Department of Health and Human Services
DEPARTMENTAL APPEALS BOARD
Appellate Division

Honey Grove Nursing Center
Docket No. A-14-51
Decision No. 2570
May 8, 2014

FINAL DECISION ON REVIEW OF ADMINISTRATIVE LAW JUDGE DECISION

Honey Grove Nursing Center (Honey Grove) appeals the decision of the Administrative Law Judge (ALJ) in *Honey Grove Nursing Ctr.,* DAB CR3039 (2013) (ALJ Decision). The Centers for Medicare & Medicaid Services (CMS) had determined to impose a $5,550 per-day civil money penalty (CMP) against Honey Grove for the period March 3, 2012 through March 9, 2012. The ALJ concluded that Honey Grove was not in substantial compliance with three Medicare participation requirements during the cited period, that CMS's determination of "immediate jeopardy" was not clearly erroneous, and that the CMP amount is reasonable.

For the reasons stated below, we uphold the ALJ Decision.

I. Background

Honey Grove is a long-term care facility located in Texas that participates in the Medicare program as a skilled nursing facility and the Medicaid program as a nursing facility. The Social Security Act (Act) establishes the requirements that a long-term care facility must meet to participate in the Medicare and Medicaid programs and authorizes the Secretary of Health and Human Services (Secretary) to promulgate regulations implementing those statutory requirements. Act §§ 1819, 1919.[1] The implementing regulations are at 42 C.F.R. Part 483. To participate in the federal programs, the facility must remain in substantial compliance with those requirements. 42 C.F.R. § 483.1(b). "Substantial compliance" means "a level of compliance with the requirements of participation such that any identified deficiencies pose no greater risk to resident health or safety than the potential for minimal harm. 42 C.F.R. § 488.301. "Noncompliance" means "any deficiency that causes a facility not to be in substantial compliance." *Id.*

[1] The Act, as amended, is available at http://www.ssa.gov/OP_Home/ssact/ssact.htm. On this website, each section of the Act contains a reference to the corresponding chapter and code in the United States Code.

State agencies survey facilities on behalf of CMS to determine whether the facilities comply with the participation requirements. 42 C.F.R. §§ 488.10-.28, 488.300-.335. The regulations specify the remedies that CMS may impose if a facility is not in substantial compliance with the participation requirements. 42 C.F.R. § 488.406. CMS may impose a per-day CMP for the number of days a facility is not in substantial compliance or a per-instance CMP for each instance of the facility's noncompliance. 42 C.F.R. § 488.430(a). A per-day CMP, which CMS imposed in this case, may range from either $50 to $3,000 per day for less serious noncompliance or $3,050 to $10,000 per day for more serious noncompliance that poses immediate jeopardy to the health and safety of residents. 42 C.F.R. § 488.438(a)(1). "Immediate jeopardy" exists when "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 imposed the per-day CMP for the period March 3 through March 9 based on a Texas state agency survey that found that Honey Grove was not in substantial compliance with the following:

- Section 483.13(b), which provides that each resident "has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion."
- Section 483.13(c)(1)(i), which provides that a facility must "[n]ot use verbal, mental, sexual, or physical abuse, corporal punishment or involuntary seclusion."
- Section 483.13(c), which requires a facility to "develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents."
- Section 483.75, which provides that a facility "must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident."

The incident giving rise to the survey involved a 77-year-old male resident of the facility identified as "Resident 1" or "Resident No. 1." Resident 1 suffered from, among other medical conditions, Alzheimer's disease, psychosis, and anxiety. He had a history of refusing care and at times could be physically and verbally aggressive towards facility staff. The surveyors found that, on March 8, 2012, a male certified nurse assistant (referred to as CNA D.M.) had abused Resident 1 by forcibly providing incontinence care (despite the resident's resistance) thereby injuring the resident. The surveyors further found that the facility Administrator (who was informed on March 3, 2012 that Resident 1 was refusing care from male aides) did not take steps adequate to prevent the abuse,

that this abuse and the failure of staff to report earlier remarks by the CNA showed that the facility had not implemented its anti-neglect policies and procedures, and that these failures showed that the facility was not properly administered.

