Department of Health and Human Services
DEPARTMENTAL APPEALS BOARD
Appellate Division

Merrimack County Nursing Home
Docket No. A-11-84
Decision No. 2424
December 5, 2011

FINAL DECISION ON REVIEW OF ADMINISTRATIVE LAW JUDGE DECISION

The Centers for Medicare and Medicaid Services (CMS), pursuant to 42 C.F.R. § 498.82, requests review of the April 8, 2011 Decision of Administrative Law Judge (ALJ) Steven T. Kessel to the extent that it reverses CMS's determination that Merrimack County Nursing Home (Merrimack) was not in substantial compliance with the requirement for nursing home participation in Medicare at 42 C.F.R. § 483.13(b) and reduces the $6,000 per-instance civil money penalty (CMP) imposed by CMS to $3,000. *Merrimack County Nursing Home*, DAB CR2352 (2011)(ALJ Decision). The ALJ upheld CMS's determination that Merrimack was not in substantial compliance with 42 C.F.R. §483.10(b)(4) but, based on his decision to reverse one of the two findings of noncompliance, concluded that a $3,000 per-instance CMP (rather than the $6,000 CMP imposed by CMS) was reasonable. Merrimack filed no appeal. We grant CMS's request for review and reverse as legally erroneous and unsupported by substantial evidence the ALJ's conclusion that Merrimack was in substantial compliance with section 483.13(b). We also reverse the ALJ's conclusion that $3,000 was a reasonable CMP amount and conclude that a $6,000 per-instance CMP is reasonable.

Applicable Law

Long-term care facilities participating in the Medicare and Medicaid programs are subject to the survey and enforcement procedures set out in 42 C.F.R. Part 488, subpart E, to determine if they are in substantial compliance with the applicable program requirements in 42 C.F.R. Part 483, subpart B. "Substantial compliance" means a level of compliance "such that any identified deficiencies pose no greater risk to resident health or safety than the potential for causing minimal harm." 42 C.F.R. § 488.301. "Noncompliance," in turn, is defined as "any deficiency that causes a facility to not be in substantial compliance." *Id.* Survey findings are reported in a Statement of Deficiencies (SOD) which identifies each "deficiency" under its regulatory requirement.

A long-term care facility found not to be in substantial compliance is subject to various enforcement remedies, including CMPs. 42 C.F.R. §§ 488.402(c), 488.406, 488.408. CMS has the option to impose a CMP whenever a facility is not in substantial compliance. 42 C.F.R. § 488.430. CMS may impose per-instance or per-day CMPs. *Id*. There is a single range of $1,000 to $10,000 for per-instance CMPs. 42 C.F.R. § 488.438(a)(2). The amount of the CMP is determined based on the factors in section 488.438(f). 42 C.F.R. § 488.438(b).

Factual Background[1]

1. The survey, CMS determinations and ALJ proceeding

Merrimack, a Boscawen, New Hampshire skilled nursing facility (SNF), participates in the Medicare program. ALJ Decision at 1. On September 15, 2010, Merrimack was surveyed for compliance with Medicare participation requirements. *Id*. The New Hampshire Department of Health and Human Services, Health Facilities Administration (State Survey Agency) conducted the survey. CMS Ex. 3. The surveyors found Merrimack out of compliance with the Medicare requirements related to a resident's right to refuse treatment, 42 C.F.R. § 483.10(b)(4), and a resident's right to be free from abuse, 42 C.F.R. § 483.13(b). ALJ Decision at 1, 2; CMS Ex. 2. CMS concurred in these findings and determined to impose a $6,000 per-instance CMP. ALJ Decision at 1; CMS Ex. 3. Merrimack requested a hearing, and CMS moved for summary judgment. ALJ Decision at 1. Merrimack opposed CMS's motion and filed a cross-motion for summary judgment. *Id*. Each party filed exhibits which the ALJ admitted into evidence.[2] *Id*. at 2. The ALJ decided the case on the written record, noting that although Merrimack "speaks vaguely of wanting an evidentiary hearing, neither party has presented me with any basis to conduct a hearing in person." *Id*. The ALJ noted, in particular, that neither party had offered testimony of any witnesses or asserted that it required a hearing to produce testimony. *Id.*

[1] Unless stated otherwise, the information in this section is drawn from undisputed findings of fact in the ALJ Decision and undisputed facts in 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.

