Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

In the Case of:	)	
	)	
Beatrice State Development Center, (CCN: 28-G002)	)	Date: September 23, 2009
	)	
Petitioner,	)	
	)	
- v. -	)	Docket No. C-08-271
	)	Decision No. CR2009
Centers for Medicare & Medicaid Services.	)	
	)	

DECISION

Petitioner, Beatrice State Developmental Center ("Petitioner" or "facility"), is a state-owned-and-operated intermediate care facility for the mentally retarded (ICF/MR), located in Beatrice, Nebraska. For more than a year, the facility was not in substantial compliance with conditions of participation for ICFs/MR, and its conditions frequently posed immediate jeopardy to client health and safety.[1] CMS finally imposed the only remedy it is authorized to impose against noncompliant ICFs/MR - terminating the facility's Medicaid participation. CMS Ex. 1, at 1. Petitioner has appealed CMS's determination.

For the reasons discussed below, I find that the facility was not in substantial compliance with the conditions of participation for ICFs/MR, and that CMS is therefore authorized to terminate its program participation.

I. Background

ICFs/MR. Among the services that a state may fund under its Medicaid program (with federal financial assistance) are services furnished in ICFs/MR. Act § 1905(a)(15). An ICF/MR is an institution whose primary purpose is to provide health or rehabilitative

[1] Residents of ICFs/MR are referred to as "clients."

services to mentally retarded individuals. The institution must meet standards prescribed by the Secretary of Health and Human Services, and must provide active treatment to all of its clients. Act § 1905(d); 42 C.F.R. § 440.150; 42 C.F.R. § 442.101(d)(1).

Each client must receive a continuous active treatment program, which includes aggressive, consistent implementation of a program of specialized and generic training, treatment, health services, and related services . . . directed toward –

> (i) The acquisition of the behaviors necessary for the client to function with as much self determination and independence as possible; and
>
> (ii) The prevention or deceleration of regression or loss of current optimal functional status.

42 C.F.R. § 483.440(a)(1).

Program requirements, referred to as "conditions of participation," are set forth at 42 C.F.R. Part 483, Subpart I. A "condition of participation" represents a broad category of services. Each condition is contained in a single regulation, which is divided into subparts called standards. Compliance with a condition of participation is determined by the manner and degree to which the provider satisfies the standards within the condition. 42 C.F.R. § 488.26(b). If deficiencies are of such character as to "substantially limit [its] capacity to furnish adequate care or which adversely affect the health and safety of [clients]," the facility does not substantially comply with the conditions. 42 C.F.R. § 488.24(b).

CMS, acting on behalf of the Secretary, makes "independent and binding determinations," based on its own surveys, as to whether ICFs/MR meet the Secretary's certification requirements. Act § 1902(a)(33)(B). CMS may cancel a facility's Medicaid provider agreement if the facility does not meet program requirements. Act § 1910(b)(1).[2] The regulations specify that "the failure to meet one or more of the applicable conditions of participation is cause for termination or non-renewal of the

[2] Section 1910(b)(1) authorizes the Secretary to "cancel approval" of an ICF/MR "at any time" if the facility fails to meet certain statutory requirements, or if she "finds grounds for termination of [her] agreement with the facility pursuant to section 1866(b)." Section 1866(b) is a Medicare provision that authorizes the Secretary to terminate a Medicare-certified facility that "fails to comply substantially" with the provisions of its provider agreement, applicable conditions of participation, or similar requirements. Thus, Congress has applied Medicare termination procedures to ICFs/MR. *See*, *Oakwood Community Center*, DAB No. 2214, at 6, n. 5 (2008) (Departmental Appeals Board found it "difficult to conceive" of any other meaningful interpretation of section 1910(b)(1)).

ICF/MR provider agreement." 42 C.F.R. § 442.101(e); *Oakwood Community Center*, DAB No. 2214, at 7 (2008).

Facility history of noncompliance. Here, the facility has a significant history of noncompliance with program requirements, and CMS has afforded it multiple opportunities to correct. In September 2006, CMS surveyors determined that the facility was not in substantial compliance with seven conditions of participation and that its deficiencies posed immediate jeopardy to client health and safety. After a follow-up survey in October 2006, CMS found that the immediate jeopardy had been removed, but that the facility's non-compliance continued at the condition level "due to existing systemic problems." CMS conducted another follow-up survey in April 2007 and found that Petitioner remained non-compliant with two conditions of participation and that its conditions again posed immediate jeopardy to client health and safety. CMS completed a follow-up survey in May 2007, and again found that, although the immediate jeopardy had been removed, the facility remained non-compliant with conditions of participation. Nevertheless, CMS allowed the facility to continue its program participation. CMS Ex. 8 at 3 (Priyanath Decl. ¶12); CMS Ex. 9.

November 2007 survey. Six months later, on November 7, 2007, CMS completed yet another survey and determined that the facility was still not in substantial compliance, and that its deficiencies again posed immediate jeopardy to client health and safety.[3] CMS Ex. 1, at 1. Specifically, CMS found that the facility was not in substantial compliance with:

- 42 C.F.R. § 483.410 (governing body and management)
- 42 C.F.R. § 483.420 (client protections)
- 42 C.F.R. § 483.430 (facility staffing)
- 42 C.F.R. § 483.440 (active treatment services)

CMS has imposed the only sanction available against substantially noncompliant ICFs/MR – termination. CMS Exs. 2, 14.

Appeal. Petitioner timely requested a hearing, and, pursuant to section 1910(b)(2) of the Act, its termination has been halted pending resolution of this case.

