



Immediate Jeopardy, Facility Liability for Employee Misconduct and Sex Abuse

Presented to the
State of Kentucky
Office of the Inspector General and Select
Members of the Provider Community
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[Some Preliminary Considerations]

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Some Preliminary Considerations

- Caring for LTC Population is Incredibly Challenging
- Nursing Homes One of Most Regulated Industries in the Country
- Surveying Is Incredibly Difficult
- Circumstances are Challenging
 - Quantity of Work is Significant
 - Nature of the Work is Challenging
- Interactive Presentation

Overview of Presentation

- Immediate Jeopardy
- Regulatory Definition
- Interpretation of Immediate Jeopardy by the DAB
- Facility Liability for Employee Errors
- Sex Abuse
 - Demented Residents abusing other Demented Residents
 - Staff Abusing Residents
- Identifying Systemic Problems that Create Deficiencies.

[Immediate Jeopardy]

- Definition: Immediate Jeopardy is defined at 42 C.F.R. 488.301:
 - “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.”

[Immediate Jeopardy]

- Ways to prove immediate jeopardy:
- Noncompliance has caused serious injury, harm, impairment, or death to a resident.
- Noncompliance is likely to cause serious injury, harm, impairment, or death to a resident.

[Immediate Jeopardy]

- Per day CMPs for Immediate Jeopardy-level deficiencies must be between \$3,050 and \$10,000 per day. 42 C.F.R. § 488.438(a)(1)(i).
- Per instance CMPs from \$1,000 to \$10,000 may be imposed for any deficiencies, including Immediate Jeopardy-level deficiencies. 42 C.F.R. § 488.438(a)(2).

[Limited Right to Appeal IJ]

- Facilities may not appeal Immediate Jeopardy Determinations that Result in Per Instance CMPs. Evergreen Commons v. CMS, DAB No. 2175 (2008)
- The regulations allow providers to challenge the level of non-compliance only if such a challenge would affect the range of the CMP imposed. There is only one range of per instance CMPs.
 - One exception – if same survey results in loss of Nurse Aid Training Program, IJ can be challenged.

[Immediate Jeopardy]

- The term likely is not defined in regulations
- American Heritage Dictionary defines likely as
 - Possessing or displaying the qualities or characteristics that make something probable
 - Within the realm of credibility; plausible
 - Probable is defined in AHD as
 - Likely to happen or to be true
 - Likely but uncertain; plausible
 - Plausible is defined in AHD as
 - Seemingly or apparently valid, likely, or acceptable; credible

[Daughters of Miriam]

- The Board's most important decision concerning the meaning of IJ came in the Daughters of Miriam case.
- Contract nurse mis-administered multiple drugs to two residents in one day. The errors were discovered that day by the facility and she was relieved of duty that day. SA called IJ.
- Res. 3 got antibiotic via IM instead of orally.
- Res 4 got Norvasc & Dilantin even though they were prescribed for resident 3s roommate. The nurse tried to give Res 4 insulin but he refused it b/c he was non-diabetic.

[Daughters of Miriam]

- ALJ found that no serious harm had actually occurred and the noncompliance posed a potential for serious harm, but serious harm was not likely.
- “CMS observes that insulin is a potentially lethal drug when mis-administered. It argues that the consequences to the resident, had the drug been administered to her, could very well have been grave. Thus, according to CMS, the resident was placed at immediate jeopardy by the nurse’s attempt to give her insulin.
- I find this reasoning to be unpersuasive. I agree with CMS that insulin is potentially a very dangerous drug when mis-administered. But, the problem with CMS’s analysis is that it has provided nothing to establish that there was a likelihood that this resident would be harmed. In this case, the nurse was stopped by the resident’s refusal to accept the medication. Conduct that might have been injurious or lethal, had it occurred, did not occur. It would be speculative, to say the least, to infer a likelihood of injury from a situation where no injurious conduct actually occurred.”

