Department of Health and Human Services
DEPARTMENTAL APPEALS BOARD
Appellate Division

Green Oaks Health and Rehabilitation Center
Docket No. A-13-117
Decision No. 2567
March 31, 2014

FINAL DECISION ON REVIEW OF ADMINISTRATIVE LAW JUDGE DECISION

Green Oaks Health and Rehabilitation Center (Green Oaks), appeals the July 18, 2013 decision of an Administrative Law Judge (ALJ) finding that Green Oaks was not in substantial compliance with two Medicare requirements for nursing facilities from July 7 through 26, 2011, and that the noncompliance with one requirement was at the immediate jeopardy level on July 7 and 8, 2011. *Green Oaks Health & Rehab. Ctr.*, DAB No. CR2861 (2013) (ALJ Decision). The ALJ sustained the imposition of civil money penalties (CMPs) of $3,650 per day for July 7 and 8, 2011 and $450 per day from July 9 through 26, 2011.

For the reasons explained below, we sustain the ALJ Decision as to the ALJ's findings of noncompliance with 42 C.F.R. §§ 483.13(c)(2) and 483.25(h), and as to his determinations that CMS's immediate jeopardy determination was not clearly erroneous and that the CMPs were reasonable. CMS did not appeal the ALJ's determinations that the facility was in substantial compliance with the requirement in section 483.13(c) that facilities implement policies against neglect and the requirements in section 483.13(c)(3) and (4) that facilities conduct thorough investigations of incidents of alleged neglect and abuse and report the results to the state agency within five days. Accordingly, we do not reach those determinations.

Legal Background

The Social Security Act (Act) sets forth requirements for nursing facility participation in the Medicare or Medicare programs and authorizes the Secretary of Health and Human Services to promulgate regulations implementing those statutory provisions. Act § 1819.[1] The Secretary's regulations are found at 42 C.F.R. Part 483. To participate in the Medicare program, a nursing facility must maintain substantial compliance with program requirements set out in Part 483.

[1] The current version of the Act can be found at http://www.ssa.gov/OP_Home/ssact/ssact-toc.htm. Each section of the Act on that website contains a reference to the corresponding United States Code chapter and section.

The Secretary contracts with state survey agencies to conduct periodic surveys to determine whether nursing facilities are in substantial compliance. Act § 1864(a); 42 C.F.R. § 488.20. The regulations require that each facility be surveyed once every twelve months, and more often if necessary, to ensure that identified deficiencies are corrected. Act § 1819(g)(2)(A); 42 C.F.R. §§ 488.20(a), 488.308. Survey findings are reported in a Statement of Deficiencies (SOD). A "deficiency" is a defined as a "failure to meet a participation requirement specified in the Act or in [42 C.F.R.] part 483." 42 C.F.R. § 488.301. Section 488.301 defines "substantial compliance" as "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." *Id.* Any "deficiency that causes a facility to not be in substantial compliance" constitutes "noncompliance." *Id.* Noncompliance is at the "immediate jeopardy" level when a nursing facility's noncompliance "has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident." *Id.*

CMS may impose remedies on a facility not in substantial compliance with the participation requirements, including per-day CMPs. 42 C.F.R. §§ 488.406, 488.430(a). A per-day CMP may accrue from the date the facility was first out of substantial compliance until the date it is determined to have achieved substantial compliance. *Id.* § 488.440(a)(1), (b). For noncompliance determined to pose immediate jeopardy, CMS may impose per-day CMPs in amounts ranging from $3,050-$10,000 per day. *Id.* §§ 488.408(e)(2)(i), (ii), 488.438(a)(1). For noncompliance at less than the immediate jeopardy level, CMS may impose per-day CMPs in amounts ranging from $50-$3,000 per day. *Id.* §§ 488.408(d)(1)(iii), 488.438(a)(1).

Factual Background[2]

The following facts are not disputed. Green Oaks is a nursing facility in Athens, Texas that participates in Medicare and Medicaid. Both noncompliance findings at issue involve an incident on July 2, 2011, when a 90-year-old resident identified as Resident 1 was found dead on the floor of his room near his wheelchair. Resident 1 suffered from Parkinson's disease, atrial fibrillation with chest pain and irregular pulse, anemia with weakness, dementia, and macular degeneration or glaucoma. He was assessed as having a history of falls, as being at high risk for falls, and as at risk for injury due to tremors and involuntary muscle movement. He required assistance from one or two staff for his activities of daily living. The resident had unobserved falls on January 25, January 30, and February 5, 2011, all of which occurred when he attempted to transfer himself from his wheelchair. Five care plans between August 3, 2010 and February 5, 2011 refer to

[2] The factual information in this section, unless otherwise indicated, is drawn from undisputed findings of fact in the ALJ Decision and the record before him and is presented to provide a context for the discussion of the issues raised on appeal. Nothing in this section is intended to replace, modify, or supplement the ALJ's findings of fact or conclusions of law.

falls he suffered in his room and list the same 12 interventions: notify the physician; assess for injuries; do not move until assessment, including vital signs, is completed; treat as ordered by the physician; complete a new fall assessment; monitor for the cause of the fall and eliminate the cause if possible; assess need for safety equipment or change in footwear; initiate a rehabilitation screen; assess for change in physical condition such as an infection; assess for a bowel and bladder program; assess for changes in the environment; and notify the family. On September 1, 2010, Resident 1's physician ordered that a chair alarm be used when he was up in his wheelchair to alert staff and to remind Resident 1 to request assistance with transfers. Orders dated September 14 and December 30, 2010 required alarms for both the wheelchair and the bed. The resident had a history of turning off the alarm on his wheelchair.

