DEPARTMENT OF HEALTH AND HUMAN SERVICES

Departmental Appeals Board

Civil Remedies Division

In the Case of:	
Vicky L. Tennant, R.N.,	DATE: June 7, 1991
Petitioner,	
- v. -	Docket No. C-329
The Inspector General.	Decision No. CR134

DECISION

On November 5, 1990, the Inspector General (I.G.) notified Petitioner that she was being excluded for five years from participation in the Medicare and any State health care programs.[1] The I. G. advised Petitioner that she was being excluded due to her conviction in the District Court for the County of Adams, State of Colorado, of a criminal offense relating to neglect or abuse of patients in connection with the delivery of a health care item or service. The I.G. further advised Petitioner that the exclusion of individuals convicted of such an offense is mandated by section 1128(a)(2) of the Social Security Act (Act), and that section 1128(c)(3)(B) of the Act provides a minimum period of exclusion for five years.

Petitioner requested a hearing on November 19, 1990, and the case was assigned to me for hearing and decision. I held a telephone prehearing conference on January 31, 1991. At this conference, the parties agreed that the case could be decided through an exchange of briefs in lieu of an in-person hearing. The I.G. submitted a motion for summary disposition on February 28, 1991. Petitioner responded on March 27, 1991. The I.G. replied on April 18, 1991.

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[1] "State health care program" is defined by section 1128(h) of the Social Security Act to include any State plan approved under Title XIX of the Act (such as Medicaid). I use the term "Medicaid" hereafter to represent all State health care programs from which Petitioner was excluded.

I have considered the exhibits submitted by the parties,[2] their arguments, and the applicable law and regulations.[3] Based on the record before me, I conclude that 1) the I.G. has authority to exclude Petitioner pursuant to section 1128(a)(2) of the Act, and 2) the five year exclusion imposed by the I.G. is mandated by law. Therefore, I sustain the exclusion imposed and directed against Petitioner.

ISSUES

The issues in this case are whether Petitioner:

1) was convicted of a criminal offense;

2) was convicted of a criminal offense relating to neglect or abuse of patients in connection with the delivery of a health care item or service.

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[2] The I.G. filed 11 exhibits with his brief, accompanied by the required declaration. These are admitted into evidence as exhibits I.G. Ex. 1 - 11. I.G. Ex. 12 was admitted into evidence by letter of May 24, 1991. Petitioner filed seven exhibits with her brief, accompanied by the required declaration. These are admitted into evidence as exhibits P. Ex. 1 - 7. P. Ex. 8 was admitted into evidence by letter of May 24, 1991.

[3] The parties' exhibits and memoranda will be referred to as follows:

I.G.'s Exhibit	I. G. Ex. (number/page)
Petitioner's Exhibit	P. Ex. (number/page)
I.G. Brief	I.G. Br. (page)
Petitioner's Response Brief	P. Br. (page)
I.G. Reply Brief	I.G. R. Br. (page)

FINDINGS OF FACT AND CONCLUSIONS OF LAW

1. Petitioner was, at all times relevant to this case, the director of nursing at Aspen Care Center West (Aspen), a skilled nursing home. P. Br. 3; P. Ex. 3; I.G. Ex. 3/9.

2. Petitioner had supervisory responsibilities and authority over other nurses and nursing aides at Aspen in her capacity as director of nursing. Petitioner's responsibilities as director of nursing included, but were not limited to, responsibility for the provision of complete and effective nursing care to each patient. I.G. Ex. 3/9 - 10; P. Ex. 3.

3. On November 8, 1985, a criminal indictment was returned in the Denver (Colorado) District Court, against "Victoria Tennant" (Petitioner Vicky L. Tennant) and others. I.G. Ex. 3.

4. Venue was designated to the Adams County District Court (District Court). I.G. Ex. 3/21.

5. Petitioner was charged with one felony and four misdemeanors. I.G. Ex. 3.

6. On September 25, 1986 all but Counts Two and Four of the Indictment were dismissed by the District Court. This decision was affirmed by the Colorado Supreme Court on November 23, 1988. I.G. Ex. 4, 5.

