Department of Health and Human Service

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

In the Case of:	)	Date: June 24, 2009
Gateway Nursing Center (CCN: 34-5329),	)	
	)	Docket No. C-07-419
Petitioner,	)	Decision No. CR1963
v.	)	
Centers for Medicare & Medicaid Services.	)	

DECISION

Petitioner, Gateway Nursing Center, violated 42 C.F.R. §§ 483.13(c) (Tag F226[1]) and 483.25 (Tag F309). Petitioner did not violate 42 C.F.R. §§ 483.13(b) or (c)(1)(i) (Tag F223).[2] A civil money penalty (CMP) of $3050 per day from January 21 to February 4, 2007 is not reasonable. A CMP of $3050 for February 5, 2007 and a CMP of $50 per day from February 6 through March 7, 2007, a total CMP of $4550, are reasonable.

[1] This is a "Tag" designation as used in the State Operations Manual (SOM), Appendix PP – Guidance to Surveyors for Long Term Care Facilities. The "Tag" refers to the specific regulatory provision allegedly violated and CMS's guidance to surveyors. Although the SOM does not have the force and effect of law, the provisions of the Act and regulations interpreted clearly do have such force and effect. *State of Indiana by the Indiana Department of Public Welfare v. Sullivan*, 934 F.2d 853 (7th Cir. 1991); *Northwest Tissue Center v. Shalala*, 1 F.3d 522 (7th Cir. 1993). Thus, while the Secretary may not seek to enforce the provisions of the SOM, she may seek to enforce the provisions of the Act or regulations as interpreted by the SOM.

[2] All references are to the revision of the Code of Federal Regulations (C.F.R.) in effect at the time of the survey, unless otherwise indicated.

I. Background

Petitioner, located in Lenoir, North Carolina, is authorized to participate in Medicare as a skilled nursing facility (SNF) and the North Carolina Medicaid program as a nursing facility (NF). Petitioner was subject to a complaint investigation survey by the North Carolina Department of Health and Human Services (state agency) that ended on February 16, 2007, and Petitioner was found not to be in substantial compliance with program participation requirements. The Centers for Medicare and Medicaid Services (CMS) notified Petitioner by letter dated March 9, 2007, that it was imposing a CMP of $3050 per day effective January 21, 2007 through February 4, 2007, and a CMP of $50 per day effective February 5, 2007 and until Petitioner returned to substantial compliance with program participation requirements. CMS also notified Petitioner that a denial of payment for new admissions (DPNA) would be imposed effective March 25, 2007, and termination of its provider agreement would be effective August 16, 2007, if Petitioner did not return to substantial compliance before those dates. The state agency conducted a revisit survey on March 19, 2007 that found that Petitioner returned to substantial compliance effective March 7, 2007. The DPNA and termination remedies were not effectuated.

Petitioner requested a hearing on April 30, 2007. The case was assigned to me for hearing and decision on May 10, 2007, and a Notice of Case Assignment and Prehearing Development Order was issued on that date. A hearing was convened on November 29, 2007, in Charlotte, North Carolina and a 263-page transcript (Tr.) of the proceeding was prepared. CMS offered and I admitted CMS exhibits (CMS Ex.) 1 through 33. Tr. 14. Petitioner offered and I admitted Petitioner exhibits (P. Ex.) 1 through 8. Tr. 15. CMS called as witnesses surveyors Amy Harroff, R.N., B.S.N., and Evelyn Thornton, R.N. Petitioner elicited testimony from Geoffrey Burbridge, M.D., and Jane Foster, R.N., Petitioner's Administrator. The parties submitted post-hearing briefs and post-hearing reply briefs.

II. Discussion

A. Issues

The issues in this case are:

Whether there is a basis for the imposition of an enforcement remedy; and

Whether the remedy proposed is reasonable.

B. Applicable Law

The statutory and regulatory requirements for participation by a long-term care facility are found at sections 1819 (SNF) and 1919 (NF) of the Social Security Act (the Act) and at 42 C.F.R. Part 483. Section 1819(h)(2) of the Act vests the Secretary of Health and Human Services (the Secretary) with authority to impose enforcement remedies against a SNF for failure to comply substantially with the federal participation requirements established by sections 1819(b), (c), and (d) of the Act.[3] Pursuant to section 1819(h)(2)(C), the Secretary may continue Medicare payments to a SNF not longer than six months after the date the facility is first found not in compliance with participation requirements. Pursuant to section 1819(h)(2)(D) of the Act, if a SNF does not return to compliance with participation requirements within three months, the Secretary must deny payments for all individuals admitted to the facility after that date – commonly referred to as the mandatory or statutory DPNA. In addition to the authority to terminate a noncompliant SNF's participation in Medicare, the Act grants the Secretary authority to impose other enforcement remedies, including a discretionary DPNA, CMPs, appointment of temporary management, and other remedies such as a directed plan of correction. Act § 1819(h)(2)(B).