[2] The ALJ Decision states, "CMS filed five proposed exhibits . . . that are designated CMS Ex. 1-CMS Ex. 5." We find no such designation on CMS's exhibits. However, the exhibits are clearly discernible by sequence and content. Merrimack's ten exhibits do contain written designations. The ALJ admitted both parties' exhibits into evidence, and there is no dispute about the contents of the record on appeal.

2. Resident 2's (R2) medical diagnoses and care plan

The noncompliance with sections 483.10(b)(4) and 483.13(b) found by CMS involves treatment of a resident identified for privacy reasons as R2. *Id*. at 2-3. At the time of the survey, R2 was a 70-year-old male resident of Merrimack whose medical diagnoses included Alzheimer's with behavioral disturbance, hearing loss and vision impairment. ALJ Decision at 3; CMS Ex. 2, at 3. R2 also suffered cognitive loss. *Id*. R2's care plan identified alteration in behaviors as a problem area and stated that this is due to "late stage dementia, hearing loss, comprehension problems, wandering, instances of physical aggression and abuse, and a question of vision impairment." P. Ex. 8, at 4; CMS Ex. 2, at 2. "The care plan recognized that the resident was prone to resist, sometimes violently, attempts to provide him with care." ALJ Decision at 3. R2's care plan provided (beginning August 10, 2010) that if R2 resisted care, staff should walk away from him and reapproach after 10 to 15 minutes.[3] *Id.*, citing CMS Ex. 2, at 2.

R2's care plan also indicated a problem with functional urinary incontinence. P. Ex. 8, at 4. Care plan approaches for dealing with this problem included a toileting program that, in turn, included escorting him to the bathroom at designated intervals. *Id*. at 4-5. The care plan approaches for the urinary incontinence problem caution that "pt. has a tendency not to accept assistance. If he is resistive, walk away and re-approach in 10-15 minutes." *Id*. at 5.

3. The incident involving R2

On September 7, 2010, a Licensed Nurse's Assistant (LNA) attempted to get R2 to his room for purposes of toileting. ALJ Decision at 3. The incident was recorded by a facility surveillance camera, and the video recording became part of the evidentiary record. *Id.* at 4; CMS Ex. 2, at 3-4; P. Ex. 10. The ALJ found that the video "does not support a finding of intentional infliction of harm. It shows the nurse's assistant attempting to guide the resident into his room, an act that might have been entirely appropriate but for the resident's demented state and his tendency to react violently when assisted by Petitioner's staff." ALJ Decision at 4. CMS disagrees with this finding. RR at 2. We discuss below this disagreement and other evidence of record that the ALJ did not discuss or, in the case of the SOD, characterized in a manner that we find clearly inconsistent with the evidence itself.

[3] More particularly, the care plan provided: "Pt. displays resistiveness to the point of pushing, scratching, or hitting. If pt. displays resistiveness, walk away and re-approach in 10 or 15 minutes." P. Ex. 8, at 4.

Standard of Review

We review a disputed finding of fact to determine whether the finding is supported by substantial evidence on the record as a whole, and a disputed conclusion of law to determine whether it is erroneous. *Guidelines – Appellate Review of Decisions of Administrative Law Judges Affecting a Provider's Participation in the Medicare and Medicaid Programs (Guidelines) (accessible at http://www.hhs.gov/dab/divisions/appellate/guidelines/prov.html)*; *Batavia Nursing and Convalescent Inn*, DAB No. 1911, at 7 (2004), *aff'd*, *Batavia Nursing & Convalescent Ctr. v. Thompson*, 143 F. App'x 664 (6th Cir. 2005).

Discussion

A. The ALJ erred in concluding that intent to inflict injury or harm is a required element of "abuse" under the regulations.

1. The phrase "willful infliction" in section 488.301 means deliberate conduct, not conduct undertaken with intent to inflict harm.

Section 483.13(b) provides that a resident "has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, or involuntary seclusion." Section 488.301 defines "abuse" as "the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish." The ALJ agreed with CMS that the LNA's treatment of R2 resulted in harm to the resident consisting of emotional distress.

