Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Appellate Division

In the Case of:	DATE: January 16, 2008
Martha & Mary Lutheran Services,	
Petitioner,	Civil Remedies CR1595 App. Div. Docket No. A-07-114
- v. -	Decision No. 2147
Centers for Medicare & Medicaid Services.	

FINAL DECISION ON REVIEW OF
ADMINISTRATIVE LAW JUDGE DECISION

Martha & Mary Lutheran Services (Petitioner) appeals the May 10, 2007 decision of Administrative Law Judge (ALJ) Steven T. Kessel. Martha & Mary Lutheran Services, CR1595 (2007) (ALJ Decision). The ALJ sustained a determination by the Centers for Medicare & Medicaid Services (CMS), based on survey findings by the Washington State Department of Social and Health Services, that Petitioner failed to comply substantially with federal requirements governing the participation of nursing homes in the Medicare and Medicaid programs. The requirement at issue here is that nursing homes must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of their residents, among other things. CMS's noncompliance determination centers on a resident who physically assaulted other residents over a six-week period. CMS determined that this failure constituted the provision of care at a substandard level requiring withdrawal of Petitioner's approval to offer a nurse aide training and competency evaluation program (NATCEP) for a period of two years.

For the reasons explained below, we sustain the ALJ Decision and affirm his findings of fact and conclusions of law.

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. A long-term care facility found not to be in substantial compliance is subject to various enforcement remedies

The Social Security Act (Act) prohibits approval of a NATCEP at any facility participating in the Medicare program "which, within the previous two years – . . . has been subject to an extended survey," which would be triggered by any finding of substandard quality of care. Section 1819(f)(2)(B)(iii)(I) of the Act; see also section 1919(f)(2)(B)(iii)(I) (the same provision for facilities participating in the Medicaid program). Regulations implementing this statutory provision require state survey agencies to withdraw approval of a NATCEP for any facility subjected to an extended survey in the preceding two years. 42 C.F.R. § 483.151(e); Desert Knolls Convalescent Hospital, DAB No. 1769 (2001). "Substandard quality of care" means one or more deficiencies (under 42 C.F.R. §§ 483.13, 483.15, or 483.25) that constitute either: immediate jeopardy to resident health or safety; a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm. 42 C.F.R. § 488.301. "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." Id. The regulations governing appeals permit a challenge by the facility to CMS's determination of the level of noncompliance where it would affect "a finding of substandard quality of care that results in the loss of approval for . . . a nurse aide training program." 42 C.F.R. § 498.3(b)(14)(ii).

Section 483.13 of 42 C.F.R., the program requirement at issue here, requires a facility to "develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property." "Abuse" is defined at 42 C.F.R. § 488.301 to mean "the willful infliction of injury, unreasonable confinement, intimidation, or

punishment with resulting physical harm, pain or mental anguish." "Neglect" is defined as "failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness." Id.

Standard of Review

Our standard of review on a disputed conclusion of law is whether ths ALJ's conclusion is erroneous. Our standard of review on a disputed finding of fact is whether the ALJ's finding 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 of the Departmental Appeals Board; Batavia Nursing and Convalescent Inn, DAB No. 1911, at 7 (2004), aff'd, Batavia Nursing & Convalescent Ctr. v. Thompson, 143 Fed.Appx. 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[1]

The Washington State Department of Social and Health Services (State agency) conducted a complaint investigation survey of Petitioner's facility on May 2 and 4, 2006, and a partial extended survey on May 15, 2006. CMS Exhibit (Ex.) 1, at 1. The State agency's findings that are the subject of the ALJ Decision centered on the actions of a male resident (identified in the ALJ Decision and in CMS's submissions as Resident #1) whose diagnoses included paranoid-type dementia and Alzheimer's disease with behavioral disturbances and anxiety and who resided on a secured dementia unit. CMS Ex. 1, at 2-3. The survey report (CMS 2567) and supporting records disclose that over a period of six weeks, Resident #1 engaged in a series of assaultive and intimidating behaviors toward other residents in the secured dementia unit, consisting of the following incidents noted in the ALJ Decision:

- On March 9, 2006, Resident #1 put his hand around the head of a female resident, Resident #2, and covered her mouth, causing her to scream for help. CMS Exs. 25, 26.