The Secretary has delegated to CMS and the states the authority to impose remedies against a long-term care facility that is not complying substantially with federal participation requirements. "*Substantial compliance* means a level of compliance with the requirements of participation such that any identified deficiencies pose no greater risk to resident health or safety than the potential for causing minimal harm." 42 C.F.R. § 488.301 (emphasis in original). A deficiency is a violation of a participation requirement established by sections 1819(b), (c), and (d) of the Act or the Secretary's regulations at 42 C.F.R. Part 483, subpart B. Facilities that participate in Medicare may be surveyed on behalf of CMS by state survey agencies in order to determine whether the facilities are complying with federal participation requirements. 42 C.F.R. §§ 488.10-488.28; 488.300-488.335. The regulations specify the enforcement remedies that CMS may impose pursuant to its delegated authority if a facility is not in substantial compliance with Medicare requirements. 42 C.F.R. § 488.406.

The Act and regulations make a hearing before an administrative law judge (ALJ) available to a long-term care facility against which CMS has determined to impose an enforcement remedy. Act § 1128A(c)(2); 1866(h); 42 C.F.R. §§ 488.408(g); 498.3(b)(13). The hearing before an ALJ is a *de novo* proceeding. *Anesthesiologists Affiliated, et al*, DAB CR65 (1990), *aff'd*, 941 F.2d 678 (8th Cir. 1991); *Emerald Oaks*,

[3] Section 1919(h)(2) of the Act gives similar enforcement authority to the states to ensure that NFs comply with the participation requirements established by section 1919(b), (c), and (d) of the Act.

DAB No. 1800, at 11 (2001); *Beechwood Sanitarium*, DAB No. 1906 (2004); *Cal Turner Extended Care*, DAB No. 2030 (2006)*; The Residence at Salem Woods*, DAB No. 2052 (2006). A facility has a right to appeal a "certification of noncompliance leading to an enforcement remedy." 42 C.F.R. § 488.408(g)(1); *see also* 42 C.F.R. §§ 488.330(e) and 498.3. However, the choice of remedies by CMS or the factors CMS considered when choosing remedies are not subject to review. 42 C.F.R. § 488.408(g)(2). A facility may only challenge the scope and severity level of noncompliance found by CMS if a successful challenge would affect the range of the CMP that could be imposed by CMS or impact the facility's authority to conduct a nurse aide training and competency evaluation program. 42 C.F.R. §§ 498.3(b)(14) and (d)(10)(i). The CMS determination as to the level of noncompliance "must be upheld unless it is clearly erroneous" (42 C.F.R. § 498.60(c)(2)), including the finding of immediate jeopardy. *Woodstock Care Center*, DAB No. 1726, at 9, 38 (2000), *aff'd, Woodstock Care Center v. Thompson*, 363 F.3d 583 (6th Cir. 2003). The Departmental Appeals Board (the Board) has long held that the net effect of the regulations is that a provider has no right to challenge the scope and severity level assigned to a noncompliance finding, except in the situation where that finding was the basis for an immediate jeopardy determination. *See e.g*., *Ridge Terrace*, DAB No. 1834 (2002); *Koester Pavilion*, DAB No. 1750 (2000).

The standard of proof or quantum of evidence required is a preponderance of the evidence. CMS has the burden of coming forward with the evidence and making a prima facie showing of a basis for imposition of an enforcement remedy. Petitioner bears the burden of persuasion to show by a preponderance of the evidence that it was in substantial compliance with participation requirements or any affirmative defense. *See Hillman Rehabilitation Center*, DAB No. 1611 (1997), *aff'd, Hillman Rehabilitation Ctr. v. United States Dep't of Health and Human Services, Health Care Fin. Admin.*, No. 98-3789 (GEB), slip op. at 25 (D.N.J. May 13, 1999); *Cross Creek Health Care Center*, DAB No. 1665 (1998); *Emerald Oaks*, DAB No. 1800; *Batavia Nursing and Convalescent Center*, DAB No. 1904 (2004), *aff'd*, *Batavia Nursing & Convalescent Ctr. v. Thompson*, 129 F. App'x. 181 (6th Cir. 2005); *Batavia Nursing and Convalescent Inn*, DAB No. 1911 (2004).

C. Findings of Fact, Conclusions of Law, and Analysis

My conclusions of law are set forth in bold followed by my findings of fact and analysis.