7. On February 24, 1989, the District Court accepted Petitioner's plea of nolo contendere to Count Four of the Indictment. Count Two was dismissed. I.G. Ex. 6, 7, 8.

8. Petitioner's plea was entered pursuant to a proposed stipulation for a deferred judgment and sentence for a period of one year. The only condition imposed upon Petitioner was that she not violate the law. If she complied with the terms of the deferred judgment, the action against her would be dismissed. I.G. Ex. 6, 7/3 - 4.

9. Count Four of the indictment charged Petitioner with "Willful Disregard of Colorado Department of Health Regulation; Section 25-1-114 C.R.S., Unclassified Misdemeanor." I.G. Ex. 3/1.

10. Colorado Department of Health regulations at 6 CCR (Code of Colorado Regulations) 1011-1 Ch. V section 4.5.4 provide that:

> Accidents and incidents resulting in possible patient injury shall be reported on special report forms. The report shall include date, time and place of incident; circumstances of the occurrence, signature of witness; time the doctor was notified; physician's report; signature of person making the report. A copy of report shall be filed in the patient's medical record. P. Ex. 3; I.G. Ex. 11.

11. Count Four charged that Petitioner and others unlawfully and willfully violated and disobeyed the provisions of the lawful regulations of the Colorado Department of Health requiring the preparation and maintenance of an incident report to document the circumstances surrounding any unusual occurrence resulting in possible injury to a patient in a licensed nursing home. I.G. Ex. 3/9.

12. Count Four related to an incident involving an Aspen resident, L.G., with advanced Huntington's Disease. This resident was incapacitated by her illness and dependent on the help of others for her survival. She was a "total care Patient". She was unable to control her own bodily movements, needed help eating and dressing, and was unable to walk or talk. She was mentally incompetent and engaged in constant involuntary movements of her arms, legs and trunk during her waking hours. I.G. Ex. 3/10.

13. On December 17, 1984, L.G. was found tightly entrapped between the bedrail and the bedframe of her bed. Her body was freed from the bed by removing the bedrail. After emergency resuscitation, L.G. was airlifted to a hospital. P. Ex. 3; I.G. Ex. 3/11 - 12.

14. After L.G.'s transport, Petitioner and Carolyn Westin, the nursing home administrator at Aspen, advised the charge nurse that the nurse's note describing the incident did not need to mention the position in which L.G. was found. The charge nurse was responsible for preparing an incident report which was required by Department regulation and Aspen internal policy. No incident report was ever prepared. I.G. Ex. 3/10 - 13; P. Ex. 3.

15. The medical records supervisor, Sharon Wasinger, upon discovering the lack of an incident report, has indicated that she told either Petitioner or Carolyn Westin that a report should be prepared. In response, Ms. Wasinger was told that no incident report was necessary, because "the incident was not unusual." Records Consultant Nancy Weber was told by Ms. Wasinger

that she advised Petitioner of the need to file an incident report. P. Ex. 3.

16. Prior to the death of L.G., Aspen's management was aware of the tragic results that could occur from the improper care of a Huntington's disease patient and the need to take corrective action. This is reflected by the death of V.C., a patient at Aspen, who died of asphyxia in her bed in similar circumstances to L.G. Prior knowledge also arose from a Department review of Aspen in the Spring of 1984. During the course of the review, Ms. Westin was told that steps had to be taken to protect another Huntington's disease patient whose bedding was observed to be unsafe. I.G. Ex. 3/11.

17. Petitioner's plea of nolo contendere constitutes a conviction for the purposes of section 1128(a)(2) of the Act. See sections 1128(1)(3) and 1128(1)(4) of the Act.

18. Notwithstanding that Petitioner's plea of nolo contendere was dismissed nunc pro tunc in March 1990, Petitioner's plea constituted a conviction of a criminal offense within the definition of section 1128(i)(3) and section 1128(i)(4) of the Act.

19. Petitioner was convicted of a criminal offense relating to neglect or abuse of patients within the meaning of section 1128(a)(2) of the Act. FFCL 1 - 18.