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

- On March 15, Resident #1 tried to take Resident #2's shirt protector, and, when she resisted, pulled it away and slapped her with it on her right shoulder and arm. CMS Exs. 27, 28.

- On March 24, Resident #1 blocked a female resident, Resident #3, in the dining room, and yelled and waved a rolled up newspaper at her. CMS Exs. 29, 30. Approximately one hour later, Resident #1 tried to pull Resident #5's wheelchair. CMS Exs. 33, 34. Some forty-five minutes after that, Resident #1 kicked Resident #4 in his left shin. CMS Exs. 31, 32.

- On April 2, in the evening, Resident #1 struck a female resident, Resident #6, after she threw water on him when he entered her room, causing red streaks on her forehead. Resident #1 had wandered into Resident #6's room several times previously that evening. CMS Exs. 37, 38.

- On April 12, Resident #1 slapped Resident #7. CMS Exs. 39, 69.

- On April 13, 2006, Resident #1 seized Resident #8 by the wrists. CMS Exs. 70, 71.

- On April 22, a female resident, Resident #9, was found in her room on her knees with Resident #1 standing over her; Resident #1 had pushed her twice, and after the second push Resident #9 fell and broke her wrist. CMS Exs. 20, 21.

ALJ Decision at 4. Petitioner transferred Resident #1 to a hospital emergency room on April 23, 2006 and subsequently refused to readmit him to Petitioner's facility. Id.; P. Ex. 10, at 1 (progress notes).

Based on these survey findings, the State agency determined that Petitioner was not in substantial compliance with the requirement to develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. 42 C.F.R. § 483.13(c). The State agency determined that Petitioner neglected to protect eight vulnerable residents from Resident #1's known repeated intimidating and aggressive physical and verbal behaviors; that Petitioner failed to recognize Resident #1's behaviors as intimidating and abusive and to revise interventions to protect residents; and that this failure resulted in a pattern of resident-to-resident abuse that created an intimidating and fearful environment for all residents on the dementia unit. CMS

Ex. 1, at 2.[2] The State agency determined that Petitioner's noncompliance constituted substandard quality of care. CMS Ex. 16, at 2.

CMS adopted the State agency's findings and recommendations and, by notice dated May 22, 2006, imposed the remedies of denial of payment for new admissions effective June 6, 2006, and noted that the citation of substandard quality of care required withdrawal of authority for Petitioner's NATCEP. CMS Ex.8. The State agency conducted a revisit survey on June 9, 2006, and found that the deficiencies identified in the prior surveys were corrected on June 1, 2006. CMS Ex. 5. By notice dated June 15, 2006, CMS thus reported that it was taking no action regarding the denial of payment for new admissions. CMS Ex. 4. However, because of the finding of noncompliance constituting substandard quality of care, the loss of NATCEP remained in effect.

The ALJ Decision

With the agreement of the parties, the ALJ conducted a hearing by telephone, on March 8, 2007. In his decision, the ALJ made the following findings of fact and conclusions of law (FFCLs):

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[2] The State agency also determined that Petitioner's noncompliance with 42 C.F.R. § 483.13(c) constituted a second deficiency, based on Petitioner's failure to recognize intimidating and aggressive behaviors between cognitively impaired resident as abuse, to provide clear policies regarding identification of such incidents as abuse, and to accurately report such incidents as abuse to the State hotline. CMS Ex. 1, at 9-10. This deficiency finding was based on the incidents involving Resident #1, as well as incidents involving actions by other residents. Id. at 13-14. The ALJ did not address this second deficiency finding in his decision because he determined that Petitioner was not in substantial compliance with the regulation as cited in the first deficiency finding and sustained CMS's determination that Petitioner's noncompliance constituted the provision of care at a substandard level, requiring the loss of NATCEP, the action that Petitioner appealed. ALJ Decision at 3, citing sections 1819(f)(2)(B)(iii), 1819(g)(2)(B)(i) of the Act. Petitioner's argument that the ALJ erred by not addressing the second deficiency finding was premised on its position that the first deficiency finding should be reversed. Because we sustain the ALJ's determination regarding the first deficiency finding, we need not address this argument further.

