Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Appellate Division

In the Case of:	DATE: April 6, 2009
Life Care Center of Gwinnett,	
Petitioner,	Civil Remedies CR1846 App. Div. Docket No. A-09-17
- v. -	Decision No. 2240
Centers for Medicare & Medicaid Services.	

FINAL DECISION ON REVIEW OF ADMINISTRATIVE LAW JUDGE DECISION

Life Care Center of Gwinnett (Life Care) timely appealed the September 24, 2008 decision of Administrative Law Judge (ALJ) Steven T. Kessel upholding the imposition of per-day civil money penalties (CMPs) by the Centers for Medicare & Medicaid Services (CMS). Life Care Center of Gwinnett, DAB No. CR1846 (2008) (ALJ Decision). The ALJ upheld the CMPs based on his conclusion that Life Care was not in substantial compliance with 42 C.F.R. § 483.13(c), which requires the development and implementation of policies and procedures to prevent neglect of residents. The CMPs were for $5,000 each day from August 25, 2007 through September 4, 2007, during which period, CMS determined, the conditions presented an immediate jeopardy to residents' health and safety, and for $500 each day from September 5, 2007 through September 18, 2007, at which time CMS determined that the facility had achieved substantial compliance. The ALJ elected not to address an additional deficiency finding under 42 C.F.R. § 483.75(l)(1), which concerns maintenance of clinical records.

Life Care excepted to the ALJ's conclusions that it was not in substantial compliance with section 483.13(c) and that it had failed to prove that CMS's determination of immediate jeopardy

was clearly erroneous. Life Care also requested that the Board review the deficiency citation under section 483.75(l)(1).

As discussed below, we uphold the ALJ's conclusions that Life Care was not in substantial compliance with section 483.13(c) and that CMS's determination that the noncompliance posed immediate jeopardy was not clearly erroneous. We also conclude, based on undisputed facts in the record developed before the ALJ, that Life Care was not in substantial compliance with section 483.75(l)(1).

We therefore uphold the ALJ Decision, as modified, and sustain the remedies imposed by CMS.

Applicable law

The federal statute and regulations provide for surveys to evaluate the compliance of nursing facilities with the requirements for participation in the Medicare and Medicaid programs and to impose remedies when a facility is found not to comply substantially. Sections 1819 and 1919 of the Social Security Act; 42 C.F.R. Parts 483, 488, and 498.[1].

"Substantial compliance" is defined as "a level of compliance with the requirements of participation such that any identified deficiencies pose no greater risk to resident health and safety than the potential for causing minimal harm." 42 C.F.R. § 488.301. "Noncompliance" means "any deficiency that causes a facility to not be in substantial compliance." Id. Thus, a noncompliance may exist even if no deficiency resulted in actual harm, so long as a potential for more than minimal harm is present.

CMS may impose a CMP for the days on which the facility is not in substantial compliance. 42 C.F.R. §§ 488.404, 488.406, 488.408. Where the noncompliance poses less than immediate jeopardy but has the potential for more than minimal harm, CMS may impose a CMP between $50 and $3,000 per day. 42 C.F.R. § 488.438(a)(1)(i). Where the noncompliance poses immediate

[1] The current version of the Social Security Act can be found at www.ssa.gov/OP_Home/ssact/comp-ssa.htm. Each section of the Act on that website contains a reference to the corresponding United States Code chapter and section. Also, a cross-reference table for the Act and the United States Code can be found at 42 U.S.C.A. Ch. 7, Disp Table.

jeopardy, CMS may impose a CMP in the range of $3,050 to $10,000 per day. 42 C.F.R. § 488.438(a)(1)(i). "Immediate jeopardy" is defined as a situation in which a provider's noncompliance "has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident." 42 C.F.R. § 488.301.

Board precedent has established that a facility must prove by the preponderance of the evidence that it is in substantial compliance. Batavia Nursing and Convalescent Center, DAB No. 1904 (2004), aff'd, Batavia Nursing & Convalescent Ctr. v. Thompson, 129 F. App'x 181 (6th Cir. 2005). In order to put the facility to its proof, CMS must initially present a prima facie case of noncompliance with Medicare participation requirements. Once CMS has presented prima facie evidence as to any material disputed facts, the burden of proof shifts to the facility to show that it is more likely than not that the facility was in substantial compliance.

Standard of review

Our standard of review on a disputed finding of fact is whether the ALJ decision is supported by substantial evidence on the record as a whole. Our standard of review on a disputed conclusion of law is whether the ALJ decision is erroneous. Guidelines for Appellate Review of Decisions of Administrative Law Judges Affecting a Provider's Participation in the Medicare and Medicaid Programs, www.hhs.gov/dab/guidelines/prov.html.

Substantial evidence is "more than a mere scintilla. It means such relevant evidence as a reasonable mind might accept as adequate to support a conclusion." Richardson v. Perales, 402 U.S. 389, 401 (1971), quoting Consolidated Edison Co. v. NLRB, 305 U.S. 197, 229 (1938). Under the substantial evidence standard, the reviewer must examine the record as a whole and take into account whatever in the record fairly detracts from the weight of the decision below. Universal Camera Corp. v. NLRB, 340 U.S. 474, 488 (1951).

