Department of Health and Human Services

# DEPARTMENTAL APPEALS BOARD

## Appellate Division

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| In the Case of: | DATE: July 31, 2008 |
| Brookshire Health Care Center, | |
| Petitioner, | Civil Remedies CR1693<br>App. Div. Docket No. A-08-48 |
| - v. - | Decision No. 2190 |
| Centers for Medicare & Medicaid Services. | |

FINAL DECISION ON REVIEW OF ADMINISTRATIVE LAW JUDGE DECISION

We affirm the November 27, 2007 decision of Administrative Law Judge (ALJ) José A. Anglada to sustain a determination by the Centers for Medicare & Medicaid Services (CMS) that Brookshire Health Care Center (Brookshire) failed to comply substantially with 42 C.F.R. § 483.15(g)(1). Brookshire Health Care Center, CR1693 (2007) (ALJ Decision). Section 483.15(g)(1) requires that a long-term care facility participating in the Medicare and Medicaid programs "must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident." CMS determined that the noncompliance posed immediate jeopardy to resident health and safety from January 25, 2006 through February 24, 2006 and continued at a lesser level through March 14, 2006. CMS imposed civil monetary penalties (CMPs) for those periods of $3,050 per day and $50 per day, respectively, and prohibited Brookshire from conducting a nurse aide training or competency evaluation program (NATCEP) for a two-year period. The ALJ sustained CMS's determinations, and Brookshire appealed. At Brookshire's request, the Board held an oral argument.

Applicable Legal Provisions

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 applicable program requirements which appear at 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. CMS may impose CMPs ranging from $3,050 - $10,000 per day for one or more deficiencies constituting immediate jeopardy and from $50 - $3,000 per day for deficiencies that do not constitute immediate jeopardy but that either cause actual harm or create the potential for more than minimal harm. 42 C.F.R. §§ 488.402(c), 488.408; 488.438(a). The regulations set out a number of factors that CMS considers in determining the amount of a CMP. 42 C.F.R. § 488.438(f).

Standard of Review

Our standard of review on a disputed conclusion of law is whether the ALJ decision is erroneous. Our standard of review on a disputed finding of fact is whether the ALJ decision is supported by substantial evidence on the record as a whole. Guidelines - Appellate Review of Decisions of Administrative Law Judges Affecting A Provider's Participation In the Medicare and Medicaid Programs; 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); Hillman Rehabilitation Center, DAB No. 1611, at 6 (1997), aff'd, Hillman Rehabilitation Ctr. v. U.S. Dep't of Health and Human Servs., No. 98-3789 (GEB) at 21-38 (D.N.J. May 13, 1999).

Case Background

The appeal involves a resident (Resident 1) who committed suicide at the facility. The following facts are undisputed. Resident 1 was a 54-year old male who was admitted to the facility from a homeless shelter in August 2005. He was confined to a wheelchair as a result of injuries to his right hip and ankle sustained in an automobile accident. Additional diagnoses included peripheral vascular disease, chronic obstructive pulmonary disease, Hepatitis C, and major depressive disorder, and he had a history of alcohol, cannabis, and narcotic addiction. He received several types of prescription painkillers and anti-anxiety agents. ALJ Decision at 7-9. Initial assessments described him

as uncooperative, dissatisfied, with a sad facial affect and persistent mood problems related to depressive disorder. While at the facility he engaged in manipulative, disruptive behaviors including angry outbursts, verbally abusing and threatening residents and staff, and abusing alcohol and illicit drugs. On February 7, 2006, Resident 1 committed suicide in his room with a handgun. Id.

Following an evidentiary hearing and post-hearing briefing, the ALJ made the following findings of fact and conclusion of law (FFCLs), all of which Brookshire disputes:

> ***A. Petitioner was not in substantial compliance with the participation requirement at 42 C.F.R. § 483.15(g)(1) based on its care of Resident 1.***
>
> > ***1. Petitioner did not review and change interventions that were not effective.***
> >
> > ***2. Petitioner did not inservice staff about how to work with a resident with manipulative behaviors.***
>
> ***B. CMS's determination that immediate jeopardy existed is not clearly erroneous.***
>
> ***C. The amount of the CMPs imposed by CMS is reasonable.***

Discussion

1. The ALJ correctly concluded that Brookshire was not in substantial compliance with the participation requirement at 42 C.F.R. § 483.15(g)(1).

The applicable regulation with which the ALJ determined that Brookshire was not in substantial compliance states--

> § 483.15 Quality of life.
>
> A facility must care for its residents in a manner and in an environment that promotes maintenance or enhancement of each resident's quality of life.
>
> * * * *
>
> (g) Social Services. (1) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.