1. Petitioner failed to comply with the requirements of 42 C.F.R. § 483.13(c) because it failed to protect its residents adequately against a verbally and physically aggressive resident.

2. Petitioner did not disprove CMS's determination that the care that Petitioner gave to its residents was of a substandard quality.

The ALJ found that the evidence offered by CMS described a pattern of mounting abuse and violence by Resident #1 directed at other residents, and that these behaviors put Petitioner's staff on notice that Resident #1 was dangerously out of control and that other residents needed to be protected from him by all reasonable means. The ALJ inferred from "the unchecked violence that Resident #1 directed at other residents over a period of more than a month" that Petitioner's staff had failed to do what was reasonable and necessary to protect other residents. The ALJ determined that this evidence was "strong prima facie proof" that Petitioner "neglected the needs of its residents in contravention of 42 C.F.R. § 483.13(c)." ALJ Decision at 4. The ALJ then found that Petitioner did not rebut CMS's prima facie case, rejecting Petitioner's contention that it took all steps that it reasonably could have taken to protect the other residents from Resident #1 (and should thus not be held accountable for its failure to protect those other residents). In doing so, the ALJ compared a facility's duties under 42 C.F.R. § 483.13 with its obligation, under a different regulation, to provide each of its residents with adequate supervision and assistance devices to prevent accidents. 42 C.F.R. § 483.25(h)(2). He noted that the latter provision has been interpreted to require a facility to implement "all reasonable efforts to protect residents against adverse events that are reasonably foreseeable," and held that a facility's "[f]ailure to protect a resident against a known or foreseeable hazard – including the possibility that a resident might be physically abused or assaulted by another resident whose aggressive behavior has become known to a facility's staff – is a failure by a facility to provide services that are necessary to prevent physical harm or mental anguish and is, thus, neglect." ALJ Decision at 3.

The ALJ noted the actions that Petitioner's staff took in March and April 2006 to address Resident #1's behaviors. These actions included informing the resident's physician on numerous occasions of the resident's behavioral problems and care; referring the resident to a mental health provider and implementing that provider's recommendations; referring the resident to a local hospital more than once for consultation, consulting with a nurse

practitioner, and implementing recommendations for adjustment of the resident's medications; and implementing increased monitoring of the resident. ALJ Decision at 5-6, and record citations therein.

The ALJ found, however, that the actions that Petitioner's staff took were obviously inadequate to protect other residents from Resident #1's abusive and violent behaviors. Those behaviors, particularly after April 1, 2006, he found, put Petitioner's staff on notice that all of the preventive measures they had implemented to protect residents from Resident #1 were failing. The ALJ concluded that well before the final incident of April 22, 2006, in which a resident's wrist was broken, Petitioner's staff should have recognized that their efforts were inadequate to protect other residents and should have done whatever was necessary to keep Resident #1 apart from the other, vulnerable residents. He found that Petitioner's staff owed the other residents a duty of taking additional necessary measures – such as segregating Resident #1 from the remainder of the resident population, or discharging the resident – in order to protect them.

The ALJ noted that failure to comply with the requirements of 42 C.F.R. § 483.13 constitutes substandard quality of care if the level of noncompliance either poses immediate jeopardy for a facility's residents or constitutes a pattern of actual harm to residents. ALJ Decision at 6. He noted that CMS had determined that Petitioner's noncompliance (under the deficiency that the ALJ sustained) constituted a pattern of actual harm but not immediate jeopardy, and that he was required to sustain that determination unless Petitioner proves that it is incorrect. Id. citing CMS Ex. 8, at 1. The ALJ noted that while Petitioner had asserted its compliance with section 483.13(c), it did not argue or offer evidence to show that, if it was deficient, its noncompliance was at a scope and severity that is less than that which CMS determined to exist. He also concluded that the evidence offered by CMS in this case strongly supported a finding of a pattern of actual harm, as Resident #1 had repeatedly assaulted other residents and some of those assaults caused injuries. Consequently, he sustained CMS's determination of substandard quality of care.