Factual Background

The following facts are not in dispute.

On August 25, 2007 between 7:30 and 8 A.M., Certified Nursing Assistant (CNA) AA took Resident 1 to a bathroom to toilet her.[2]

[2] In writing up their observations in the Statement of Deficiencies (SOD), the surveyors assigned initials to some of

(To be continued. . .)

Resident 1 required extensive assistance with mobility and was totally dependent on staff for toileting and hygiene. She had a history of transient ischemic attacks, severely limited mental functioning, and had been assessed as at risk for bleeding and bruising as a result of receiving a blood thinner, Coumadin. Because she was taking Coumadin, Resident 1's care plan called for gentle handling in transfers to avoid bumps and cuts. While CNA AA and Resident 1 were in the bathroom, Resident 1 ended up on the floor.

According to CNA AA, she lowered Resident 1 to the floor after Resident 1 began descending to the floor. CNA AA left the resident and summoned CNA BB, who helped CNA AA return Resident 1 to her wheelchair. Neither CNA reported the incident to the charge nurse, even though Life Care's policies required reporting all resident falls.

About 10 A.M., CNA AA found Resident 1 crying and holding her left forehead where there was swelling and bruising. CNA AA then took the resident to Licensed Practical Nurse (LPN) CC. LPN CC assessed Resident 1 and called Registered Nurse (RN) McFarlane, who also performed an assessment. Neither nurse found any sign of neurological compromise. Because of the apparent head injury, LPN CC nevertheless called Resident 1's daughter and her doctor, who ordered that she be assessed at the hospital.

As part of determining Resident 1's condition, the nurses asked CNA AA, among others, if she were aware of what could have caused the bruise. While CNA AA told the nurses she had toileted Resident 1 earlier that morning, she still did not mention that Resident 1 had fallen while in the bathroom. As a result of its initial investigation, Life Care concluded Resident 1 had an injury of unknown origin.

Resident 1 was transported to the hospital about noon. At the hospital she was diagnosed as having a subarachnoid hemorrhage, which is a closed injury to the head. Resident 1's condition continued to deteriorate; she was transferred to hospice care and died on September 8, 2007.

On September 1, 2007, a week after the incident, CNA BB told the nursing staff about having helped CNA AA get Resident 1 off the floor on August 25. She said that she had not reported the fall

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(Continued. . .)
the staff members and numbers to the residents involved, and we continue to use the same nomenclature here.

because she thought that CNA AA had done so. CNA BB also reported that CNA AA had called her at home and told her not to tell anyone about the incident.

Life Care reopened its investigation of the injury, and in the course of the second investigation, CNA AA admitted that on August 25, while in the bathroom, Resident 1 "went down" but asserted that she (CNA AA) had "helped her down" (P. Ex. 19, at 47) or "lowered her to the ground" (id. at 46). She admitted also that she had called CNA BB and told her not to tell anyone about the incident. Life Care fired CNAs AA and BB.

Entries on a Neurological Assessment Flowsheet purport to show the results of neurological checks and vital sign readings taken by LPN CC beginning at 8 A.M. and approximately every fifteen minutes thereafter until Resident 1's departure to the hospital. CMS Ex. 2, at 9. LPN CC acknowledged that she did not make these entries until at least the end of her shift, and that, in fact, she did not begin checking the resident's status until 10:30 A.M. that morning when she learned of the head injury. She admitted that the records were not accurate. The Director of Nursing stated to the surveyor that the entries on the flowsheet for times prior to 10:30 "represented falsified documentation." CMS Ex. 2, at 10. Life Care also fired LPN CC.

Analysis[3]

1. The ALJ did not err when he concluded that, based on its care of Resident 1, Life Care was not in substantial compliance with 42 C.F.R. § 483.13(c).

Section 483.13(c) provides:

> The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.

"Neglect" is defined as a "failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness." 42 C.F.R. § 488.301. The Board has repeatedly held that multiple or sufficiently serious examples of neglect may support a reasonable inference that a facility has failed to

[3] We have fully considered all arguments raised by Life Care on appeal and reviewed the full record, regardless of whether we have specifically addressed particular assertions or documents in this decision.

implement an anti-neglect policy within the meaning of the regulation. See, e.g., Liberty Commons, DAB No. 2031 (failure to follow latex allergy precautions procedures); Emerald Oaks, DAB No. 1800 (2001) (delay in contacting the resident's physician about sudden changes in the resident's condition and abnormal vital signs until a second episode occurred); Barn Hill Care Center, DAB No. 1848 (medication errors and untimely medication passes by one nurse on a single day).

In order to meet the regulatory standard, the written policies and procedures and their implementation must be designed to actually prohibit neglect of residents. The regulations must be read in light of the plain statutory intent that the requirements governing care in nursing facilities must be adequate to "protect the health, safety, welfare and rights of the residents . . . ." Section 1819(f)(1) of the Act. A written policy must adequately address the risks of neglect. An anti-neglect policy that exists only on paper provides no benefit to the residents whom the regulation is intended to protect. Procedures which are not carried out in practice are worthless. Training or other measures to implement a policy can only be understood as sufficient if those measures are calculated to ensure that neglect is prevented. This conclusion is inherent in the common meaning of the term "implement," which is to "carry out . . , esp: to give practical effect to and ensure actual fulfillment by concrete measures . . . ." Webster's 3d Int'l Dictionary at 1134.

