that Resident # 4's daughter asked that CNA # 1 "no longer provide care to [the] resident" because she was "rude" and "disrespectful/hateful." CMS Ex. 21 at 1. The initial report does not provide any substantial details of an interview of the resident or her daughter, other than that Resident # 4 thought CNA # 1 was "rude" but liked her anyway, and the initial report does not elaborate on the basis for why the resident's daughter thought that CNA # 1 was rude, disrespectful, and hateful. CMS Ex. 21 at 1. The facility reported that CNA # 1 was moved to another unit temporarily and educated on her tone of voice. CMS Ex. 21 at 1.

The facility reported the incident to the State OIG on June 14, 2014. CMS Ex. 21 at 3-5. For the first time, on June 17, 2014 (nearly a month after the incident), the facility investigated the allegation by interviewing other residents. CMS Ex. 21 at 5. The facility acknowledged that it was tardy in submitting the report because the report "stemmed from the most recent complaint survey" and that the facility "has reviewed all grievances back to February of 2013." CMS Ex. 21 at 4. While the facility's report of the abuse allegation portrays Resident # 4 as volatile, confused, and mentally impaired, I observe that the resident's daughter, and not the resident, reported the grievance. CMS Ex. 21 at 1. The facility did not substantiate abuse based on its interview with Resident # 4.[11]

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[10] Petitioner misrepresents the evidence in this case and denies that it substantiated the allegation of abuse, stating: "Petitioner notes that after the surveyors cited a deficiency regarding the matter, the Center's managers reexamined it, repeated resident and staff interviews, and did report it to the appropriate State agencies as an *un*substantiated allegation of abuse. P. Ex. 30, 32; CMS Ex. 16." (emphasis in original). I observe that Petitioner's own submission of P. Ex. 32 includes the administrator's statement that "this is an amended reported [sic] substantiating this allegation . . . ." P. Ex. 32 at 3. Petitioner argued that "CMS' summary of the evidence in its Prehearing Brief is so terse as to be materially misleading," yet Petitioner, and not CMS, offered misleading arguments. P. Br. at 5.

[11] Resident # 4 was assessed as having a Brief Interview of Mental Status (BIMS) score of 10 in May 2014, which correlates to moderate cognitive impairment. CMS Ex. 20 at 56; *see* Long-Term Care Resident Assessment Instrument 3.0 User's Manual, Section C0050 (Summary Score), *https://www.cms.gov/Medicare/Quality-Initiatives-Patient-*

May 26, 2014

Resident # 1 reported that she refused a rectal suppository medication on May 26, 2014, to include using her hand to attempt to block the insertion of the suppository, and that MA # 1 administered it despite her refusal. CMS Ex. 8 at 2. A facility employee made the following report of Resident # 1's allegation of abuse:

> I answered the call light . . . and asked what she needed and she said she had a problem, the woman passing meds forced her to take a suppository. She stated she had used the bathroom all day and the day before and did not want to take it. She said she put her hand back there to stop her and she moved her hand out of the way and give it to her anyway. I reported to the nurse.

CMS Ex. 14 at 2. An account given to an LPN reported the following:

> She reported to me that she did not want her suppository tonight but that [MA # 1] had given it to her anyway. She stated she tried to put her hand behind her to say "no" but that she [had] moved her hand out of the way and administered the suppository anyway.

CMS Ex. 14 at 3. Petitioner reported that MA # 1 was "pulled . . . off [the] floor" and asked to write a statement. CMS Ex. 14 at 3-5. MA # 1 provided an account of the incident in which she reported that the resident consented to the medication and said "thank you," and her account went on to explain that the resident and her roommate both said "I love you" when she was leaving the room and she responded "I love you all too." CMS Ex. 14 at 5. In a May 30, 2014 report to the state, the facility stated that the "allegation of abuse can not be substantiated," but that MA # 1 had been terminated. CMS Ex. 14 at 7; *see* CMS Ex. 9 at 2.

One June 25, 2014, the facility submitted an amended report to the State OIG, at which time it stated that "[b]ased upon re-investigation of this incident the facility substantiates abuse."[12] CMS Ex. 14 at 9. The letter does not identify the information that was

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Assessment-Instruments/NursingHomeQualityInits/Downloads/MDS-30-RAI-Manual-V113.pdf (last visited July 24, 2017).

