Department of Health and Human Services
DEPARTMENTAL APPEALS BOARD
Appellate Division

Yakima Valley School
Docket No. A-11-85
Decision No. 2422
November 22, 2011

FINAL DECISION ON REVIEW OF ADMINISTRATIVE LAW JUDGE DECISION

Yakima Valley School (YVS) appeals the April 8, 2011 decision of Administrative Law Judge (ALJ) Richard J. Smith. *Yakima Valley School*, DAB CR2350 (2011) (ALJ Decision). The ALJ upheld the determination by the Centers for Medicare & Medicaid Services (CMS) that YVS failed to comply substantially with requirements at 42 C.F.R. §§ 483.13(c)(3) and 483.25(h) based on a survey completed July 16, 2009. The ALJ also sustained CMS's determination that YVS's noncompliance posed immediate jeopardy to residents and constituted substandard quality of care. Consequently, the ALJ upheld the suspension of YVS's nurse aide training and competency evaluation program (NATCEP) for a two-year period beginning July 16, 2009.

On appeal to the Board, YVS contests the determination that conditions at the facility posed immediate jeopardy to residents and constituted substandard quality of care. YVS does not challenge the underlying deficiencies identified in the survey, nor does it dispute that it failed to comply with the requirements at sections 483.13(c)(3) and 483.25(h).

For the reasons discussed below, we affirm the ALJ Decision. We first explain why we reject CMS's argument that the appeal is now moot. We then discuss the standard for reviewing a CMS immediate jeopardy determination, under which YVS had the burden to prove that CMS clearly erred in determining that YVS's failure to comply with the participation requirements caused or was likely to cause serious injury or harm to residents. Discussing the evidence and testimony, we explain that YVS did not meet that burden. Finally, we sustain the ALJ's conclusion that YVS's noncompliance constituted substandard quality of care requiring suspension of its NATCEP under the applicable regulations and statutes.

Applicable legal authority

The Social Security Act (Act) and federal regulations provide for state agencies to conduct surveys of long-term care facilities that participate in Medicare or Medicaid to evaluate their compliance with the participation requirements of the programs. Act

§§ 1819, 1919; 42 C.F.R. Parts 483, 488, and 498.[1] A facility's failure to meet one or more participation requirements constitutes a "deficiency." 42 C.F.R. § 488.301. "Substantial compliance" means a level of compliance such that "any identified deficiencies pose no greater risk to resident health or safety than the potential for causing minimal harm." *Id*. "Noncompliance" is defined as "any deficiency that causes a facility to not be in substantial compliance." *Id.*

The seriousness of a facility's noncompliance is a function of its "severity" (whether the noncompliance has created a "potential" for "more than minimal" harm, resulted in "actual harm," or placed residents in "immediate jeopardy") and "scope" (whether the noncompliance is "isolated," constitutes a "pattern," or is "widespread"). 42 C.F.R. §§ 488.301, 488.404(b). The most severe noncompliance is that which puts one or more residents in "immediate jeopardy." *Id.*; State Operations Manual (SOM), CMS Pub. 100-07, Appendix Q -- *Guidelines for Determining Immediate Jeopardy*.[2] Immediate jeopardy is defined as a situation in which the noncompliance "has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident." 42 C.F.R. § 488.301.

"Substandard quality of care" means that a facility has one or more deficiencies related to the requirements at 42 C.F.R. §§ 483.13, 483.15, or 483.25 that constitute either: immediate jeopardy to resident health or safety; a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm. 42 C.F.R. § 488.301.

The participation requirements involved here are found at 42 C.F.R. §§ 483.13(c) and 483.25(h). Section 483.13(c) provides that a facility must "develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents. . . ." Section 483.13(c)(3) requires the facility to "have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress." Section 488.301 defines "abuse" as "the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish." "Neglect" is defined as "failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness." *Id.* The Board has sustained findings of noncompliance under section 483.13(c) where a facility "neglected to protect its residents from abuse by other residents." *Martha & Mary Lutheran Services*, DAB No. 2147, at 12 (2008).

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[1] The current version of the Social Security Act can be found at http://www.socialsecurity.gov/OP_Home/ssact/ssact.htm.

[2] The SOM is available at http://www.cms.gov/manuals/Downloads/som107ap_q_immedjeopardy.pdf.

Section 483.25(h)(2) requires a facility to ensure that each "resident receives adequate supervision . . . to prevent accidents." The Board has held that section 483.25(h)(2) places an affirmative duty on facility staff "to intervene and supervise . . . behaviorally impaired residents in a manner calculated to prevent them from causing harm to themselves and each other." *Vandalia Park*, DAB No. 1940, at 18 (2004), *aff'd, Vandalia Park v. Leavitt*, No. 04-4283 (6th Cir. Dec. 8, 2005); *Woodstock Care Center,* DAB No. 1726 (2000), *aff'd, Woodstock Care Ctr. v. Thompson*, 363 F.3d 583 (6th Cir. 2003).