I held a hearing in Omaha, Nebraska on November 19, 2008. Messrs. Thomas B. York and Donald Zaycosky appeared on behalf of Petitioner, and Mr. Harry B. Mallin

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[3] At the same time, CMS determined that the immediate jeopardy abated effective November 7, 2007. CMS Ex. 1, at 1. Surveyors subsequently returned to the facility, and completed another follow-up on March 4, 2008, finding substantial noncompliance at the immediate jeopardy level. CMS Ex. 4. CMS then determined that the immediate jeopardy was removed as of March 7, 2008, but that the substantial noncompliance continued. CMS Ex. 8, at 5; CMS Brief, at 2.

appeared on behalf of CMS. I admit into evidence CMS exhibits (CMS Exs.) 1-21 and Petitioner's exhibits (P. Exs.) 1-129 and 500-759. Tr. 3; *See* Pre-Hearing Conference Order, at 2 (August 29, 2008).[4] The parties have submitted pre-hearing briefs (CMS Br.; P. Br.) and closing briefs (CMS Cl. Br.; P. Cl. Br.). CMS filed a reply brief (CMS Reply).

Without asking that they be admitted as exhibits, Petitioner submits with its closing brief 24 additional documents, numbered P. Exs. 130-153. Petitioner's justification for such a late submission lacks coherence. First, it complains that CMS made "no reasonable attempt to cross-examine its expert witnesses," so those witnesses had no opportunity to "address . . . any of the documents on which they relied if challenged as to any of their findings."[5] Next, it alludes to the ALJ's "great reliance on the individual documents to dispute the findings of the surveyors."[6] Petitioner then suggests that I should "accept and weigh heavily the uncontradicted and unchallenged opinions of [its] experts based on

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[4] With its pre-hearing submissions, Petitioner included a substantial number of proposed exhibits, beginning with P. Ex. 1 and ending with P. Ex. 759. However, for reasons that were not explained, Petitioner's numbering of exhibits skipped from P. Ex. 129 to P. Ex. 500; no exhibits numbered P. Ex. 130 through P. Ex. 499 were included. In error, I assumed that Petitioner had submitted 759 consecutively numbered exhibits, and, during the August 28, 2008 pre-hearing conference, announced that Petitioner had submitted 759 exhibits, numbered P. Ex. 1 through P. Ex. 759. Remarkably, neither party pointed out my error during the pre-hearing conference, during the in-person hearing, nor anytime thereafter. Upon my review of the entire record, I discovered the error.

[5] Petitioner repeatedly makes this puzzling allegation. In fact, Petitioner's witnesses had the opportunity to address these and all other relevant issues in their written direct testimony. *See*, Acknowledgment and Initial Pre-hearing Order, at 3 ¶¶ 4, 5 (February 11, 2008). Moreover, it is not the responsibility of CMS counsel to advance Petitioner's case through cross-examination.

[6] In this regard, Petitioner may be confused. I have repeatedly emphasized that the issue before me is whether the facility was in substantial compliance with Medicaid conditions of participation fcr ICFs/MR. I also noted that many of the deficiencies cited were based on record review (as this decision illustrates). Since the documents that form the basis for the deficiencies are in the record, and my review here is *de novo*, cross-examining the surveyor about their contents or arguing with her about the legal conclusions she drew from them was not the most effective use of time. *See*, *e.g.*, Tr. 15-16, 18-19, 20 ("Now if a surveyor comes in and says, [']I observed an incident of abuse,['] obviously, that surveyor would have to be produced and you would be entitled to cross-examine them. But if the surveyor goes into the facility and says, [']I looked at your documents where you documented abuse['] . . . I have the document [and] I'll draw my own conclusions from the document.")

their voluminous document review," but "senses that [the ALJ] may have wanted even more exhibits placed into evidence." Petitioner then offers "without formally moving their admission" the newly-submitted documents "to assist [the ALJ] in understanding how the Petitioner's experts relied on additional documents to assist the Board in its review." P. Cl. Br. at 20.

Not surprisingly, CMS asks that the documents be excluded from the record. Inasmuch as Petitioner has not asked that the documents be admitted, and has offered no good cause for the long delay in their submission (ten months after its submissions were due, nine months after it received CMS's submission, and five months after the in-person hearing), the documents are not admitted.

II. Issue

The sole issue before me is whether, at the time of the November 2007 survey, Petitioner was in substantial compliance with the Medicaid conditions of participation governing ICFs/MR.

III. Discussion

A. The facility was not in substantial compliance with 42 C.F.R. § 483.420 because it did not adequately implement policies and procedures prohibiting mistreatment, neglect and abuse of its clients; its staff failed to report immediately allegations of mistreatment, neglect, abuse and injuries of unknown source; and it did not take appropriate corrective action in response to verified violations.

ICFs/MR must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of facility clients. Among other prohibitions, facility staff may not use physical, verbal, sexual or psychological abuse or punishment. 42 C.F.R. § 483.20(d) (1). The facility must ensure that all allegations of mistreatment, neglect, or abuse, as well as injuries of unknown source, are reported immediately to the facility administrator and appropriate state officials. Alleged violations must be investigated thoroughly, and the results of those investigations must be reported to the administrator or his/her designated representative as well as to other officials in accordance with state law. If the alleged violation is verified, appropriate corrective action must be taken. 42 C.F.R. 483.420(d)(4).

Facility policies establish the standard of care that the facility expects its staff to provide and they are evidence of professional standards of care. *The Laurels at Forest Glen*, DAB No. 2182, at 18 (2008); *Oxford Manor*, DAB No. 2167, at 5-6 (2008) Here, consistent with the regulations, the facility's neglect and abuse policy required all employees to "report all observed or suspected cases of abuse or neglect . . . ." CMS

Ex. 12, at 3; P. Ex. 741, at 2.[7] The policy defines abuse as "any knowing, intentional, or reckless act or omission on the part of a person which results in physical, sexual, verbal, or mental abuse, unreasonable confinement, cruel punishment, exploitation, or denial of essential care, treatment or services to a protected individual." CMS Ex. 12, at 4; P. Ex. 741, at 2. Physical abuse is further defined as "[a]ny knowing, intentional, or reckless act or omission which results in physical injury, pain, or anguish." Physical injury includes fractures, bruises, lacerations, as well as physical pain. CMS Ex. 12, at 4; P. Ex. 741, at 4.

