The Commonwealth of Massachusetts
Executive Office of Health and Human Services
Department of Public Health
Division of Health Professions Licensure
Board of Registration of Nursing Home Administrators
239 Causeway Street, Suite 500, 5th Floor, Boston, MA 02114
(617) 973-0806
(617) 973-0988 TTY

January 17, 2013

By First Class Mail and Certified Mail No. 7010 2780 0001 8675 8411
Anthony J. Cichello, Esq.
Krokidas & Bluestein LLP
600 Atlantic Avenue, 19th Floor
Boston, MA 02210

COPY

By Hand
Anne McLaughlin, Esq.
Office of Prosecutions
Department of Public Health
Division of Health Professions Licensure
239 Causeway Street, Suite 400
Boston, MA 02114

Re: Board of Registration of Nursing Home Administrators
In the Matter of Sister Philip Ann Bowden
Docket No. NHA-2010-005

Dear Attorneys Cichello and McLaughlin:

Please find enclosed a copy of the *Board Ruling on Prosecuting Counsel's Motion for Partial Summary Decision* in the matter referenced above, which has been corrected on page 1 by deleting the word "Proposed" in the Ruling's title.

Sincerely,

Sally Graham
Executive Director

Enclosure

COMMONWEALTH OF MASSACHUSETTS

SUFFOLK COUNTY

BOARD OF REGISTRATION OF
NURSING HOME ADMINISTRATORS

In the Matter of Sister Philip Ann Bowden License No. NH5186 License Expiration June 30, 2013	Docket No. NHA-2010-005

BOARD RULING ON PROSECUTING COUNSEL'S MOTION FOR PARTIAL SUMMARY DECISION

I. Procedural Background

This matter comes before the Board of Registration of Nursing Home Administrators ("Board") on Prosecuting Counsel's Motion for Partial Summary Decision ("Motion"). The Board issued an Order to Show Cause ("Order") on February 7, 2012. Respondent Sister Philip Ann Bowden ("Respondent") filed her Answer to said Order on February 21, 2012. On October 26, 2012, Prosecuting Counsel filed her Motion for Partial Summary Decision ("MPSD").[1]

[1] The Order to Show Cause includes allegations that the facility failed to provide adequate staffing for two units on the night shift and that Respondent failed to comply with the requirements of standards developed and administered by the Board in violation of G.L. c. 112, § 115. Prosecuting Counsel did not move for summary decision relative to these allegations.

Respondent filed her Opposition to Prosecuting Counsel's Motion for Partial Summary Decision ("Opposition") on November 16, 2012. [2]

II. Ruling on Motion

For the reasons set forth below, Prosecuting Counsel's Motion for Partial Summary Decision is ALLOWED in part and DENIED in part. [3]

III. Exhibits

Prosecuting Counsel submitted and/or referenced the following exhibits in support of her MPSD. [4]

1. Order to Show Cause, issued February 7, 2012
2. Respondent's Answer to Order to Show Cause, filed February 21, 2012
3. Respondent's Record of Standing, dated October 26, 2012
4. Board regulations at 245 CMR 2.00
5. Department of Public Health ("DPH") regulations at 105 CMR 150.000
6. Letter: from Bonner, DPH, Division of Health Care Quality, to Respondent, Marian Manor, dated February 26, 2010
7. Survey Report of Department of Health and Human Services Centers for Medicare & Medicaid Services ("CMS")
8. Electronic Code of Federal Regulations: 42 CFR 483.13
9. Affidavit of Paul DiNatale

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[2] Hearings in the instant matter were scheduled for December 5, 2012, January 14, 2013, and January 23, 2012. On October 11, 2012, Prosecuting Counsel filed a Motion to Continue the Pre-Hearing Conference scheduled for November 5, 2012, and the first day of hearing scheduled for December 5, 2012 so as to allow her to file this MPSD. On October 22, 2012, Respondent filed a response opposing a continuance of the proceedings, and on October 23, 2012, Prosecuting Counsel filed a response to Respondent's opposition to her motion. The Board granted Prosecuting Counsel's motion on October 24, 2012.

On October 31, 2012, Respondent filed and the Board granted a motion for an extension of time to file an Opposition to the MPSD. With her Opposition to Prosecuting Counsel's MPSD, Respondent filed her affidavit and a request for hearing on the MPSD. Respondent's request for a hearing on the motion is denied. Respondent submitted a lengthy and clear Opposition which has been carefully reviewed by the Board; Respondent did not indicate in what way a hearing would advance the Board's understanding of the issues involved.

[3] The Board rules on the Motion without entering its Final Decision and Order so as to allow Respondent an opportunity for a hearing on the issue of sanctions.

[4] Exhibits 1 - 15 are referenced in and attached to Prosecuting Counsel's MPSD as Exhibits A - NO.

10. Letter: From Shaw, CMS, to Respondent, dated April 12, 2010
11. Letter from Hughes, CMS, to Anthony J. Chichello, dated April 28, 2010
12. Electronic Code of Federal Regulations: 42 CFR 483 (contents, §483.75 [partial])
13. Electronic Code of Federal Regulations: 42 CFR 488 (contents, §§ 488.300, 488.301, 488.303 [partial])
14. Board regulations at 245 CMR 2.15
15. Ruling on Prosecuting Counsel's Motion for Partial Summary Decision, *In the Matter of Jeffrey N. Heinze*, Docket No. NH 05-006, issued May 21, 2007; Consent Agreements: *Luman* Matter, Docket No, NH 03-017 (executed May 16, 2005); *Coughlin* Matter, Docket No. NH 00-020 (executed 1/29/01); *Grimes* Matter, Docket No. NH 97-042 (executed December 8, 1997)

IV. Findings of Fact

The MPSD alleges certain undisputed facts, supported by the exhibits enumerated above. The Board now finds as undisputed facts established in the record and not subject to genuine dispute the following:

1. On or about February 20, 2009, the Board issued Respondent a license to practice as a Nursing Home Administrator in the Commonwealth of Massachusetts ("Commonwealth"), License No. NH5186. Respondent's license is current and will expire on June 30, 2013, unless renewed. (Exhibits 1, 2, 3)
2. From on or about January 24, 2009, Respondent was employed as Nursing Home Administrator at Marian Manor for the Aged and Infirm ("Marian Manor" or the "facility"), a non-profit, long–term care facility operated by the Carmelite Sisters for the Aged and Infirm in Boston, Massachusetts.
3. Pursuant to G.L. c. 112, §108, and the Board's regulations at 245 CMR 2.02, as Nursing Home Administrator, Respondent was responsible for the general administration of Marian Manor. (Exhibits 1, 2, 4, 13)
4. In accordance with Massachusetts Department of Public Health regulations regarding the licensure of long-term care facilities, nursing home

administrators are responsible for, among other things, a) ensuring that services required by patients or residents are available on a regular basis and provided in an appropriate environment consistent with established policies; and b) directing competent personnel, establishing and maintaining current written personnel policies, and establishing and maintaining personnel practices and procedures that encourage good patient or resident care. 105 CMR 150.002 (C)-(D). (Exhibit 5)

5. Pursuant to federal regulations at 42 CFR 483.13 (c) and (c)(1)(i), nursing homes must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents; more specifically, staff are prohibited from verbally, mentally, sexually, or physically abusing residents. In accordance with 42 CFR 483.13 (c)(2) - (4), a facility must ensure that all alleged violations involving mistreatment, neglect, or abuse are reported immediately to the administrator of the facility and to other officials in accordance with state law; that thorough investigations of such alleged violations occur; and that the results of such investigations are reported to the administrator or her designated representative within five (5) working days of the incident. (Exhibits 7, 8)

6. Pursuant to federal regulations governing the administration of nursing homes, such facilities are required to comply with applicable federal, state, and local laws and regulations and with accepted professional standards and principles that apply to professionals providing services in such facilities. 42 CFR 483.75 (b). Pursuant to Massachusetts Department of Public Health regulations regarding the licensure of long-term care facilities, such facilities are responsible for compliance with all applicable laws and regulations of legally authorized agencies. 105 CMR 150.002 (A)(2) (Exhibits 5, 12)

7. In accordance with the Board's regulations at 245 CMR 2.15 (1) and (4), grounds for discipline against Nursing Home Administrators include: (1) failing to exercise proper regard for the health, safety, and welfare of

patients; and (4) violation of local, state, or federal statutes or regulations related to nursing home administration. (Exhibit 14)

8. On or about February 2, 2010, the Department of Public Health, Division of Health Care Quality ("DHCQ"), completed a complaint survey at Marian Manor prompted by allegations of abuse perpetrated by a Certified Nursing Aide ("CNA"). (Exhibits 1, 2, 6, 7)