20. On November 5, 1990, the I.G. excluded Petitioner from participating in Medicare and directed that she be excluded from participation in Medicaid, pursuant to section 1128(a)(2) of the Act.

21. There are no disputed issues of material fact in this case and summary disposition is appropriate

22. The exclusion imposed and directed against Petitioner is for five years, the minimum mandatory period for exclusions authorized pursuant to section 1128(a)(2) of the Act.

23. The exclusion imposed and directed against Petitioner by the I.G. is mandated by law.

RATIONALE

The I.G. excluded Petitioner from participation in the Medicare and Medicaid programs after concluding that Petitioner had been convicted of a criminal offense relating to neglect or abuse of patients in connection with the delivery of a health care item or service, within the meaning of section 1128(a)(2) of the Act. Petitioner contests her exclusion, and argues: 1) that at the time the I.G. excluded her in November 1990 the criminal action against her had already been dismissed nunc pro tunc in March 1990, pursuant to a deferred judgment; and 2) even assuming that there is a conviction involving the failure to file an incident report, such failure does not meet the statutory requirement that the conviction must relate to neglect or abuse of patients in connection with the delivery of a health care item or service. Petitioner's contentions are without merit.

1. Petitioner was convicted within the meaning of sections 1128(i)(3) and 1128(i)(4) of the Act.

Petitioner pled nolo contendere to the offense of Willful Disregard of Colorado Department of Health Regulation, via a stipulation for deferred judgment and sentence. The District Court judge who heard Petitioner's plea, deferred judgment and sentence for a period of one year, the only condition being that Petitioner not violate the law. This case was finally dismissed on February 10, 1991, nunc pro tunc[4] to March 1990.

Petitioner contends that because the I.G. excluded Petitioner in November 1990, approximately six months after the case against Petitioner was dismissed by the District Court, the I.G. is without authority to exclude her. P. Br. 6 - 8. I disagree. Under Section 1128(i)(3), an individual is defined as "convicted" "when a plea of guilty or nolo contendere by the physician or individual has been accepted by a Federal, State, or local court." Under section 1128(i)(4), an individual is considered to have been convicted when "the physician or individual has entered into participation in a first offender or other program where judgment of conviction has been withheld." Petitioner pled nolo contendere (a

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[4] Black's Law Dictionary defines nunc pro tunc as, "Now for then . . . A phrase applied to acts allowed to be done after the time when they should be done, with a retroactive effect, i.e., with the same effect as if regularly done." Black's Law Dictionary, Fourth Edition, West Publishing Co., 1951.

conviction under 1128(1)(3)), and was then accepted into a deferred adjudication program (a conviction under section 1128(1)(4)). The District Court judge specifically accepted Petitioner's plea and informed Petitioner that if she broke the conditions of her probation, she would be sentenced. I.G. Ex. 7/5. As the administrative law judge (ALJ) stated in Ronald Allen Cormier, DAB Civ. Rem. C-206 at 14 (1990):

> . . . the fact that a plea of guilty or nolo contendere is held in abeyance or subsequently expunged does not mean that the plea is not a conviction within the meaning of section 1128(i). This section specifically provides that guilty or nolo contendere pleas which are accepted by courts are "convictions" regardless whether the conviction or other record is subsequently expunged, or whether judgment of conviction has been withheld.

There is nothing in the Act that prohibits the I.G. from excluding a Petitioner after a case has been dismissed following a deferred adjudication.[5] For the purposes of the Act, it is the fact of the conviction itself, as defined in this case by sections 1128(i)(3) and 1128(i)(4), that gives the I.G. the authority to exclude. The date upon which the action is dismissed as part of a deferred adjudication proceeding is irrelevant for the purposes of the Act. Thus, I find that Petitioner was convicted within the meaning of the Act.

2. Petitioner was convicted of a criminal offense relating to the neglect or abuse of patients in connection with the delivery of a health care item or service.

Having found that Petitioner was convicted of a criminal offense, I must now decide whether that conviction relates to the neglect or abuse of patients in connection with the delivery of a health care item or service. As the ALJ stated in Dawn Potts, DAB Civ. Rem. C-291 (1991) at 6:

> Under section 1128(a)(2), the statutory criteria may be met in one of two circumstances. First, a party

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[5] In this case on the date that the I.G. excluded Petitioner, November 5, 1990, Petitioner's case had not yet been dismissed. Petitioner's case was not dismissed until February 10, 1991, although the County Court made the dismissal retroactive to March 1990.

