Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

The Bridge at Rockwood,
(CCN: 44-5143)

Petitioner,

v.

Centers for Medicare & Medicaid Services

Docket No. C-15-2874

Decision No. CR4978

Date: November 30, 2017

DECISION

This case presents yet another depressing example of a long-term-care facility failing to protect a vulnerable resident from the abusive behavior of another and then failing to report the abuse.

Petitioner, The Bridge at Rockwood, is a long-term-care facility, located in Rockwood, Tennessee, that participates in the Medicare program. Following a complaint investigation, completed March 27, 2015, the Centers for Medicare & Medicaid Services (CMS) determined that the facility was not in substantial compliance with multiple Medicare program requirements and that its deficiencies posed immediate jeopardy to resident health and safety. CMS imposed civil money penalties (CMPs) of $7,850 per day for 85 days of immediate jeopardy and $300 per day for 67 days of substantial noncompliance that was not immediate jeopardy.

Petitioner appeals eight of the ten deficiencies cited. Order Following Prehearing Conference dated May 25, 2017.

Based on the deficiencies Petitioner does not challenge, I find that, from January 1 through June 1, 2015, the facility was not in substantial compliance with Medicare program requirements, and CMS is authorized to impose a CMP of at least $50 per day. 42 C.F.R. §§ 488.408(d)(1)(iii); 488.438(a)(1)(i).[1]

With respect to the issues Petitioner appealed, I find that:

- from January 1 through June 1, 2015, the facility was not in substantial compliance with: 42 C.F.R. §§ 483.13(b) and (c); 483.25(h); and 483.75;

- from January 1 through March 26, 2015, those deficiencies posed immediate jeopardy to resident health and safety; and

- the penalties imposed are reasonable.

Because I find that the deficiencies cited under sections 483.13, 483.25(h), and 483.75, by themselves, justify the remedies imposed, I decline to review the remaining deficiencies, 42 C.F.R. §§ 483.10(b)(11) and 483.75(o)(1). *Heritage Plaza Nursing Ctr.*, DAB No. 2829 at 4, n.3 (2017); *Beechwood Sanitarium*, DAB No. 1824 at 19 (2002). In any event, the facility would be hard-pressed to establish compliance with section 483.10(b)(11), which requires that the facility immediately consult with a resident's physician and notify his family of any change in condition. As the following discussion explains, the licensed practical nurse (LPN) who documented the purported consultations and notifications was an employee who regularly falsified records. Her documentation is therefore highly suspect.

Background

The Social Security Act (Act) sets forth requirements for nursing facilities to participate in the Medicare program and authorizes the Secretary of Health and Human Services to promulgate regulations implementing those statutory provisions. Act § 1819. The Secretary's regulations are found at 42 C.F.R. Part 483. To participate in the Medicare program, a nursing facility must maintain substantial compliance with program requirements. To be in substantial compliance, a facility's deficiencies may pose no greater risk to resident health and safety than "the potential for causing minimal harm." 42 C.F.R. § 488.301.

The Secretary contracts with state survey agencies to survey skilled nursing facilities in order to determine whether they are in substantial compliance. Act § 1864(a); 42 C.F.R. § 488.20. Each facility must be surveyed annually, with no more than fifteen months elapsing between surveys, and must be surveyed more often, if necessary, to ensure that

[1] In this decision, I cite to the regulations in effect at the time of the survey.

identified deficiencies are corrected. Act § 1819(g)(2)(A); 42 C.F.R. §§ 488.20(a); 488.308. The state agency must also investigate all complaints. Act § 1819(g)(4).

In this case, responding to complaints that a facility nurse failed to distribute ordered medications and that the same nurse falsified medication records, a surveyor from the Tennessee Department of Health (state agency) visited the facility. CMS Exhibit (Ex). 2. On March 27, 2015, he completed an investigation and partially extended survey. CMS Ex. 1. Based on his findings, CMS determined that the facility was not in substantial compliance with multiple program requirements:

- **42 C.F.R. § 483.10(b)(11) (Tag F157) (resident rights – notification of changes) at scope and severity level K (pattern of substantial noncompliance that poses immediate jeopardy to resident health and safety)**;[2]

- **42 C.F.R. §§ 483.13(b) and 483.13(c)(1)(i) (Tag F223) (staff treatment of residents: abuse) at scope and severity level K**;

- **42 C.F.R. § 483.13(c) (Tag F224) (staff treatment of residents: policies and procedures to prohibit mistreatment, neglect, and abuse) at scope and severity level K**;

- **42 C.F.R. §§ 483.13(c)(1)(ii)-(iii) and 483.13(c)(2)-(4) (Tag F225) (staff treatment of residents: investigate and report allegations of abuse) at scope and severity level K**;

- **42 C.F.R. § 483.13(c) (Tag F226) (policies to prohibit abuse and neglect) at scope and severity level K**;

- 42 C.F.R. § 483.20(k)(3)(i) (Tag F281) (resident assessment: professional standards of quality) at scope and severity level D (isolated instance of substantial noncompliance that causes no actual harm with the potential for more than minimal harm);

- **42 C.F.R. § 483.25(h) (Tag F323) (quality of care: accident prevention) at scope and severity level K**;

- **42 C.F.R. § 483.75 (Tag F490) (administration) at scope and severity level K**;

[2] I highlight, in bold, the deficiencies Petitioner has appealed.