> Resident #2 was harmed. That harm was in the form of emotional distress. That is made manifest by the resident's violent reaction to nurse's assistant's attempt to guide him into his room. That this level of emotional distress might not have been present in the case of a non-demented resident is no defense to the fact that this resident suffered emotional distress as a result of the nurse's assistant's inappropriate act.

ALJ Decision at 5. Nonetheless, the ALJ concluded that the LNA did not abuse R2.

> The elements of abuse defined by the regulation are not present here. The nurse's assistant plainly committed an error of judgment, but that does not rise to the level of abuse. The evidence establishes that the nurse's assistant contravened the resident's plan of care by attempting to guide him into his room against his

> will. But that error is not axiomatically abuse. What is lacking here is the element of intent. Nothing about the nurse's assistant's conduct suggests that she intended to inflict injury or harm. Indeed, her actions would have been entirely appropriate but for Resident #2's unique demented state.

Id. at 4 (emphasis added).

CMS asserts, and we agree, that the ALJ erred as a matter of law by concluding that there must be an intent to inflict injury or harm in order to find "abuse" under section 483.13(b), as that term is defined in section 488.301. Section 488.301 defines abuse as an infliction of injury, unreasonable confinement, intimidation or punishment that is "willful." The regulation does not use the word "intentional." While the word "willful" can have a number of dictionary definitions, the Board has held that as used in section 488.301, the word "willful" means that the actor must have acted deliberately, not that the actor must have intended to inflict injury or harm (or one of the other specified types of prohibited conduct). *Britthaven, Inc., d/b/a/ Britthaven of Smithfield*, DAB No. 2018, at 4 (2006), citing *Western Care Management Corp., d/b/a Rehab Specialties Inn*, DAB No. 1921, at 14 (2004); *Vandalia Park*, DAB No. 1939, at 9 (2004).

In *Britthaven of Smithfield*, the Board upheld the ALJ's conclusion that a nurse's telling a blind resident to "[s]top yelling before someone comes and slaps your face again" was willful intimidation of the resident because the statement was made "deliberately to modify [the resident's] behavior" and "would be intimidating and frightening to someone who was blind and had no way of knowing whether he was in further immediate and imminent danger." DAB No. 2018, at 10-11. In *Vandalia Park*, DAB No. 1939, at 12 (2004), the Board agreed with the ALJ "that the regulation does not require that the purpose of the actor [staff restraining a resident for catheterization] be to inflict harm, but rather that the action have been undertaken deliberately."[4] As we discuss later, we find no substantial evidence to support the ALJ's finding that the LNA was merely attempting to lead or guide R2 to his room. However, even if one accepts the ALJ's description of her conduct, there is no question that the LNA's actions were deliberate and, therefore, "willful." The ALJ and Merrimack both agree that the incident involved physical contact with R2 by the LNA, and the ALJ did not find, nor does Merrimack argue, that the physical contact was inadvertent or accidental. The ALJ stated that the LNA "placed her hands on the resident and led him towards the room" and "then put her hands on the

[4] The Board remanded to the ALJ for a hearing, however, because it found disputed issues of material fact on this issue.

resident's back and attempted to push him into the room." ALJ Decision at 3. This is clearly deliberate behavior. Merrimack's response to CMS's appeal quotes this statement by the ALJ and also states that "the staff member first placed her hand on Resident #2's arm . . . ." Response Br. at 3. This further description by Merrimack is clearly a description of deliberate physical contact. Thus, under the Board's holding in *Britthaven of Smithfield*, the LNA engaged in "willful" (deliberate) conduct.