The policy defines neglect as a "failure to provide minimal services or resources to meet basic needs." Examples of neglect include withholding, or inadequately providing, food, hydration, clothing, medical care and good hygiene. Leaving a protected individual unattended is an example of neglect. CMS Ex. 12, at 4; P. Ex. 741, at 3-4.

The policy specifically requires that "**[e]mployees will intervene immediately, as needed, to protect individuals** if abuse/neglect is suspected, observed or reported. Intervention is provided regardless of the source of the abuse and regardless of whether [the employees] are responsible for the individual's supervision." (emphasis in original) CMS Ex. 12, at 5; P. Ex. 741, at 5. After insuring the individual's safety, employees "are mandated" to report *immedictely* allegations of an abuse/neglect incident to their designated supervisor/management staff. CMS Ex. 12, at 6; P. Ex. 741, at 5. The Neighborhood Services Team Leader or his/her designee immediately insures the protection of the alleged victim, and ensures that the investigation process is begun. CMS Ex. 12, at 6; P. Ex. 741, at 6.

CMS finds no particular fault with the written policy, and neither do I. However, a written policy has no value if it is not effectively implemented. Sufficient examples of abuse and/or neglect demonstrate that the policy has not been implemented. *Emerald Oaks*, DAB No. 1800, at 12 (2001).[8]

Petitioner complains generally that the November 2007 (and March 2008) surveys "place an inordinate amount of emphasis" on the staff treatment of clients standard found at 42 C.F.R. § 483.420(d), pointing out that the November survey "dedicates 23 pages of citations to that deficiency alone." P. Ex. 126, at 10. At the same time, notwithstanding

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[7] The facility apparently amended its policy three months after the survey, in February 2008. P. Ex. 543. However, the policy relevant to this inquiry is the one that was in effect in November 2007.

[8] Because the deficiency was with implementation, not the content of the written policy, I reject Petitioner's assertion that, based on amendments to its policies and procedures made prior to the conclusion of the survey, it "was 100% compliant at the conclusion of the November 2007 survey." P. Cl. Br. at 22.

the sheer number of deficiencies cited, Petitioner characterizes the multiple citations as "only isolated and minor incidents of deficiencies, which do not rise to the level of non-compliance." P. Br. at 6; P. Cl. Br. at 185.

Providing a vulnerable population with a safe environment is critically important, and CMS justifiably takes a dim view of mistreatment, abuse and neglect, particularly when it involves staff mistreatment of clients. If clients are not safe, the facility cannot hope to achieve any of their treatment goals, and the client's need for treatment justifies housing them in the institution, so I reject the suggestion that surveyor emphasis on mistreatment, abuse, and neglect could ever be "inordinate." Here, the list of deficiencies cited is long because the surveyors found so many problems. Indeed, given the number and seriousness of the incidents cited, I find no merit to Petitioner's claim that the events were "isolated" and "minor."

I discuss several of these incidents, occurring between August 31 and October 4, 2007:[9]

August 31, 2007. (Case # 07-187)[10] When he was not in his room, Client 42 required one-to-one supervision to prevent him from stealing food. This was a safety issue because Client 42 was on a restricted diet. P. Ex. 79, at 4. On August 31, 2007, however, his assigned supervisor was distracted by another client's acting out with a pair of scissors. While unsupervised, Client 42 went into the kitchen and managed to eat a pie – or some portion thereof – as well as an onion, and an additional unidentified item or items. Staff stopped him, took away the remaining food, and cleaned his hands and face, but they left him in his food-soiled clothing. They seated him on the living room couch and did not allow him to move. When he attempted to stand, a staff member, Developmental Technician (DT) Larry Warnsing, pushed him back down onto the couch by his head. A short time later, Client 42 again tried to stand, and a second staff member, DT Clarence Farley, pushed him back down onto the couch, again by his head. P. Ex. 79, at 16-17, 23, 27.

[9] Understandably, the facility's investigative reports include conflicting statements from staff and witnesses. In sorting through the conflicts, I accept the ultimate conclusions and findings of the facility administrator and/or other reviewing officials. To protect client privacy, I do not identify the specific units where the incidents occurred, but note that each occurred at a different address, which shows that the facility's deficiencies were not limited to one unit, but were more wide-spread.

[10] Petitioner complains that the surveyors did not adequately document their findings. Documentation is "adequate" if it describes the specific deficiencies that resulted in CMS's determination. *See* 42 C.F.R. § 488.18(a). In this case, the statement of deficiencies describes in significant detail all of the incidents that I discuss here (as well as numerous others). Petitioner's own documents then confirm those survey findings. For CMS's "documentation" of Case # 07-187, for example, *see* CMS Ex. 1, at 51-57; *see also* CMS Ex. 15, at 22-47 and CMS Ex. 16 at 2-29.

When asked specifically about this incident, Petitioner's witness, Craig Blum, PhD,[11] agreed that the "behavior of pushing someone down is not an appropriate behavior." Tr. 79.

Facility staff, however, were either unaware of these incidents, did not consider them significant, or simply chose to ignore them. But Tricia Kingsley, Chief Advocate for Nebraska Advocacy, was visiting the unit; she observed and reported the events. P. Ex. 79, at 3-5. An investigative report was completed on September 10, 2007, and reviewed by the facility administrator, Deb Uarich, who directed the Human Resources Manager and the 3rd Shift Manager to "take appropriate corrective action with Larry Warnsing for his physical abuse" of the resident, and to "take appropriate corrective action with Clarence Farley for his physical abuse and neglect" of the resident. P. Ex. 79, at 18. It seems that DT Farley was responsible for changing the client into clean clothing, which he failed to do – hence, the neglect finding. CMS Ex. 1, at 50-55; P. Ex. 79, at 4. Administrator Uarich set a September 28, 2007 due date for documentation of the corrective action.