Case background[3]

YVS is a nursing facility for individuals with developmental disabilities that is owned and operated by the State of Washington and participates in Medicaid. The Washington Department of Social and Health Services (State agency) conducted an unannounced abbreviated, partial extended, and complaint investigation survey of YVS that ended on July 16, 2009.[4] The survey findings related to multiple incidents of physical aggression by a resident identified as Resident 1 (R1) against six other YVS residents in the same living unit. R1 was a physically-fit, 180-pound, 18-year-old male, "with a history of difficulty maintaining social boundaries and impaired executive and social judgment." ALJ Decision at 9. R1 was "very fast-moving, impulsive, fully mobile, and agile," and his "behaviors include coarse and scatological language and behavior, propositioning nurses for sex acts, attempting to expose himself, being physically aggressive, and verbally offensive." *Id.* R1's diagnoses included "mild mental retardation, autism, post-traumatic stress syndrome, obsessive-compulsive disorder, and behavioral disorders." *Id.*

At the time of the survey, YVS used a Level of Supervision (LOS) scale to rank its residents according to the intensity of staff supervision that each resident required. Jt. Stipulation ¶ 16. The scale ranged from a level of one, the lowest supervision level, to a level of five, requiring the highest degree of supervision. *Id.* ¶ 17. For residents on LOS 4, YVS personnel "were to position supervision in a manner to prevent danger or harm to self and others," and one-to-one staffing was required, "allowing as much social space as possible or per care plan." *Id.* ¶ 21. For residents on LOS 5, YVS personnel "were to maintain two-to-one staffing within arms['] length of the resident." *Id.* ¶ 22.

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[3] This discussion is presented for the convenience of the reader and draws on the parties' "List of Joint Factual Stipulations" and other undisputed facts. Nothing in this section is intended to revise or replace any of the ALJ's factual findings.

[4] YVS and the Washington Department of Social and Health Services, Aging and Disability Services Administration, Residential Care Services (the State survey agency) are administered by separate divisions of Washington's Department of Social and Health Services.

YVS used a form titled, "YVS Resident Occurrence/Incident Investigation Report" to document incidents and investigations of resident violence. *Id.* ¶ 28; CMS Ex. 10. YVS reports documented the following incidents:

- A February 14, 2009 report states that R1 struck R2 in the stomach and struck R6 on the upper leg. The report states that there were no signs or symptoms of pain and no injuries to either resident-victim, as well as no adverse side effects. Jt. Stipulation ¶ 29; CMS Ex. 10, at 1-4.

- A March 1, 2009 report states that R1 kicked R6 on the arm. The report states "No injury to [the resident kicked]." Jt. Stipulation ¶ 30; CMS Ex. 10, at 5.

- A March 8, 2009 report states that R1 hit R8 on the head. The report states that no injuries or psychological distress were identified after this incident. Jt. Stipulation ¶ 31; CMS Ex. 10, at 8-9.

- An April 14, 2009 report states that R1 tried to bite R5 on the back of the neck, kicked R5 on the lower back, and kicked R9 on the chest. No injuries or psychological distress were identified following this incident. Jt. Stipulation ¶ 32; CMS Ex. 10, at 13-14, 20-21.

- A June 13, 2009 report states that R1 kicked R6 on the thigh. No injuries or psychological distress were identified following this incident. Jt. Stipulation ¶ 33; CMS Ex. 10, at 22-23.

- A June 14, 2009 report states that R1 hit R7 on the shoulder. No injuries were identified following the incident, "but the victim stated that the incident made him angry and afraid." Jt. Stipulation ¶ 34; CMS Ex. 10, at 25-26; CMS Ex. 14, at 58. Four days later, the social worker "documented that there [were] no noted residual signs or symptoms of harm or distress." Jt. Stipulation ¶ 34.

- A June 16, 2009 report stated that when R1 was passing another resident in the hallway he slid his hand down the front of the other resident's sweat pants. The report indicates that staff immediately intervened and that it was not known if R1 touched the other resident's "private area." Jt. Stipulation ¶ 35; CMS Ex. 10, at 28-31.

Based on the incident reports, additional records and interviews, the July 16, 2009 State agency survey concluded that YVS was not in substantial compliance with sections 483.13 and 483.25. CMS Exs. 1-2. The State agency found that YVS "failed to thoroughly investigate and protect residents from further abuse while the investigations

[of the cited incidents] were in progress." CMS Ex. 1, at 3. According to the survey statement of deficiencies, "the investigations did not evaluate whether the current interventions [for R1] were consistently being followed, the effectiveness of the interventions, or whether additional interventions were needed." *Id.* at 3-4. In addition, "there were no additional protective strategies put in place to protect the vulnerable residents during the course of the investigations . . . ; consequently, residents were subjected to repeated abusive behavior." *Id.* at 4. The State agency also determined that YVS "failed to provide sufficient supervision to prevent [six] residents from being physically attacked by R1." *Id.* at 5. The State agency determined that the deficiencies posed immediate jeopardy and constituted substandard quality of care. CMS Ex. 2.

By letter dated July 23, 2009, CMS notified YVS that CMS concurred in the State agency findings and determinations. CMS Ex. 3. CMS also notified YVS that it had determined that the immediate jeopardy was abated on July 16, 2009. As a result of CMS's determination, YVS lost its authority to operate its NATCEP for a two-year period, beginning July 16, 2009.

YVS timely requested an ALJ hearing to contest CMS's determination that the cited deficiencies posed immediate jeopardy and substandard quality of care.

The ALJ Decision

The ALJ conducted an in-person hearing in Seattle, Washington, on August 9 and 10, 2010. Based on the evidence and testimony, the ALJ determined that YVS failed to comply substantially with 42 C.F.R. §§ 483.13(c)(3) and 483.25(h). The ALJ concluded that YVS "failed to thoroughly determine the facts surrounding" the incidents wherein R1 hit, kicked or inappropriately touched other residents. ALJ Decision at 13. "This failure," the ALJ concluded, "was particularly egregious given the increasing frequency of R-1's attacks on other residents," and "led to a subsequent failure to determine whether one-on-one supervision was being implemented properly and . . . was adequate." *Id.* In addition, the ALJ concluded, YVS failed to determine what other interventions were required and "failed to prevent further potential abuse of R-1's victims while the investigations were in progress." *Id.* The ALJ found that YVS breached its duty of care under section 483.25(h) because it did not take action to prevent foreseeable, aggressive and abusive conduct by R1 against other residents who were mentally and/or physically vulnerable. *Id.* at 14.