The surveyors allege in the Statement of Deficiencies (SOD) dated February 16, 2007, that Petitioner violated 42 C.F.R. §§ 483.13(b) and 483.13(b)(1)(i) [4] (Tag F223) (scope

[4] There is no 42 C.F.R. § 483.13(b)(1)(i). The surveyors recite the language of 42 C.F.R. § 483.13(c)(1)(i) under Tag F223 and I recognize that the surveyors' reference to § 483.13(b)(1)(i) was a simple clerical error. The erroneous citation caused no prejudice to Petitioner as the language of the correct subsection is recited.

and severity (S/S) J), 483.13(c) (Tag F226) (S/S J), and 483.25 (Tag F309) (S/S D). CMS Ex. 2. The surveyors allege that the violations of 42 C.F.R. §§ 483.13(b) and (c)(1)(i) (Tag F223) and 483.13(c) (Tag F226) posed immediate jeopardy to Petitioner's residents from January 21, 2007 to February 5, 2007. CMS Ex. 2, at 1. The alleged violations cited under Tags F223 and F226 are closely related and they involve the same facts so they are discussed together.

1. Petitioner did not violate 42 C.F.R. § 483.13(b).

2. Petitioner violated 42 C.F.R. § 483.13(c).

3. Immediate jeopardy was clearly erroneous from January 21, 2007 to February 4, 2007 but not clearly erroneous as to February 5, 2007.

(a) Facts.

Resident 1, a female born in 1915, was 91 years old when the events that gave rise to the deficiency occurred. Her diagnoses included severe dementia with psychosis, confusion and poor judgment; depression; muscle atrophy and weakness with difficulty walking and lack of coordination; spinal stenosis, degenerative disc disease, and osteoarthritis, and chronic back pain; peripheral neuropathy, and she had a history of sleeping during the day and then screaming and yelling during the night. CMS Ex. 11, at 6-13. According to a Minimum Data Set (MDS) with an assessment reference date of October 9, 2006 and an MDS from January 2007, and her care plan, Resident 1 ambulated with a wheelchair and required supervision and assistance when using her wheelchair. CMS Ex. 11, at 16-17, 38; P. Ex. 1, at 9.

During the early morning of February 5, 2007, Resident 1 was yelling and screaming. One of Petitioner's staff, LPN John Tellefsen, directed the Certified Nurse Assistants (CNAs) to get Resident 1 out bed and into her wheelchair. Resident 1 was wheeled to the front desk and she was quiet for 30 to 45 minutes but then started screaming again that she wanted to go home. LPN Tellefsen then wheeled her outside the facility for one to three minutes and told Resident 1 that it was too cold for her to go home. Resident 1 was wearing only a hospital gown and diaper. Resident 1 was reported to say that she nearly froze to death. CMS Ex. 14, at 7, 11-12, 13, 14. During the early morning hours on February 5, 2007, the outdoor temperature in the area ranged from 23 to 28 degrees Fahrenheit. CMS Ex. 23, at 3, 9. The incident was reported to an R.N. and LPN on February 5, 2007, but not to the Administrator of the facility. CMS Ex. 14, at 17. Petitioner does not dispute that this incident occurred. Tr. 23-24.

The evidence shows that on February 8, 2007, LPN Tellefsen was suspended pending investigation of the incident of February 5, 2007. He was not scheduled to work and did not return to the facility after his shift ended at about 7:00 p.m. on February 5, 2007. He was terminated effective February 12, 2007. CMS Ex. 14, at 1-2.

The surveyors also alleged in the SOD that a similar incident involving LPN Tellefsen wheeling Resident 1 outside into the cold occurred on January 21, 2007, the date the surveyors found immediate jeopardy began. CMS Ex. 2, at 1, 7, 9-10, 12, 16, 18-21. The surveyors report in the SOD that on February 15, 2007, a nurse gave them a statement written by CNAs 3, 4, and 5, in which the CNAs state that there were two instances when LPN Tellefsen took Resident 1 outside – January 21, 2007 and February 4/5, 2007. CMS Ex. 2, at 7, 19; Tr. 75. The SOD indicates that the surveyors interviewed CNA 3 on February 16, 2007, she alleged that she witnessed the incident on February 5, 2007, but the SOD does not indicate she mentioned the alleged January 21 incident. The SOD indicates the surveyors interviewed CNA 4 on February 16, 2007, she indicated she was not present the night of February 5, but she alleged facts about an incident on January 21, 2007. The SOD indicates the surveyors interviewed CNA 5 on February 16, 2007 and she claimed to have witnessed the incident on January 21, 2007. CMS Ex. 2, at 7-9, 18-19, 20-21. The surveyors also allege in the SOD that on February 16, 2007, the Administrator stated that incidents occurred on both January 21, 2007 and February 5, 2007, and also stated that it was not unusual for staff to take Resident 1 outside for redirection. CMS Ex. 2, at 9-10, 21. Petitioner does not concede before me that the incident occurred on January 21, 2007. The evidence shows that CNA 3 was Brenda Gill, CNA 4 was Tammy Hamby, and CNA 5 was Alice Caton.[5] The written statement to which the surveyors refer is in evidence as CMS Ex. 14, at 10 and P. Ex. 7. Subsequent statements by CNA Gill and CNA Hamby indicate that they did not witness an incident on January 21, 2007. CMS Ex. 14, at 8, 9. CNA Caton's pay record shows that she was not paid for working on January 21, 2007. P. Ex. 2, at 5. CNA Gill's pay record shows that she was not paid for working on January 21, 2007. P. Ex. 4, at 4. All three CNAs were disciplined by Petitioner after the survey in March 2007 for having made false statements to the surveyors and for impeding Petitioner's investigation of possible resident abuse. CMS Ex. 14, at 3-5; Tr. 48. Surveyor Harroff testified that the three CNAs alleged a second incident occurred but she could not say when it occurred as Petitioner failed to investigate. She testified that the surveyors nevertheless declared immediate jeopardy as of January 21, 2007 based upon the three CNAs' written

