Department of Health and Human Services
DEPARTMENTAL APPEALS BOARD
Appellate Division

Oceanside Nursing and Rehabilitation Center
Docket No. A-11-33
Decision No. 2382
May 23, 2011

FINAL DECISION ON REVIEW OF ADMINISTRATIVE LAW JUDGE DECISION

Oceanside Nursing and Rehabilitation Center (Oceanside) appealed the October 15, 2010 decision of Administrative Law Judge Steven T. Kessel sustaining the determination of the Centers for Medicare & Medicaid Services (CMS) that Oceanside was not in substantial compliance with Medicare participation requirements. *Oceanside Nursing and Rehabilitation Center*, DAB CR2269 (2010) (ALJ Decision). The ALJ sustained remedies of a civil money penalty (CMP) of $5,200 per day for the period March 13 through May 3, 2009, during which, CMS determined, Oceanside's deficiencies placed its residents in immediate jeopardy, and of $350 per day for the period May 4 through June 24, 2009.

For the reasons explained below, we conclude the ALJ Decision is supported by substantial evidence and free from harmful legal error.

Applicable Law

The Social Security Act (Act) and federal regulations provide for state agencies to conduct surveys of nursing facilities that receive Medicare and Medicaid funds to evaluate their compliance with the participation requirements of those programs. Act §§ 1819, 1919; 42 C.F.R. Parts 483, 488, and 498.[1] A facility's failure to meet one or more participation requirements, set forth at 42 C.F.R. Part 483, subpart B, constitutes a "deficiency." 42 C.F.R. § 488.301. "Noncompliance" is defined as "any deficiency that causes a facility to not be in substantial compliance." *Id*. "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." *Id*. Surveyor findings are reported in a statement of deficiencies (SOD), which identifies each deficiency under its regulatory requirement. 42 C.F.R. §§ 488.325, 488.404; State Operations Manual (SOM), CMS Pub. 100-07, App. P – Survey Protocol for Long Term Care Facilities (available at http://www.cms.hhs.gov/Manuals/IOM/list.asp), § V.

[1] The current version of the Social Security Act can be found at http://www.socialsecurity.gov/OP_Home/ssact/ssact.htm.

A facility determined to be not in substantial compliance is subject to enforcement remedies, including CMPs. 42 C.F.R. §§ 488.402(c), 488.406, 488.408. A per-day CMP may accrue from the date the facility was first out of compliance until the date it achieved substantial compliance. 42 C.F.R. § 488.440(a)(1), (b). For noncompliance determined to pose less than immediate jeopardy to facility residents, CMS may impose a per-day CMP ranging from $50-$3,000 per day. 42 C.F.R. § 488.408(d)(1)(iii). For noncompliance determined to pose immediate jeopardy to facility residents, CMS may impose a per-day CMP ranging from $3,050-$10,000 per day. 42 C.F.R. § 488.408(e)(1)(iii). "Immediate jeopardy" is defined as "a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident." 42 C.F.R. § 488.301.

Case Background

Oceanside is a skilled nursing facility in Georgia. The State survey agency completed a recertification survey of Oceanside's facility on April 25, 2009 and issued an SOD that identified 14 deficiencies, including five deficiencies at the immediate jeopardy level. The State survey agency completed a revisit survey on May 4, 2009, and CMS determined based on that survey that immediate jeopardy had been abated by May 4, 2009. It is undisputed that, as a result of the next revisit on July 2, 2009, Oceanside was determined to have achieved substantial compliance as of June 25, 2009. *See* P. Pre-Hearing Br. at 2.

Oceanside timely requested an ALJ hearing to dispute the findings of noncompliance. The ALJ received the parties' briefs, convened an in-person hearing on July 6, 2010, and admitted the parties' proposed exhibits. The ALJ addressed only the five immediate jeopardy-level deficiencies involving the facility's care of six residents, on the ground that those deficiencies were sufficient to justify the remedies that CMS determined to impose, which the ALJ sustained. We address those deficiencies in the order that the ALJ did.

The ALJ focused on five residents, designated to protect their privacy as Resident # 5, Resident # 8, Resident T, Resident # 6, and Resident C.

Standard of Review

The Board's standard of review on a disputed conclusion of law is whether the ALJ decision is erroneous. *Guidelines – Appellate Review of Decisions of Administrative Law Judges Affecting a Provider's Participation in the Medicare and Medicaid Programs,* http://www.hhs.gov/dab/divisions/appellate/guidelines/prov.html; *Batavia Nursing and Convalescent Inn*, DAB No. 1911, at 7 (2004), *aff'd*, *Batavia Nursing & Convalescent Ctr. v. Thompson*, 143 F. App'x 664 (6th Cir. 2005). The Board's standard of review on a

disputed finding of fact is whether the ALJ decision is supported by substantial evidence on the record as a whole. *Id*.

Analysis

1. *The ALJ's determination that Oceanside was not in substantial compliance with 42 C.F.R. § 483.13(c) is supported by substantial evidence and not legally erroneous.*

The regulation states that a facility "must develop and implement written policies and procedures that prohibit mistreatment, neglect and abuse of residents," with "neglect" defined to mean the "failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness." 42 C.F.R. §§ 483.13(c), 488.301. The ALJ's finding of noncompliance at the immediate jeopardy level was based on the facility's care of Residents # 8, T, and # 6. The ALJ found no credible evidence supporting allegations of neglect concerning a fourth resident, Resident C, who fell while attempting to shower, on the ground that CMS's findings were based on uncorroborated and unsupported hearsay. ALJ Decision at 8. CMS did not appeal that finding.

Oceanside states that CMS did not allege that Oceanside failed to develop policies and procedures to prohibit mistreatment, neglect, or abuse, but that Oceanside failed to implement those policies. Oceanside Request for Review of ALJ Decision (RR) at 3. Although neither party cited to particular provisions of those policies, Oceanside does not argue that the specific incidents the ALJ addressed under this deficiency represented the provision of care consistent with its policies against neglect; instead, Oceanside argues that they were isolated occurrences insufficient to establish a failure to implement its policies against neglect. We review the ALJ's findings and Oceanside's arguments for each resident below.

Resident # 8

Resident # 8 was a 51-year-old individual, incapacitated by strokes, who had lost the use of both legs, was unable to turn his lower body or ambulate, and was dependent on facility staff for transfers. Because a wheelchair had provided him with inadequate protection, he had been assigned a "Broda chair," a type of wheeled chair that provides increased stability and greater protection against falls by maintaining its user in a less upright position than a wheelchair. P. Ex. 16, at 2; CMS Ex. 42, at 7, 9. Facility staff knew that the Broda chair would not completely protect the resident from falling, and thus developed a care plan for the resident instructing that he be monitored for

appropriate positioning when in the Broda chair. ALJ Decision at 3, citing CMS Ex. 42, at 9.[2] The care plan also required that he be supervised while he smoked. CMS Ex. 42, at 8.

It is undisputed that, on January 8, 2009, Resident # 8 was not transferred to a Broda chair upon his return to the facility from a doctor's appointment to which he had been transported in a regular wheelchair. *Id*. at 5. Instead, upon his arrival he was transported in the regular wheelchair to the dining room, was served a meal, and was then transported in the wheelchair by another resident to a patio. *Id*.; ALJ Decision at 3-4. There, he smoked unsupervised and fell while in the wheelchair, sustaining a fractured clavicle. ALJ Decision at 4; CMS Ex. 42, at 5-6, 9.

The ALJ concluded that Oceanside violated the regulation because its staff "contravened the express instructions in the resident's care plan when they failed to assure his safe transfer to a Broda chair, failed to monitor the resident, and allowed him to smoke unsupervised." ALJ Decision at 4. The ALJ rejected Oceanside's view of the fall incident on January 8, 2009 as an isolated event caused by another resident. He concluded instead that the events of that day evidenced "a breakdown in the support and surveillance system" that had been "supposedly . . . implemented for Resident # 8" by facility staff, who knew the resident's safety required him to be transferred to a Broda chair upon his return to the facility and not only failed to do so, but permitted "a whole sequence of events in which the resident remained in a regular wheelchair without staff intervention." *Id*.