- 42 C.F.R. § 483.75 (*l*)(1) (Tag F514) (administration: clinical records) at scope and severity level E (pattern of substantial noncompliance that causes no actual harm with the potential for more than minimal harm);

- **42 C.F.R. § 483.75(o)(1) (Tag F520) (administration: quality assessment and assurance) at scope and severity level K**.

CMS Ex. 1.[3]

Surveyors revisited the facility on June 10, 2015. Based on their findings, CMS determined that the facility returned to substantial compliance on June 2, 2015. CMS Ex. 35 at 1.

CMS imposed against the facility CMPs of $7,850 per day for 85 days of immediate jeopardy (January 1 – March 26, 2015), and $300 per day for 67 days of substantial noncompliance that was not immediate jeopardy (March 27 – June 1, 2015), for penalties totaling $687,350 ($667,250 + $20,100). CMS Ex. 35 at 7.

Petitioner timely requested review.

On July 18, 2017, I convened a hearing, via video conference, from the offices of the Departmental Appeals Board in Washington, D.C. Ms. Erin Shear and Ms. Audrey Williams appeared from Atlanta, Georgia, on behalf of CMS. Mr. Joseph Bianculli represented Petitioner, The Bridge at Rockwood, and appeared from our offices in Washington, D.C. Transcript (Tr.) 4-5.

The parties filed pre-hearing briefs (CMS Br.; P. Br.) and post-hearing briefs (CMS Post-hrg. Br.; P. Post-hrg. Br.). Petitioner filed a reply brief (P. Reply). I admitted into evidence CMS Exs. 1-68 and P. Exs. 1-23. Order Following Prehearing Conference at 2-3 (May 25, 2017); Tr. 7.

Issues

The issues before me are:

[3] The surveyor confirmed (and Petitioner does not dispute) that a staff nurse did not administer ordered medications and that she falsified medication records. Yet, for reasons it has not explained, CMS did not cite these serious irregularities as bases for its noncompliance findings, so those issues are not before me. *See* Tr. 11-13. The surveyors also cited the facility under a Tennessee rule governing nurse aide training and competency. CMS Ex. 1 at 141-43. Under federal rules, such a violation puts the facility out of substantial compliance with 42 C.F.R. § 483.75(b). However, CMS did not cite a deficiency under this provision, and the issue is therefore not before me.

1. From January 1 through June 1, 2015, was the facility in substantial compliance with: 42 C.F.R. §§ 483.13(b) and (c); 483.25(h); and 483.75;

2. If, from January 1 through March 26, 2015, the facility was not in substantial compliance with those requirements, did its deficiencies then pose immediate jeopardy to resident health and safety; and

3. If the facility was not in substantial compliance, are the penalties imposed – $7,850 per day for the period of immediate jeopardy and $300 per day for the period of substantial compliance that was not immediate jeopardy – reasonable.

Discussion

1. The facility was not in substantial compliance with 42 C.F.R. §§ 483.13(b) and (c); and 483.25(h) because staff did not prevent an aggressive resident from abusing a vulnerable one; and they did not immediately report or thoroughly investigate instances of abuse or potential abuse.[4]

Program requirements: 42 C.F.R. § 483.13(b) and (c) (Tags F223, 225, and 226). The regulation governing resident behavior and facility practices mandates that each resident "has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion." 42 C.F.R. § 483.13(b). Abuse is defined as "the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish." 42 C.F.R. § 488.301.

In order to keep residents free from abuse, facilities must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents. Among other requirements, the facility must ensure that all alleged violations are reported immediately to the facility administrator and appropriate state officials. 42 C.F.R. § 483.13(c). The facility must have evidence that all alleged violations are thoroughly investigated, and it must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator (or designated representative) and to the appropriate state officials within five working days of the incident. If the violation is verified, the facility must take appropriate action. 42 C.F.R. § 483.13(c)(2), (3), and (4).