> who is convicted of patient neglect or abuse will be found to have been convicted of an offense within the meaning of the section. Ronald Allen Cormier, DAB Civ. Rem. C-206 (1990). Second, a party who is convicted of an offense relating to patient neglect or abuse will be found to have been convicted of an offense within the meaning of the section." See Summit Health Limited, dba Marina Convalescent Hospital, DAB Civ. Rem. C-108 (1989).

In this case, Petitioner was the director of nursing in a nursing home. As such, she was responsible for the nursing care of each of the patients in the home. One of her patients, a completely helpless individual, L.G., was found trapped between the bedrail and bedframe of her bed. L.G. was airlifted to a hospital, where she died. As a result of this incident, Petitioner was charged in an indictment with one felony and four misdemeanor criminal offenses. FFCL 3, 12. Petitioner pled guilty to one misdemeanor count of her indictment, failure to file an incident report. FFCL 7. By Colorado statute, an incident report has to be filed with the State after every unusual incident in a nursing home, and a copy of the report has to be placed in the individual patient's file. FFCL 10. No incident report was filed in L.G.'s case. FFCL 14. As director of nursing, it was Petitioner's duty to ensure that an incident report was filed with the State and a copy placed in the patient's file. The nurse who had the specific responsibility to prepare the report was under the direct supervision of Petitioner. Moreover, Petitioner advised the nurse as to the content of the notation in the patient file and not to file an incident report with the State. FFCL 1 - 2, 10 - 16.

Petitioner argues that her conviction does not relate to neglect or abuse of a patient. She states: 1) there is an absence of the required relationship between the criminal offense and the delivery of the service to patients; 2) the I.G. improperly utilized the indictment against Petitioner, which is outside the record in this case; 3) Petitioner's conduct did not amount to neglect or abuse of a patient; 4) the failure to file an incident report did constitute a breach of Petitioner's duty of care owed to L.G.; 5) any duty of care owed was between the regulatory agency and the nursing home; and 6) this case did not concern an affirmative duty of care (to protect beneficiaries from harm) as did Potts, supra., but was an indirect duty to historically record institutional events. P. Br. 8 - 11.

Contrary to Petitioner's arguments, I find that Petitioner's failure to file an incident report does relate to an affirmative duty of care owed to patients in connection with her delivery of a health care item or service, and that Petitioner breached that duty of care when she did not ensure that the individual under her supervision who had responsibility to file the incident report met that responsibility. It is evident that the duty to file the required incident report was more than a duty owed by Aspen to the regulatory agency, as is reflected in Petitioner's conviction for willfully disregarding the State regulation. This State regulation imposed a duty on Petitioner that had a direct relationship to patient care. Furthermore, I find that Petitioner's failure to ensure that the incident report was filed directly related to her duty to care for a patient, L.G., who was entrusted to Petitioner's care. Lastly, I find that Petitioner's breach of affirmative duties of care to patients of the nursing home in general and to patient L.G. in particular, amount to patient neglect in connection with a health care item or service, as set forth in section 1128(a)(2).

In order to determine whether Petitioner's criminal offense related to the neglect or abuse of patients in connection with the delivery of a health care item or service, I had to examine all the relevant facts. In this case I have primarily relied on two pieces of evidence to ascertain the facts surrounding Petitioner's nolo contendere plea to count four of her indictment. One is the "Factual Basis," P. Ex. 3, which was admitted at Petitioner's sentencing hearing as the factual basis for her plea. See I.G. Ex. 7/3. The other is Count 4 of Petitioner's indictment, the count to which Petitioner pled guilty, I.G. Ex. 3/ 9 - 13. Together these two pieces of evidence led to my conclusion that Petitioner's conviction met the elements of section 1128(a)(2).