Oceanside does not dispute the ALJ's findings of fact regarding the events of January 8, 2009 that culminated in the resident's fall from a standard wheelchair while smoking unsupervised on the patio, with one exception. The ALJ found that a member of Oceanside's staff took the resident in the standard wheelchair to the dining room upon his return to the facility from his medical appointment. Oceanside contends that the resident was actually taken to the dining room in the standard wheelchair by staff of the company that had transported him from the doctor's appointment. Oceanside argues that it was not responsible for the actions of the transport company staff or for those of another resident who took Resident # 8 to the smoking patio without the knowledge of Oceanside's staff. Oceanside describes the resident's fall as "an isolated event in which another resident was able to circumvent the Facility's policies and procedures" that does not indicate a "pattern of neglect or substandard care" nor "establish that the Facility failed to implement policies and procedures to prohibit neglect . . . ." RR at 14.

[2] The ALJ also suggested that the care plan specifically instructed staff to "[m]ake sure to place [the resident] back in Broda chair following doctors appointments where he is transferred via w/c." ALJ Decision at 3, citing CMS Ex. 42, at 10. This intervention, however, appears to have been added after his fall on January 8, 2009.

While the record does not permit a definitive determination of whether the resident was taken to the dining room by an employee of Oceanside or the transport company, that issue is irrelevant.[3] The facility had ultimate responsibility for following the resident's care plan, which required that he be placed in a Broda chair instead of a standard wheelchair, be monitored while in the Broda chair, and be permitted to smoke only under the supervision of staff. CMS Ex. 42, at 8, 9. The facility took none of those actions, despite his having been in the facility long enough to be taken to the dining room, consume a meal, and then be taken to the patio, where he fell. For all this to have happened without the staff's apparent awareness demonstrates that the facility was not following its care plan, which supports the ALJ's conclusion that Oceanside failed to comply substantially with the regulation. *See, e.g.*, *The Cottage Extended Care Center*, DAB No. 2145, at 5 (2008) (failures to provide resident with care required by her care plan supported the ALJ's finding of noncompliance with section 483.13(c)), *aff'd sub. nom Cox Retirement Properties, Inc. v. Johnson*, 323 F. App'x 668 (10th Cir. 2009). As CMS points out, the former administrator testified that several facility staff members would have had the opportunity to have seen the resident upon his entrance into the facility, including staff in both the human resources office and the receptionist area, and two or three staff members in the dining room. Tr. at 156-61. Yet, Oceanside does not claim that any staff member intervened to ensure Resident # 8's transfer to a Broda chair.

Thus, with the possible exception of the ALJ's isolated statement that the resident was transported to the dining room by facility staff, which was not material to his overall conclusions, substantial evidence supports the ALJ's findings concerning Resident # 8.

Resident T

Resident T was a 60-year-old man with diagnoses including angina pectoris and cerebrovascular disease, who had sustained multiple gunshot wounds and had gait problems and sometimes walked with the aid of a walker. A previous resident of the facility, he had been most recently admitted from a local jail on June 23, 2008 and was known to have "behavioral problems" including alcohol abuse while outside the facility, and verbal abusiveness towards other residents. ALJ Decision at 4-5, citing CMS Ex. 43, at 14-15; *see* CMS Ex. 43, at 3 (care plan for mood and behavior).

[3] Oceanside cites the written testimony of the administrator of Oceanside's management company (who was a former administrator of the facility) that the transport company failed to follow the facility's protocol by taking Resident # 8 to the dining room in a standard wheelchair, rather than bringing him directly to the nurse's station to be checked back into the facility. P. Ex. 16, at 2-3 (Amer Decl.). However, the former administrator testified at the hearing that he did not personally observe the events of January 8, 2009, but "looked over the incident report next day when the resident came back." Tr. at 147-49. No such incident report is in the record. The nurse's notes state only that after the resident's arrival "via Doris transport," he was taken to the dining room in a regular wheelchair "per staff." CMS Ex. 42, at 5. It is unclear if the reference means that staff reported to the author that Resident # 8 was moved to the dining room in a regular wheelchair or that he was moved to the dining room by facility staff.

On January 5, 2009, shortly after his return to the facility from an absence during which he consumed alcohol, Resident T–

> began shouting, cursing, and demanding that Petitioner's staff attend to him. . . . He then threw an object (a can of cookies) at a nursing assistant and continued to curse and throw objects from his room into a hallway. . . . The resident refused to calm down, and Petitioner's staff called the police. The resident eventually was transferred to a local hospital for evaluation.

ALJ Decision at 5, citing CMS Ex. 43, at 10, 11, 15-16.
The ALJ found that Resident T was a "violence prone, abusive individual," noting that facility staff assessed the resident on April 26, 2009 as having "high potential for violence . . . brought on by alcohol consumption" and recorded that he "becomes surly and verbally aggressive towards others" and "is ambulatory and goes outside facility and buys his own alcohol" despite being "aware of the facility's policy prohibiting alcohol from being brought into the building." *Id.*, quoting CMS Ex. 43, at 5. The ALJ concluded that Oceanside was not in substantial compliance due to "lack of planning . . . to address the obviously violent proclivities of Resident T." *Id*. at 6. As evidence the ALJ cited Oceanside's failure to have developed a care plan that specifically addressed the resident's "behavior and proclivities" at any time between his admission on June 23, 2008 and his reassessment on April 26, 2009. *Id*. at 5. Yet, he was already assessed with behavioral and anger issues documented during this period and had demonstrated "clearly violent behavior." *Id*.; *see also* CMS Ex. 29, at 17-20; CMS Ex. 43, at 9-18.

Oceanside contends, as it did before the ALJ, that the resident posed no threat to other residents because his anger during the outburst on January 5 was directed at staff. RR at 12-13. Oceanside notes that no psychiatric symptoms were documented during his subsequent hospitalization, and argues that no evidence shows "that any later verbal outbursts were more severe than the January instance." *Id*. Oceanside's attempt to downplay the seriousness of the resident's behaviors ignores the many examples of adverse conduct implicating other residents documented in the facility records. Nursing and progress notes and assessments from September and December 2008, and March and April 2009 report frequent hostility, "[p]ersistent anger with self or others," yelling at family members in the dining room, "cursing" at another resident, belligerence and verbal abusiveness toward a physician, and having arguments with his roommate. CMS Ex. 29, at 3, 17-20; CMS Ex. 43, at 13, 14, 16, 18. They state that Resident T "[e]asily instigates arguments" and describe him as "easily annoyed with staff and other residents." CMS Ex. 29, at 3, 18. Even where such behaviors did not directly target another resident, the public nature of these explosions of temper could reasonably be expected to frighten or distress vulnerable residents observing them. *See Illinois Knights Templar Home*, DAB No. 2396, at 12 (2011) (staff member's threatening conduct towards other staff member "had the potential to intimidate and cause mental anguish to the two residents who were

within hearing distance."). Yet Oceanside points to no evidence of efforts to plan for or address the impact of these outbursts on other residents.

The records also indicate that Resident T's abusive behaviors followed his consumption of alcohol, reportedly off facility premises, and document that he regularly consumed alcohol. *Id*. Significantly, Oceanside did not cite evidence that would undermine the ALJ's finding that facility staff failed to "plan systematically to address these issues." ALJ Decision at 5.

The record thus supports the ALJ's finding that "staff knew that the resident was a dangerous individual, that his personal problems were exacerbated by his access to alcohol, and that he occasionally engaged in outbursts that posed risks for other residents." *Id*. We find no error in his conclusion that Oceanside's "failure to plan for, and to address, the resident's problems strongly supports a finding that the staff neglected not only the needs of Resident T but those of other residents who were potential victims of the resident's anger." *Id*.