Life Care concedes that the failure of the two CNAs to alert the nursing staff to Resident 1's fall was improper and violated the facility's own policy and that "prompt reporting and response to falls is critical." RR at 38. Life Care nevertheless argues that the responsibility for any neglect lies solely with the individual staff members involved and should not be attributed to any failure by the facility as an entity to develop and implement anti-neglect policies. According to Life Care, it was in substantial compliance with section 483.13(c) because it had developed and implemented written policies to prohibit neglect by requiring reporting of falls.

The undisputed facts and substantial evidence in the record support the ALJ's conclusion that Life Care neglected the resident's needs in a manner that provided a basis for a reasonable inference that the facility failed to implement a policy adequate to prohibit neglect. As the ALJ pointed out, the two CNAs plainly failed to report immediately that Resident 1 had fallen. ALJ Decision at 3. It was also undisputed that they failed to make a report despite the fact that the resident's care

planning identified her as at special risk from falls or injuries (due in part to the Coumadin) and therefore in need of gentle handling. Id. at 3-4, 8. Further, CNA AA failed to provide important and truthful information during the initial investigation of Resident 1's injury (then considered of unknown origin). Id. at 4; P. Ex. 26, at 2. Indeed, in at least three different statements made over several days, CNA AA did not honestly describe the incident. CMS Ex. 10, at 1, 16, and 17. Only a week later did CNA BB confess that she knew Resident 1 had "fallen" and that she had not reported the "fall" either. Id. at 11. She stated that CNA AA had called her at home the day before and told her to conceal the fall. Id. at 9-10, 11-12, 14. Only after CNA BB's confession did CNA AA provide information about the circumstances of Resident 1's fall. CMS Ex. 10, at 13, 18. Finally, LPN CC, when alerted to the fact that Resident 1 had a lump on her head, failed to accurately chart her care of Resident 1, and, as found below, recorded false data as to neurological checks allegedly occurring between 8 A.M. and 10:30 A.M. CMS Ex. 2, at 10.

Taken together, these facts demonstrate that Resident 1's needs for prompt and accurate assessment and monitoring for consequences of this fall were neglected by multiple staff members over a significant period of time. It is undisputed that, even after Resident 1's admission to the hospital, the facility failed to obtain or provide accurate information about the events preceding her injury.

Absent a contrary showing by Life Care, this evidence reasonably supports the conclusion that the facility was in noncompliance with section 483.13(c) because it either did not have an anti-neglect policy and procedures sufficiently clear to prohibit the neglect that occurred or had not implemented its policy in a manner that would effectively prevent such neglect.[4] In order to rebut that conclusion, Life Care points to its written falls policy and submitted some evidence about training provided to its staff about that policy. Life Care argues that its policy and

[4] For this reason, we reject Life Care's argument on appeal that CMS failed to make a prima facie case under section 483.13(c). See RR at 30-36, 30 (stating that "CMS's allegations simply do not even address [implementation of a policy], i.e., in legal terms, do not establish the elements of a prima facie violation of [section 483.13(c)]." As discussed above, the record supports a conclusion that Life Care did not have or did not implement policies to prohibit neglect of the kind that occurred.

its implementation of the policy were sufficient to prove its compliance despite the conduct of these staff members. We conclude that the ALJ properly rejected this argument. ALJ Decision at 5-6.

In that regard, Life Care points to a policy on falls published by Life Care Centers of America, Inc. (its parent company) as part of a document titled "Incident Management Process Policies and Procedures." P. Ex. 23, at 1, 2. The section of that publication titled "Falls Management" provides, inter alia, that "[w]hen a resident has a fall, the charge nurse will be notified immediately." Id. at 7. Life Care acknowledged before the ALJ (and the Board) that Resident 1 did experience a fall within the meaning of its policy. As Life Care admitted, "standard nursing practice is to refer to any involuntary change in position to a lower plane as a 'fall.'" P. Post-Hearing Br. at 2, n.1; see also RR at 4, at n.2.[5] Life Care also acknowledged that its policies required the CNAs to report this fall immediately. See, e.g., P. Post-Hearing Br. at 3, 6, 18; RR at 4, 30. Life Care asserts, however, that the CNAs simply disregarded its falls policy and made faulty decisions. See, e.g., RR at 4, 7, 36-41. Life Care argues that such failures by individual staff members should not form the basis for finding the facility noncompliant with section 483.13(c). Id.

This argument is unavailing in that the written falls policy sets out a specific procedure to be followed by staff observing a resident experience a fall, i.e., to notify the charge nurse immediately. P. Ex. 23, at 7. Any staff that provided direct care to the residents (which would mainly mean the CNA staff) and observes a fall is thus entrusted with the duty of following the notification procedure. There is no question on this record that the CNA staff members did not implement procedures adopted by the facility to prohibit neglect. We discuss the facility's direct responsibility to comply with the regulations through its staff in more detail below, but note here that, having chosen to develop procedures that rely on CNAs to notify charge nurses, the

[5] It is therefore not clear why the ALJ appears at times to be uncertain whether to refer to the incident as a "fall." See, e.g., ALJ Decision at 3 ("either the resident fell to the floor or suffered an altered state of consciousness and was lowered to the floor"). The record contains no evidence of what precisely caused the resident's descent, but it is undisputed that this lowering of the resident to the floor constituted a fall under applicable nursing standards of care.

facility cannot now disown the CNAs' failure to implement that procedure.