Analysis

Petitioner disputes the ALJ's FFCL No. 1 and the ALJ's determination, in his supporting discussion, that Petitioner failed to take all necessary and reasonable steps to protect its residents from Resident #1's violent behaviors. Petitioner's

essential argument is that it had policies and procedures in place prohibiting mistreatment, neglect, and abuse of residents, as required by section 483.13(c), and that it implemented those policies and procedures by taking all reasonable measures to address Resident #1's aggressive behaviors and by dealing with those behaviors sufficiently. P. Request for Review (RR) at 9, citing P. Ex. 42, at 2-3, revised policy on Resident Abuse/Neglect Prevention, Management, and Reporting. In particular, Petitioner asserts that from February through April 2006 its staff were "always monitoring" the resident's mood, which was generally stable with very periodic agitation, and that this monitoring was "nearly constant" and that it generally employed "one-on-one" monitoring and/or "line of sight" monitoring when the resident's mood worsened. Id. at 3, 7-8, citing P. Ex. 49, at 2. Petitioner asserts that as the resident's condition deteriorated in March 2006 it implemented new interventions such as adjusting his medication, redirecting his attention, and admitting Resident #1 to a local hospital for observation and consultations with local community mental health providers. Id. at 5.

Petitioner argues that the ALJ imposed a strict liability standard by ignoring Petitioner's efforts to address Resident #1's violent and aggressive behaviors and by imposing liability regardless of those efforts. P. RR at 12. Because it implemented policies and procedures to prevent abuse, Petitioner argues, section 483.13(c) does not support a deficiency here.

For the following reasons, we conclude that the ALJ Decision is supported by substantial evidence and contains no error of law.

First, the ALJ did not hold Petitioner to a strict liability standard. Instead, he stated that Petitioner had to do what was reasonable and necessary to protect its residents from Resident #1. ALJ Decision at 4. In addition, the ALJ noted some other measures that Petitioner could have, but did not, implement to protect its residents from the violent and aggressive actions of Resident #1, such as segregating Resident #1 from the remainder of the resident population or discharging Resident #1 in order to protect them.[3] Id. at 5.

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[3] In fact, Petitioner did discharge the resident, by sending him to the hospital and refusing to readmit him, but not until after the April 22 incident that left a female resident with a broken wrist. P. Ex. 10, at 1. Taking such measures at an earlier point would have spared that resident her serious

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Second, substantial evidence in the record supports the ALJ's finding that Petitioner failed to do what was reasonable and necessary to protect its residents from Resident #1. ALJ Decision at 4. Most telling is the evidence regarding Petitioner's monitoring of Resident #1. The evidence demonstrates that Petitioner never fully implemented its reported strategy of increasing its monitoring to detect and head off aggressive behaviors by the resident following the deterioration of the resident's condition in March 2006, and that this strategy, to the extent it was implemented, was not effective.

Petitioner's claim that its monitoring was nearly constant is at odds with its own contemporaneous records of its observations of the resident. These are "Observation Record" sheets on which Petitioner's staff would record their observations of the resident at 15 or 30 minute intervals, depending on the format of the sheet.[4] P. Ex. 6; CMS Ex. 49. There are no records showing monitoring prior to March 11, although the first reported incident that is the subject of the deficiency finding, in which the resident placed his hand around the head of a female resident and covered her mouth, occurred on March 9. Id. The records cease after March 19 and do not resume until March 24 at 4:30 p.m., shortly after the first of the three incidents that day, at 4:20 p.m., which involved the resident blocking, yelling and waving a rolled up newspaper at a female resident. P. Ex. 6, at 18 (Observation Records); CMS Ex. 29-34 (facility Resident Occurrence Reports); CMS Ex. 49, at 15. While observations were recorded at most of the designated intervals for the remainder of March 24 and March 25, some gaps appear in the records for March 26 and the records cease after that date and do not resume until April 13. P. Ex. 6, at 1, 2, 21-22; CMS Ex. 49, at 13, 15, 17, 19-21, 23, 25, 28. In the interim, Resident #1 struck a female resident on April 2, slapped a resident on April 12, and, in an incident on March 27 that was not noted in the ALJ Decision, approached and began following a female resident who was with an aide, pulled the hair of a staff member who intervened, and grabbed the resident's arm before being redirected. CMS Exs. 35,

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[3](...continued)
injury and prevented at least some of the numerous incidents noted in the record.