In a notice dated September 18, 2007 (signed September 19) Supervisor Mary Klein advised DT Warnsing that his August 31 behavior constituted abuse/neglect in violation of state and federal law as well as the facility policy on abuse/neglect. "Such behavior is not tolerated when dealing with individuals living on this campus." CMS Ex. 16, at 2. The notice directed him to view something called "Signs and Symptoms of Abuse/Neglect and the Responsibility of Reporting," and to take an accompanying quiz. He was also directed to attend a six-hour class on de-escalating situations and managing people. The notice advised him that, in the future, he should contact his shift manager or supervisor if he needed assistance or had a question regarding a behavioral problem, and directed him to meet with his manager bi-weekly over a 60-day period to discuss any questions or problems. CMS Ex. 16, at 2-4.

In a memo to DT Farley, dated October 2, 2007 (which is obviously later than Administrator Uarich's September 28 deadline), Team Leader Greg Butler described the August 31 incident, along with a second incident in which DT Farley threatened another client with physical harm and called him a "jerk." Team Leader Butler concluded that the allegations against DT Farley had been substantiated. As a result, he was "being issued an informal conference" which involved "work improvement expectations." CMS Ex. 16, at 20-24; CMS Ex. 15, at 49-61.

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[11] Dr. Blum has a PhD in counseling. He is currently the vice-president for quality management of a management services consulting organization. He has a private consulting business, and performs surveys for the Joint Commission on Accreditation of Healthcare Organizations. P. Ex. 83. He first visited the facility in June 2008. Tr. 77.

CMS questions this minimal level of corrective action, which, it points out, is comparable to that imposed for such minor infractions as tardiness. Petitioner maintains that its management had no choice because its collective bargaining agreements mandate progressive discipline in the face of employee misconduct. I find this unpersuasive. Petitioner has not submitted the relevant provision of the collective bargaining agreement, but, no matter what that agreement says, facilities are simply not free to bargain away the health and safety of their residents. Moreover, Petitioner's claim rings hollow inasmuch as this represented the fifth allegation of abuse/neglect leveled against DT Farley in less than a year. P. Ex. 79, at 17; CMS Ex. 15, at 62-63.

Thus, at the time of the November survey, the implicated staff members were still working with facility clients. When questioned about that, the facility's acting administrator, Ron Stegemann, told federal surveyor Sahana Priyanath, that he was "unaware of any reason why they would not be able to." CMS Ex. 1, at 62; *see* CMS Ex. 8, at 4 (Priyanath Decl. ¶ 15).

In disciplinary notices dated December 2007, the Director of Developmental Disabilities for the State of Nebraska concluded that staff's failure to address client needs for personal hygiene (i.e., leaving Client 42 in soiled clothing) was abuse and neglect, violating state and federal law as well as the facility policy on abuse/neglect. P. Ex. 79, at 19. Restricting the client's movement for no apparent reason was also abuse and neglect, and violated state and federal law and the facility policy on abuse/neglect. P. Ex. 79, at 19.

Perhaps even more disturbing than these specific instances of abuse and neglect are the staff's undisputed descriptions of the environment in which they occurred. The investigative reports describe an institution in chaos.

> [T]he living unit . . . was very chaotic and . . . staff really didn't know what they were supposed to be doing . . . . the most senior staff on [the] shift . . . had only been working for a short while and didn't know what she should be charting.

P. Ex. 79, at 5.

> [Staff member] really can't recall much about what happened . . . because of all the chaos of so many people going in and out of the living unit.

P. Ex. 79, at 8.

> Staff [were] all inexperienced regular staff, pulled staff and overtime staff. The lead staff for 1st shift for the day was a new employee who had only been working on the unit for about one month and had not been in-serviced on the

> individuals['] programs, supervision levels, what all needed to be done each day, what all needed to be charted or how to chart the events of the day.
>
> The living unit was for a time in a state of total chaos, with staff not knowing each others['] names, the supervision cards were being passed around so much that no one really knew who had what card and when and no one really knew who was working when on the living unit.
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> * * * *
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> There have been several investigations on [the unit]. It is noted that there have been inexperienced and unfamiliar staff involved in many of the investigations. It is also noted that [the unit] has 8-9 individuals with supervision levels of enhanced or higher which places the staff working in a position of jeopardy because of not being able to provide the levels of supervision when other individuals are displaying inappropriate behaviors.

P. Ex. 79, at 15.

The facility's own staff thus recognized that the unit's chaos, inexperienced staff, and high maintenance clients created an environment ripe for mistreatment, neglect, and abuse.

September 23, 2007. (Case #07-195)[12] On September 23, 2007, DT Jeannie Stevens was apparently working a double shift. She completed her first shift at 3:00 p.m., left the facility on a personal errand, and returned to begin her second shift at 4:15 p.m. No back-up staff were assigned responsibility for her clients during her absence. Other staff were aware of her absence and knew that her assigned residents required toileting, but they were unable or unwilling to assist. When DT Stevens returned, no one mentioned that her five assigned clients had not been toileted, and she did not inquire about them. She apparently did not check them nor take any of them to the toilet until an hour later. At 5:15 p.m., when it was time to prepare them for supper, she found that three of the residents were "soaked with urine" and two had had bowel movements. P. Ex. 59, at 9, 11, 13.

Although she recognized that her clients had been neglected during her absence, DT Stevens delayed reporting the neglect. P. Ex. 59, at 13.

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[12] See CMS Ex. 1, at 64-66 for surveyor documentation of this situation.

Petitioner denies any findings of neglect with respect to the five individuals. P. Cl. Br. at 195. However, the record establishes that, following an investigation and conflicting conclusions as to staff accountability for the neglect, Administrator Elton Edmond concluded that the five individuals assigned to DT Stevens had been neglected. He nevertheless pointed out that the demands on remaining staff would have made it difficult for them to check and change the residents in DT Stevens' absence. (*See* Staffing Discussion, *infra*.)[13] He also noted:

> There appears to be a break down in the communication between these staff and their willingness to work with each other. This lack of communication also contributed to the clients not being checked/changed until the later time.

P. Ex. 59, at 13. He recommended that the team leader implement strategies for improved communication about clients, workloads, and the need to work together. He also recommended corrective action against DT Stevens for late reporting of the neglect. P. Ex. 59, at 13.