CMS explained this requirement in its State Operations Manual (SOM) under "tag" F250, which Brookshire submitted as an exhibit. "'Medically-related social services' means services provided by the facility's staff to assist residents in maintaining or improving their ability to manage their everyday physical, mental, and psychosocial needs." P. Ex. 22 (SOM, App. PP at F250). As the ALJ noted, the SOM states that examples of medically-related social services "might include" services such as "[d]ischarge planning services (e.g., helping to place a resident on a waiting list for community congregate living, arranging intake for home care services for residents returning home, assisting with transfer arrangements to other facilities)"; "[p]roviding or arranging provision of needed counseling services"; "[t]hrough the assessment and care planning process, identifying and seeking ways to support residents' individual needs"; and "[f]inding options that most meet the physical and emotional needs of each resident." Id.; ALJ Decision at 8. Factors that the SOM describes as having a "potentially negative effect on physical, mental, and psychological well being include an unmet need" for dental care, among other things. P. Ex. 22. The SOM further notes that the types of conditions to which a facility should respond with social services by staff or referral include, among other conditions, behavioral symptoms, the presence of a chronic disabling medical or psychological condition, depression, chronic or acute pain, difficulty with personal interaction and socialization skills, and abuse of alcohol or other drugs. Id. Additionally, "[t]he facility is responsible for the safety of any potential resident victims while it assesses the circumstances of the resident[']s behavior," and "it is the responsibility of the facility to identify the medically-related social service needs of the resident and assure that the needs are met by the appropriate disciplines." Id.

The ALJ found that Brookshire did not substantially comply with the regulation essentially because Brookshire failed to change its approaches to addressing the resident's behaviors, which were not working, when those behaviors escalated in January 2006, and failed to train its staff in dealing with the resident's behaviors.[1]

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[1] CMS determined that Brookshire was not in substantial compliance with two other participation requirements at the immediate jeopardy level with respect to Resident 1: 42 C.F.R. § 483.25(f)(1) (Mental and Psychosocial Functioning, F Tag 319); and 42 C.F.R. § 483.75(h) (Use of Outside Resources, F Tag 500). The ALJ made no findings concerning those requirements as he determined that the violation of 42 C.F.R. § 483.15(g)(1)

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a. Substantial evidence supports the ALJ's finding that the resident's problematic behaviors were escalating in January 2006.

Brookshire does not dispute the accounts of Resident 1's behaviors in the Statement of Deficiencies (SOD) and the ALJ Decision, but argues that the behaviors did not "escalate" in January 2006, and that there was thus no need for Brookshire to change its approaches to dealing with the resident. Brookshire argues that the ALJ misinterpreted a January 29, 2006 progress note by Dr. Williams, the facility's Medical Director and one of the physicians who treated the resident, that "[p]er staff, there has been an ↑ in disruptive behaviors, noncompliance, and angry outbursts." CMS Ex. 19, at 83 and P. Ex. 4, at 104; see ALJ Decision at 11, 17. Brookshire argues that the upward arrow in this note means that the resident's behaviors, which had subsided during November and December 2005, were "increasing" but "not escalating" when the resident "began to act out" in January 2006. Petitioner Request for Review (P. RR) at 9.

That argument is inconsistent with the plain meaning of "escalate" – "to increase, enlarge, or intensify" and "to increase in intensity or extent"[2] – and with the record, which is undisputed and supports the ALJ's finding. The ALJ cited Brookshire's "behavior logs," nurse's notes, and a social service progress note that describe the following incidents. For example, on January 12, 2006, a staff member reported Resident 1 was under suspicion for smoking marijuana, as the smell was present and Resident 1 was the only one there. On January 20, 2006, after a nurse explained to Resident 1 that he could not sign out two hours in advance of his departure, Resident 1 stated

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[1](...continued)
provided a sufficient basis for the enforcement remedies that CMS proposed, and because the amount of the per-day CMPs for the periods of immediate and less than immediate jeopardy noncompliance were at the minimum level provided in the regulations and would thus not change regardless of how many of the three cited deficiencies the ALJ sustained. ALJ Decision at 6-7. As we sustain the ALJ Decision based on the regulation that the ALJ addressed, we do not discuss further CMS's determinations that Brookshire was not in substantial compliance with 42 C.F.R. §§ 483.25(f)(1) and 483.75(h).

[2] *The American Heritage® Dictionary of the English Language, 4th Edition* (Houghton Mifflin Company, 2004) http://dictionary.reference.com/browse/escalate (accessed July 28, 2008).

"I have rights & I will do what I damn well please." On January 21, 2006, Resident 1 went behind the nurse's station, looked through papers for a staff member's phone number and into the cigarette container for his cigarettes, and become "loud and rude" when staff spoke to him, declaring that he "did what he wants." On January 23, 2006, when a nurse informed Resident 1 that another resident was using the portable phone and that she would bring it to him when he was done, Resident 1 stated: "I bet I know who is on the phone, the same SOB that is always on the phone" and "I'll go in that punks room & take it. I need to use the phone!" ALJ Decision at 12, 13, citing CMS Ex. 19, at 142, 217-18, 230.

The incident that the ALJ considered "[p]erhaps most unsettling" apart from the resident's suicide occurred on the morning of January 25, 2006. ALJ Decision at 15. Resident 1 entered a staff meeting being chaired by Kathi Duke, Continuous Quality Improvement (CQI) Director of Brookshire's parent corporation and asked if he could address the group. When told to wait until after the meeting to voice his concerns, he left the meeting stating "I could take ten of you out." A half-hour later the resident came to the Director of Nursing's Office, where the CQI Director advised the resident that she would be glad to address his concerns but that he did not need to threaten staff. In response, the Resident stated, "It is not a threat. I can take them out anytime I want to." Id., citing CMS Ex. 19, at 219; see also Tr. at 111, 122-23. At 5:30 p.m. that day, Resident 1 unplugged and took a cordless phone while another resident was on the phone. At 7:25 p.m. Resident 1 went behind the nurse's desk into the cigarette box; although he denied this, two other residents watched him do it. At 8:00 p.m., the resident complained about another resident using the phone and yelled and cursed at the nurse, declaring that "it is my business I speak for everyone." At 9:00 p.m. he went into the room of another resident who had just turned on his light, and came out yelling and cursing at the nurse, saying that the light had been on for 30 minutes; when the resident was told it was not his concern he said "everything is [my] concern. I speak for everyone." ALJ Decision at 13-14, citing CMS Ex. 19, at 142-43.