[12] Petitioner, in its brief, blatantly misrepresents the findings of the amended report, stating: "Following this second investigation, the Center's Administrator and nurse managers again determined that they could not substantiate any allegation of abuse because there was no evidence that [CNA # 1] had done anything inappropriate, and the circumstantial evidence was inconsistent with the Resident's complaint. P. Ex. 26." P. Br. at 14. Petitioner's copy of the amended report documenting the results of the "re-

discovered upon re-investigation that prompted the facility to substantiate the allegation of abuse.[13] CMS Ex. 14 at 9.

June 3, 2014

Resident # 2 reported the following information at a Resident Council Meeting on June 4, 2014:

> [Another resident] stated that there was a problem with [CNA # 1] not taking [Resident # 2] to the bathroom . . . [The Resident] stated that [Resident # 2] needed to go to the bathroom and [CNA # 1] told [Resident # 2] she would have to wait. [Resident # 2] said she told [CNA # 1] that she would pee the bed and [CNA # 1] told her to just pee the bed and we would clean it up.

CMS Ex. 17 at 6. Petitioner initially handled the complaint through its grievance progress. CMS Ex. 17 at 5. CNA # 1 explained, when interviewed, that the resident told her that she needed to go to the bathroom and that she would "pee her pants" if she had to wait to use the bathroom, and that CNA # 1, in response, told her she was busy with other residents and that she "would clean her up if she were incontinent [and] would be back." CMS Ex. 17 at 1.

The facility ultimately substantiated that this was abuse in a report date June 20, 2017, as will be discussed in detail below.[14] CMS Ex. 17 at 7-10.

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investigation" is identical to the version CMS submitted as CMS Ex. 14 at 9. As cited above, Petitioner stated that upon re-investigation, "the facility substantiates abuse." CMS Ex. 14 at 9; P. Ex. 26. In fact, Petitioner went as far as to argue that "this is a textbook example of a proper investigation and conclusion, as it is unclear what more the Center's staff could have done to investigate this matter." P. Br. at 14.

[13] Mr. Cook, the facility's former Administrator, testified that he "could not substantiate that the Resident's report was true," in part, based on her "history of exaggeration and making false reports about staff." P. Ex. 62 at 8. Mr. Cook testified that he terminated MA #1, and "I believe that the result may have been unfair to a long term employee." However, the facility's abuse coordinator *substantiated* that abuse had occurred in a report dated June 25, 2014. CMS Ex. 14 at 9. It is disturbing that the facility's administrator would lament the firing of an employee who the facility determined had committed abuse on a resident.

[14] While the facility substantiated this allegation of abuse, it seems to contradict this concession in testimony. "I do not consider a ten minute wait for toileting in such circumstances while a staff member was otherwise occupied to be unreasonable." P. Ex.

June 11, 2014

An initial report to the State OIG, dated June 12, 2014, states that Resident # 2 reported that CNA # 1 "told her not to call her guardian." CMS Ex. 18 at 1. The facility reported in its written narrative, dated June 15, 2014, there was a "post-it note on the resident's face sheet requesting that the guardian's [telephone] number not be given to the resident under any circumstances." CMS Ex. 18 at 2. The facility's report states that the OIG surveyor, who was on site, "reported to [the director of nursing] that she was aware of an allegation made by [Resident # 2]." CMS Ex. 18 at 2. Nothing in the facility's initial report to the State OIG explicitly indicates that CNA # 1 threatened Resident # 2, yet the facility suspended CNA # 1 a day later, on June 12, 2014, and terminated her employment on June 16, 2014. CMS Ex. 29 at 3-4; *but see* testimony of Director of Nursing Ramona Barker, acknowledging the allegation that CNA # 1 "told the Resident not to complain to her family member because she might be fired, which presumably might be at least an implicit threat of retaliation or abuse." P. Ex. 59 at 15. The facility, in its initial report to the State OIG, determined that it could not substantiate abuse or neglect. CMS Ex. 18 at 3.