Inasmuch as *all* the employees on the unit were aware of the neglect, but only DT Stevens reported it, I find puzzling and disturbing Administrator Edmond's decision to limit corrective action to the person who reported.

October 4, 2007. (Case # 07-204)[14] Donald Farnsworth was a psychology intern who, on the afternoon of October 4, 2007, observed DT Mike Weber "forcefully" slap Client 53 on his left shoulder, then grab the resident's shirt sleeve and pull him from the kitchen into the day room. Intern Farnsworth did not intervene to protect the resident, nor did he immediately report the abuse, claiming that he "was unsure of whether or not it qualified as abuse" and he wanted to consult his supervisor. He delayed speaking to his supervisor because he had a previous commitment to talk to one of the individuals in the unit. P. Ex. 80, at 4-6. He eventually reported the incident to his supervisor, the facility's acting director of psychology, but, remarkably, the acting director of psychology purportedly did not know whether the incident qualified as abuse. After reviewing the facility policy on abuse, and consulting the investigations administrator and acting CEO, Intern Farnsworth finally reported the incident. P. Ex. 80, at 6, 8, 11; CMS Ex. 1, at 57-59.

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[13] Petitioner submitted two Reports of Investigation of this incident, each dated September 28, 2007 (P. Exs. 58 and 59). P. Ex. 58 is labeled "Original Report" and substantiates neglect on the part of two employees and recommends corrective action. P. Ex. 59 is labeled "Corrected Report" and states that although neglect occurred, it was not attributable to the employees involved. The only employee discipline recommended in P. Ex. 59 is for the late reporting of the neglect.

[14] See CMS Ex. 1, at 57-60 for surveyor documentation.

Dr. Blum agreed that slapping a client, and dragging him away by his shirt constitutes abuse. Tr. 81.

Although the client apparently did not sustain any visible injuries from the encounter (aside from a stretched-out tee-shirt), he had fading bruises and partially healed marks on his left shoulder and upper arm. P. Ex. 80, at 3, 6, 14. The investigator reviewed progress notes for the prior month, but found no reference to any bruising. No incident reports indicated that bruising was found and reported "even though the marks [were] readily visible and should have been reported by any staff member who assisted [R53] with bathing or dressing." Staff opined that the bruising may have emerged after an October 2, 2007 incident in which Client 53 fell and hit his head. No progress notes reported that the resident had twice on October 4, 2007, been taken to the out-patient clinic. P. Ex. 80, at 3, 12.

Other disturbing aspects to this incident underscore staff's pervasive disregard for the reporting and investigative requirements of section 483.420. Although she should have immediately obtained witness statements, the shift's team leader, Connie Brancheau, did not do so because, she claimed, "everyone seemed clueless as to any potential abuse/neglect incident that had occurred on the unit" and she "felt it important to not taint the case by providing details to staff" until the investigator conducted a formal interview. P. Ex. 80, at 3, 12, 14. She subsequently wrote a confusing report, suggesting that she had witnessed the event, which she had not. P. Ex. 80, at 12, 14.

At the time of the survey, DT Weber was also still working with clients, and, again, the facility's acting administrator, Ron Stegemann, told federal surveyor, Sahana Priyanath, that he was "unaware of any reason why [DT Weber] would not be able to." CMS Ex.1, at 62; see P. Ex. 8, at 4 (Priyanath Decl. ¶15).

Other unexplained injuries. Nor was Client 53 the only facility client with unexplained injuries. Among the most disturbing is the situation of Client 159. The surveyors reviewed her plan which required that she receive a one-to-one level of supervision and that her supervisor remain within five to eight feet of her at all times. Staff assigned to her would be responsible for no other clients. Yet, incident reports dated 9/4, 9/20, 9/21, 10/1, 10/14, and 10/17 describe multiple unexplained injuries. CMS Ex. 1, at 34-35, 45-46. Apparently the facility's Acting Quality Improvement Director could not explain why these incidents had not been thoroughly investigated nor why corrective action had not been taken. CMS Ex. 1, at 35. Nor could Petitioner's witnesses explain how someone purportedly receiving such close supervision could suffer so many unexplained injuries. Tr. 73.

Petitioner concedes that the survey report accurately reflects the contents of its investigative report, but again argues that, had its staff been allowed to offer direct testimony at the administrative hearing, they would have reviewed the incident report, the client's individual program plan and behavior plan to show that the facility "had taken

steps to address the injury in this instance." P. Cl. Br. at 163; *but see* footnote 5, above. Petitioner then cites P. Ex. 131, its investigation of the October 17 injury, which is among the documents it withheld and submitted with its closing brief. Petitioner also argues that the facility's incident review team was not required to review every incident "in order to establish patterns or trends across the facility." P. Cl. Br. at 163.

Petitioner also faults the surveyor criticism that, in investigating Client 159's injuries, no statements were taken from staff responsible for providing her one-to-one supervision. Citing the un-admitted P. Ex. 131, Petitioner maintains that the investigation summary "clearly indicates that Ms. Patti Eglers, who was the 1:1 staff at the time the injury was observed, was interviewed." P. Cl. Br. at 178; *see also* P. Cl. Br. at 203. DT Eglers submitted a statement in which she reported that she went into the client's room "to relieve Holly" when she noticed a bruise on the client's forearm. The investigator then obtained statements from employees who had no contact with the client, but did not include a statement from "Holly" nor any other staff member who might have been assigned to Client 159 when the injury occurred. Since not properly admitted, P. Ex. 131 is not before me and Petitioner may not rely on it. Nevertheless, its admission would not have furthered Petitioner's case. To the contrary, the document confirms the surveyor findings and underscores the inadequacy of the facility's investigation.