The ALJ also sustained CMS's determination that the deficiencies posed immediate jeopardy. YVS had the burden to prove that CMS's finding of immediate jeopardy was clearly erroneous, the ALJ stated, but failed to meet that burden. The ALJ concluded that R1's "attacks . . . were serious and risky" and that the victims of R1's behaviors were

"vulnerable by reason of mental or physical disabilities, or both." *Id.* at 15. Moreover, the ALJ stated, it was "nothing other than extremely fortuitous [] that R1's physical assaults on vulnerable residents had not yet caused any of them actual physical harm." *Id.* at 16. "The pattern of R-1's behavior," the ALJ concluded, "was dangerous, unconsented-to by [his] victims, frightening to [his] victims, and intolerable by any reasonable standards in the setting of a skilled nursing home specifically dedicated to caring for residents with severe mental and physical impairments." *Id.*

Finally, the ALJ determined that under the regulations and statute, YVS's noncompliance was a form of substandard quality of care and, thus, required the suspension of YVS's NATCEP for two years.

Standard of Review

Our standard of review on a disputed conclusion of law is whether the ALJ decision is erroneous. *Guidelines - Appellate Review of Decisions of Administrative Law Judges Affecting a Provider's Participation in the Medicare and Medicaid Programs (Guidelines)*, http://www.hhs.gov/dab/divisions/appellate/guidelines/index.html. Our standard of review on a disputed finding of fact is whether the ALJ decision is supported by substantial evidence on the record as a whole. *Id.*

Discussion

1. We reject CMS's request to deny review.

CMS argues that the Board should deny Yakima's request for review as moot because Yakima "no longer has a claim in this case." CMS Br. at 23. CMS also asserts that the "remedies drive the administrative process." *Id.* at 21. For both assertions, CMS relies on the fact that the 2-year bar to Yakima's operation of its NATCEP program, which CMS describes as "the only remedy that was actually imposed," was completed before Yakima's reply brief was filed. CMS's argument conflates the concepts of appeal rights and mootness, whereas the concepts are distinct.

The bulk of CMS's argument relies on Board cases involving situations in which CMS found a facility noncompliant but either did not impose or rescinded any previously imposed remedies. *Id.* at 21-23. Those cases do not apply here for several reasons. The cited cases all involve initial determinations under section 498.3(b)(13), which applies only to noncompliance findings which "result in the imposition" of a specified remedy. The Board determined that where no remedy is imposed or any remedies imposed have been rescinded no initial determination exists. *See Columbus Park Nursing Home*, DAB No. 2316 (2010) ("Applying the plain language of the regulations, the Board has long

held that a SNF or NF has no right to an ALJ hearing to contest survey deficiency findings where CMS has not imposed any of the remedies specified at section 488.406 based on those findings, or where CMS imposed, but subsequently rescinded, any such remedies." – citations omitted). Yakima's appeal arises under sections 498.3(b)(14)(ii) and (16), which make a substandard quality of care finding resulting in the loss of NATCEP an "initial determination" subject to appeal. Loss of NATCEP is not a remedy that CMS decides to impose or rescind but, rather, a consequence that follows by action of law when a facility with or seeking approval for a NATCEP program is found to have provided substandard quality of care. Act §§ 1819(f)(2)(B)(iii)(I), 1919(f)(2)(B)(iii)(I); 42 C.F.R. §§ 483.151(b)(2), 483.151(e); 488.301; 488.310.

Mootness doctrine, where properly applied, ends an appeal, but it does so based on the tribunal's conclusion that there is no longer an injury capable of being redressed by a favorable decision, not based on the absence of a right to appeal. In Federal courts, Article III mootness arises from the "case and controversy" requirement of Article III of the U.S. Constitution. As such, the doctrine is not directly applicable to administrative proceedings as a bar to adjudicating the merits of a case. *Climax Molybdenum Co. v. Secretary of Labor, Mine Safety, and Health Administration,* 703 F.2d 447, at 451 (10th Cir. 1983); *see also Ohio Dept. of Job and Family Services,* DAB No. 2023, at 12 (2006) (rejecting mootness argument while noting that "ACF acknowledges that Article III law on case and controversy is not directly applicable but . . . that considerations of judicial economy should still militate against permitting an appeal where no effective relief is possible."). Nevertheless, an administrative adjudicatory body may, in appropriate circumstances, dismiss as moot a case that can no longer be meaningfully adjudicated. CMS, however, offers no explanation of why the mere expiration of the NATCEP bar, by its own terms, should preclude our reaching the merits of this case based on mootness concepts. *Id.* at 20-21. CMS does not identify any Board case in which an appeal has been found moot on this basis.

Moreover, while courts have generally concluded that no case or controversy exists where no live dispute persists between the parties, there are well-recognized exceptions, such as the persistence of a collateral consequence that a favorable court decision could redress. Yakima puts this exception in issue here by asserting that the loss of its NATCEP program and the substandard quality of care finding that triggered that loss (and continues to exist) "have a continuing impact on [Yakima]." Reply Br. at 12. CMS does not dispute this assertion or address the issue it raises. Thus, while we do not hold that a challenge to a substandard quality of care finding can never become moot, CMS has fallen far short of persuading us to find this challenge moot based solely on the fact that the period of loss of NATCEP approval concluded before our decision issued.