[Kessel's take on IJ – D of M]

- The regulation does not explicitly define what is meant by the word "serious." However, both the common and ordinary meaning of the word and its use within the context of the regulation explain its meaning. In ordinary parlance, "serious" means something that is dangerous, grave, grievous, or life-threatening. *Word Reference.com English Dictionary*. The regulation plainly uses the word in that sense. The regulation makes it clear that "serious" injury or harm are incidents that are outside the ordinary by linking these two terms directly to the terms "impairment" and "death." A "serious" injury or harm, then, is an injury or harm that is grave, that requires extraordinary care, or which has lasting consequences. An injury that requires, for example, hospitalization, or which produces long-term impairment, or which causes severe pain, is a "serious" injury. That distinguishes the injury or harm from a situation that is temporary, which is easily reversible with ordinary care, which does not cause a period of incapacitation, which heals without special medical intervention, or which does not cause severe pain.

[Kessel cont'd]

- In *Innsbruck*, an appellate panel of the Departmental Appeals Board explained that a likelihood of serious injury, harm, impairment, or death means more than a mere potential for harm or a possibility that harm may occur. The regulations provide that a deficiency that is substantial but not at the immediate jeopardy level may exist where there is a potential for more than minimal harm to a resident. Consequently, there must be a much higher potential for harm in order for there to be immediate jeopardy. In the context of the regulations, a "likelihood" of serious injury or harm means that serious injury or harm is the *likely* - and not just the potential - consequence of a deficiency. *Id.*
- Neither the regulations nor the Board appellate panel in *Innsbruck* define "likelihood." **However, the commonly understood meaning of the term "likely" is that something is more probable than not. Here, I employ the term "likelihood" to mean that it is more probable that a serious injury or harm will occur than not.**
- **In any case where a finding of immediate jeopardy is at issue CMS has the burden of coming forward with sufficient evidence to establish prima facie proof that the regulatory definition of immediate jeopardy is satisfied.**

The Board's Decision in Miriam

- The Board Rejects the idea that “likely” means “more likely than not.”
- The term “likely” is ordinarily or commonly used to describe an outcome or result that is “probable” or “reasonably to be expected” though “less than certain.” Webster’s New World Dictionary (2nd CollegeEd.); see also The American Heritage Dictionary of the English Language (4th ed.); Black’s Law Dictionary (5th ed.) (defining “likely” to mean “probable”). Also, the term “likely” — and its synonym “probable” — suggest a greater degree of probability that a particular event will occur than the terms “possible” or “potential.” See Webster’s New World Dictionary (2nd CollegeEd.) (definition of “probable”); Black’s Law Dictionary (5th ed.) (defining “probable” as “having more evidence for than against,” and defining “possible” as “capable of existing” and “free to happen or not”). In this regard, we have emphasized that a “mere risk” of serious harm is not equivalent to a “likelihood” of such harm.

[Board's D of M decision]

- The Board also rejected the idea that CMS had to make a prima facie case of Immediate Jeopardy. The Board concluded CMS's decision to find immediate jeopardy was **presumptively valid**. To overturn a finding of immediate jeopardy the **FACILITY** was required to show CMS's was clearly erroneous in its decision to call immediate jeopardy.

[Board's D of M Decision]

- The Board Ignored the ALJ's Analysis of "Serious"
- "We think this definitional exercise was unnecessary insofar as its purpose was to set the framework for deciding whether CMS had proved a prima face case. As discussed, CMS had no such burden. Under the correct analytical framework, CMS's immediate jeopardy determination is presumed to be correct. In other words, it is presumed that the harm or threatened harm resulting from the noncompliance was in fact serious. DMC has the burden to rebut the presumption with evidence and argument showing that the harm or threatened harm did not meet any reasonable definition of 'serious.'"

[Immediate Jeopardy]

- Immediate Jeopardy findings must be upheld unless the facility proves that the Immediate Jeopardy finding is “clearly erroneous.” 42 C.F.R. 498.60(c)(2).
 - “Under the clearly erroneous standard, we cannot meddle with a prior decision . . . simply because we have doubts about its wisdom or think we would have reached a different result. To be clearly erroneous, a decision must strike us as more than just maybe or probably wrong; it must . . . strike us as wrong with the force of a five-week-old unrefrigerated dead fish.” Vandalia Park v. CMS, DAB CR1120 (2003).

Summary of the DAB's

[conclusions regarding Immediate Jeopardy]

- Immediate Jeopardy determinations are presumptively valid in litigation before the DAB
- The Provider has the burden of showing the Immediate Jeopardy determination is “clearly erroneous.”
- The term “likely” doesn’t require a showing that serious harm is “more likely than not” to occur.

