Department of Health and Human Services
DEPARTMENTAL APPEALS BOARD
Appellate Division

Brenham Nursing and Rehabilitation Center
Docket No. A-15-1
Decision No. 2619
February 20, 2015

FINAL DECISION ON REVIEW OF ADMINISTRATIVE LAW JUDGE DECISION

Petitioner Brenham Nursing and Rehabilitation Center (Brenham), a skilled nursing facility (SNF) in Texas, requested review of an Administrative Law Judge's (ALJ) decision sustaining the imposition of civil money penalties (CMPs) totaling $84,400 by the Centers for Medicare & Medicaid Services (CMS). CMS imposed the CMPs as a remedy for Brenham's failure to be in substantial compliance with Medicare participation requirements for long-term care facilities codified in federal regulations. *Brenham Nursing & Rehab. Ctr.*, DAB CR3312 (2014) (ALJ Decision). CMS found noncompliance, at the immediate jeopardy level, with provisions of 42 C.F.R. § 483.13(c) that require facilities to develop and implement policies preventing abuse and neglect, report and thoroughly investigate all allegations of abuse and neglect and report the results of all investigations in accordance with state law; and with 42 C.F.R. § 483.75, which requires facilities to be administered effectively and efficiently to attain or maintain the highest practicable physical, mental and psychosocial well-being of each of its residents.[1] Following a hearing and based on de novo review of the record, the ALJ upheld CMS's findings of noncompliance with these regulations as well as CMS's determination that the noncompliance put Brenham's residents in immediate jeopardy. The ALJ also upheld the amount of the CMPs, finding them reasonable under the applicable regulatory factors. On appeal, Brenham disputes the ALJ's conclusions that it was not in substantial compliance with the cited requirements, asserting that the ALJ's findings are not supported by substantial evidence in the record. Brenham also disputes the ALJ's conclusions that CMS's determination of immediate jeopardy was not clearly erroneous and that the amounts of the CMPs were reasonable.

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[1] CMS also found immediate jeopardy-level noncompliance with section 483.13(c)(1)(ii)-(iii) but the ALJ did not address those findings of noncompliance because CMS had not offered evidence on them. ALJ Decision at 5 n.2. CMS cited noncompliance (at less than the immediate jeopardy level) with additional regulatory requirements during the survey at issue, *see* CMS Ex. 4, but at the hearing the parties agreed to limit the hearing to the immediate jeopardy-level noncompliance addressed in the ALJ decision and our decision. Tr. at 25-26. A single finding of noncompliance provides a basis for imposing one or more remedies, 42 C.F.R. § 488.402(c), and, as we discuss later, the noncompliance upheld by the ALJ is sufficient to support his determination that the amount of the CMPs is reasonable.

For the reasons discussed below, we reject Brenham's arguments and affirm the ALJ Decision.

Legal Background

To participate in the Medicare program, a long-term care facility, including a SNF, must be in "substantial compliance" with the requirements in 42 C.F.R. Part 483. 42 C.F.R. §§ 483.1, 488.400. Under agreements with the Secretary of Health and Human Services, state survey agencies conduct onsite surveys of facilities to verify compliance with the Medicare participation requirements. *Id*. §§ 488.10(a), 488.11; *see also* Social Security Act §§ 1819(g)(1)(A), 1864(a).[2] State survey agencies conduct periodic surveys as well as surveys to investigate complaints that facilities are violating one or more of the participation requirements. 42 C.F.R. § 488.308.

A state survey agency reports any "deficiencies" it finds in a Statement of Deficiencies (SOD), which identifies each deficiency under its regulatory requirement. A "deficiency" is any failure to comply with a Medicare participation requirement, and "substantial compliance" means "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 (also defining "noncompliance" as "any deficiency that causes a facility to not be in substantial compliance").

CMS may impose one or more remedies on noncompliant facilities, including per-day and/or per-instance CMPs. 42 C.F.R. §§ 488.402(b)-(c), 488.406, 488.408(d)(1)(iii)-(iv), 488.408(e)(1)(iii)-(iv), and 488.430(a). When CMS imposes a per-day CMP for noncompliance at a level less than immediate jeopardy, it chooses an amount within the "[l]ower range" of $50-$3,000 per day. 42 C.F.R. §§ 488.438(a)(1)(ii), 488.408(d)(1)(iii). When CMS imposes a per-day CMP for noncompliance that it has determined poses immediate jeopardy, CMS must impose a CMP within the "[u]pper range" of $3,050-$10,000 per day. *Id.* §§ 488.438(a)(1)(i), 488.408(e)(1)(iii). The regulations define "Immediate jeopardy" 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.* § 488.301.

[2] The current version of the Social Security Act can be found at http://www.socialsecurity.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. Also, a cross-reference table for the Act and the United States Code can be found at 42 U.S.C.A. Ch. 7, Disp Table.