2. YVS failed to prove that CMS's immediate jeopardy determination was clearly erroneous. [5]

The standard of review of a CMS immediate jeopardy determination

Immediate jeopardy, as noted above, is defined by regulation as a situation wherein a facility's noncompliance "has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident." 42 C.F.R. § 488.301. As the ALJ stated and YVS acknowledges, once CMS establishes a prima facie case of noncompliance with Medicare and Medicaid participation requirements, the "burden rests on [the] Petitioner to prove that CMS's determination of immediate jeopardy is clearly erroneous." ALJ Decision at 15; YVS Br. at 19-20. The "clearly erroneous" standard, the Board has explained, is highly deferential and places a heavy burden on the facility to upset CMS's finding regarding the level of noncompliance. *See, e.g., Claiborne-Hughes Health Center,* DAB No. 2179, at 20, (2008), *aff'd, Claiborne-Hughes Health Center v. Sebelius*, 609 F.3d 839 (6th Cir. 2010), *quoting Liberty Commons Nursing & Rehab Center*, DAB No. 2031 at 18 (2006), *aff'd, Liberty Commons Nursing & Rehab Ctr.--Johnston v. Leavitt*, 241 F. App'x 76 (4th Cir. 2007). When CMS issued the nursing facility survey, certification and enforcement regulations, it acknowledged that "distinctions between different levels of noncompliance … do not represent mathematical judgments for which there are clear or objectively measured boundaries." 59 Fed. Reg. 56,116, 56,179 (1994). "This inherent imprecision is precisely why CMS's immediate jeopardy determination, a matter of professional judgment and expertise, is entitled to deference." *Daughters of Miriam Center,* DAB No. 2067, at 15 (2007).[6]

The regulations do not explain the meaning of the terms "likely" or "serious" in the definition of "immediate jeopardy." The Board has held, however, that under the clearly erroneous standard, the harm or threatened harm caused by the noncompliance is presumed to be serious, and the facility "has the burden to rebut the presumption with evidence and argument showing that the harm or threatened harm did not meet any reasonable definition of 'serious.'" DAB No. 2067, at 9. The term "likely," the Board has stated, is synonymous with "probable" and "reasonably to be expected," and suggests that the degree of probability that an event may occur is greater than "possible" or

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[5] While YVS does not contest the determination that it failed to comply with sections 483.13(c)(3) and 483.25(h), YVS does assert that several subsidiary findings and conclusions in the ALJ's discussion of the facility's failure to comply with those regulations are not supported by substantial evidence or constitute errors of law. P. Br. at 3-5, 11-18. Because YVS makes these arguments in the context of appealing only the immediate jeopardy determination, we address the contentions in our analysis of the immediate jeopardy issue.

[6] The clearly erroneous scope of review applies by force of regulation, as well as Board precedent, to CMS determinations of the level of noncompliance in CMP cases. 42 C.F.R. § 498.60(c)(2).

"potential." *Id*. at 10 (dictionary citations omitted). The Board has further recognized that serious harm or injury can be psychological as well as physical in nature, and that serious psychological harm can result from one resident's unrestrained acts of intimidation or sexually aggressive behavior towards another resident. *See, e.g., Somerset Nursing and Rehabilitation Facility,* DAB No. 2353 (2010); *see also* SOM, Appendix Q (stating that "psychological harm [is] as serious as physical harm.").[7]

YVS's arguments

Before the Board, YVS argues that "the testimony admitted at the hearing was absolutely clear" that no actual injury or harm to residents resulted from its noncompliance. YVS Br. at 8-9. Consequently, YVS maintains, "the focus narrows to whether YVS's noncompliance was *likely* to cause *serious* injury, harm, impairment, or death to other YVS residents." *Id.* at 9 (emphasis in original). YVS argues that the evidence and testimony of R1's history of aggressive behaviors and staff's "intimate knowledge" of R1 and the other residents on his living unit show that CMS's immediate jeopardy determination was "clearly erroneous based on any reasonable definition of the terms 'likely' and 'serious.'" *Id.* at 27-28. According to YVS, R1's care plans, medical evaluations, records of professional clinical services provided, and the testimony of YVS witnesses conclusively demonstrate that R1 "had no history of injuring other residents at YVS and that he was being provided intensive services and supervision to prevent such harm from occurring." *Id.* at 5.

R1 had 20 short-term stays at the facility between July 2005 and October 2007, YVS states, and his "aggressive behavior toward peers" was always "of such low magnitude that his actions never resulted in any need for medical treatment . . . ." *Id.* at 2, 6, 10, 22. In "eight of the nine incidents" identified in the survey," YVS argues, "R1 hit or kicked the other resident just once," using an "open-handed slap with little force, never with a closed fist and never with significant force." *Id.* at 7. While R1 "was certainly capable of causing serious injury if he used his strength and determination to do so," YVS further argues, "he purposely avoid[ed] such outcomes," had "no motivation or intent to injure other residents," and only sought attention "to get what he want[ed]." *Id.* at 22-23. Moreover, YVS contends, the hearing testimony established that YVS staff knew the other residents on R1's living unit "extremely well" and knew they were not susceptible to physical or psychological injury from R1's behavior. *Id.* at 23-24. In light of R1's

[7] In addition, the SOM lists "situations that most likely create jeopardy to an individual's psychological and/or physical health and safety" and "trigger" scrutiny to determine whether residents were or are in immediate jeopardy. SOM, Appendix Q. The situations listed include, among other things, "inadequate supervision to prevent physical altercations," "lack of intervention to prevent individuals from creating an environment of fear," "sexual harassment," and serious physical injuries "such as head trauma or fractures." *Id.*

history, staff experience, and the facility's familiarity and understanding of its residents, YVS argues, there was no likelihood that R1 would cause serious harm to other residents.