[5] CMS indicates in Addendum D to its Post-Hearing Brief that Tammy Hamby was CNA 3, Brenda Gill was CNA 4, and Alice Caton was CNA 5, consistent with the testimony of Surveyor Thornton at hearing. Tr. 107. However, the CMS Addendum D is inconsistent with the notations on the evidence that CMS offered at hearing. CMS Ex. 14, at 3, 5, 8, 9, and 10. The identity of the CNAs is not disputed and the correctness of their identifiers as used by the surveyors has no impact on my factual findings and conclusions.

statement. Tr. 41-43. Surveyor Thornton agreed that it was not possible to determine the date of a second incident, but she believed a second incident occurred. Tr. 102. Surveyor Thornton also testified that when she interviewed CNAs Hicks and Hamby about an incident on January 21, 2007, they told her they had not witnessed the incident but had heard about it. Tr. 104, 142-43, 163-64.

Petitioner's Administrator, Jane Foster, testified the first she had heard about an incident on January 21, 2006 was when Surveyor Thornton showed her a copy of the statement of the three CNAs (CMS Ex. 14, at 10) on February 16, 2007 at about 8:30 a.m. She also testified that she did not agree that two incidents actually occurred contrary to what is stated in the SOD. She testified that she told surveyors that she was unaware of any incident on January 21, 2007, prior to being told by Surveyor Thornton. Tr. 204-06, 238-39. She testified that after being told about the alleged incident she interviewed CNAs Gill, Hamby, and Caton. Based on her investigation, she concluded that the statement of the three CNAs was false and all three employees were disciplined. She also concluded that there was no other credible evidence of any other incident involving Resident 1. Tr. 207-12, 235-36; P. Exs. 2-4.

Administrator Foster testified that she was first informed of the incident on February 5, 2007 at 8:30 p.m. on February 7, 2007, when she was called at home by a former employee who heard that a complaint was going to be filed. She immediately called her Director of Nursing, Pat Hafner, and they agreed to begin the investigation the next morning. Tr. 226-28. She participated in an interview of LPN Tellefsen. He admitted he took Resident 1 outside on February 5, 2007, but only briefly to show her it was too cold for her outside, and only after all other efforts to stop her yelling failed. He denied any other incident. Tr. 230-33.

There is no dispute that Petitioner had an Abuse Prevention Program policy that was originally issued in February 2005. CMS Ex. 17, at 1-6; P. Ex. 6. Petitioner's abuse prevention policy requires each employee to immediately report any suspected abuse. CMS Ex. 17, at 1; P. Ex. 6, at 1.

(b) Analysis.

The surveyor's alleged in the SOD that Petitioner violated 42 C.F.R. §§ 483.13(b) and 483.13(c)(1)(i) (Tag F223) because Petitioner failed to ensure that Resident 1 was not subject to mental abuse on two occasions; that immediate jeopardy began on January 21, 2007, the date of the first alleged incident; that immediate jeopardy was abated on February 5, 2007, the date LPN Tellefsen left the facility; and that after February 5, 2007, the Petitioner remained out of compliance with the two regulatory provisions with the potential for more than minimal harm pending completion of training staff and incorporating corrections into Petitioner's quality assurance program. CMS Ex. 2, at 1. The surveyors allege that Petitioner also violated 42 C.F.R. § 483.13(c) (Tag F226)

because Petitioner failed to implement its written policies and procedures for the reporting of abuse as evidenced by the alleged incidents involving Resident 1. CMS Ex. 2, at 12. The allegations regarding immediate jeopardy were the same as those under Tag F223. CMS Ex. 12, at 13. The surveyors specifically alleged that Petitioner failed to implement specific provisions of its abuse prevention policy. CMS Ex. 12, at 13-14. The CMS arguments to me are consistent with the allegations of the SOD, except CMS also argues that a similar incident involving Resident 1 occurred December 17, 2006. CMS Post-Hearing Brief (CMS Brief) at 4-13; CMS Reply Brief (CMS Reply) at 3-8.