Case Background

A. Procedural background

From April 22 through April 26, 2013, the Texas Department of Aging and Disability Services (State agency) conducted an onsite survey of Brenham's facility to determine if it was in substantial compliance with Medicare participation requirements for SNFs. CMS Exs. 3, 6. In a letter dated May 16, 2013, CMS notified Brenham of its determination, based on the survey, that Brenham failed to meet the requirements of participation in the Medicare program. CMS Ex. 6. CMS found the facility out of compliance with the following requirements: 42 C.F.R. § 483.13(c), which requires facilities to develop and implement written policies and procedures to prohibit abuse and neglect; 42 C.F.R. § 483.13(c)(2), which requires facilities to report all allegations of abuse and neglect immediately to the facility administrator and other officials in accordance with state law; 42 C.F.R. § 483.13(c) (3), which requires facilities to thoroughly investigate all allegations of abuse and neglect; 42 C.F.R. § 483.13(c)(4), which requires facilities to report the results of investigations of alleged abuse and neglect to other officials in accordance with State law within five working days of the incident and to take appropriate action if the alleged violation is verified; and 42 C.F.R. § 483.75, which requires facilities to be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental and psychosocial well-being of each of its residents. *Id*. CMS determined the noncompliance with each of these requirements to be at the immediate jeopardy level. *Id*. CMS imposed two per-instance CMPs – one in the amount of $6,000 for the noncompliance with section 483.13(c) and one in the amount of $2,500 for the noncompliance with the administration requirements in section 483.75.[3] *Id.*

In a letter dated May 21, 2013, CMS notified Brenham that it was revising the CMPs imposed in the May 16, 2013 letter by rescinding the per-instance CMPs identified therein and imposing, instead, a CMP in the amount of $6,600 per day from April 22 through April 25, 2013 and $2,000 per day for the period beginning April 26, 2013 and continuing until the facility came into substantial compliance. CMS Ex. 7.

In a letter dated July 19, 2013, CMS notified Brenham that a revisit survey had been conducted on June 6, 2013 and that the facility was still not in substantial compliance with the requirements found out of compliance during the April 26, 2013 survey but at a level less than immediate jeopardy. CMS Ex. 8. The letter notified Brenham that based on the findings of the June 6, 2013 survey, it was imposing a per-day CMP in the amount of $5,500 for one day of immediate jeopardy on June 5, 2013 and a $500 per-day CMP beginning June 6, 2013 and continuing until further notice from CMS. *Id*.

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[3] For per-instance CMPs, there is only one amount range ($1,000-$10,000) regardless of the level of noncompliance. 42 C.F.R. § 488.438(a)(2).

In a letter dated September 13, 2013, CMS notified Brenham that CMS had determined that Brenham achieved substantial compliance with Medicare requirements effective May 25, 2013. CMS Ex. 9. The letter also informed Brenham that based on the results of informal dispute resolution (IDR) CMS was rescinding remedies imposed for the noncompliance found on the June 6, 2013 survey, including the CMP in the amount of $5,500 per day for June 5, 2013 and the CMP of $500 per day beginning June 6, 2013. *Id*.

On July 15, 2013, Brenham filed a timely request for hearing on the findings of the April 26, 2013 survey and resulting remedies. The ALJ to whom the case had been reassigned held a hearing on May 12, 2014. During the hearing, Brenham cross-examined two of the CMS witnesses (surveyor LS and surveyor KBL) for whom CMS had filed written direct testimony. The ALJ identified and admitted into evidence CMS Exhibits 1, 2, 4-18, 21-28, 53-58, 60, 63-64, 66-67, 75, 76, 86-88, 90-98, 101 and 103. The ALJ identified and admitted Petitioner Brenham's Exhibits 1-44. The parties submitted post-hearing briefs.

B. Factual Background[4]

All of the noncompliance citations at issue involve Brenham's care of a 101-year old resident of its facility, identified on the SOD as Resident #4. ALJ Decision at 2. We use an abbreviated version of that identifier – R.4 – for simplicity. R.4's medical diagnoses included osteoporosis, pressure sores, depression and anxiety. *Id*., *citing* CMS Ex. 26, at 49, 58. R.4's cognitive impairments were so severe that she was not aware of the season, her room location, the names and faces of Brenham staff or even that she was in a nursing facility. *Id*., *citing* CMS Ex. 26, at 81. The resident was wholly dependent for her care on Brenham staff, and her resistance to care exacerbated her condition. *Id*., *citing* CMS Exs. 17-18, 31, 58, 59, 81. On April 12, 2013, two members of Brenham's nursing staff – CNA Q and CNA R – discovered while bathing R.4 that she had extensive bruising.[5] *Id*., *citing* CMS Ex. 26, at 161; CMS Ex. 97, at 7. The bruises were massive and covered much of R.4's body. *Id*., *citing* CMS Ex. 15, at 1 (Special Report of surveyor KL); CMS Ex. 101, at 3 (Written Direct Testimony of surveyor LS, who observed the bruising). The bruising was continuous, extended from the resident's breast and under both arms to

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[4] The information in this section is drawn from the ALJ Decision and the record before the ALJ and is recited for background purposes only, not to replace the ALJ's factual findings.

[5] On the SOD, CMS used alphabetical identifiers for staff members. We use the same identifiers. A list of staff members with their corresponding identifiers appears in CMS Exhibit 13. We identify the two surveyors who testified by their initials.

below both sides of her rib cage and wrapped around R.4's posterior thoracic area. R.4's left elbow exhibited extensive bruising and swelling, and her left foot was swollen and had a six-inch by two-inch bruise that extended from the ankle to the toes. *Id.*; *see also* CMS Ex. 23 at 36 (LS notes)

CNAs Q and R reported their discovery of the bruises to the evening shift charge nurse (LVN B) on April 12, 2013, the same date they discovered them. ALJ Decision at 3. The extensive bruising stunned LVN B, and she notified Brenham's director of nursing (DON #1). *Id.*, *citing* CMS Ex. 13, at 1; CMS Ex. 15, at 3-4; *see also* CMS Ex. 4 (SOD), at 50. LVN B subsequently completed a two-page Resident Accident or Incident Report (Incident Report). *Id.*, *citing* CMS Ex. 4, at 29; CMS Ex. 26, at 157-158; CMS Ex. 101, at 4-5.