On January 28, 2006, at 11:00 a.m., Resident 1 went into another resident's room and turned off that resident's IV pump, stating it was beeping. At 5:30 p.m., Resident 1 refused a nurse's request to come in from the front porch, stating "I don't have to . . . I can do anything I want." At 6:00 p.m., another resident who had been visiting Resident 1 was found "sloppy drunk" by a nurse who then found an empty fifth bottle of Jack Daniel's in Resident 1's room. On January 29, 2006, Resident 1 was found on the front porch smoking a "blunt" and refused to take a drug

test.[3] Id. at 13-14, citing CMS Ex. 19, at 141, 218; see also CMS Ex. 19, at 220. In response to the resident's suspected use of marijuana Brookshire began discharge proceedings, serving him on January 30, 2006 with notice that he would be discharged in 30 days, which Brookshire rescinded and reissued on February 6, 2006. ALJ Decision at 15, 17, citing CMS Ex. 19, at 269, Tr. at 214, and P. Br. at 11-12.[4]

On February 1, 2006, at 9:00 p.m., Resident 1 asked for information about another resident's medication, was told that the nurse could not give him such information by state law, and became insistent on being answered, and "wrote this nurse up" by putting a note regarding his complaint about the nurse under the facility's Administrator's door. On February 2, 2006, Resident 1 came to the nurse's desk to ask about a noise, was told it was an IV pump, and stated "who's is it, why don't you turn it off instead of sitting on your lazy butt & do something." Id. at 14, citing CMS Ex. 19, at 141.

Finally, on February 7, 2006, Resident 1 was found on the floor next to his bed with blood around his head and died after being taken to the emergency room. He had shot himself, and a police investigation determined that he had purchased two guns from a local pawn shop, which he picked up on February 3, 2006. Id. at 15, citing CMS Ex., CMS Ex. 18, at 27, CMS Ex. 19, at 71-72, and P. Ex. 7, at 1.

Brookshire argues that although the resident's problematic behaviors increased during January 2006, they were no worse than during August through October 2005, when, Brookshire states, Resident 1 used inappropriate language, could be verbally abusive, made notations in his own chart, and began having angry outbursts toward the staff.[5] P. RR at 7. Contrary to what

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[3] A "blunt" is a cigar stuffed with marijuana. *Dictionary.com. Unabridged (v 1.1),* Random House, Inc. http://dictionary.reference.com/browse/blunt (accessed July 28, 2008).

[4] Brookshire reports that it rescinded the initial notice because Brookshire had failed at that time to secure an alternative placement for the resident. See, e.g., Tr. at 163-64 (testimony of CQI Director).

[5] The ALJ cited facility records from that period that also record incidents of Resident 1 cursing and yelling at staff, arguing with other residents, manipulating staff, violating the facility smoking policy, seeking pain patches, complaining about

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Brookshire argues, the record of incidents in January 2006 shows ways in which the resident's acting out was indeed worse than it had been during August through October 2005, most notably in the form of the resident taking a portable phone from another resident, using marijuana, supplying hard liquor to another resident, and making and repeating a threat to staff in a manner more direct and disturbing than any of the behaviors recorded in the earlier period. Moreover, his actions during January 2006 occurred over a period of less than three weeks versus the earlier period of two and a half months.

In characterizing the increase in the resident's behaviors, the ALJ reasonably relied on the uncontroverted descriptions in the facility's records and on Dr. William's contemporaneous note, rather than the later testimony of Brookshire's CQI Director that she did not consider the resident's behaviors to have escalated in January 2006. Tr. at 163. The SOD also describes the resident's behaviors as having begun to escalate in January 2006, as did the surveyor who prepared the SOD. CMS Ex. 2, at 4; Tr. at 8, 26, 28-29. The surveyor is a registered nurse and the acting supervisor of long-term care in the Alabama Department of Public Health, and may be presumed to possess expertise in assessing a resident's behavior based on review of a facility's records.[6] Tr. at 4.

It is not relevant to our analysis whether the resident's "disruptive behaviors, noncompliance, and angry outbursts" in January 2006, as the facility's physician described them (CMS Ex. 19, at 83; P. Ex. 4, at 104), escalated in comparison to his behaviors in August through October 2005, or only in comparison

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meals, becoming easily agitated when the staff did not meet his demands, and threatening another resident on October 9, 2005. ALJ Decision at 10, citing CMS Ex. 19, at 122, 125, 126, 127, 193-96, 198, 200, 204; see also CMS Ex. 19, at 202. The resident had refused a mental health consultation to address "maladaptive behaviors" on October 11, 2005, stating that he did not want any services other than to see a "prescribing psychiatrist;" the facility physician who saw him initially but dismissed him as a patient and Dr. Williams suspected that Resident 1's problems were largely related to excessive narcotics. ALJ Decision at 10, citing CMS Ex. 19, at 176.