[4] The sheets are pre-printed with observation times; most have marked spaces for observations every 15 minutes, but some, like the following, only have spaces for observations every 30 minutes. See, e.g., P. Ex. 6, at 3-6, 10, 11, 15, 16, 20; CMS Ex. 49, at 1, 2, 12, 19 (Observation Records).

36 (facility Resident Occurrence Reports). There are no Observation Records after April 13. This absence of records confirming that Petitioner monitored the resident on an ongoing basis is consistent with the declaration of the State Surveyor that, after each incident, Petitioner's staff would monitor the resident or separate him from other residents, but that it was not clear that the staff followed through on the measures they started, and would stop an intervention after a few days. CMS Ex. 72, at 6.

Petitioner also reports that it abandoned "one-on-one" monitoring because the resident's agitation increased when being followed by the monitor, and thereafter switched to "line of sight" monitoring. P. RR at 7-8. Yet, the evidence indicates staff could not ensure constant observation of the resident through "line of sight" monitoring. The State Surveyor testified by declaration that the secured dementia unit where the resident resided was "shaped like a square" so Petitioner's staff could not see the resident around corners. CMS Ex. 72, at 6. She also testified that it took 18 seconds at her normal pace "to walk one side of the square." Id. Petitioner does not directly dispute these observations, but merely states that when doing line of sight monitoring, "staff would keep relatively close to [Resident #1], but far enough away so as to avoid increased agitation." P. Ex. 49, at 3 (decl. of unit manager of Petitioner's secured dementia unit). This does not preclude the possibility that staff could nonetheless lose sight of the resident or that he could evade observation when staff was distracted, which, as we discuss later, happened prior to two of the reported incidents. Petitioner thus should have been aware that its strategy of line of sight monitoring could be impeded by the design of its facility and could not be relied upon to deprive the resident of opportunities to invade other resident rooms or engage in aggressive acts, without being observed.

Petitioner seems to concede that there were gaps in its observation of Resident #1, when it asserts that its monitoring was "nearly constant" and that it did one-on-one or line of sight monitoring "when the resident's mood changed." P. RR at 7 (emphasis added); see also P. Ex. 51, at 2 (declaration of Petitioner's unit manager and former Interim Director of Nursing stating that the facility kept the resident on "one-to-one or close contact observation as needed" (emphasis added)). Given the erratic and volatile nature of the resident's behavior as shown by Petitioner's records, Petitioner should have known that a reactive strategy of monitoring and intervening after his mood changed for the worse would not afford other residents the protection to which they were entitled at all times under the

regulations. At the very least, Petitioner should have known that reactive monitoring would not work after it failed to prevent multiple documented altercations. Petitioner's unit manager and former Interim Director of Nursing described the "periodic unpredictability" of the resident's agitated moods and how he could be "agitated one moment and stable the next." P. Ex. 51, at 2. A social work clinician for Petitioner also reported that the resident was "generally unpredictable." P. Ex. 48, at 2. The unit manager of Petitioner's secured dementia unit stated that it was very difficult to predict when Resident #1's difficult behaviors would reappear or to determine the triggers for those behaviors, despite the staff's best efforts to identify triggers. P. Ex. 49, at 2. Those behaviors, she reported, were generally short term and would dissipate quickly; he would be fine for an extended period of time, and then "unexpectedly aggressive behaviors would manifest and just as quickly disappear." Id.