Facility Liability for Acts of Employees

- Facilities Commonly Argue That They Should Not Be Responsible For the Bad Acts of their Employees if the Management Trained and Monitored them Properly
- Is this a good argument?
- Is this consistent with the rule in other areas of the law / other industries?
 - Employee at peanut factory uses unsanitary techniques despite proper training/supervision causes salmonella outbreak around the country that kills 2 small children and a senior citizen. Who is liable?
 - Exxon Valdez – Who is liable?

Explanation of Respondeat Superior

- Courts rely on the doctrine of respondeat superior as the basis of a master's liability for injuries to third persons caused by the acts or omissions of his servants. Under the doctrine of respondeat superior, a master may be found vicariously liable for a tort committed by his servant if the tort was committed within the “scope of employment.” The doctrine is an exception to the general principle of tort law that liability can be found only upon personal fault. “An injured third party has the benefit of proceeding against both the master and the servant.” The applicability of the doctrine depends upon whether: (1) there is a master and servant relationship between the employer and employee who commits the tort; and (2) the tort was committed within the scope of the employee's employment

Justifications for Respondeat Superior

- (1) it tends to compel employers to promote accident avoidance;
- (2) it tends to provide greater assurance of compensation for accident victims, and;
- (3) because this rule applies to all nursing homes, the costs associated with it are evenly distributed throughout the industry.

Statutory Requirement of Principal Liability for the Acts of Agents

- Section 1819(h)(2)(B)(ii) of the Social Security Act, which gives the Secretary of the Department of Health and Human Services the authority to impose CMPs, incorporates the provisions of section 1128A(a) of the Act, which states at subpart (I), “A principal is liable for penalties . . . for the actions of the principal's agent acting within the scope of the agency.”

Respondent Superior is Accepted by ALJs

- N.C. State Veterans Home v. CMS, DABCR 1855 (2008)
 - Petitioner cannot escape responsibility by arguing that the facility was diligent in its hiring practices and the staff understood the facility's abuse reporting and investigation requirements. **Contrary to Petitioner's contention, I do not have to look for a deficient facility practice outside the actions of the staff entrusted to act on behalf of the facility. Consequently, the deficient facility practice, in this case, is unequivocally found in the improper conduct of those that the facility empowered to act on its behalf. The facility, as a business entity, exists only in contemplation of the law, and can only perform the functions of a long-term care provider through the employees it chooses and empowers to act on its behalf.** Acceptance of Petitioner's argument as sufficient justification for a finding of substantial compliance would render the law and regulations applicable here, meaningless.

[Bryden Place v. CMS]

- Bryden Place v. CMS, DABCR 1365 (2005)
 - An ALJ has refused to hold a facility liable where the prohibited conduct was displayed by a sole employee who was not acting within the scope of his responsibilities on behalf of the facility because the occasion on which he verbally abused a resident was his day off.
 - The facility had no reason to believe the employee was a threat to residents

Types of Sexual Abuse of Nursing Home Residents

Residents Abusing Other Residents

- Cognitively Impaired Residents Abusing Residents
- Cognitively Intact Residents Abusing Residents

Staff Abusing Residents

Visitors Abusing Residents

Demented Residents Abusing Other Residents

- Peace River Nursing and Rehab Center
- January 2006 Survey
 - Found Immediate Jeopardy existed in the facility since May 2005 (over 6 months)
 - Assessed a CMP of appx. \$1 million dollars
 - Terminated the facility from participating in the Medicare/Medicaid Programs
 - No appeal – facility paid over \$400K to

Peace River

- Resident 22 – (p. 4) On June 25, 2005, Resident 22 was found in a female resident's room holding her down in bed and rubbing his body on top of hers saying "I sorry." He was pulled off her and redirected.
- (p. 4) The next day he was found in her room kissing the same resident on one occasion and in her bed with her on another occasion. The female resident had her dress pulled up, but her brief was intact.
- Other than redirecting Resident 22, nothing was done to prohibit the resident from wandering the halls and molesting other residents.

[Peace River]

- Was this a sufficient response?
- What was wrong with it?
- In the absence of some evidence to suggest the facility corrected the problem, could the government start IJ and run it up until the time of the survey?
- Does this look like the type of noncompliance that would result in termination?

Peace River

- Resident 21 – From May 2005 through October 2005 facility records show more than 20 separate instances of Resident 21 sexually molesting residents in the following ways:
 - (p. 6) “Staff reports that (R21’s) sexual behavior is getting worse. Noted to be putting hand down females’ pants all of the time.”