[6] "Surveyors are professionals who use their judgment, in concert with Federal forms and procedures, to determine compliance" and who receive "comprehensive training" from CMS. 42 C.F.R. §§ 488.26(c)(3), 488.314(b). Brookshire has not disputed the qualifications of the surveyors here.

to November and December 2005 when, the ALJ found, his behaviors "seemed to subside" (ALJ Decision at 11). The uncontroverted increase in the resident's behaviors, beginning in January 2006, supports the ALJ's finding that Brookshire's approaches to addressing those behaviors were not working and that Brookshire's response was inadequate.

b. Substantial evidence supports the ALJ's finding that Brookshire failed to review and change interventions that were not effective when the resident's problematic behaviors escalated in January 2006.

Brookshire argues that interventions it had in place prior to January 2006 were adequate to address Resident 1's behaviors. Oral Argument Tr. at 14. The record shows, however, that Brookshire failed to adequately respond to the resident's behaviors or investigate their causes as required by Brookshire's Behavior Management Policy and the care plan that Brookshire developed for Resident 1.[7]

The Behavior Management Policy required Brookshire's Social Service Director (SSD) to investigate any possible family or personal problems and any change in customary routines or adjustment problems, to monitor on a weekly basis the effectiveness of an individual resident's behavior management plan, to revise the behavior management plan weekly or as needed,

[7] Brookshire argues that the ALJ did not address CMS's assertion that Brookshire failed to investigate Resident 1's behaviors. The ALJ characterized that assertion, and CMS's additional assertions that Brookshire failed to follow through with its Behavioral Management Policy and the resident's care plan, as amounting to a determination, which the ALJ sustained, that Brookshire failed to review the policy and plan and change interventions that were not effective when the resident's behaviors escalated in January 2006. ALJ Decision at 7-8. The ALJ determined that Brookshire's principal response to the escalation in Resident 1's behaviors was to serve him with a notice of discharge from the facility, and that the facility did not update the care plan to manage the resident's behaviors during the 30 days that he was to have remained at the facility following service of the discharge notice. Id. at 17. Implicit in the ALJ's description of Brookshire's responses to the various incidents is that the response did not include any investigation of the causes. Although Brookshire did make some attempts to address some of Resident 1's concerns, such as his complaints about meals (Tr. at 265-66), the record does not indicate the type of investigation of causal factors contemplated by Brookshire's policy and the regulation.

and to submit a written weekly report. CMS Ex. 19, at 144-45. The Policy also required the facility to identify residents with new or worsening behaviors who are in need of specific behavioral interventions in order to "bring dangerous or disruptive behavior under control" and to "intervene immediately to seek the causative agent/contributing factor when the resident exhibits a change in behavior, by consulting other staff, exploring possible environmental and other preventable causes," and advises that medical evaluation for behaviors may be necessary. Id. The care plan that Brookshire developed in September 2005 to address Resident 1's behaviors required the facility to investigate the resident's threatening statements to staff as quickly as possible and to document the behavior in the behavior management book and the resident's chart; and to state the facility's expectations and limits with the resident and what is expected. Id. at 152.

Brookshire has not documented that it responded to the resident's behaviors in January 2006 by taking all of the measures required by the Behavior Management Policy and the care plan. Most significantly, despite the many incidents and outbursts by the resident during January 2006, there are no care plan entries concerning the resident's behavior or his mental condition between November 21, 2005 and February 6, 2006, at which time the only approaches listed were to present the resident with a discharge letter and to discuss placement plans with him. P. Ex. 4, at 58. Brookshire does not dispute the ALJ's findings that Brookshire recorded few instances in the "behavior logs" prior to January 10, 2006, and that thereafter it failed to record in the logs all of the incidents reflected in other facility records, such as nurses notes. See ALJ Decision at 10, 12, 14-15. Brookshire also does not dispute the ALJ's finding that in January 2006 Brookshire failed to fill out the behavior logs fully; as the ALJ noted, the logs are designed to record why the behavior occurred, the approach used to address the behavior, whether the approach was successful and if not, why, and the resident's behavior subsequent to the intervention. Id. at 12. The design of the behavior logs is consistent with Brookshire's Behavior Management Policy and the resident's care plan, above, requiring that the facility investigate problematic behaviors to determine their causes. As the ALJ found, the behavior logs for January 2006 "really only" state the resident's behaviors, and do not consistently contain the information they were designed to record or document that Brookshire took the measures required by its own policy and the care plan. Id.