The ALJ does not mention the Board's holdings in *Britthaven of Smithfield* and *Vandalia Park*. Merrimack suggests that the Board made a holding in *Beverly Health and Rehabilitation Center-Williamsburg*, DAB No. 1748 (2000) that is inconsistent with the Board's holdings in *Vandalia Park* and *Britthaven of Smithfield*. Response Br. at 10-12. We disagree. In the *Beverly* case, the Board did uphold a decision in which the ALJ treated intent to harm as a requisite element of abuse and concluded CMS had not made a prima facie case of abuse because there was no evidence a resident who attempted to unplug the respirator of his roommate to stop annoying noise intended to harm the roommate. DAB No. 1748, upholding *Beverly Health and Rehabilitation of Williamsburg*, DAB CR653 (2000). However, the Board did not specifically endorse or adopt the "intent to harm" analysis of the ALJ. Rather, the Board upheld the ALJ because "[t]he undisputed facts . . . strongly establish that no willful behavior was involved or likely to have occurred here." DAB No. 1748, at 9. The Board further stated that "the risk of abuse must be determined within the regulatory definition of abuse, as, in relevant part, 'the *willful infliction* of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or *mental anguish*.'" *Id*., citing 42 C.F.R. § 488.301 (emphasis added by *Beverly* panel). Both statements track the regulatory language "willful" without defining the term, much less holding that "willful" means that the resident actor intended to injure or harm his roommate.[5]

As CMS notes, there is only one statement in *Beverly* that arguably implies support of the ALJ's "intent to harm" analysis in that case. *See* RR at 7-8. In that statement, the Board concluded that it was unnecessary to infer that the actor resident "lacked the capacity to engage in any willful injurious conduct" because "no such broad inference is necessary to demonstrate that R. 2 had no injurious intent or motive in connection with R. 1 and the respirator." DAB No. 1748, at 9 (emphasis added). However, in context, the quoted statement does not support a conclusion that the Board was endorsing the ALJ's view that "intent to harm" was a necessary element of abuse. The Board made the statement when

[5] The same is true of the Board's statement that it found no evidence that the resident actor's conduct was "willfully injurious," a statement to which Merrimack points. *See* Response Br., at 12.

agreeing with the ALJ that "there is nothing showing that R 2 was aware of any connection between the machine plugged into the wall and the other person in the room or that R. 2 intended any impact on R. 1." DAB No. 1748, at 9 (2000). In this context, it seems clear the Board was focusing not on the resident actor's intentions toward his roommate but, rather, on whether the resident actor's action was "deliberate," that is, whether he even realized that unplugging a machine that was making an annoying noise would somehow impact a resident rather than just stop the noise. We thus conclude that the Board decision in *Beverly* is not inconsistent with the Board's later holdings in *Britthaven of Smithfield* and *Vandalia Park*.

2. *Substantial evidence supports a conclusion that the conduct willfully engaged in by the LNA intimidated and unreasonably confined R2, resulting in harm in the form of emotional distress.*

As indicated above, the ALJ concluded that the LNA's conduct resulted in harm to R2 in the form of emotional distress. That R2 suffered emotional distress is clear from the record, and Merrimack does not dispute this, although, as discussed later, it questions the degree of that emotional distress. The ALJ did not expressly determine whether the LNA's conduct, which we have determined was "willful," inflicted injury, intimidation, unreasonable confinement or punishment, which is also an element of the definition of abuse. Arguably, one could conclude that the ALJ's finding that R2 was harmed would have required him to find that the LNA inflicted injury on R2 had the ALJ done the proper analysis. However, we need not decide this since, as discussed below, we conclude that substantial evidence supports a finding that the LNA inflicted intimidation and unreasonable confinement on R2.

We find no support in the record for the ALJ's benign characterization of the LNA's conduct. The ALJ's characterization of the LNA's behavior as simply attempting to lead or guide R2 to his room for toileting is not supported by the video, on which the ALJ relies for that characterization. We have watched the video, and it unambiguously shows the LNA using physical force on R2 by pulling his arms and then pushing him toward his room with her hands on his back. The nature and extent of the LNA's physical contact with the resident is apparent from the video's depiction of both the LNA's conduct and R2's strenuous, even desperate, efforts to resist her, efforts that resulted in the LNA's falling to the floor. The ALJ's characterization of the LNA's conduct as merely "attempting to guide [R2] into his room . . ." is also inconsistent with the surveyor's report on the SOD of what she saw when viewing the video with Merrimack's Administrator.

> Staff D, LNA . . . approached [R2] who displayed resistance by attempting to push away [the LNA] . . . [The LNA] does not walk away or attempt to re-approach [R2] later but continues the interaction with [R2] in which [the LNA] is observed placing hands on [R2's] arm and attempting to pull [R2] towards [R2's] room. [R2] is observed attempting to free arm from [LNA's] hands when [LNA] releases [R2's] arm and [LNA] then placed both hands onto [R2's] back and pushes [R2] into the room.