[Peace River]

- (p. 6) “Noted to have hand down female resident’s blouse holding Resident’s breast in hand and kissing her mouth.”
- (p. 6) “After I arrived 2 CNAs reported to me that resident was caught feeling 2 female residents in their private areas below the waist.”

Peace River

- (p. 7) “Called to room by CNA. Noted in bed – Resident 21 and female resident lying in bed. Resident 21 had his hand down her pants. When he saw staff he pulled his hand out.
- (p. 9) “Sexual behavior has gotten worse. Was noted to be touching every female in his immediate surrounding, supervisor notified.”

[Peace River]

- Aside from the sheer volume of incidents, does anything in terms of documentation and facility response seem odd to you?

Peace River

- The female victims are almost never identified
 - Their families aren't notified of what is happening.
 - Nothing is done to attend to their physical or emotional concerns; no assessment as to any trauma. There doesn't seem to be a pressing need to protect these women.
- Rarely a mention of notifying supervisors.
- Very few incident reports.
- Interventions limited to redirecting/1x1 for very short periods of time and sporadic pharmacological interventions.

Peace River

- Facility is treating the molestation of these women as though it is simply a problem behavior with no victim (in the absence of physical injury or sexual penetration).
- (p. 18) Many months where Quality Improvement Committee did not discuss protecting the female residents.
- (p. 18) Administrator said he did not consider the female residents to have been abused.

[Peace River]

- Why was this facility terminated?
- The inability of the management and staff to appreciate that the female residents were victims.
- The ongoing nature of this violation – more than 6 months.
- This situation led to the conclusion that the operators of this facility could not meet minimum expectations of safety

[Carver Living Center]

- Female resident (R2) was engaging in inappropriate sexual activity with numerous male residents, but one in particular (R3) - she thought he was her husband at times.
- (p. 20 -21) She was found in bed with Resident 3 naked from the waist down. She was dressed, taken out of the room, social worker notified her family. The DON and the Administrator were notified.

[Carver Living Center]

- (p. 22) Nurses notes also indicated that she had been putting her hands in other male residents' pants and fondling them.
- (p. 19) Staff generally redirected R2 whenever she engaged in this type of conduct. The staff also notified her family, planned a psychiatric referral and care planned to minimize the conduct

[Carver Living Center]

- Notice the Change in Approach:
 - (p. 23) “Observed in room with Resident 3 (Resident 3’s room) in bed with her. Privacy Maintained.”
 - (p. 25) Other times Residents 2 and 3 were separated when attempting to have sexual intercourse.

[Carver Living Center]

- Facility's response not perfect, but the staff did do a much better job of approaching this issue than at Peace River.
- Facility notified the families of Residents 2 and 3
 - However, there is no indication that the other male residents' families were notified
- Nurses' Notes identify the affected residents.

[Carver Living Center]

- (p. 26-27) The DON involved the Ombudsman because she believed that the Residents were not incompetent and could consent to sexual activity.
- DON was trying to respect their rights.
- Ombudsman and Family of Resident 2 did not agree that the Resident should be engaging in sexual activity.

[Carver Living Center]

- What is wrong with the facility's response?

[Carver Living Center]

- No Psychiatric Assessment to see if Resident 2 (or any of the male residents) had the capacity to consent to sexual activity.
- Capacity to Consent Handout

Staff Abusing Residents

- **Consult America – Cottage Hills - Alabama**
- Facility was cited for violating tags F223 (abuse), F225 (failure to investigate/report abuse allegations), F226 (failure to implement policies to prevent abuse) and F490 (administration) – all at the immediate jeopardy level.
- IJ ran for 29 days.
- Facility settled and paid a total CMP of \$182,000 (original CMP was approximately \$240,000).
- Prior to this survey, facility had a good survey history.

[How did this good facility go bad?]

- Surveyors arrived at the facility due to two late, but self-reported incidents of abuse.
- (p. 1) On 7/14/06, an LPN pulled a residents hair and shoved her. The resident allegedly hit the nurse in the face with a can of Ensure. The LPN was not suspended or sanctioned in any way. The LPN had the resident transferred to the Hospital for a psychiatric evaluation.

How did this good facility go bad?