9. Following the complaint survey, on or about February 26, 2010, the DHCQ sent a letter and Statement of Deficiencies to Marian Manor, directed to the attention of Respondent as Administrator ("DHCQ letter"). The deficiencies at Marian Manor, constituting resident abuse, the failure to report such abuse to the facility administration, and insufficient staffing, were found to be "isolated deficiencies that constitute actual harm as well as a widespread pattern of deficiencies that constitute potential harm that is not immediate jeopardy ...". The DHCQ determined that Marian Manor was "out of substantial compliance with the federal regulations applicable to long-term care facilities." More specifically, Marian Manor had failed to ensure that staff immediately reported allegations of abuse and a pattern of intimidation perpetrated by a CNA against ten (10) residents between approximately November 2009 and January 2010. [5] (Exhibits 6, 7)

10. The DHCQ made the following recommendations to the U. S. Department of Health and Human Services, Centers for Medicare & Medicaid Services ("CMS"): a) that Marian Manor's participation in the Medicaid and Medicare programs be terminated on August 2, 2010 unless the facility achieved substantial compliance by then; and b) that CMS impose a civil monetary

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[5] Multiple CNA and nursing staff members at Marian Manor witnessed and/or were aware of physically and verbally abusive acts perpetrated by the CNA at issue. Although some CNAs reported certain abusive acts to nurses, the nurses failed to immediately report the abusive conduct to facility managers and the conduct continued for approximately three months until it was finally reported to management and Respondent in late January 2010. (Exhibit 7)

Abusive conduct directed at residents by the CNA at issue included, but was not limited to, rough handling and squeezing of a male resident's genitals to the point where the patient cried out in pain; rough treatment of residents, including pushing residents into the side bars of their beds and into a wall; physical threats; and verbal threats, intimidation, and demeaning remarks. One CNA stated to the surveyor that the cries and screams of a patient abused by the abusive CNA were audible through the patient's closed door to the nurses sitting at the nursing station directly across the hall. (Exhibit 7)

penalty in the amount of $50 - $3,000 per day effective from the date non-compliance was initially established. (Exhibit 6)

11. The DHCQ letter advised Respondent of the right to file a written request for a review of the cited deficiencies through an informal dispute resolution ("IDR") process. A request for IDR was not filed. (Exhibits 6, 9)

12. On March 7, 2010, Marian Manor submitted a Plan of Correction addressing the deficiencies cited in the Statement of Deficiencies, which DHCQ accepted. (Exhibits 1, 2)

13. By letter from CMS dated April 12, 2010 ("CMS letter"), Respondent was advised that the "Substandard Quality of Care" cited by DHCQ as a result of its February 2, 2010 survey would lead to the automatic termination of Marian Manor's provider agreement with the Medicare and Medicaid programs unless substantial compliance was achieved and verified on or before August 2, 2010, and to the denial of payment for new admissions unless substantial compliance was achieved and verified on or before May 2, 2010. The CMS letter also notified Respondent of the imposition of civil money penalties totaling $18,000 ($400 per day for the period of February 2, 2010 – March 18, 2010) (Exhibits 10, 13)

14. The CMS letter advised Respondent of the right to appeal by filing a written request for a hearing before an administrative law judge. Marian Manor did not request a hearing, waiving its appeal rights. The CMS letter also notified Respondent that waiver of the right to a hearing would result in a 35% reduction in the Civil Money Penalty, from $18,000 to $11,700. By letter dated April 28, 2010, Attorney J. Chichello was advised by CMS that the agency had received and processed the waiver of appeal rights filed on behalf of Marian Manor and that the agency had reduced the Civil Money Penalty by 35%. (Exhibits 1, 2, 10, 11)

IV. Rulings of Law

1. Based on Finding of Fact ¶ 1, above, the Board has jurisdiction to hear this case.

2. Based on Findings of Fact ¶¶ 2-14, above, and in accordance with 245 CMR 2.15 (4), Respondent is subject to discipline under 245 CMR 2.15 and G.L. c. 112, § 61 for violations of state and federal laws and regulations related to nursing home administration.

Discussion

Rule 1.01(7)(h) of the Standard Adjudicatory Rules of Practice and Procedure, 801 CMR 1.00 *et seq.*, provides in relevant part that "When a Party is of the opinion that there is no genuine issue of fact relating to ... a claim... and he is entitled to prevail as a matter of law, the Party may move, with or without supporting affidavits, for summary decision on the claim ...".

The standards governing summary decision in an administrative proceeding correspond to those articulated in the cognate rule of civil procedure, M.R.Civ.P. 56. *Catlin v. Board of Registration of Architects*, 414 Mass. 1, 7 (1992). Rule 56 provides that a court shall grant a motion for summary judgment "if the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter of law." M.R.Civ.P. 56(c). *Theran v. Rokoff*, 413 Mass. 590, 591 (1992). A party moving for summary judgment bears the burden of affirmatively demonstrating that there is no genuine issue of fact on every relevant issue raised by the pleadings; all inferences from the underlying facts must be drawn in the light most favorable to the party opposing the motion. *Attorney General v. Bailey*, 386 Mass. 367, 371 (1982); *Mack v. Cape Elizabeth School Board*, 553 F.2d 720,722 (1st Cir. 1977). All doubts as to the existence of a genuine issue of material fact must be resolved against the party moving for summary judgment. *Noble v. Goodyear Tire & Rubber Co.*, 34 Mass. App. Ct. 397,402 (1993).

Prosecuting Counsel asserts that at all times relevant to this proceeding, Respondent was the Nursing Home Administrator at Marian Manor and that in that position, Respondent was responsible for events that led to DHCQ's citation

of the facility for substandard care that failed to comply with state and federal law. More specifically, Prosecuting Counsel maintains that Respondent was responsible for the facility's failure to ensure that a CNA's repeated instances of abuse directed at ten (10) residents over a period of approximately three months were reported immediately to Respondent and to state officials as required by state and federal law and regulations. Prosecuting Counsel contends that such conduct subjects Respondent to discipline pursuant to 245 CMR 2.15 (1) and (4) and G.L. c. 112, § 61, for her failure to exercise proper regard for the health, safety, and welfare of Marian Manor residents and for violations of state and federal statutes and regulations related to nursing home administration. Prosecuting Counsel further maintains that Respondent is subject to discipline for deceit, malpractice, and gross misconduct in the practice of nursing home administration as well as for unprofessional conduct and conduct that undermines public confidence in the integrity of the profession. [6] The Board agrees that Respondent is subject to discipline pursuant to 245 CMR 2.15 (4). However, the Board finds that based on the record before it, summary decision is not warranted on the remaining claims including, but not limited to, the claim that Respondent acted in violation of 245 CMR 2.15 (1) and is subject to discipline for deceit, malpractice, and gross misconduct in the practice of the profession pursuant to G.L. c. 112, § 61.

In accordance with federal and state regulations at 42 CFR 483.1 - 483.75 and at 105 CMR 150.002 (A)(2), Marian Manor, as a nursing home participating in Medicare and Medicaid programs, was required to adhere to certain requirements, including operating and providing services in compliance with all applicable federal, state, and local laws, regulations and codes and in accordance with accepted professional standards and principles.

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[6] In support of her MPSD, Prosecuting Counsel cited the Board's ruling in *In the Matter of Jeffrey N. Heinze*, NH 05-006. The facts in the *Heinze* case are sufficiently distinct from the facts before the Board for the ruling in *Heinze* to serve as a basis for finding that Respondent engaged in deceit, malpractice, and gross misconduct in the practice of the profession under G.L. c. 112, § 61, and failed to exercise proper regard for the health, safety, and welfare of the abused Marian Manor residents under 245 CMR 2.15 (1).

Also pursuant to state regulations at 105 CMR 150.002 (C) and (D), Marian Manor as a facility participating in Medicaid and Medicare programs, was obligated to ensure that services required by residents were available on a regular basis and provided in an appropriate environment consistent with established policies. Additionally, Marian Manor and Respondent were required to direct competent personnel and establish procedures that encouraged good patient or resident care. Federal regulations at 42 CFR 483.13(c) specifically required that all alleged violations of mistreatment, neglect, or abuse be reported immediately to the Nursing Home Administrator and to other officials in accordance with state law.

