Facility Policies Can Become a Basis for Assessing Civil Monetary Penalties

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In *Brenham Nursing & Rehab. Ctr. v. U.S. Dep't of Health & Human Servs*., No. 15-60272, 2016 WL 454320 (5th Cir. Feb. 4, 2016), the United States Court of Appeals for the Fifth Circuit upheld a Final Agency Decision of the United States Department of Health and Human Services (DHHS) affirming a civil monetary penalty (CMP) for noncompliance with Medicare participation requirements. Skilled nursing facility providers across the country should take note of this decision, as the controlling factor upon which the CMP was upheld was the facility?s failure to comply with its own policies.

This case illustrates an ominous and growing trend: state surveyors are using a facility?s policies, not state or federal regulations or federal manual provisions, to assess CMPs

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In *Brenham*, two certified nurse assistants (CNAs) discovered that a cognitively impaired 101 year-old resident had extensive bruising covering much of her body. The CNAs reported the bruising to the charge nurse, who informed the Director of Nursing (DON) and completed an incident report. The DON summarily concluded that the bruising was caused by a Hoyer Lift and did not report or investigate the incident further.

State surveyors who inspected the facility discovered the resident?s bruising and reported that the facility was noncompliant at an ?immediate jeopardy? level. The surveyors cited 42 CFR § 483.13(c), which requires facilities to develop and implement written policies and procedures that prohibit mistreatment, neglect and abuse of residents. That regulation also requires reporting of such incidents, including injuries of unknown origin, followed by a thorough investigation.

Brenham argued that 42 CFR § 483.13(c) merely required the facility to report alleged violations involving mistreatment, neglect or abuse, including injuries from an unknown source[1] In its brief, it asserted that it reached ?the reasonable and professional conclusion that the bruising incident did not meet the guidelines for reporting accidents and incidents? because there was no evidence of the requisite abuse or neglect, and there was no injury of unknown origin. DHHS argued that 42 CFR § 483.13(c) mandates that a facility develop and implement written policies and procedures to prevent the mistreatment, neglect and abuse of its residents. In concluding that this regulation was violated, DHHS

states that Brenham failed to implement its anti-abuse policies.[2]

The Court?s decision turned on two internal policies that surveyors claimed the facility did not follow. First, the Court found that its ?Accident and Incidents? policy requires Brenham to immediately report and investigate suspected neglect or abuse, including ?injuries of an unknown source.? Second, the Court found that ?Facility Abuse? policy required the facility ?to develop and implement a systematic process to investigate allegations of abuse, neglect and/or exploitation so that such events can be accurately and timely investigated and reported to the proper authorities.?[3]

The Court affirmed the DHHS Departmental Appeals Board?s (DAB) conclusion that Brenham was obligated to report and investigate the resident?s bruising as potentially linked to abuse and neglect because the bruising was an injury of unknown origin. Importantly, the DON?s summary conclusion that the bruising was caused by a Hoyer Lift and did not need to be reported was rejected as a defense, citing as ?undisputed evidence: (1) though Resident 4's bloodwork indicated her blood cell counts were slightly low, Brenham's management ruled out a hematological disorder as a possible cause; (2) CNA Q told surveyors that Brenham's DON instructed her to corroborate the Hoyer Lift causation theory, but CNA Q and CNA R nevertheless denied transferring Resident 4 with a Hoyer Lift; (3) LPN B told surveyors that Hoyer Lift equipment was not present in Resident 4's room; (4) Resident 4's care plan did "not address transfers at all, much less call for use of a Hoyer Lift;" and (5) both Resident 4's physician and Brenham's medical director opined that the bruising should have been reported. Thus, Brenham violated its own policy by not reporting the incident to state officials and not implementing a ?systematic process to investigate? the bruising, which would have led to a different causation conclusion.

This case serves as a clear reminder that facilities must not only have and effectuate their internal policies, but they must write those policies in a manner that is clear and not susceptible of requiring more than state and federal regulations require. Here, the DON?s summary conclusion did not evidence a systematic process of investigation and made it easier to find that the federal requirement ?to investigate thoroughly? was violated.

We expect this decision to be followed broadly. As such, it may be prudent for skilled nursing facility operators to review their policies to be certain that they are properly tailored to ensure that the facility is capable of following them.

[1] *Brenham Nursing & Rehab. Ctr. Petitioner, v. U.S. Dep't of Health & Human Servs., Respondent,* 2015 WL 5471575 (C.A.5), 22.
[2] *Brenham Nursing & Rehab. Ctr., Petitioner, Appellant, v. U.S. Dep't of Health & Human Servs., Respondent, Appellee,* 2015 WL 6470932 (C.A.5), 37.
[3] *Brenham Nursing & Rehab. Ctr. v. U.S. Dep't of Health & Human Servs.*, No. 15-60272, 2016 WL 454320, at *3 (5th Cir. Feb. 4, 2016).

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