Brenham had a written policy for investigating and reporting accidents and incidents which incorporated by reference the standards of the Texas Department of Aging and Disability Services for investigating suspicions of abuse. ALJ Decision at 8, *citing* CMS Ex. 27, at 1 (document entitled "Accidents and Incidents – Investigating and Reporting"). The incorporated State standards included guidelines for reporting possible incidents of abuse which "require, at a minimum, that a facility report to State authorities all incidents that require medical attention . . . [and] conduct and document a thorough investigation of each incident and develop a plan of action designed to prevent recurrence." *Id.*

A nurse practitioner first saw the bruising on April 15, 2013 (three days after it was discovered) while she was making rounds. CMS Ex. 3, at 14. She ordered x-rays nearly two weeks after the bruising was discovered. ALJ Decision at 3, *citing* CMS Ex. 101, at 4; *see also* CMS Ex. 26, at 195 (x-ray report). The Incident Report stated that R.4's treating physician was informed of the bruising on April 12, 2013, but the physician told surveyors he did not learn of it until April 23, 2013. ALJ Decision at 3, *citing* CMS Ex. 15, at 4; *see also* CMS Ex. 26, at 157. Brenham's medical director was not informed of the bruising until April 22, 2013. ALJ Decision at 3, *citing* CMS Ex. 15, at 4-5.

Standard of Review

We review a disputed finding of fact to determine whether the finding is supported by substantial evidence in the record as a whole, and a disputed conclusion of law to determine whether it is erroneous. *Departmental Appeals Board, Guidelines for Appellate Review of Decisions of Administrative Law Judges Affecting a Provider's Participation in the Medicare and Medicaid Programs*, http://www.hhs.gov/ dab/divisions/appellate/ guidelines/prov.html; *Golden Living Ctr. – Frankfort,* DAB No. 2296 at 9-10 (2009), *aff'd*, *Golden Living Ctr.-Frankfort v. Sec'y of Health & Human*

Servs., 656 F.3d 421 (6th Cir. 2011). Substantial evidence means "such relevant evidence as a reasonable mind might accept as adequate to support a conclusion." *Richardson v. Perales*, 402 U.S. 389, 401 (1971), *quoting Consolidated Edison Co. v. NLRB*, 305 U.S. 197, 229 (1938).

Under the substantial evidence standard, the Board does not re-weigh the evidence or overturn an ALJ's "choice between two fairly conflicting views" of the evidence; instead, the Board determines whether the contested finding could have been made by a reasonable fact-finder "tak[ing] into account whatever in the record fairly detracts from [the] weight" of the evidence that the ALJ relied upon. *Universal Camera Corp. v. NLRB*, 340 U.S. 474, 488 (1951); *see also Allentown Mack Sales & Service, Inc. v. NLRB*, 522 U.S. 359, 377 (1998); *Golden Living Ctr. – Frankfort,* DAB No. 2296, at 9-10.

Analysis

A. Substantial evidence in the record as a whole supports the ALJ's decision to uphold CMS's findings of noncompliance with sections 483.13(c), 483.13(c)(2)-(4) and 483.75, and the ALJ committed no legal error.

As the ALJ noted, the material facts, set forth above "are essentially undisputed even if the parties dispute the inferences to be drawn from the facts and their legal significance." ALJ Decision at 2. Based on those facts, which derive largely from facility records and policies, surveyor observations and interviews, and witness testimony, the ALJ determined that Brenham's response to the discovery of R.4's bruising was not in substantial compliance with sections 483.13(c), 483.13(c)(2)-(4) and 483.75. These regulations, in relevant part, provide as follows:

> **483.13 Resident behavior and facility practices**.
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> * * *
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> (c) *Staff treatment of residents*. The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents . . . .
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> * * *
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> (2) The facility must ensure that all alleged violations involving mistreatment, 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).

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

(4) The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident . . . .

483.75 Administration.

A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.

With respect to section 483.13(c), the ALJ found that Brenham failed to implement its anti-neglect and abuse policies, which incorporated the State guidelines and required Brenham to "conduct and document a thorough investigation of each incident and develop a plan of action designed to prevent recurrence."[6] ALJ Decision at 8. The ALJ found that "[Brenham] manifestly did not comply with these policies[,]" stating,

There is no evidence showing that the report to [DON #1] prompted [DON #1] to initiate an extensive investigation into the causes of [R.4]'s bruising or even into the extent and seriousness of the . . . injuries. There is nothing to show, for example, that [Brenham's] management appointed any

[6] The ALJ noted the State guidelines addressed "resident-to-resident abuse but no[t] . . . specifically those incidents that might comprise staff-to-resident abuse." ALJ Decision at 8. However, he assumed Brenham interpreted the guidelines to cover both types of alleged abuse because "[i]f Petitioner interprets these guidelines to apply only to resident-to-resident abuse, then Petitioner would have had no policy in place to deal with possible staff-to-resident abuse and that would be a regulatory violation." *Id*. at 8 n.4. The ALJ added, "Moreover, Petitioner had no way of knowing whether [R.4]'s bruises resulted from [either type of] abuse without thoroughly investigating the incident that led to the bruising." *Id*. Brenham does not challenge the ALJ's assumption but notes the record also contains a "Brenham Nursing and Rehabilitation Center Facility Abuse Prohibition Policy and Procedure." RR at 10 n.36, *citing* CMS Ex. 64. That policy specifically covers staff-to-resident abuse and requires the facility "to develop and implement a systematic process to investigate allegations of abuse, neglect and/or exploitation so that such events can be accurately and timely investigated and reported to the proper authorities." CMS Ex. 64, at 4; *see also* CMS Ex. 4 at 18-19 (SOD citing both the accident/incident policy and abuse/neglect prohibition policy). Thus, although the ALJ did not specifically discuss the abuse and neglect prohibition policy, that policy, like the accident/incident policy he did discuss, supports his conclusion that Brenham failed to implement its own policies when it did not thoroughly investigate and report R.4's massive bruising.