Petitioner argues that any use of her indictment to explain the circumstances surrounding her conviction, I.G. Ex. 3, is improper. I disagree. In the case of Norman C. Barber, D.D.S., DAB Civ. Rem. C-198 (1991), the ALJ stated:

> It is consistent with congressional intent to admit limited evidence concerning the facts upon which the conviction was predicated in order to determine whether the statutory criteria of section 1128(a)(2) have been satisfied. Congress could have conditioned imposition of the exclusion remedy on conviction of criminal offenses consisting of patient neglect or abuse. Had it used the term "of"

> instead of the term "relating to" in section 1128(a)(2), that intent would have been apparent. Had Congress done so, then, arguably, no extrinsic evidence would be permitted in a given case to explain the relationship between the criminal conviction and the underlying conduct. However, Congress intended that the exclusion authority under section 1128(a)(2) apply to a broader array of circumstances. It mandated that the Secretary exclude providers who are convicted of criminal offenses "relating to" patient neglect or abuse in connection with the delivery of a health care item or service. The question . . . is whether the criminal offense which formed the basis for the conviction relates to neglect or abuse of patients, not whether the court convicted Petitioner of an offense called "patient abuse" or "patient neglect."

Id., at 10 - 11. The appellate decision in Dewayne Franzen, DAB App. 1165 (1990), is instructive on the issue of the scope of the ALJ's examination in determining the nature of a criminal offense under section 1128 (a)(1) and (2). The appellate panel, relying on H. Gene Blankenship v. The Inspector General, DAB Civ. Rem. C-67 (1989), held that:

> [T]he ALJ, the finder of fact, can look beyond the findings of the state court to determine if a conviction was related to Medicaid. Therefore the ALJ's characterization of an offense is not limited to the state court's or the violated statute's precise terms for purposes of determining whether a conviction related to Medicaid. Dewayne Franzen at 6.

In this case nothing in the factual basis for Petitioner's plea admitted in the District Court significantly contradicts the sequence of events as set forth in Count 4 of Petitioner's indictment. Rather, taken together the two exhibits help to explain the conduct which gave rise to Petitioner's conviction.

Petitioner's conviction resulted solely from her failure to prepare or require those employees under her control to prepare an incident report. This report would have documented an unusual occurrence, the position in which L.G. was found, which resulted in patient injury. This failure amounted to a failure of a duty of care Petitioner owed to her patient, L.G., as well as to other patients who might suffer injuries as a result of a similar incident. Such reports are to be filed so that the State can take steps to ensure the prevention of

future incidents or accidents. The report is placed in a patient's file to ensure that such incidents or accidents are not repeated with respect to that patient. Thus, the report serves an important function in patient care, the protection of patients from repetitive incidents and accidents by alerting anyone reading that patient's records of previous problems. Neglecting to file an incident report or neglecting to ensure one's employees file such a State required report, is a dereliction of the duty of care owed to that patient.[6] The State regulation at issue (Section 25-1-114 C.R.S.) imposes a duty of care which Petitioner was convicted of "willful[ly]" disregarding. In this case, I need not make a finding as to the motivation that led Petitioner to willfully disregard this health regulation. I note, however, that the factual setting developed in the indictment suggests that Aspen, and Petitioner as a management official of the nursing home, may have been concerned about the potential adverse consequences that such an incident report would have had, considering the existence of an earlier patient death under similar circumstances, and the failure of Aspen to take corrective action to ensure that the incident was not repeated. The purpose of the State regulation is to prevent the exact circumstance that occurred at Aspen -- the reoccurrence of a patient death that arguably could have been avoided by more diligent patient care.