It is undisputed that on February 2, 2010, DHCQ conducted a complaint survey at Marian Manor and determined that alleged mistreatment and abuse of residents had occurred and was not reported to Respondent as required by law and regulation. DHCQ found deficiencies that were isolated deficiencies constituting actual harm as well as a widespread pattern of deficiencies that constituted potential harm that was not immediate jeopardy. Pursuant to 42 CFR 488.301, the deficiencies constituted substandard quality of care. Hence, DHQC determined that the facility was not in substantial compliance with federal and state laws and regulations. [7]

The Board's regulation at 245 CMR 2.15 (1) provides that grounds for disciplinary action include the failure of a Nursing Home Administrator to exercise proper regard for the health, safety, and welfare of facility residents. The Board's regulation at 245 CMR 2.15 (4) provides that violations of local, state, or federal statutes or regulations related to nursing home administration constitute grounds for discipline against a licensed Nursing Home Administrator. In the instant case, the resident abuse and failure to immediately report such abuse underlying the violations of law were egregious and antithetical a nursing home's federally mandated duty to provide care in a manner that maintains the "highest

[7] A facility such as Marian Manor would have been deemed to have been in "substantial compliance" if deficiencies identified at the facility posed no greater risk to residents' health and safety than the potential for causing harm. A lack of substantial compliance was deemed "noncompliance". 42 CFR 488.301

practicable" level of residents' physical, mental, and psychosocial well-being (42 CFR 483.75). For a period of approximately three (3) months several CNAs and nurses at Marian Manor witnessed and heard complaints about a CNA's physical abuse, physical and verbal threats, and intimidation of ten (10) Marian Manor residents. During this entire period of time, not a single staff member reported the abusive conduct to Respondent, who was by law responsible for the general administration of Marian Manor. As a result, the CNA was free to continue her pattern of abusive behavior against an extremely vulnerable population.[8] Such circumstances, involving an utter breakdown in critical and legally mandated communication, are alarming to the Board and subject Respondent, as Nursing Home Administrator of Marian Manor, to discipline pursuant to 245 CMR 2.15 (4). Moreover, Respondent's violation of the Board's regulations constitutes grounds for discipline under G.L. c. 112, § 61, for any offense against the laws of the Commonwealth relating to the practice of the profession.

In her Opposition to the MPSD, Respondent states that the "...only non-frivolous argument raised by Prosecuting Counsel is a claim that because the Facility was found to have survey deficiencies, Sister Philip should be deemed responsible for violations of ...statutes and regulations related to nursing home administration and, therefore subject to discipline by the Board." Nevertheless, Respondent contends that it is misguided to suggest that the mere fact of a facility's violation of law, no matter how trivial, constitutes grounds for discipline. Were this the case, Respondent argues, the overwhelming majority of Nursing Home Administrators would be, as a matter of law, subject to discipline without regard to the severity of the violations and the specifics of the licensee's conduct. Respondent's position fails to take into account the Board's discretion in issuing Orders to Show Cause and determining an appropriate disciplinary sanction should any sanctions be warranted. Respondent is entitled to a hearing on sanctions at which she may address the issue of the propriety of discipline and

[8] The abused residents had mental acuity deficits that ranged from short and long term memory failure to severe cognitive impairment. (Exhibit 7)

the issue of an appropriate sanction should the Board deem discipline to be warranted.

In her Opposition, Respondent argued that for a variety of reasons summary decision should be denied on the remaining allegations that are the subject of Prosecuting Counsel's MPSD. While the Board does not find all of Respondent's arguments meritorious, the Board agrees with Respondent that the evidence before it on this MPSD does not warrant findings that based on undisputed material facts, Respondent engaged in gross misconduct, deceit, and malpractice in the practice the profession. In this matter, proof of such allegations requires an evidentiary hearing with the presentation of sufficient and more detailed evidence regarding Respondent's conduct, and in all probability, expert testimony as to standards of professional practice as a Nursing Home Administrator.[9]

Based on the foregoing, Prosecuting Counsel's Motion for Partial Summary Decision is ALLOWED in part and DENIED in part.

Respondent is hereby notified that she has the right to a hearing on the issue of sanctions. Respondent will waive this right if she fails to complete and return the enclosed form to the Administrative Hearings Counsel within ten (10) days of the issuance of this Ruling. Respondent's failure to request a hearing on sanctions by returning the enclosed form in a timely manner will result in the Board deciding on sanctions without Respondent's input. If Respondent fails to request a sanctions hearing within ten (10) days, the Board may revoke, suspend or take other disciplinary action against Respondent's license to practice as a Nursing Home Administrator in the Commonwealth of Massachusetts.

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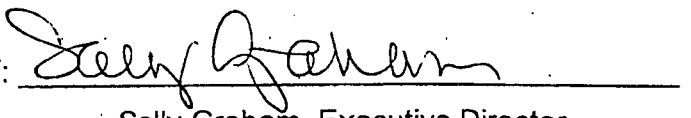
[9] In support of her MPSD, Prosecuting Counsel cited the Board's ruling in *In the Matter of Jeffrey N. Heinze*, NH 05-006. The facts in the *Heinze* case are sufficiently distinct from the facts before the Board for the ruling in *Heinze* to serve as a basis for finding that Respondent engaged in deceit, malpractice, and gross misconduct in the practice of the profession and failed to exercise proper regard for the health, safety, and welfare of the abused Marian Manor residents.

The Board voted to adopt the within Ruling on Prosecuting Counsel's Motion for Partial Summary Decision at its meeting on December 20, 2012, by the following vote: In favor: Nancy Lordan, NHA; William Graves, NHA; Roxanne Webster, RN; Janet Cutter, RN; Mary McKenna, EOEA; David Becker, NHA; James Divver, NHA; and Michael Baldassarre, NHA. Opposed: None. Abstained: None. Absent: Sherman Lohnes, DPH.

Based on its adoption of the within Ruling on Prosecuting Counsel's Motion for Partial Summary Decision, at its meeting on December 20, 2012, the Board voted to dismiss Paragraphs 3, 5(b), 8, 10, 11 (dismissal of the words, "for deceit, malpractice, and gross misconduct in the practice of the profession or"), and 12 of the Order to Show Cause dated February 7, 2012, by the following vote: In favor: Nancy Lordan, NHA; William Graves, NHA; Roxanne Webster, RN; Janet Cutter, RN, MassHealth; Mary McKenna, EOEA; David Becker, NHA; James Divver, NHA; and Michael Baldassarre, NHA. Opposed: None. Abstained: None. Absent: Sherman Lohnes, DPH.

Board of Registration of Nursing Home Administrators

BY: 

Sally Graham, Executive Director

DATE: December 21, 2012

NOTICE TO:

Anthony J. Cichello, Esq. (By First Class and Certified Mail 7010 2780 0001 8675 8411)
Anne McLaughlin, Esq. (By Hand)

Anthony J. Cichello, Esq.
Krokidas & Bluestein LLP
600 Atlantic Avenue, 19th Floor
Boston, MA 02210

Anne McLaughlin, Esq.
Office of Prosecutions
Department of Public Health
Division of Health Professions Licensure
239 Causeway Street, Suite 400
Boston, MA 02114

COMMONWEALTH OF MASSACHUSETTS

SUFFOLK COUNTY

BOARD OF REGISTRATION
OF NURSING HOME ADMINISTRATORS

In the Matter of Sister Philip Ann Bowden License No. NH 5186 License Expiration 6/30/13	Docket No. NHA-2010-005

FINAL DECISION AND ORDER

Procedural Background

This matter comes before the Board of Registration of Nursing Home Administrators ("Board") for determination of an appropriate sanction and issuance of a Final Decision and Order following the December 21, 2012 Board Ruling on Prosecuting Counsel's Motion for Partial Summary Decision ("MPSD"). In ruling on the MPSD, the Board determined that in accordance with Board regulations at 245 CMR 2.15 (4), Respondent Sister Philip Ann Bowden ("Respondent") was subject to discipline pursuant to 245 CMR 2.15 and G.L. c. 112, § 61, for violations of state and federal laws and regulations related to nursing home administration.[1]

[1] The Board's Ruling on Prosecuting Counsel's Motion for Partial Summary Decision is incorporated by reference herein. In brief, at all times relevant to this proceeding Respondent was the Nursing Home Administrator at Marian Manor for the Aged and Infirm ("Marian Manor" or "the facility"), a long-term care facility operated by the Carmelite Sisters. In February 2010, the Department of Public Health, Division of Health Care Quality ("DHCQ"), completed a complaint survey at Marian Manor prompted by allegations of resident abuse perpetrated by a Certified Nursing Assistant ("CNA"). The DHCQ found deficiencies at Marian Manor arising from the abuse of 10 residents and the staff's failure to report such abuse over a period of about three (3) months. The DHCQ determined that Marian Manor was "out of substantial compliance with federal regulations applicable to long-term care facilities".

Board regulations at 245 CMR 2.15 (4) provide that grounds for discipline against Nursing Home Administrators include violation of local, state, or federal statutes or regulations related to nursing home administration. In accordance with DHCQ's findings, Respondent was deemed subject to discipline pursuant to 245 CMR 2.15 (4) (for violation of local, state, or federal statutes or

Following the Board's issuance of its Ruling on the MPSD, Respondent filed a timely request for a hearing on the issue of sanctions. A hearing was convened on January 23, 2013, before Administrative Hearings Counsel Vivian Bendix pursuant to G.L. c. 30A and the Standard Rules of Adjudicatory Practice and Procedure at 801 CMR 1.00 *et seq.* Respondent was present and represented by Anthony J. Cichello, Esq. Prosecuting Counsel was Anne McLaughlin, Esq. In addition to and on behalf of Respondent, testimony was offered by Elizabeth Theresa Freeman and Barbara Bailey Gill.