After Resident 1 had fallen from his chair on January 25 and January 30, 2011, Green Oaks on January 31, 2011 had in an in-service training for its staff where the facility announced that if a resident in a wheelchair with a chair alarm is taken to the resident's room, the resident must be placed in bed and not left unattended in his wheelchair. Green Oaks had already had an in-service training for its staff on June 1, 2010, where the facility announced that a resident with a chair alarm was not to be left unattended in the bathroom or while using the toilet.

Sometime before noon on July 2, 2011, Resident 1 was left unattended in his room in his wheelchair by a CNA. That CNA later reported that she had turned on the chair alarm and left the room to assist a second CNA and then left to work in a different corridor. The second CNA testified that the resident's room was in her line of sight when she was in the hall, but that she left the hall for a period of time without asking anyone to watch the resident. When she returned, she found the resident on the floor and the chair alarm was not sounding. Several staff testified that the alarm was off. The resident was pronounced dead at approximately noon on July 2, 2011. Witnesses differed over whether the resident had a large hematoma between his eyes when he was found on the floor, with some stating that what was observed was a prominent vein, not a hematoma. The administrator of Green Oaks' facility was told, on July 2, 2011, of this incident involving Resident 1.

The Texas Department of Aging and Disability Services (state agency) conducted a survey of Green Oaks' facility from July 6 through 8, 2011 and determined Green Oaks was not in substantial compliance with several quality of care requirements in the regulations in its care of Resident 1 and other residents who were at risk for falls, and that one of the instances of noncompliance posed immediate jeopardy to resident health and safety on July 7 and 8, 2011. CMS proposed enforcement remedies including a CMP of $5,650 per day for July 7 and 8, 2011, and of $1,000 per day for the period July 9 through July 26, 2011. CMS subsequently determined that Green Oaks returned to substantial compliance on July 27, 2011, and imposed reduced CMPs of $3,650 per day for July 7 and 8, 2011 and $450 per day for the period July 9 through 26, 2011.

The ALJ received the parties' briefs and exhibits and conducted an in-person evidentiary hearing on June 4, 5, and 6, 2013. In his decision, the ALJ determined that Green Oaks, as evidenced by its care of Resident 1, was noncompliant with requirements of the regulations obliging facilities to provide adequate supervision and assistance devices to avoid accidents (42 C.F.R. § 483.25(h)), and to immediately report to the state agency alleged violations of facility policies prohibiting neglect (42 C.F.R. § 483.13(c)(2)). The ALJ rejected CMS's allegation that Green Oaks was also noncompliant with the requirement at section 483.13(c) that facilities develop and implement policies and procedures prohibiting mistreatment, neglect, abuse, or misappropriation of resident property, and requirements at 483.13(c)(3) and (4) that a facility thoroughly investigate allegations of neglect and abuse and report the results of investigations to the state agency within five days. ALJ Decision at 7, 13-14, 18-19. CMS did not appeal those ALJ determinations. The ALJ sustained as not clearly erroneous CMS's determination that the noncompliance with the requirement to provide adequate supervision and assistance devices to avoid accidents posed immediate jeopardy on July 7 and 8, 2011. *Id*. at 24-31. He also sustained the CMP amounts as reasonable.[3] *Id*. at 31-33.

The record before the Board consists of the record before the ALJ, the parties' briefs, and the transcript of an oral argument convened at Green Oaks' request on February 5, 2013.

Analysis

1. The ALJ's determination that Green Oaks was not in substantial compliance with 42 C.F.R. § 483.25(h) is supported by substantial evidence and free of legal error.

The introductory language of the quality of care regulation at 42 C.F.R. § 483.25 states that "[e]ach resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care." Section 483.25(h) requires that a facility "must ensure that … [t]he resident environment remains as free of accident hazards as is possible," § 482.25(h)(1), and that "[e]ach resident receives adequate supervision and assistance devices to prevent accidents," § 482.25(h)(2).

[3] The ALJ also concluded that Green Oaks' noncompliance rendered Green Oaks ineligible by law to be approved to conduct a nurse aide training program for a period of two years. ALJ Decision at 4-5. However, he found that Green Oaks had no right to review of that determination because the parties agreed that Green Oaks did not have an approved nurse aide training program at the time of the survey. *Id*. at 4-5, 33. Neither party disputed that determination.

Numerous Board decisions have explained the requirements under section 483.25(h)(2).[4] For example, the Board has held that section 483.25(h)(2) requires a facility to 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." *Briarwood Nursing Ctr.*, DAB No. 2115, at 5 (2007), *citing Woodstock Care Ctr. v. Thompson*, 363 F.3d 583, at 589 (6th Cir. 2003) (facility must take "all reasonable precautions against residents' accidents"), *affirming Woodstock Care Ctr.*, DAB No. 1726 (2000). A facility must also "provide supervision and assistance devices that reduce known or foreseeable accident risks to the highest practicable degree, consistent with accepted standards of nursing practice." *Century Care of Crystal Coast*, DAB No. 2076, at 6-7 (2007), *aff'd, Century Care of Crystal Coast v. Leavitt*, 281 F. App'x 180 (4th Cir. 2008).