An amendment to the initial report to the State OIG, dated June 20, 2014, amended the findings of the June 16, 2014 report and addressed both the June 3 and June 11 allegations of abuse. CMS Ex. 17 at 7. That report indicates that CNA # 1's directive to Resident # 2 not to call her guardian stemmed from complaints Resident # 2 made that she was not being taken to the bathroom. The report explained that when CNA # 1 informed Resident # 2 that she could not take her to the toilet, Resident # 2 immediately called her guardian; however, the evidence suggests that CNA # 1 is the staff member who answered the telephone call from the family member complaining about the resident's care.[15] When CNA # 1 returned to the room, CNA # 1 "informed her . . . not to call who ever she called ever again and that she [resident] was going to get her [CNA] fired."[16] CMS Ex. 17 at 9; *see* P. Ex. 62 at 10 (testimony of Steven Cook that, "[as] far

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61 at 4. Petitioner misunderstands the nature of abuse; it has not refuted the allegation that its employee told a resident to urinate in her bed, which would humiliate and degrade the dignity of this resident. Contrary to this witness's assertions, it does not matter whether the resident did not ultimately urinate in her bed. Rather, the issue is that CNA # 1 told a resident to urinate on herself in bed when she expressed a desire to go to the bathroom.

[15] CNA # 1 was reportedly too busy to toilet a resident who reported that she was about to "pee herself," but the evidence suggests that she had enough time to answer a telephone call.

[16] CNA # 1 may have had good reason to fear that she would be fired; she had previously been counseled for the following:

as I know, no one other than [CNA #1] knew that the Resident had complained to the family member, the Resident did not tell anyone, and [CNA #1] did not report this call to anyone."). The report to the OIG also indicates that the guardian reported in a telephone conversation with the business office that "CNA # 1 had told [R]esident # 2 not to call her guardian . . . about any problems and that [R]esident # 2 shouldn't call her anymore." CMS Ex. 17 at 8. The facility indicated that "the re-investigation of this event and information obtained therefrom . . . now warrants and amended finding that "*this allegation of abuse is substantiated*." [17] CMS Ex. 17 at 10 (emphasis in original).

- Leaving residents wet.
- Failing to document resident care activities.
- Failing to properly care for residents.

CMS Ex. 29 at 1. The counseling statement included the following expectations and timelines:

- Residents will be carefully checked and changed to included [sic] bed linen each round. Starts immediately, will always continue.
- Properly document and inform charge nurse when completed. Starts immediately, continue always.
- Pay more attention to residents ADLs [and] needs, take scheduled breaks away from resident care area . . . .

CMS Ex. 29 at 1.

[17] The copy of the letter informing the State OIG that Petitioner had substantiated the allegation of abuse does not identify its author, and Petitioner has not objected to the submission of this document or disputed its authenticity. Contrary to the finding made in letter, the Director of Nursing testified that she and the facility administrator "concluded that these facts were at best ambiguous and did not support a conclusion that [CNA #1] threatened the Resident with any sort of retaliation." P. Ex. 59 at 16. Likewise, the Administrator testified that he and the abuse coordinator "decided that while [CNA #1's] reported statement to the Resident might have been unprofessional and inappropriate, it did not rise to the level of a threat or verbal abuse" and "I did not think that she had abused, neglected, or threatened the Resident." Being that the Director of Nursing and the Administrator have denied that Resident # 2 was abused, and the Administrator testified that the facility's abuse coordinator shared the same opinion, it is unknown who determined that abuse had been substantiated.

In summary, the facility substantiated four allegations of abuse that occurred in a nearly 13-month period, and initially treated two of those substantiated allegations of abuse as grievance complaints.

3. The facility was not in substantial compliance with 42 C.F.R. §§ 483.13(b), (c), (c)(1)(i), and (c)(2)-(4) because its residents were not free from abuse, its administration and staff did not follow the facility's policies and procedures for preventing abuse, and the facility did not immediately report or thoroughly investigate instances of abuse or potential abuse.[18]

Petitioner argues that it complied with these regulations, in that its residents were not abused, it followed its own policies and controlling regulations, and that it properly handled and investigated the incidents detailed herein. In doing so, Petitioner refuses to acknowledge that it has already substantiated four incidents involving abuse and contends "there is no regulatory bright line dividing 'allegations of abuse' from 'grievances.'" P. Br. at 24. Petitioner's arguments are not only contrary to its own findings substantiating abuse of its residents, but also contradict the evidence.