Resident # 6

Resident # 6 was a 64-year-old man highly prone to sustaining injuries who fell on numerous occasions prior to falling in his room on March 13, 2009. ALJ Decision at 6; CMS Ex. 28, at 1, 19. He complained of pain daily beginning on March 14. CMS Ex. 28, at 28-31. An x-ray of his right hip that his physician ordered by telephone on March by 16 was negative, but the resident's complaints of pain continued. *Id*. at 29. On March 18, a physician examined the resident for the first time since his fall. *Id*. at 30. The physician then sent him to a hospital, where a CT scan that day disclosed a fractured femur and dislocation of the right hip. *Id*.

The ALJ determined that the facility "neglected the needs of Resident # 6 by failing to plan for, and to take actions to address, the resident's complaints of pain." ALJ Decision at 7. The ALJ pointed out that despite the resident being "in at least intermittent pain beginning on March 14, 2009," facility staff "was to say the least unsystematic in actually providing care to address the resident's complaints of pain." *Id*. The ALJ noted that Oceanside gave the resident "non-prescription pain medication only twice during the five day period before the resident was hospitalized" and then "Lortab only once" on March 19 "notwithstanding their assessment of the resident's pain as being of moderate severity." *Id*. After that, he found, the facility "did not administer another dose to the

resident until March 26."[4] *Id*. He also found that the facility "never systematically addressed that pain," doing "[n]o planning . . . to address the resident's complaints" and holding "no discussions about managing the resident's pain . . . with the resident's physician." *Id*.

Oceanside does not dispute the ALJ's recitations of the record of the facility's treatment of Resident # 6 but characterizes that record differently than did the ALJ. Oceanside argues that it attentively monitored the resident's condition following the fall and provided adequate pain medication. RR at 9. Oceanside downplays the severity of the resident's pain following the fall, pointing out that he initially denied having pain, was able to do "right knee flexion actively" on March 14, "did not express any distress" on March 15 and experienced only pain "upon movement" on March 15 and March 16 and had "mild" pain on March 16. RR at 7, citing CMS Ex. 28, at 28-29. Oceanside further points out that the records show that the resident experienced a quiet night and "rested well" on the evenings of March 17 and 18. *Id*. Oceanside also asserts that following his return from the hospital on the evening of March 18 the resident "continued to receive treatments and assistance with ADLs, and often voiced no complaints" and that his "condition was being followed and he was receiving appropriate services and care." RR at 9.

The ALJ rejected as unpersuasive Oceanside's assertions that the resident's complaints of pain were infrequent and addressed by facility staff, or that staff "engaged in 'repeated consultation' with the resident's physician about the resident's complaints." ALJ Decision at 7, citing Petitioner's Post-Hearing Br. at 10. The ALJ noted that the resident's complaints of pain "were not minimal," that he "voiced these complaints consistently, for a period of several days, whenever he was asked by Petitioner's staff," and that nevertheless "these complaints did not prompt the staff to do a systematic assessment of the resident's pain nor did they prompt the staff to develop a plan to deal with that pain." *Id*. He also pointed out that the first consultation with the resident's physician "did not take place until several days had elapsed after the resident sustained his fall" and that the resident's complaints of pain, "[i]n the interim . . . did not prompt consultation." *Id*.

[4] The ALJ and CMS both state that Oceanside staff gave Resident # 6 Lortab on March 18 and cite the Medication Administration Record (MAR) as evidence. ALJ Decision at 7 and CMS Resp. at 15, citing CMS Ex. 28, at 9. The MAR states that the resident received Lortab once on March 19 but not on March 18, as Oceanside asserts. CMS Ex. 28, at 9; RR at 8-9; *see* CMS Ex. 5, at 5 (SOD stating that Lortab was ordered on March 18 but no documentation that it was administered until March 19); *see also* CMS Ex. 28, at 27 (physician order for Lortab received 11:45 p.m. on March 18) and 30 (resident returned to facility from hospital at 11:30 p.m. on March 18, 2009). Given that the ALJ described a sequence of events in which "[t]he resident returned to the facility on the evening of March 18 . . . staff assessed the resident's pain on March 19, 2009 . . . [and] staff administered Lortab to the resident on the 18th," it appears that the ALJ may have meant that staff administered Lortab to the resident on the 19th, which is consistent with the records that the ALJ cites. ALJ Decision at 7-8. We therefore consider the date referred to in the ALJ Decision as a mere clerical error.

The record supports the ALJ's evaluation of the evidence and his inferences therefrom. Nurse's notes record Resident # 6 as complaining of pain daily from March 14 through March 19, the day following his return from the hospital, at which time a pain assessment tool rated the pain as "6" on a scale where 4-6 is moderate, 7-10 severe. CMS Ex. 28, at 28-31. The record indicates that the facility gave the resident a nonprescription pain medication once on March 16 and the Tylenol for which he had a pre-existing physician's order once on March 17, and administered Lortab on March 19 after his return from the hospital at 11:30 pm the previous night, and then not again until March 26, with additional doses on March 27, 30 and 31. ALJ Decision at 6; CMS Ex. 28, at 9, 28-30. The record contains no nurse's notes or pain assessment tools after March 19 and thus no record of whether he continued to complain of pain at that time. We note medication records show that he was given Lortab on March 27, 30 and 31, 2009, and notes from the revisit survey on May 4, 2009 state that a pain assessment was done on April 24, 2009 and the resident received Lortab for pain on April 27. CMS Ex. 28, at 9; CMS Ex. 45, at 6. This history supports an inference that pain continued to be an issue for Resident # 6 well after March 19, yet there is no evidence of any systematic assessment or planning occurring relating to the resident's pain at any time during this period.

Oceanside does not specifically dispute the ALJ's finding that it failed to develop a plan to deal with the pain Resident # 6 complained of beginning on March 14, the day after his fall. A handwritten addition dated March 13, 2009 on a care plan for the resident's falls does state a goal that the resident "will not have severe pain over the next 90 days." CMS Ex. 28, at 19-20. The only intervention noted on that document, however, was the March 18 prescription for Lortab following his hospitalization, with increasing doses to be given as needed depending on the degree of pain. Additionally, the nurse's notes show that a "Medicare Meeting" convened for the resident on the morning of March 18, addressed tube feedings and treatment of esophageal cancer, but the notes make no mention of treatment of the resident's pain. CMS Ex. 28, at 30. These documents are consistent with the ALJ's finding that the facility did little to address the resident's pain prior to his hospitalization.

Oceanside asserts that the allegation in the SOD that staff did not notify Resident # 6's physician of his complaints of pain until after the CT scan revealed the resident had suffered a fractured femur and a dislocated hip "offers a distorted view of the circumstances involved" because a nursing note shows that the physician was notified of the fall on March 13, the day it happened. RR at 6-7, citing CMS Ex. 28, at 28. That note shows that immediately after the fall the resident denied pain (he began complaining of pain consistently the following day), so there was no error in the ALJ's observation that staff did not inform the physician of the resident's *pain* until several days after his complaints of pain began. Oceanside cites nothing in the record to support its contention that after March 19, the "medical record shows that he continued to receive treatments

and assistance with ADLs, and often voiced no complaints." RR at 9. As noted, there are no nurse's notes after March 19, 2009 in the record.[5] Even if the resident "often" did not complain, Oceanside's statement implies that the complaints of pain did continue at other times. Pain treatment was still required at least through the end of the month, as noted above.

As CMS points out, the first administration of pain medication to Resident # 6 was on March 16 at 6 p.m., which was forty-six hours after Resident # 6 began complaining of pain to his right leg . CMS Ex. 28, at 28, 29. Substantial evidence in the record thus supports the ALJ's determinations that the facility responded only intermittently to repeated complaints of pain associated with a dislocated hip and fractured femur, and that it failed to adopt any systematic approach to dealing with the pain.