The Board has also held that where a facility in its policies or care plans requires that specific measures be taken in caring for residents, those measures are evidence of the facility's evaluation of what must be done to attain or maintain a resident's "highest practicable physical, mental, and psychosocial well-being" as required by the overarching introductory language to section 483.25. *Azalea Court*, DAB No. 2352, at 9 (2010) (citations omitted), *aff'd, Azalea Court v. U.S. Dep`t of Health & Human Servs.*, 482 F. App'x 460 (11th Cir. 2012). Thus, for example, where a facility developed a plan of care to prevent a resident from eloping, its failure to provide the degree of monitoring and supervision the plan of care required evidenced noncompliance with section 483.25(h). *Cedar Lake Nursing Home*, DAB No. 2288, at 6-7 and 7 n.4 (2009) *aff'd, Cedar Lake Nursing Home v. U.S. Dep't of Health & Human Servs.*, 619 F.3d 453 (5th Cir. 2010).

The ALJ found in relevant part that:

- A fall by Resident 1 was foreseeable because he was assessed as having a history of falls from his wheelchair and as being at high risk for falls.

- Green Oaks had, in an in-service training session on January 31, 2011, "announced policies to staff regarding the supervision required for residents with an order for an alarm in their wheelchair" that required that if a resident in a wheelchair with a chair alarm is taken to the resident's room, the resident must be placed in bed and not left unattended in his wheelchair. Green Oaks had previously instructed its staff during an in-service training session on June 1, 2010 that a resident with a chair alarm was not to be left unattended in the bathroom or while using the toilet.

[4] CMS and the ALJ did not specify the applicable subsection of the regulation with which Green Oaks was noncompliant, but based their findings of noncompliance on lack of supervision, which is addressed in subsection (h)(2).

- Green Oaks' staff violated the facility's in-service instructions and failed to provide adequate supervision and assistance devices to prevent accidents by leaving Resident 1 unattended in his room in an alarmed wheelchair on July 2, 2011, after which the resident fell from his wheelchair and the alarm in his chair failed to sound. The fact that the alarm did not sound when Resident 1 fell from his chair showed that the alarm was either off or malfunctioning, and in either case that intervention was not effective at the time of the fall.

ALJ Decision at 8-11, 21-22, citing CMS Ex. 12, and P. Ex. 2 at 1, 4. The ALJ thus concluded that Green Oaks violated 42 C.F.R. § 483.25(h), and that the violation posed a risk for more than minimal harm and was a basis for the imposition of an enforcement remedy. *Id*. at 19.

Green Oaks chiefly argues that the ALJ erred by relying on the January 31, 2011 in-service training that instructed staff not to leave a resident with a chair alarm unattended in the wheelchair in the resident's room. Green Oaks does not dispute that its staff were given those instructions, but argues that they were not facility policy or protocol or required by regulation and were "unworkable and impractical." RR at 24; *see* Transcript (Tr.) of Oral Argument at 9 ("that in-service [is] not a facility protocol, it's not a facility policy, it's certainly not a regulatory requirement [and] makes absolutely no sense the way that it's worded"). Further, Green Oaks argues that a chair alarm does not prevent a fall in any event. Green Oaks' arguments are not persuasive. The ALJ carefully considered the same arguments below and rejected them, and we conclude that his analyses are well-founded.

In section 3 of this analysis addressing the ALJ's determination that Green Oaks was not in substantial compliance with 42 C.F.R. § 483.13(c)(2), we reject Green Oaks' argument that the in-service instructions were not part of the facility's "policies." Even if they were not considered to be part of the facility's policies, however, Green Oaks was still obliged to apply the in-service instructions not to leave the resident unattended in his room in his alarmed wheelchair because those instructions represented the facility's determination on how to care for the resident and other residents who were similarly situated, and ensure that he received adequate supervision to prevent accidents. Green Oaks concedes that it did not follow those instructions for Resident 1 on July 2, 2011.

Green Oaks argues that it should not be faulted for the failure to follow the in-service instructions on July 2, 2011 because chair alarms do not prevent falls. The ALJ found, however, that a wheelchair alarm could prevent a fall if staff were near enough to respond in time, and he pointed out that the physician's order for the chair specifically stated that one purpose of the alarm was "to alert staff." ALJ Decision at 22, citing P. Ex. 5, at 1; *see also Community Skilled Nursing Centre*, DAB No. 1987, at 13 n.7 (2005) (finding that a chair alarm can prevent falls if staff reach a resident after the activation of an alarm and before a fall or if the alarm reminds a forgetful resident not to try to walk). Green

Oaks' argument that chair alarms do not prevent falls is true only if staff are not close enough to respond to an alarm, which supports the ALJ's conclusion that staff's failure to follow in-service instructions to remain in the resident's room while he was in the wheelchair violated section 483.25(h)(2). As the ALJ noted, the in-service training was the only new intervention to address Resident 1's fall risk after January 2011 and was apparently followed by staff until July 2, 2011, when the instructions were not followed and the resident fell. ALJ Decision at 23.