Exhibits

1. Affidavit of Sister Philip Ann Bowden, O. Carm., dated November 15, 2012
2. Abuse/Stress Management Training Document for All Staff Inservice, September 2008
3. U.S. Department of Health and Human Services Centers for Medicare and Medicaid Statement of Deficiencies and Plan of Correction for survey completed February 2, 2010, printed February 26, 2010
4. Attendance/Sign-In sheets for in-service training for CNAs, various dates in September 2009
5. Attendance/Sign-In sheets for in-service training for nursing staff, various dates in September 2009

Discussion

Respondent's Testimony/Presentation Relative to Sanction

Respondent's Professional Background

Respondent entered the Order of the Carmelite Sisters of the Aged and Infirm in 1964. In accordance with the mission of the Carmelite Sisters, she was trained to love and respect the elderly and in working with the elderly, to provide a home-like, kind, loving, dignified, and safe environment. In her nearly forty (40) years of serving

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regulations related to nursing home administration) and G.L. c. 112, § 61 (for any offense against the laws of the Commonwealth relating to the practice of the profession).

in Carmelite nursing homes, she has endeavored to implement the Order's mission and create such an environment.

After receiving a nursing degree in 1973, Respondent practiced as a nurse in various Carmelite nursing homes in New York and Ohio. In about 1985, Respondent became an assistant administrator at a 264-bed nursing home in the Bronx, New York. Attending evening school, Respondent earned a Bachelor of Science in Health Care Administration. In 1991, Respondent was licensed as a Nursing Home Administrator in New York State and was appointed as the Nursing Home Administrator for a 432-bed Carmelite nursing home in Queens, New York, where she served until February 2009. During her tenure, the facility underwent extensive renovations, earned high praise, and was found to be deficiency free in the vast majority of surveys conducted. Prior to Respondent's tenure at Marian Manor, there had not been a single instance of abuse at any nursing home where Respondent had served as the Nursing Home Administrator and Respondent had never been the subject of a disciplinary proceeding or discipline by any licensing or regulatory entity.

Marian Manor

Upon becoming Nursing Home Administrator at Marian Manor in February 2009, Respondent reviewed all policies, procedures, and training programs. She attended an orientation program that included the subject of resident abuse. Respondent thought that the program effectively conveyed to staff that unkindness and abuse of residents would not be tolerated in any form, psychological, verbal, or physical, and that any suspicion of abuse or abuse was to be immediately reported.

An in-service training on abuse was conducted in September 2009. All staff on all shifts were required to (and did) attend and to complete a quiz. It was made crystal clear to employees that it was mandatory to report abuse, allegations of abuse, or the suspicion of abuse. Respondent also confirmed with Marian Manor's Human Resources Department that background checks (Criminal Offender Record Information ("CORI"), prior discipline by a licensing board) were performed on all newly hired employees. Marian Manor has a warm and friendly staff, who receive frequent praise from residents and their families.

Respondent resides at Marian Manor. She is a "hands-on" administrator and is very much present throughout the facility throughout the day. She has an "open door policy" and makes it clear that she is available to meet with residents, their family members, and staff. Respondent leads by example, encouraging kindness and openness on the part of all staff, supervisors, and administrators.

Respondent's work day begins between 6:00 and 6:30 a.m. and runs until after dinner, sometimes ending as late as 9:00 or 10:00 p.m. Throughout the day, Respondent checks in and meets with staff, circulates throughout the facility, and observes and interacts with residents in their rooms and in common areas, such as the various dining rooms. Additionally, Respondent maintains communication with the families of residents. Sometimes, Respondent resumes work in the late evening to visit the units to ensure things are running as they should. Every couple of months, Respondent gets up in the middle of the night to check in on the night shift. Since Respondent lives on the premises, the night staff knows to call on her when issues arise that require her attention.

In short, Respondent knows each of the 260 – 275 residents who reside at Marian Manor. They are "her life". Additionally, there are ten (10) Sisters who act as resident advocates in the various units. It is their job to listen to the residents, convey problems residents experience to nursing supervisors and administrators, and advocate on behalf of the residents.

The Abuse Incidents

Elizabeth Theresa Freeman ("Ms. Freeman") has been the night shift nursing supervisor at Marian Manor since 1989. As soon as Ms. Freeman learned of the incidents of abuse that are the subject of this case, she reported them to the Director of Nursing ("DON"), who immediately reported them to Respondent. Respondent was horrified and ensured that the accused perpetrator, a CNA, was immediately suspended. She directed the DON to launch a thorough investigation, and instructed nursing and social work staff to assess the patients who were alleged to have been abused. (Upon assessment, none of the patients exhibited signs of abuse). Families

of the allegedly abused patients and the Department of Public Health were promptly notified of the situation.

The investigation conducted by the DON confirmed that the accused CNA had engaged in abusive behavior with certain patients. Two nurses assigned to the unit had supposedly been informed of the abuse. They were both experienced nurses at Marian Manor, one having served as in-service director with responsibility for teaching staff about abuse and other training areas. Both nurses denied having witnessed any abuse and denied having been told of any abuse. With respect to the abusive CNA, although they were told by her colleagues that they "gotta watch out for her," they never related that information to Ms. Freeman. The nurses claimed that Patient A, who was the subject of repeated abuse, always cried out when he was touched and therefore his cries would not have led them to conclude he was being abused.

The investigation resulted in the termination of the abusive CNA, the two CNAs who observed the abuse, and the two nurses on the unit who supervised the CNAs.

Following the investigation, Respondent believes that it is likely that the offending CNA intimidated the two CNAs who witnessed her abusive conduct. She was a large woman and according to her CNA colleagues, made some threatening comments about what she and her boyfriend could do to harm or kill people. As to the utter breakdown in communication between the nurses supervising the unit and their supervisor, Respondent noted that the nurses asserted they were not told of any specific instances of abuse and felt that there was friction between the CNAs that could have led to untrue negative statements on the part of some CNAs against a co-worker. Additionally, the nurses reported that the offending CNA, a single mother of four young children, was a good worker, who was always gracious and the first to volunteer extra help when needed.

Changes Following Abuse Incident

Within a day of learning about the alleged abuse, Respondent arranged for intensive abuse training for all nursing staff. Staff were given concrete examples of

circumstances that would constitute abuse and instructed on reporting any abuse or suspected abuse to their unit nursing supervisors, and up the chain of command if no satisfactory response ensued. Training of non-nursing staff followed. Since the incident, abuse training has been conducted quarterly and abuse prevention and reporting is discussed at every nursing meeting.

Various other changes have been instituted at Marian Manor to help prevent any further instances of abuse. All policies and procedures have been reviewed. A "knock and enter" program instructs nursing staff who hear noise behind a closed door to open the door and check for abuse. Unannounced staff observation has been enhanced, and new audit tools implemented to ensure staff compliance with the facility's policies and procedures. Written policy now explicitly calls for staff to report not only actual and alleged abuse, but also suspected abuse. Triggers have been identified for immediate investigation of care giving.

Respondent's Position on Sanctions

Respondent accepts full responsibility for the operation of Marian Manor. She and her supervising staff were "horrified" that residents had suffered abuse and that they remained unaware of the abuse for several months. She has asked herself over and over again whether there was anything she could have done to have prevented the incidents, but she feels that the systems and policies that were in place and with which she was so familiar, including the trainings, should have been adequate. She was consistently present throughout the facility and in constant contact with administrators, staff, and residents. Respondent fostered an environment where it was clear that residents were to be treated with kindness, dignity, and respect at all times and that nothing less would be tolerated.

Respondent believes that the circumstances do not warrant discipline of her license. She has done everything "humanly possible" to prevent abuse of Marian Manor's residents.

Testimony of Elizabeth Theresa Freeman

Ms. Freeman has worked at Marian Manor continuously since 1984, initially as a nurse's aide and, since 1987, as a Licensed Practical Nurse. Since 1989, she has been the nursing supervisor on the night shift, with responsibility for oversight of eight (8) nurses (Registered Nurses and Licensed Practical Nurses) and 23 CNAs. Ms. Freeman makes rounds throughout the facility, usually three (3) times during the night shift. She has instructed staff to leave the doors to residents' rooms slightly ajar, in a manner that affords the residents privacy, but enables someone to hear if something is amiss. As she makes her rounds, she glances into the resident's rooms.

Prior to the incidents at issue, abuse training at Marian Manor was conducted annually. At times, staff were given copies of the facility's written policies on abuse. Now, each new staff member is given a set of the facility's written policies at orientation. Ms. Freeman conducted the September 2009 in-service training on abuse with the night shift staff. Her attendance sheets show that all staff attended, including the perpetrator of the abuse at issue and the CNAs and nursing staff involved in the failure to report. She stressed to staff that there was zero tolerance for any type of abuse; that all resident complaints and incidents had to be reported to her for investigation regardless of the mental status of the resident; and that it was the responsibility of each staff member to report any harm and abuse that they believed occurred even if they did not actually witness the injury or abuse.