We also find evidence in the record that at least CNA AA was confused about whether a controlled descent constituted a fall under the facility's written policy. The Life Care investigators reported that, even after CNA AA had admitted that Resident 1 had been on the floor, she stated to them that Resident 1 "did not fall nor hit her head, which is why [CNA AA] did not feel the need to inform her nurse." CMS Ex. 10, at 18. Further, in a state hearing on whether CNA AA was guilty of neglect, CNA AA testified that she was unaware on August 25 that what happened in the bathroom constituted a fall and an incident that facility policy required her to report. ALJ Decision at 6. CNA AA testified that Life Care trained her that she must report falls. P. Ex. 25, at 32. After testifying that she had had to lower Resident 1 to the floor, she was asked "when you had to lower the resident to the floor . . . you didn't think that was a reportable incident at that time?" CNA AA answered –

> I didn't think that because she didn't have any – any – I didn't see any – fall, she didn't fall, she didn't have any bruises and she didn't --- she was not having – showing any signs of pain . . . .

Id. at 48; see also at 39, 40. Based on this and other testimony, the hearing officer at the state hearing found that CNA AA "did not consider the occurrence to be a fall since she assisted the Resident in her descent from the bar [that she had been holding]."[6] P. Ex. 20, at 5. Therefore, in multiple settings (including one under oath), CNA AA asserted that she did not understand that the incident in the bathroom was a reportable fall.

[6] The state hearing officer went on to find that CNA AA had not neglected Resident 1 because "[t]he record as a whole does not support a conclusion that physical harm occurred as a result of [CNA AA's] failure to report an occurrence that she did not interpret as a reportable 'fall.'" P. Ex. 20, at 6. The basis for the state hearing officer's conclusion that CNA AA did not neglect Resident 1 would be contrary to federal standards on noncompliance which require only a showing that the noncompliance had the potential for causing more than minimal harm, not that it caused actual harm. As we discuss later, Life Care's failure to have and implement policies and procedures to prohibit neglect caused or was likely to cause serious injury to this particularly vulnerable elderly person.

Life Care's falls policy does not make clear that any involuntary change in position to a lower plane is a fall. Thus, even assuming that staff were familiar with the terms of the written policy, Life Care has not shown that non-nursing staff, such as CNAs, should have understood that lowering a resident to the floor, whether or not the resident appeared to have been hurt in the process, was a reportable fall.[7] Therefore, merely informing the CNAs of the terms of the facility's falls policy and its reporting procedure would not alone be sufficient to comply with section 483.13(c). In order to effectuate the intention that all falls be reported to a professional nurse, either the scope of that duty needed to be spelled out in the policy itself or the care staff needed to be educated on that scope (i.e., the breadth of the meaning of "fall") through explicit communication or training.

Life Care asserts that it did train CNAs, including CNA AA, about its falls policy. In support of this assertion, Life Care points to a training sign-in sheet at CMS Exhibit 4, at 3 as proving that CNA AA "had been inserviced regarding [its falls policy] only a few weeks before this incident." RR at 20; see also id. at 2, 4, 6, 30, 38, 41. The document to which Life Care points, however, merely shows that a 30-minute training session occurred on the following topic:

> If any of our residents fall in a faint or gets unconscious and if any member of staff needs assistance then – A CODE BLUE MUST BE CALLED. There must be a sense of urgency – it may be a matter of LIFE & DEATH.

CMS Ex. 4, at 3. Thus, the sheet shows only that this training event addressed situations in which residents faint or lose consciousness. Indeed, if anything, the sheet raises the

[7] The transcript of the state hearing demonstrates that neither counsel nor the hearing officer were familiar with the nursing definition of "fall." For example, CNA AA's counsel asked her, "Did you help [Resident 1] down or did she fall down?", to which CNA AA answered "I helped her down because she didn't fall." P. Ex. 25, at 39. Neither the hearing officer nor counsel for the State objected here or elsewhere that, under the nursing definition of "fall," Resident 1 had experienced a fall. See also id. at 48. Thus, it is apparent that the correct understanding of "fall" in the context of nursing care is not self-evident and, if not set forth in the policy, requires training for non-professional staff.

question of whether the training left CNA AA with the impression that reportable falls are those that involve such losses of consciousness or other such dramatic circumstances. It certainly does not show that CNAs were instructed that an unplanned lowering of a resident to the ground was a reportable fall. .While Life Care submitted written testimony by the apparent instructor at this training, her statement said nothing about this or any other training session. P. Ex. 27.

Further, Life Care points to no other evidence in the record showing that its falls training ensured that non-professional care staff had an understanding of the nursing definition of fall.[8] Moreover, we see nothing in the record that would tend to show that CNAs, as part of their certification training, are taught the nursing definition of fall. Thus, the record does not show that Life Care's CNAs would have understood that unplanned controlled lowering was a reportable fall. Absent persuasive evidence that Life Care acted to ensure such an understanding, the ALJ reasonably found that Life Care had not met its burden to show substantial compliance.