Green Oaks does not state on appeal why the in-service instructions were "completely unworkable and impractical." RR at 24. From the ALJ Decision it is apparent, however, that Green Oaks is referring to the testimony of its director of nursing, which the ALJ cited, that staff cannot make a resident in an alarmed wheelchair get into bed, and Green Oaks' argument that one-on-one care had not been ordered for the resident. ALJ Decision at 11. Green Oaks argues that the physician's order for a chair alarm to alert staff meant that the physician did not intend Resident 1 to have one on one supervision and expected he would at times be unattended. RR at 8. Even though a physician did not order that the resident receive one-on-one care, a chair alarm could still have been effective in alerting nearby staff if the resident fell or attempted to transfer while outside his room in the common areas of the facility. The physician's order for a chair alarm thus does not compel a conclusion that the physician expected the resident to be unsupervised while in the wheelchair in his room, where he might be more likely to attempt to self-transfer to bed, placing him at increased risk for falls. The ALJ did not address the director of nursing's testimony that a facility cannot make a resident get into bed. It is not clear, in any case, why a facility would have to compel a reluctant resident to get into bed, as opposed to have someone remain with the resident on occasions when bed was unacceptable or else move the resident to a shared space instead of leaving the resident alone in the room. The ALJ found, however, that staff were aware of the in-service instruction and apparently followed it. Green Oaks does not argue that staff attempted to follow the in-service instruction with Resident 1 on July 2, 2011 and that the resident refused to get into bed. Green Oaks also cites no documentation that it determined prior to July 2 that chair alarms were an ineffective intervention for residents at risk for falls such as Resident 1, either because staff could not make him get into bed or for any other reason, and Green Oaks does not allege on appeal that it communicated to staff any disavowal or revocation of the in-service training instructions.

Green Oaks also argues that the ALJ "equated an isolated statement in a facility in-service … to a regulatory standard" which "sends a very dangerous message." RR at 24. This argument has no merit. That the regulatory standards of care do not require specific interventions does not lessen Green Oaks' obligation to implement those measures that it has, through its directions to its staff, determined are necessary to prevent accidents. The Board "has explained that the federal requirements are based on an 'outcome-oriented' approach, in which the regulations establish outcomes facilities must achieve, but provide each facility with flexibility to select methods to achieve them that are appropriate to its

own circumstances and needs." *Azalea Court* at 9 (citations omitted). The Board there rejected the facility's argument that section 483.25(h) did not require it to take specific measures to prevent resident elopements and safeguard wheelchair-bound residents who smoked. The Board stated that a facility's "failure to take measures that are reasonably necessary, under the circumstances," to achieve an outcome required by the regulation "is indeed evidence of noncompliance, *even though the regulation does not specify the particular measures that the facility must or may take to achieve these outcomes*." *Id*. (emphasis added). Similarly, the Board stated in *Glenoaks Nursing Ctr*., DAB No. 2522 (2013) that the regulations "permit facilities some flexibility in choosing the methods they use to provide supervision or assistive devices to prevent accidents, so long as the chosen methods constitute an adequate level of supervision for a particular resident's needs" and that a facility, in choosing its methods, "is obligated to anticipate reasonably foreseeable accidents that might befall a resident and take steps – such as increased supervision or the use of assistance devices, for example – calculated to prevent them." *Glenoaks Nursing Ctr*. at 8, citing *Windsor Health Care Ctr.*, DAB No. 1902, at 5 (2003), *aff'd, Windsor Health Care Ctr. v. Leavitt*, 127 F. App'x 843 (6th Cir. 2005), and *Aase Haugen Homes, Inc.*, DAB No. 2013 (2006).

Here, the facility exercised the flexibility permitted by the regulation when it determined to address the risk of falls by residents such as Resident 1, who had a history of falls and was determined to be at high risk of falls, by instructing its staff not to leave residents with chair alarms in their wheelchairs unattended in their rooms. Those instructions represented the facility's determination of a measure staff was to take to ensure that residents at risk for falls received adequate supervision to prevent accidents, as required by section 483.25(h)(2). The ALJ found that Green Oaks provided the in-service training in response to the falls Resident 1 experienced in January 2011; that the in-service instructions were "followed and a practice in the facility" from January 31, 2011 until the resident fell on July 2, 2011; that facility staff including the director of nursing and the CNA responsible for Resident 1's care were aware of the in-service instructions; and that staff reported to the facility administrator that another CNA had left Resident 1 in his wheelchair unattended in his room contrary to those instructions. ALJ Decision at 8, 10-12, 16, 21. Green Oaks on appeal does not dispute these specific findings. Green Oaks does deny that the resident "had an extensive history of falls" and argues that his risk for falls had decreased, but does not dispute that he remained at risk for falls or that he had fallen in his room three times in January and February 2011 while attempting to transfer from his wheelchair. RR at 8, 10; CMS Ex. 8, at 20-24, 28.

Thus, Green Oaks' in-service training instructions represented Green Oaks' determination of how its staff should best care for residents who had been provided chair alarms to address their risk of falls, and its failure to follow those instructions amounted to failure to provide the level of supervision of Resident 1 that it determined was needed to prevent falls. *See* ALJ Decision at 23 (Green Oaks' "failure to ensure the interventions requiring supervision were effectively implemented, supports the conclusion that

Petitioner failed to take all reasonable steps to prevent an accidental fall from the wheelchair, or to mitigate the risk for harm due to such an accident."). Green Oaks' failure to follow the in-service instructions is accordingly evidence of its noncompliance with the requirement in section 483.25(h) to provide adequate supervision to prevent accidents.

Even if Green Oaks' failure to follow the in-service instructions not to leave a resident with a chair alarm unattended in a wheelchair in the resident's room were not evidence of noncompliance with section 483.25(h)(2) (which we conclude it is), we would still conclude that the ALJ did not err in finding that Green Oaks was not in substantial compliance with the regulation. Green Oaks was required to demonstrate that it took "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." *Glenoaks* at 7-8. The order for a chair alarm and other interventions in place as of the resident's prior falls in January and February 2011 were clearly not adequate to prevent the resident from falling three times when attempting to transfer himself from his wheelchair. As the ALJ noted, the implementation of the policy from the in-service instruction was the only new intervention to address Resident 1's fall risk during the period January 31 to July 2, 2011. ALJ Decision at 23. As the ALJ pointed out, Green Oaks knew that the resident had disabled his chair alarm in the past yet Green Oaks identified no intervention to address this problem. *Id*. at 22. Thus, we agree with the ALJ that the alarm in itself was not an effective intervention at the time of the fall and that the facility had failed to assess the need to modify existing interventions or adopt new interventions in light of the information it had about the issues with the resident's alarm.