Analysis

On review of the record, we concur in the ALJ's determination that the evidence and testimony produced by YVS does not prove that CMS's immediate jeopardy determination was clearly erroneous. Indeed, the weight of the evidence clearly supports the ALJ determination under any standard. YVS's own records document its understanding that R1, a 180-pound, agile and impulsive 18-year-old, had a history of aggressive behaviors and was capable of inflicting significant physical and psychological harm on others. For example, YVS's February 27, 2009 "Positive Behavior Support Plan" for R1 begins, "[R1] has always used his muscles more than his words to get what he wants." YVS Ex. 37, at 1. The "Challenging behaviors" listed in the document include "Inappropriate sexual touching, typically of female caregivers," "Striking or choking others or an SSD teacher," "Destroying furnishings and furniture," "Episodic physical agitation and unpredictable . . . anger episodes requiring two-man standing or seated restraint, and mat use at times," and "Demanding negative-attention-seeking: running indoors, pinching, grabbing, yelling, licking staff member's face . . . ." *Id.* at 2. The support plan further states that R1 "needs supervision" not only to protect him from others, but also "to protect others from his actions." *Id.* at 1. It states that in case of a "Physical assault on person with body (hands, feet, head) or with an object," staff should "Secure other clients or distract," and, "if needed, prepare to use blue matt [sic]. Use two-man escort." *Id.* at 8.

An April 17, 2009 Status Summary for Guardianship Review further states that R1's behaviors included "violence, self exposure, or other actions which appear to have the goal of creating emotional shock." YVS Ex. 8, at 1. Moreover, the facility documented, R1's "severe executive (self-regulatory and cognitive-social) deficits [were] the most striking feature of his 2008-2009 clinical presentation," and he was "unable to predict the effects of his impulsive social behavior . . . ." *Id.* at 2. Similarly, YVS's April 14 and April 21, 2009 care plans for R1 noted his "history of physical assault" and "verbal confrontation and hostility towards other resident." CMS Ex. 10, at 15-18; YVS Ex. 12, at 1-2. "If [R1] seems agitated," the care plans directed, "keep him away from other residents as much as possible," and if "assaultive or self injurious behavior poses a threat to the safety of self or others, report immediately." *Id.* The care plans listed R1's aggressive actions to include: "hits, kicks, pulls hair, foul language and bites." *Id.* "Be aware that . . . he may 'hit and run,'" the care plans provided, and "[a]nticipate that he could dash quickly away and strike another resident or staff." *Id.* The plans also stated, "Discuss with other staff member in advance that he may move suddenly when redirected [and] Establish a signal to alert staff of high risk action." *Id.* Moreover, the plans

warned, "When redirecting R1 back to his room due to SIB/behavior toward other residents or staff – make sure that the path is clear and no other residents are within the line of potential harm." CMS Ex. 10, at 17.

Consistent with the facility's records, YVS's Director of Nursing (DON) testified, "You couldn't predict when he was going to run down the hall, and you couldn't predict when he was going to be upset and which way he was going to go, if he was going to . . . divert himself away from staff . . . they were not able to prevent him from running and kicking" other residents. YVS Ex. 41, at 102-103. YVS Attendant Counselor Jacob Welch testified that R1's aggressive behavior was "unpredictable" and occurred on the "spur of the moment." Tr. at 207. According to Mr. Welch, R1 "could jump up and just go running . . . to the back . . . [or] expose himself." *Id.* R1 "doesn't give any signs that he's agitated," Mr. Welch stated, and hits other residents "out of convenience. . . . As long as they were in the way." *Id.* at 207-08. YVS's clinical psychologist, Dr. Earl Wilson, testified that it was a "fair statement" that "despite the effort of staff to intervene and prevent, there still [were] instances where R1 has hit and kicked another resident." *Id*. at 359. While YVS "never had an ambulance to the school based on anything that [R1] did," Dr. Wilson testified, R1's assaults against staff had caused bruising, irritation and stress. *Id.* at 309-310. Dr. Wilson also acknowledged that R1 "had the capability to increase his aggression depending on [the] circumstances." *Id.* at 335.

Thus, YVS's own records and witnesses' testimony provide ample support to conclude that YVS administrators and staff knew R1 to have "a propensity for violent physical assault," as the ALJ concluded. ALJ Decision at 12. Moreover, the language used in the facility documentation evidences that R1's aggressive outbursts, which included striking, choking, kicking and biting others, created a "threat to the safety" of others and a "high risk" of physical harm that reasonably could be considered serious based on the plain meaning of the word. *See, e.g., Merriam-Webster Online Dictionary,* at http://www.merriam-webster.com/dictionary/serious (defining "serious" as "having important or dangerous possible consequences <a serious injury>"); *Encarta World English Dictionary,* at http://www.bing.com/dictionary/search?q=define+serious (defining "serious" as "very bad or great," "dangerous, harmful," or "important or grave enough to require thought and attention"). The descriptions in YVS's records also indicate that many of R1's behaviors, such as inappropriate sexual touching, using "foul language," and exposing himself with the intent to "creat[e] emotional shock," posed what reasonably could be considered serious psychological harm to others. YVS Exs. 12, 37; CMS Ex. 13, at 43. Furthermore, the facility records make clear that the professionals who assessed and developed R1's care plans determined that monitoring R1 required vigilance, communication and coordination by YVS personnel to ensure the safety not only of staff, but of other facility residents.