Brookshire asserts that it responded quickly and appropriately after the resident threatened staff that he "could take ten of you out" because it convened a meeting of staff from all disciplines and department heads to discuss the incident and

because the resident recanted or apologized to Kathi Duke, the CQI Director. See Tr. at 113. Brookshire relies on the testimony of its expert witness, Dr. Thompson, to the effect that the recantation indicates that the facility addressed the matter. Oral Argument Tr. at 19, 29; Tr. at 398-400. While it appears that Ms. Duke and the expert accepted Resident 1's apology or recantation as meaning he was not a real threat, the record shows that the facility had earlier identified the resident as engaging in manipulative behaviors, and that the SSD, Sherry Brown, recognized that the resident would typically apologize following his angry outbursts but would then repeat the behavior. CMS Ex. 19, at 152 (care plan, Sept. 6, 2005); P. Ex. 15, at 75 (SSD statement). Dr. Thompson's testimony does not address this aspect of the resident's behavior. See P. Ex. 16; Tr. at 374-409. The facility's reliance on the resident's apology is also questionable in light of the fact that the resident had issued threats in the past, was described as angry, and had a history of behaviors that could be perceived as threatening. P. Ex. 4, at 143 (Nurses Summary Sheet, Sept. 26, 2005); P. Ex. 15, at 39, 43, 60 (post-suicide statements of staff and Resident 1's roommate); see ALJ Decision at 19, citing P. Ex. 15, at 43, 60-61, 105, 127. The resident had also asked the Administrator if he could bring guns into the facility. Tr. at 211-12 (testimony of Acting Administrator); P. Ex. 15, at 40 (statement of SSD). Dr. Thompson acknowledged the resident's potential for violence, stating (as the ALJ pointed out) that if anything, he would have expected the resident to act out by assaulting a staff member, rather than by taking his own life. ALJ Decision at 19, citing Tr. at 395. Thus, in considering Dr. Thompson's testimony as a whole in light of other evidence in the record, the ALJ could reasonably find that the facility did not respond appropriately in accepting the resident's expression of regret for his threat to staff rather than taking further steps to address the threatening behavior.

Brookshire also has not shown that its response complied with its expert's belief that a facility should investigate why a resident makes threats. Tr. at 398-400. The facility has not shown that it made any serious attempt to investigate the causative factors of the resident's threatening statements following the resident's apology, which appeared to close the matter as far as Brookshire was concerned. Brookshire also has not shown that it responded to the threats or to the increase in the resident's behaviors in the manner required by its own Behavior Management Policy. That policy required its SSD to investigate any possible family or personal problems and any change in customary routines or adjustment problems, and to monitor, on a weekly basis, the effectiveness of the resident's behavior management plan and to

revise the behavior management plan weekly or as needed, and to submit a written weekly report. CMS Ex. 19, at 144-15. The Policy further required the facility to identify residents with new or worsening behaviors who are in need of specific behavioral interventions in order to "bring dangerous or disruptive behavior under control" and to "intervene immediately to seek the causative agent/contributing factor when the resident exhibits a change in behavior, by consulting other staff, exploring possible environmental and other preventable causes," and advises that medical evaluation for behaviors may be necessary. Id. Brookshire has not shown that this was done in response to the resident's worsening behavior during January 2006. Similarly, the resident's care plan required Brookshire to, among other things, investigate threatening statements as quickly as possible and to document the behavior in the behavior management log and the resident's chart; and to state the facility's expectations and limits with the resident and what is expected. Id. at 152. While the CQI Director said facility staff had addressed limits and expectations with the resident in the past, there is no indication that they did so in response to his threat to staff on January 25. See Tr. at 136, 142. She did not, moreover, allege that the facility investigated the cause of the behavior. See Tr. at 111-13, 162-63 (following the resident's apology, "[t]he decision was made . . . that no further action was needed"). The incident was also not documented in the resident's behavior management logs. P. Ex. 18.

Brookshire argues that it investigated Resident 1's behaviors by referring him to mental health counseling services from a consulting agency, on August 31 and October 11, 2005, but that the resident refused those attempts to evaluate him, as was his right as an alert and oriented resident. P. Ex. 4, at 100, 109; CMS Ex. 19, at 176. These referrals do not establish that the SSD investigated the possible causes of the resident's behaviors in January 2006, including his threat to staff, or that the SSD attempted to determine what triggered the behaviors, as required by Brookshire's Behavior Management Policy. As Brookshire recognizes, the mental health counselors simply met with Resident 1 to see if he would accept services; this is not equivalent to providing therapy or even evaluating his mental health. Moreover, Brookshire provided no evidence that it did any follow up on the resident's refusal of mental health counseling to determine if he would accept psychiatric services from some other source or to encourage Resident 1 to accept mental health services from the consulting agency.

Brookshire points out that the resident saw his personal psychiatrist, Dr. Adams, on several occasions while in the

facility, and that the facility administered to Resident 1 the medication that Dr. Adams prescribed. Dr Adams, who treated the resident on a pro bono basis while he resided in the facility, saw the resident on December 3, 2005 and February 5, 2006 and made a "brief visit" to the nursing home in the interim, and had 2-3 phone contacts with resident while he was at Brookshire and faxed prescriptions to the facility. P. Ex. 6, at 1, 2 (progress reports); P. Ex. 13 (affidavit); Tr. at 286-88. Dr. Adams had previously treated Resident 1 during the period 2000 through 2004. During that time, Dr. Adams stated, the resident was depressed and had suicidal ideation. Tr. at 282-83. Dr. Adams assessed Resident 1 as having post traumatic stress disorder and "major depressive disorder." P. Ex. 6. Brookshire cites Dr. Adams's testimony and statements that Resident 1's mental health improved during the course of Dr. Adam's treatment "as evidenced by decreased anxiety, paranoia, and depressive symptoms," and his testimony that Resident 1 appeared to be doing well when last seen two days prior to the suicide, as evidence that the facility adequately addressed the resident's needs. P. Ex. 5; P. Ex. 13, at ¶¶ 4-5.