Program requirement: 42 C.F.R. § 483.25(h) (Tag F323). Under the statute and the "quality of care" regulation, each resident must receive, and the facility must provide, the necessary care and services to allow a resident to attain or maintain the highest

[4] My findings of fact/conclusions of law are set forth, in italics and bold, in the discussion captions of this decision.

practicable physical, mental, and psychosocial well-being, in accordance with the resident's comprehensive assessment and plan of care. Act § 1819(b); 42 C.F.R. § 483.25. To achieve this, the regulation mandates, among other requirements, that the facility "ensure" that each resident's environment remains as free of accident hazards as possible and that each resident receives adequate supervision and assistive devices to prevent accidents. The facility must therefore eliminate or reduce a known or foreseeable risk of accidents "to the greatest degree practicable." *Del Rosa Villa*, DAB No. 2458 at 7 (2012); *Clermont Nursing & Convalescent Ctr.*, DAB No. 1923 at 9-10 (2004), *aff'd, Clermont Nursing & Convalescent Ctr. v. Leavitt*, 142 F. App'x 900 (6th Cir. 2005); *accord*, *Briarwood Nursing Ctr.*, DAB No. 2115 at 5 (2007) (holding that the facility must "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."). A facility is permitted the flexibility to choose the methods it uses to prevent accidents, but the chosen methods must constitute an "adequate" level of supervision under all the circumstances. *Briarwood* at 5; *Windsor Health Care Ctr.*, DAB No. 1902 at 5 (2003), *aff'd, Windsor Health Care Ctr. v. Leavitt*, 127 F. App'x 843 (6th Cir. 2005).

Facility policies – abuse: The facility had in place written policies to prohibit abuse, including a policy that addressed "resident-to-resident" abuse. According to that policy, staff must immediately intervene if they observe any form of abuse toward another resident. They must also complete physical assessments of the residents involved to determine potential injuries, immediately notify the facility administrator and/or DON, closely supervise the residents, notify the physician and families, notify "social services/chaplain" for follow-up and continued monitoring, and update care plans as needed. CMS Ex. 25 at 3.

The policy mandates that *all* allegations of abuse be investigated and reported to the appropriate agencies. The facility administrator or designee must make all reasonable efforts to investigate and address "alleged reports, concerns, and grievances." The person observing the incident must *immediately* report and provide a written statement that includes the resident's name, date, time, and place of the incident, and staff involved. The statement must describe what happened. CMS Ex. 25 at 3-4.

The policy also requires staff follow-up. All allegations must be reported timely to the state agency. The social services department (and/or chaplain) must monitor the resident's emotional well-being following the incident and refer for psychological/psychiatric services as needed. Staff must inform the resident's physician and family of the outcome of the facility's investigation. All allegations of abuse must be reviewed at the quality assurance meetings "for any further resolution related to educational opportunities." CMS Ex. 25 at 4.

A separate policy addresses managing aggressive behavior. Its articulated purposes are: to protect residents and staff from harm and to control aggressive incidents; and to protect residents from injuring themselves or others. The policy instructs staff to "establish control of the situation[,]" specifically, to remove residents from the area; to give the aggressive resident space; avoid standing too close or touching the aggressive resident, except for safety; take a calm approach without raising your voice; "convey the expected acceptable behavior"; talk and listen to the resident, trying to identify the stimulus for the aggressive behavior; and notify the physician if the resident was physically aggressive, injured, or if the "current interventions or orders" failed to calm him down. CMS Ex. 29.

Resident 2 (R2). At the time of the survey, R2 was a 74-year-old man, admitted to the facility in August 2013, suffering from dementia, paralysis, chronic airway obstruction, depression, anxiety, dysphasia, and multiple other impairments. He had muscle weakness and difficulty walking. CMS Ex. 4 at 5, 7. Because he took anticoagulants, he was at risk for abnormal bleeding or hemorrhage. CMS Ex. 4 at 20. He scored a five out of 30 on his mental status exam, indicating that he was severely impaired. CMS Ex. 4 at 24. He had significant problems understanding and communicating with others. CMS Ex. 4 at 18.

Resident 10 (R10). R10 was a 77-year-old man suffering from Alzheimer's dementia and depression. CMS Ex. 11 at 1, 4. He was admitted to the facility on December 8, 2014. Prior to his admission, he was in a psychiatric unit, which admitted him from an assisted living situation "due to behavior issues and vascular dementia." CMS Ex. 11 at 1, 4. Upon admission to the psychiatric unit, he was described as paranoid, occasionally combative, and non-cooperative. He had recently become more violent and aggressive. The night before his admission, he hit a nurse at the assisted living facility. CMS Ex. 11 at 1, 4.

The facility recognized that R10's behaviors could put others at risk. Specifically:

- An assessment dated November 11 describes him as "in good strength." The assessment warns: "He is an elopement risk and a fall risk and he *could be a risk to other residents who cannot fight*." CMS Ex. 11 at 2, 4-5 (emphasis added);

- In his care plan, staff identified behavior problems and set, as a goal, that he would not harm himself or others. CMS Ex. 14 at 8, 9; *see* CMS Ex. 11 at 43 (behavioral assessment entries indicating that the resident was physically and verbally abusive to staff);

- In a care plan conference summary, dated December 10, 2014, staff confirmed that R10 could be physically abusive. CMS Ex. 14 at 19;

- A behavioral assessment, dated December 18, describes R10 as verbally and physically abusive toward staff. CMS Ex. 14 at 21, 24;

- Another assessment, dated December 20, indicates that R10 had delusions and that, over the previous week, he had exhibited "physical behavioral symptoms directed toward others" (which, according to the form, could mean hitting, kicking, pushing, scratching, grabbing, or abusing others sexually). He had also exhibited verbal behaviors, such as threatening, screaming, or cursing at others. CMS Ex. 14 at 32, 38.