42 C.F.R. § 483.13(b), (c), and (c)(2)-(4) (Tags F223, 225, and 226). As relevant for purposes of this case, abuse is the "willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish." 42 C.F.R. § 488.301.

The regulation governing resident behavior and facility practices mandates that each resident "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) and (c)(1). In order to keep residents free from abuse, facilities must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents. Among other requirements, the facility must ensure that all alleged violations are reported immediately to the facility administrator and appropriate state officials. 42 C.F.R. § 483.13(c). The facility must have evidence that all alleged violations are thoroughly investigated, and it must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator (or designated representative) and to the appropriate state officials within five working days of the incident. If the violation is verified, the facility must take appropriate action. 42 C.F.R. § 483.13(c)(2), (3), and

[18] Further, although CMS's brief included another deficiency, at an unspecified level of scope and severity, based on Petitioner's failure to comply with 42 C.F.R. § 483.15(a) (Tag F241, Dignity), I need not address this alleged deficiency. I find that the other cited deficiencies addressed herein are sufficient to support the remedies imposed, and therefore, I do not need to address this deficiency. *Claiborne-Hughes Health Ctr. v. Sebelius*, 609 F.3d 839 (6th Cir. 2010).

(4). The facility's own policy for abuse, neglect, and misappropriation requires that all allegations of abuse will be reported immediately to the charge nurse, the suspected perpetrator will be removed from resident care areas and immediately suspended pending the outcome of the investigation, and that "[a]ll allegations of abuse will be investigated and reported . . . within the timeframe allotted by the state agency." CMS Ex. 32 at 8-9.

Abuse: 42 C.F.R. §§ 483.13(b) and 483.13(c)(1): I do not need to independently evaluate whether Petitioner's residents were abused on at least four occasions, because Petitioner substantiated four separate allegations of abuse in its reports to the State OIG. CMS Exs. 14 at 9; 16 at 12; 17 at 10. Petitioner has not argued, either in its briefing or its witness testimony, that it erroneously substantiated abuse in those four instances. In fact, Petitioner argued, with respect to the rough treatment of Resident # 2 on May 15, 2013, that "after the surveyors cited a deficiency regarding the matter . . . the Center's managers reexamined it, repeated resident and staff interviews, and did report it to the appropriate State agencies as an *un*substantiated allegation of abuse" (P. Br. at 16), when in fact Petitioner had substantiated the same allegation of abuse following its re-investigation. CMS Ex. 16 at 12.

In summary, Petitioner reported to the State OIG that it had substantiated the following allegations of abuse:

1. On May 15, 2013, MA # 1 was rough with Resident # 2 when using a lift to transfer her to bed. CMS Ex. 16 at 12.

2. On May 26, 2014, MA # 1 forcibly administered a suppository to Resident # 1 despite her refusal of that medication. CMS Ex. 14 at 9.

3. On June 2, 2014, CNA # 1 told Resident # 2 that she could not take her to the bathroom, that Resident # 2 should go to the bathroom in her bed, and that CNA # 1 would clean up if Resident # 2 soiled her bed. CMS Ex. 17 at 10.

4. On June 11, 2014, CNA # 1 threatened Resident # 2 and told her not to call her guardian again to report abuse. CMS Ex. 17 at 10.

Petitioner admitted that the allegations of abuse were substantiated, and I see no basis to disturb Petitioner's own findings. While Petitioner, for purposes of its appeal, seems to be mired in a suspension of reality in which it refuses to acknowledge that it already substantiated these allegations of abuse, it has presented no reason why its own investigative findings were in error or should be disregarded. Therefore, based on the four substantiated allegations of abuse, Petitioner did not meet the condition requiring it to ensure that Resident # 1 and Resident # 2 were "free of verbal, sexual, physical, and mental abuse" as required by 42 C.F.R. §§ 483.13(b) and (c)(1).

Failure to report and investigate: 42 C.F.R. 483.13(c)(2)-(4). As I previously discussed, Petitioner substantiated allegations that two of its employees committed abuse on four occasions. Pursuant to 42 C.F.R. § 483.13(c)(2)-(4), a facility has a duty to investigate and report abuse and neglect. The reporting requirements are triggered by any *allegation* of abuse, whether or not it is recognized as such by the facility. *Illinois Knights Templar Home*, DAB No. 2369 at 11, 12 (2011).