2. The failures of care that the ALJ found with respect to Residents # 8, T, and # 6 are sufficient to establish noncompliance with section 483.13(c).

Oceanside argues that the instances of alleged neglect with respect to the three residents for whom the ALJ sustained CMS's findings, even if true, were not sufficient to support a "broader conclusion . . . that the Facility had failed to implement policies and procedures to prohibit neglect." RR at 5. Oceanside argues that the DAB has recognized a "difference between a facility failing to implement required policies and procedures and instances of staff violating those policies and procedures" and that the regulation "addresses adopting effective anti-neglect and abuse policies, not targeting isolated events." *Id*., citing *Life Care Center of Hendersonville*, DAB CR542 (1998); *Emerald Oaks*, DAB No. 1800 (2001).

At the outset, we reject Oceanside's effort to minimize the significance of the ALJ's findings as "a few isolated events involving three residents out of a total of 81 residents in the Facility at that time." RR at 6. The survey findings for this deficiency were based on a sample of a total of nineteen residents. RR at 5; CMS Ex. 5, at 3. CMS's and the ALJ's findings that the facility was negligent in its care of three of the sampled residents thus carry far greater significance with respect to the facility's overall care of its patient population than Oceanside admits.

[5] Oceanside also alleges inaccuracies in some allegations in the SOD that the ALJ did not adopt in his decision. RR at 6. Oceanside disputes the SOD allegation that "the resident had not received even the Tylenol when he complained of pain," but the ALJ found that the facility administered Tylenol in response to the resident's complaints of pain on March 17, as Oceanside states. ALJ Decision at 6; RR at 8, citing CMS Ex. 5, at 5; CMS Ex. 28, at 6, 29. Oceanside disputes "CMS's suggestion that Resident # 6 did not receive Lortab until a day after it was ordered" on March 18, noting that the resident did not return to the facility from the hospital until 11:30 p.m. on March 18, and received his medication on March 19. RR at 8, citing CMS Ex. 28, at 9, 30; *see* CMS Ex. 5, at 5 (SOD). The ALJ did not make any finding of delay in administering Lortab after it was prescribed upon the resident's return from the hospital but did point out that the MAR indicates that the resident was not again given Lortab until March 26, and that the facility "gave the resident Lortab only once, notwithstanding their assessment of the resident's pain as being of moderate severity." ALJ Decision at 6, 7.

The Board has repeatedly held that "multiple or sufficient examples of neglect may support a reasonable inference that a facility has failed to develop or implement policies and procedures that prohibit neglect." *Dumas Nursing and Rehabilitation, L.P.*, DAB No. 2347, at 15 (2010) (citations omitted). The focus, thus, is not simply on the number or nature of the instances of neglect (i.e., failure to provide necessary care or services) but on whether the facts found by the ALJ surrounding such instance(s) demonstrate an underlying breakdown in the facility's implementation of the provisions of an anti-neglect policy. *See Columbus Nursing & Rehabilitation Center*, DAB No. 2247, at 27 (2009) (question is "whether the circumstances presented, viewed as a whole, demonstrate a systemic problem in implementing policies and procedures"); *Liberty Commons Nursing & Rehab Center – Johnston*, DAB No. 2031 (2006)(upholding ALJ's inference of failure to implement anti-neglect policy where staff failed to take several precautions required by latex allergy policy for a resident with known allergy), *aff'd*, *Liberty Commons Nursing & Rehab Ctr. – Johnston v. Leavitt*, 241 F. App'x 76 (4th Cir. 2007). The ALJ decision in *Hendersonville* on which Oceanside relies is not applicable because, as the Board has noted in a prior case, *Hendersonville* involved "a truly isolated error in judgment by a single employee notwithstanding the facility's best efforts to provide appropriate care." *Liberty Commons*, DAB No. 2031, at 15. In contrast to that isolated error by a single employee, the findings here indicate repeated instances of facility staff neglecting the needs of the three residents by failing to adhere to instructions in their care plans, to plan adequately to address their needs, or to follow facility policies. As discussed, multiple staff members were in a position to have seen Resident # 8 without the Broda chair during the period in which he was returned to the facility and was taken from the entrance to the dining room and from there to the patio, but none intervened. The outburst by Resident T on which the surveyors focused was but one of many noted in the facility's records. The records also indicate that Resident # 6 complained of pain over multiple days without receiving appropriate attention to his needs. These failures fully support an inference of breakdowns in facility implementation of neglect policies.

We thus sustain the ALJ's determination that Oceanside was not in substantial compliance with 42 C.F.R. § 483.13(c).

3. *The ALJ's determination that Oceanside was not in substantial compliance with 42 C.F.R. § 483.20(k)(3)(ii) is supported by substantial evidence and not legally erroneous.*

The regulation requires that "[t]he services provided or arranged by the facility must . . . (ii) Be provided by qualified persons in accordance with each resident's written plan of care." The ALJ concluded that Oceanside failed to comply substantially with the requirements of this regulation in its care of Residents # 8, # 4, and # 5. As with the prior deficiency, the ALJ found no credible evidence supporting allegations concerning Resident C.

Resident # 8

We discussed the facts concerning this resident above and agreed with the ALJ that those facts amounted to failure to comply substantially with section 483.13(c). The ALJ pointed out that staff "was instructed to keep Resident # 8 in a Broda chair, with special emphasis on assuring that he would be transferred immediately to this chair upon return from a visit to his doctor" and the resident "was supposed to be supervised while smoking." ALJ Decision at 9. The ALJ determined that Oceanside did not comply substantially with the regulation because Oceanside "plainly failed to provide these services to the resident." *Id*.

On appeal, Oceanside cites its argument in appeal of the ALJ's findings under section 483.13(c), and asserts that "the factual defects in regard to the evidence adduced as to Resident # 8 compromise[] this deficiency cited under [section 483.20(k)(3)(ii)] as well." RR at 15. We discussed above why we found no material factual defects in the ALJ's findings regarding this resident, and how those facts that were material were undisputed. Accordingly, the arguments we rejected there provide no basis to reverse the ALJ's determination that Oceanside in its care of Resident # 8 was not in substantial compliance with the regulation. Plainly, the facility did not follow the care plan for staff services that it developed for this resident.

Resident # 4

The ALJ found that this resident, whom Oceanside had assessed as being a high risk for falling, fell on four occasions while in his room between June 20 and October 7, 2008, and fell again on January 22, February 7, and March 27, 2009. ALJ Decision at 9; CMS Ex. 26, at 11, 16, 17, 19, 22-23. Oceanside does not dispute those findings.

The ALJ found that facility staff failed to implement, "either consistently or at all," interventions it developed to protect the resident against falling. ALJ Decision at 9. On February 4, 2009, the resident's physician ordered use of a chair alarm, along with his bed alarm. CMS Ex. 26, at 10. After the resident fell again on February 7, the alarms were found not to be operational. *Id*. at 7, 9. The facility then planned to have the alarms checked every two hours. *Id*. at 9. Yet, staff instead checked the bed and chair alarms only once every eight-hour shift. ALJ Decision at 9, citing CMS Ex. 26, at 25. The ALJ also noted that two of the three nurses interviewed during the April survey "were unable to say which residents were supposed to have their alarms monitored, and they admitted that there was no system in place at Petitioner's facility for checking alarms." *Id.*, citing CMS Ex. 18, at 1, 3. This evidence, the ALJ concluded, established "a clear failure by Petitioner's staff to follow instructions to check the resident's bed alarm at two-hour intervals" as well as "confusion by Petitioner's staff concerning which residents were to be monitored and whether there was a system for assuring that monitoring would take place." *Id*. at 10.