For reasons no one has explained, the staff decided that R10 – an aggressive and potentially violent resident – and R2 – a vulnerable and effectively defenseless resident – should room together. *See* CMS Ex. 4 at 8; CMS Ex. 13 at 5.

The unexplained injuries – December 18, 2014. On December 18, 2014, nursing staff observed new bruises on both of R2's shoulders. Because he was so cognitively impaired, R2 could not explain how the bruising occurred. Staff reported the injuries to the state agency, indicating that they had investigated but could not determine the cause. According to the facility's investigative report, staff examined all residents and found no other injuries of undetermined origin. CMS Ex. 4 at 10; CMS Ex. 7 at 6-7; CMS Ex. 9 at 1-2, 6-9.

The investigative report was simply wrong. In fact, facility staff had found other injuries of undetermined origin; on December 18 (the same day staff first observed R2's bruises), a nurse reported scratches on R10's chest. CMS Ex. 10. That each of the two roommates presented with unexplained injuries on the same day surely merited additional investigation as well as greater vigilance to ensure that the roommates were not injuring each other.

The New Year's altercations. Sometime in the early hours of January 1, 2015, R10 attacked Nurse Aide Julian Adams. Nurse Aide Adams discovered R10 harassing a sleeping R2, tampering with R2's privacy curtain and bed linens. When Nurse Aide Adams intervened, R10 responded by attempting to choke him and succeeded in scratching his neck, making him bleed. Nurse Aide Adams extricated himself from the resident's grasp and exited the room, leaving R2 alone with R10. CMS Ex. 15; *see* CMS Ex. 3 at 9, 83; CMS Ex. 68 at 3 (Cole Decl. ¶ 11); P. Ex. 2 at 3; P. Ex. 23 at 2 (Adams Decl.).

Nurse Aide Adams intended to report the attack to his supervisor, Licensed Practical Nurse (LPN) Traci Moss, but could not find her. She had left the unit without telling

anyone where she was going.[5] Nurse Aide Adams reported the incident to LPN Melissa Cross, who instructed him to "tell Traci." CMS Ex. 16 at 1; CMS Ex. 17 at 2; CMS Ex. 3 at 83; P. Ex. 2 at 1, 3.

Nurse Aide Adams then left the building to have a cigarette. He told Surveyor Michael Cole that he did so because he needed the time to "settle [himself] down." CMS Ex. 3 at 9, 83; CMS Ex. 68 at 3 (Cole Decl. ¶ 12); P. Ex. 23 at 3 (Adams Decl.) ("Actually, I wanted to settle down myself because I was startled by [R10's] sudden actions."). He found LPN Moss smoking on the front porch. He told her about the incident and showed her the scratches on his neck. She told him to clean the scratches with alcohol. She did not then return to the floor but remained on the porch, smoking, as did Nurse Aide Adams. CMS Ex. 3 at 83; P. Ex. 23 at 2 (Adams Decl.).

In the meantime, for another ten minutes or so, LPN Cross continued working at the nurses' station. When she heard a yell, she went into the room shared by R2 and R10. She discovered R10 on top of R2, in R2's bed.[6] R2 "let out a yell." LPN Cross left the room and ran up the hall for help. She returned with Nurse Aide Alethea Swicegood. They pulled R10 off R2. LPN Cross reported that she saw bite marks on R2 and that R2 was "crying tears." They kept the residents separated, and, eventually, Nurse Aide Adams and LPN Moss reappeared. CMS Ex. 16; CMS Ex. 17; P. Ex. 2 at 1-2. Nurse Aide Adams confirmed that R2's hand was swollen, and he was crying loudly for his mother. CMS Ex. 68 at 3 (Cole Decl. ¶ 16).

In a witness statement, dated January 1, 2015, and an undated follow-up statement, Nurse Aide Swicegood graphically describes the incident: at about 3:00 a.m. (she estimated the time was "about 20 minutes" after Nurse Aide Adams left the building following his conversation with LPN Cross and his unsuccessful search for LPN Moss), she heard LPN Cross screaming her name. She ran into the residents' room. There, she saw R10 lying naked on top of R2, with his forearm on R2's neck. He was biting R2. LPN Cross was attempting, unsuccessfully, to get R10 off R2. R10's mouth was bloody and he "looked like an enraged zombie cannibal." CMS Ex. 17; CMS Ex. 68 at 3-4 (Cole Decl. ¶ 17). Nurse Aide Swicegood tried to get between the residents, telling R10 that he needed to stop hurting R2. R10 replied that he did not want to stop. The two women eventually separated the residents. About then, Nurse Aide Adams returned to the room, and R10

[5] LPN Moss was the same nurse who failed to administer ordered medications and falsified medication records.