Here, the facility initially handled two later-substantiated allegations of abuse as grievances. Petitioner contends that "every nursing facility must . . . have and use a 'grievance' process to investigate resident complaints that do not rise to the level of 'allegations of abuse,'" and that it properly used its grievance process. P. Br. at 1-2. Petitioner further argues that "not every resident complaint, even if it involves staff behavior, is an 'allegation of abuse,' and so it is neither necessary nor useful for nursing facilities to launch a full 'abuse investigation,' including staff suspensions, resident interviews, and other disruptions in resident care, in response to every complaint." P. Br. at 22. Petitioner argues that it properly handled these reports as grievances rather than as allegations of abuse and therefore it did not fail to substantially comply with 42 C.F.R. § 483.13(c)(2)-(4). P. Br. at 1-3.

Once again, Petitioner's arguments are clouded by the fact that Petitioner fails to recognize that it substantiated abuse in two of the incidents that it initially processed as grievances. In handling the later-substantiated May 15, 2013 and June 2, 2014 reports of abuse as grievances, the facility did not report these allegations to the State OIG until June 14, 2014 and June 16, 2014, respectively, which was well beyond the five-day reporting period required by 42 C.F.R. 483.13(c)(4). Petitioner attempts to justify its failure to report allegations of abuse and unpersuasively argues that there is a lack of clarity regarding whether it should process resident complaints such as the ones discussed above as grievances or as allegations of abuse that must be timely reported to the appropriate outside entities. Petitioner argues that the State OIG "informed Petitioner's managers during and following the survey in this case that it now considers *any* resident complaint, regardless of the topic, to be an 'allegation of abuse' that requires a report to the state, staff suspensions, a full investigation, and the like," and uses the example that the State OIG stated that 'even a single lost sock' must be reported. P. Br. at 2. Regardless of what the State OIG told Petitioner's managers about the seriousness of the loss of a sock and whether it should be reported as an allegation of abuse, I review the cited deficiencies under the applicable federal regulations. As I previously discussed, abuse for purposes of the instant case, is "the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish."[19] 42 C.F.R. § 488.301. Petitioner's investigations ultimately substantiated that

[19] Kentucky has a nearly identical definition of abuse. *See* K.R.S. § 209.020 (8) defines "abuse" as "the infliction of injury, sexual abuse, unreasonable confinement, intimidation, or punishment that results in physical pain or injury, including mental

abuse had actually occurred in these two instances; it is inexcusable that Petitioner did not treat these incidents, at the time it learned of them, as *allegations* of abuse that must be reported within the five days required by 42 C.F.R. § 483.13(c)(4). Petitioner had five days to report alleged abuse, and pursuant to state law, it was required to report suspected abuse to the State OIG, Adult Protective Services, and the Ombudsman and did not do so. P. Exs. 59 at 5; 64 at 3. The complaints by its residents were not nuisance complaints of lost socks; rather, these complaints reported physical and verbal abuse of residents by Petitioner's employees.

Facility policies – abuse and neglect policies and procedures (42 C.F.R. § 483.13(c)). The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. The facility's policy requires that "[a]ll allegations are to be reported within the timeframe allotted by the state agency" and that "[a]ll allegations of abuse will be investigated and reported to the appropriate agencies." CMS Ex. 32 at 8-9.

Petitioner substantiated that two incidents involving Resident # 2 were abuse, but did not follow its own policy that required it to report the mere *allegations* of abuse to the State OIG in a timely manner. The facility did not comply with the requirements of the regulations and its own policy because, as discussed above, it did not report the allegations of abuse. Section 483.13(c)(1)(i) obligates the facility to protect its residents by developing and implementing policies that prevent resident abuse. Because the facility did not keep its residents free from abuse and did not carry out its own policies for preventing abuse, it was not in substantial compliance with sections 483.13(b) and 483.13(c). Further, pursuant to the facility's own policy, "[a]ll allegations are to be reported within the timeframe allotted by state agency." CMS Ex. 32 at 9. Petitioner, by processing reports of later-substantiated abuse as grievances, and not reporting them as alleged abuse within five days, failed to comply with the reporting requirements of 42 C.F.R. § 483.13(c)(2)-(4) and its own policy.

4. The facility was not in substantial compliance with 42 C.F.R. § 483.10(b)(4) because a facility employee did not allow a resident to refuse medication.