> individual to coordinate an investigation. No extensive interviews were conducted of [Brenham's] staff. No attempt was made to identify all of the personnel or residents who might have had access to [R.4] prior to April 12 or on that date. No efforts were made to find out whether R.4 might have been subjected to physical violence or to determine whether any individual posed an ongoing threat to the welfare of this resident or of other residents. No investigation was initiated into the possibility that an accident hazard of some sort might have been the cause of the resident's injuries.

Id. at 3. Relying on these findings (and other findings that we discuss when addressing Brenham's arguments), the ALJ also concluded that Brenham did not comply with section 483.13(c)(3) because it did not thoroughly investigate the possibility that R.4 was abused.[7] ALJ Decision at 7.

The ALJ concluded that Brenham did not comply with section 483.13(c)(2) "because it made no report to the Texas State agency concerning the possibility that [R.4] had been injured as a consequence of abuse or neglect." ALJ Decision at 5. The ALJ noted that Brenham "did not make that notification initially nor . . . after it had communicated with the resident's physician and its medical director, both of whom opined that a report was appropriate." *Id*. The ALJ concluded that Brenham did not comply with section 483.13(c)(4) "because it did not notify State authorities of the results of any investigation that it conducted into the potential abuse of [R.4]." *Id.* at 8. The ALJ added, "Of course, [Brenham] did not conduct an investigation as is mandated by regulation so it is axiomatic that it didn't provide the State with the sort of notification that is contemplated by the regulation." *Id*.

We conclude, as discussed below, that substantial evidence in the record as a whole supports the ALJ's conclusion that Brenham was not in substantial compliance with each of these regulatory provisions.

1. *Brenham does not dispute that R.4 sustained extensive bruising not observed by its staff prior to April 12, 2013.*

Brenham does not dispute that staff caring for R.4 discovered bruising on R.4 on April 12, 2013 and that the bruising was not observed prior to that date. Although Brenham's request for review ("RR") tends to understate the seriousness of R.4's bruising (see RR at 8, stating "It is uncontested [R.4] . . . exhibited bruising on her back . . ."), Brenham does

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[7] The ALJ also noted that "even the most basic care for [R.4] was, inexplicably, delayed[,]" citing the nearly two-week delay in sending her for x-rays, despite her vulnerability to fractures because of osteoporosis; the failure to notify her physician until 11 days after the bruising was discovered; and the failure to inform Brenham's medical director until April 22, 2013. ALJ Decision at 3.

not actually challenge the ALJ's finding that the bruising was "extensive," "massive," and "cover[ed] much of [R.4]'s body." ALJ Decision at 2. The ALJ relied on the surveyor's description of the bruising as "continuous and extend[ing]from the resident's breast and under both of her arms below both sides of her rib cage . . . [and] wrap[ping] around [R.4]'s posterior thoracic area" . . . [with] extensive bruising and swelling on the resident's left elbow[,] . . . a six-inch by two-inch bruise that extended from the ankle to the toes [of her left foot] and ankle was swollen." *Id.* Brenham employee LVN B stated that she was "stunned when she observed the bruising on [R.4] and notified the DON immediately." CMS Ex. 3, at 15.

Brenham does not dispute either the surveyor's description of the bruising or the "stunned" reaction of LVN B. Indeed, in its request for review, Brenham relies on the surveyor's description of the bruising as a reason to oppose CMS's motion to introduce in this proceeding what CMS asserts are photographs of the bruising taken by a surveyor who did not testify. CMS tried to introduce the photos into evidence at the beginning of the ALJ hearing, stating they had just received them that morning, but the ALJ excluded the photos as untimely. Transcript of May 12, 2014 Hearing ("Tr.") at 14-15. CMS now moves the Board to admit the photographs under 42 C.F.R. § 498.86(a), which permits the Board to admit evidence into the record in addition to the evidence introduced at the ALJ hearing if it "considers . . . the additional evidence is relevant and material to an issue before it." In its response opposing the motion, Brenham states, "Because the record clearly describes the bruising and confirms [the] known origin, the photographs are cumulative, redundant and irrelevant even if they could be authenticated by a disclosed CMS witness." Brenham Nursing and Rehabilitation Center's Response to Motion to Introduce Evidence and Reply to Response to Request for Review and Objection to Wiktorik Declaration and Unauthenticated Photographs at 7. We agree that the photographs should not (and will not) be admitted because they are cumulative of the descriptions of R.4's bruising already in the record.[8] We also conclude that the descriptions in the record are substantial evidence supporting the ALJ's finding that the bruising was "extensive," "massive" and "covered much of R.4's body." However, as we discuss below, we do not agree with Brenham's statement that these descriptions (or any other evidence of record) "confirm . . . [the] known origin" of the bruising.

[8] Accordingly, we need not decide here whether 42 C.F.R. § 498.86 authorizes the Board to admit relevant and material evidence rejected by the ALJ as untimely.

2. *Substantial evidence supports the ALJ's finding that the record did not establish a known source of R.4's bruising or that the facility conducted an investigation thorough enough to rule out abuse or neglect as the source.*

The ALJ found that the record evidence did not establish that Brenham conducted a thorough investigation to determine the cause of the bruising and rule out the possibility of abuse or neglect. As previously stated, the ALJ cited, for example, the absence of any evidence that Brenham made efforts to identify individuals who had access to R.4 prior to discovery of the bruising, to do extensive staff interviews, to determine whether any individual posed an ongoing threat to residents or to determine whether an accident hazard might have caused the bruising. The ALJ stated, "To this day the cause of the resident's bruises and other injuries remains unknown. . . . Petitioner and its staff made only half-hearted efforts, at best, to learn how and why the resident was hurt." ALJ Decision at 2.