The ALJ could reasonably treat Dr. Adams's testimony as having limited probative value because Dr. Adams was apparently unaware of the resident's problematic, threatening behaviors. The facility's staff did not inform Dr. Adams of Resident 1's behaviors that staff recorded in the nurses notes, such as his threat to staff to "take ten of you out" and his alleged marijuana use. Tr. at 300-01. When Brookshire's Risk Management Nurse called Dr. Adams on February 1, 2006, it was to inform him of a complaint Resident 1 had about his medication (that it was missing or that a facility nurse had ordered the medication from the facility pharmacy, rather than using medication that the resident's friend was supposed to obtain from a Veterans Administration pharmacy), and she did not talk to him about the facility having issued a discharge notice to Resident 1.[8] Tr. at

[8] We also note that, although Brookshire argues that it administered to Resident 1 the medication ordered by his psychiatrist, the record indicates that the facility did not provide Resident 1 with the full amount of the antidepressant medication that Dr. Adams prescribed on December 3, 2005 until approximately a month later. On December 3, Dr. Adams prescribed a total of two milligrams of Clonazepam daily, to be given as one-half milligram doses in the morning and at noon, and a one milligram dose at the hour of sleep (which the facility recorded as 9 p.m and then switched to 5 p.m.). P. Ex. 4, at 81, 83 (physician orders); 86, 87 (facility records). Yet, facility

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248-52, 259-60. Brookshire also submitted no evidence that social services staff coordinated with Dr. Adams to address the resident's behaviors. Thus, Dr. Adams believed that Resident 1, whom he knew had abused alcohol and drugs in the past, was not engaging in substance abuse at Brookshire, and had assumed, incorrectly, that the resident had no access to such substances at the facility. Tr. at 288-89, CMS Ex. 19, at 177 (progress note).

Brookshire's failure to inform Dr. Adams about the resident's behaviors undermines Brookshire's claim that the resident's contacts with Dr. Adams adequately addressed the resident's escalating behaviors. While Brookshire argues that it could not disclose information about Resident 1's condition to persons outside the facility without the resident's consent, Brookshire did not identify any specific prohibition on sharing with physicians such as Dr. Adams information about the resident that was needed for the resident's treatment, nor did it document that it tried to obtain the resident's consent to disclose information to outside physicians and that the resident refused to provide consent. Dr. Adams could not have addressed those behaviors if he was unaware of them.

We also note that at the ALJ hearing, Dr. Adams testified that Resident 1 had or exhibited many of the risk factors for suicide (such as having a psychiatric disorder including depression or a personality disorder, alcohol or substance abuse and a significant medical illness such chronic pain, and access to firearms). Tr. at 301-02. This testimony, if anything, indicates that, while Brookshire's witnesses testified that Brookshire could not have anticipated Resident 1's suicide, better coordination with his psychiatrist could have made the facility more aware of the risk.

Brookshire also argues that it addressed Resident 1's behaviors through the "guardian angel" program it implemented in January 2006 and the efforts of the facility Administrator, who met with the resident and discussed issues related to his adjustment to the facility. The "guardian angel" assigned to Resident 1 was an administrative assistant and CNA who met with Resident 1 to discuss his concerns on January 10, 18, and 25, 2006, and saw him in the facility on a daily basis and socialized with him. Tr. at

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[8](...continued)
medication records show that the facility did not begin administering the one-milligram evening dose until January 2006 and did not administer that dose during December. P. Ex. 4, at 307, 313.

263-77; see also P. Ex. 10 (Guardian Angel logs). While the ALJ did not discuss the guardian angel program, Brookshire's arguments about the program do not demonstrate any error in the ALJ Decision. Brookshire submitted no evidence that the guardian angel had training in mental health issues or in dealing with a depressed, angry individual with chronic pain who manifested the sort of behaviors that the resident displayed during that time. Even if she had been trained, she would not have been in a position to address issues related to Resident 1's behavior, as she was not aware of the resident's threat to staff, or of the fact that he had received a discharge notice; the only concern the resident voiced to her involved the time it took for residents to receive their meals. Tr. at 267, 271. While the Administrator discussed the facility's smoking policy with the resident, most of their interactions appear to have consisted of conversations about the resident's military background, the care of other residents at the facility, and recreational interests such as fishing and gun collecting. Tr. at 205-12. The Administrator did not review the behavior logs for the resident, and was not aware of the resident's "cursing and doing various other things." Tr. at 232. The resident's "concerns" that he and the Administrator discussed involved the treatment of other residents and the amount of time it took them to receive their meals. Tr. at 231. Significantly, Brookshire's expert agreed with the ALJ's observation that Resident 1 tended to appear charming, likeable and affable to physicians such as his own psychiatrist and Brookshire's medical director, and did not display to them the sorts of difficult behaviors described in the nurses notes and other facility records. Tr. at 383-84. The ALJ could reasonably determine that the fact that the facility Administrator described a cordial relationship with Resident 1 and did not personally encounter troubling behaviors did not mean that the facility had no obligation to address such behaviors when they occurred.