Right to refuse medical treatment (42 C.F.R. § 483.10(b)(4), Tag F155). Pursuant to 42 C.F.R. § 483.10(b)(4), a resident has the right to refuse treatment.

The facility substantiated the report of abuse that MA # 1 forcibly administered a suppository to Resident # 1 despite the resident's refusal of that medication. In doing so, the facility violated the requirement Resident # 1 be allowed to accept or refuse

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injury." The facility policy submitted at CMS Ex. 32 does not contain a definition of abuse, so I presume that the facility applied the state and federal definitions of abuse.

treatment, and to make choices about her life. CMS Ex. 14 at 9; 42 C.F.R. § 483.10(b)(4).

5. The facility was not in substantial compliance with 42 C.F.R. § 483.75 because the facility was not governed in a manner that enabled it to use its resources effectively to attain or maintain the highest practicable physical, mental, and psychosocial well-being of its residents.

Administration (42 C.F.R. § 483.75, Tag 490). The facility must be governed in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. A finding of substantial noncompliance in the facility's administration may derive from findings of substantial noncompliance in other areas. Based on the other immediate jeopardy conditions, the facility did not comply with 42 C.F.R. § 483.75. The DAB has explained:

> [W]here a facility has been shown to be so out of compliance with program requirements that its residents have been placed in immediate jeopardy, the facility was not administered in a manner that used its resources effectively to attain the highest practicable physical, mental, and psychosocial well-being of each resident.

Asbury Center at Johnson City, DAB No. 1815 at 11 (2002); *see Stone County Nursing and Rehab. Ctr.*, DAB No. 2276 at 15-16 (2009). As I will discuss in the next section, I find that the facility's deficiencies posed immediate jeopardy to resident health and safety. Therefore, the facility was not in substantial compliance with 42 C.F.R. § 483.75.

Moreover, as discussed above, Petitioner's failures were directly attributable to administrative failures. The facility's administration disregarded facility policies when it failed to investigate and report timely allegations of resident abuse by its employees. The facility was therefore not administered in a manner that used its resources effectively to attain or maintain the highest practicable physical, mental, and psychosocial well-being of its residents and was not in substantial compliance with 42 C.F.R. § 483.75.

6. CMS's determination that the facility's substantial noncompliance posed immediate jeopardy to resident health and safety is not clearly erroneous.

Immediate jeopardy. Immediate jeopardy exists if a facility's noncompliance has caused or is likely to cause "serious injury, harm, impairment, or death to a resident." 42 C.F.R. § 488.301. CMS's determination as to the level of a facility's noncompliance (which would include an immediate jeopardy finding) must be upheld unless it is "clearly

erroneous." 42 C.F.R. § 498.60(c). The DAB has observed repeatedly that the "clearly erroneous" standard imposes on facilities a "heavy burden" to show no immediate jeopardy and has sustained determinations of immediate jeopardy where CMS presented evidence "from which '[o]ne could reasonably conclude' that immediate jeopardy exists." *Barbourville Nursing Home*, DAB No. 1931 at 27-28 (2004), *citing Koester Pavilion*, DAB No. 1750 (2000); *see Daughters of Miriam Ctr.*, DAB No. 2067 at 7, 9 (2007).

In challenging the immediate jeopardy determination, Petitioner argues, with little elaboration and no factual support, that "there is no evidence from which the Court could conclude that the Surveyor's observations, even if taken as violations of the regulation, support a finding that such violations caused any risk of harm to anyone, much less the 'likelihood' of death or serious harm." P. Br. at 25.