Honey Grove requested an ALJ hearing to challenge the noncompliance findings and enforcement remedy. After the parties agreed that no in-person hearing was necessary, the ALJ issued his decision based on the written record, concluding that Honey Grove was not in substantial compliance with the cited participation requirements during the period March 3, 2012 through March 9, 2012, that CMS's determination that the noncompliance was at the immediate jeopardy level was not clearly erroneous, and that the CMP amount is reasonable.

II. Standard of Review

We review a disputed finding of fact to determine whether the finding is supported by substantial evidence in the record as a whole, and a disputed conclusion of law to determine whether it is erroneous. *Departmental Appeals Board, Guidelines -- Appellate Review of Decisions of Administrative Law Judges Affecting a Provider's Participation in the Medicare and Medicaid Programs* (Guidelines), available at http://www.hhs.gov/dab/divisions/appellate/guidelines/prov.html.

III. Analysis

A. The ALJ's conclusion that Honey Grove was not in substantial compliance with sections 483.13(b) and (c)(1)(i) is supported by substantial evidence and free of legal error.

Section 483.13(b) provides that each resident "has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion." Section 483.13(c)(1)(i) provides that a facility must "[n]ot use verbal, mental, sexual, or physical abuse, corporal punishment or involuntary seclusion." "Abuse" is defined in related regulations as "the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish." 42 C.F.R. § 488.301.

As the ALJ pointed out, noncompliance with these requirements can be found even if no actual abuse of a resident occurred. ALJ Decision at 5. In *Western Care Management, Corp., d/b/a Rehab Specialties Inn.,* DAB No. 1921 (2004) (*Rehab*), the Board said:

> The goal of section 483.13(b) is to keep residents free from abuse. This goal cannot be achieved if a facility could be found in compliance even though it failed to take reasonable steps to protect residents from potentially injurious acts which it knew or should have known might occur and which might be willful . . . .

Rehab at 14; *see also Rehab* at 12 (noting that section 483.10 requires a facility to "protect and promote" residents' rights). The Board has also noted that "considerations of foreseeability are inapposite when staff abuse has occurred," because "a facility acts through its staff and cannot disown the consequences of the actions of its employee." *Gateway Nursing Ctr.*, DAB No. 2283, at 8 (2009).

1. The ALJ's finding that CNA D.M. abused Resident 1 is supported by substantial evidence and free of legal error.

Here, the ALJ's found that CNA D.M. had, in fact, abused Resident 1 on March 8, 2012, causing significant new bruising on Resident 1's arms and a new skin tear on his right wrist. *Id.* at 8-9. Among other things, the ALJ noted the following:

- CNA D.M. admitted to providing incontinency care to Resident 1 on March 8, 2012 and that Resident 1 went "haywire" during that care, but that the CNA completed the care anyway.

- Although Resident 1's care plan required CNA D.M. to "stop and return later" when Resident 1 was agitated during care, CNA D.M. did not follow this approach.

- Resident 1 reported the abuse and identified CNA D.M. as the perpetrator, and Resident 1's roommate confirmed that Resident 1 began to "fight" with CNA D.M.

- Staff members found new bruises on Resident 1's arms (with no reasonable explanation for their cause but the intervening abuse by CNA D.M.) and also found a fresh skin tear on Resident 1's right wrist (which is the same hand that CNA D.M. said Resident 1 was swinging).

