Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Yakima Valley School
(CCN: 50-A261),

Petitioner

v.

Centers for Medicare and Medicaid Services.

Docket No. C-09-745

Decision No. CR2350

Date: April 8, 2011

DECISION

I sustain the determination of the Centers for Medicare and Medicaid Services (CMS) to withdraw its approval of Petitioner Yakima Valley School's (YVS), Nurse Aid Training and Competency Evaluation Program (NATCEP) for two years, effective July 16, 2009.

I. Background

Petitioner is a nursing home owned and operated by the State of Washington and located in Selah, Washington. That State's Department of Social and Health Services (State agency) conducted an unannounced, abbreviated, partial-extended complaint survey of Petitioner's facility that ended on July 16, 2009. By letter dated July 20, 2009, Petitioner was notified that the July survey found immediate jeopardy deficiencies that constituted substandard quality of care on July 15, 2009, but the immediate jeopardy was abated on July 16, 2009. CMS Ex. 2. By letter dated July 23, 2009, Petitioner was notified that the deficiencies were determined to be immediate jeopardy at scope and severity level K, constituting a pattern in nature. CMS Ex. 3. CMS notified Petitioner that it would be imposing a discretionary denial of payments for new admissions (DPNA) if Petitioner did

not return to substantial compliance before August 7, 2009 and that approval for Petitioner's NATCEP must be withdrawn because substandard quality of care had been cited. *Id*. By letter dated July 30, 2009, CMS corrected its earlier notice letter and notified Petitioner that the deficiencies were at a scope and severity "level K, isolated and constituting immediate jeopardy to resident health and safety." CMS Ex. 2, at 5. By letter dated August 5, 2009, Petitioner was notified that the deficiencies were found to be corrected on July 29, 2009. CMS Ex. 4. By letter dated August 5, 2009, Petitioner was notified that it was in substantial compliance and the DPNA would not be imposed. CMS Ex. 5. By letter dated September 28, 2009, Petitioner was notified that approval of its NATCEP was withdrawn for two years, effective July 16, 2009. CMS Ex. 7.

Petitioner timely requested a hearing before an Administrative Law Judge (ALJ), and the case was assigned to me for hearing and decision. I conducted an in-person hearing in Seattle, Washington, on August 9 and 10, 2010. CMS offered exhibits (CMS Exs.) 1 through 16, which were admitted into evidence. Petitioner offered exhibits (P. Exs.) 1 through 41, which were also admitted into evidence. CMS elicited testimony from P. A. Becker, the surveyor employed by the State agency. Petitioner elicited testimony from M. J. Barney, an attendant counselor level 3 (AC3) for cottages 103 and 104 located at Petitioner's facility, J. A. Welch, an attendant counselor level 1 (AC1) who at times was part of the enhanced staffing for cottages 103 and 104 at Petitioner's facility, E. F. Wilson, Ph.D., Petitioner's clinical psychologist, and T. K. Winegar, Petitioner's Superintendent and Administrator. Each party submitted a post hearing brief (CMS Brief and P. Brief, respectively) and a reply brief (CMS Reply and P. Reply, respectively). Petitioner submitted an attachment, identified as Appendix Q of the State Operations Manual, along with its post hearing brief.

II. Issues, Applicable Law, Findings of Fact and Conclusions of Law

A. Issues

The issues in this case are:

1. Whether Petitioner failed to comply with one or more Medicare participation requirements;

2. Whether CMS's determination as to the immediate jeopardy level of noncompliance was clearly erroneous; and

3. Whether the remedy imposed is reasonable.

B. Applicable Law and Regulations

Petitioner is considered a long-term care facility under the Social Security Act (Act) and regulations promulgated by the Secretary of Health and Human Services (Secretary). The statutory requirements for participation by a long-term care facility are found at sections 1819 and 1919 of the Act, and at 42 C.F.R. Part 483. Sections 1819 and 1919 of the Act vest the Secretary with authority to impose civil money penalties (CMPs) and other remedies against a long-term care facility for failure to comply substantially with participation requirements.

Pursuant to the Act, the Secretary has delegated to CMS the authority to impose various remedies against a long-term care facility that is not complying substantially with federal participation requirements. Facilities which participate in Medicare may be surveyed on behalf of CMS by State survey agencies in order to ascertain whether the facilities are complying with participation requirements. 42 C.F.R. §§ 488.10-488.28; 42 C.F.R. §§ 488.300-488.335.