YVS's ongoing failure to monitor R1 adequately and to protect other residents from him, and the consequent likelihood that serious physical injury or harm to residents would ensue, is evidenced in the reports that documented the nine assaults[8] by R1 against six other YVS residents between February and June 2009. According to the reports, in eight instances staff did not prevent R1 from slapping, hitting or kicking other residents in vulnerable areas of the body, including the stomach, head and chest, or from attempting to bite a resident on the back of the neck. CMS Ex. 10. The February 14, 2009 report describes the incident that day as "related to increasing aggressive behavior/assaults" by R1. *Id.* at 1. The report on the March 8, 2009 incident describes R1's behavior as a "violent outburst" wherein R1 "hit R8 (another resident) on the head," "grabbed [an employee's] arm and bit it [and] then bit both of his own forearms." CMS Ex. 10, at 8. Moreover, the reports show that R1 twice struck two different residents during the same outburst even though his care plan directed that he be escorted to ensure that "no other residents are within the line of potential harm," and YVS's policy was to ensure that personnel were in position to prevent R1 from inflicting harm on others. *Id.* at 1, 13, 17; Tr. at 166.

As the surveyor testified, "despite the fact that [R1] had been assigned a one-on-one [attendant counselor] and lived in a cottage with enhanced staffing, [YVS] failed in [its] duty to analyze and determine whether the Care Plan was being followed and to revise it appropriately to be able to protect the other residents from abuse." Tr. at 67. Furthermore, the surveyor testified, "The residents have a right to be free from abuse and this continual repeated number of incidents did not show that that was being maintained." *Id.* The ALJ aptly concluded that "the fact that there were three incidents in four days from June 13 to June 16, 2009," notwithstanding YVS's own policy to "[e]nsure the development of appropriate plans of correction to prevent the recurrence" of such incidents, demonstrated that YVS's repeated failure to protect residents from R1's assaults pending its investigations was particularly egregious. ALJ Decision at 12; CMS Ex. 11, at 17. In light of the number and frequency of R1's assaults against other residents between February and June 2009, and YVS's admitted failure to thoroughly investigate the incidents, failure to protect other residents from R1 pending the

[8] YVS argues that the ALJ and CMS incorrectly "refer to the incidents of aggression by [R1] as constituting 'physical attacks.'" YVS Reply at 2; *see also* YVS Br. at 18. According to YVS this "very charged language meant to communicate a significant level of violence aimed at a particular individual, with an obvious inference of both an intent to seriously injure or harm and a likelihood that such serious injury or harm would occur." *Id.* For the reasons explained in this analysis, regardless of whether R1's actions are labeled "incidents of aggression," "assaults," or "attacks," the record demonstrates that CMS did not clearly err in determining that YVS's repeated failure to prevent the behaviors was likely to result in serious physical and emotional harm to other residents.

investigations, and failure to sufficiently monitor R1, we conclude that CMS did not clearly err in determining that YVS's noncompliance was likely to result in serious physical harm to other residents, even if such harm had not already occurred.

Moreover, ample evidence and testimony support the conclusion that YVS's noncompliance resulted in actual psychological harm to one resident and also was likely to result in serious psychological harm to other residents. As the ALJ noted, YVS's documentation of the June 14, 2009 incident indicates that the resident R1 struck and attempted to bite "stated that the incident made him angry and afraid." CMS Ex. 14, at 58. This shows actual psychological harm to this resident. It also shows that YVS's ongoing failure to protect other residents from R1's repeated assaults would likely cause fear, anger and anxiety in R1's victims. In addition, the testimony and evidence show that it was "quite common" for R1 to "expose himself . . . to the other residents or staff," and that YVS failed to prevent R1 from putting his hand down the front pants of another male resident (a patently aggressive sexual act, regardless of whether R1 actually touched the victim's "private area"). Tr. at 170; CMS Ex. 10, at 28-29. As reflected in the facility note to monitor the victim of the assault for psychological harm, these behaviors were likely to produce the "emotional shock" intended. CMS Ex. 10, at 28-29. Indeed, Dr. Wilson testified that while R1 "doesn't want to hurt the body," he "goes for the disturbing effect on the consciousness of the other person." Tr. at 284. For example, R1 might bite and leave teeth marks (but not break the skin), "put his mouth on someone . . . in order to gross people out," or strike out, but "pulls his punches." *Id*. at 283-84. In light of this evidence, we conclude that CMS did not err, clearly or otherwise, in determining that YVS's noncompliance was likely to result in serious psychological harm to facility residents.

We also reject YVS's contention that the evidence conclusively establishes that it was unlikely R1's behavior would result in serious harm to other residents because in the past the force with which R1 hit (using an open-handed slap with little force, never with a closed fist), kicked, or bit (never breaking the skin) other residents was minimal and because R1 did not intend to seriously harm other residents. YVS Br. at 7; Tr. at 159, 165, 201-204; P. Ex. 41, at 31. During the hearing, YVS counsel and witnesses attempted to demonstrate how R1 typically hit or kicked other residents. Tr. at 171-179; 346-351. The ALJ found that the "demonstrations showed enough force that a prepared healthy victim was moved from a standing position by the force of the assault," and that the actions "portrayed enough impact to constitute a battery and to definitely qualify as abuse" under the program regulations and YVS's own abuse policy. ALJ Decision at 14, citing Tr. at 171-79; 346-51; CMS Ex. 11, at 13. YVS argues that the ALJ incorrectly focused on the first demonstration, which according to Mr. Barney's testimony, was inaccurate, and that the second demonstration showed R1's slaps to have much less force. YVS Reply at 7. Regardless of which demonstration the ALJ focused on, the participants

in both demonstrations admitted that they had not actually observed all of the assaults by R1 that were documented in the seven incident reports underlying the survey findings. Tr. at 171; 183; 313. Thus, we cannot conclude that either demonstration accurately reflected the degree of force used by R1 during those documented incidents. Moreover, the reports of the incidents suggest that the force used by R1 was greater than that modeled in either hearing demonstration. Specifically, the March 8 report described R1's behavior as a "violent outburst" during which R1 hit another resident on the "head, bit staff on forearm, [and] bit [his] own arms." CMS Ex. 10, at 8. In addition, the documentation of the June 13 incident indicates that facility staff expected the victim of that assault might develop bruising, stating "watch R6 on alert for possible bruising . . . probably tomorrow," and noted that the action taken by the unit nurse in response to the assault was "first aid." CMS Ex. 10, at 22-23. The documentation on the June 14 incident, moreover, showed that the "type of injury" sustained by the victim of that assault was "psychological harm." *Id.* at 26.