Id. at 8-9 (citations omitted). The ALJ agreed with CMS that, "in order for CNA [D.M.] to continue giving incontinent care to a resident who was going 'haywire,' he had to exert more physical force against the resident than the resident was exerting to escape the situation." *Id.* at 9. In exerting that force, the ALJ found, CNA D.M. caused injury to Resident 1, thus abusing him. *Id.*

In its request for review, Honey Grove does not take exception to any of the ALJ's specific findings regarding the March 8 incident or raise any specific challenge to his evaluation of the evidence regarding this incident. Indeed, Honey Grove says it is "undisputed that the altercation between Resident No. 1 and CNA D.M., whatever the cause, resulted in physical harm to Resident No. 1." Request for Review (RR) at 5. In its reply brief, however, Honey Grove argues for the first time that the CNA's actions did not constitute abuse because the CNA was simply trying to do his job and was not

willfully trying to injure or intimidate the resident. Reply Br. at 6-7. This argument is not only untimely but also lacks merit. The term "willful" as used in the applicable definition of abuse does not require that the perpetrator intends to injure or harm the victim, but only that the action be deliberate and not inadvertent or accidental. *Merrimack County Nursing Home*, DAB No. 2424, at 5 (2011) (*Merrimack*) and cases cited therein.

Here, the ALJ could reasonably conclude from the undisputed facts outlined above that CNA D.M.'s actions that inflicted injuries on Resident 1were deliberate and not inadvertent or accidental and therefore constituted abuse. Indeed, those facts are similar to the facts that the Board found constituted abuse in *Merrimack,* which involved an aide using physical force to compel a resident who resisted into his room, despite a care plan directive to walk away if the resident resisted. *Id.; see also Britthaven, inc, d/b/a Britthaven of Sprinfield,* DAB No. 2018 (2006) (various incidents of abuse, including using force to provide care). Moreover, other evidence in the record here buttresses our conclusion that CNA D.M's actions were willful. As we discuss below, CNA D.M. had previously made statements to other staff indicating that he would continue to provide incontinence care to Resident 1 even if he resisted, despite the direction in the care plan to stop providing care when Resident 1 was agitated.

The March 8 incident of abuse is sufficient to show noncompliance with the cited requirements because, as noted above, a facility is responsible for the acts of its employees and because the CNA's acts resulted in more than minimal harm. As we discuss next, the ALJ also addressed whether the facility knew or should have known about the **potential** for abuse of Resident 1 in order to determine whether the facility's noncompliance started on March 3, as the surveyors and CMS found.

2. The ALJ's finding that the facility knew or should have known on March 3, 2012 of the potential for abuse of Resident 1 but failed to take reasonable steps to prevent abuse is supported by substantial evidence and free of legal error.

The ALJ found that Honey Grove's staff knew, or should have known, on March 3, 2012 that there was a potential for abuse or neglect involving Resident 1. ALJ Decision at 5. The ALJ gave two reasons for this finding. First, the facility Administrator had learned through a phone call from a supervisory nurse on March 3, 2012 that Resident 1 did not want to receive care from male aides, and, second, Resident 1's aggressive behavior was well-documented, with his behavior issues escalating in late 2011 and early 2012. *Id.* at 5-6. When the Administrator "learned of a factor – care by male staff members – that was a likely trigger for at least some of

Resident 1's apoplexy and behavioral problems," the ALJ concluded, it was reasonably foreseeable that (1) "allowing male staff members to provide care to Resident 1, who in turn was likely to refuse care from male aides, may have created prolonged periods where Resident 1 did not receive necessary care" and (2) "Resident 1's already-escalating behavior problems and outbursts of physical aggression might increase upon receiving care from male aides." *Id.* at 6.

The ALJ further found that the Administrator's response to learning of Resident 1's gender preference for his care providers "demonstrates that she must have recognized the potential for abuse or neglect." *Id.* at 7. According to the ALJ, the Administrator's "decision to have only female aides provide care to Resident 1 . . . was a reasonable step to prevent potential neglect or abuse against him" because that "approach was likely to have mitigated a foreseeable triggering factor for Resident 1's resistance of care and physical aggression towards staff." *Id.* The ALJ found, however, that the Administrator did not take reasonable steps to "formalize Resident 1's new care approach," relying instead on word-of-mouth to make sure that no males provided care to him, which was "a deficient means of preventing potential abuse or neglect." *Id.* at 7-8.