Green Oaks cites an ALJ decision reversing CMS's findings of noncompliance with sections 483.13(c) and 483.25(h) as holding that a facility should not be held liable for "failure to follow an impractical in-service 'directive'" where the facility "did all that it could reasonably be expected to do in caring for" a resident. RR at 26-27, *citing Mabee Health Care Ctr.*, DAB CR2525 (2012). However, that decision demonstrates no error in the ALJ Decision here. First, ALJ decisions do not carry precedential weight and are not binding on the Board or other ALJs. *Lopatcong Ctr.*, DAB No. 2443, at 12 (2012); *Universal Health Care – King*, DAB No. 2383, at 9 (2011). Second, the present case is distinguishable from *Mabee* regarding section 483.25(h) because Green Oaks here did not show that it took effective measures to address the resident's risk of falls and the facts are otherwise not analogous. *See* CR2525, at 11-13 (ALJ found "no evidence that [the resident] suffered an accident or fall" and that staff "did all that it reasonably could be expected to do in caring for" the resident).

We thus conclude the ALJ's determination that Green Oaks was not in substantial compliance with section 483.25(h) was supported by substantial evidence and free of legal error.

2. The ALJ did not err in concluding that CMS's determination that the noncompliance with 42 C.F.R. § 483.25(h) posed immediate jeopardy was not clearly erroneous.

Immediate jeopardy exists when a nursing 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. CMS's determination as to the level of noncompliance of a nursing facility in a CMP case – which includes that the noncompliance posed immediate jeopardy – "must be upheld unless it is clearly erroneous." *Id*. § 498.60(c)(2). As the ALJ noted, this requirement places "a heavy burden" on a facility to overturn CMS's finding of immediate jeopardy. ALJ Decision at 24; *Magnolia Estates Skilled Care*, DAB No. 2228, at 23 (2009).

The ALJ found that Green Oaks' failure to observe its policy not to leave residents with chair alarms unattended in their wheelchairs in their rooms posed immediate jeopardy to at least seven of Green Oaks' residents who, like Resident 1, were at risk for falls and had been given alarms, because they were "were at risk for likely serious harm, injury, impairment, or death due to" that failure. ALJ Decision at 30. Such residents, he found, were at risk for contusions, fractures, head injuries, and resulting death due to falls from their wheelchairs, beds, or toilets. *Id*. He found the immediacy or likelihood that serious injury, harm, impairment, or death would result in the near future to be "evident from the number of residents at risk and the fact that Resident 1 fell from his chair when unsupervised." *Id*.

Green Oaks asserts that it "implemented (and subsequently re-evaluated) measures to minimize the risk of any similar incident occurring with another resident in the future" and that "[t]his was confirmed by the surveyors who could find no actual or potential harm to any resident in the facility at the time of the survey." RR at 36-37, citing Tr. at 259-60, 384-85, 967-69. This assertion misstates the testimony and the basis for the immediate jeopardy determination. One surveyor testified that she and another surveyor did not "identify in the [SOD] any specific resident" who was in danger of immediate harm when the surveyor was in the facility. Tr. at 384. There was no reason, however, for the surveyors to provide the facility with the identities of individual residents who were at risk of harm from Petitioner's noncompliance, because during the survey the facility itself furnished that information: the director of nursing provided the surveyors with a list of seven residents with personal alarms. CMS Ex. 4, at 20 (SOD). Both surveyors confirmed that the risk posed to such other residents by the facility's noncompliance was a basis for the immediate jeopardy determination. Tr. at 166, 385. Green Oaks' citation of the testimony of one of the surveyors that the incident with

Resident 1 was the only "incident" of which she was aware thus has no bearing on the risk posed to those other residents. Tr. at 259-60. The facility also acknowledged that there were other residents at risk for falls, and a CNA testified that there were other residents at the facility with the same kind of alarm as the facility used with Resident 1. Tr. at 38-39, 469. Green Oaks has not shown that the surveyors (or the state agency or CMS) ever determined that the noncompliance with section 483.25(h)(2) did not pose a risk of serious harm to residents other than Resident 1.

The ALJ thus correctly found Resident 1's death did not diminish the risk of serious harm posed by the facility's noncompliance to the other residents at risk for falls who had alarms. *See* ALJ Decision at 30 (noting SOD statement that seven other residents were at risk for accidents and injury due to Green Oaks' noncompliance). He also correctly rejected Petitioner's argument that any immediate jeopardy ceased with the death of Resident 1. *Id.*