If anything, the ALJ's findings understate the seriousness of the resident's falls, two of which resulted in fractures, and the extent of the facility's failure to implement the care plan, shown by undisputed evidence in the record. Nurse's notes disclose that two days after the resident fell on January 22, 2009, he complained of pain in his right hip and was unable to bear weight on his leg and was discovered to have a fracture of his right hip. CMS Ex. 26, at 18. Two days after he fell on February 7, 2009, he complained of pain in his chest and was discovered to have three fractured ribs. *Id*. at 19, 20; *see also* CMS Ex. 5 (SOD) at 23, 35.

Additionally, the ALJ could properly have addressed an allegation that surveyors saw this resident in his wheelchair without the self-release seat belt that his physician had ordered on March 30, 2009 as a fall prevention measure, but the ALJ declined to do so, on the mistaken ground that it was not cited in the SOD or CMS's pre-hearing brief. ALJ Decision at 9. This allegation does appear in the SOD, albeit in the discussion of another deficiency (which the ALJ sustained and we address below), noncompliance with section 483.25(h). CMS Ex. 5, at 36. The SOD states that the resident was seen without the safety belt in place four times on April 23, 2009 between 9:45 a.m. and 4:00 p.m. and 14 times on April 24, 2009 between 7:20 a.m. and 3:10 p.m. The Board has held that "the SOD is a contemporaneous record of the survey agency's observations and investigative findings, and . . . CMS may make a *prima facie* showing of noncompliance based on that document if the factual findings and allegations it contains are specific, undisputed, and not inherently unreliable." *Guardian Health Care Center*, DAB No. 1943, at 14 (2004) (citations omitted). Oceanside had notice from the SOD that permitting the seat belt to go unused was a basis for CMS's imposition of sanctions against it and did not dispute the accuracy of the observations.

Oceanside does not dispute any of the ALJ's findings about the facility's failure to check the resident's chair alarm but instead points to "other fall precautions" it says were in place. RR at 17. Oceanside cites nurse's notes indicating that after the fall on February 7, 2009, the resident's bed "was in the lowest position and locked, the bed side rails were up, the bed alarm in place, and the chair alarm was also noted to be working properly." *Id.*, citing P. Ex. 18, at 1. The facility's "Unusual Occurrence/Incident Report" for the fall on February 7, 2009, however, actually indicates that the alarm was <u>not</u> working, stating "Bed alarm was no Ø working, now working properly." CMS Ex. 26, at 7.

Oceanside also argues that the fall on March 27 did not evidence a deficiency because the nurse's note reporting the fall states that the chair alarm had been removed or shut off by the resident. RR at 17-18, citing CMS Ex. 26, at 22. The ALJ, however, appears to have cited this and the other falls primarily as verifying that the resident "was very susceptible to falling," as also evidenced by the facility's assessment of him. ALJ Decision at 9. Oceanside cites facility records as showing that planned interventions were in place. RR at 17-18. These records show only that bed and chair alarms were checked on each shift.

CMS Ex. 26, at 17-22, 25. These records do not undercut the ALJ's finding that Oceanside failed to follow instructions to check the bed alarm every two hours. ALJ Decision at 9.[6]

Resident # 5

Resident # 5 was a 44-year-old woman who had suffered a stroke and was "greatly debilitated." ALJ Decision at 10; CMS Ex. 5, at 24. It is not disputed that a surveyor saw the resident "on several occasions" on April 23 and 24, 2009 without the hand rolls and palm protectors that her care plan required to treat flexion contractures of both hands. ALJ Decision at 10, citing CMS Ex. 27, at 16; RR at 18.

As below, Oceanside argues that one of the two hand rolls would not have been effective. While acknowledging that "[c]ontractures are a common medical occurrence and hand rolls a common intervention," Oceanside asserts that the resident's right hand "had a continuous opening and closing movement" which meant "a hand roll would not have stayed in the resident's right hand." RR at 18, citing CMS Ex. 5 at 24.

The ALJ rejected that argument, as do we, because the issue for the purpose of determining noncompliance with this regulation was whether services were provided "in accordance with" the resident's written plan of care. ALJ Decision at 10. As the ALJ stated, Oceanside was obligated to follow the care plan it developed for the resident, which required the use of hand rolls. *Id*. There is no evidence that facility medical staff determined that this intervention required by the care plan was not effective. Absent such determination, and modification of the resident's care plan to reflect it, we agree that the facility was obliged to follow the care plan.

Oceanside also argues that "[t]he rejection of Resident 'C' by the ALJ . . . compromises this deficiency cited under F282 as well." *Id*. For the same reasons that the failures of care that the ALJ found with respect to Residents # 8, T, and # 6 were sufficient to establish noncompliance with section 483.13(c), the removal from CMS's case of findings with respect to resident C did not mean that CMS failed to show noncompliant treatment of a sufficient number of residents to sustain a deficiency determination under this regulation as well. Oceanside failed to provide care to Resident # 8 in accordance with his plan of care, and moreover failed to provide appropriate care to two other residents.

We thus sustain the ALJ's determination that Oceanside was not in substantial compliance with 42 C.F.R. § 483.20(k)(3)(ii).

[6] Oceanside also questions the SOD finding that the chair alarm was not in place on March 12, 2009 when a staff member caught the resident after he stumbled upon getting out of his chair, because the nurse's note describing the incident does not indicate that the alarm was not in place. RR at 17, citing CMS Exs. 5, at 24; 26, at 21. The ALJ did not cite this incident among the bases for his conclusions, so we need not resolve this dispute.

4. *The ALJ's determination that Oceanside was not in substantial compliance with 42 C.F.R. § 483.25(h) is supported by substantial evidence and not legally erroneous.*

The regulation requires a facility to ensure that the resident environment "remains as free of accident hazards as is possible" and that each resident "receives adequate supervision and assistance devices to prevent accidents." 42 C.F.R. § 483.25(h)(1), (2). While not making a facility strictly liable for accidents, the regulation does require the facility to take all reasonable steps to ensure that a resident receives supervision and assistance devices that meet his or her assessed needs and mitigate foreseeable risks of harm from accidents. *Golden Living Center -Riverchase*, DAB No. 2314, at 7-8 (2010), and cases cited therein.

The ALJ found noncompliance due to the facility–

- not transferring Resident # 8 to a Broda chair upon his return from the doctor's appointment, not monitoring him while he was on the premises, and not supervising him while he smoked, constituting failures to supervise the resident by providing him the care he needed to protect him from falling, and "to provide the resident with an assistance device, a Broda chair;" and,

- failing to assure that Resident # 4's bed alarm was checked as often as directed, and to have in place a system that would tell its staff which of its residents needed to have his or her alarm checked.

On appeal, Oceanside relies on the same arguments it made in appeal of the ALJ's conclusion that Oceanside failed in its treatment of these two residents to comply substantially with the requirements discussed earlier, i.e., 42 C.F.R. §§ 483.13(c) (Resident # 8), and 483.20(k)(3)(ii) (Residents # 8 and # 4). In those arguments, Oceanside did not dispute the ALJ's findings of fact that were essential to his conclusions under this regulation. In the absence of any specific argument as to why the failures the ALJ sustained, and which Oceanside did not dispute, did not also amount to failures to ensure that the resident environment remained as free of accident hazards as is possible, and to provide adequate supervision to avoid accidents, we sustain the ALJ's deficiency determination.

5. *The ALJ's determination that Oceanside was not in substantial compliance with 42 C.F.R. § 483.75 is supported by substantial evidence and not legally erroneous.*

The regulation requires a facility to administer its resources effectively and efficiently so as to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. The Board has held that a finding that a facility was

noncompliant with section 483.75 may, in appropriate circumstances, derive from findings of noncompliance with other participation requirements. *Stone County Nursing and Rehabilitation Center*, DAB No. 2276, at 15-16 (2009) (citing cases).

