

COMMONWEALTH OF MASSACHUSETTS

RECEIVED BY
APR 23 2012
MULTI-BOARD

SUFFOLK COUNTY

BOARD OF REGISTRATION OF
NURSING HOME ADMINISTRATORS

IN THE MATTER OF)
J. Michael Rivers, NHA)
License No. 1853)
License Expires 6/30/12)
_____)

DOCKET NO. NHA-2011-004

CONSENT AGREEMENT FOR REPRIMAND

The Massachusetts Board of Registration of Nursing Home Administrators ("Board") and J. Michael Rivers, a Nursing Home Administrator ("Administrator" or "NHA") licensed by the Board, License No. NH1853 ("Licensee"), hereby stipulate and agree that the following information shall be entered into, and become a permanent part of, the Licensee's records maintained by the Board.

1. The Licensee agrees to enter into this Consent Agreement for Reprimand ("Consent Agreement" or "Agreement") to resolve the complaint filed against his NHA license identified as Docket No. NHA-2011-004 ("the Complaint") without resort to a formal adjudication of such Complaint. The allegations contained in the Complaint are as follows:
2. On or about February 21, 1985, the Board issued to the Licensee a license to practice as a Nursing Home Administrator, License No. NH1853. The Licensee's license status is current with an expiration date of June 30, 2012 .
3. The Licensee served as the licensed Nursing Home Administrator of Springside of Pittsfield, a 112-bed long-term care facility located at 255 Lebanon Avenue, Pittsfield, Massachusetts ("Springside" or "Facility"), from July 21, 2008 to August 27, 2010.
4. On or about August 5, 2010, the Department of Public Health, Division of Health Care Quality ("the Department" or "DPH") completed a complaint survey ("survey") at the Facility involving allegations of abuse of Facility residents (DPH Reference #10-0841). The Department generated a Statement of Deficiencies ("SOD") bearing the same date. Among the deficiencies identified in the SOD was a deficiency (Tag F 226) with respect to 42 CFR 483.13(c), which states, "The facility must develop and implement written policies that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident policy."

5. Springside's Patient Abuse Policy, dated July 1, 2009, stated that the Administrator or designee was responsible for implementing policies and procedures that prohibit abuse; anyone who witnessed an incident of suspected resident abuse was to tell the abuser to stop immediately and orally report the incident to his/her supervisor immediately; the notified supervisor was to report the suspected abuse immediately to the Administrator or designee; the staff person alleged to have committed the act of abuse was to be immediately removed from duty pending investigation; the Administrator, upon receiving a report of suspected abuse, was to conduct a thorough investigation and, depending on the results of the investigation, implement corrective actions; and the Administrator was to analyze all occurrences to determine what changes were needed, if any, to policies and procedures to prevent further occurrences.
6. Based on investigation of the complaint, the Department determined that the requirements of 42 CMR 413.13(c), relative to resident behaviors and facility practices, had not been met based on the following:
 - (a) During the 11 p.m. to 7 a.m. shift that began on July 24, 2010, and ended on July 25, 2010, at about 4:30 a.m. CNA #1 witnessed the another CNA (Accused CNA) place a slipper sock over Resident #1's mouth and shove Resident #1's arm when Resident #1 yelled during care.
 - (b) CNA #1 did not report the alleged incident immediately, but told CNA #6 and CNA #7 about the incident during the 3 p.m. to 11 p.m. shift on July 25, 2010.
 - (c) CNA #6 and CNA #7 did not report their knowledge of the alleged incident.
 - (d) When CNA #2 arrived for her shift beginning at 11 p.m. on July 25, 2010, CNA #1 told CNA #2 that the Accused CNA had placed a slipper sock over Resident #1's mouth during the prior 11 p.m. to 7 a.m. shift, and CNA #2 told Nurse #1.
 - (e) Nurse #1 did not immediately report the allegation and the Accused CNA worked with Resident #1 during the 11 p.m. to 7 a.m. shift starting on July 25, 2010 and ending on July 26, 2010.
 - (f) The Director of Nursing ("DON") reported that Nurse #1 reported the allegation to the Nurse Manager on July 26, 2010, and the Nurse Manager reported the allegation to the DON.
 - (g) CNA #3 had also observed the Accused CNA cover Resident #1's mouth with a slipper sock on at least three (3) occasions, one of which occurred during the 11 p.m. to 7 a.m. shift on July 2, 2010. CNA #3 stated that she had reported the alleged incidents to Nurse #2 and Nurse #3; Nurse #2 and Nurse #3 stated that CNA #3 had not done so.
 - (h) CNA #3 stated that she had also witnessed the Accused CNA yell at, swear at, and slam Resident #2, Resident #3, and Resident #4 into a seated position in their

chairs on several occasions when Resident #2, Resident #3, and Resident #4 were not compliant with the Accused CNA request for them to remain seated.