Green Oaks also argues that under CMS's guidance to surveyors in Appendix Q to its State Operations Manual (SOM), the deficiency under section 483.25(h) should not have been cited at the immediate jeopardy level because the facility did not bear "culpability" for the noncompliance. RR at 35-37. Appendix Q lists culpability as one of three components of immediate jeopardy that surveyors address in evaluating the information garnered in survey. *See Pinecrest Nursing & Rehab. Ctr.*, DAB No. 2446, at 18-19 (2012) citing SOM App. Q § V(C).[5] However, "culpability" as used in Appendix Q "is not a part of the regulatory definition of immediate jeopardy." *Pinecrest Nursing & Rehab. Ctr.* at 21, citing 42 C.F.R. § 488.301, and *N. Car. State Veterans Nursing Home, Salisbury*, DAB No. 2256, at 17 (2009). The Board has held that the SOM is "guidance issued by CMS on the issue of immediate jeopardy" that "is instructive, but unlike the regulations, it is not controlling authority." *Agape Rehab. of Rock Hill*, DAB No. 2411, at 19 (2011); *see also Foxwood Springs Living Ctr.*, DAB No. 2294, at 9 (2009) ("While the SOM may reflect CMS's interpretations of the applicable statutes and regulations, the SOM provisions are not substantive rules themselves."). Thus, even if Green Oaks were not culpable for the noncompliance, it would not render CMS's determination of immediate jeopardy clearly erroneous. In any event, contrary to the facility's contention, the ALJ found the facility was culpable because staff had been trained not to leave a resident with an alarm unattended in the bathroom or his or her room but did so anyway, and because the facility did not show that after Resident 1's fall on July 2, it took action to ensure that this policy was enforced or that other effective interventions were implemented for the other residents with alarms and at risk for falls. ALJ Decision at 30. As discussed above, Green Oaks does not dispute that staff were aware of the requirements of the in-service instructions.

[5] The SOM is available at http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS1201984.html.

Green Oaks further argues, as it did below, that CMS's not having cited Green Oaks' noncompliance with section 483.13(c) at the immediate jeopardy level barred CMS from finding that the noncompliance with section 483.25(h) posed immediate jeopardy because both findings stem from the incident involving Resident 1 and "[a]n incident either is or is not immediate jeopardy, and here the surveyors determined twice that it was not." RR at 37. The ALJ rejected this argument on the grounds that: (1) it did not address Green Oaks' burden of showing that the immediate jeopardy determination was clearly erroneous; and (2) Green Oaks' failure to report the alleged neglect to the state agency as specifically required by section 483.13(c) "did not bear directly upon the quality of care delivered to residents as did the deficiency under [section 483.25(h)]." ALJ Decision at 30-31. Green Oaks did not address the ALJ's reasons and has shown no error in them. Green Oaks has identified no persuasive reason why it was unreasonable for CMS to determine that the facility's failure to timely report the alleged neglect of Resident 1 did not pose the same likelihood of harm to other residents at risk for falls as did the neglect itself, i.e., Green Oaks' failure to follow its policy for the care of residents with chair alarms, which could directly impact those residents. Immediate jeopardy attaches to the consequences threatened by a particular failure to comply with regulatory requirements and is not limited to the incident that may expose the presence of the noncompliance.

We accordingly conclude Green Oaks did not meet its burden of showing that CMS's immediate jeopardy determination was clearly erroneous.

3. The ALJ's determination that Green Oaks was not in substantial compliance with 42 C.F.R. § 483.13(c)(2) is free of legal error and supported by substantial evidence.

The ALJ also concluded Green Oaks was not in substantial compliance 42 C.F.R. § 483.13(c)(2). Section 483.13(c) requires that nursing facilities have "written policies and procedures that prohibit mistreatment, neglect, and abuse of residents," and subsection (c)(2) requires, as relevant here, that a facility "ensure that all alleged violations involving neglect, or abuse, including injuries of unknown source … are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency)." Provisions of Texas law the ALJ cited require the owner or employee of a long-term care facility to report immediately to the state agency, the Texas Department of Aging and Disability Services, if he has cause to believe that the physical or mental health or welfare of a resident has been or may be adversely affected by neglect, and to report immediately on learning of the alleged abuse, neglect, or exploitation. ALJ Decision at 15, citing 40 Tex. Admin. Code §§ 19.601(c)(2), 19.602, and Tex. Health & Safety Code § 242.122(a), (c) (recodified September 28, 2011 without substantive changes as Tex. Health & Safety Code § 260A.002(a), (c)).

The ALJ found that having left the resident unattended in his room in his alarmed wheelchair contrary to the in-service training instructions "arguably amounted to neglect" because it entailed a failure to deliver necessary services – *i.e.*, appropriate supervision – necessary to prevent physical harm. *Id*. at 14. The ALJ further found that staff had reported to the administrator that a CNA had left Resident 1 in his alarmed wheelchair unattended in his room but the administrator "failed to report to the state agency immediately as required by both Texas and federal law the alleged neglect by [the] CNA[.]" *Id*. at 16. The ALJ concluded that Green Oaks was noncompliant with section 483.13(c)(2) because "it is undisputed that [Green Oaks'] Administrator and [director of nursing] failed to report the alleged incident of neglect immediately to the state agency as required" by that regulation, and that the administrator's "failure to recognize an allegation of neglect and to notify the state agency immediately posed a risk for more than minimal harm to other residents in the facility subject to physical or mental harm due to neglect." *Id*.

As noted above, Green Oaks argues that the ALJ erred by relying on the January 31, 2011 in-service training that instructed staff not to leave a resident with a chair alarm unattended in the wheelchair in the resident's room as showing that the facility had a policy that a resident with a chair alarm, such as Resident 1, was not to be left unattended in the wheelchair in the resident's room. Green Oaks argues that the in-service instructions were not facility policy because during the hearing a state surveyor "admitted that an in-service is <u>not</u> a facility's protocol" and because the facility's "fall risk policy/protocol does not state anywhere that residents are not to be left unattended in their rooms if they have a personal alarm." RR at 14, citing Tr. at 404 (Green Oaks' emphasis), and P. Ex. 1.