The efforts of the guardian angel and the Administrator appear to have been in the nature of socializing and casual conversations. Thus, the ALJ could reasonably find that they were no substitute for an investigation of the causes of the resident's behaviors by the SSD, and not the substantive efforts to have the resident's mental issues addressed by qualified professionals, as anticipated by the SOM, the Behavioral Management Policy, and the care plan.

Accordingly, we conclude that substantial evidence supports the ALJ's determination that when the resident's problematic behaviors escalated in January 2006, Brookshire failed to review and change interventions that were not effective. The record

also supports the ALJ's finding that Brookshire's principal response to the increase in Resident 1's behaviors was to serve him with the notice of discharge from the facility. As noted earlier, the only care plan entry after November 21, 2005 concerning Resident 1's behavior was about presenting the resident with a discharge letter and discussing placement plans with him. See, e.g., P. Ex. 4, at 58. The record does not reflect that, prior to serving the resident with the discharge notice, Brookshire ever informed the resident that discharge from the facility was a possible consequence of his behaviors or his failure to follow facility rules. The record indicates, moreover, that the SSD was not involved in helping the resident to adjust after the second notice of discharge was given, even though the resident had a strong reaction to the first notice. CMS Ex. 19, at 235-38 (SSD's notes from January 30 - February 7, 2006, indicating that the resident threatened to sue for slander upon being given the first discharge notice, and reflecting no services related to the discharge, other than locating another facility for the resident). Finally, as the ALJ noted, the facility needed to address threatening behaviors that might arise during the 30 days the resident was expected to remain following the second notice of discharge, but did not take adequate steps to do so.

c. Substantial evidence supports the ALJ's finding that Brookshire failed to inservice staff about how to work with a resident with manipulative behaviors.

Brookshire disputes the ALJ's FFCL A.2: "Petitioner did not inservice staff about how to work with a resident with manipulative behaviors." Brookshire asserts that it provided training to its staff on addressing behaviors of residents. Oral Argument Tr. at 5, 11-12. The training records and the CQI Director's testimony that Brookshire cites do not support this assertion and show no error in the ALJ's FFCL. Of the inservice training sessions that occurred prior to the suicide of Resident 1, the only session that the ALJ found could be of any relevance was a ten-minute session on January 11, 2006, on documenting residents' behavior in the behavior log. There is no indication that this or any other training session prior to the suicide dealt with how to address those behaviors and how to work with a resident who displayed them. ALJ Decision at 18, citing P. Ex. 20, at 1.

Brookshire relies on the fact that the CQI Director answered affirmatively when asked whether the training (including the training after the resident's suicide) "related to dealing with resident's behavior" even though the training records did not use

the word "behavior." Tr. at 114-15. She did not, however, explain how or in what manner any of the training sessions (which lasted ten minutes, except for two sessions of five and fifteen minutes, respectively) addressed dealing with behaviors similar to those that Resident 1 displayed. In any event, the ALJ could reasonably give more weight to training records than to her testimony. Brookshire does not explain how training provided after the resident's suicide shows any error in the deficiency determination, except to the extent that Brookshire argues it attained substantial compliance at a date earlier than CMS determined and the ALJ sustained. There is nothing in this record, and nothing in Ms. Duke's testimony, that staff were inserviced on how to work with Resident 1, or with any resident displaying the manipulative behaviors Resident 1 displayed.

d. The ALJ did not err in concluding that CMS's finding of immediate jeopardy was not clearly erroneous, or in determining the period of noncompliance.

"Immediate jeopardy" is defined as "a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident." 42 C.F.R. § 488.301. CMS's determination that a deficiency constitutes immediate jeopardy is a determination of the level of noncompliance which "must be upheld unless it is clearly erroneous." 42 C.F.R. § 498.60(c)(2); Woodstock Care Center, DAB No. 1726, at 9 (2000), aff'd, Woodstock Care Center v. Thompson, 363 F.3d 583 (6th Cir. 2003). The provider bears the burden of proving that CMS's immediate jeopardy determination is clearly erroneous. E.g., Liberty Commons Nursing & Rehab Center v. Johnston, DAB No. 2031 at 18-19 (2006), aff'd, Liberty Commons Nursing and Rehab Center – Johnston v. Leavitt, 241 F. App'x 76 (4th Cir. 2007).

The ALJ sustained CMS's determinations that Brookshire's noncompliance posed immediate jeopardy to resident health or safety for the period January 25 through February 24, 2006, and less than immediate jeopardy for the period February 25 through March 14, 2006.[9] Brookshire argues that even assuming

[9] CMS determined that immediate jeopardy began when Resident 1 threatened facility staff at a staff meeting on January 25, 2006 and was removed on February 25, 2006, the date that Brookshire began audits to assess residents for any issues related to adaptation to the nursing home, and that noncompliance at the lower level continued until Brookshire completed inservice training of its staff, completed the audits, and "educated its

(continued...)