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[8] The Administrator's written testimony states that Life Care did conduct training on clinical policies including the need to report falls and other incidents. She testified that both CNAs had received in-service trainings on reporting incidents. She described the CNAs' failure to report "the incident in the shower room" as a "serious error, since we specifically train all our staff about exactly that scenario." P. Ex. 26, at 6. The ALJ did not address this testimony in his decision. He did note that, since the CNA claimed that the resident was lowered without falling, she "may have concluded that her non-reporting of the incident was literally consistent with the facility policy," despite the fact that "the incident mandated immediate reporting and in fact much more whether or not the resident fell." ALJ Decision at 6. The Administrator did not explain what she meant by "exactly that scenario," nor did she discuss specifically whether the staff was trained to understand that even lowering a resident to the floor without apparent injury constituted a reportable fall. She did not explain how she knew the content of any particular training nor did she specify when training on falls was provided. The ALJ could, therefore, reasonably determine that the Administrator's statement was vague, without foundation, and conflicted with the record evidence of CNA AA's confusion. We, therefore, do not consider this testimony sufficient to undercut the conclusion that Life Care did not implement a policy to ensure that its staff would alert professionals immediately to all falls.

2. Life Care is responsible for failing to implement anti-neglect policies as demonstrated by the actions of its staff.

As mentioned above, Life Care seeks to draw a distinction between a nursing facility and its staff in terms of assigning responsibility for staff conduct or inaction which results in a noncompliance finding. Specifically here, Life Care argues that CNAs AA and BB engaged in conduct that the facility did not "authorize[]" or "tolerate[]." RR at 37-38.

The ALJ addressed whether a "facility [can] be separated under the law from the individual acts of its staff." ALJ Decision at 7. He stated:

> The Act and regulations make a facility responsible for all of its staff's actions because it is those actions which comprise the care that residents receive. Emerald Oaks, DAB No. 1800, at 7, n.3 (2001); Barn Hill Care Center, DAB No. 1848 (2002). The care rendered by any skilled nursing facility to its residents depends on the performance of the facility's individual staff members. . . . Separating actions by the staff from the facility simply makes no sense given that the facility would not exist and it would not provide care to residents but for the individual actions of its staff.

ALJ Decision at 7.

Life Care contends that "there is nothing CMS or any nursing facility can do" about "[th]e fact . . . that some small number of employees . . . always will be ignorant, scared, at the bottom of the class, or simply bad apples . . . ." RR at 39. It argues that Congress meant to hold facilities responsible only for factors that were within a facility's control and that sanctions for the behavior of "employee misfeasance or faithlessness" serve no regulatory purpose." Id. at 38-39.

While we do not disagree that facilities face a risk that some employees may prove to be incompetent or dishonest, we disagree that no policy purpose is served by holding facilities responsible for incompetent or dishonest staff conduct. Facilities are responsible for providing care in accordance with federal participation requirements. Facilities perforce carry out this responsibility in part through their selection, training and supervision of their staff. Therefore, only facilities are able to take action to prevent incompetent or dishonest

individuals from harming residents. Sanctions on facilities for failing to implement policies and procedures to prohibit neglect or abuse through their staff serve the obvious goal of encouraging facilities to maintain hiring, training and supervision practices that protect residents. To hold otherwise would permit facilities to cut corners on staffing, training or supervision and to escape responsibility for resulting shortfalls in care by blaming (and perhaps terminating) individual staff members without making changes that would prevent recurrence.

Life Care argues here that, since the focus of section 483.13(c) is on the development and implementation of policies and procedures, the fact that an employee did something wrong would not necessarily establish that its management had failed to develop and implement policies. It asserts that, here, "the real issue is (or ought to be) whether Petitioner did 'all it could' to reduce the possibility that [CNA AA] or any other employee would fail to report a fall."[9] RR at 40.

[9] We note that Life Care makes various references to the doctrine of agency/respondeat superior (RR at 4, 7, 37), suggesting that the Board has relied on such tort concepts in the past but arguing that it is inapplicable and "has limits" (RR at 7). We disagree that the Board has employed tort or contract law in holding facilities responsible for ensuring that they achieve substantial compliance with program participation requirements. On the contrary, the Board has relied on the facility's statutory and regulatory responsibility to provide the care required by its residents regardless of what staff it uses to accomplish that. See Royal Manor, DAB No. 1990 (2005); Cherrywood Nursing and Living Center, DAB No. 1845 (2002). In any case, while Life Care does not go on to brief the law of agency or respondeat superior, its point seems to be similar to its argument about the scope of a citation under section 483.13(c) – that a facility should not be held accountable for the actions of its staff if the facility "did all it could to minimize instances of employee misfeasance or misbehavior." RR at 8. This argument fails for a number of reasons. First, as the ALJ pointed out, the Act and regulations make a facility responsible for the actions of its staff because "it is those actions which comprise the care the residents receive." ALJ Decision at 7. Second, as discussed, our decision here rests in part on a conclusion that Life Care failed to prove that it did in fact do "all it could to minimize instances of employee misfeasance or misbehavior."