At the time of the incident, she had the utmost confidence in the nurses supervising the CNAs. The nurse who had been at Marian Manor for years, Diane, had conducted trainings and staff development and would bring to her attention any bruises or skin tears on a resident. Both nurses who supervised the offending CNA described her as a good worker, but Diane acknowledged that one of the CNAs had told her to "keep her eyes and ears open" for the offending CNA. When Ms. Freeman initially learned about the offending CNA's behavior from another CNA, she was appalled and immediately conveyed the information to the DON. An investigation was commenced at once.

Respondent has a constant presence at Marian Manor, and she knows she can call on Respondent at any time of the night. Respondent frequently stops by the nursing office at the end of Ms. Freeman's shift to check in about particular residents and general issues that may have arisen. She has observed Respondent making unannounced rounds to the units, talking with staff and residents.

Testimony of Barbara Bailey Gill

Barbara Bailey Gill ("Ms. Gill"), a Registered Nurse, entered the Order of the Carmelite Sisters with Respondent in 1964 and trained with Respondent for three (3) years. Ms. Gill left the Order seven (7) years later. For twenty-six (26) years, until 1999, she worked at Massachusetts General Hospital ("MGH") in various capacities. In her retirement, she helps people care for elderly and frail people in their homes. She has also been on Marian Manor's Board of Directors for the past eight (8) years. In that capacity, she has visited and walked through Marian Manor periodically, speaking with residents and their families. Consistently, she has observed residents being cared for with great kindness. She has also had friends who have resided at Marian Manor and witnessed the excellent, attentive care they received around the clock.

Ms. Gill has observed Respondent with Marian Manor's residents and staff. Respondent effectively communicates with staff and has nurtured a wonderful atmosphere and spirit at the facility. To Respondent, resident care is of paramount importance and she would never tolerate incidents of abuse or unkindness towards residents. The incidents at issue did not in any way diminish Ms. Gill's confidence in Respondent. The nursing staff "fell down on their jobs"
and they were appropriately disciplined.

Argument on behalf of Respondent

This case involves a horrible fact situation that led to a flawed finding that Respondent had violated the law. Nevertheless, the issue before the Board is whether a sanction is appropriate, and if so, what sanction.

The abuse that occurred at Marian Manor ran counter to everything to which Respondent has dedicated her life. Being the Nursing Home Administrator at Marian Manor is not a job for Respondent; it's her vocation and life. She is omnipresent throughout the facility, working from early morning well into the evening. She knows and interacts with each person who lives and works there. Respondent has never tried to minimize the egregious nature of the abuse that occurred and she has acknowledged her responsibility for the operation of Marian Manor. Yet, because Respondent was responsible does not mean that she was culpable.

The Department of Public Health found that adequate policies and training regarding abuse prevention and reporting were in place at Marian Manor. Indeed, the proper policies, systems, and trainings were in place, including training that occurred just two (2) months before the onset of the offending CNA's abusive behavior. Respondent, herself, had participated in training. She had a strong night shift staff in place, from Ms. Freeman to Diane, who had been at Marian Manor for 25 years as a nurse and staff educator. Diane and others knew what they were supposed to do in situations involving abuse or allegations of abuse; they simply failed to do it. Their conduct was inexcusable and in some ways inexplicable.

Respondent's response to the incidents of abuse was horror and an immediate need to figure out what could be learned to prevent a recurrence. The individuals involved were all disciplined, more training was instituted, new policies such as "knock and enter" were implemented, and additional systems checks were put in play.

Marian Manor is Respondent's home and life. It is a model nursing home and Respondent is precisely the type of Nursing Home Administrator the Board should want. She has been in the profession of caring for the elderly and infirm for 40 years and has shown no signs of slowing down. Discipline in this case is inappropriate and will serve no purpose.

Prosecuting Counsel's Argument

Prosecuting Counsel asserted that the Board has all the information it needs to consider the issue of sanctions and she leaves it to the Board in its wisdom to render a decision.

In accordance with the Board's Ruling on Prosecuting Counsel's Motion for Partial Summary Decision; the statements and exhibits introduced at the hearing on sanctions; the Board's responsibility to protect the public health, safety and welfare; and the Board's duty to maintain the public's confidence in the integrity of the profession of Nursing Home Administrator, the Board enters the following Order:

ORDER

Discussion

As established in this proceeding and acknowledged by Respondent, as the licensed Nursing Home Administrator at Marian Manor Respondent was responsible for all facility operations. Respondent was thus properly accountable for the effectiveness of Marian Manor's training of staff on resident abuse and the supervision of night shift staff.

Further, as established in this proceeding and acknowledged by the Board, prior to the resident abuse that is the subject of this proceeding, Marian Manor had in place written policies and procedures, and had in-serviced facility staff annually, on resident abuse. According to testimony of the nursing supervisor on the night shift with responsibility for oversight of eight (8) nurses (RNs and LPNs) and 23 CNAs, staff resident abuse training was conducted annually; staff were given copies of the facility's written policies on resident abuse; in September 2009 she conducted an in-service training on resident abuse with all night shift staff, including the perpetrator of the abuse at issue and the CNAs and nursing staff involved in the failure to report; she stressed to staff that there was "zero tolerance" for any type of abuse; all resident complaints and incidents had to be reported to her for investigation regardless of the

mental status of the resident; and it was the responsibility of each staff member to report any harm and abuse that they believed had occurred even if they had not actually witness the injury or abuse. The night shift nursing supervisor noted that the two (2) RNs who had failed to report either the warning given to them by the perpetrating CNA's colleagues to "watch out for her" or the resident abuse at issue were both experienced nurses at Marian Manor, one having served as in-service director with responsibility for teaching staff in various training areas, including resident abuse. Respondent testified that upon becoming the Administrator at Marian Manor in February 2009, she reviewed all facility policies, procedures, and training programs and attended an orientation program that included the subject of resident abuse and thought that the program effectively conveyed to staff that abuse of residents would not be tolerated in any form and that any suspicion of abuse or abuse was to be immediately reported. In September 2009, an in-service training on abuse was conducted, which all staff were required to attend and to complete a quiz. According to Respondent, it was made "crystal clear" to employees that it was mandatory to report abuse, allegations of abuse, or the suspicion of abuse.

In spite of Marian Manor's written policies and procedures, orientation programs and in-servicing staff on resident abuse, four (4) CNAs and two (2) RNs on the 11 p.m. to 7 a.m. shift failed to immediately report to facility administration the egregious abuse and intimidation of 10 residents perpetrated by a CNA when it began in November 2009, which abuse and intimidation included rough handling and squeezing a male resident's genitals to the point the resident cried out in pain; rough treatment of residents, including pushing residents into the side bars of their beds and into a wall; physical threats; verbal threats; intimidation and demeaning remarks; the two (2) RNs failed to report the abuse and intimidation[2] despite being informed of the perpetrating CNA's conduct by three (3) of the four (4) CNAs who worked with her; the two (2) RNs failed to report the abuse and intimidation despite being told by at least one (1) CNA that they should "watch out for" the perpetrating CNA's interaction with residents; and the two (2) RNs failed to report the abuse and

[2] A Registered Nurse or Licensed Practical Nurse who has reasonable cause to believe that an elderly person is suffering from, or has died as a result of, abuse is mandated by law to immediately report such abuse. G.L. c. 19A, § 15 and 244 CMR 9.03(6)(a)(1).

intimidation despite witnessing some of the perpetrating CNA's abusive behaviors. As a result of the failure of the CNAs and RNs to report the resident abuse and intimidation, 10 residents were subjected to such abuse and intimidation for a period of approximately three (3) months, at which time one (1) of the CNAs finally submitted written allegations of resident abuse by the perpetrating CNA to her supervisor.

The case before the Board is not about an isolated instance of resident abuse and intimidation witnessed by another staff member and immediately reported, or about a solitary instance of abuse witnessed by another staff member and reported within a few days of its occurrence. Here the resident abuse and intimidation perpetrated by a CNA involved multiple instances of abuse of 10 vulnerable residents, and the failure of multiple staff, both CNAs and RNs with personal knowledge of the abuse, to report any instance of the abuse for approximately three (3) months, flagrantly ignoring their unambiguous responsibility under law, regulation, and facility policies and procedures to immediately report the abuse.

The Board evaluates each complaint against a licensed Nursing Home Administrator involving allegations of resident abuse at the facility for which the Administrator is responsible on a case by case basis. In evaluating each case, the Board considers factors such as the number and frequency of instances of resident abuse at the facility; the number of CNAs, licensed nurses, and/or other staff at the facility who failed to report the abuse; and the length of time between the occurrence of the abuse and its reporting to facility administration and oversight agencies as required by federal and state laws and regulations. Where there are multiple instances of abuse involving multiple residents, and multiple facility staff know about the abuse, yet fail to immediately report it, the Board may draw the inference that a facility's policies and procedures governing resident abuse, and its staff training on resident abuse, were not adequate to serve its intended purpose, to the detriment of facility residents.