- (i) The Accused CNA admitted that she had covered Resident #1's mouth and shoved Resident #1's body during the provision of care on a couple of occasions due to personal stress.
7. With respect to Paragraph 6(f), above, on July 26, 2010, at 7:00 a.m., Nurse #1, the LPN supervisor on the 11 p.m. to 7 a.m. shift, left a note on the Unit Manager's door indicating that an incident had occurred. The Licensee was informed of the note left on the Unit Manager's door when he arrived at the Facility on July 26, 2010, between 8:00 and 8:30 a.m.
 8. On July 26, 2010, the Licensee learned, for the first time, of the July 24 - 25, 2010 incident and took the following actions: He began an internal investigation and interviewed all 11 p.m. to 7 a.m. shift employees; suspended CNAs #1, #2, #6, and #7 and Nurse #1 for the alleged incident and failure to report the alleged incident; fired the Accused CNA; notified DPH; held round-the-clock meetings with all staff to review the Facility abuse policy; sent a letter to all residents' families regarding the incident; met with Resident #1 and family; and developed and implemented a Plan of Correction.
 9. On or about August 17, 2010, the Department completed another complaint survey at the Facility involving allegations of abuse of a Facility resident (DPH Reference #10-0934). The Department generated an SOD bearing the same date. Among the deficiencies identified in the SOD was a deficiency (Tag F 223) with respect to 42 CFR 483.13(b) and 42 CFR 483(b)(1)(i). Section 483.13(b) states, "The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion." Section 483.13(b)(1)(i) states, "The facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion."
 10. Based on investigation of the complaint, the Department determined that the requirements of 42 CMR 413.13(b) and 483.13(b)(1)(i) had not been met based on the following:
 - (a) On August 12, 2010 at approximately 6:45 a.m., the Unit Manager of Unit C was in her office and noticed Resident #1 sitting in a wheelchair near the nurses' station. The Unit Manager observed the Accused CNA bring Resident #1 to the bathroom in the hallway. The Unit Manager heard Resident #1 yell "no" and then heard another voice, which was muffled. The Unit Manager went and opened the bathroom door and observed Accused CNA tell Resident #1 something to the effect that "you are going to get dressed now "bitch"". The Unit manager called the Accused CNA by name, but the Accused CNA did not respond. The Unit Manager observed the Accused CNA punching Resident #1 and the Unit Manager tried to get between Resident #1 and the Accused CNA, but the Accused CNA grabbed Resident #1's arm and then pulled Resident #1's hair. The Unit Manager called for help and several staff members responded. The Unit Manager said that Nurse #1, who responded, was able to position the Accused CNA up against a

wall so that another staff person was able to wheel Resident #1 out of the bathroom.

- (b) A Resident Incident Report, which was not signed or dated, indicated that on August 12, 2010, at approximately 6:45 a.m., Resident #1 was involved in a physical abuse incident with a staff member; there were red marks on Resident #1's body; there were a few scratches and a small bruise on Resident #1's lower left arm; Resident #1's scalp was pink where the Resident's hair had been pulled; and some of Resident #1's hair was on Resident #1's lap.
- (c) On August 13, 2010, the Facility reported the incident of abuse involving Resident #1 to the Department and the Licensee subsequently submitted a Plan of Correction dated August 29, 2010, identifying the corrective actions the Facility had taken.

11. The August 17, 2010 SOD (DPH Reference #10-0934) further identified a deficiency (Tag F225) with respect to 42 CFR 483.13(c)(2)-(4), which states:

"(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.

(2) The 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 and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).

(3) The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.

(4) The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken."

12. Based on investigation of the complaint, Department surveyors determined that the requirements of 42 CMR 413.13(c)(2)-(4) had not been met based on the following:

- (a) As a result of the Department's complaint investigation on August 5, 2010, the Department determined that allegations of resident abuse that occurred in early July 2010 and on July 25, 2010, had not been reported immediately by Facility staff to the Facility's administrator; a Facility investigation was not begun; and the Facility had not taken action to protect residents from further harm while an investigation was in progress.