The ineffectiveness of Petitioner's on-again, off-again monitoring of the resident's whereabouts is also evident from the incident records, which demonstrate that the resident, notwithstanding his infirmities, was capable of acting out in a quick and sudden manner, and did so when the staff's attention was drawn elsewhere. Progress notes relating to the incident on April 2, when Resident #1 struck a female resident, state that Resident #1 was "often" kept in sight due to his behaviors, but that on that particular evening the staff member was "charting" at the time of the incident and did not see the resident enter the room of his victim. P. Ex. 10, at 10. The same entry indicates that the resident had been redirected out of the female resident's room several times that evening, that he "frequently" would go into that room "quietly" on the "NOC shift," and that he would close the door and would be undiscovered until Petitioner's staff was alerted by the female resident or opened the door for rounds. Id. Records of the April 12 incident state that staff were there to intervene but were unable to stop him as "he is quick" and the staff were "just [not] quick enough." P. Ex. 39, at 3, 6. The facility's records of the final incident, in which the resident pushed down female Resident #9, states that the staff member who had been watching him had turned away to give another resident medication, and that when she turned back, Resident #1 was gone and had entered Resident #9's room before staff could get to him. CMS Ex. 21, at 4; P. Ex. 41, at 4. The report states that he "can move very quickly when he wants to." Id. By that late date, the resident's proclivities and his capacity for stealth, speed and violence should have been well known to Petitioner, and it should have been aware of the

negative consequences that could result from leaving him unattended and unobserved, however briefly.

Petitioner's argument that it took all reasonable measures to protect its residents from physical abuse by Resident #1 is also not borne out by the facility's plan of care for the resident. P. Ex. 2. The most recent update of the plan was in October 2005 (Id. at 21), as was the most recent entry related to the resident's dementia (Id. at 3). And although the plan shows that Petitioner had warnings about the resident in September 2004 (such as problems with altered coping related to anxiety and agitation, combativeness, and entering other residents' rooms, Id. at 2-3), the interventions listed in the plan make no mention of the need to protect other residents from Resident #1.

We thus conclude that substantial evidence in the record supports the ALJ's conclusion that Petitioner failed to comply with 42 C.F.R. § 483.13(c) because it neglected to protect its residents from abuse by other residents.

Petitioner also questioned whether the deficiency was properly cited under section 483.13(c), which, Petitioner correctly states, requires facilities to "develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents." P. RR. at 9. Petitioner asserts that it had such policies, citing the "Resident Neglect/Abuse Prevention, Management, and Reporting" policy in Petitioner's Exhibit 42. Indeed Petitioner's policy does assert a "zero tolerance for abuse and neglect" and states, inter alia, that the policy's purpose is to "protect residents from abuse or neglect through prevention," to "initiate protective measures when abuse or neglect is suspected or known," and to "prevent further abuses and safeguard the general welfare of residents." Id. The problem, and the reason why the deficiency was cited under section 438.13(c), is that Petitioner's staff did not adequately implement those policies, at least where prevention of resident-to-resident abuse was concerned.[5] In a number of cases, the

[5] Petitioner also questions whether CMS properly cited this deficiency under section 483.13(c), because the survey report cites this deficiency using the alpha-numeric "tag" F224, and CMS's guidelines to surveyors, in addressing section 483.13(c), direct that tag 224 be used for "deficiencies concerning mistreatment, neglect or misappropriation." P. Br. at 9, citing CMS State Operations Manual, Appendix PP, *Guidance to Surveyors for Long Term Care Facilities*. Petitioner states, "Arguably none

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Board has upheld findings of noncompliance under section 438.13(c) based on a facility's failure to adequately implement its anti-neglect policies. E.g. Liberty Commons Nursing & Rehab Center – Johnston, DAB No. 2031 (2006), aff'd, Liberty Commons Nursing and Rehab Center – Johnston v. Leavitt, 241 Fed.Appx. 76 (4th Cir. 2007); Barn Hill Care Center, DAB No. 1848 (2002). The regulations define neglect as a "failure to provide goods and services necessary to avoid physical harm, mental anguish . . . ." 42 C.F.R. § 488.301. There is substantial evidence here that Petitioner neglected to adequately monitor Resident #1's whereabouts with respect to other residents or take other steps to protect those residents and that this neglect caused not only physical harm but mental anguish on multiple occasions, sometimes to the same resident.[6] Moreover, our decision here is consistent with our decisions in Britthaven, Inc., DAB No. 2018 (2006), and Mountain View Manor, DAB No. 1913 (2004), in which we upheld ALJ findings of noncompliance with section 483.13(c) that involved failure to prevent resident-to-resident abuse.