In applying the factors outlined above to the circumstances of this case, involving 10 residents, many instances of resident abuse, the failure of multiple facility CNA and RN staff to immediately report the abuse and intimidation to Marian

Manor's administration, and the delay of approximately three (3) months before the abuse was properly reported, during which time the residents were subjected to ongoing abuse, the Board draws the inference that Marian Manor's training of staff on resident abuse and reporting of abuse was not adequate to protect facility residents from abuse and intimidation. While the Board acknowledges that the Respondent took numerous measures to prevent the abuse of residents at Marian Manor and to ensure timely the reporting of suspected cases of abuse, those measures proved inconsequential when facility employees entrusted to act on behalf of the facility failed to act on their training and instead demonstrated utter disregard for the safety and dignity of the vulnerable residents under their care.

In arriving at the sanction in this case, the Board has also considered the many and timely actions that the Respondent took after she was notified of the resident abuse and intimidation that had occurred, including immediately suspending the CNA accused of the abuse; assessing the residents subjected to the abuse; immediately initiating an investigation into the allegations of abuse; arranging for intensive training on resident abuse, abuse prevention and abuse reporting for all nursing staff and non-nursing staff; reviewing all facility policies and procedures; enhancing the observation of employees by supervisory personnel, including unannounced observations during care giving, engaging in efforts to identify and follow up on any changes in employee behavior or affect that may affect performance; terminating the perpetrating CNA and one of the two (2) RNs on the night shift from employment, and disciplining and re-training the other facility staff who had failed to report the perpetrating CNA's abusive conduct.

The Board hereby imposes a REPRIMAND on Respondent's Nursing Home Administrator license, License No. NH5186.

The Board adopted the foregoing Final Decision by the following vote: Board members present and voting in favor: Roxanne Webster, RN; Nancy Lordan, NHA; James Divver, NHA; William Graves, NHA; Sherman Lohnes, DPH; Mary McKenna,

EOEA; Janet Cutter, RN, MassHealth; David Becker, NHA; and Michael Baldassarre, NHA. Opposed: None. Abstained: None. Board members not present: None.

The Board adopted the foregoing Order by the following vote: Board members present and voting in favor: Roxanne Webster, RN; Nancy Lordan, NHA; James Divver, NHA; William Graves, NHA; Sherman Lohnes, DPH; Mary McKenna, EOEA; Janet Cutter, RN, MassHealth; David Becker, NHA; and Michael Baldassarre, NHA. Opposed: None. Abstained: None. Board members not present: None.

Board of Registration of Nursing Home Administrators:

By: Nancy Lordan, NHA /JHS
Nancy Lordan, NHA, Chair

Effective Date of Order: 3/28/13

RIGHT OF APPEAL

Respondent is hereby notified of her right to appeal this Final Decision and Order pursuant to M.G.L. c. 30A, §§ 14 and 15, within thirty (30) days of receipt of this Final Decision and Order.

NOTICE TO:

BY FIRST CLASS MAIL AND CERTIFIED MAIL NO. 7012 0470 0001 3611 5837
Anthony J. Cichello, Esq.
Krokidas & Bluestein
600 Atlantic Avenue, 19th Floor
Boston, MA 02114

BY HAND:
Anne McLaughlin, Esq.
Prosecuting Counsel
Division of Health Professions Licensure
Department of Public Health
239 Causeway Street, 4th Floor
Boston, MA 02108

COMMONWEALTH OF MASSACHUSETTS

SUFFOLK COUNTY

BOARD OF REGISTRATION OF
NURSING HOME ADMINISTRATORS

In the Matter of Sister Philip Ann Bowden License No. NH5186 License Expiration June 30, 2013	Docket No. NHA-2010-005

BOARD RULING ON PROSECUTING COUNSEL'S MOTION FOR PARTIAL SUMMARY DECISION

I. Procedural Background

This matter comes before the Board of Registration of Nursing Home Administrators ("Board") on Prosecuting Counsel's Motion for Partial Summary Decision ("Motion"). The Board issued an Order to Show Cause ("Order") on February 7, 2012. Respondent Sister Philip Ann Bowden ("Respondent") filed her Answer to said Order on February 21, 2012. On October 26, 2012, Prosecuting Counsel filed her Motion for Partial Summary Decision ("MPSD").[1]

[1] The Order to Show Cause includes allegations that the facility failed to provide adequate staffing for two units on the night shift and that Respondent failed to comply with the requirements of standards developed and administered by the Board in violation of G.L. c. 112, § 115. Prosecuting Counsel did not move for summary decision relative to these allegations.

Respondent filed her Opposition to Prosecuting Counsel's Motion for Partial Summary Decision ("Opposition") on November 16, 2012. [2]

II. Ruling on Motion

For the reasons set forth below, Prosecuting Counsel's Motion for Partial Summary Decision is ALLOWED in part and DENIED in part. [3]

III. Exhibits

Prosecuting Counsel submitted and/or referenced the following exhibits in support of her MPSD. [4]

1. Order to Show Cause, issued February 7, 2012
2. Respondent's Answer to Order to Show Cause, filed February 21, 2012
3. Respondent's Record of Standing, dated October 26, 2012
4. Board regulations at 245 CMR 2.00
5. Department of Public Health ("DPH") regulations at 105 CMR 150.000
6. Letter: from Bonner, DPH, Division of Health Care Quality, to Respondent, Marian Manor, dated February 26, 2010
7. Survey Report of Department of Health and Human Services Centers for Medicare & Medicaid Services ("CMS")
8. Electronic Code of Federal Regulations: 42 CFR 483.13
9. Affidavit of Paul DiNatale

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[2] Hearings in the instant matter were scheduled for December 5, 2012, January 14, 2013, and January 23, 2012. On October 11, 2012, Prosecuting Counsel filed a Motion to Continue the Pre-Hearing Conference scheduled for November 5, 2012, and the first day of hearing scheduled for December 5, 2012 so as to allow her to file this MPSD. On October 22, 2012, Respondent filed a response opposing a continuance of the proceedings, and on October 23, 2012, Prosecuting Counsel filed a response to Respondent's opposition to her motion. The Board granted Prosecuting Counsel's motion on October 24, 2012.

On October 31, 2012, Respondent filed and the Board granted a motion for an extension of time to file an Opposition to the MPSD. With her Opposition to Prosecuting Counsel's MPSD, Respondent filed her affidavit and a request for hearing on the MPSD. Respondent's request for a hearing on the motion is denied. Respondent submitted a lengthy and clear Opposition which has been carefully reviewed by the Board; Respondent did not indicate in what way a hearing would advance the Board's understanding of the issues involved.

[3] The Board rules on the Motion without entering its Final Decision and Order so as to allow Respondent an opportunity for a hearing on the issue of sanctions.

[4] Exhibits 1 - 15 are referenced in and attached to Prosecuting Counsel's MPSD as Exhibits A - NO.

10. Letter: From Shaw, CMS, to Respondent, dated April 12, 2010
11. Letter from Hughes, CMS, to Anthony J. Chichello, dated April 28, 2010
12. Electronic Code of Federal Regulations: 42 CFR 483 (contents, §483.75 [partial])
13. Electronic Code of Federal Regulations: 42 CFR 488 (contents, §§ 488.300, 488.301, 488.303 [partial])
14. Board regulations at 245 CMR 2.15
15. Ruling on Prosecuting Counsel's Motion for Partial Summary Decision, *In the Matter of Jeffrey N. Heinze*, Docket No. NH 05-006, issued May 21, 2007; Consent Agreements: *Luman* Matter, Docket No, NH 03-017 (executed May 16, 2005); *Coughlin* Matter, Docket No. NH 00-020 (executed 1/29/01); *Grimes* Matter, Docket No. NH 97-042 (executed December 8, 1997)

IV. Findings of Fact

The MPSD alleges certain undisputed facts, supported by the exhibits enumerated above. The Board now finds as undisputed facts established in the record and not subject to genuine dispute the following:

1. On or about February 20, 2009, the Board issued Respondent a license to practice as a Nursing Home Administrator in the Commonwealth of Massachusetts ("Commonwealth"), License No. NH5186. Respondent's license is current and will expire on June 30, 2013, unless renewed. (Exhibits 1, 2, 3)
2. From on or about January 24, 2009, Respondent was employed as Nursing Home Administrator at Marian Manor for the Aged and Infirm ("Marian Manor" or the "facility"), a non-profit, long–term care facility operated by the Carmelite Sisters for the Aged and Infirm in Boston, Massachusetts.
3. Pursuant to G.L. c. 112, §108, and the Board's regulations at 245 CMR 2.02, as Nursing Home Administrator, Respondent was responsible for the general administration of Marian Manor. (Exhibits 1, 2, 4, 13)
4. In accordance with Massachusetts Department of Public Health regulations regarding the licensure of long-term care facilities, nursing home

administrators are responsible for, among other things, a) ensuring that services required by patients or residents are available on a regular basis and provided in an appropriate environment consistent with established policies; and b) directing competent personnel, establishing and maintaining current written personnel policies, and establishing and maintaining personnel practices and procedures that encourage good patient or resident care. 105 CMR 150.002 (C)-(D). (Exhibit 5)