This argument has no merit. The surveyor testified that she did not see the in-service instructions "carried over from that in-service into a formal policy," not that a facility's in-service instructions to its staff on how to care for residents at risk for falls do not constitute part of its overall policies staff applies in caring for those residents. Tr. at 404. The facility clearly treated the in-service instructions as a facility policy for certain residents within its population regardless of the form it took. We therefore agree with the ALJ that Green Oaks' not having incorporated its in-service training instructions into its formal written policies does not mean that it was not obliged to follow those instructions in caring for residents who had been provided chair alarms to address their risk of falls. *See* ALJ Decision at 23 ("[Green Oaks] must be bound by its *announced* policy or protocols, even though not reduced to writing") (emphasis added).

Green Oaks, while not disputing that it failed to follow the requirements of the in-service training and did not report that failure to the state agency, nevertheless argues that the ALJ erred by going "outside the finding of the state" in the SOD that Green Oaks "**<u>failed to investigate and report a death involving unusual circumstances</u>** to the state agency for 1 of 3 residents sampled for falls (Resident #1)." Oral Argument Tr. at 6; RR at 23,

citing CMS Ex. 4, at 2 (SOD) (Green Oaks' emphasis). Green Oaks argues that the SOD "clearly state[s] the violation is predicated on failure to report a death involving unusual circumstances" and "doesn't say failure to report neglect" and that it is "not proper for an ALJ … to go outside the basic allegation in the Statement of Deficiencies." Oral Argument Tr. at 5, 8.

The ALJ rejected that argument, and the record supports his determination. The SOD fully states the requirements of section 483.13(c), including the requirement at paragraph (c)(2) that "all alleged violations involving … neglect … are reported immediately to … officials in accordance with State law." CMS Ex. 4, at 1. Then, after the statement quoted by Green Oaks, the SOD further explains:

> Resident #1 had a history of falls from his wheelchair. The resident was to have a personal alarm when in his wheelchair and in his bed and **staff were not to leave Resident #1 in his wheelchair in his room unattended. On 7/2/11, the resident was left unattended in his room in his wheelchair.** The resident fell from his wheelchair and was found unresponsive on the floor in his room. The personal alarm was not sounding. The resident was pronounced dead a short time later. The facility did not thoroughly investigate **the incident or report to the state agency**.

Id. at 2 (emphasis added). This statement clearly informed Green Oaks of the connection between the deficiency determination and Green Oaks' failure to observe its requirement that the resident not be left unattended in his room in his wheelchair. Moreover, the plan of correction Green Oaks submitted in response to the SOD findings includes "[d]isciplinary action to CNAs who brought resident to room and CNAs who left resident unattended" among its corrective actions. *Id*. at 1. The plan of correction also states in several places that the facility had conducted and would conduct in-service training on abuse and neglect and would review the facility's abuse and neglect policy with all new hires. The ALJ found that Green Oaks had a policy that prohibited abuse, neglect, and misappropriation of resident property, which policy defined neglect as "failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness." ALJ Decision at 12, quoting CMS Ex. 9, at 3, and P. Ex. 12, at 3. Green Oaks' policy required any employee who becomes aware of an allegation of abuse, neglect, or misappropriation to report to a supervisor, the director of nursing, or the administrator immediately, and that Green Oaks report to the state agency in accordance with state law. *Id*., citing CMS Ex. 9, at 9, and P. Ex. 12, at 9. We thus agree with the ALJ that the surveyors' allegations contained in the SOD encompassed failure to report possible neglect and were clear enough to provide Green Oaks reasonable notice of what to defend in this case. ALJ Decision at 16, n.13.

Green Oaks also argues that provisions of Texas law the ALJ cited are not applicable because "[a]s the ALJ pointed out during the hearing, this case does not involve an allegation of abuse, neglect, or exploitation." RR at 6. Green Oaks appears to refer to, and misinterpret, the ALJ's observation that CMS under this deficiency did not cite Green Oaks for neglect, but for failing to report an allegation of neglect. Tr. at 265, 432. The ALJ concluded, however, that Green Oaks was noncompliant because "it is undisputed that [Green Oaks'] Administrator and [director of nursing] failed to report the alleged incident of neglect immediately to the state agency as required by 42 C.F.R. § 483.13(c)(2)." ALJ Decision at 14 (emphasis added). Green Oaks does not dispute the ALJ's finding that reporting requirements of Texas law the ALJ cited covered incidents of alleged neglect.

Green Oaks further argues, as it did before the ALJ, that there is no federal regulation specifically requiring reporting of resident deaths, and that Texas law requires the reporting of resident deaths only if the death occurs under unusual circumstances or there is cause to believe that the resident has been subjected to abuse, neglect, or exploitation. RR at 5-7. Green Oaks argues that this requirement did not apply because Resident 1 died of natural causes and not from a fall and might have died before he fell from the chair. *Id*. These arguments demonstrate no error in the ALJ Decision because the ALJ based his noncompliance determination on Green Oaks' failure to report alleged neglect stemming from its failure to follow its policy on caring for residents with chair alarms and not on any requirement to report a death. Green Oaks' arguments do not address, and show no error in, the ALJ's conclusion that Green Oaks was noncompliant for failing to report the alleged incident of neglect that occurred when Resident 1 fell from the wheelchair after staff admittedly failed to follow the in-service instructions that the resident not be left unattended in his room in his wheelchair.[6] While the ALJ "agree[d] with [Green Oaks] that CMS has cited no federal or state law that requires reporting a death to the state agency that may be enforced against" Green Oaks, he stated that "federal and state law clearly require immediate reporting when there is a failure to deliver services necessary to prevent or avoid harm to a resident" and that "the allegation that [the CNA] left Resident 1 unattended in his room, in his wheelchair … is an allegation of neglect" that had to be reported under section 483.13(c)(2). ALJ Decision at 17.