We agree with Life Care that the terms of section 483.13(c) concern more than whether an individual staff member committed an individual act of neglect, mistreatment or abuse. The Board has previously stated that section 483.13(c) "addresses a deficiency related to lack of an effective policy as opposed to one directed at the occurrence of neglect itself." Emerald Oaks, DAB No. 1800, at 17. Therefore, under section 483.13(c), a relevant inquiry is whether the facility has implemented an effective anti-neglect policy in a situation where one or more residents in the facility are suffering neglect at the hands of one or more staff members.

Here, two CNAs failed to properly care for Resident 1 by notifying the nurse of the fall as required by facility policy. While Life Care asserts that these CNAs disregarded its falls policy, it has failed to show that it trained any of its CNAs as to what constituted a fall within that policy. Therefore, Life Care has, in fact, failed to show that "it did all it could" to implement its policy.

3. Life Care's contentions regarding the appropriate standard of review, burden of proof, and notice are without merit.

Life Care identifies the "crux" of its argument on the burden of proof and notice as follows.

> CMS alleged as a matter of fact that Resident # 1 fell and was injured in the shower room. CMS concluded that this fall triggered some regulatory obligation to respond immediately, and that Petitioner's failure to do so constituted neglect in violation of Section 483.13(c)(1)(i). Thus, this is the unusual case where, if the evidence fails to support CMS' *factual* allegations, then there may be no possibility of a violation at least as alleged by CMS. But ALJ Kessel held that whether or not the Resident fell and was injured was immaterial, because he relied on a different *factual* theory of the case for his conclusion.

RR at 26 (emphasis in original). In other words, Life Care takes the position that CMS failed to prove facts that were essential to its noncompliance determination (e.g., that the fall was the cause of an injury) and that the ALJ then impermissibly based the determination on facts that Life Care did not have notice were at issue.

Life Care's assertions are without merit. First, while CMS did allege (and Life Care has not disputed) that Resident 1 fell in

the bathroom, the basis for the deficiency finding did not depend (as Life Care claims) on a finding that the fall resulted in any specific injury. CMS Ex. 2, at 1. Rather, the SOD states that the facility "failed to prohibit neglect regarding the failure of a certified nursing assistant to inform nursing staff of an accident involving [Resident 1]" and that this failure "resulted in the potential for serious harm to this resident, for whom nursing staff was unaware of any incident having occurred involving the resident for a period of approximately three hours, at which time the resident presented with an injury of unknown origin and was subsequently diagnosed with a subarachnoid hemorrhage." Id. The deficiency thus lay in the CNA's failures to report the fall when it happened, later when a bruised lump was discovered on Resident 1's head, and even when directly asked and then interviewed as part of the facility's investigation of the injury. The deficiency does not depend on any showing that either the lump or the eventual hemorrhage were direct results of the unreported fall. Moreover, whether Resident 1 was hurt in the fall was, as the ALJ recognized, not material to CMS's finding of noncompliance because actual harm is not a required element of either a determination of noncompliance or a determination of immediate jeopardy.[10]

Second, Life Care's assertion that the ALJ committed a prejudicial error by relying on a different "factual theory" than CMS did is also not grounds for reversal. Both CMS's and the ALJ's determinations rest on findings that the CNAs should have reported the events in the bathroom so that a nurse could have assessed and monitored Resident 1 to determine whether she was injured, which Life Care does not dispute. What Life Care does dispute is whether these, and other facts, are grounds for concluding that it had failed to "develop and implement written policies and procedures that prohibit . . . neglect." as required by section 483.13(c). As discussed above, the ALJ concluded, as do we, that Life Care failed to implement such policies and

[10] Similarly, we reject Life Care's argument that the ALJ erred by not granting its request for a subpoena for certain of Resident 1's hospital medical records that Life Care argued could allow its expert witness to state whether she "had suffered a fall that caused a brain injury." RR at 9. Whether Resident 1's ultimately fatal brain hemorrhage was caused by her fall or by some neurological event that immediately preceded and caused the fall or by some other phenomenon is not material to determining whether Life Care was in substantial compliance with section 483.13(c) and whether the noncompliance posed immediate jeopardy.

procedures, including failing to provide through adequate training an understanding by staff of their responsibilities. While the ALJ discussed Life Care's failure to train CNAs to recognize "subtle neurological events," he also relied (as do we) on the fact that CNA AA may have concluded that her failure to report was consistent with the facility's falls policy. ALJ Decision at 6. As discussed above, Life Care points to no evidence to show that it did train CNAs on what constituted a "fall" under its policy or in some other way took concrete measures to ensure that staff would alert professionals to events of the kind that occurred.

Life Care also argues that the ALJ committed prejudicial error by basing his conclusion of noncompliance in part on his finding that Life Care had failed to train its CNAs to recognize "subtle signs that suggest a potentially grave change in condition in a resident like Resident # 1." RR at 31, citing ALJ Decision at 6. We conclude that Life Care presented persuasive arguments as to why CNAs need not have training in "subtle" neurological signs and symptoms in order for the facility to ensure that they would know to alert a professional nurse to assess a resident who fell for whatever reason. We also conclude, however, to the extent that the ALJ believed such training was required, that opinion is not necessary to support his ultimate conclusion of noncompliance.