Brenham disputes these findings. Brenham asserts that the accident/incident report its staff created following discovery of the bruising is evidence that it conducted an investigation and determined that the source of the bruising was not abuse or neglect. Brenham points, in particular, to the following statements in the report:

> Evidence of Abuse, Neglect or Exploitation: __ Yes _√ No
>
> Physician notified. Evaluated for possible cause. Labs (CBC) collected to rule out pathological cause. Suggested cause from Hoyer lift sling.

RR at 13 (citing CMS Ex. 26, at 178-79). Brenham contends the ALJ ignored this evidence, but that is not true. The ALJ acknowledged the report but concluded that it –

> is not a report of an investigation. To call it cursory would be to understate the lack of information in the report. Although the report documents that the resident was bruised it says nothing about the cause of the bruises. There is no analysis at all of what happened and why.

ALJ Decision at 6.

In reviewing the arguments, exhibits and testimony, we must consider not only the evidence relied on by the ALJ but also "take into account whatever in the record fairly detracts from the weight of the decision below." *Golden Living Ctr. Frankfort*, DAB No. 2296, at 10, *citing Life Care Ctr. of Bardstown*, DAB No. 2233, at 9 (2009); *Britthaven, Inc., d/b/a Britthaven of Smithfield*, DAB No. 2018, at 2 (2006), *citing Universal Camera*

Corp. In so doing, we must consider "whether conflicting evidence in the record has been addressed by the ALJ and whether the inferences drawn by the ALJ are reasonable." *Britthaven* at 2, *citing Barry D. Garfinkel, M.D.*, DAB No. 1572, at 5-6 (1996), *aff'd*, *Garfinkel v. Shalala*, No. 3-96-604 (D. Minn. June 25, 1997). We find nothing in the accident/incident report (or the fact it was created) that detracts from the ALJ's conclusion that Brenham failed to conduct a thorough investigation to determine the cause of the bruising or to rule out the possibility of abuse or neglect.

The ALJ could reasonably infer that the accident/incident report is not evidence of an investigation or, at least not the "thorough investigation" required by the regulations to rule out possible abuse or neglect. The report consists of two pages. CMS Ex. 26, at 178-79. The report's bare statement that there was an "evaluation for possible cause," absent more information about the content and extent of that evaluation, is not evidence of an investigation at all, much less a thorough one. Moreover, the ALJ reasonably concluded Brenham did not rule out the possibility of abuse or neglect, notwithstanding someone's having put a check mark in the "No" box. The statements that a blood test was done "to rule out [a] pathological cause" and that a Hoyer lift sling was a "[s]uggested cause," are, as the ALJ stated, "hypotheses," not evidence that Brenham determined the cause of the bruising following an investigation. ALJ Decision at 4.

Moreover, as the ALJ noted, Brenham itself ruled out the theory that a blood disorder caused the bruising based on the blood tests ordered by facility management four days after discovery of the bruises. ALJ Decision at 4. DON #1 told the surveyors he asked the nurse practitioner to order the test and also told the surveyors that he reviewed the results and they showed no hematological disorder.[9] CMS Ex. 97, at 7.

Although Brenham persists in mentioning the blood disorder theory, it does not affirmatively dispute the ALJ's finding that its management ruled out that possible cause. Instead, Brenham focuses on management's alternative theory that the bruising was caused during a transfer by Hoyer Lift, which, as the ALJ noted, is "a machine that utilizes a sling to transfer debilitated or helpless individuals from a location such as a bed to another location such as a wheelchair." ALJ Decision at 4. The ALJ found that Brenham management "made no credible efforts to determine whether a botched Hoyer Lift transfer was the cause . . . and the theory . . . is not grounded in fact." *Id.* Substantial evidence supports that finding. As the ALJ noted, CNA Q and CNA R, both of whom

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[9] The test showed a hemoglobin count below normal range – 10.6 as compared to 12.0-15.6 grams per deciliter. CMS Ex. 3, at 48. However, given DON #1's statements and the fact that Brenham did not do any intervention based on this result prior to the survey but, instead, moved on to the Hoyer Lift theory, Brenham apparently did not view the low hemoglobin as a possible source of the bruising. That it did not do so undercuts the testimony of Brenham's expert witness, based on record review only, that "the resident's low hemoglobin count and high prothrombin time [the latter on a test done more than a week after the blood test in issue] contributed to the bruising rather than abuse or neglect." P. Ex. 44, at 4-5, *quoted in* RR at 13. In any event, the fact that a blood factor would "contribute to" bruising does not rule out abuse and neglect as a primary cause of the bruising.

cared for R.4 on the day in question and discovered her bruising, denied using a Hoyer Lift to transfer the resident. *Id.*; CMS Ex. 97, at 7. CNA Q persisted in her denial even while telling the surveyor that DON #1 had instructed her to tell the surveyor that she did use the Hoyer Lift, notwithstanding her denial. *Id.* DON #1 conceded that he did not document a Hoyer Lift as the potential cause of the bruising. CMS Ex. 4, at 32. Brenham does not dispute the statements by the CNAs who cared for the resident and discovered her bruising, and they are supported by the statements of LVN B that there was no Hoyer Lift in the room and no sling under R.4 when she went to assess the resident after the CNAs discovered the bruising. CMS Ex. 15, at 3. In addition, Brenham does not dispute that R.4's care plan did not address transfers at all, much less call for use of a Hoyer Lift. *See* CMS Ex. 26, at 132-48 (care plan); Tr. at 84 (surveyor testimony that R.4 "did not have a plan of care [for] a hoyer lift.").