Convictions for criminal offenses based on violations of laws which impose duties on health care providers

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[6] Petitioner has attempted to argue, via an affidavit of a registered nurse involved in nursing home care, that the violation to which Petitioner pled guilty is not related to the delivery of health care to a patient, does not result in a breach of duty to the patient, and thus is not related within the meaning of section 1128(a)(2). At best, this is merely the affiant's opinion. Colorado public health regulations and statutory law both establish that the filing of an incident report is a duty of care owed both to nursing home patients and the public. See I.G. Ex. 10, 11. The affiant's statutory interpretation is also contradicted by the action of the Colorado Board of Nursing which determined in a letter of admonition that Petitioner was "responsible to see that physicians orders were carried out and that charting contained the essential information." The view of the Board of Nursing is that Petitioner's failure to provide documentation concerning the L.G. incident was a serious matter. See I.G. Ex. 12.

constitute patient neglect and are subject to the minimum mandatory exclusion provisions of section 1128(a)(2). In the case of Dawn Potts, supra, Ms. Potts was employed in a supervisory position in a residential facility for mentally retarded persons. Ms. Potts learned that an employee whom she supervised had allegedly struck a resident. Pursuant to the Florida law under which Ms. Potts was convicted, a person is to immediately report to state authorities any incident of neglect or abuse of an aged or disabled person that they know or reasonably suspect to have occurred. Ms. Potts did not report this episode to State authorities. Ms. Potts was convicted of this offense, and eventually excluded by the I.G. pursuant to section 1128(a)(2). The ALJ found that Ms. Pott's conviction amounted to neglect of a patient because: 1) the individual against whom an abusive act was allegedly perpetrated was a patient in a health care facility; 2) the allegedly abusive act was perpetrated in connection with the delivery of a health care item or service; and 3) Ms. Pott's failure to report the allegations of abuse constituted an act of "neglect" within the meaning of section 1128(a)(2). Dawn Potts at 6 - 7. The ALJ stated that:

> [I]t is not relevant to the question of whether Petitioner was convicted of a criminal offense within the meaning of the Act whether or not the patient actually was abused . . . The act which triggered Petitioner's conviction and which ultimately is the basis for the exclusion in this case is Petitioner's failure to report an allegation of abuse, where Petitioner was under a duty to make such a report. Her failure to report such an allegation was an act of neglect under Florida law and within the meaning of section 1128(a)(2).

Similarly, in this case it is not necessary to find that Petitioner's conviction was for neglect or abuse of a patient. The act which triggered her conviction was the failure to report an unusual incident which she, as Director of Nursing at Aspen, had a duty to report and which directly impacted on the safety and health of patients under her care and the state's need to monitor nursing home conditions to ensure that the welfare of patients were properly met. Petitioner's failure to report was "neglect" within the meaning of section 1128(a)(2).

3. The exclusion imposed and directed against Petitioner is mandated by law.

Sections 1128(a)(2) and 1128(c)(3)(B) of Act require the I.G. to exclude individuals and entities from the Medicare and Medicaid programs, for a minimum period of five years, when such individuals and entities have been convicted of a criminal offense relating to neglect or abuse of patients in connection with the delivery of a health care item or service. Congressional intent is clear from the express language of section 1128(c)(3)(B):

> In the case of an exclusion under subsection (a), the minimum period of exclusion shall be not less than five years . . .

Since Petitioner's criminal offense meets the statutory requirements of section 1128(a), the I.G. must apply the minimum mandatory five year exclusion applicable to a section 1128(a) offense as set forth in section 1128(c)(3)(B) and I do not have any discretion to modify such an exclusion.[7]

CONCLUSION

Based on the law and the undisputed material facts in the record of this case, I conclude that the I.G. properly excluded Petitioner from the Medicare and Medicaid programs for a period of five years, pursuant to sections 1128(a)(2) and 1128(c)(3)(B) of the Social Security Act.

/s/

Edward D. Steinman
Administrative Law Judge

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6 Section 1128(a)(2) convictions of the type here illustrate a difficult situation for the ALJ. The customary issues of the reasonableness of the exclusion and the trustworthiness of Petitioner are not before the ALJ. The congressionally mandated minimum exclusion of five years must be imposed without regard to the factors set forth in 42 C.F.R. 1001.125. Congress, as a matter of legislative policy, determined that petitioners convicted of criminal offenses related to patient neglect or abuse pose such a threat to program beneficiaries and recipients that a minimum of five years is necessary to protect them from the risks arising from the convictions. In cases such as this, application of the minimum mandatory exclusion imposes a result which appears disproportionate to the crime for which the health care provider was convicted. Unfortunately, I have no discretion to alter the imposed exclusion.