Accordingly, we sustain the ALJ's determination that Green Oaks was not in substantial compliance with section 483.13(c)(2).

[6] The ALJ accordingly did not rely on Green Oaks' expert testimony that the resident's death was not a death that had to be reported under Texas law. ALJ Decision at 16-17.

4. The ALJ's determination that the CMPs were reasonable was supported by substantial evidence and was not legally erroneous.

An ALJ or the Board determines de novo whether a CMP is reasonable based on facts and evidence in the appeal record concerning the factors specified in section 488.438. *See* 42 C.F.R. § 488.438(e), (f); *Senior Rehab. & Skilled Nursing Ctr.*, DAB No. 2300, at 19-21 (2010), *aff'd*, *Senior Rehab. & Skilled Nursing Ctr. v. Health & Human Servs.*, 405 F. App'x 820 (5th Cir. 2010); *Lakeridge Villa Healthcare Ctr.*, DAB No. 2396, at 14 (2011). Those factors are: 1) the facility's history of noncompliance, including repeated deficiencies, 2) its financial condition, 3) the severity and scope of the noncompliance and "the relationship of the one deficiency to other deficiencies resulting in noncompliance," and 4) the facility's degree of culpability, which includes neglect, indifference, or disregard for resident care, comfort or safety. 42 C.F.R. §§ 488.438(f), 488.404(b), (c)(1). With respect to culpability, however, "[t]he absence of culpability is not a mitigating circumstance in reducing the amount of the penalty." *Id*. § 488.438(f)(4). Once an ALJ has determined that CMS had a valid legal basis (namely, the existence of noncompliance) to impose a CMP, the ALJ (or the Board on appeal) may not reduce that CMP to zero or below the regulatory minimum amount. *Id*. § 488.438(e)(1); *Somerset Nursing & Rehab. Facility*, DAB No. 2353, at 26-27 (2010); *modified on other grounds, Somerset Nursing & Rehab. Facility v. U.S. Dep't of Health & Human Servs.*, 502 F. App'x 513 (6th Cir. 2012).

Green Oaks argues that the CMP amounts ($3,650 for the two days of immediate jeopardy on July 7 and 8, 2011 and $450 per day from July 9 through 26, 2011) are unreasonable because there was no resident harm, and because CMS "did not carry its burden of proof to establish the reasonableness" of the CMPs or "present any evidence that the proposed penalty amounts are justified, or that it followed the factors set forth in sections 488.438 and 488.404." RR at 38. Green Oaks also argues that "CMS did not affirmatively show that the facility was out of compliance on any day between July 9 and 26, 2011." *Id*.

The Board has held that a facility "bears the burden of introducing evidence or argument challenging specific regulatory factors at 42 C.F.R. § 488.438(f) for determining the reasonableness of the CMP amount." *Ridgecrest Healthcare Ctr.*, DAB No. 2493, at 12 (2013), citing *The Windsor House*, DAB No. 1942, at 62 (2004). There is, moreover, "a presumption that CMS has considered the regulatory factors" in setting the amount of the CMP "and that those factors support" the CMP amount CMS imposed. *Id*. at 13, citing *Coquina Ctr.*, DAB No. 1860, at 32 (2002).

Green Oaks has not met its burden of demonstrating that the CMP amounts are not supported by the regulatory factors. The ALJ found that Green Oaks had presented no evidence of its financial status and had not argued that it is unable to pay the CMP, and Green Oaks does not challenge those findings on appeal. ALJ Decision at 32. Green

Oaks concedes that, as the ALJ found, it had a prior citation for noncompliance with section 483.25 in July 2008, and does not dispute that it was cited for noncompliance with unspecified requirements of section 483.13(c) in November 2010. *Id*.; Oral Argument Tr. at 18. As discussed above, the ALJ's finding that the resident was left unattended despite staff awareness of the in-service training requirements supported his finding that Green Oaks was culpable for the noncompliance. The ALJ, moreover, in considering the regulatory factors, acknowledged the lack of evidence that the noncompliance had resulted in actual harm, but pointed to the presence of the other factors and noted that the per-day CMP amounts are at the low end of the authorized ranges, which he found appropriate. ALJ Decision at 32-33. We thus conclude that Green Oaks has not shown that the CMP amounts are unreasonable or that the ALJ failed to appropriately consider the regulatory factors. *See Ridgecrest Healthcare Ctr*. at 13 ("[b]ecause Ridgecrest did not proffer any relevant evidence that falls within the scope of the regulatory factors, we have no basis to conclude that the per-day amount of the CMP should be revised.").

Finally, Green Oaks has not argued, or provided any basis to conclude, that it corrected the noncompliance any earlier than CMS determined, and there is thus no ground to reduce the CMP on that basis. *See Owensboro Place & Rehab. Ctr*., DAB No. 2397, at 12 (2011) (facility "bears the burden of showing that it returned to substantial compliance on a date earlier than that determined by CMS," and Board "has rejected the idea that CMS must establish a lack of substantial compliance during each day in which a remedy remains in effect.").

Conclusion

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

/s/
Sheila Ann Hegy

/s/
Leslie A. Sussan

/s/
Stephen M. Godek
Presiding Board Member