The regulations define the term "substantial compliance" to mean "a level of compliance with the requirements of participation such that any identified deficiencies pose no greater risk to resident health or safety than the potential for causing minimal harm." 42 C.F.R. § 488.301. Non-compliance that is immediate jeopardy is defined as "a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident." *Id.*

In this case, the State agency was required to withdraw Petitioner's approval to conduct a NATCEP. Pursuant to sections 1819(b)(5) and 1919(b)(5) of the Act, skilled nursing facilites (SNFs) and nursing facilites (NFs) may only use nurse aides who have taken a training and competency evaluation program. Sections 1819(e) and 1919(e) of the Act impose upon the states the requirement to specify what NATCEPs they will approve that meet the requirements established by the Secretary and a process for reviewing and reapproving those programs using criteria set by the Secretary. Pursuant to sections 1819(f)(2) and 1919(f)(2) the Secretary was tasked to develop requirements for approval of NATCEPs and the process for review of those programs. The Secretary promulgated regulations at 42 C.F.R. Part 483, subpart D. Pursuant to 42 C.F.R. § 483.151(b)(2) and (e)(1) a state may not approve and must withdraw any prior approval of a NATCEP offered by a skilled nursing or nursing facility that: (1) has been subject to an extended or partial extended survey under sections 1819(g)(2)(B)(i) or 1919(g)(2)(B)(i) of the Act; (2) has been assessed a CMP of not less than $5000; or (3) that has been subject to termination of its participation agreement, a DPNA, or the appointment of temporary management. Extended and partial extended surveys are triggered by a finding of "substandard quality of care" during a standard or abbreviated standard survey and involve evaluating additional participation requirements. "Substandard quality of care"

occurs where surveyors identify one or more deficiencies related to participation requirements established by 42 C.F.R. § 483.13 (Resident Behavior and Facility Practices), § 483.15 (Quality of Life), or § 483.25 (Quality of Care) that are found to constitute either immediate jeopardy, a pattern of or widespread actual harm that does not amount to immediate jeopardy, or a widespread potential for more than minimal harm that does not amount to immediate jeopardy with no actual harm. 42 C.F.R. § 488.301.

The Act and regulations make a hearing before an ALJ available to a long-term care facility against which CMS has determined to impose an enforcement remedy. Act § 1128A(c)(2); 1866(h); 42 C.F.R. §§ 488.408(g); 498.3(b)(13). The hearing before an ALJ is a *de novo* proceeding. *Anesthesiologists Affiliated, et al*, DAB CR-65 (1990), *aff'd*, 941 F.2d 678 (8th Cir. 1991); *Emerald Oaks*, DAB No. 1800, at 11 (2001); *Beechwood Sanitarium*, DAB No. 1906 (2004); *Cal Turner Extended Care*, DAB No. 2030 (2006)*; The Residence at Salem Woods*, DAB No. 2052 (2006). A facility has a right to appeal a "certification of noncompliance leading to an enforcement remedy." 42 C.F.R. § 488.408(g)(1); *see also* 42 C.F.R. §§ 488.330(e) and 498.3. However, the choice of remedies by CMS or the factors CMS considered when choosing remedies are not subject to review. 42 C.F.R. § 488.408(g)(2). A facility may only challenge the scope and severity level of noncompliance found by CMS if a successful challenge would affect the range of the CMP that could be imposed by CMS or impact the facility's authority to conduct a nurse aide training and competency evaluation program. 42 C.F.R. §§ 498.3(b)(14) and (d)(10)(i). The CMS determination as to the level of noncompliance "must be upheld unless it is clearly erroneous" (42 C.F.R. § 498.60(c)(2)), including the finding of immediate jeopardy. *Woodstock Care Center*, DAB No. 1726, at 9, 38 (2000), *aff'd, Woodstock Care Center v. Thompson*, 363 F.3d 583 (6th Cir. 2003). The Departmental Appeals Board (the Board) has long held that the net effect of the regulations is that a provider has no right to challenge the scope and severity level assigned to a noncompliance finding, except in the situation where that finding was the basis for an immediate jeopardy determination. *See e.g.*, *Ridge Terrace*, DAB No. 1834 (2002); *Koester Pavilion*, DAB No. 1750 (2000). Review of a CMP by an ALJ is subject to 42 C.F.R. § 488.438(e).

The standard of proof or quantum of evidence required is a preponderance of the evidence. CMS has the burden of coming forward with the evidence and making a *prima facie* showing of a basis for imposition of an enforcement remedy. Petitioner bears the burden of persuasion to show by a preponderance of the evidence that it was in substantial compliance with participation requirements or any affirmative defense. *See Hillman Rehabilitation Center*, DAB No. 1611 (1997), *aff'd, Hillman Rehabilitation Center v. United States Dep't of Health and Human Services,* No. 98-3789, 1999 WL 34813783 (D.N.J. May 13, 1999); *Cross Creek Health Care Center*, DAB No. 1665 (1998); *Emerald Oaks*, DAB No. 1800; *Batavia Nursing and Convalescent Center*, DAB No. 1904 (2004)*, aff'd, Batavia Nursing & Convalescent Center v. Thompson*, 129 F.

App'x. 181 (6th Cir. 2005); *Batavia Nursing and Convalescent Inn*, DAB No. 1911 (2004).

C. Findings of Fact, Conclusions of Law, and Discussion

I make findings of fact and conclusions of law to support this decision. I set them forth below as separate headings in bold type, and then discuss each in detail.

1. The parties stipulated that certain facts are undisputed.

On March 25, 2010, the parties submitted a List of Joint Factual Stipulations. These facts are undisputed. At the time of the July survey, Petitioner used a Level of Supervision (LOS) scale from LOS 1 (low supervision) to LOS 5 (high supervision) "to rank its residents according to the intensity of staff supervision that each resident required." The LOS scale directed that "for residents on LOS 4, staff were to position supervision in a manner to prevent danger or harm to self and others; one-to-one staffing at bedside to maintain a medical treatment or one-to-one supervision allowing as much social space as possible or per care plan. An acute care plan is required."