[6] Curiously, LPN Cross's statement does not mention that R10 was naked, which she must have noticed and which should be considered significant. Publically removing his clothes was one of R10's behaviors. CMS Ex. 11 at 4.

was "at least" willing to sit on his own bed, so LPN Swicegood left to get ice. CMS Ex. 3 at 83-84; CMS Ex. 15 at 1; CMS Ex. 17 at 3; P. Ex. 2 at 4.

Nurse Aide Swicegood told Surveyor Cole that she personally observed the assault for "at least" ten minutes; "pillows and side tables were scattered everywhere." CMS Ex. 68 at 4 (Cole Decl. ¶ 17). She also reported that 25-30 minutes elapsed between the beginning of the attack and the time LPN Moss finally appeared. CMS Ex. 17 at 3; *see* P. Ex. 2 at 2, 4.

The nurses removed R2 from the room, putting him in the day room. According to the ambulance record, at 3:56 a.m., the facility called emergency medical services and sent R2 to the emergency room. CMS Ex. 6 at 1.[7] The record includes a physician's telephone order, prepared by LPN Moss, dated January 1 at 4:00 a.m., directing the facility to send R2 to the hospital for evaluation and treatment "if indicated." CMS Ex. 4 at 14.

R2 returned at about 6:30 a.m. with a new order for antibiotics. CMS Ex. 4 at 10, 14-15; CMS Ex. 5 at 1, 2; P. Ex. 2 at 2, 4. He had bruising at the wrist on his left hand, on his right middle knuckle, and on his chest, at the left side of his ribcage. His left hand was swollen. CMS Ex. 4 at 11; *see* CMS Ex. 7 at 1, 4 (describing "large, swollen bruise to top of left hand, bite mark to middle knuckle and thumb").

The facility's post-incident response. At some point, LPN Moss called the facility's director of nursing (DON), Russ Sutton, who said that he would "take care of it" the following day. P. Ex. 2 at 2. In his own undated report, DON Sutton wrote that LPN Moss called him at 4:30 a.m. to report that R10 was found on top of R2 and that R2 had received several bites and his hand looked swollen. CMS Ex. 18; CMS Ex. 15; *see* CMS Ex. 3 at 9, 83; CMS Ex. 68 at 3 (Cole Decl ¶ 11). LPN Moss told him – inaccurately – that they had moved R10 to a different room (CMS Ex. 18 at 1); in fact, they moved R2 to a different room. According to his note, DON Sutton instructed LPN Moss to call R2's physician and to send R2 out for an evaluation. CMS Ex. 18 at 1. This is confusing; by 4:30 a.m., R2 was already at the emergency room.

Staff apparently determined that they would keep the residents safe by imposing 15-minute checks on both R2 and R10. A monitoring record indicates that LPN Moss checked on R2 every 15 minutes from 4:30 until 7:00 a.m. CMS Ex. 34. But, again, this could not have been accurate because R2 was not even at the facility between 4:30 and

[7] As I discuss in more detail below, facility staff were not careful about reporting accurately the timing of these events. In my view, the time noted on the ambulance record is the most reliable evidence as to the time the facility called emergency medical services. I find particularly unreliable the timing of events reported by LPN Moss, all of which are questionable, and some of which are verifiably wrong.

6:30 a.m. He was in the emergency room. A similar report, initialed by someone else, indicates that staff checked on R10 every 15 minutes between 4:30 and 7:00 a.m. CMS Ex. 34 at 2. The record includes no evidence that staff took any precautions between 7:00 a.m. and 12:15 p.m., when they transferred R10 to a geri-psych hospital. CMS Ex. 14 at 116.

The facility's investigation of the incident was minimal. LPN Moss filled out investigative reports for each resident. Her reports are neither complete, consistent, nor accurate. On R2's reports, she left most of the questions unanswered. The times she listed cannot possibly be accurate. She reported that the incident occurred at 4:30 a.m., but more reliable evidence establishes that the incident had concluded well before then and that R2 was in the emergency room at 4:30 a.m. CMS Ex. 6 at 1; CMS Ex. 7 at 1, 4. Elsewhere on the form, she claimed that she notified R2's physician at 4:45 a.m., the family at 5:00 a.m., and spoke to DON Sutton at 4:30 a.m. CMS Ex. 7 at 2, 4.

She offered no specific information about the altercation except to describe "immediate actions" as "separated residents immediately." CMS Ex. 7 at 1, 4. She did not mention R10's earlier altercation with Nurse Aide Adams. She wrote that no first aid or other treatment was given, which is not accurate. CMS Ex. 7 at 2, 4. She left blank most of the section asking for a summary of the investigation (interviews, investigative findings, actions implemented), except to write that neither the resident nor his family participated in the investigation. She answered "yes" to the question about whether the resident's care plan had been reviewed or revised. CMS Ex. 7 at 3, *but see* CMS Ex. 7 at 5 (care plan section left blank).