CMS Ex. 2 at 3-4; s*ee also* CMS Ex. 2, at 1-2 (the same passage used in the deficiency citation that the ALJ upheld – freedom to refuse treatment). The ALJ cites the SOD account but recharacterizes the surveyor's description of the LNA "attempting to pull [R2] towards his room" as "attempted to lead [R2] into his room . . . ." ALJ Decision at 3, citing CMS Ex. 2, at 1-2. The ALJ further states, consistent with the SOD account, that the LNA "put her hands on the resident's back" but then, citing Merrimack's brief, recharacterizes what the SOD describes as "push[ing] [R2] into the room" as "attempted to push him into the room." *Id*., citing P. Br. at 3. The ALJ gives no explanation for describing the LNA's behavior differently than what the surveyor reported on the SOD. The ALJ also does not explain the discrepancy between the SOD account of what appears on the video (the LNA's pulling and pushing R2) and the ALJ's more benign finding about what appears on the video (the LNA's "attempting to guide the resident into his room"). In addition, the record contains no evidence rebutting the SOD account and, most significantly, does not contain any testimony by the Administrator to contradict the surveyor's account of what she and the Administrator saw on the video. The SOD account is entirely consistent with what we observed on the video, which we discussed above. The ALJ provided no explanation for disregarding or mischaracterizing the nature of the videotaped interaction.

The ALJ also does not discuss the SOD report of the surveyor's interview with the Administrator and DON. The surveyor reported that during the interview –

> Administrator and . . . [DON] indicated that . . . [the] LNA did not follow [R2's] care plan and that [the LNA] had unprivileged contact and rough handling utilizing physical interventions of pushing and pulling [R2]. [R2's] behavior escalated as a result with [R2] becoming physically abusive toward [the LNA] resulting in [the LNA] receiving injury.

CMS Ex. 2, at 4. There is no evidence of record rebutting this SOD account of the interview. Moreover, this account and the SOD account of what appears on the video are consistent with statements made by Merrimack in its hearing request, which was filed by the Administrator. In that document, Merrimack states as follows:

> On review of the video it is noted that [the LNA] approaches resident for care, resident is seen pushing [LNA]. [LNA] takes the arm of the resident and pulls him toward a room, she then places two hands on his back and shoves him towards that room. [R2] grabs [LNA's] arm and does not let go, [LNA] yells for help and staff begin to come to her aide [sic] as [R2] pushes her to the floor. The video is clear that this event occurred and was unwitnessed by any other staff member. [LNA] was shown this video and interviewed as part of the abuse investigation. She admittedly stated that her approach was wrong. She was subsequently terminated at the conclusion of this investigation.

Hearing Request at 2. Based on the foregoing, we conclude that substantial evidence in the record as a whole (including evidence contradicting the ALJ's findings that he did not address in his decision) does not support the ALJ's finding that the conduct in which the LNA engaged with respect to R2 was merely an attempt to lead or guide the resident to his room. Rather, substantial evidence of record shows that the LNA ignored the directive in R2's care plan to leave if the resident resisted care and, instead, physically pulled and shoved R2 toward his room in an effort to make him comply with her attempt to provide care. The LNA continued this conduct despite resistance by the resident that was so vigorous as to ultimately knock the LNA to the floor. In our view, and applying the Board precedent discussed earlier, this evidence amply supports a conclusion that the LNA engaged in conduct (holding the resident and attempting to physically force him into his room against his will) that constitutes a deliberate infliction of unreasonable confinement and a deliberate infliction of intimidation within the meaning of section 483.13(b).

In reaching this conclusion, we have considered, but reject, Merrimack's arguments that there was no intimidation or unreasonable confinement. Merrimack argues that *Britthaven of Smithfield* supports its position "that the LNA's conduct did not rise to the level of willful intimidation." Response Br. at 7. Merrimack does not deny that the LNA's conduct in this case was deliberate, but argues that "[t]hreatening the resident [in *Britthaven of Smithfield*] with physical abuse (particularly when he can't see) is an

obvious example of intimidation [that] stands in stark contrast to the actions of the LNA in the present case." *Id*. While we recognize that the cases are not factually identical, we find no factual differences material to our conclusion here that the LNA's conduct was intimidating. Merrimack acknowledges that R2 "was upset." *Id*. Merrimack does not explain why "being upset" is not consistent with having feelings of fear or intimidation, especially in a nursing home resident with Alzheimer's disease and serious cognitive deficits who displays agitated and aggressive behavior and resists care.