The ALJ held that Oceanside's failures to comply with the three regulations addressed above "are, ultimately, a failure of Petitioner's management to implement policies and procedures that protect residents against staff misfeasance." ALJ Decision at 12. As examples, the ALJ cited Oceanside's failure to "have had a system in place to assure that its residents who wore, or were supplied with, alarms had those devices checked regularly," and its failure to assure that Resident # 8 was in a Broda chair at all times when he was on premises and awake, which the ALJ found was a failure by Oceanside's management "to assure that staff was properly trained to assure that the resident received the care that had been ordered for him." *Id*.

On appeal, Oceanside argues that the ALJ's determination is not supported by substantial evidence, and relies on the same arguments it makes in appeal of the other deficiency determinations. Above, we found that those arguments identified no error in the ALJ's factual findings supporting the prior deficiency determinations, with the possible exception of which staff placed Resident # 6 in the wheelchair on his return. The ALJ thus did not err in relying on those findings as a basis for his conclusion that Oceanside was not in substantial compliance with section 483.75.

6. *The ALJ's determination that Oceanside was not in substantial compliance with 42 C.F.R. § 483.75(o)(1) is supported by substantial evidence and not legally erroneous.*

The regulation requires that a facility "must maintain a quality assessment and assurance committee consisting of – (i) The director of nursing services; (ii) A physician designated by the facility; and (iii) At least 3 other members of the facility's staff." The ALJ determined that Oceanside was not in substantial compliance with this requirement based on a surveyor's interview with Oceanside's quality assurance coordinator. ALJ Decision at 12-13. He cited surveyor's notes recording that the quality assurance coordinator acknowledged that the quality assurance committee had not discussed who would assure that restraints and safety devices would be monitored appropriately, that Oceanside did not have any program to identify residents who are at risk for falling, and that the quality assurance committee had not identified any resident who had a problem with pain. *Id*., citing CMS Ex. 30 (surveyor's notes), at 13-14. Additionally, the survey recorded that the coordinator stated that the quality assurance committee had not discussed problems associated with resident behavior. *Id*. Oceanside disputes none of these findings, nor the ALJ's finding (*id*. at 12-13) that the quality assurance coordinator was unable to say whether the facility had conducted previously planned in-service training of its staff to implement a pain assessment protocol. The ALJ concluded that the ineffectiveness of the

quality assurance committee was shown by its failure to identify and address "obvious quality of care problems" including "a failure . . . to implement a system for monitoring alarms . . . a failure to assure that falls prone residents were systematically and adequately protected . . . [a]nd . . . a failure to address residents' pain in a systematic and thorough manner." *Id*. at 13.

As with the preceding deficiency, Oceanside argues that this finding should be reversed because the ALJ based his determination on his analysis of the prior deficiencies under sections 483.13, 483.20 and 483.25, and rests on its challenges to those deficiencies as being "equally applicable here." RR at 20. Oceanside points to no particular evidence documenting efforts by its quality assurance committee to ensure facility compliance with those regulations. Our determination that substantial evidence supports the ALJ's findings of noncompliance with those requirements also supports his conclusion that Oceanside was not in substantial compliance with 42 C.F.R. § 483.75(o)(1). We also find no legal error and uphold the ALJ's conclusion.

7. Oceanside has shown no clear error in CMS's determination that the deficiencies posed immediate jeopardy.

Immediate jeopardy is noncompliance that "has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident." 42 C.F.R. § 488.301. The ALJ sustained CMS's determination that each of the five deficiencies he addressed and sustained were at the immediate jeopardy level. ALJ Decision at 13-14; CMS Ex. 5, at 3, 21, 32, 45, 47. The ALJ found that Residents # 4, # 6, and # 8 "were all at risk of serious harm as a consequence of Petitioner's failure to provide them with care that complied with regulatory requirements" and that "Petitioner's failure to address systematically and comprehensively the violent outbursts of Resident T put other residents, at least, at a risk for serious harm." ALJ Decision at 13.

The regulations at 42 C.F.R.§ 498.60(c)(2) state that CMS's determination of the level of noncompliance "must be upheld unless it is clearly erroneous." The Board has repeatedly held that under the "clearly erroneous" standard, CMS's determination "is presumed to be correct," and the facility "has a heavy burden to demonstrate clear error" in CMS's determination regarding the level of noncompliance. *Brian Center Health and Rehabilitation/Goldsboro*, DAB No. 2336, at 9 (2010) (citations omitted); *see also Liberty Commons Nursing & Rehab Center – Johnston* at 18.

We agree with the ALJ that Oceanside has not shown CMS's findings of immediate jeopardy to be clearly erroneous. *See* ALJ Decision at 13. Oceanside claims that "the alleged deficiencies did not exist. Consequently, the issue of the severity of the deficiency is not presented." RR at 20. Since we have upheld the findings of noncompliance, the issue of the severity of that noncompliance is presented, and Oceanside has the heavy burden to show CMS's immediate jeopardy determination is clearly erroneous.

Three residents, # 8, # 6, and # 4, sustained fractures as a result of lapses in care, and Resident # 6 received only minimal treatment to alleviate the pain he complained of daily beginning one day after the fall that resulted in his hospitalization. *See, e.g.*, *Golden Living Center - Riverchase*, DAB No. 2314, at 9 (2010) and *Britthaven of Chapel Hill*, DAB No. 2284, at 10 (2009) (fractures constitute serious harm); *Sunbridge Care and Rehabilitation for Pembroke*, DAB No. 2170, at 34 n.20 (2008) (fractured distal femur "would be serious actual harm for anyone"), *aff'd, Sunbridge Care & Rehabilitation for Pembroke v. Leavitt*, 340 F. App'x 929 (4th Cir. 2009); *Barbourville Nursing Home*, DAB 1962, at 12 (2005), *aff'd, Barbourville Nursing Home v. U.S. Dep't of Health & Human Servs.*, 174 F. App'x (6th Cir. 2006) ("[w]here significant, ongoing pain is the likely result of a facility's treatment of a resident, that treatment can reasonably be viewed as placing the resident in serious jeopardy."). Leaving aside Resident # 4's fall on March 27, 2009 when he may have turned off his chair alarm, the impact of the facility's failure to implement the care plan for this resident despite six other falls between June 20, 2008 and February 7, 2009 is obviously serious.[7]

Oceanside also argues as it did before the ALJ that the findings for Residents # 4 and # 8 and Resident T could not have been the basis for CMS's immediate jeopardy determination because they derive from incidents that occurred in January 2009, whereas CMS imposed per-day CMPs at the immediate jeopardy level beginning on March 13, 2009. RR at 10, 13, 15; ALJ Decision at 13-14. That argument has no merit. The Board has held that a facility's noncompliance or failure to meet a participation requirement "is what constitutes the deficiency, not any particular event that was used as evidence of the deficiency" and that "[t]here is no requirement that the duration of a remedy coincide with particular events that form the evidence of lack of substantial compliance." *Regency Gardens Nursing Center*, DAB No. 1858, at 21 (2002); *see also Sheridan Health Care Center*, DAB No. 2178, at 43 (2008) (citing *Regency Gardens*). That CMS chose not to impose a CMP as of January 2009 (as it would have been entitled to do) does not mean that it could not rely on the incidents during that month as evidence of the onset of immediate jeopardy. Once immediate jeopardy is found to be present, the burden is on the facility to demonstrate that corrective actions have abated the danger. *Brian Center Health and Rehabilitation/Goldsboro* at 8, citing *Pinehurst Healthcare & Rehabilitation Center*, DAB No. 2246 (2009). Oceanside presented no evidence that it took any action to abate the situation before the survey. CMS could therefore choose to impose the CMP beginning on any date during the period in which immediate jeopardy was present and to continue the immediate jeopardy CMP until the facility abated the danger. The date CMS selected to initiate the CMP coincided with a fall by Resident # 6 but the fall was merely an additional example of the consequences of the continuing immediate jeopardy

[7] The ALJ found that Resident T's outbursts presented at least a "risk for serious harm" to other residents. While he did not find this resident alone presented a likelihood of serious harm, we find no error in the ALJ's treatment of the dangers of Resident T's violent proclivities as forming part of the overall likelihood of serious harm arising from the multiple deficient conditions at Oceanside's facility. ALJ Decision at 13-14.

conditions. *See Florence Park Care Ctr.*, DAB No. 1931, at 26-27 (2004) (fall on March 12, 2002 was example of immediate jeopardy-level noncompliance for which CMP imposed beginning in April); *Regency Gardens* (incident of improper care cited as example of immediate-jeopardy level occurred prior to the date on which immediate jeopardy-level CMP began, but no intervening evidence that immediate jeopardy abated). For these reasons, Oceanside's further argument that CMS had "no basis for commencing the jeopardy period prior to the survey date of April 25, 2009" also has no merit. RR at 22.