On appeal, Honey Grove does not take specific exception to any of the ALJ's factual findings about Resident 1's escalating behaviors or to the ALJ's findings about what the Administrator was told and how she responded. Nor does Honey Grove deny that abuse is more likely when a resident engages in behaviors such as those exhibited by Resident 1.[2] Instead, Honey Grove focuses not on a resident's right to be free from abuse, but on the extent to which a facility needs to recognize a resident's preference for certain caregivers. Honey Grove argues that a resident's rights are limited by various anti-discrimination requirements, including Title VII of the Civil Rights Act of 1964, that a facility is required to meet resident needs only where "practicable," and that it is not practicable to provide care in a way that would discriminate against certain employees. RR at 5. According to Honey Grove, in rejecting its argument about the law applicable to gender preference, the ALJ misconstrued the Seventh Circuit's decision in *Chaney v. Plainfield Healthcare Ctr.,* 612 F.3d 908 (7th Cir. 2010) (*Chaney)* as holding that any gender preference is reasonable. *Id.* According to Honey Grove, the ALJ missed the crux of the cases such as *Chaney* – that the "gender must be the *same* gender as the patient, and the preference must be based on the patient's desire for privacy or modesty." *Id.* at 6-7 (italics in original). Resident 1, Honey Grove points out, said he preferred female staff to care for him because they are "more gentle" and "for certain things." *Id.* at 7.

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[2] Honey Grove says that it "does not concede that the Administrator's initial attempt at a female-only policy was a way of acknowledging that males will always illicit a negative response from Resident No. 1 and therefore abuse." RR at 9. Nothing in the ALJ Decision suggests that he viewed the Administrator's action as acknowledging that abuse would always occur in those circumstances. Instead, the ALJ viewed the action as acknowledging the increased risk of abuse. Given the vulnerability of nursing facility residents such as Resident 1, we agree with the ALJ that Honey Grove was obligated to take action once it learned of his escalating behaviors.

Honey Grove's arguments are premised on Honey Grove's mischaracterization of the ALJ Decision as "accepting the use of discrimination," finding that gender discrimination is "reasonable," and treating the regulations as requiring discrimination in response to a resident's preferences. *Id.* at 6-12. The ALJ reached no such conclusions, however.

Honey Grove is correct that *Chaney* established the reasonableness of acceding to a resident's gender preference **only** where the preference is for care by someone of the same gender and is based on the resident's desire for privacy or modesty. 612 F.3d at 913. The ALJ did not, however, conclude that the Administrator's female-only policy was non-discriminatory. Instead, the ALJ was addressing whether, in the face of evidence that Resident 1's aggressive behaviors and refusal of care were escalating in a manner that affected the care he was receiving and that placed him at a greater risk for abuse, Honey Grove fulfilled its obligation to ensure that he was free from abuse. The ALJ did say that Honey Grove had not demonstrated that preventing male aides from providing care to Resident 1 was prohibited gender discrimination because *Chaney* "suggests that limiting a resident's contact with one gender is permissible by law." ALJ Decision at 10-11. The ALJ made this statement, however, only after pointing out that it was Honey Grove itself that "actually developed and later implemented the alleged discriminatory practice" by amending Resident 1's care plan.[3] *Id.* at 10. The key point the ALJ made about Honey Grove's arguments about the alleged conflict between resident rights and anti-discrimination laws was that they were irrelevant to the issues before him – a conclusion with which we agree. *Id.*

Contrary to what Honey Grove argues, nothing in the ALJ Decision interprets the regulations as requiring Honey Grove to take any particular step in response to a resident's behaviors that subject a resident to potential abuse. Instead, the ALJ specifically said that the "exact steps a facility must take are left to the facility's discretion so long as they are reasonable." *Id.* at 10, citing *Woodstock Care Ctr. v. Thompson,* 363 F.3d 583, 586 (6th Cir. 2003). In this context, the ALJ concluded that the Administrator's decision was "a reasonable step to prevent potential neglect or abuse" against the resident because the "approach was likely to have mitigated a foreseeable

[3] Honey Grove suggests that the surveyors required this care plan change, but points to no evidence to support this assertion. RR at 11.