Furthermore, describing R2 as "being upset" seriously understates his response to the LNA's conduct. As Merrimack does not dispute, the record shows that R2 was so upset that he aggressively resisted the LNA and ultimately pushed her to the floor. Merrimack asserts that R2 "was *never* in any danger, nor did he fear or have reason to fear the LNA based on her actions." *Id*. (emphasis in original) This assertion, too, is undercut by the vigor with which R2 fought the LNA's attempts to take him to his room for toileting. It is also undercut by the ALJ's findings, undisputed by Merrimack, that R2 was at risk for falls and that "[a]ttempting to guide the resident into his room against his will and in light of his uniquely demented state clearly exacerbated this resident's risk of falling and posed a risk for causing that resident to suffer from severe physical harm." ALJ Decision at 6. Merrimack asserts that R2 "clearly [was] not intimidated enough to do what he thought the LNA was asking him to do (i.e. go into his room to use the toilet)." RR at 7. This assertion fails to explain why a response – compliance – that might reasonably be expected from a healthy, fully cognizant person faced with intimidating conduct could reasonably be expected from a nursing home resident with Alzheimer's disease and serious cognitive deficits. The assertion also is irrelevant since the definition of "abuse" requires only "intimidation" without specifying any particular response to the intimidation.

We also find no basis for Merrimack's attempt to distinguish this case from *Britthaven of Smithfield* by asserting that "there is no evidence that the LNA [unlike the nurse in *Britthaven of Smithfield*] was guiding the resident to his room in an attempt to 'modify his behavior.'" *Id*. As we have discussed, characterizing what the LNA did as "guiding the resident to his room" is inconsistent with what the video depicts and other evidence of record shows. But even if one accepted Merrimack's characterization (as the ALJ apparently did), the LNA was clearly trying to get R2 to go to his room rather than resisting care which, reasonably viewed, qualifies as an attempt to modify his behavior. In any event, the alleged factual distinction, even if true, would not change our conclusion, based on the record in this case that the LNA's conduct intimidated R2.

In support of its assertion that the LNA's conduct does not constitute unreasonable confinement, Merrimack states, "To argue that directing the Resident into his own bedroom constituted unreasonable confinement is akin to arguing that a resident who would rather sleep in the hallway than in his bedroom is being unreasonably confined when redirected by staff to his bed." Response Br. at 8. This is a mischaracterization of the LNA's conduct and how it impacted R2. The video clearly shows the LNA physically pulling R2 by the arms and pushing him forcefully with her hands on his back from the hallway toward his room. The restriction of R2's ability to move freely was such that the resident finally got the LNA to release him only by struggling to the point where he managed to grab the LNA's arms and push her to the floor. The facility's Administrator and DON aptly described the LNA's physical conduct as "unprivileged contact and rough handling utilizing physical interventions of pushing and pulling Resident #2." CMS Ex. 2, at 2, 4. Moreover, the facility admits that the LNA's conduct was in violation of R2's care plan directive to leave the resident and return later if he resisted care.

B. A per-instance CMP in the amount of $6,000, not $3,000, is reasonable.

When CMS elects to impose a per-instance CMP, as it did here, the CMP amount must be in the range of $1,000 to $10,000 per instance regardless of the scope and severity of the noncompliance.[6] In reviewing the amount of a CMP to determine if it is reasonable, an ALJ may not reduce a CMP to zero, review CMS's exercise of discretion to impose a CMP or consider any factors other than those specified in section 488.438(f) of CMS's regulations. 42 C.F.R. § 488.438(e); *Senior Rehabilitation and Skilled Nursing Center*, DAB No. 2300, at 19-20 (2010).

In this case, CMS imposed a $6,000 per-instance CMP. The ALJ found that amount unreasonable in light of his conclusion that Merrimack was in substantial compliance with section 483.13(b).