The facility failed to timely investigate and report abuse. In fact, the facility's refusal to report the alleged abuse, but instead to handle the reported abuse through its internal grievance process, undoubtedly contributed to its failure to terminate an employee for *more than a year* after an employee abused a patient. *See* CMS Ex. 16 (grievance report that MA # 1 was "rough" on Resident # 2 in May 2013, and Petitioner's substantiated report of abuse in June 2014, at which time the facility reported it had terminated the employee in May 2014). As a result, this abusive employee continued to care for the facility's residents for a lengthy period of time following her abuse of Resident # 2. In fact, this same employee committed abuse in an incident on May 26, 2014 when she forcibly administered a suppository to Resident # 1. CMS Ex. 14. If this employee had been terminated at the time she abused Resident # 2 in May 2013, she would not have been able to again commit abuse in May 2014. *See Libertywood Nursing Ctr. v. Sebelius*, 512 F. App'x 285; 2013 WL 729786 (4th Cir. 2013), *quoting Libertywood Nursing Ctr.*, DAB CR2388 (2011) (The facility "can hardly be allowed to benefit from such disregard for its vulnerable resident[]."). While I need not find that the facility's noncompliance caused actual harm or injury to a resident, it is apparent that residents suffered actual harm in that one resident was forcibly given a suppository against her wishes, another resident was physically handled in a rough manner, and a resident was mistreated when she was told to go to the bathroom in her bed and then abused yet again by the same employee because she had reported the abuse. So long as the deficiencies are *likely* to cause serious injury or harm, they pose immediate jeopardy. Petitioner had a pattern of not timely reporting and investigating abuse, and effectively allowed an abusive employee to continue to care for its residents for a year, thereby exposing its residents to potential abuse by this employee.[20] CMS's determination that the deficiencies posed immediate jeopardy to resident health and safety is therefore not clearly erroneous.

[20] Petitioner does not challenge the duration of immediate jeopardy. I point out that the first substantiated abuse allegation occurred in May 2013 and Petitioner did not report this abuse until more than a year later in June 2014, and the offender continued to be

7. The penalties imposed are reasonable.

To determine whether the CMPs are reasonable, I apply the factors listed in 42 C.F.R. § 488.438(f): 1) the facility's history of noncompliance; 2) the facility's financial condition; 3) factors specified in 42 C.F.R. § 488.404; and 4) the facility's degree of culpability, which includes neglect, indifference, or disregard for resident care, comfort or safety. The factors in 42 C.F.R. § 488.404 include: 1) the scope and severity of the deficiency; 2) the relationship of the deficiency to other deficiencies resulting in noncompliance; and 3) the facility's prior history of noncompliance in general and specifically with reference to the cited deficiencies. Petitioner has not argued that the CMP is inappropriate, nor does it claim that it is unable to pay the CMP. Further, CMS has not contended that prior noncompliance was a factor in the CMP. Despite Petitioner's lack of argument regarding the CMP imposed, I will nonetheless address why the CMP is reasonable.

I consider whether the evidence supports a finding that the amount of the CMP is at a level reasonably related to an effort to produce corrective action by a provider with the kind of deficiencies found, and in light of the above factors. I am neither bound to defer to CMS's factual assertions, nor free to make a wholly independent choice of remedies without regard for CMS's discretion. *See, e.g., Barn Hill Care Ctr.*, DAB No. 1848 at 21 (2002).

Here, CMS imposed a penalty of $5,300 per day for each day of immediate jeopardy, which is at the low end of the range for the applicable per day CMP ($3,050-$10,000). 42 C.F.R. §§ 488.408(e)(1)(iii); 488.438(a)(1)(i). For the period of substantial noncompliance that was not immediate jeopardy, CMS imposed a penalty of $100 per day, also at the very low end of the applicable penalty range ($50-$3,000). 42 C.F.R. § 488.408(d)(1)(iii); 488.438(a)(1)(ii). Considering the relevant factors, these penalties are reasonable. If anything, these penalties are too low considering that there are five immediate jeopardy level deficiencies, all of which involve Petitioner's employees' abuse of residents and the facility's failure to investigate and report the abuse. The facility's administration disregarded the policies in place to protect residents from abuse, and it failed to timely investigate and report allegations of abuse. Based on the four substantiated incidents of employee abuse of residents, alone, a CMP of $5,300 per day is warranted.

For these reasons, I find that the CMPs are reasonable.

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employed by Petitioner until June 2014. A 30-day period of immediate jeopardy is lenient under the circumstances.

IV. Conclusion

From May 26 through July 30, 2014, the facility was not in substantial compliance with Medicare program requirements and, from May 26 through June 24, 2014, its deficiencies posed immediate jeopardy to resident health and safety. The penalties imposed – $5,300 per day for 30 days of immediate jeopardy and $100 per day for 36 days of substantial noncompliance that was not immediate jeopardy – are reasonable.

/s/
Leslie C. Rogall
Administrative Law Judge