Thus, the facility did not implement policies to prevent mistreatment, neglect, and abuse. The undisputed evidence establishes multiple examples involving a variety of staff and clients. Incidents were not reported immediately; clients suffered unexplained injuries which were neither reported nor investigated; staff did not seem even to recognize instances of mistreatment/neglect/abuse. Critical staff were unaware of their investigative responsibilities. I find that these deficiencies adversely affect the health and safety of facility clients. The facility is therefore not in substantial compliance with 42 C.F.R. § 483.420, and, on that basis alone, without regard to any other deficiencies, CMS may terminate its ICF/MR provider agreement. 42 C.F.R. § 442.101(e).

B. The facility was not in substantial compliance with 42 C.F.R. § 483.430 because it consistently lacked sufficient direct care staff to manage and supervise clients in accordance with their individual program plans.

The facility must provide sufficient direct care staff to manage and supervise clients in accordance with their individual program plans. 42 C.F.R. § 483.430(d).

Throughout its long and extraordinarily repetitive closing brief, Petitioner points to the same testimony of witnesses who describe generally the procedures the facility had in place to achieve adequate staffing levels and to assure that staff were trained and competent. P. Cl. Br. at 33-35, 238-239, 249-250. Neighborhood Services Assistant Administrator Cheryl L. Scheele testified that the Neighborhood Assistant Administrator would "monitor the staffing levels on an on-going basis," and "re-assign and re-allocate employees as needed." According to Assistant Administrator Scheele, home managers

ensure adequate numbers of staff, and, "in conjunction with Developmental Specialists[,] monitor the staffing levels daily to ensure the assignment of adequate numbers of staff . . . to each home to meet the needs of the individuals." If staffing numbers are low,

> the Home Manager in conjunction with the Developmental Specialists will get their staffing numbers up to at least the minimum number of staff needed for each home by scheduling on-call staff, living unit staffing pool staff and by scheduling regular staff for voluntary overtime . . . . The facility also has a process in place for pulling staff and holding staff over to meet the needs of the individuals should the numbers for a specific home be low on a specific day.

P. Ex. 94, at 1.[15]

Of course, that the facility had a staffing system in place does not establish that its direct care staff were sufficient "to manage and supervise clients in accordance with their individual program plans," as required by 42 C.F.R. § 483.430(d), and, here, the system's inadequacies are well-documented, as the above discussion suggests. Indeed, the incidents described above show a staff ill-equipped to treat clients with the level of care, protection, and dignity they require.

For example, the situation on August 31, 2007, reflects the procedures described by Assistant Administrator Scheele, but also illustrates an inadequately staffed unit. "Staff [were] all inexperienced regular staff, pulled staff and overtime staff." The lead staff for the first shift "was a new employee who had only been working on the unit for about one month and had not been in-serviced on the individuals' programs, supervision levels, what needed to be done each day, what all needed to be charted or how to chart the events of the day." P. Ex. 79, at 15. Plainly, the facility did not have staff that were capable of managing and supervising the clients.

Nor was this an unusual situation for that unit. Both the incident investigator and the facility administrator pointed out the "numerous investigations" there, and staff's inability "to safely provide care and supervision." P. Ex. 79, at 17.

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[15] Unfortunately, Petitioner's closing brief is replete with mis-citations to the record. Because Petitioner submitted so many exhibits, which include multiple statements from multiple individuals (rather than one declaration per witness), such errors make it difficult to locate the support for some of its arguments. Here, for example, Petitioner quotes repeatedly from Assistant Administrator Scheele's statement which is found at P. Ex. 94, at 1, but Petitioner repeatedly (and incorrectly) cites to P. Ex. 127.

> There have been several investigations on [the unit]. It is noted that there have been inexperienced and unfamiliar staff involved in many of the investigations. It is also noted that [the unit] has 8-9 individuals with supervision levels of enhanced or higher which places the staff working in a position of jeopardy because of not being able to provide the levels of supervision when other individuals are displaying inappropriate behaviors.

P. Ex. 79, at 15.

The September 23, 2007 incident (involving clients who were not toileted) demonstrates the facility's staffing inadequacies in a different unit. Five clients were neglected because no back-up staff covered for DT Stevens during her absence. Indeed, while acknowledging that clients went unsupervised and neglected, the facility administration did not hold staff accountable because the demands on them were too great to afford them an opportunity to care for the clients. P. Ex. 59, at 4, 9, 13. The findings thus establish an institutional staffing problem that plainly violates section 483.430(d).

And the staffing problems were not limited to these two units. The investigator of the October 4 slapping incident could not even determine who was responsible for supervising the resident since "all four staff on duty signed for all the individuals' supervision in the same order." P. Ex. 80, at 12, 14.

Finally, the survey report form describes multiple additional instances in which clients were denied necessary services due to inadequate staffing. CMS Ex. 1, at 86-100. Petitioner does not deny any of these specific findings, but instead complains about the adequacy of the surveyor notes. P. Cl. Br. at 66-68, 209-211. I discuss below how any purported inadequacies in surveyor performance do not invalidate adequately documented deficiencies. Moreover, although the notes are terse, as Petitioner's own chart shows, they detail a significant number of staffing deficiencies. P. Cl. Br. at 67. ("Tammy can't get aquatic therapy [because] of lack of staff"; "PT scheduled – don't get it [because] no staff to drive over and get it"; "Could not go to specialized work assignment [due to] inexperienced staff"; "9/3/07 can't do showers"; "8/20/07 shortage of staff 'house chaotic' can't run behavior plans").

Thus, notwithstanding the systems it had in place to assure adequate staffing ratios, the record establishes that the facility's staff-sharing practices repeatedly placed inexperienced and untrained staff in situations they were ill-equipped to handle. The facility was therefore not in substantial compliance with 42 C.F.R. § 483.430(d), and its staffing inadequacies were so pervasive as to "substantially limit" its "capacity to furnish adequate care" and to "adversely affect the health and safety" of facility clients, which puts the facility out of substantial compliance at the condition level. 42 C.F.R. § 488.24(b).

C. Based on its widespread failure to protect clients from mistreatment, abuse and neglect, as well as its failure to provide sufficient direct care staff to manage and supervise clients, the facility's governing body did not adequately direct the facility and was therefore not in substantial compliance with 42 C.F.R. § 483.410.