The LOS scale directed that for residents on LOS 5, Petitioner's "staff were to maintain two-to-one staffing within arms length of the resident." LOS 5 "was for residents who had the potential to cause frequent severe danger to self and to others."

A care plan for Resident 1 (R-1) dated August 25, 2008 states:

> During waking hours: LOS 4 Supervision must be positioned in a manner to prevent danger or harm to self or others. One-to-one staffing at bedside to maintain a medical treatment or one-to-one supervision allowing as much social space as possible. Acute care plan is required. This was increased on 5/13/08.

CMS Ex. 16, at 12.

An updated care plan for R-1 was created on April 14, 2009. CMS Ex. 10, at 15-19. While at YVS, R-1 had been followed by George Petzinger, M.D., YVS's consulting psychiatrist.

E. F. Wilson, Ph.D., Petitioner's licensed clinical psychologist, wrote a review of R-1's condition on April 17, 2009 in a document entitled "Yakima Valley School Resident Status for Guardianship Review." CMS Ex. 13, at 43-47. This document states that R-1 "is, at age 18, in 2009, dependent 24/7 on supervision by competent caregivers to prevent self and other harm . . . . He may react with many actions including: violence, self-exposure, or other actions which appear to have the goal of creating emotional shock." CMS Ex. 13, at 43.

Seven incidents occurred at Petitioner's facility involving R-1 in a four-month period. The incidents occurred on February 14, 2009, March 1, 2009, March 8, 2009, April 14, 2009, June 13, 2009, June 14, 2009, and June 16, 2009. The YVS Resident Occurrence/Incident Investigation Report (incident report) was completed by Petitioner's staff on the same day as each incident described.

An incident report on February 14, 2009 reveals that R-1 struck two residents with his hand, one in the stomach (R-6) and the other in his leg (R-2). The incident report "further indicates there were no signs and symptoms of pain and no injuries to either resident, as well as no adverse side effects." CMS Ex. 10, at 1-2.

An incident report reflects that R-1 kicked another resident (R-6) on his arm on March 1, 2009 and states "[n]o injuries to Resident 6." CMS Ex. 10, at 5.

An incident report indicates that on March 8, 2009 R-1 hit another resident (R-8) on the head, and identifies no injuries or psychological distress experienced by R-8 following this incident. CMS Ex. 10, at 8-12.

An incident report records that although R-1 was prevented from successfully biting a resident (R-5), R-1 kicked one resident (R-5) on the lower back and another resident (R-9) on the chest on April 14, 2009, and identifies no injuries or psychological distress sustained by R-5 or R-9 following the incident. CMS Ex. 10, at 13-21.

An incident report reflects that on June 13, 2009 R-1 kicked another resident (R-6) on the thigh, and identifies no injuries or psychological distress suffered by R-6 following this incident. CMS Ex. 10, at 22-24.

An incident report documents that on June 14, 2009 R-1 hit another resident (R-7) on the shoulder and identifies no physical injuries to R-7 following this incident. However, the victim of the June 14, 2009 incident, R-7, stated that the incident made him angry and afraid. CMS Ex. 10, at 25-27. Four days after the June 14, 2009 incident, the social worker documented that there were no noted residual signs or symptoms of harm or distress on the part of R-7. CMS Ex. 10, at 25.

An incident report records that on June 16, 2009 R-1 was passing another resident in the hallway. R-1 thrust his hand down the front of the other resident's sweatpants very quickly. The report indicates that the staff immediately intervened and that it was unknown if R-1 touched the other resident's private area. No injuries or psychological distress sustained by the victim were identified following this incident. CMS Ex. 10, at 28.

2. I make a *de novo* review of this case.

Petitioner attempts to discredit the way the survey was conducted and in particular criticizes the surveyor's alleged failure to make inquires into the level of force R-1 employed during the seven incidents and the surveyor's alleged failure to interview the attendant counselors providing care to R-1. Petitioner's attempt is irrelevant. The issue is not how the survey was conducted, but rather whether the surveyor's allegations are supported by the evidence at hearing. The hearing before me is a *de novo* review of whether the allegations are supported by the evidence. Inadequate survey methodology, even if demonstrated — and I make no finding that the methodology employed in this survey was inadequate in any way whatsoever — does not invalidate citations based on adequately-documented deficiencies. 42 C.F.R. § 488.318(b)(2). *Northlake Nursing and Rehabilitation Center*, DAB No. 2376, at 10-11 (2011); *North Carolina State Veterans Nursing Home*, DAB No. 2256, at 23 (2009); *Jewish Home of Eastern Pennsylvania*, DAB No. 2254, at 15 (2009).

3. Petitioner failed to comply with the regulation at 42 C.F.R. § 483.13(c)(3) during the July 16, 2009 survey.

During the July 16, 2009 survey, Petitioner was found to be out of compliance with the regulation at 42 C.F.R. § 483.13(c)(3). This regulation provides that:

> (c) Staff treatment of residents. The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.
>
> * * *
>
> (3) The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.