Furthermore, even if R1 previously did not intend to inflict serious harm or injury on other residents, YVS's assessments reveal that R1's past intentions would not be a reliable indicator of the potential harm that might ensue from his aggressive actions in the future. As noted, YVS itself documented that R1 had "severe executive (self-regulatory and cognitive-social) deficits," and he was "unable to predict the effects of his impulsive social behavior." YVS Ex. 8, at 2. Thus, even assuming R1 intended only to gain attention and inflict minor harm during these incidents, YVS could not reasonably rely on that intent with respect to its obligation to prevent future harm since R1 was not able to regulate his outbursts or understand the consequences of his behaviors. Given R1's impulsivity, strength, agility, and lack of judgment, even Dr. Wilson appeared to acknowledge that R1 might seriously injure other residents notwithstanding his intentions, testifying that it was "highly predictable that [R1 was] not going to hurt people *other than accidentally*." Tr. at 283 (emphasis added).

We also concur in the ALJ's conclusion that the likelihood and severity of harm posed by R1's behaviors and YVS's noncompliance was compounded by the vulnerabilities of R1's victims. As the surveyor testified, to evaluate the likelihood that R1's actions would cause serious harm, one would need to consider "the person who is the recipient of [his assaults] and their condition, how fragile they are, [and] how immobile they are." Tr. at 75. YVS's DON stated in her April 14, 2010 Declaration, "All [YVS] residents are developmentally disabled with diagnoses ranging from severe mental retardation to autism." YVS Response to CMS Motion for Summary Judgment, Att. 2, at ¶ 4. Of the six residents whom R1 struck, hit, kicked, inappropriately touched, or attempted to bite during the April 2009 through June 2009 period, the record shows two were wheelchair-bound, most lacked the ability to communicate, one was particularly susceptible to bruising, and only one could communicate verbally. CMS Exs. 10, 14 ; Tr. at 162.

Surveyor Becker testified that all of the victims of R1's prior outbursts were "very vulnerable . . . cognitively impaired people." Tr. at 69. Because of the residents' mobility impairments, the surveyor testified, "somebody running up, pushing [or] kicking [them] could result in harm in a number of different scenarios, perhaps a loss of balance and a fall with an injury that way; punching into organ areas certainly [has the] potential of causing underlying organ damage; also the biting possibilities." *Id.* at 68-69; 73-74. Moreover, the surveyor testified, even "if the aggressive person doesn't demonstrate an intent to harm the victim," there would not necessarily be less likelihood of serious injury or harm. *Id.* at 76. The likelihood of serious injury stems from the aggressor's actions, not his intent.

The surveyor also observed that the residents' cognitive impairments and lack of ability to communicate made it difficult to assess the harm that resulted from R1's assaults. According to the surveyor, the residents were "very vulnerable in the fact that they were unable with only one exception to really even speak to their feelings. All that was left was the observation of the biological indicators, are they eating, are they sleeping? Do they appear to be fearful?" [9] *Id.* at 69. While the surveyor stated that there was no evidence that R1's aggressive behavior had yet caused any serious injury or harm, her testimony indicated that such harm could not be ruled out because of the resident-victims' severe cognitive impairments and because the medical records did not show follow-up by the social worker or nursing staff. *Id.* at 69-71. The difficulties posed in assessing harm to vulnerable residents is reflected in YVS's own abuse policy, which directs that "In instances of abuse of a vulnerable adult who is unable to express or demonstrate physical harm, pain, or mental anguish, the abuse is *presumed to cause physical harm, pain or mental anguish."* CMS Ex. 11, at 22 (emphasis added). In this case, YVS presented testimony to support its argument that its witnesses "knew all the residents on R1's living unit extremely well," that the residents "could communicate in nonverbal ways and make their feelings known," and that they "were neither fearful nor intimidated by his behavior and were not vulnerable to injury as a result of it." YVS Reply at 5 (citations omitted). The arguments and testimony, however, are belied by YVS's own records, which document that after the June 14, 2009 incident, R7 stated that R1's assault made R7 "angry and afraid," and that staff was instructed to "monitor for bruising and psychological trauma." CMS Ex. 14, at 58. Further, both resident-victims R6 and R8, the evidence and testimony show, had expressive and receptive aphasia,

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[9] YVS argues, as it did below, that the survey finding of immediate jeopardy was based on unfounded assumptions and speculation because the surveyor did not ask YVS personnel about "the amount of force involved in [R1's] aggressive behavior" or "their assessment of [the] risk posed by R1's aggressive behavior." YVS Br. at 9-11, 25. The ALJ correctly explained that arguments about the inadequacy of survey methodology are irrelevant because an ALJ's review is *de novo*. ALJ Decision at 7. Moreover, YVS personnel, not the surveyor, had the duty to document in the facility records such details about R1's aggressive behavior and the risk posed by it.

indicating that they would have had difficulty receiving and expressing information. CMS Ex. 14, at 23, 51; Tr. at 37, 42-43. Thus, under YVS's own policy, R1's assaults of those victims should have been considered to have caused physical and/or mental harm.