She provided little information on her R10 reports, again leaving blank virtually all of the section relating to the investigative summary. CMS Ex. 13 at 9. She also wrote that the incident occurred at 4:30 a.m., that she notified his physician of the incident at 4:30 a.m., his family at 6:00 a.m., and DON Sutton at 4:00 a.m. Notifying DON Sutton of the event a half hour before it occurred would, of course, have been impossible. CMS Ex. 13 at 5, 7, 8.

The facility did not report the incident to the state agency. Surveyor Cole learned of it when he visited to investigate the medication irregularities.

Facility noncompliance: quality of care. As Petitioner acknowledges, R2 and R10 lived in a unit designed for residents suffering from dementia, who required a "closely monitored environment." P. Post-hrg. Br. at 6, 8. R10 required even closer supervision than most because he was so combative and because he was an elopement risk. He was a man who could no longer control himself, which put him (and others) at significant risk of injury. So long as R2 roomed with R10, R2 required close supervision to ensure his safety. *See* 42 C.F.R. § 483.25(h).

Yet, facility staff provided these residents virtually no supervision during the early hours of January 1, 2015. LPN Moss, the nurse responsible for supervising the unit, had disappeared without telling anyone where she would be; the nurse aide responsible for the two residents also left the building. Although she knew that LPN Moss was not available, the remaining nurse (who, in fairness, was not assigned to monitor R2 and R10) did not step in to assure that the residents were properly supervised during LPN Moss's absence.

Nor was this the only time staff failed to provide these residents with the level of supervision they required. Following the incident, they imposed 15-minute checks on R2 and R10. However, LPN Moss falsified records by documenting that she checked on R2 every 15 minutes between 4:30 and 7:00 a.m. She could not have done so between 4:30 and 6:30 a.m. because he was at the emergency room. Because her documentation is so unreliable, it does not establish that she ever checked on him.

Staff may have checked on R10 between 4:30 a.m. and 7:00 a.m., but no evidence suggests that they did so after 7:00 a.m. Thus, even though they selected a specific method for supervising the residents (15-minute checks), staff did not comply with their own directive.

Because the facility did not provide R2 and R10 with the levels of supervision they required to meet their assessed needs and to mitigate foreseeable risks of harm from accidents, it was not in substantial compliance with 42 C.F.R. § 483.25(h).

Facility noncompliance: abuse. That the facility failed to keep R2 free from physical abuse is beyond question. R2 was asleep in his bed when an aggressive (and naked) resident attacked him. R10 lay on top of R2; placed a forearm across R2's neck; bit R2's hand; and bruised his wrist, hand, and ribcage. Because of the attack, R2 ended up in the emergency room. CMS Ex. 4 at 10, 11, 14-15; CMS Ex. 5 at 1, 2; CMS Ex. 6; CMS Ex. 7 at 1, 4; CMS Ex. 16, CMS Ex. 17; P. Ex. 2.

Remarkably, Petitioner denies that the incident happened as described in the witness statements. According to Petitioner, LPN Cross and Nurse Aide Swicegood reported that "they found [R10] leaning over [R2], and when they told him to stop, he simply stood up and sat down on his bed." P. Post-hrg. Br. at 21. This is plainly false. Although the facility's investigation was insufficient, and the witness statements were incomplete, the witnesses agreed that R10 attacked R2, was found on top of him, had his forearm pressed against R2's neck, was biting him, and refused to stop when ordered:

- LPN Cross reported: "[w]e . . . pulled [R10] off [R2]." CMS Ex. 16; P. Ex. 1 at 1;

- Nurse Aide Swicegood wrote: R10 "was on top of [R2]"; he was naked; "forearm choking" and "biting"; R10 "very much did not want to stop 'hurting [R2].'" CMS Ex. 17 at 1; P. Ex. 1 at 6;

- Nurse Aide Swicegood reiterated that R10 "was naked on top of [R2], biting him [and] had his forearm on his neck – Melissa was trying to get him off [R2]"; R10 "had a bloody mouth [and] looked like an enraged zombie cannibal – I walked between [them] telling [R10] he needed to 'stop' [;] 'stop hurting him' [and R10] stated he did 'not want to stop hurting' [R2]." CMS Ex. 17 at 2-3; P. Ex. 1 at 4-5.

I consider these contemporaneous statements the most reliable accounts of the event. *See Cedar Lake Nursing Home*, DAB No. 2390 at 9 (2011) (finding that an administrative law judge may reasonably accord more weight to "eyewitness contemporaneous statements" than "after-the-fact testimony"); *accord, Woodland Oaks Healthcare Facility*, DAB No. 2355 at 8 (2010).