42 C.F.R. § 483.13(c)(3).

"Abuse" is "the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish." 42 C.F.R. § 488.301. Willful means that the action was deliberate. Even a resident who does not possess his full mental capabilities can take deliberate action in the sense that the resident " intends his or her actions to have consequences." *Singing River Rehabilitation & Nursing Center*, DAB CR1838, at 15 (2008). A resident does not need to have intended harm for the resident's action to be willful. *See Wayne View Convalescent Center*, DAB CR1502

(2006). Hitting, kicking, pushing down another person are all considered abuse. *See Western Care Management Corp.* DAB No. 1921 (2004). Petitioner's own policy provides that physical abuse includes biting, kicking, pushing, shoving, and slapping. CMS Ex. 11, at 15. Petitioner's policy also provides that sexual abuse includes inappropriate or unwanted sexual touching. *Id.* "Neglect" is defined as "failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness." 42 C.F.R. § 488.301

The Board addressed the scope of the regulation at 42 C.F.R. § 483.13(c) in *Martha & Mary Lutheran Services*, DAB No. 2147 (2008). That case involved the failure of a facility to protect its residents adequately against a verbally and physically aggressive resident. There, the Board sustained the ALJ's determination comparing a facility's duty under 42 C.F.R. § 483.13 to protect all its residents from neglect with its obligation, under 42 C.F.R. § 483.25(h)(2), to provide individual residents with adequate supervision and assistance devices to protect against accidents. The Board noted that the latter provision has been interpreted to require a facility to implement "all reasonable efforts to protect residents against adverse events that are reasonably foreseeable," and also held that a facility's "[f]ailure to protect a resident against a known or foreseeable hazard - including the possibility that a resident might be physically abused or assaulted by another resident whose aggressive behavior has become known to a facility's staff - is a failure by a facility to provide services that are necessary to prevent physical harm or mental anguish and is, thus, neglect." *Martha & Mary Lutheran Services*, DAB No. 2147, at 6, citing DAB CR1595, at 3 (2007); *see also Emerald Oaks*, DAB No. 1800, at 17 (2001).

Although the title of 42 C.F.R. § 483.13(c), "[s]taff treatment of residents" could be read to focus the section upon staff actions toward residents, the substantive language of the section does not limit the obligation of the facility to regulating or controlling staff and resident interaction. Rather, the substantive language of the section imposes a general obligation upon a provider to prohibit mistreatment, neglect, and abuse of its residents or the misappropriation of their property, without limiting the focus of the required policies to a specific source, i.e., staff, visitors, or other residents. Decisions of the Board in the cases cited above are consistent with my interpretation.

Subsection (c)(3) of section 483.13 plainly states that the facility must thoroughly investigate all alleged violations and have evidence of that thorough investigation. This subsection places an affirmative duty on the facility to prevent further potential abuse while the investigation is in progress. A facility has a duty to identify residents who are at risk for "abusing" other residents. The participating facility must develop interventions to prevent occurrences, monitor for changes that would trigger abusive behavior, and reassess interventions on a regular basis.

Petitioner provides 24-hour-per-day direct care to developmentally-disabled residents. Residents are housed in cottages with eight residents per cottage. Cottages 103 and 104 are side-by-side cottages with a garage in between the cottages. Cottages 103 and 104 were a special unit designed for residents with challenging behaviors. Tr. at 209. R-1 resided in cottage 104 with seven other residents and attending staff. R-1, at the time of the survey, was a physically-fit 18-year-old male, weighing approximately 180 pounds, with a history of difficulty maintaining social boundaries and impaired executive and social judgment. R-1 is described as very fast-moving, impulsive, fully mobile, and agile. Tr. at 63. R-1's behaviors include coarse and scatological language and behavior, propositioning nurses for sex acts, attempting to expose himself, being physically aggressive, and verbally offensive. R-1 was diagnosed as having mild mental retardation, autism, post-traumatic stress syndrome, obsessive-compulsive disorder, and behavioral disorders. Tr. at 64; CMS Ex. 13, at 43. The surveyor testified that during the survey, Dr. Wilson, whom it will be recalled was at the time on YVS' staff as its clinical psychologist, described R-1 as exhibiting conscious anti-social behavior, possibly requiring two-to-one supervision all the time. CMS Ex. 13, at 29; Tr. at 64-65. Dr. Wilson testified that R-1 would react to numerous things that occurred around him, and that it was therefore difficult to predict when R-1 would become aggressive. Dr. Wilson also testified that R-1 was a "reactor and also a strategic planner of aggression." Tr. at 337-8. R-1 was repeatedly described by witnesses at the hearing as attention-seeking, and desiring "stimulus items" such as toys, games, and electronic devices. Tr. at 282, 297, 309. There is no doubt at all that R-1 was and is a difficult and unpredictable young man. R-1's Behavior Support Plan (BSP) dated February 27, 2009 describes R-1 as someone who "always uses his muscles more than his words to get what he wants." P. Ex. 37, at 1.