5. Pursuant to federal regulations at 42 CFR 483.13 (c) and (c)(1)(i), nursing homes must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents; more specifically, staff are prohibited from verbally, mentally, sexually, or physically abusing residents. In accordance with 42 CFR 483.13 (c)(2) - (4), a facility must ensure that all alleged violations involving mistreatment, neglect, or abuse are reported immediately to the administrator of the facility and to other officials in accordance with state law; that thorough investigations of such alleged violations occur; and that the results of such investigations are reported to the administrator or her designated representative within five (5) working days of the incident. (Exhibits 7, 8)

6. Pursuant to federal regulations governing the administration of nursing homes, such facilities are required to comply with applicable federal, state, and local laws and regulations and with accepted professional standards and principles that apply to professionals providing services in such facilities. 42 CFR 483.75 (b). Pursuant to Massachusetts Department of Public Health regulations regarding the licensure of long-term care facilities, such facilities are responsible for compliance with all applicable laws and regulations of legally authorized agencies. 105 CMR 150.002 (A)(2) (Exhibits 5, 12)

7. In accordance with the Board's regulations at 245 CMR 2.15 (1) and (4), grounds for discipline against Nursing Home Administrators include: (1) failing to exercise proper regard for the health, safety, and welfare of

patients; and (4) violation of local, state, or federal statutes or regulations related to nursing home administration. (Exhibit 14)

8. On or about February 2, 2010, the Department of Public Health, Division of Health Care Quality ("DHCQ"), completed a complaint survey at Marian Manor prompted by allegations of abuse perpetrated by a Certified Nursing Aide ("CNA"). (Exhibits 1, 2, 6, 7)

9. Following the complaint survey, on or about February 26, 2010, the DHCQ sent a letter and Statement of Deficiencies to Marian Manor, directed to the attention of Respondent as Administrator ("DHCQ letter"). The deficiencies at Marian Manor, constituting resident abuse, the failure to report such abuse to the facility administration, and insufficient staffing, were found to be "isolated deficiencies that constitute actual harm as well as a widespread pattern of deficiencies that constitute potential harm that is not immediate jeopardy ...". The DHCQ determined that Marian Manor was "out of substantial compliance with the federal regulations applicable to long-term care facilities." More specifically, Marian Manor had failed to ensure that staff immediately reported allegations of abuse and a pattern of intimidation perpetrated by a CNA against ten (10) residents between approximately November 2009 and January 2010. [5] (Exhibits 6, 7)

10. The DHCQ made the following recommendations to the U. S. Department of Health and Human Services, Centers for Medicare & Medicaid Services ("CMS"): a) that Marian Manor's participation in the Medicaid and Medicare programs be terminated on August 2, 2010 unless the facility achieved substantial compliance by then; and b) that CMS impose a civil monetary

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[5] Multiple CNA and nursing staff members at Marian Manor witnessed and/or were aware of physically and verbally abusive acts perpetrated by the CNA at issue. Although some CNAs reported certain abusive acts to nurses, the nurses failed to immediately report the abusive conduct to facility managers and the conduct continued for approximately three months until it was finally reported to management and Respondent in late January 2010. (Exhibit 7)

Abusive conduct directed at residents by the CNA at issue included, but was not limited to, rough handling and squeezing of a male resident's genitals to the point where the patient cried out in pain; rough treatment of residents, including pushing residents into the side bars of their beds and into a wall; physical threats; and verbal threats, intimidation, and demeaning remarks. One CNA stated to the surveyor that the cries and screams of a patient abused by the abusive CNA were audible through the patient's closed door to the nurses sitting at the nursing station directly across the hall. (Exhibit 7)

penalty in the amount of $50 - $3,000 per day effective from the date non-compliance was initially established. (Exhibit 6)

11. The DHCQ letter advised Respondent of the right to file a written request for a review of the cited deficiencies through an informal dispute resolution ("IDR") process. A request for IDR was not filed. (Exhibits 6, 9)

12. On March 7, 2010, Marian Manor submitted a Plan of Correction addressing the deficiencies cited in the Statement of Deficiencies, which DHCQ accepted. (Exhibits 1, 2)

13. By letter from CMS dated April 12, 2010 ("CMS letter"), Respondent was advised that the "Substandard Quality of Care" cited by DHCQ as a result of its February 2, 2010 survey would lead to the automatic termination of Marian Manor's provider agreement with the Medicare and Medicaid programs unless substantial compliance was achieved and verified on or before August 2, 2010, and to the denial of payment for new admissions unless substantial compliance was achieved and verified on or before May 2, 2010. The CMS letter also notified Respondent of the imposition of civil money penalties totaling $18,000 ($400 per day for the period of February 2, 2010 – March 18, 2010) (Exhibits 10, 13)

14. The CMS letter advised Respondent of the right to appeal by filing a written request for a hearing before an administrative law judge. Marian Manor did not request a hearing, waiving its appeal rights. The CMS letter also notified Respondent that waiver of the right to a hearing would result in a 35% reduction in the Civil Money Penalty, from $18,000 to $11,700. By letter dated April 28, 2010, Attorney J. Chichello was advised by CMS that the agency had received and processed the waiver of appeal rights filed on behalf of Marian Manor and that the agency had reduced the Civil Money Penalty by 35%. (Exhibits 1, 2, 10, 11)

IV. Rulings of Law

1. Based on Finding of Fact ¶ 1, above, the Board has jurisdiction to hear this case.

2. Based on Findings of Fact ¶¶ 2-14, above, and in accordance with 245 CMR 2.15 (4), Respondent is subject to discipline under 245 CMR 2.15 and G.L. c. 112, § 61 for violations of state and federal laws and regulations related to nursing home administration.

Discussion

Rule 1.01(7)(h) of the Standard Adjudicatory Rules of Practice and Procedure, 801 CMR 1.00 *et seq.*, provides in relevant part that "When a Party is of the opinion that there is no genuine issue of fact relating to ... a claim... and he is entitled to prevail as a matter of law, the Party may move, with or without supporting affidavits, for summary decision on the claim ...".

The standards governing summary decision in an administrative proceeding correspond to those articulated in the cognate rule of civil procedure, M.R.Civ.P. 56. *Catlin v. Board of Registration of Architects*, 414 Mass. 1, 7 (1992). Rule 56 provides that a court shall grant a motion for summary judgment "if the pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to a judgment as a matter of law." M.R.Civ.P. 56(c). *Theran v. Rokoff*, 413 Mass. 590, 591 (1992). A party moving for summary judgment bears the burden of affirmatively demonstrating that there is no genuine issue of fact on every relevant issue raised by the pleadings; all inferences from the underlying facts must be drawn in the light most favorable to the party opposing the motion. *Attorney General v. Bailey*, 386 Mass. 367, 371 (1982); *Mack v. Cape Elizabeth School Board*, 553 F.2d 720,722 (1st Cir. 1977). All doubts as to the existence of a genuine issue of material fact must be resolved against the party moving for summary judgment. *Noble v. Goodyear Tire & Rubber Co.*, 34 Mass. App. Ct. 397,402 (1993).

Prosecuting Counsel asserts that at all times relevant to this proceeding, Respondent was the Nursing Home Administrator at Marian Manor and that in that position, Respondent was responsible for events that led to DHCQ's citation

of the facility for substandard care that failed to comply with state and federal law. More specifically, Prosecuting Counsel maintains that Respondent was responsible for the facility's failure to ensure that a CNA's repeated instances of abuse directed at ten (10) residents over a period of approximately three months were reported immediately to Respondent and to state officials as required by state and federal law and regulations. Prosecuting Counsel contends that such conduct subjects Respondent to discipline pursuant to 245 CMR 2.15 (1) and (4) and G.L. c. 112, § 61, for her failure to exercise proper regard for the health, safety, and welfare of Marian Manor residents and for violations of state and federal statutes and regulations related to nursing home administration. Prosecuting Counsel further maintains that Respondent is subject to discipline for deceit, malpractice, and gross misconduct in the practice of nursing home administration as well as for unprofessional conduct and conduct that undermines public confidence in the integrity of the profession. [6] The Board agrees that Respondent is subject to discipline pursuant to 245 CMR 2.15 (4). However, the Board finds that based on the record before it, summary decision is not warranted on the remaining claims including, but not limited to, the claim that Respondent acted in violation of 245 CMR 2.15 (1) and is subject to discipline for deceit, malpractice, and gross misconduct in the practice of the profession pursuant to G.L. c. 112, § 61.

In accordance with federal and state regulations at 42 CFR 483.1 - 483.75 and at 105 CMR 150.002 (A)(2), Marian Manor, as a nursing home participating in Medicare and Medicaid programs, was required to adhere to certain requirements, including operating and providing services in compliance with all applicable federal, state, and local laws, regulations and codes and in accordance with accepted professional standards and principles.