[6] The ALJ correctly stated that he had no authority to address the scope and severity of Merrimack's noncompliance because CMS had imposed a per-instance CMP (which has only one range) and because there was no finding of substandard quality of care leading to a loss of the facility's authority to conduct nurse aide training. *See* ALJ Decision at 5, citing 42 C.F.R. § 498.3(b)(14),(16) and 42 C.F.R. § 498.3(d)(10)(i). CMS did notify Merrimack that it was subject to the statutory prohibition on nurse aide training being conducted by or in the facility, but this notice was based on the imposition of a CMP of $5,000 or more, not on a finding of substandard quality of care. *See* CMS Ex. 3, at 3. Neither party has identified any issue regarding the loss of authority to offer or conduct nurse aide training.

> CMS determined to impose a per-instance penalty of $6,000 based on Petitioner's alleged noncompliance with two regulations governing residents' rights and abuse. However, the evidence in this case establishes only one failure by Petitioner to comply substantially with regulatory requirements. That Petitioner contravened only one and not two regulations, in the context of this case's evidence, reduces the seriousness of its noncompliance.

ALJ Decision at 5-6. The ALJ then concluded that a CMP of $3,000 was reasonable based on the seriousness of the facility's noncompliance with section 483.10(b)(4). The ALJ noted in general that "[r]esidents in skilled nursing facilities are by definition individuals who are incapable of caring for themselves " and that "[u]se of force against a nursing home resident is axiomatically an act that would put that resident at risk for harm." *Id*. at 6. The ALJ then found that the risk of harm to R2 "was more than theoretical." *Id*. The ALJ continued:

> The resident was identified by Petitioner's staff a being at risk from falls. P. Ex. 8 at 5. Attempting to guide the resident into his room against his will and in light of his uniquely demented state clearly exacerbated this resident's risk of falling and posed a risk for causing that resident to suffer from severe physical harm.

Id.

On appeal, each party asserts that the reasonableness of the amount of the CMP should be determined by whether we uphold or reverse the ALJ's determination to overturn the CMS finding of noncompliance with section 483.13(b). That is, Merrimack asserts that we should uphold the $3,000 if, as it requests, we uphold the ALJ's conclusion that it was in substantial compliance with section 483.13(b), and CMS asserts that we should restore the full $6,000 CMP amount if we reverse the ALJ on that issue, as we have done. We find a $6,000 CMP reasonable in light of that reversal and in light of the seriousness of the deficiencies. We agree with the ALJ that the deficiency findings causing Merrimack's noncompliance were serious and find that although the ALJ discussed those findings only in the context of his upholding the finding of noncompliance with section 483.10(b)(4), the same deficiency findings are the basis for the now-reinstated finding of noncompliance with section 483.13(b). As the ALJ found, the actions of the LNA resulted in emotional distress to R2 and posed a very real risk that he would fall and suffer serious physical injury. In fact, the LNA's pulling and pushing of R2, coupled with R2's vigorous physical resistance to the LNA, posed a very real threat of physical injury to R2 even absent a fall. We also note that the record contains evidence of

Merrimack's history of serious noncompliance, a history cited by the State agency when recommending the $6,000 per-instance CMP amount to CMS. *See* CMS Ex. 1 (State agency notice letter) at 2; *see also* CMS Ex. 4 (AEM Nursing Home Enforcement History). Although the ALJ did not cite this history, it is further evidence that the $6,000 CMP amount is reasonable, and we so conclude.

Conclusion

For the reasons stated above, we reverse the statement in the ALJ's finding of fact and conclusion of law (FFCL) 1 that "[t]he preponderance of the evidence establishes that Petitioner complied with the requirements of 42 C.F.R. § 483.13(b)" (ALJ Decision at 2) and replace that statement with the following: "Petitioner is not in substantial compliance with the requirements of 42 C.F.R. § 483.13(b)." We otherwise affirm the ALJ's FFCL 1. We reverse the ALJ's FFCL 2 (ALJ Decision at 5) and substitute the following: "A per-instance CMP of $6,000 is reasonable."

/s/
Constance B. Tobias

/s/
Leslie A. Sussan

/s/
Sheila Ann Hegy
Presiding Board Member