But even if we accepted, which we do not, that a Hoyer Lift transfer caused the bruising, that would not necessarily preclude a legally valid conclusion that the facility failed to implement its abuse and neglect policies. For example, Brenham provided no evidence that R.4 was assessed to determine if using a Hoyer Lift on her was a safe and appropriate transfer method. Nor did Brenham investigate the possibility that staff misused the device during a lift or had not been adequately trained in its proper use. After looking at pictures of R.4's bruises, her treating physician told the surveyor that "logically you would look into abuse and/or neglect, potentially picking the Resident up and dropping her." CMS Ex. 3, at 52. He also told the surveyor that while the bruising "could have been caused by some sort of improper lifting . . . it would have had to have been vigorous."[10] *Id.* It is also undisputed that facility staff in-service records for April 2013 did not show any training on transfer techniques; DON #1 told the surveyor he had not conducted any in-service training on use of a Hoyer Lift, or any other type of transfers, after the incident involving R.4; and the administrator told the surveyors that in-service sessions on use of a Hoyer lift should have been conducted.[11] CMS Ex. 15, at 3, 5.

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[10] This testimony as well as the fact that no sling was found in R.4's room tends to undercut Brenham's assertion that the bruising was caused by pressure from the sling on the Hoyer Lift. *See* RR at 8, 13.

[11] Brenham asserts here, as it did below, that it trained all of its employees on its abuse and neglect prevention and related policies. RR at 10-11. However, the ALJ found that Brenham "did not offer proof that specific members of its staff actually did receive training other than acknowledgments that for four individuals (including two caregivers) the individuals were trained on the facility 'Prohibition of Abuse Policy and Procedure.'" ALJ Decision at 9, *citing* P. Ex. 5. Brenham does not specifically challenge that finding here, and we see no reason to disturb it. In any event, Brenham's failure to investigate and report possible abuse or neglect was the principal basis for finding that Brenham did not implement its abuse and neglect and related policies, not failure to train. *See e.g.* Tr. at 48-49 (testimony of surveyor KBL, *cited by* Brenham in RR at 10-11).

Instead of relying on the statements of employees with personal knowledge of the incident, Brenham relies heavily on the uncontested written direct testimony of its expert witness, a registered nurse consultant who testified based only on record review. Brenham points to this witness's testimony that the accident/incident report "confirms no evidence of abuse, neglect or exploitation," that "[t]he Nurse Practitioner employed by [R.4's] treating physician was promptly notified upon discovering the bruise . . .," that "[DON #1] informed the facility's Abuse Prohibition Officer and Administrator and they determined that the bruising occurred from a Hoyer Sling during a transfer . . . ," and "[a] plan of care was put into place and the resident was assessed by the Nurse Practitioner, labs were ordered, x-rays ordered and continued monitoring provided." RR at 13 (citations omitted). Brenham alleges that the ALJ improperly discounted the expert witness's testimony, *id*. at 7, when he found it "not to be credible" because she "was not a witness to any of the events that are at issue here" but, "[r]ather, . . . reviewed some of the evidence in the case and pronounced herself satisfied that Petitioner was compliant with regulatory requirements." ALJ Decision at 5 n.3.

The Board defers to ALJ findings on the weight and credibility of testimony, absent a compelling reason to do otherwise. *See, e.g*., *Woodland Oaks Healthcare Facility*, DAB No. 2355, at 7 (2010); *Gateway Nursing Ctr*., DAB No. 2283, at 7 (2009), *citing Koester Pavilion*, DAB No. 1750, at 15, 21 (2000). We find no compelling reason here. Brenham ignores the fact that the ALJ discounted this testimony not only because the witness had no personal knowledge of the incident but also because he found her testimony "simply not grounded in reality." *Id*. The record as a whole supports that finding. As stated above, the ALJ reasonably found the accident/incident report, on which this witness's testimony relied, insufficient evidence of an investigation thorough enough to rule out possible abuse or neglect. The witness's statement, based on the report, that the nurse practitioner was "promptly notified upon discovering the bruise" is inconsistent with the nurse practitioner's statement to surveyors that she was not notified until she made rounds in the building on April 15, 2013, three days after the nursing staff discovered the bruising and reported it to DON #1. It is undisputed that blood tests were not ordered until four days after the bruising was discovered and that the nurse practitioner did not order x-rays until April 22, 2013, during the survey. Nor does Brenham dispute that the nurse practitioner told the surveyors she did not know why x-rays were not ordered when the bruising was discovered. CMS Ex. 3, at 105. Thus, none of the expert witness's testimony undercuts the ALJ's findings in any material respect.

In addition, as the ALJ noted, although the accident/incident report suggests R.4's treating physician was notified at the time the report was created, the physician told surveyors he did not learn of the bruising until April 23, 2013. ALJ Decision at 3 n.1; CMS Ex. 15, at 4-5. The ALJ noted that Brenham had not identified any corroborating evidence – such as "nurses' notes, records of phone or other communications with the

physician, or physician's orders" – that the physician was notified on April 12 as indicated in the accident/incident report. ALJ Decision at 3 n.1. The ALJ found that in the absence of any corroborating evidence, "the best and most credible evidence of when the physician was first informed is the physician's own recollection." *Id.* The record as a whole supports the ALJ's finding about the lack of corroborating evidence, and the ALJ could reasonably give more weight to the physician's statement.