The regulations provide that a 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). The definition for "abuse" is found at 42 C.F.R. § 488.301, which provides that abuse is "the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish." Section 483.13(c) of 42 C.F.R. provides:

> (c) Staff treatment of residents. The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.
>
> (1) The facility must--
>
> (i) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;

According to CMS there were three incidents that I need to consider. Though not alleged in the SOD as the basis for a deficiency, CMS argues that Petitioner's clinical records reflect that on December 17, 2006, Petitioner's staff took Resident 1 outside when other efforts to redirect her from yelling failed. CMS Brief at 5, n.4; 11; CMS Reply at 3, n.3.[6] The December 17, 2006 progress note reflects the time 7:00 p.m. indicating that Resident 1 was taken outside at or before that time. The note also indicates that the resident was taken outside for the legitimate purpose of attempting to redirect her. I am aware of no authority to support a proposition that taking a resident outside is abuse per se. Further, the record includes no evidence that permits an inference that taking the resident outside might have been abusive, such as low outdoor temperature, the clothing worn at the time, or evidence related to the demeanor or behavior of staff that took her outdoors. The fact that the event was recorded in Petitioner's clinical records is inconsistent with an inference that the event was perceived to be an incident of abuse by staff. Furthermore,

[6] CMS incorrectly states in its reply brief the date was December 6, 2006, citing CMS Ex. 44, at 11. The dates for the progress notes at CMS Ex. 44, at 11 are December 16 through 19, 2006.

the surveyors did not allege that the progress note from December 17, 2006 reflected abuse and they did not allege that conduct violated any regulations even though they clearly had the progress note at the time they made their findings. Because the SOD includes no allegations regarding an incident on December 17, 2006, Petitioner was not on notice to defend any alleged deficiency based on an incident on that date. Based upon my decision on the deficiencies alleged, I find it unnecessary to remand the case to CMS to address this new issue raised after hearing or to reopen the record for the taking of further evidence. 42 C.F.R. § 498.56.

CMS also encourages me to conclude that Resident 1 was wheeled outside on or about January 21, 2007, and that that also constituted an incident of abuse. The evidence does not support a conclusion that Resident 1 was taken outside on or about January 21, 2007. In finding that an incident occurred on or about January 21, 2007, the surveyors relied upon an undated and unsigned written statement that indicates on its face that it was a statement of Brenda Gill, Tammy Hamby, and Alice Caton. It is alleged in the statement that they:

> [W]itness [sic] the matter of John Tellefson [sic] taking the patient [Resident 1] out side [sic] on two occasion [sic] because she was loud and could not sleep. So instead of giving her something to calm her down he put her out in the cold 1-21-07 and 2-4-07. [H]e left her out about 35 to 45 seconds at a time.

CMS Ex. 14, at 10; P. Ex. 7.

In different hand-writing is the statement:

> John Tellefson [sic] took resident out B Hall on 1-21-07 and Alice Caton was coming up hall and heard resident yelling and asking nurse to bring her back in and bring her 'some firewood she was freezing to death.'

CMS Ex. 14, at 10; P. Ex. 7. The surveyors received the statement from LPN Corley who told the surveyors that on the morning of February 6, 2007, she heard CNAs Gill, Hamby, and Caton discussing the incident and she had the CNAs write the statement but she thought that R.N. Walsh, who was with her at the time, had turned-in the statement.[7] CMS Ex. 2, at 6-7, 18-19; Tr. 75-78, 162. Surveyor Thornton testified that she

[7] According to Surveyor Harroff, there was a second page to the statement that included a statement by LPN Corley and R.N. Walsh that they signed. However, the second page was not offered or admitted as evidence and Petitioner denied any knowledge of a second page. Tr. 75-78.