The facility must identify an individual or individuals to constitute its governing body, which exercises general policy, budget, and operating directions over the facility. 42 C.F.R. § 483.410.

The Departmental Appeals Board has held that a finding of substantial noncompliance in facility administration may derive from findings of substantial noncompliance in other areas. S*ee, e.g., Asbury Center at Johnson City*, DAB No. 1815, at 11 (2002); *Odd Fellow and Rebekah Health Care Facility*, DAB No. 1839, at 7 (2002) (Immediate jeopardy finding put facility out of substantial compliance with regulation requiring that facility be administered in a manner that used its resources effectively to attain the highest practicable physical, mental, and psychosocial well-being of each resident); *Sunbridge Care Center*, DAB No. 2170, at 33 (2008), *aff'd*, *Sunbridge Care and Rehabilitation Center v. Leavitt*, No. 08-1603 (4th Cir. 2009) (Staff's inability to comply with and enforce the facility's written policy puts the facility out of substantial compliance with regulation requiring that facility be administered in a manner that used its resources effectively to attain the highest practicable physical, mental, and psychosocial well-being of each resident 42 C.F.R. § 483.75).

Thus, because the facility's governing body failed to protect facility clients from mistreatment, abuse, and neglect, and because it failed to provide adequate staffing, the facility was not in substantial compliance with 42 C.F.R. § 483.410.[16]

D. The facility must meet requirements for program participation without regard to the quality of the survey.

Petitioner has challenged few of the factual findings described above, but instead bases its case on purported surveyor errors. Citing 42 C.F.R. §§ 488.18(a) and 488.26(d), Petitioner asserts that survey findings "must be adequately documented" and suggests that that, unless the surveyors follow every step set forth in Appendix J of the State

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[16] The facility's substantial noncompliance with three conditions of participation was persuasively established and sufficient to support the termination. I therefore do not reach the issue of whether the facility was in substantial compliance with 42 C.F.R. § 483.440, which requires that each client receive a continuous active treatment program. *See Beechwood Sanitarium*, DAB No. 1824, at 19 (2002).

Operations Manual (SOM), "the findings in the Statement of Deficiencies are not accurate." P. Cl. Br. at 5-6.

The courts and the Board have pointed out that, while provisions of the SOM may provide useful guidance as to CMS's interpretations of applicable law, its provisions do not constitute enforceable, substantive rules. *Beverly Health and Rehabilitation Services v. Thompson*, 223 F. Supp. 2d 73, at 99-106 (D.D.C. 2002); *Oakwood Community Center*, DAB No. 2214, at 16 (2008); *Aase Haugen Homes, Inc.*, DAB No. 2013, at 15 (2006).

Moreover, the sections that Petitioner relies on do not apply to CMS. CMS conducts some of its own surveys, but it also contracts with state survey agencies to perform the survey function. Act, § 1864(a); 42 C.F.R. §§ 488.10; 488.20. Petitioner relies on provisions that govern the performance of *state* survey agencies, not federal survey teams: "The findings of the *State agency* with respect to each of the conditions . . . must be adequately documented." (emphasis added) 42 C.F.R. § 488.18(a); "The *State survey agency* must use the survey methods, procedures and forms that are prescribed by CMS." (emphasis added). 42 C.F.R. § 488.26(d). These regulation describe the means by which CMS can monitor a state agency's performance. CMS may sanction a state survey agency for inadequate survey performance (42 C.F.R. § 488.320). But the regulations are explicit: "*Inadequate survey performance does not . . . invalidate adequately documented deficiencies*." (emphasis added) 42 C.F.R. § 488.318(b)(2).

Finally, even if section 488.18(a) applied to CMS (which it does not), that subpart also explains what "adequate" documentation means with respect to a noncompliant facility: "a description of the specific deficiencies which resulted in the [state] agency's recommendation," and "any provider. . . response." Here, the survey report form sets forth in considerable detail "a description of the specific deficiencies" that led to CMS's determination, and I consider it more than adequate documentation. CMS Ex. 1.

E. Petitioner's objections to the procedures followed are without merit.

Petitioner has also submitted lengthy arguments addressing issues other than the actual survey findings that resulted in CMS's determination to terminate the facility's program participation. Without losing sight of our purpose here – which is to decide whether the facility was in substantial compliance with the conditions of participation – I now consider Petitioner's complaints about the procedures followed in this case.

Petitioner complains that I amended my initial order and directed it to file the first round of submissions.

Although Petitioner's February 1, 2008, hearing request was timely, Petitioner admits that it did not satisfy the regulatory requirements for a valid hearing request because it did not identify the specific issues and findings of fact and conclusions of law with which

the Petitioner disagreed, nor specify the basis for its contending that those findings were incorrect. 42 C.F.R. § 498.40(b). On April 7, 2008, CMS moved to dismiss the inadequate hearing request. In a response dated April 16, 2008, Petitioner argued that it could not reasonably have filed a valid hearing request within 60 days because the survey report form "was extremely detailed and complicated" and the facility was in negotiations with CMS to resolve or at least limit the issues. Petitioner also complained that its efforts were further complicated because a follow-up survey yielded an even lengthier statement of deficiencies.

But by mid-April Petitioner had known of the cited deficiencies for five months, and more than four months had passed since it received CMS's termination notice, which included notice of its appeal rights. Nevertheless, Petitioner did not come forward with a valid hearing request; instead, it claimed that it required *additional* time for filing. In my view, a facility is not entitled to more time to file its hearing request simply because of the number of deficiencies cited. To hold otherwise would lead to the ironic and wholly undesirable result of affording additional rights to those facilities with the most deficiencies cited. And the truly deficient facility would be allowed to continue its program participation for the longest time of all, just by arguing that it needed the most amount of time to determine its defense.