Brenham also argues that a CMS surveyor witness (surveyor LS) "acknowledged" at the hearing that "the incident was investigated" when she answered "yes" to a question about whether the facility, when creating the accident/incident report, interviewed one of the CNAs who discovered the bruising.[12] RR at 14-15. However, while the surveyor acknowledged that interviewing one CNA and creating the accident/incident report could be considered <u>part</u> of an investigative process, she testified unequivocally that the interview and report alone did not satisfy the requirement that an injury of unknown source be "thoroughly investigated." *See* Tr. at 75 ("They did not thoroughly investigate what happened to [R.4], no, sir."); Tr. at 77 ("Not this [accident/incident report] by itself, no, sir. That doesn't cover a thorough investigation, just this one piece of document[.]"). The surveyor explained that to do the thorough investigation required by the regulation, and the facility's own policies, she would have expected the facility, for example, to interview aides who cared for the resident before the bruising was discovered and to also interview nurses.[13] Tr. at 85. There is no dispute the facility did not do this. Indeed, there is no evidence the facility even interviewed the second CNA caring for the resident when the bruising was discovered.

Brenham also cites Resident Review Worksheets completed by surveyor LS during the survey and an Observations Rounds Worksheet that are in evidence. RR at 9. Brenham does not make a specific argument based on these exhibits but appears to suggest that this surveyor ruled out possible abuse and neglect as a cause of the bruising since one of the worksheets (entitled Resident Daily Life Review) states that "[t]here are no identified concerns" for the requirement that "Residents are free from unexplained physical injuries and there are no signs of resident abuse." *Id.* (*citing* CMS Ex. 26, at 1-2). This evidence

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[12] Brenham makes a similar assertion about testimony by surveyor KL. *See* RR at 14 & n.61 (*citing* Tr. at 49, 54). However, as that testimony itself indicates, surveyor KL acknowledged only that the facility had created the accident/incident report and that nursing staff had notified DON #1 of the bruising. Neither the cited testimony nor any other testimony by surveyor KL states that these actions alone constituted a thorough investigation.

[13] The ALJ also rejected Brenham's argument that the surveyor acknowledged that the bruising incident was investigated. ALJ Decision at 7-8. The ALJ essentially found that in her responses to the questions from Brenham's counsel, the surveyor was only acknowledging creation of the accident/incident report and the interviewing of one CNA in connection with what some facility staff said was an "investigation." He found this testimony "meaningless" absent definition of the term "investigation" and not "evidence to show that [Brenham] conducted the thorough investigation that is demanded by the regulation." *Id.*

does not support such a suggestion. As surveyor LS testified, she completed the worksheets during her initial, brief tour of the facility, when she first entered the facility, at which time she saw R.4 but had not yet done a comprehensive review of the resident involving observation and interviews. Tr. at 68-70. The surveyor later did observe the bruising, and her description of the bruising (discussed earlier) confirmed its extensive nature even though more than a week had passed since the bruising was first discovered. Moreover, the surveyor's recording of her observations and interviews in her survey notes evidences her clear concern about the unexplained source of the bruising and the potential for abuse. *See, e.g*. CMS Ex. 23, at 21, 22-23, 34, 36.

For the reasons stated above, we conclude that the ALJ's conclusion that Brenham violated sections 483.13(c) and 483.13(c)(3), and its own policies, by not thoroughly investigating R.4's massive bruising to determine the source of that bruising is supported by substantial evidence and free of legal error.

3. *Based on our conclusions above, we summarily affirm the ALJ's determinations that Brenham also was not in substantial compliance with the reporting requirements of section 483.13(c)(2) and (4) and the administration requirements in section 483.75.*

In addition to conceding its staff's April 12, 2013 discovery of extensive bruising on R.4, Brenham does not dispute that LVN B observed the bruising and reported it to DON #1. Brenham also does not dispute the ALJ's finding that its staff did not report the bruising to the Texas State Agency as required by the regulation and its own policies (by incorporation of Texas standards – *see* ALJ Decision at 8) for injuries of unknown source.[14] Brenham argues that it had no duty to report the bruising because, contrary to the ALJ's findings, it investigated and determined that the bruising was caused by a blood disorder or a Hoyer Lift. Accordingly, Brenham asserts, the bruising was not an "injur[y] of unknown source" within the meaning of section 483.13(c)(2). RR at 3-4, 12-16. Since we have already rejected that argument, we need not further discuss the failure to report the possible abuse (or the results of what Brenham purports was an "investigation"), and we summarily uphold the ALJ's finding of noncompliance with section 483.13(c)(2) and (4). We note, however, that Brenham's argument ignores undisputed evidence that R.4's treating physician and Brenham's Medical Director told surveyors the bruising should have been reported. ALJ Decision at 5; CMS Ex. 15, at 4, 5; CMS Ex. 97, at 7, 8.

[14] There is no evidence of a report to the Texas State Agency in the record, and DON #1 told the surveyors he had not reported the incident. CMS Ex. 15, at 3.

With respect to the ALJ's conclusion that Brenham also was not in substantial compliance with section 483.75 (effective and efficient administration), Brenham argues only that the ALJ had no basis for that conclusion given what Brenham asserts, again contrary to the ALJ findings, is management's compliance with the investigation requirements in section 483.13(c). Since we reject the premise on which Brenham predicates its sole argument for reversing the ALJ's conclusion on section 483.75, we need not address that argument further and summarily uphold the ALJ's finding of noncompliance with section 483.75.