interviewed CNAs Hamby and Hicks and they denied witnessing an incident on January 21, 2007, but they told her that they heard about an incident on that date. Tr. 104, 164. Surveyor Thornton also interviewed CNA Caton, who worked at Petitioner's facility every other weekend and claimed to have witnessed LPN Tellefsen returning from outside pushing Resident 1 in her wheelchair during the night shift on January 21, 2007. CMS Ex. 18, at 31-32; Tr. 154. Surveyor Thornton agreed on cross-examination that Petitioner's records show that CNA Caton did not work January 21, 2007. Tr. 146-47. She testified that she did not question CNA Caton's credibility, but rather concluded that she simply had the wrong date. Tr. 152, 165. However, she admitted on cross-examination that CNA Caton admitted to her that she did not actually witness the incident on February 5, 2007, contrary to her prior assertion that she witnessed two incidents. Tr. 164-67; CMS Ex. 14, at 10. Surveyor Thornton also admitted in response to my questioning, that CNA Caton was the only person who alleged she actually saw an incident on or about January 21, 2007. Tr. 165. After reviewing all the evidence, including the surveyors' testimony regarding their interviews of staff related to an alleged incident on or about January 21, 2007, I conclude that the hearsay statements do not have sufficient indicia of reliability to be accepted as weighty evidence that LPN Tellefsen took Resident 1 outside on or about January 21, 2007, or at any time between December 17, 2006 and February 4, 2007. Accordingly, I conclude that the evidence does not show that an incident of abuse occurred on or about January 21, 2007, contrary to the allegations of the surveyors and CMS.

There is no dispute that during the early morning on February 5, 2007, LPN Tellefsen took Resident 1 outside in her hospital gown and diaper and that it was cold outside. Tr. 23-24; P. Br. at 5. The evidence shows that Resident 1 was outside only briefly and the expert testimony of Resident 1's physician was that her brief exposure was unlikely to cause her any physical harm. Tr. 122-30. The evidence shows that LPN Tellefsen took Resident 1 outside in an effort to make her stop yelling. Viewed from Petitioner's perspective, LPN Tellefsen was simply redirecting Resident 1 by convincing the judgmentally impaired resident that it was too cold for her to be outside and thereby quieting her. The other perspective is that LPN Tellefsen took Resident 1 outside to scare or intimidate her, thereby quieting her. "Abuse" as defined in the Secretary's regulations includes willful intimidation and mental anguish. 42 C.F.R. § 488.301. Petitioner's abuse prevention policy also includes intimidation that results in mental anguish within its definition of abuse. P. Ex. 6, at 1. Considering the facts that: it was cold outside, a fact no doubt known to LPN Tellefsen; that Resident 1 was wearing only a hospital gown and a diaper at the time; and that the resident suffered an impaired mental state; I conclude that LPN Tellefsen's act of wheeling the resident outside, even for a brief period, constituted an act of intimidation that was abusive. The reported statement of Resident 1 following the incident is sufficient evidence that she suffered fear or some other form of mental anguish as a result of the incident. The suggestion by Petitioner that LPN Tellefsen may have acted innocently or exercised bad judgment (CMS Ex. 14, at 6),

does not change the abusive nature of the incident. Accordingly, I conclude that the incident on February 5, 2007, was an incident of abuse.

The Board has held that "[p]rotecting and promoting a resident's right to be free from abuse necessarily obligates the facility to take reasonable steps to prevent abusive acts, regardless of their source." *Western Care Management Corp.*, DAB No. 1921, at 12 (2004); *Pinehurst Healthcare & Rehabilitation Center*, DAB No. 2246, at 5 (2009). The Board's prior holdings reflect the conclusion that 42 C.F.R. § 483.13(b) does not make a facility strictly liable for all incidents of abuse that may occur. In this case, I find that Petitioner did take reasonable steps to protect its residents, including Resident 1 from abuse. Surveyor Harroff testified that Petitioner had an abuse prevention policy that met the requirements of the regulation, though staffs' delay in reporting the incident is evidence the policy was not fully implemented. Tr. 33. My review of Petitioner's abuse prevention policy (P. Ex. 6) reveals that it had all the elements required by the regulation and suggested by the SOM.[8] 42 C.F.R. § 483.13(c); SOM, App. PP, Tag F226. The evidence also shows that staff was appropriately screened, staff was aware of Petitioner's abuse prevention policy, and staff was regularly trained regarding abuse prevention. Tr. 59. The evidence does not show that Petitioner had any reason to foresee that LPN Tellefsen would abuse Resident 1 in the manner that he did. The evidence also shows that when on February 7, 2007, Petitioner's DON and Administrator learned of the February 5, 2007 incident they immediately took action to investigate, suspended LPN Tellefsen to ensure he did not return to the facility, subsequently terminated LPN Tellefsen, filed all required reports (Tr. 53, 55), and took other actions consistent with Petitioner's abuse prevention policy and 42 C.F.R. § 483.13(c). Accordingly, I conclude that Petitioner did not violate 42 C.F.R. §§ 483.13(b) or 483.13(c)(1)(i) as alleged by the surveyors.