- (p. 2) Two days later (7/16/06) the same LPN slapped a resident in the face, slammed her head on the wheelchair armrest (injuring her neck) and she pulled out the resident's hair (leaving her bald in one or two quarter inch size places on her head). 3 staff members had to pull the LPN off the resident. The Resident called the police. The family called the SA on 7/18/06. The facility self-reported on 7/27/06.

How did a good facility go bad?

- (p. 14-15) As part of their investigation, the surveyors interviewed 11 residents. 6 of 11 of the residents said they would feel uncomfortable reporting complaints about the direct care staff to the administration.
- 6 of 11 identified a particular CNA (CNA 5) as being very loud and verbally abusive.

[Consult America]

- Exposing other residents' penises
 - R12 told the surveyor that CNA 5 exposed two other residents' penises to him.

[Consult America]

- R 12 was admitted to the facility with diagnoses to include Anxiety Disorder, Diabetes, Hypertension, Methadone Patient. R 12 had no short or long term memory problems, modified independence cognitive skills for daily decision-making. There were no indicators of delirium-periodic disordered thinking/awareness coded for R12 on his most recent MDS.

[Consult America]

- Did the Resident Report these allegations?
 - Resident 12 indicated that he had told a male nurse about CNA 5 exposing his roommates' penises to him but nothing was done about it.
 - The nurse denied this.
- Did he tell other residents about them?
 - Another resident (R 1) reported that R 12 told her about the CNA exposing other residents' penises and about the CNA

[Consult America]

- If this is all there was to the story, what do you think the government should do?
 - Assume the Resident is telling the truth?
 - Assume the Resident is lying or is confused?
- What would you do if you were the surveyor and this is the information you received?
 - How would you follow-up?

Would you ask if there had been any
other complaints about CNA 5?

○ If you did you would have found out that:

- (p. 22) A female resident (R1) had (a) been told by R 12 about CNA 5's exposing residents' penises to other residents, and about him roughly throwing R5 (b) The same resident observed CNA 5 throw a resident (R13) into his bed.
- **R1 told the Chief Director of Operations about “some of the things going on in the facility” who responded – get a photo of it, because that is proof, otherwise, I don’t want to hear about it. (p. 22-23)**

[Consult America]

- (p. 23) A female resident reported to another CNA that she had been handled roughly by CNA 5 and one occasion had been thrown in bed so hard that he almost broke her arm. That CNA reported the incident to the DON.
- What did the DON do? What should she have done?

[Consult America]

- (p. 24) The DON met with the resident and the CNA who brought this to her attention, and listened to the resident describe how CNA 5 had abused her.
- The DON confirmed with the CNA that she was talking about CNA 5 and then said he was going on PRN and wouldn't be here much. Then she walked out of the room.

[Consult America]

- Was this a sufficient response?
- What did it communicate?
- (p. 24)
 - The DON denied that it occurred.
- (p. 24) The CNA who was there at the meeting between the DON and the resident told the surveyor the administration “ would let CNA 5 get away with anything.”

[Consult America]

- Allegations of forcible sodomy
 - R 12 tearfully informed the surveyor that a CNA (CNA 5) had forced him to have anal intercourse and oral sex with him. He gave a very detailed description and indicated that he was terrified of this CNA.

[Consult America]

- Did the Facility create this sexual predator?
- No.
- Did the Facility create the conditions where a sex-offender could thrive?
- Yes

[Consult America]

- Conditions that Encourage would-be abusers to abuse residents:
- (1) Explicit tolerance of violence and intimidation
 - LPN 1 – Nothing done after 7/14 hair pulling
 - LPN 1 – Waited almost two weeks to report incident that occurred 7/16
 - CNA 5 – DON did nothing about reported abuse
 - CNA 5 – “Admin would let him get away with anything”
 - General – Chief Dir. Of Operations – “get a picture”