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[6] In support of her MPSD, Prosecuting Counsel cited the Board's ruling in *In the Matter of Jeffrey N. Heinze*, NH 05-006. The facts in the *Heinze* case are sufficiently distinct from the facts before the Board for the ruling in *Heinze* to serve as a basis for finding that Respondent engaged in deceit, malpractice, and gross misconduct in the practice of the profession under G.L. c. 112, § 61, and failed to exercise proper regard for the health, safety, and welfare of the abused Marian Manor residents under 245 CMR 2.15 (1).

Also pursuant to state regulations at 105 CMR 150.002 (C) and (D), Marian Manor as a facility participating in Medicaid and Medicare programs, was obligated to ensure that services required by residents were available on a regular basis and provided in an appropriate environment consistent with established policies. Additionally, Marian Manor and Respondent were required to direct competent personnel and establish procedures that encouraged good patient or resident care. Federal regulations at 42 CFR 483.13(c) specifically required that all alleged violations of mistreatment, neglect, or abuse be reported immediately to the Nursing Home Administrator and to other officials in accordance with state law.

It is undisputed that on February 2, 2010, DHCQ conducted a complaint survey at Marian Manor and determined that alleged mistreatment and abuse of residents had occurred and was not reported to Respondent as required by law and regulation. DHCQ found deficiencies that were isolated deficiencies constituting actual harm as well as a widespread pattern of deficiencies that constituted potential harm that was not immediate jeopardy. Pursuant to 42 CFR 488.301, the deficiencies constituted substandard quality of care. Hence, DHQC determined that the facility was not in substantial compliance with federal and state laws and regulations. [7]

The Board's regulation at 245 CMR 2.15 (1) provides that grounds for disciplinary action include the failure of a Nursing Home Administrator to exercise proper regard for the health, safety, and welfare of facility residents. The Board's regulation at 245 CMR 2.15 (4) provides that violations of local, state, or federal statutes or regulations related to nursing home administration constitute grounds for discipline against a licensed Nursing Home Administrator. In the instant case, the resident abuse and failure to immediately report such abuse underlying the violations of law were egregious and antithetical a nursing home's federally mandated duty to provide care in a manner that maintains the "highest

[7] A facility such as Marian Manor would have been deemed to have been in "substantial compliance" if deficiencies identified at the facility posed no greater risk to residents' health and safety than the potential for causing harm. A lack of substantial compliance was deemed "noncompliance". 42 CFR 488.301

practicable" level of residents' physical, mental, and psychosocial well-being (42 CFR 483.75). For a period of approximately three (3) months several CNAs and nurses at Marian Manor witnessed and heard complaints about a CNA's physical abuse, physical and verbal threats, and intimidation of ten (10) Marian Manor residents. During this entire period of time, not a single staff member reported the abusive conduct to Respondent, who was by law responsible for the general administration of Marian Manor. As a result, the CNA was free to continue her pattern of abusive behavior against an extremely vulnerable population.[8] Such circumstances, involving an utter breakdown in critical and legally mandated communication, are alarming to the Board and subject Respondent, as Nursing Home Administrator of Marian Manor, to discipline pursuant to 245 CMR 2.15 (4). Moreover, Respondent's violation of the Board's regulations constitutes grounds for discipline under G.L. c. 112, § 61, for any offense against the laws of the Commonwealth relating to the practice of the profession.

In her Opposition to the MPSD, Respondent states that the "...only non-frivolous argument raised by Prosecuting Counsel is a claim that because the Facility was found to have survey deficiencies, Sister Philip should be deemed responsible for violations of ...statutes and regulations related to nursing home administration and, therefore subject to discipline by the Board." Nevertheless, Respondent contends that it is misguided to suggest that the mere fact of a facility's violation of law, no matter how trivial, constitutes grounds for discipline. Were this the case, Respondent argues, the overwhelming majority of Nursing Home Administrators would be, as a matter of law, subject to discipline without regard to the severity of the violations and the specifics of the licensee's conduct. Respondent's position fails to take into account the Board's discretion in issuing Orders to Show Cause and determining an appropriate disciplinary sanction should any sanctions be warranted. Respondent is entitled to a hearing on sanctions at which she may address the issue of the propriety of discipline and

[8] The abused residents had mental acuity deficits that ranged from short and long term memory failure to severe cognitive impairment. (Exhibit 7)

the issue of an appropriate sanction should the Board deem discipline to be warranted.

In her Opposition, Respondent argued that for a variety of reasons summary decision should be denied on the remaining allegations that are the subject of Prosecuting Counsel's MPSD. While the Board does not find all of Respondent's arguments meritorious, the Board agrees with Respondent that the evidence before it on this MPSD does not warrant findings that based on undisputed material facts, Respondent engaged in gross misconduct, deceit, and malpractice in the practice the profession. In this matter, proof of such allegations requires an evidentiary hearing with the presentation of sufficient and more detailed evidence regarding Respondent's conduct, and in all probability, expert testimony as to standards of professional practice as a Nursing Home Administrator.[9]

Based on the foregoing, Prosecuting Counsel's Motion for Partial Summary Decision is ALLOWED in part and DENIED in part.

Respondent is hereby notified that she has the right to a hearing on the issue of sanctions. Respondent will waive this right if she fails to complete and return the enclosed form to the Administrative Hearings Counsel within ten (10) days of the issuance of this Ruling. Respondent's failure to request a hearing on sanctions by returning the enclosed form in a timely manner will result in the Board deciding on sanctions without Respondent's input. If Respondent fails to request a sanctions hearing within ten (10) days, the Board may revoke, suspend or take other disciplinary action against Respondent's license to practice as a Nursing Home Administrator in the Commonwealth of Massachusetts.

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[9] In support of her MPSD, Prosecuting Counsel cited the Board's ruling in *In the Matter of Jeffrey N. Heinze*, NH 05-006. The facts in the *Heinze* case are sufficiently distinct from the facts before the Board for the ruling in *Heinze* to serve as a basis for finding that Respondent engaged in deceit, malpractice, and gross misconduct in the practice of the profession and failed to exercise proper regard for the health, safety, and welfare of the abused Marian Manor residents.

The Board voted to adopt the within Ruling on Prosecuting Counsel's Motion for Partial Summary Decision at its meeting on December 20, 2012, by the following vote: In favor: Nancy Lordan, NHA; William Graves, NHA; Roxanne Webster, RN; Janet Cutter, RN; Mary McKenna, EOEA; David Becker, NHA; James Divver, NHA; and Michael Baldassarre, NHA. Opposed: None. Abstained: None. Absent: Sherman Lohnes, DPH.

Based on its adoption of the within Ruling on Prosecuting Counsel's Motion for Partial Summary Decision, at its meeting on December 20, 2012, the Board voted to dismiss Paragraphs 3, 5(b), 8, 10, 11 (dismissal of the words, "for deceit, malpractice, and gross misconduct in the practice of the profession or") , and 12 of the Order to Show Cause dated February 7, 2012, by the following vote: In favor: Nancy Lordan, NHA; William Graves, NHA; Roxanne Webster, RN; Janet Cutter, RN, MassHealth; Mary McKenna, EOEA; David Becker, NHA; James Divver, NHA; and Michael Baldassarre, NHA. Opposed: None. Abstained: None. Absent: Sherman Lohnes, DPH.

Board of Registration of Nursing Home Administrators

BY: _____

Sally Graham, Executive Director

DATE: December 21, 2012

NOTICE TO:

Anthony J. Cichello, Esq. (By First Class and Certified Mail 7012 0470 0001 3611 9088)
Anne McLaughlin, Esq. (By Hand)

Anthony J. Cichello, Esq.
Krokidas & Bluestein LLP
600 Atlantic Avenue, 19th Floor
Boston, MA 02210

Anne McLaughlin, Esq.
Office of Prosecutions
Department of Public Health
Division of Health Professions Licensure
239 Causeway Street, Suite 400
Boston, MA 02114

SUMMARY DECISION HAS BEEN GRANTED IN THIS CASE

TO REQUEST A HEARING ON SANCTIONS YOU MUST RETURN THIS COMPLETED FORM TO THE BOARD WITHIN TEN (10) DAYS

Vivian Bendix, Esq.
Administrative Hearings Counsel
Division of Health Professions Licensure
Office of General Counsel, Department of Public Health
239 Causeway Street, Suite 500
Boston, MA 02114

Re: In the Matter of Sister Philip Ann Bowden
Docket No. NHA-2010-005

To the Board of Registration of Nursing Home Administrators

(1) Please schedule a hearing on sanctions before the Board.

(2) Here is my telephone number and address to which all mail should be sent:

Name: _____

Address: _____

_____

Telephone: _____

Signed: _____

Dated: _____

Mail this form to the Administrative Hearings Counsel at the above address.