CMS characterizes this case as concerning protecting vulnerable residents from being physically assaulted by R-1, who had a history of aggressive behavior. The victims of these assaults (R-2, R-5, R-6, R-7, R-8, and R-9) were vulnerable, cognitively-impaired residents with severe developmental disabilities including serious intellectual deficits, many of them lacking the ability to communicate and some victims (R-7 and R-9) who were wheelchair-bound. One victim, R-6, is described as particularly susceptible to bruising. R-1 was known to cause bruising to staff members. Tr. at 335. R-1 was also able to increase his level of aggression depending on the circumstances. *Id.* R-1 was known to break away from the staff and able to move ahead of staff. Tr. at 357. Partially because R-1 was so agile that he could move ahead of the staff supervising him, R-1 was able to assault his fellow residents successfully.

Petitioner describes R-1's attacks as *de minimis* in their effect on the attacker's victims. Dr. Wilson stated that there was a high probability that R-1 was "not going to hurt people, other than accidentally" (Tr. at 283), that R-1 might bite and leave teeth marks but would not break the skin of his victim, and that R-1 "pulls his punches. He goes for the disturbing effect on the consciousness of the other person. He doesn't want to hurt

the body." Tr. at 284. Dr. Wilson further describes R-1's behavior as "high frequency of light weight harassing behaviors" (Tr. at 296) and low intensity behaviors (Tr. at 311).

Incident investigations or reports — informally referred to as "IRs" — at YVS were performed at two levels. The first level was an immediate overview of the incident to determine whether changes needed to be made to the resident's care. Tr. at 381-386. The second phase was a deeper, more detailed level of investigation into the incident and was only used when the incident rose to a greater degree of seriousness. Evidently, all the incidents involving R-1 never got past the first phase of investigation. Ms. Winegar, whom it will be recalled was the administrator of YVS's facility, reviewed the incident reports, but never reviewed a second phase of investigation concerning the incidents with R-1. Tr. at 402-403. Petitioner never produced any phase two investigations concerning any of these incidents as evidence before me. Ms. Winegar implied that a phase two investigation would not be necessary for any of the incidents concerning R-1 because a phase two investigation would be required only if actual harm had been sustained by the other victim-residents. Tr. at 293, 295.

The phase one incident reports consistently failed to provide information concerning how much force was used by R-1, whether R-1's care plan was being properly followed, whether one-on-one supervision was applied at the time of each incident and the proximity of the one-on-one caregiver to R-1 at the time of each incident. Tr. at 33, 39, 41, 44-45, 51, 53, 57; CMS Ex. 10, at 1, 5, 8, 13, 22, 25, 28. Ms. Becker, the surveyor, testified that the incident reports failed to indicate whether the one-on-one caregiver was "intervening appropriately, positionally, and with the appropriate intervention to protect the other residents in the face of [R-1's] aggression." Tr. at 41. The incident reports further failed to provide an adequate plan for preventing further physical aggression by R-1. Tr. at 34-35, 39-40, 41-42, 46, 52, 54, 59; CMS Ex. 10, at 5, 8, 13, 22. Some of the incident reports merely direct the staff to make no changes in R-1's care plan and in the level of R-1's supervision. CMS Ex. 10, at 8, 13, 22, 25. The incident reports failed to identify the triggering events for each incident. Tr. at 39.

The testimony of Mr. Welch, an AC1, also demonstrates that the phase one investigations were not thorough. Phase one investigations are documented by the incident reports and witness statements. Mr. Welch observed the incident of April 14, 2009 where R-1 attempted to bite R-5 on the back of the neck, and then kicked R-5 on the lower back and kicked R-9 on the chest. CMS Ex. 10, at 13. Mr. Welch admitted that his witness statement of the April 14, 2009 incident does not reflect where he was positioned with respect to R-1. Tr. at 353-54. Mr. Welch's witness statement for the June 13, 2009 incident, where R-1 kicked R-6 on the right thigh, did not reflect where Mr. Welch was positioned at the time of the incident. Tr. at 354; CMS Ex. 10, at 24. Mr. Welch's witness statement did not describe what triggered R-1's aggressive behavior prior to the June 13, 2009 incident. Tr. at 344; CMS Ex. 10, at 24. Similarly, Mr. Welch's witness statement for the June 14, 2009 incident, where R-1 walked past R-7 and hit R-7 on the

shoulder, did not reflect where Mr. Welch was positioned at the time of the incident and did not describe what triggered R-1's aggressive behavior. Tr. at 355-356; CMS Ex. 10, at 27. Although, Mr. Welch did testify that he observed the April 14, June 13, and June14 incidents and staff were right next to R-1 (Tr. at 351), Mr. Welch's witness statements which were made closer in time to the incidents do not reflect that information. Again, Mr. Welch has demonstrated that his witness statements were not complete and thorough.

Ms. Melanie Kohler, Petitioner's Director of Nursing, was asked during the survey whether there was anything other than the phase one incident reports and attached witness statements as a record of the investigation of these seven incidents. Ms. Kohler did not provide any other documentation. Tr. at 61; CMS Ex. 13, at 27; P. Ex. 41. According to Petitioner, Ms. Kohler conducts phase two investigations including developing plans of prevention. P. Br. at 19. However, no evidence of any phase two investigations conducted for any of the seven incidents were provided during the hearing.