8. Oceanside has not shown that it attained substantial compliance or abated the immediate jeopardy earlier than the dates that CMS determined and the ALJ sustained.

It is undisputed that CMS determined, based on the State survey agency's revisit on July 2, 2009, that Oceanside had achieved substantial compliance as of June 25, 2009. *See* P. Post-Hearing Br. at 3. Oceanside argues that it achieved substantial compliance earlier than that date, because it "conducted in-services for its staff . . . on April 27, 2009 . . . [that] succeeded in completely eliminating the bases for the surveyors' deficiency allegations." RR at 22-23. The ALJ rejected that claim, finding that Oceanside's materials relating to the training "do not prove that Petitioner's staff actually was thoroughly trained to address the problems identified by the surveyors," that they "are merely lists of the course material that ostensibly was taught to the staff," and they "do not prove how thoroughly this material was taught, how well the staff absorbed the subject matter that was taught to them[.]" ALJ Decision at 14.

Substantial evidence supports the ALJ's determination. The materials Oceanside submitted are, as the ALJ found, rather cursory and provide little assurance that Oceanside had indeed trained its staff with sufficient thoroughness to assure CMS that problems identified in the survey that resulted in the noncompliance would not recur. Most importantly, as the ALJ also found, the materials Oceanside submitted do not indicate "whether the staff then put into practice the information that they received from the in-service training." *Id*. Both Oceanside's plan of correction (POC) and the in-service training materials required Oceanside to put into place specific measures and practices, the successful implementation of which could not be verified based merely on the reports of in-service training having occurred, including the following:

- Regarding treatment of resident pain, the POC stated that the medication nurse "will implement the protocol" mentioned in the POC; that all new hires "will be inserviced;" that any resident identified with pain issues "will be discussed;" and that staff would call a resident's physician in the event of visceral pain. CMS Ex. 5, at 4, 46 (POC); *see also* P. Ex. 6, at 3 (in-service materials).

- Addressing staff failure to timely check bed alarms, the POC called for staff to use an hourly check form, to correct any issues discovered during the hourly checks, and to replace alarms found not in working order. CMS Ex. 5, at 5.
- The POC called for discussion of resident safety issues in "the Department Head meeting based on the twenty-four hour report as recorded by the shift medication nurses" Monday through Friday, and by the "RN supervisor and charge nurses" on the weekend. *Id.*
- The in-service training materials for falls instructed staff to assess residents for risk factors on admission, answer call bells "ASAP" and assist with transfers, and included instructions on moving and positioning residents. P. Ex. 7, at 3, 8.
- The POC called for "the DON, ADON and Week-end RN supervisor" to "monitor the system" and required that "results will be reported to the QA Team monthly, quarterly or until resolved." CMS Ex. 5, at 6.
- The POC states that smoking residents "will be monitored" and that smoking monitors "will supervise" the smoking residents. *Id*. at 24-25, 32-33.

The nature of these corrective actions, as well as the fact that they operated prospectively, necessarily means that in-service training of facility staff on April 27, 2009 could not alone establish that the facility had successfully implemented the practices and procedures required in the POC and training materials. Not all of these corrections could be implemented through in-service training, or only through in-service training. Moreover, since they operated prospectively, CMS could reasonably require evidence that the new practices and requirements were actually put into effect in order to verify that the facility had attained substantial compliance with the requirements for nursing facilities to participate in Medicare.

That such further verification may be needed is recognized in the regulations and the Board's decisions. Section 488.454(a)(1) requires that remedies CMS imposes remain in effect until the facility has achieved substantial compliance as determined by CMS or the State "based upon a revisit or after an examination of credible written evidence that it can verify without an on-site visit." A facility's "noncompliance is deemed to be corrected or removed only when the incidents of noncompliance have ceased and the facility has implemented appropriate measures to ensure that similar incidents will not recur." *Life Care Center of Elizabethton*, DAB No. 2367, at 16 (2011), citing *Florence Park Care Ctr.* at 30 (2004). Even if a POC is accepted, the facility is not regarded as in substantial compliance until CMS determines, "usually through a revisit survey," that the deficiency no longer exists. *Barn Hill Care Center*, DAB No. 1848, at 10 (2002); *Cross Creek Health Care Center*, DAB No. 1665, at 3 (1998); *see also Briarwood Nursing Center*, DAB No. 2115 (2007) ("[t]he accrual of per diem penalties ends when the facility is found to have indeed achieved substantial compliance, usually through a revisit unless the deficiency is of a nature that correction can be verified through written evidence alone").

Given staff's failure to timely check Resident # 4's bed alarm despite an order for checks every two hours, the State survey agency and CMS were justified in declining to accept the POC's mere representation that hourly checks would be performed, and instead requiring a revisit and/or review of records to verify that those measures had indeed been implemented. Similarly, shipping documentation Oceanside submitted showing that supplies such as hand rolls were ordered by April 27, 2009 does not establish that staff put those items to appropriate use, which was at issue in the case of Resident # 5. P. Ex. 11. Thus, we agree with the ALJ that CMS was not required to accept mere assertions that staff were instructed to comply with practices or policies. CMS could reasonably require evidence of corrections in practice.

We do not agree with the ALJ's additional conclusion that documentary evidence "is, as a matter of law, insufficient to establish that Petitioner corrected its deficiencies" that "involved errors by Petitioner's staff in determining how, and in what way, to provide care" to residents. ALJ Decision at 14. The ALJ based that conclusion on the preamble to the final rule adopting section 488.454(a)(1), which provides an example of "cases in which documentation cannot confirm the correction of noncompliance, and in these cases an on-site revisit is necessary." 59 Fed. Reg. 56,116, 56,207 (Nov. 10, 1994). The ALJ concluded that as "a matter of law," the date of the revisit survey was "the earliest date when immediate jeopardy could have been abated due to the nature" of Oceanside's non-compliance. ALJ Decision at 16.

The Board rejected the ALJ's same conclusion, in a recent decision issued subsequent to the ALJ Decision now on appeal, *Omni Manor Nursing Home*, DAB No. 2374 (2011). As the Board stated there, the regulation "states, without qualification, that CMS or a state may verify a return to substantial compliance either by conducting a revisit or by reviewing credible written evidence" and thus "makes it clear that a revisit is a discretionary, not mandatory, method of doing this verification." *Omni Manor Nursing Home* at 4. The regulation thus "does not, as a matter of law," require verification of substantial compliance solely by means of a revisit survey, "but, rather, gives CMS or a state discretion to make that determination either through a revisit survey or through a review of credible written evidence." *Id*. at 5. We also pointed out that the ALJ undercut his analysis by observing, as he did here, that "[d]eficiencies that involve staff members' providing care to residents are not deficiencies that <u>normally</u> can be certified as corrected based solely on a review of documents," evincing a recognition that some certifications involving staff care can be based solely on document review. *Omni Manor Nursing Home* at 6, *citing* DAB CR2213, at 5 (Board's emphasis); ALJ Decision at 15. We incorporate here our analysis in *Omni Manor*. We also note that the ALJ's assertion that CMS cannot find a return to substantial compliance on any date earlier than the revisit is undercut by the fact that CMS did in this case determine that the facility remedied all of the deficiencies as of June 25, 2009, based on a revisit survey that took place on July 2, 2009.