triggering factor for Resident 1's resistance of care and physical aggression toward staff." *Id.* at 7. The ALJ went on to find, however, that this step was a "deficient means" of preventing abuse because the Administrator relied only "on word-of-mouth" to implement her decision. *Id.* at 7-8. In other words, the ALJ faulted the facility for not doing more to implement the only new care approach on which it had decided.[4]

The Administrator conceded that she had informed only the two night charge nurses about Resident 1's behaviors. CMS Ex. 4, at 20. Other staff, including the Assistant Director of Nurses, were not informed that Resident 1 did not want male aides to provide care. CMS Ex. 23, at 4. Honey Grove correctly argues that the record contains evidence that some CNAs were well aware of Resident 1's preferences and did accommodate them at least part of the time. *See, e.g.,* CMS Ex. 23, at 4-5. This evidence, however, does not undercut the ALJ's finding that the Administrator's actions were inadequate to implement the Administrator's directive, which was the only step the Administrator took to protect Resident 1.

Honey Grove nonetheless suggests that the "informal nature of the employees' coordination implies that they understood that the gender and racial preference were not legal." Reply Br. at 5. Perhaps one could imply from the employees' actions that **they** understood that acceding to Resident 1's preferences might not be legal. On the other hand, the Administrator's actions suggest she thought a female-only policy was legal. The Administrator did not testify that the reason she did not formally implement her directive was that she thought it was illegal. Even if she had so testified, moreover, that would not establish that Honey Grove met its obligation to take reasonable steps to prevent abuse of Resident 1. If a policy to limit which aides could provide care to Resident 1 would be discriminatory, then Honey Grove was obligated to take other steps to address Resident 1's escalating behaviors, but does not allege that it did so.

Honey Grove further argues that the Administrator's failure to make her directive formal "is acceptable considering there is evidence that female employees had reported being groped and therefore refusing to care" for Resident 1 and that it had to balance Resident 1's preference for female aides with a need to protect female staff from Resident 1's sexual advances toward them. *Id.* This argument (which Honey Grove raised in its

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[4] In its reply brief to the Board, Honey Grove points to the Statement of Deficiencies and the surveyors' declarations as showing that "CMS *did* act to require the facility to use white, female-only care providers with respect to Resident 1" and arguably to require the facility "to honor the preferences of any resident with respect to gender and race." Reply Br. at 3 (italics in original). Our review is of the ALJ Decision, not of the surveyors' or CMS's actions. Moreover, at least one of the surveyors testified more generally that her concern was about Honey Grove's "failures to intervene appropriately" to prevent abuse. CMS Ex. 23, at 10. Nothing in her declaration indicates that a female-only policy was the only intervention she would have considered appropriate.

prehearing brief but which the ALJ did not address) is also flawed. The notes from Resident 1's record which Honey Grove listed in its prehearing brief as showing that he made advances toward female aides are mostly from the period after the March 8 incident with CNA D.M. P. Prehearing Br. at 8-13. While the list includes one report of Resident 1 making an inappropriate statement to a female aide on February 15, that report also noted that the female aide did not refuse to continue providing services to him. CMS Ex. 17, at 4; CMS Ex. 4, at 6. Declarations by staff about Resident 1's sexual advances do not state when those advances occurred. P. Ex. 4.

Even assuming that Resident 1 had made sexual advances to female aides prior to the incident with CNA D.M., however, this behavior would not excuse Honey Grove's failure to take reasonable steps to protect the resident from abuse. Honey Grove provided no evidence that the Administrator was even aware of such behaviors during the relevant time period, much less any evidence that such behaviors explained why the Administrator did not do more to protect Resident 1 from abuse.[5]

Honey Grove's assertions that it was and is confronted with an impossible dilemma are, in our view, an attempt to divert attention from the real issues in the case. The assertions are based on the premise that the only alternatives available to Honey Grove "were to refuse to provide incontinent care until Resident No. 1 consented, assign only white female nurses with a history of being acceptable to Resident No. 1, or discharge him." Reply Br. at 5. Yet, Honey Grove has never explained why the Administrator could not have taken other steps to address the situation, such as working with male aides to ensure that they treated Resident 1 gently, providing training on how to cope with Resident 1's behaviors, or asking Resident 1's interdisciplinary care team to consider other care plan interventions to address his escalating behaviors such as requesting an adjustment to his anti-anxiety medications or providing for more frequent toileting.[6]

Thus, we affirm the ALJ's conclusion that, as of March 3, 2012, Honey Grove was not in substantial compliance with the anti-abuse requirements because it failed to take reasonable steps to address Resident 1's increased risk of abuse after the facility knew or should have known of that risk and that failure had the potential for more than minimal harm.