According to Petitioner, all the residents in cottages 103 and 104 exhibited aggressive or challenging behaviors at one time or another. Tr. at 357. Mr. Barney, an AC3, testified that there have been "a lot of incidents" where residents hit, kicked or bit each other and stated that "they're quite used to it." Tr. at 153-54. Ms. Winegar testified that given YVS's population, there were going to be some assaults. Tr. at 399. At the hearing, Mr. Welch testified that suffering from aggressive behavior by R-1 was part of the other residents' daily lives. Tr. at 209. Mr. Welch confirmed this testimony on cross-examination:

> Q: And I believe you testified yesterday that all the residents in cottages 103 and 104 exhibited challenging behaviors, isn't that correct?
>
> A: That's correct.
>
> Q: In fact, I believe you testified that they were all placed together in these cottages to keep them away from other residents, is that correct?
>
> A: Yes.
>
> Q: And I believe that you testified that hitting, kicking, and biting were a part of their daily routines, isn't that correct?
>
> A: Correct.
>
> Q: So it's expected that a certain amount of hitting, kicking and biting would occur in these cottages, isn't that correct?

A: Correct.

Tr. at 357-8.

YVS seems to have decided at some point that it would have to expect and accept a certain level of disruptive and even dangerous behavior from R-1 and that the staff could not realistically hope to protect the other residents from R-1. For, example, the plan for prevention section of the incident report concerning the March 1, 2009 incident notes, "[d]iffcult to prevent as R-1 is very quick and the staff has no inkling as to when his behaviors is (sic) going to take place – Does have LOS IV, but R-1 is very quick and fast – [continue] to monitor." CMS Ex. 10, at 5. No evidence was presented to me suggesting that Petitioner did anything to protect its other vulnerable residents or to increase the supervision that R-1 received. R-1's supervision was maintained at LOS 4. No evidence was presented that, prior to the survey, R-1's level of supervision was increased to a LOS 5. More importantly, no documentation was presented that Petitioner's staff even considered the possibility of instituting a LOS 5 for R-1. No documentation was presented that Petitioner's staff considered separating R-1 from his fellow residents to protect them from potential abuse.

R-1 was well-known to Petitioner's staff as having a propensity for violent physical assault. R-1's care plan dated April 14, 2009, has a section in it entitled "Potential for Violence" in which is noted R-1's history of physical assaults toward other residents including hitting, kicking, pulling hair, biting, his "hit and run" style of assault, and that R-1 was known to "dash quickly away and strike another resident or staff." CMS Ex. 10, at 15-16.

Mr. Barney testified that when a resident intends to hit or kick another resident it was "almost impossible to stop the first incident." Tr. at 191. However, R-1 was twice able to physically assault more than one resident at the same time and staff failed to prevent the second assault, even though R-1 was under a LOS 4.

YVS failed to prevent further potential abuse of R-1's victims while the investigations were in progress. There is no mention of keeping R-1 separated from his victims, of preventing future contact with his victims, or of increasing the LOS. This is particularly evidenced by the fact that there were three incidents in four days from June 13 to June 16, 2009. The incident of June 14, 2009 plainly demonstrates Petitioner's failure to prevent further potential abuse by R-1. During the incident of June 14, 2009, R-1 hit R-7 on the shoulder and R-7 reported being angry and afraid. Following the June 14 incident, R-1 was allowed to get close enough to R-7 for a conversation. Mr. Welch testified that this conversation occurred "[w]ithin a few hours. It wasn't even – it could have been right after." Tr. at 205. Petitioner completely failed to prevent further potential abuse of R-7 by permitting R-1 to approach R-7 close enough and for a sufficient period of time to

allow a conversation to take place even though R-1 had abused R-7 just a few hours earlier.

I find that Petitioner failed to comply with 42 C.F.R. § 483.13(c)(3). Petitioner failed to thoroughly determine the facts surrounding the seven incidents. This failure was particularly egregious given the increasing frequency of R-1's attacks on other residents. This lapse led to a subsequent failure to determine whether one-on-one supervision was being implemented properly and whether R-1's level of supervision was adequate. Petitioner failed to determine which additional interventions were required. In addition, Petitioner failed to prevent further potential abuse of R-1's victims while the investigations were in progress.

4. Petitioner failed to comply with the regulation at 42 C.F.R. § 483.25(h) during the July 16, 2009 survey.

The regulation at 42 C.F.R. § 483.25 provides that:

> Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and pyschosocial well-being, in accordance with the comprehensive assessment and plan of care.
>
> * * *
>
> (h) Accidents. The facility must ensure that-
>
> > (1) The resident environment remains as free of accident hazards as is possible; and
> >
> > (2) Each resident receives adequate supervision and assistive devices to prevent accidents.