Contrary to YVS's contentions, substantial evidence in the record also supports the ALJ's finding that YVS accepted disruptive and even dangerous behavior from R1. ALJ Decision at 12. Mr. Welch testified that all of the residents in R1's residence unit exhibited challenging behaviors and that hitting, kicking and biting "were a part of their daily routines;" for that reason, they were "all placed together . . . to keep them away from other residents." Tr. at 357-59. Mr. Barney testified that there were "a lot of incidents" wherein residents hit, kicked, or bit each other, that "this type of incident or activity is not rare," and that the residents were "quite used to it." Tr. at 153-54. In Mr. Welch's opinion, moreover, the incidents when R1 hit and kicked other residents despite staff efforts to intervene and prevent the assaults were "an acceptable level of physical aggression." *Id.* at 359. In the "plan for prevention" section of the March 1, 2009 report, staff noted, "Difficult to prevent as R1 is very quick and the staff has no inkling as to when his behaviors is [sic] going to take place – Does have LOS [4], but R1 is very quick and fast – [continue] to monitor." CMS Ex. 10, at 5. As the ALJ pointed out, Mr. Barney testified that it was "almost impossible to stop the first incident" when a resident had an aggressive outburst against other residents. ALJ Decision at 12, citing Tr. at 191. R1, however, twice physically assaulted more than one resident during a single outburst and staff failed to prevent the second assault, even though R1 was under LOS 4. *Id.* Thus, substantial evidence supports the ALJ's finding that YVS concluded that no additional protection of other residents from R1's behaviors was required, even though staff repeatedly failed to prevent his assaults and expected his impulsive, aggressive behaviors to continue.

We also find no merit in YVS's argument that the record does not support the ALJ's finding that there was "no mention of keeping R1 separated from his victims, of preventing future contact with his victims, or of increasing the LOS." ALJ Decision at 12. YVS argues that its witnesses gave testimony that increasing R1's supervision level to LOS 5 was not an appropriate option because it would have elevated R1's aggressiveness and could not have prevented R1 from initiating physical contact with other residents. YVS Br. at 12, citing Tr. at 158, 166, 211, 297-98, 379-80; P. Ex. 41, at 24-27. YVS's argument takes the ALJ's statement out of context. The ALJ's finding was made in the context of evaluating whether YVS thoroughly investigated R1's assaults against other residents and prevented further potential abuse pending the investigations, as required under section 483.13(c)(3). ALJ Decision at 12. While YVS's witnesses gave post-hoc testimony that LOS 5 was not an appropriate option for R1, there was no mention in the investigation documentation that YVS staff considered increasing R1's LOS or otherwise keeping R1 separated from his victims during the

investigations to protect the other residents. As the ALJ pointed out, there were three incidents in four days, from June 13 to June 16, 2009, and the records relating to the June 14 incident show that R1 hit R7 on the shoulder and that the assault made R7 angry and afraid. *Id.* Nevertheless, later that day YVS permitted R1 to approach R7 "to allow a conversation to take place, even though R1 had abused R7 just a few hours earlier." *Id.* at 12-13. Thus, the ALJ reasonably concluded that the absence of contemporaneous evidence showing that YVS considered separating R1 from his victims during the incident investigations supported the determination that YVS failed to comply substantially with section 483.13(c)(3).

Finally, we reject YVS's suggestion that CMS's determination of immediate jeopardy was unwarranted because "some disruptive behavior is inevitable in a congregate facility like YVS, where residents are not the typically elderly and frail individuals that one finds in most nursing homes." YVS Reply Br. at 13. While the "model of a village-like community is admirable in many ways," the ALJ explained, YVS is a Medicaid-certified nursing facility. ALJ Decision at 16. As a program participant, YVS was responsible for preventing foreseeable aggressive conduct by R1 that could harm the other residents for whom it was responsible. *See, e.g., Somerset Nursing & Rehabilitation Facility*, DAB No. 2353 (2010); *Columbus Nursing & Rehabilitation Center*, DAB No. 2247 (2009). Here, while YVS maintains that its staff "work constantly" to eliminate residents' "challenging behaviors," YVS Reply Br. at 13, the evidence and testimony show that CMS did not err in determining that YVS's failure to sufficiently investigate R1's assaults of multiple vulnerable residents, failure to protect those residents from R1 pending the investigations, and failure to sufficiently monitor R1, were likely to result in serious physical and/or psychological harm to other residents. Accordingly, we sustain the ALJ's determination.

3. The deficiencies constituted substandard quality of care and required a two-year suspension of YVS's NATCEP.

The Act prohibits approval of a NATCEP at any facility participating in Medicare or Medicaid "which, within the previous two years . . . has been subject to an extended survey," which would be triggered by any finding of substandard quality of care. Act §§ 1819(f)(2)(B)(iii)(I), 1919(f)(2)(B)(iii)(I). As noted above, "substandard quality of care" means one or more deficiencies with the requirements at 42 C.F.R. §§ 483.13, 483.15, or 483.25 that constitute, among other things, immediate jeopardy to resident health or safety. 42 C.F.R. § 488.301. Regulations implementing the statute require state survey agencies to withdraw approval of a NATCEP for any facility subjected to an extended survey in the preceding two years. 42 C.F.R. §§ 483.151(b)(2), 483.151(e), 488.310. In light of our conclusion that CMS did not err, clearly or otherwise, in

determining that YVS's failure to comply with the requirements at sections 483.13(c) and 483.25(h) posed immediate jeopardy, we conclude that the deficiencies constituted substandard quality of care, and we sustain the ALJ's determination that loss of approval of YVS's NATCEP for a period of two years was mandated.

Conclusion

For the reasons explained above, we affirm the ALJ Decision.

/s/
Steven M. Godek

/s/
Leslie A. Sussan

/s/
Sheila Ann Hegy
Presiding Board Member