But even the employees' written declarations, prepared for these proceedings, do not directly contradict anything said in the witness statements. LPN Cross now attempts to downplay the sheer awfulness of the incident, but she does not contradict the essentials of the statement she made at the time it occurred. She confirms that she heard a yell, entered the room, and found R10 on R2's bed, biting him. In contrast to her earlier written statement, she now says, for the first time, that R10 was "kneeling over" R2 rather than "on top of" him. P. Ex. 18 at 2. As a practical matter, this alteration doesn't make R10's actions any less abusive. LPN Cross confirms that R10 was biting R2's hand, and that she *ran for help*, from which I infer that she assessed this to be a situation that she could not handle by herself.[8] She also confirms that she and Nurse Aide Swicegood *together* separated the men and that Nurse Aide Swicegood took R10 to his side of the room; so much for the claim that R10 "simply stood up" and returned to his bed when asked to do so. P. Ex. 18 at 2.

Nurse Aide Swicegood's written declaration deviates even less from her contemporaneous statements, in part, because her declaration omits a lot of details. She repeats that LPN Cross yelled for her, that she immediately went to the room, that she directed R10 to stop, that the two women were able to separate the residents and de-escalate the situation. She calmed R10 and led him to the side of his bed. When Nurse Aide Adams returned, she left to get ice. P. Ex. 21 at 1. Significantly, Nurse Aide Swicegood does not deny any of her previous statements.

[8] Indeed, in a March 26, 2015 statement, Nurse Aide Adams describes LPN Cross as "frantic and yelling for help and Traci." P. Ex. 2 at 3.

Contrary to Petitioner's suggestions, R10's behavior is neither normal nor acceptable in a long-term care facility or anywhere else; it is abuse.

Also contrary to Petitioner's claims, the attack was both foreseeable and preventable.

Petitioner sets up a false dichotomy, arguing that facilities have very little choice – either: 1) they accept the demented and aggressive resident, understanding that, while "undesirable," some level of resident-on-resident aggression is inevitable; or 2) they "permanently disqualify" R10 and others like him from ever living in a long-term-care facility. But, Petitioner argues, these individuals have to live somewhere, and the risk of behavioral incidents "is an appropriate tradeoff" to the alternative of leaving them to "languish in less appropriate facilities (or not receive care at all)." P. Post-hrg. Br. at 24-25.

This is nonsense. Recognizing that some residents may become aggressive, even violent, facilities nevertheless can and should keep all of their residents safe. Here, the facility fell short in multiple ways, including:

- Staff seem to have disregarded R10's November 2014 assessment, which warned that "he could be a risk to other residents who cannot fight." CMS Ex. 11 at 1-2, 4-5.

- The facility housed this demented, aggressive, and reasonably strong resident with a man who suffered muscle weakness, was partially paralyzed, had difficulty breathing, and could not communicate his problems to others. CMS Ex. 4 at 5, 7, 18, 24.

- When, on December 18, the two roommates presented with injuries (R2's bruises and R10's scratches) consistent with an altercation, staff disregarded entirely R10's injuries. Instead, they reported – falsely – that no resident other than R2 suffered injuries of undetermined origin. CNS Ex. 4 at 10, 96; CMS Ex. 7 at 6-7; CMS Ex. 9 at 1-2, 7-9; CMS Ex. 10.

- After declaring R2's injuries to be of undetermined cause, staff investigated no further and took no action to ensure that altercations between the two roommates would not occur.

- In the middle of the night (December 31-January 1), the nurse responsible for the dementia unit abandoned her post and was hiding out on the smoking porch. Even after she learned about R10's altercation with Nurse Aide Adams, she did not return to the unit to investigate or to ensure that the residents were safe.

- Nurse Aide Adams came upon an aggressive and potentially violent resident disturbing his roommate. When he intervened, the aide was himself attacked and injured. But he then left, so that he could "collect himself." I do not doubt that he was upset and in need of recovery time; however, some other staff should have stepped in to ensure the safety of the two residents.

  I reject Petitioner's suggestion that the attack on Nurse Adams was a common occurrence and of no particular concern. R10 did not "merely" scratch Nurse Aide Adams. He grabbed him around the neck, attempting to choke him, and, in the process, managed to scratch him, drawing blood. Moreover, in reporting the incident, Nurse Aide Adams did not describe it as inconsequential; he repeatedly characterized it as an "attack." CMS Ex. 15 at 1 ("I was telling Traci that [R10] *had attacked* me as I tried to get him away from [R2] . . ."); CMS Ex. 16 (Nurse Aide Adams "told me [R10] *attacked* him."); CMS Ex. 17 at 2 (Nurse Aide Adams "was *attacked* [and] clawed on the neck by" [R10]; P. Ex. 1 at 1 ("he told me [R10] *attacked* him") (duplicate at CMS Ex. 16); P. Ex. 2 at 1 (Nurse Aide Adams "told me [R10] *attacked* him . . .") (emphasis added). And Nurse Aide Adams has also consistently justified his remaining on the smoking porch by explaining that he had to collect himself following the upsetting attack. CMS Ex. 3 at 9, 83; CMS Ex. 68 at 3 (Cole Decl. ¶ 12); P. Ex. 23 at 2 (Adams Decl.).