I do conclude, however, that Petitioner was in violation of 42 C.F.R. § 483.13(c) because it failed to fully implement its abuse prevention policy based upon the evidence in this case. There is no dispute that Petitioner had an abuse prevention policy that satisfied regulatory requirements. CMS Ex. 17, at 1-6; P. Ex. 6; Tr. 33. There is also no dispute

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[8] The SOM is not a substantive regulation promulgated pursuant to the Administrative Procedure Act (APA) (5 U.S.C. § 500 *et. seq.*) and the provisions of the SOM are not enforceable as law. Rather, SOM provisions reflect the CMS interpretation of the Act and regulations implementing the Act and provide policy guidance for surveyors. Although SOM provisions are not enforceable as law, the provisions of the Act and the Secretary's regulations they interpret are. *See Vencor Nursing Centers, L.P. v. Shalala*, 63 F. Supp. 2d. 1, 11-12 (D.D.C. 1999); *Beverly Health & Rehabilitation Services, Inc., et al. v. Thompson*, 223 F. Supp. 2d 73, 98-103 (D.D.C. 2002); *Cal Turner Extended Care Pavilion*, DAB No. 2030 (2006); s*ee also State of Indiana by the Indiana Department of Public Welfare v. Sullivan*, 934 F.2d 853 (7th Cir. 1991); *cf. Northwest Tissue Center v. Shalala*, 1 F.3d 522 (7th Cir. 1993).

that staff was aware of Petitioner's abuse prevention policy and that staff received regular training on the policy. Tr. 59. However, it is also undisputed that the incident that occurred on February 5, 2007 was not reported by staff to the Administrator or DON until February 7, 2007, despite the fact that staff recognized the incident as possible abuse of Resident 1. The regulations require that "[t]he facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property are reported immediately to the administrator of the facility . . . ." 42 C.F.R. § 483.13(c)(2). Petitioner's policy provided that each employee is responsible to report abuse (P. Ex. 6, at 1) and required that staff be instructed that they are required to report immediately "any knowledge or suspicion of suspected abuse, neglect, mistreatment, and/or misappropriation of property" (P. Ex. 6, at 4). Staff failed to immediately report the suspected abuse on February 5, 2007, a violation of both the regulation and Petitioner's policy. Although a single event might not always be sufficient evidence of a failure to implement a policy, in this case the number of staff, including CNAs, LPNs, and R.N.s, who observed the event or indicated knowledge of the event on February 5, 2007, but failed to report, is sufficient evidence of a general failure by Petitioner to ensure its policy was fully implemented as required. Accordingly, I conclude that Petitioner violated 42 C.F.R. § 483.13(c).[9]

"Immediate jeopardy means a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment or death to a resident." 42 C.F.R. § 488.301. The surveyors declared that immediate jeopardy for Petitioner's residents began on January 21, 2007 and ended on February 5, 2007. CMS Ex. 2, at 1, 13. The surveyors' determination that immediate jeopardy began on January 21, 2007, was based upon their conclusion that an incident of

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[9] The surveyors stated at hearing and CMS alleges in its briefs that Petitioner failed to implement its abuse prevention policy because it failed to investigate the incident that allegedly occurred on or about January 21, 2007. Tr. 32-33, 41-43; CMS Brief at 12; CMS Reply at 7-8. According to the SOM Guidance to Surveyors, failure to adequately investigate an allegation of abuse would normally be cited under Tag F225. SOM, App. PP, Tag F225. Tag F225 was not cited by the surveyors in this case. Thus, other than the general allegations under Tag F226, arguably Petitioner was not properly noticed to defend the adequacy of its investigation. Furthermore, the evidence adduced does reflect that an investigation was conducted when the Administrator was advised of the alleged incident. Administrator Foster testified that she told the surveyors that she had no knowledge of an alleged incident on January 21, 2007 prior to being told about it by the surveyors and being shown the CNAs statement (CMS Ex. 14, at 10). Obviously she had not investigated the alleged incident in January prior to hearing the allegation. She testified that she then investigated the three CNAs and their allegations. Tr. 206-12; P. Ex. 2, 3, 4. I find it unnecessary to address the adequacy of the investigation of the alleged January 21, 2007 incident or whether it amounted to a violation of Petitioner's policy, as I conclude that Petitioner violated 42 C.F.R. § 483.13(c) on other grounds.

abuse occurred on or about that date. Tr. 41. I have concluded that the evidence does not establish that an incident of abuse occurred prior to the incident during the early morning of February 5, 2007. Accordingly, I find and conclude that the determination that immediate jeopardy existed from January 21, 2007 through February 4, 2007 was clearly erroneous.