The ALJ's error in holding that Oceanside, as a matter of law, could not have attained substantial compliance earlier than CMS determined was harmless, however, as he did not rely solely on that holding. As discussed, he found the in-service training materials inadequate to demonstrate substantial compliance. As we also observed, the POC and training materials do not prove that Oceanside attained substantial compliance on April 27, 2009.

9. The ALJ did not err in sustaining the amount of the CMP.

CMS imposed a $5,200 per-day CMP for the period of immediate jeopardy, an amount that is in the lower third of the authorized range, $3,050 - $10,000 per day. The ALJ found the $5,200 per-day CMP imposed for the period of immediate jeopardy was reasonable due to the seriousness of the five deficiencies, through which the facility "put several of its residents at great risk of injury or harm by virtue of its failure to provide care for them that met professional standards of care and regulatory requirements." ALJ Decision at 16. He found the facility's failures exemplified by its having "allowed a resident (Resident T) to reside on its premises for an extended period, knowing that this resident was prone to alcohol abuse and violence, yet failing to develop a comprehensive plan to deal with the resident's proclivities;" by the facility having "failed to implement the basic protections that the staff had determined to be necessary" for Resident # 4, who Oceanside "identified . . . as being at great risk for falls;" and by having allowed Resident # 8 "to be in the facility in an ordinary wheelchair and to smoke unsupervised" despite knowing "that Resident # 8 was highly vulnerable to falling if not placed in a protective Broda chair[.]" *Id*. He further found the seriousness of the deficiencies "magnified by the fact that Petitioner was noncompliant at an immediate jeopardy level of noncompliance across a whole range of regulatory requirements." *Id*.

While arguing that the total CMP is unfair and "by far out of proportion with the nature and severity of the alleged deficiencies as well as the speed with which the Facility implemented a plan of correction when advised of the surveyors' allegations," Oceanside does not challenge the specific points of the ALJ's analysis of the seriousness of the deficiencies. RR at 23. Oceanside instead argues that the ALJ erred by failing to properly consider Oceanside's financial condition.[8] *Id*. Oceanside argues on appeal, as it did below, that it has been losing money, citing its owner's testimony that it has neither a

[8] The facility's financial condition and the scope and seriousness of the deficiencies are two of the limited regulatory criteria at 42 C.F.R. § 488.438(f)(1)-(4) which an ALJ may consider in determining the amount of a CMP; the others are the facility's history of noncompliance, including repeated deficiencies, and the facility's degree of culpability. *See* ALJ Decision at 16. Oceanside cites no evidence regarding its history of noncompliance or its own culpability and we do not address those factors. *See Alden Town Manor*, DAB No. 2054, at 31 (2006) ("CMS is not required to present evidence on any or all of these factors" in section 488.404, and ALJ or the Board weighs evidence on factors if offered by the facility).

reserve fund nor a line of credit that it could utilize to pay the CMP, and raises the prospect that liability for the CMP will force it to consider Chapter 11 bankruptcy. RR at 24-25, citing Tr. at 91, 96.

The Board has long held, based on the preamble to the regulation stating the relevant factors in setting a CMP, that the correct inquiry in considering a facility's financial condition is whether the facility can show that it lacks "adequate assets to pay the CMP without having to go out of business or compromise resident health and safety." *Gilman Care Center*, DAB No. 2357, at 7 (2010), and cases cited therein. The ALJ found that the assertion of Oceanside's owner that Oceanside would consider Chapter 11 bankruptcy was not a contention that the facility would go out of business, because that "form of bankruptcy . . . would enable Petitioner to continue to operate even if insolvent." ALJ Decision at 17, citing Tr. at 97. The ALJ also found Oceanside's reports that it had a net income loss during the first five months of 2010 of more than $282,000 and an operating loss for the prior two years "does not tell the entire story of Petitioner's financial condition" because Oceanside "is one of several interrelated entities with common ownership" and "gross revenue of . . . about $75 million per year." *Id.*, citing Tr. at 85, 93.

Oceanside does not dispute the ALJ's findings about its common ownership with other facilities or their gross revenues, nor his observation that it thus has "access to very significant resources that could be used to pay the civil money penalties that are at issue here." ALJ Decision at 17. It has thus shown no basis to overturn the ALJ's findings about its financial condition. As the ALJ stated, ignoring such shared resources could "be an open invitation for skilled nursing facilities to avoid paying" CMPs by encouraging them "to contend that they must be treated as isolated facilities regardless of the financial wherewithal of the entity or individual that owns them along with other similar facilities." *Id*.

Oceanside argues that the ALJ did not "properly take into account" the impact of paying the total CMP amount of $283,400. RR at 25. The ALJ did expressly consider, and reject, the claim that the total was "unreasonably large." ALJ Decision at 17. We also note that, even had we accepted (which we do not) Oceanside's clams of financial hardship, we could not by law reduce the total below $164,200, reflecting the minimum per-day CMPs for the immediate jeopardy and non-immediate jeopardy periods. 42 C.F.R. §§ 488.408, 488.438. Oceanside offered no showing that the difference between the minimum and actual total amounts ($119,200) would drive it out of business or compromise resident care.

Oceanside also reports in its reply before us that ownership of the facility "was transferred during the late summer of 2010" to "an entity completely unrelated to the former owner" of the facility. Oceanside Reply at 2. Rather than confirming "the

provider's weak financial circumstances," as Oceanside states, *id*., its sale, apparently as a going concern, supports the ALJ's determination that the CMP was not likely to force it out of business.

Oceanside also argues that the CMP should be reduced because the new owner is not culpable for the deficiencies. Culpability, defined as "neglect, indifference or disregard for resident care, comfort or safety," refers to the conditions in a facility that gave rise to the deficiencies for which CMPs are imposed. 42 C.F.R. § 488.438(f)(4). The facility's subsequent acquisition by a new owner does not diminish the facility's culpability. Regulations provide that when a facility's ownership changes, the existing provider agreement is automatically assigned to the new owner subject to all applicable statutes and regulations and to the terms and conditions under which it was originally issued, including compliance with applicable health and safety standards. 42 C.F.R. § 489.18(c), (d). The Board has confirmed that the new owner of a facility thus "acquires the relevant compliance history /issues" of the facility. *Kenton Healthcare*, LLC, DAB No. 2186, at 31 (2008); *CarePlex of Silver Spring*, DAB No. 1683, at 11-13 (1999); *CarePlex of Silver Spring*, DAB No. 1627 (1997). Those issues include the facility's responsibility for remedies imposed for its failure to comply substantially with the regulations setting out the conditions of participation. Thus, to the extent the facility's culpability for the noncompliance was a factor in determining the amount of the CMP, that remains a factor in determining the reasonableness of the CMP amount, regardless of who now owns the facility.

We thus sustain the ALJ's determination that the $5,200 per-day CMP imposed for the period March 13 through May 3, 2009 was reasonable.

Oceanside did not appeal the ALJ's determination upholding the $350 per-day CMP imposed for the period May 3 through June 24, 2009, the period during which, CMS determined, the deficiencies did not pose immediate jeopardy. We sustain that determination as well.

Conclusion

For the reasons explained above, we sustain the ALJ Decision.

_____/s/_____
Sheila Ann Hegy

_____/s/_____
Constance B. Tobias

_____/s/_____
Leslie A. Sussan
Presiding Board Member