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[5] Honey Grove's arguments about race discrimination are similarly misplaced. CMS did not allege, and the ALJ did not find, that the Administrator knew or should have known that race was a factor triggering such behaviors, and there is no evidence that race factored into the Administrator's decision making.

[6] CMS argues that the Administrator should have put her female-only directive into Resident 1's care plan. The ALJ did not conclude that the Administrator was required do so. Nor do we so conclude. The care plan is to be developed by an interdisciplinary team based on the resident's comprehensive assessment. 42 C.F.R. § 483.20(k). Of course, the Administrator could have brought the problem to the attention of the interdisciplinary team to develop new approaches to the resident's escalating behaviors, but there is no allegation that she did so.

B. The ALJ's conclusion that Honey Grove was not in substantial compliance with section 483.13(c) is supported by substantial evidence and free from legal error.

Section 483.13(c) provides, in pertinent part:

> *Staff treatment of residents.* The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.
> (1) . . .
> (2) The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).

Honey Grove had two relevant policies, one policy prohibiting abuse and requiring that staff be trained in issues related to abuse (including in what constitutes abuse) and another policy requiring any employee "who has cause to believe that the physical or mental health or welfare of a resident has been or may be adversely affected by abuse or neglect" to report the abuse. ALJ Decision at 11, citing CMS Exs. 24, 25. CMS did not argue that these policies did not meet the regulatory requirements, but cited Honey Grove for failure to implement its anti-abuse policies and procedures.

The ALJ concluded that there was a "systematic breakdown" in Honey Grove's implementation of its anti-abuse policies and procedures, as evidenced by the fact that, "within a short period [of time], multiple staff members violated [Honey Grove's] anti-abuse policies on separate occasions." ALJ Decision at 11-13. The ALJ based this conclusion on his findings that CNA D.M. had abused Resident 1, and that, on three occasions shortly before that abuse, CNA D.M. had made remarks in the presence of other facility staff that they should have reported to the Administrator under the anti-abuse policy but did not timely report. *Id.* Specifically, the ALJ found that CNA D.M. had announced to staff members that he told Resident 1 the following: (1) "he was gonna have to be changed whether he liked it or not, so turn your ass over"; (2) "You can get changed the easy way or the hard way"; and (3) "I have to change you whether you like it or not." *Id.* at 12, citing CMS Exs. 10, at 1 and 22, at 7. The ALJ found that the use of profanity and such statements while providing care to Resident 1 served "no purpose other than to intimidate the resident so he acquiesces to the care, and it is likely to cause abusive mental anguish in a resident who does not want to receive that care." ALJ Decision at 12. The ALJ inferred from the failure of any staff member to report these statements that "either they did not recognize potential abuse, which violated the facility's anti-abuse policy, or they recognized the potential abuse by CNA D.M. but did not report it, which also violated the facility's anti-abuse policy." *Id.* at 13.

Honey Grove's request for review does not take specific exception to the findings the ALJ made regarding how the staff violated the facility's anti-abuse policy, other than the belated argument that CNA D.M.'s actions on March 8 were not willful and therefore not abuse – an argument that we rejected above. Honey Grove argues generally that the ALJ failed to "apply the appropriate standards to the evidence and correctly interpret the law." RR at 3. Honey Grove does not, however, allege any specific error in the ALJ's analysis of whether it was in substantial compliance with section 483.13(c). Honey Grove's arguments about the need to balance resident preferences with anti-discrimination laws are clearly irrelevant to that analysis.

Accordingly, we affirm the ALJ's conclusion that Honey Grove was not in substantial compliance with section 483.13(c).