The ALJ addressed the inadequacy of the training only in light of Life Care's argument that the CNA's neglect should not be the basis of a finding that the facility had not developed and implemented anti-neglect policies and procedures. Ample other evidence and bases already discussed support the determination of noncompliance. The fundamental problem here is that CNA AA evidently did not recognize a fall or appreciate the importance of reporting such an incident involving a resident with special needs reflected in her care plan of which at least CNA AA should have been aware, while CNA BB also failed to report the information she had to the nursing staff. These failures demonstrate a lack of implementation which Life Care's evidence does not overcome. Given our resolution of these other issues, the ALJ's discussion of the CNAs' lack of neurological training was unnecessary and therefore harmless error.

Finally, Life Care's argument that it had inadequate notice of what was at issue before the ALJ is not persuasive. RR at 27. Life Care's exhibits and briefing before the ALJ show that it understood that the issue was whether it had developed and implemented written anti-neglect policies and procedures relevant to the events in the bathroom. P. Pre-Hearing Br. at 2, 21; P.

Post-Hearing Br. at 16-26. To that end, Life Care submitted its falls policy, proffered testimony about the policy and training on the policy, and argued that it had in fact implemented the policy but that the CNAs had chosen to disregard it. We have already explained why we did not find this evidence sufficient.

4. Life Care was not in substantial compliance with 42 C.F.R. § 483.75(l)(1).

Life Care was also cited for noncompliance with 42 C.F.R. § 483.75(l)(1), which provides in pertinent part:

> The facility must maintain clinical records on each resident in accordance with accepted professional standards and practice that are complete, accurately documented, readily accessible, and systematically organized.

The ALJ did not address this citation, finding it unnecessary to do so in order to decide the case. ALJ Decision at 2. In its Request for Review, Life Care requests that the Board do so. RR at 41. We conclude that the undisputed evidence establishes that LPN CC, the first nurse to learn about Resident 1's lump, falsified data about her care of Resident 1 between 8 A.M. and 10:30 A.M. Based on this finding, we conclude that Life Care was not in substantial compliance with section 483.75(l)(1).

The SOD alleged two factual bases for this citation, both related to charting by LPN CC, who testified that she learned about the head injury "sometime after 10 A.M." P. Ex. 30, at 1. First, the SOD relied on LPN CC's entry of a nurse's note stating that on August 25, 2007 at 8 A.M. she was called by CNA AA to observe Resident 1's head injury and, thereafter, called the family and doctor, who ordered that Resident 1 be taken to the hospital. CMS Ex. 2, at 9. Second, the SOD relied on a Neurological Assessment Flowsheet completed by LPN CC that purported to document that Resident 1's "neurological status had been assessed at approximate 15 minute intervals on 08/25/2007 from 8:00 a.m. until the resident's transfer to the hospital at 12:00 noon." Id.

To address these findings, Life Care submitted written testimony from LPN CC stating as follows:

> I do recall [August 25] was busy, and so I did not complete my charting until toward the end of my shift that evening. Charting at the end of the shift is not unusual, although the facility prefers that significant incidents should be

> charted immediately. When I wrote my notes regarding the incident, I mistakenly wrote that I had assessed the Resident at 8 A.M., rather than at about 10:30 A.M., and I wrote that I checked the Resident's vital signs and did neurochecks from 8 A.M. until the Resident left to the hospital. In fact, I did such checks from 10:30 until she left. I understand that this mistake caused considerable confusion during the survey, and I ultimately was terminated for this documentation error, but I can assure the Court that I did not intend to mislead anyone, and just made a simple misstatement about the time at the end of a long day. When the mistake was brought to my attention, I wrote a note correcting it.

P. Ex. 30, at 4.

The 13 entries on the Neurological Assessment Flowsheet sheet for the time period 8 A.M. to 12 P.M. indicate that LPN CC was regularly monitoring Resident 1's "level of consciousness," "pupil response," "motor functions," "pain response," and "BP [blood pressure]." CMS Ex. 3, at 5. The blood pressure entries are numerical values, such as 105/70, 110/70, 110/68, 105/72. CMS Ex. 3, at 5; see also CMS Ex. 2, at 9. LPN CC says she did not begin monitoring Resident 1 until 10:30, but offers no explanation for the eight specific blood pressure figures entered between 8 A.M. and 10:30 A.M., leaving as the most reasonable inference that she made them up.[11] Thus, at a minimum, the blood pressure readings prior to 10:30 A.M. constitute false records, not explained by a simple mistake by LPN CC about when she actually started monitoring. Indeed, the SOD states, and Life Care does not deny, that Nurse DD (who was the Director of Nursing (CMS Ex. 6, at 7)), "stated that the neurochecks documented as completed by LPN 'CC' on the morning of 8/25/2007 represented falsified documentation." CMS Ex. 2, at 10.

Life Care argues that the incorrect entries were "inconsequential" errors that "did not pose even the potential

[11] As to how she remembered information about the checks that she asserted she actually began performing at 10:30 A.M., LPN CC testified that, at least for the first check, she "recorded all of these signs on a piece of scrap paper on my medications cart." P. Ex. 30, at 2. This assertion casts further doubt on her testimony that she mistakenly recorded entries as starting at 8 A.M., because her alleged notes should have prompted her to realize she had not been monitoring Resident 1 since 8 A.M.

for any harm to anyone" because Resident 1 was already in the hospital by the time the entries were made. RR at 42.