- (b) During the course of the investigation of the abuse incident of August 12, 2010, involving the Accused CNA repeatedly striking and yelling at Resident #1, the Department learned that that in mid-July 2010 Resident #1 had reportedly called out "don't kick me" or words to that effect when the Accused CNA entered Resident #1's room to provide care. CNA #1 said that on August 12, 2010, CNA #1 told the Unit Manager about the following incident that happened between Resident #1 and the Accused CNA in mid-July 2010: CNA #1 said that at approximately 11 p.m. on July 19, 2010, CNA #1 heard Resident #1's alarm sound, but CNA #1 did not go into Resident #1's room because CNA #1 knew that Accused CNA was in Resident #1's room already. CNA #1 stated that one or two minutes later CNA #1 heard Resident #1 screaming. CNA #1 and CNA #4 entered the Resident's room that the Accused CNA had already entered. CNA #1 said the Accused CNA was standing with the Accused CNA's hands half way up in the air. The Accused CNA told CNA #1 that Resident #1 said that the Accused CNA had kicked Resident #1 or words to that effect. CNA #1 told the Accused CNA to leave the room. CNA #1 asked Resident #1 what had happened and Resident #1 responded that "the black woman kicked" Resident #1 or words to that effect. CNA #1 noticed a little pinpoint open area on Resident #1's shin.
- (c) CNA #1 did not remember if CNA #1 or CNA #4 brought the Supervisor to Resident #1's room. CNA #1 stated that after telling the Supervisor what had happened, the Supervisor told CNA #1 and CNA #4 to leave the room and shut the door, so CNA #1 and CNA #4 left the room. CNA #1 stated that later that night, she asked the Supervisor what happened and the Supervisor responded that the Supervisor had "taken care of the issue" or words to that effect; the Supervisor did not offer any other information. CNA #1 said that the following night CNA #1 asked Nurse #2 what had happened regarding Resident #1's allegation, and Nurse #2 only said it had been "taken care of" or words to that effect.
- (d) Nurse #2 stated that Nurse #2 was by the nurses' station getting report from the previous shift and heard the alarm go off at approximately 11 p.m. on July 18, 2010, Nurse #2 heard Resident #1 yelling something to the effect that "she kicked me, she kicked me." Nurse #2 did not get involved as she was taking report. Nurse #2 said that the Supervisor told Nurse #2 something to the effect that the Supervisor had "checked out the situation" and the allegation was not credible. Nurse #2 said the Supervisor did not ask Nurse #2 to write a statement regarding Nurse #2's observations.
- (e) CNA #3 stated that at approximately 11 p.m. on July 18, 2010, CNA #3 was at the nurses' station when Resident #1's alarm sounded. CNA #3 said that CNA #3 asked the Accused CNA to go check on Resident #1's room. CNA #3 said soon after the Accused CNA went into Resident #1's room, CNA #3 heard Resident #1 screaming. CNA #3 said CNA #3 was busy with another resident and did not get a chance to ask what had happened until later in the shift. CNA #3 said CNA #3 asked the Supervisor what had happened and the Supervisor responded that the Supervisor took care of everything. CNA #3 said CNA #3 did not inquire again as the Supervisor said all was taken care of and what could CNA #3 do.

- (f) The DON and the Administrator said that on or about 8/12/10, during the course of the investigation regarding the Accused CNA abusing Resident #1 on August 12, 2010, CNA #1 reported that sometime in July 2010, when CNA #1 and CNA #4 entered Resident #1's room and the Accused CNA was already in the room, the Accused CNA said to CNA #1 and CNA #4 something to the effect that Resident #1 had accused the Accused CNA of kicking Resident #1. The DON and the Administrator stated that CNA #1 reported that after the Accused CNA left Resident #1's room, Resident #1 said "that black girl kicked me" or words to that effect. The Administrator and the DON stated that CNA #1 reported that she had told the Supervisor. The DON said CNA #1 reported observing a tiny open area on Resident #1's leg. The statement of Resident #1 was not reported to the Facility Administrator or investigated by the Facility at that time, and no action was taken to protect Resident #1 or other residents from further harm while an investigation was in progress.
- (g) The DON's practice was to review the weekend Supervisor's report the first thing on Monday mornings. The DON recalled that on July 19, 2010, she reviewed the weekend Supervisor's notes and found a note regarding Resident #1's behavior. The weekend Supervisor's report of July 18, 2010, covering the 11 p.m. to 7 a.m. shift, indicated that Resident #1 had increased agitation, yelled at the staff, and threatened to walk home, and stated that staff hit and kicked Resident #1 and that staff kept Resident #1 a prisoner.
- (h) When the DON checked for an incident form and statement, there were none.
- (i) The DON went to Resident #1's room on Unit C and spoke with the Resident as to whether the Resident had any pain and how the Resident was treated by staff. The Resident had no complaints and the DON did not observe any marks on the bottom half of the Resident's legs. The DON also spoke with the Unit Manager, who had received report from the 11 p.m. to 7 a.m. nursing staff and there was no report of any incident or statement from the nursing staff. The DON stated that at that time the DON did not think there was any issue and did not investigate further.
- (j) There were no written nursing progress notes for July 17, 18, 19, or 20, 2010, available in Resident #1's record.
13. When notified of the alleged August 12, 2010 incident at about 7 a.m., the Licensee came immediately to the Facility and suspended the Accused CNA, who had been escorted off the premises after the incident by the Unit Manager, consistent with the Licensee's instructions and longstanding policy of zero tolerance for physical abuse. Resident #1 was medically assessed. An internal investigation was begun and the Director of Nursing was promptly suspended. The police department, Resident #1's family, and DPH were notified.
14. The Accused CNA who abused a Facility resident in July 2010 was not the Accused CNA who abused a Facility resident in August 2010.