The Board has also explained the requirements of 42 C.F.R. § 483.25(h)(2) in numerous decisions. *Golden Living Centers — Riverchase*, DAB No. 2314, at 6-7 (2010); *Eastwood Convalescent Center,* DAB No. 2088 (2007); *Liberty Commons Nursing and Rehab — Alamance,* DAB No. 2070 (2007); *Century Care of Crystal Coast*, DAB No. 2076 (2007), *aff'd, Century Care of the Crystal Coast*, 281 F. App'x 180 (4th Cir. 2008); *Golden Age Skilled Nursing & Rehabilitation Center*, DAB No. 2026 (2006); *Estes Nursing Facility Civic Center*, DAB No. 2000 (2005); *Northeastern Ohio Alzheimer's Research Center*, DAB No. 1935 (2004); *Woodstock Care Center*, DAB No. 1726 (2000), *aff'd*, *Woodstock Care Center v. Thompson*, 363 F.3d 583 (6th Cir. 2003). Section 483.25(h)(2) does not make a facility strictly liable for accidents that occur, but it does require that a facility take all reasonable steps to ensure that a resident receives

supervision and assistance devices that meet his or her assessed needs and mitigate foreseeable risks of harm from accidents. *Woodstock Care Center v. Thompson*, 363 F.3d at 589 (a nursing home must take "all reasonable precautions against residents' accidents").

CMS claims that Petitioner failed to provide sufficient supervision of R-1 to protect the other residents from R-1's physical attacks. During the hearing, Petitioner's witnesses, Mr. Welch and Mr. Barney, and Petitioner's counsel, Mr. Dee, provided me with hitting and kicking demonstrations to illustrate R-1's typical assaults. Tr. at 171-179, 346-351. The live demonstrations showed enough force that a prepared healthy victim was moved from a standing position by the force of the assault. Tr. at 176. I note that the live demonstrations portrayed enough impact to constitute a battery and to definitely qualify as abuse. The live demonstrations would also qualify as abuse under Petitioner's own abuse policy.

As I described above, YVS seemed to accept physically abusive behavior on the part of R-1 toward other vulnerable residents as acceptable because perceived as unavoidable and *de minimis* in danger or significance. YVS knew R-1 posed a risk of physical abuse to other residents because YVS knew that R-1 had an established history of abuse towards other residents. R-1 was known to be very quick, physically fit, and young. Petitioner's staff could not anticipate and did not know when R-1's physical attacks would take place. R-1 physically assaulted other residents repeatedly in a period of four months. Three attacks happened within only four days. Twice R-1 was able to assault more than one resident in the same incident without his one-on-one supervising caregiver intervening to stop the second assault. If LOS 4 supervision was adequate or implemented properly then the LOS 4 care-giver providing supervision should have been positioned in a manner to prevent danger or harm to R-1 and others residents. It is undisputed that R-1 was able to physically abuse other residents seven times in a four-month period, in spite of the LOS 4 supervision provided by Petitioner. All these facts lead me to the inescapable conclusion that LOS 4 supervision was either inadequate *per se* or was not being implemented properly by Petitioner's staff. YVS never reevaluated the way LOS 4 was being implemented. YVS never considered changing the level of its supervision to LOS 5. YVS never separated R-1 from the other residents he had either repeatedly victimized or who were potentially the next victims of his unpredictable but violent outbursts. YVS never instituted LOS 5 supervision until after immediate jeopardy was cited by the survey. In response to the immediate jeopardy finding, Petitioner also isolated R-1 from other residents by placing him in a living unit with staff only. There is no evidence that Petitioner pursued any other options to address R-1's continued aggression. The Board has held that a facility's duty of care is, "breached where a facility fails to take action to prevent foreseeable aggressive conduct by mentally impaired residents that impact other residents." *Columbus Nursing & Rehabilitation Center*, DAB No. 2247, at 9 (2009). A resident so inadequately supervised that he has the opportunity to repeatedly assault other residents and engage in an incident of possible

sexual touching demonstrates a failure on YVS's part to adequately supervise R-1 to prevent accidents and a failure to comply with the requirements of 42 C.F.R. § 483.25.

5. CMS's finding of immediate jeopardy was not clearly erroneous.

I have already found that CMS has established a *prima facie* case that Petitioner was not in substantial compliance with federal requirements for nursing facilities participating in the Medicare and Medicaid program. Furthermore, I sustain CMS's finding that Petitioner's level of non-compliance for both these deficiencies constitutes immediate jeopardy.

The regulations define immediate jeopardy as a situation in which a provider's non-compliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident. 42 C.F.R. § 488.301. A finding of immediate jeopardy does not require a finding of actual harm but also encompasses a situation that is likely to cause harm. The burden rests on Petitioner to prove that CMS's determination of immediate jeopardy is clearly erroneous. Petitioner has not met that burden here.

Petitioner has never seriously denied the occurrence of the deficiencies themselves. The main thrust of Petitioner's case is that these deficiencies do not amount to immediate jeopardy. Petitioner alleges that "[n]ot only did [R-1] never cause any injury, his aggressive behavior was of such low magnitude that his actions *never resulted in any need for medical treatment, any bruising, any first aid, or even any need for band-aids or ointments*." P. Br. at 31 (italics in the original). Petitioner misunderstands the nature of the term "immediate jeopardy." No showing of actual harm is necessary to establish Petitioner's failure to protect its residents exposed to immediate jeopardy by its failure to adequately supervise R-1 or its failure to fully investigate the incidents involving R-1. All that need be demonstrated is a likelihood of serious harm occurring. *See, e.g., Daughters of Miriam Center*, DAB No. 2067 (2007).