Petitioner also argues that while "[t]he facts of this case are similar to those of Woodstock Care Center," the facts here "argue

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[5](...continued)
of these issues are raised here." Id. That is incorrect. Petitioner's failure to protect its residents from another resident constituted "neglect" of those residents and was the basis for the finding of noncompliance with section 483.13(c) that CMS cited under tag F224 and that the ALJ upheld. Furthermore, the same portion of the Guidelines that Petitioner cited states that a resident's right to be free from "mistreatment, neglect or misappropriation" includes "the facility's identification of residents whose personal histories render them at risk for abusing other residents . . . ." Id. (emphasis added). But even assuming citation under section 483.13(c) was somehow inconsistent with the Guidelines, the Board would be bound to apply the regulation which, as discussed above, clearly provides a basis for the finding of noncompliance.

[6] Petitioner's records indicate that Resident #2, the female resident who was on the receiving end of Resident #1's behaviors in the altercations on March 9 and March 15, reported being scared after each incident. CMS Ex. 25, at 2, 4; Ex. 27, at 1, 2. The State Surveyor reported in her declaration that the female resident who suffered a broken wrist at the hands of Resident #1 on April 22 was afraid to leave her room the next day and that she visibly relaxed when told that Resident #1 was no longer in the facility. CMS Ex. 72, at 7.

for an entirely different outcome." P. RR at 11, citing Woodstock Care Center, DAB CR623 (2000). We disagree. Petitioner cites the greater number of violent incidents and the higher number of serious injuries in Woodstock as well as what Petitioner describes as "little proof" that Woodstock monitored its residents or adopted measures designed to prevent future incidents. Petitioner's efforts to distinguish Woodstock are not persuasive. Nothing in that decision or in the Board's affirming decision, Woodstock Care Center, DAB No. 1726 (2000), aff'd, Woodstock Care Ctr. v. Thompson, 363 F.3d 583 (6th Cir. 2003), establishes a minimum threshold of permissible resident-to-resident abuse. To the extent that this case and Woodstock both involve allegations that inadequate monitoring and supervision by staff allowed resident-to-resident abuse, the situations are more similar than different. In any event, we find that substantial evidence supports the ALJ's determination that Petitioner failed to effectively implement its zero-tolerance neglect policy or to comply with the federal regulation prohibiting neglect.

For the above reasons, we sustain FFCL No. 1.

Petitioner does not specifically challenge FFCL No. 2, in which the ALJ concluded that Petitioner did not disprove CMS's determination that the care that Petitioner gave to its residents was of a substandard quality. Petitioner does state that "not only does the prima facie evidence not support CMS's determination that Petitioner's deficiencies showed a substandard quality of care, but [Petitioner] has rebutted what evidence was presented." P. RR at 18. However, Petitioner makes no independent argument as to why the deficiency cited under 42 C.F.R. § 483.13(c) does not constitute substandard quality of care but, rather, merely relies on its argument that it was in substantial compliance with the regulation. Substandard quality of care includes a deficiency under 42 C.F.R. § 483.13 that constitutes a pattern of actual harm that is not immediate jeopardy, which is what CMS found and the ALJ upheld here. 42 C.F.R. § 488.301. We have concluded that substantial evidence supports the ALJ's neglect findings, which on their face evidence a pattern of actual harm. Since that scope and severity level of noncompliance constitutes substandard quality of care as a matter of law and Petitioner makes no independent challenge to the substandard quality of care determination, we uphold FFCL No. 2 summarily.

Conclusion

Based on the above analysis, we uphold the ALJ Decision in its entirety and sustain the ALJ's FFCLs.

/s/
Judith A. Ballard

/s/
Leslie A. Sussan

/s/
Sheila Ann Hegy
Presiding Board Member