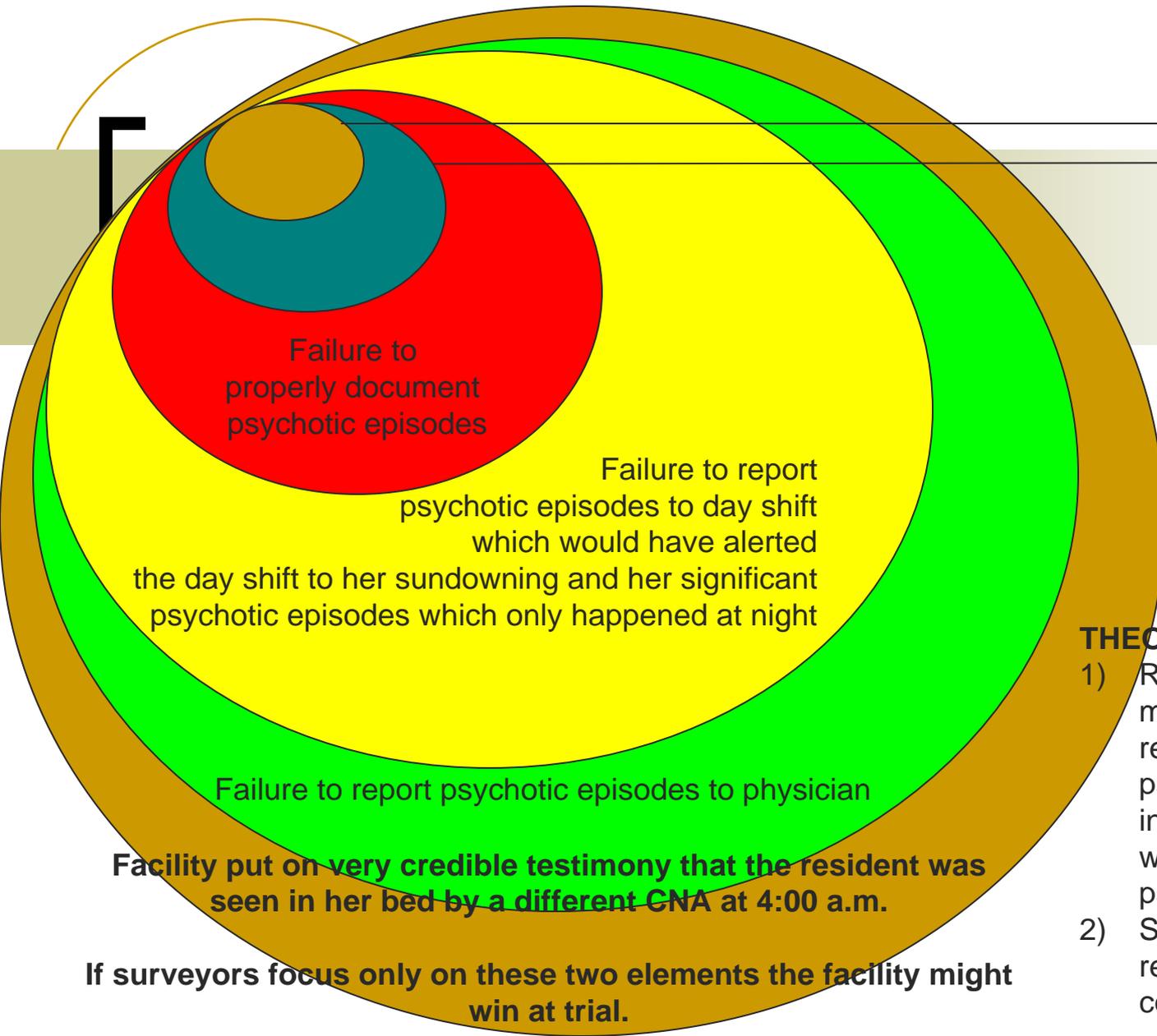
Briarwood Nursing Center

- Facilities (and Surveyors) Must Not Miss Systemic Problems Because They Identify a Discreet Employee Error.
- Why?

Briarwood Nursing Center

- When facilities and surveyors miss the systemic problem causing a deficiency they fail to put in place changes that will keep residents safe.
 - Facility management doesn't recognize the problem.
 - Surveyors don't require the right plan of correction.

A Thorough Investigation Produces A More Comprehensive Theory Of The Case



CNA mistake -- not trying to find a resident who was not in her room at 11:30pm and whose bed was made b/c the CNA assumed the resident was sleeping at an aunt's house (the aunt worked at the facility)

RN error in marking the resident present during the midnight census, even though the RN did not actually see the resident in bed at 12:00 a.m.;

THEORY OF CASE:

- 1) Resident's anti-psychotic meds were being dose-reduced at the same time her psychotic episodes were increasing b/c her physician was never notified of her psychotic episodes.
- 2) Staff failed in monitoring the resident and reporting her condition accurately.