I have determined that YVS seems to have decided at some point that it would have to expect and accept a certain level of disruptive, even violent, behavior from R-1 and that the staff could not protect the other residents from R-1. Once Petitioner had reached this mindset, the evidence persuades me that it then it allowed itself to see R-1's attacks on others as *de minimis*. Even Dr. Wilson testified that R-1's behavior was merely "lightweight harassing behaviors." Tr. at 297. The attacks were something that on a school ground or in a recreation-center gym might amount to little more than rough-housing or horseplay, but at YVS and among its residents these behaviors were serious and risky business. The victims of R-1's outbursts were without exception vulnerable by reason of mental or physical disabilities, or both. In each case the attack came as R-1 rushed up and suddenly kicked, hit or shoved his victim, and ran off — all abruptly and without any sort of warning or prelude. R-1 was known to YVS to have caused bruising

to healthy staff members and was known to YVS to be able to increase his level of aggression when circumstances prompted him to do so. Tr. at 335. In one case R-1 grabbed his victim and thrust his arm down the victim's trousers. Now, although the emotional effects of these assaults on their victims is a fairly obvious subject of concern, it is true that there is no serious argument that any bruising, bleeding, torn clothing, or other obvious physiological injury resulted from the attacks. This absence of physiological damage may be the reason that YVS has maintained that the incidents cannot even be described fairly as "attacks."

Petitioner's argument is meritless. Petitioner overlooks the fact that its facility is a nursing home caring for vulnerable residents, not a playground or a gym. In one incident, R-7 expressed fear and anger which is clearly suggestive of psychological harm. In spite of R-7's fear and anger, R-1 was allowed to get close to R-7 and to speak to R-7 shortly after R-1 hit R-7. P. Br. at 15. Petitioner did not take any steps to protect R-7 after being hit by R-1. It was only fortuitous — indeed nothing other than extremely fortuitous — that R-1's physical assaults on vulnerable residents had not yet caused any of them actual physical harm.

The pattern of R-1's behavior was dangerous, unconsented-to by its victims, frightening to its 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. YVS's view of the incidents and its approach to controlling them and protecting other residents may in part be because Petitioner views itself as a residential habitation center, and perhaps sees its environment as more comparable to a village than for what it is: a certified nursing facility. The model of a village-like community is admirable in many ways, and nothing in this decision should be understood as critical of it as long as that model serves the purpose of ensuring the safety and happiness of the community's members. But in a community of those largely unable to protect themselves, YVS misunderstood its fundamental obligation to limit R-1's danger to them. As a result, YVS failed to investigate and document R-1's persistent and repeated outbursts adequately because YVS simply did not take them seriously enough and in context. The Board has held that "thorough investigations are critical in identifying not only what has happened in a particular incident but also in identifying 'patterns and trends that may constitute abuse.'" *Britthaven, Inc. d/b/a/Britthaven of Smithfield*, DAB No. 2018, at 12 (2006). A facility has "a duty to investigate a possible incident of abuse sufficiently so that it and its staff are apprised of all the facts necessary to form a reasoned conclusion as to what happened so as to protect residents from additional abuse." *Singing River Rehabilitation & Nursing Center*, DAB CR1838, at 14 (2008).

Given the vulnerability of the other residents at YVS, R-1's physical attacks were serious. The victims of R-1's outbursts were without exception quite typical of that population, vulnerable by reason of mental or physical disabilities, sometimes both. R-

1's victims included: R-2, who was profoundly mentally retarded and unable to communicate in a meaningful manner; R-5, who was severely mentally retarded and had expressive language difficulties; R-6, who was mentally retarded, had expressive and receptive aphasia (difficulty receiving and expressing information), had impaired mobility and was in a wheelchair for a period of time; R-7, who was wheelchair-bound and expressed anger and fear after R-1's attack; R-8, who was unable to communicate meaningfully and had gait problems; and R-9, who displayed severe mental retardation, hearing loss, and was wheelchair-bound. YVS's failure to thoroughly investigate the seven incidents of R-1's aggressive behavior and its failure to adequately supervise R-1 left the other residents, particularly those in cottages103 and 104, unprotected from serious abuse. Therefore, I cannot find CMS's determination of immediate jeopardy for both these deficiencies clearly erroneous.

6. The deficiencies constituted substandard quality of care and revocation of Petitioner's NATCEP is mandated.

As a matter of law, CMS must revoke Petitioner's NATCEP for a period of two years. As a result of an extended survey, Petitioner was found to manifest substandard quality of care and deficiencies at a level of immediate jeopardy. Consequently, loss of NATCEP for a period of two years is mandated. Act § 1819(f)(2)(B)(iii)(I)(b).

/s/
Richard J. Smith
Administrative Law Judge