This argument is baseless for several reasons, principally because it ignores the undisputed evidence that eight of the 13 purported blood pressure readings on the Neurological Assessment Flowsheet were falsified. A willingness to record false data strikes at the heart of the integrity of clinical records. Plainly, LPN CC's actions constituted a failure to "maintain clinical records . . . in accordance with accepted professional standards and practice that are . . . accurately documented." Moreover, such false records create a potential for more than minimal harm to residents given that they are intended to be relied on in making treatment decisions. Even though these records did not form the basis for treatment decisions for this resident because she had been hospitalized by the time they were made, the nurse's recording of false data casts doubt on the reliability of the facility's other records. Based on these facts, we conclude that Life Care was not in substantial compliance with section 483.75(l)(1).

5. The ALJ did not err in concluding that Life Care failed to prove that CMS's determination of immediate jeopardy was clear erroneous.

"Immediate jeopardy" is defined as a situation in which a provider's noncompliance "has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident." 42 C.F.R. § 488.301.

CMS's determination that a noncompliance constitutes immediate jeopardy must be upheld unless it is clearly erroneous. 42 C.F.R. § 498.60(c); see also Beverly Health Care Lumberton, DAB No. 2156, at 4 (2008), citing Woodstock Care Center, DAB No. 1726, at 39 (2000), aff'd, Woodstock Care Ctr. v. Thompson. The Board has held that section 498.60(c) "places the burden on the SNF [skilled nursing facility] - a heavy burden, in fact - to upset CMS's finding regarding the level of noncompliance." Liberty Commons, DAB No. 2031, at 18 (2006), aff'd, Liberty Commons Nursing and Rehab Center - Johnston v. Leavitt, 241 F. App'x 76 (4th Cir. 2007), quoting (with emphasis in original) Barbourville Nursing Home, DAB No. 1962 (2005), aff'd, Barbourville Nursing Home v. U.S. Dep't of Health & Human Servs., No. 05-3241 (6th Cir. April 6, 2006).

As discussed below, the records shows that the failure to assess and monitor frail elderly residents who have fallen, particularly those on anticoagulant therapy, is likely to cause them serious

injury. Therefore, we conclude that the ALJ did not err in holding that CMS's immediate jeopardy determination was not clearly erroneous. The following evidence supports this determination.

Life Care's own falls policy shows that falls frequently result in serious injuries in a frail elderly population. It states:

> Reducing the risk for falls is a key component in managing the long term needs of nursing home residents and minimizing the number of injuries that often result in debilitating outcomes for residents. The cumulative impact of resident falls in terms of injuries, deaths, and costs is formidable. Each fall affects a resident's short and long term outlook and quality of life.

P. Ex. 23, at 4, 6.

Life Care does not dispute the ALJ's finding that that, because falls pose a high risk of serious injury for an elderly person, residents who fall require prompt assessment and subsequent monitoring of their condition. Indeed, Life Care's falls policy reflects this standard of care, requiring falls notification of the charge nurse "immediately" and assessment by the nurse "for injuries prior to moving the resident." P. Ex. 23, at 7. Additionally, the policy requires taking vital signs; notifying, among others, the doctor and the next shift; and making follow-up observations documented through "72 hour 'alert' charting." Id. at 7-8.

In this case, because there was no immediate reporting, there was no immediate assessment and no monitoring prior to approximately 10:30 A.M. That failure posed a particular danger here since Resident 1 was on Coumadin and therefore susceptible to bleeding. ALJ Decision at 3. Additionally, a report of the events in the bathroom could have prompted nursing staff to consider whether Resident 1 had suffered a neurological event that caused the fall and to address that possibility promptly. Indeed, LPN CC wrote in a statement dated September 8, 2007 that if CNA AA "had just told the true we could had assess the incident different. Would have call 911 right away." P. Ex. 19, at 19 (verbatim from original). Even if there were nothing that Life Care's nursing staff could have done to prevent the fatal consequence of Resident 1's subarachnoid hemorrhage, this would not excuse Life Care's failure to do a timely assessment and to monitor this resident.

Life Care argues that "there is no evidentiary basis to extrapolate this single omission to a finding [that] all of Petitioner's residents thereby were placed in danger of 'likely serious harm or death.'" RR at 44. We reject this argument. First, the standard is not whether "all" of Petitioner's residents were in danger. Second, it is reasonable to assume that other residents were in danger since CNAs AA and BB cared for other residents and demonstrated that they did not understand or were willing to ignore the falls policy, a resident's care plan (here for caution in avoiding bumps during transfers), the danger of falls to elderly people, or the need for assessment of falls. Moreover, if these CNAs did not understand these aspects of care, it is reasonable to be concerned that other staff also did not understand, putting additional residents at risk.

Conclusion

We sustain the ALJ's numbered findings of fact and conclusions of law. We also conclude, based on the record before the ALJ, that Life Care was not in substantial compliance with section 483.75(l)(1). Thus, we modify the ALJ's decision accordingly.

_____/s/_____
Judith A. Ballard

_____/s/_____
Stephen M. Godek

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