15. On August 18, 2010, the Department notified the Licensee that as a result of the complaint investigation conducted on August 17, 2010 (DPH Reference Number 10-0934), the Department had determined that conditions at Springside constituted immediate jeopardy to resident health and safety, imposed a limitation on all admissions to the Facility, and directed the Facility to take immediate corrective action.
16. While the Licensee was Springside's Administrator, Facility staff did not immediately report incidents of resident abuse that had occurred in early July 2010, in mid-July, and on July 25, 2010, to the Licensee; a Facility investigation was not begun; and the Facility did not take action to protect residents from further harm while an investigation was in progress.
17. While the Licensee was Springside's Administrator, another incident of resident abuse occurred at the Facility on August 12, 2010, which incident the Facility reported to the Department on August 13, 2010.
18. While the Licensee was Springside's Administrator, he failed to ensure that an effective system was developed and implemented to ensure allegations of abuse were immediately reported and investigated, and that residents were protected while an investigation was in progress.
19. The Licensee, as an Administrator, has a duty to exercise proper regard for the health, safety, and welfare of facility residents pursuant to Board regulations at 245 CMR 2.15.
20. The Licensee acknowledges that the allegations contained in the Complaint, if proved at an administrative hearing, could provide sufficient grounds for the Board to take disciplinary action against his license to practice as a Nursing Home Administrator pursuant to M.G.L. c. 112, § 115 and 245 CMR 2.15.
21. The Licensee understands that this Consent Agreement for Reprimand constitutes disciplinary action against his Nursing Home Administrator license.
22. In consideration of the Licensee's execution of this Consent Agreement, the Board agrees not to pursue additional action before itself based upon the allegations set forth in the Complaint.
23. The Licensee acknowledges that his decision to enter into this Consent Agreement is a final act and is not subject to reconsideration or judicial review.
24. The Licensee states that he has used legal counsel in connection with his decision to enter into this Consent Agreement or, if he has not used legal counsel, that the decision not to do so has been one taken of his own free will.
25. The Licensee agrees to return to the Board, either by hand or certified mail, two (2) duplicate originals of this Consent Agreement signed, witnessed and dated, within ten (10) days of his receipt of the unsigned, proposed Agreement from the Board.

26. The Licensee understands that, after its Effective Date, this Consent Agreement constitutes a "public record" within the meaning of M.G.L. c. 4, § 7 subject to public disclosure and that the Board may forward a copy of this Agreement to other licensing boards or law enforcement entities, or both, as well as to any other individual or entity as required by law.
27. The Licensee certifies that he has read this document entitled "Consent Agreement." He understands that he has a right to formal adjudication concerning the allegations against him and that during said adjudication he would possess the right to confront and cross-examine witnesses, to call witnesses, to present evidence, to testify on his own behalf, to contest the allegations, to present oral argument, to appeal to the courts, and all other rights as set forth in the Massachusetts Administrative Procedures Act, M.G. L. c. 30A, and the Standard Adjudicatory Rules of Practice and Procedure, 801 CMR 1.01 *et seq.* Licensee further states that he understands that in executing this document entitled "Consent Agreement," he is knowingly and voluntarily waiving his right to formal adjudication and to all of the related rights listed above.

BY LICENSEE:

J. Michael Rivers

J. Michael Rivers, NHA

4/11/12
Date

Dawn M. Leeming
Witness (signature)

Dawn M. Leeming
Witness (print name)

BY THE BOARD:

Sally Graham

Sally Graham, Executive Director

4/11/2012
Date (Effective Date)

FOR BOARD USE

An original copy of this Consent Agreement signed by the Board was sent to Licensee/Licensee's attorney on 4/23/12 by Certified Mail No. 7010 2780 00018675 8923 by JHS.