The surveyors were of the opinion that a potential for serious harm, physical or mental, existed prior to LPN Tellefsen's departure from the facility around 7:00 a.m. on February 5, 2007, but that immediate jeopardy was abated that day with his departure from the facility. CMS Ex. 2, at 1, 11, 13, 22; Tr. 85. Resident 1 was exposed to the cold for only a brief period and the unrebutted expert testimony is that she was unlikely to suffer serious harm or death on account of that exposure. However, it is not necessary for actual serious harm or death to occur, it is sufficient that it was likely such harm could occur. *Pinehurst Healthcare & Rehabilitaiton Center*, DAB No. 2246, at 13 (2009). Petitioner has not met its heavy burden to show that the determination that immediate jeopardy was posed for Resident 1 and other residents on February 5, 2007, was clearly erroneous. Accordingly, I conclude that there was immediate jeopardy for one day – February 5, 2007.

4. Petitioner violated 42 C.F.R. § 483.25 (Tag F309).

The regulation requires that a facility provide necessary care and services for a resident to "attain and maintain the highest practicable physical, mental, and psychological well-being in accordance with the comprehensive assessment and plan of care." 42 C.F.R. § 483.25. The surveyor's allege that Petitioner failed to follow its care plan for one resident by failing to monitor oxygen saturation levels. CMS Ex. 2, at 24. Petitioner advised me at hearing that it would not continue to pursue its appeal of the violation of 42 C.F.R. § 483.25 (Tag F309). Petitioner further stated on the record that it did not dispute the imposition of a $50 per day CMP for the period Petitioner was not in substantial compliance. Tr. 24-25; Petitioner's Post-Hearing Brief (P. Brief) at 5, n.1. Accordingly, I conclude that Petitioner violated 42 C.F.R. § 483.25 (Tag F309) as alleged in the SOD.

5. A civil money penalty (CMP) of $3050 per day from January 21 to February 4, 2007 is not reasonable.

6. A CMP of $3050 for February 5, 2007 is reasonable.

7. A CMP of $50 per day from February 6 through March 7, 2007 is reasonable.

If a facility is not in substantial compliance with program participation requirements, CMS has the authority to impose one or more of the enforcement remedies listed in 42 C.F.R. § 488.406, including a CMP. CMS may impose a CMP for the number of days

that the facility is not in compliance or for each instance that a facility is not in substantial compliance. 42 C.F.R. § 488.430(a). There are two ranges for per day CMPs. 42 C.F.R. §§ 488.408, 488.438. The upper range of CMPs of $3050 to $10,000 per day is reserved for deficiencies that constitute immediate jeopardy to a facility's residents, and, in some circumstances, for repeated deficiencies. 42 C.F.R. §§ 488.438(a)(1)(i), (d)(2). The lower range of CMPs of $50 per day to $3000 per day is reserved for deficiencies that do not constitute immediate jeopardy, but either cause actual harm to residents, or cause no actual harm, but have the potential for causing more than minimal harm. 42 C.F.R. § 488.438(a)(1)(ii). In this case, CMS imposed a CMP of $3050 per day for the period of immediate jeopardy from January 21 to February 4, 2007, and a CMP of $50 per day from February 6 through March 7, 2007. CMS Ex. 4, at 2.

I have concluded the immediate jeopardy existed for one day only, February 5, 2007. Accordingly, a CMP of $3050 per day from January 21 through February 4, 2007 is not reasonable. The minimum authorized CMP for one day of immediate jeopardy is $3050. Accordingly, a CMP of $3050 for February 5, 2007 is reasonable. Further, Petitioner conceded on the record at hearing that there is a basis for imposing a $50 per day CMP for the remaining period of noncompliance. Tr. 24. A CMP of $50 per day is the lowest CMP authorized if there is a basis for imposing an enforcement remedy. Accordingly, a $50 per day CMP for the period February 6, 2007 through March 7, 2007 is reasonable. The total CMP of $4550 (1 day at $3050 and 30 days at $50) is reasonable.

Generally, the reasonableness of any enforcement remedy is reviewed de novo applying the regulatory factors at 42 C.F.R. § 488.438(f): (1) the facility's history of non-compliance, including repeated deficiencies; (2) the facility's financial condition; (3) the seriousness of the deficiencies as set forth at 42 C.F.R. § 488.404; and (4) the facility's degree of culpability. In this case, the proposed CMP amounts are reasonable as a matter of law as they are the minimum amounts authorized.

III. Conclusion

For the foregoing reasons I conclude that Petitioner violated 42 C.F.R. §§ 483.13(c) (Tag F226) and 483.25 (Tag F309); but Petitioner did not violate 42 C.F.R. §§ 483.13(b) or 483.13(c)(1)(i) (Tag F223). I further conclude that a CMP of $3050 per day from January 21 to February 4, 2007 is not reasonable. However, a CMP of $3050 for February 5, 2007 and a CMP of $50 per day from February 6 through March 7, 2007, a total CMP of $4550, are reasonable.

/s/
Keith W. Sickendick
Administrative Law Judge