B. We affirm the ALJ's conclusion that CMS's determination of immediate jeopardy was not clearly erroneous.

CMS cited Brenham's noncompliance with each requirement at the immediate jeopardy level. "[I]immediate jeopardy means 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." 42 C.F.R. § 488.301. ALJs and the Board may not overturn CMS's determination of the level of noncompliance, which includes immediate jeopardy, unless that determination is clearly erroneous. *Id.* § 498.60(c)(2). The ALJ concluded Brenham had not shown CMS's determination of immediate jeopardy to be clearly erroneous. Brenham disputes that conclusion, characterizing the level of its noncompliance as "a technical violation at best with regard to the one resident [R.4] and one incident underlying all four immediate jeopardy" findings. RR at 21. Here, as before the ALJ, Brenham offers no basis for the "technical violation" characterization, and we agree with the ALJ that the massive bruising affecting multiple parts of R.4's body, a description Brenham has not challenged, was "a serious injury by any measure." ALJ Decision at 9.

We also reject, as did the ALJ, Brenham's argument that because the bruising identified by its staff on April 12, 2013 had begun to heal by the time of the April 24, 2013 survey, there was no basis for finding immediate jeopardy. In rejecting this argument, the ALJ stated as follows:

> [T]he bruising sustained by [R.4] is not the essential element of immediate jeopardy. The immediate jeopardy . . . consists of Petitioner's cavalier failure to deal with the implications of the bruising and the probability for new harm to [R.4] and to other residents caused by this failure. Petitioner had no way of knowing whether an abusive individual lurked on its staff or among its residents because it made no effort to find out whether that was so. Consequently, Petitioner could not protect its residents because it did not know whether there had been abuse and if so, what constituted its cause.

Id. at 10. Brenham does not dispute the ALJ's reasoning, and we concur in it. The facility's failure to make a serious attempt to try to determine the source of R.4's bruising, such as by interviewing all staff who had come into contact with her just prior to discovery of the bruising – not just one CNA – is inexplicable and evidences a serious breakdown in the implementation of its abuse and neglect prohibition and accident/incident investigation policies that posed a likelihood of further harm to R.4 as well as a likelihood of harm to all other residents.

We need not address Brenham's remaining arguments discussing the immediate jeopardy determination because they are reiterations of its arguments for why the ALJ should not have upheld CMS's determination that it was not in substantial compliance, not arguments about the basis for its assertion that CMS's determination of the level of its noncompliance is clearly erroneous. For the reasons stated above, we uphold the ALJ's conclusion that Brenham did not show CMS's immediate jeopardy determination to be clearly erroneous.

C. We affirm the ALJ's determination that the amounts of the CMPs are reasonable.

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), *mod. on other grounds*, *Somerset Nursing & Rehab. Facility v. U.S. Dep't of Health & Human Servs*., 502 F. App'x 513 (6th Cir. 2012).

The ALJ noted that the per-day CMP range for immediate jeopardy level noncompliance is $3,050 to $10,000 per day and for non-immediate jeopardy level noncompliance $50 to $3,000 per day. ALJ Decision at 10. He then applied the factors set forth above and determined that both the $6,600-per-day CMP for the period of immediate jeopardy and the $2,000-per-day non-immediate jeopardy-level CMP for the period of noncompliance

following the abatement of immediate jeopardy were reasonable amounts within those ranges. *Id.* at 10-11. The ALJ cited two reasons why the amounts were reasonable: 1) the "extremely serious" nature of the noncompliance, including, for example, the possibility that "R.4 had been badly beaten by an abusive individual, either a member of Petitioner's staff or another resident" and, since Brenham management did not rule out that possibility, the further possibility that an abusive individual was still in the facility and jeopardizing the well-being of other residents; and 2) Brenham's "especially high" culpability because although management was on notice right away of R.4's serious injuries, it not only "ignored the possibility of abuse but it attempted to cover up that possibility" by "direct[ing] the staff to invent a story to explain the resident's bruising – that the bruising was the consequence of a botched Hoyer lift transfer – that had no basis in fact and that management knew had no basis in fact." *Id*. at 11.

Brenham asserts that the CMP amounts were "not based on the mandatory [f]actors . . . under 42 C.F.R. § 488.438(b)," suggesting that CMS did not consider these factors when imposing the CMPs. RR at 25. However, CMS's notice letter expressly indicated that CMS considered the factors and, with respect to the "financial condition" factor, gave Brenham an opportunity to "submit pertinent financial information (for our consideration) . . . ." CMS Ex. 7, at 3. Moreover, the ALJ, as stated above, expressly discussed the regulatory factors in his de novo review. It was Brenham's burden to "'introduce[e] 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), *quoting 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, *quoting Coquina Ctr*., DAB No. 1860, at 32 (2002). Brenham does not challenge the ALJ's assessment of the factors, much less cite any evidence that might undercut it. Instead, Brenham makes arguments that have no merit. Brenham complains that CMS, in notices dated five days apart, changed the per-instance CMPs to per-day CMPs, a change that resulted in increasing the amounts of the CMPs. RR at 23-24. Brenham cites no law prohibiting this change, and CMS's choice of remedy, which is what Brenham in effect challenges, is not subject to appeal. 42 C.F.R. § 488.408(g)(2). Brenham also asserts that a survey conducted in June 2013 "found similar deficiencies and [an] identical Tag (with different residents)" but that CMS imposed CMPs in lesser amounts than it did for the noncompliance found on the April 2013 survey. RR at 24. Brenham further asserts that the findings of noncompliance on the June survey and the remedies imposed were rescinded following informal dispute resolution. *Id.* As the ALJ found, those findings were made based on a different survey and, thus, together with the remedies imposed based on those findings, "are based on different evidence than that which is at issue here and are, therefore, irrelevant." ALJ Decision at 12.

Based on the foregoing, we uphold the ALJ's conclusion that the amounts of the CMPs imposed for the noncompliance determinations made based on the April 26, 2013 survey are reasonable.

Conclusion

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

/s/
Leslie A. Sussan

/s/
Constance B. Tobias

/s/
Sheila Ann Hegy
Presiding Board Member