C. The ALJ's conclusion that Honey Grove was not in substantial compliance with section 483.75 is supported by substantial evidence and free of legal error.

Section 483.75 provides that a facility "must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident." A finding of noncompliance with this requirement is usually based on findings of noncompliance with other participation requirements. *Cedar View Good Samaritan*, DAB No. 1897, at 23-24; *Asbury Ctr. at Johnson City*, DAB No. 1815, at 11 (2002).

Here, the ALJ found that Honey Grove's noncompliance with sections 483.13(b), (c), and (c)(1)(i) establish that Honey Grove "did not administer its facility in a manner that prevented abuse of a resident, let alone in a manner that ensured the highest practicable well-being for residents." ALJ Decision at 13. The ALJ further found that the Administrator "did not effectively communicate and execute an essential approach to address Resident 1's preference for care from female aides and, in turn, did not protect Resident 1 from potential abuse or neglect." *Id.*

As noted above, Honey Grove argues generally that the ALJ failed to apply the appropriate standards to the evidence and correctly interpret the law. RR at 3. Honey Grove does not, however, allege any specific error in the ALJ's analysis of whether Honey Grove was in substantial compliance with section 483.75. To the extent that Honey Grove's arguments regarding discrimination are an attempt to excuse the

Administrator's failure to "communicate and execute" her female-only directive, we reject those arguments for the reasons explained above. In particular, we reiterate that there is no evidence that the reason the Administrator did not formally implement that directive is that she viewed it as discriminatory, but, even if there was such evidence, that would not explain why the Administrator did not take other steps to prevent reasonably foreseeable abuse to Resident 1. We also note that the types of behaviors Resident 1 exhibited are not uncommon in nursing facilities, as shown by past Board cases such as *Merrimack*. In order to effectively and efficiently administer a facility to meet the goal of attaining and maintaining residents' highest practicable well-being, an administrator should have the skills necessary to manage staff in a way that both complies with anti-discrimination requirements and reflects a knowledge of various approaches that will ensure that residents are protected from abuse.

D. Honey Grove's arguments do not provide a basis for reducing the amount of the CMP.

Honey Grove argues that the CMP is "punitive and unreasonable" because the facility was legally unable to be in substantial compliance and therefore we should reduce the amount of the CMP. Reply Br. at 2.

We disagree. In determining that the CMP amount was reasonable, the ALJ considered the regulatory factors set out at 42 C.F.R. §§ 488.438(f), 488.404(b), (c), including the seriousness (scope and severity) of the noncompliance, the facility's history of noncompliance, and the facility's culpability.[7] The ALJ found that Honey Grove was "highly culpable for its overall noncompliance" based on: (1) the act of its employee, CNA D.M., who abused Resident 1 rather than diffusing the situation when Resident 1 resisted care; and (2) the failure by the Administrator to ensure reasonable steps were taken to prevent abuse and neglect of Resident 1. ALJ Decision at 16.

Honey Grove's arguments on appeal certainly do not provide a basis for lessening the level of culpability of CNA D.M. for forcibly providing care to Resident 1 rather than stopping when the resident resisted, as directed in his care plan. Nor do they excuse the Administrator's failure to take reasonable steps to prevent abuse of Resident 1 once it was foreseeable that such abuse might occur. As discussed above, Honey Grove provided no testimony from the Administrator about why she did not do more. Also, contrary to what Honey Grove argues, other steps were available if the Administrator had thought she could not legally implement her initial decision to have only female aides care for Resident 1, but there is no evidence she took any such steps.

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[7] As noted above, the ALJ concluded that CMS's immediate jeopardy determination was not clearly erroneous. ALJ Decision at 14; 42 C.F.R. § 498.60(c). On appeal, as before the ALJ, Honey Grove does not offer any specific evidence or argument that the immediate jeopardy determination was clearly erroneous.

Conclusion

For the reasons stated above, we uphold the ALJ Decision.

/s/
Constance B. Tobias

/s/
Stephen M. Godek

/s/
Judith A. Ballard
Presiding Board Member