noncompliance there was no immediate jeopardy. Brookshire argues that Resident 1's suicide does not demonstrate immediate jeopardy because the ALJ specifically declined to address whether or not the suicide resulted from Brookshire's noncompliance. ALJ Decision at 8. Brookshire also argues that there was no likelihood of serious injury, harm, impairment, or death to other residents because the care of other residents was not at issue in the SOD, and because Resident 1 never harmed others and was considered by Brookshire's staff and its expert not to present a threat of harm to others. Brookshire characterized CMS's determination as hindsight speculation, and cites ALJ decisions holding that serious injury, harm, impairment or death must be the likely consequence of the noncompliance, as opposed to simply a mere possibility or speculation. See also, e.g., Innsbruck Healthcare Center, DAB No. 1948, at 5 (2004) (a mere risk of serious harm is not equivalent to a likelihood of serious harm).[10] Brookshire further argues that any threat that Resident 1 posed to others ceased upon his suicide on February 7, 2006 and does not support CMS's determinations that the period of immediate jeopardy continued through February 24, 2006, and that

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[9](...continued)
alert and oriented residents regarding resident rights and responsibilities." ALJ Decision at 18, citing CMS Ex. 4, at 2, CMS Br. at 39; see also CMS Ex. 4, at 19-20 (SOD).

[10] In this respect, Brookshire argues that the State agency surveyors who surveyed the facility following Resident 1's suicide cited no deficiencies, and that CMS directed the State agency to cite the three immediate jeopardy-level deficiencies. The State agency's determinations did not bind CMS and are not relevant to our analysis, as the law clearly provides CMS with authority to determine the existence of noncompliance and its scope and severity. See section 1819(h) of the Social Security Act (42 U.S.C. § 1395i–3(h)) (providing that a state makes recommended findings regarding noncompliance and recommends actions to remedy the noncompliance but the Secretary makes findings of noncompliance and decides what remedial actions to take); Lake Mary Health Care, DAB No. 2081, at 5-7 (2007) (rejecting the provider's arguments that CMS should not have found noncompliance under a federal requirement additional to the one cited by the state and should not have determined that immediate jeopardy existed when the State had cited the noncompliance at lesser level, and confirming that CMS's finding of noncompliance and imposition of remedies for a determination of immediate jeopardy must take precedence over the state's position).

the noncompliance then continued at less than immediate jeopardy through March 14, 2006.

The Board must sustain CMS's determination that the noncompliance posed immediate jeopardy unless Brookshire demonstrated that CMS's determination is clearly erroneous. Brookshire did not make that showing. As the ALJ discussed, Resident 1's pattern of behavior at the facility, and the opinion of Brookshire's expert witness, show that Brookshire's assertion that Resident 1 posed no threat to others is not credible. Resident 1's behaviors included threatening staff and another resident, abusing drugs and alcohol and providing alcohol to another resident, and bringing guns into the facility. Brookshire's expert witness, Dr. Thompson, acknowledged the resident's potential for violence towards others. ALJ Decision at 19, citing Tr. at 395. The record as a whole, including these circumstances, shows that CMS's determination that the resident posed a likelihood of serious harm to other residents was not clearly erroneous. That CMS did not assess Brookshire's noncompliance until after Resident 1's suicide does not mean that its determination was impermissibly based on hindsight or speculation. Surveys of facilities are based in part on reviews of facility records and are thus necessarily retrospective; this is consistent with the outcome-based approach to evaluating nursing home performance. See Lake Mary at 17-18, and authorities cited therein.

Brookshire's argument that the immediate jeopardy ceased with Resident 1's suicide misapprehends the nature of the noncompliance. Brookshire's noncompliance was not failure to prevent the resident's suicide, an issue the ALJ declined to address, and the threat to other residents was posed not simply by Resident 1. Brookshire's noncompliance resulted from its failure to take measures, required by the regulation and its own policies, to recognize and respond to disruptive behaviors by *any* resident that are likely to cause serious harm if not addressed in accordance with those policies and the regulation. (In this respect, we note that Resident 1's roommate assisted Resident 1 in concealing the two handguns despite being aware that the guns were not permitted in the facility. CMS Ex. 19, at 5 (investigation report).) Brookshire's failure to respond adequately to threatening, disruptive, aggressive, and manipulative behaviors when exhibited by Resident 1 shows that Brookshire was ill equipped to address them in any resident. Thus, the immediate jeopardy did not end with Resident 1's suicide but continued until the facility began assessing and educating *all* of its residents, and training its staff, and the noncompliance continued at a lower level until that process was complete. Brookshire makes no other arguments regarding the

period of noncompliance. Accordingly, we sustain CMS's and the ALJ's determination of the periods of noncompliance at the immediate jeopardy and the less than immediate jeopardy levels.

The amounts of the CMPs that CMS imposed for those periods, $3,050 and $50 per day, respectively, are the minimum per-day amounts that CMP may impose under the statute and regulation. And, as the ALJ discussed, a deficiency under 42 C.F.R. § 483.15 at the immediate jeopardy level, which constitutes a finding of "substandard quality of care," requires withdrawal of a facility's approval to offer a NATCEP, as does the imposition of a CMP of not less than $5,000. 42 C.F.R. §§ 483.151(b)(2), (e)(1); 488.301. We thus sustain without further discussion the ALJ's conclusions sustaining the amount of each CMP and prohibiting Brookshire from conducting a NATCEP for a two-year period.

Conclusion

Based on the above analysis, we uphold the ALJ's Decision.

/s/
Leslie A. Sussan

/s/
Constance B. Tobias

/s/
Judith A. Ballard
Presiding Board Member