Moreover, although Petitioner cites the burden of responding to such an extensive list of deficiencies for its failure to meet the regulatory requirements, it claims throughout its closing brief that, due to CMS's practice of cross-referencing deficiencies, "a small number of alleged findings are reported in multiple locations throughout the survey." P. Cl. Br. at 48. *See also*, P. Cl. Br. at 55 ("In reality there are *very few deficiencies* actually reported in the survey.") Petitioner was required only to identify with which of those purportedly "small number" of findings and conclusions it disagreed and why. Sixty days was not an unreasonable amount of time in which to do that.

In an April 23, 2008 order, I nevertheless denied CMS's motion to dismiss, citing Board decisions in *The Carlton and the Lake*, DAB No. 1829 (2002) and *Alden Nursing Center – Morrow*, DAB No. 1825 (2002), which direct ALJs to "choose remedies short of outright dismissal to effectuate regulatory purposes" of requiring specificity in hearing requests. However, in order to achieve the regulatory purposes of requiring Petitioner to specify what it was appealing, and to avoid any additional delay of the administrative process, I simply directed Petitioner to file its pre-hearing exchanges first, and directed CMS to file its exchanges 30 days later. Petitioner had 55 days from the date of my order in which to comply, not an unreasonable amount of time. *See, e.g.* 42 C.F.R. § 498.17(b) (party afforded 20 days in which to submit rebuttal statements or additional evidence); Rule 12 FRCP (20 days for responsive pleadings).

Citing the Board's decision in *Hillman Rehabilitation Center*, DAB No. 1611 (1997), *aff'd Hillman Rehabilitation Center v. HHS*, No. 98-3789 (D.N.J. May 13, 1999), Petitioner complains that it was "denied a fair opportunity to learn what CMS claimed

was a *prima facie* case and to prepare a response to that alleged *prima facie* case." P. Cl. Br. at 6, note 5.[17] Petitioner's assertion that it was required "to proceed without the benefit of knowing the specifics and factual support for Respondent's allegations" is simply not so. P. Cl. Br. at 8. CMS's "extremely detailed" statement of deficiencies, more than adequately set forth CMS's *prima facie* case. *See Oxford Manor*, DAB No. 2167, at 2 (A statement of deficiencies may function both as a notice document and as evidence of the facts asserted therein. If a finding is not disputed, CMS need not present evidence in support of that finding).

Moreover, Petitioner confuses an evidentiary standard with procedural rules. The regulations give the ALJ the authority to determine the order in which the evidence and the arguments of the parties are presented. 42 C.F.R. § 498.60; *Beechwood Sanitarium*, DAB No. 1824, at 17 (2002). In *Beechwood*, the Petitioner faulted the ALJ for his disinclination to rule on the adequacy of CMS's case prior to demanding that Petitioner respond to CMS's claims, arguing that the ALJ's actions were "unfair and impractical" and hampered Petitioner's efforts to forward its case "in the most effective and efficient manner possible." *Beechwood* at 16. Citing 42 C.F.R. § 498.60, the Board ruled that "the regulation clearly provides that the ALJ has the discretion to set the process for presentation of the parties' arguments." *Beechwood* at 17; *See also VITAS HealthCare Corporation of California*, DAB No. 1782, at 2 (2001) (Board cites with approval "many common practices, such as allowing presentation of witnesses out of order and admitting exhibits prior to the in-person hearing," and concludes that the parties to the administrative process "routinely benefit from such flexibility.")

Further, Petitioner received CMS's pre-hearing submissions four months before the in-person hearing, and did not ask leave to supplement its own pre-hearing exchange. My pre-hearing order specifically sets forth a procedure by which the parties can do so:

> A party may move to amend its pre-hearing exchange . . . .
> I will decide a motion to supplement a pre-hearing exchange based on considerations of good cause and absence of prejudice to the opposing party.

Acknowledgment and Initial Pre-hearing Order, at 2-3 (2008).

Finally, without citing to any portion of the record, Petitioner complains that it was denied "reasonable opportunity to challenge the allegations of the CMS surveyors," and was "not allowed to fully inquire as to the flawed methodology of the survey." In this regard Petitioner complains that CMS presented the testimony of only one surveyor.

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[17] *Hillman* set out the parties' respective burdens of going forward and burdens of proof. I do not even consider application of the *Hillman* standard to this case since, under any reasonable standard, the evidence so overwhelmingly establishes that the facility was not in substantial compliance with program requirements.

Nothing precluded Petitioner from calling as its own witness any one from whom it sought to elicit testimony. If not willing to cooperate, Petitioner could have asked that the witness be subpoenaed pursuant to 42 C.F.R. § 498.58.

Otherwise, Petitioner cites no specific point in the record where it was not allowed to ask a relevant question and I am puzzled by its suggestion that it was not allowed to cross-examine the surveyor in the manner it wanted.

I am bound to inquire fully into all of the matters at issue and to receive in evidence testimony of witnesses and documents that are "relevant and material." 42 C.F.R. § 498.60(b). Although I repeatedly explained the *de novo* nature of this review, and advised Petitioner that inadequate survey performance does not invalidate adequately documented deficiencies, I nevertheless, afforded counsel wide latitude in questioning the surveyor. See Tr. 14 ("I'm letting you ask these questions, but this is a good example of the kinds of questions that are not helpful to me."); Tr. 21 ("I'm going to let you do this any way you want. I've told you . . . what I think I'm reviewing here. I'll let you do it any way you want. You have all of today. You can even go into a couple of hours tomorrow and then you're finished . . . . And if you think I'm wrong, that's fine. You'll take it up . . . .")

In addition to being afforded wide latitude at the hearing, Petitioner has submitted 389 exhibits and a whopping 550 pages of argument (including pre-hearing and closing briefs) all of which I have reviewed and considered, which should have offered it sufficient opportunity to present its case in full.

IV. Conclusion

For the reasons discussed above, I find that the facility was not in substantial compliance with at least three conditions of participation for Medicaid-certified ICFs/MR -- 42 C.F.R. §§ 483.410, 483.420, and 483.430. CMS is therefore authorized to terminate its program participation.

/s/ Carolyn Cozad Hughes
Administrative Law Judge