  I also view with some skepticism Nurse Aide Adams' relatively recent assertion that he remained in the room until R10 was safely and calmly in bed. P. Ex. 23 at 2. In the report he generated on the morning of the incident, he made no such statement. CMS Ex. 15. He told Surveyor Cole that he left the room, in search of LPN Moss, but he did not mention the state R10 was in when he left. CMS Ex. 68 at 3 (Cole Decl. ¶¶ 11, 12). Some evidence suggests that Nurse Aide Adams may have told LPN Moss that R10 was agitated and she needed to respond. CMS Ex. 68 at 3 (Cole Decl. ¶ 14). In any event, R10 was volatile and unreliable, and staff could not reasonably assume that they could safely leave him alone with the roommate he had so recently attempted to unsettle.

- Knowing that R10 had attacked Nurse Aide Adams and that the responsible nurse was nowhere to be found, LPN Cross did not check on the residents nor direct anyone else to do so.

- Knowing that neither nurse was responding to the potential dangers, Nurse Aide Adams nevertheless remained smoking on the porch and did not check on the residents.

In short, no one among the staff felt compelled to ensure the residents' safety until LPN Cross heard an altercation in progress.

Because facility staff did not keep its residents free from physical abuse, the facility was not in substantial compliance with 42 C.F.R. § 483.13(b).

Facility noncompliance: failure to report. Ultimately, I need not find that R10 abused R2 in order to find that the facility was not in substantial compliance with section 483.13. The regulation and the facility's own policies require the facility to report timely to the state agency *all* allegations. CMS Ex. 25 at 4. The reporting requirements are triggered by any *allegation* of abuse, whether or not it is recognized as such by the facility. *Illinois Knights Templar Home*, DAB No. 2369 at 11-12 (2011). By itself, the facility's failure to report the abuse to the state agency puts the facility out of substantial compliance with section 483.13(c).

Petitioner maintains that it was not required to report the abuse because R10 "was incapable of forming the intent to abuse." P. Post-hrg. Br. at 23. This defense fails for two reasons. First, any assault upon a resident raises the specter of abuse and must therefore be investigated and reported. The facility's own policy requires that *all allegations* be investigated and reported. Second, the Departmental Appeals Board has rejected the notion that an impaired individual cannot be capable of "willfully" inflicting injury. So long as the resident's actions are "deliberate," rather than accidental or inadvertent, they are considered "willful" within the meaning of the regulation. *Merrimack Cnty. Nursing Home*, DAB No. 2424 at 4-5 (2011); *Singing River Rehab. & Nursing Ctr.*, DAB No. 2232 at 12-13 (2009) (suggesting that, so long as a mentally ill resident did not act "by accident," his conduct was abusive). Here, R10 admitted that he wanted to hurt R2, and, when told to stop, he said he wanted to continue hurting R2. The attack on his roommate was not an accident; it was deliberate.

The facility also violated the reporting requirements of section 483.13(c), when, following discovery of R2's bruises on December 18, staff falsely reported to the state agency that his were the only injuries of undetermined origin detected, not disclosing that R2's roommate was also injured that day.

Nor did the facility "thoroughly investigate" either incident, which was required by section 483.13(c) and the facility's policies. The facility's investigation of R2's December 18 injuries was so poor that facility staff overlooked (intentionally or negligently) evidence of the resident's roommate's injuries. Investigating the January 1 incident seems to have fallen to LPN Moss, an employee notorious for neglecting her duties (see discussion below). Her reports answer few of the relevant questions and, as noted above, provide timelines that are impossible. Most significant, they say nothing about her own accountability for the incident.

Violating its own policies, the facility did not report to the state agency a significant incident of abuse, which puts it out of substantial compliance with section 483.13(c).

2. The facility was not in substantial compliance with 42 C.F.R. § 483.75 because it was not administered in a manner that enabled it to use its resources effectively to attain or maintain the highest practicable physical, mental, and psychosocial well-being of its residents.

42 C.F.R. § 483.75 (Tag 490). The facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.

Facility noncompliance: administration. A finding of substantial noncompliance in the facility's administration may derive from findings of substantial noncompliance in other areas.

> [W]here a facility has been shown to be so out of compliance with program requirements that its residents have been placed in immediate jeopardy, the facility was not administered in a manner that used its resources effectively to attain the highest practicable physical, mental, and psychosocial well-being of each resident.

Asbury Ctr. at Johnson City, DAB No. 1815 at 11 (2002); *Odd Fellow & Rebekah Health Care Facility*, DAB No. 1839 at 7 (2002); *Stone Cnty. Nursing & Rehab. Ctr*., DAB No. 2276 at 15-16 (2009). As discussed below, I find that the facility's deficiencies posed immediate jeopardy to resident health and safety, which, by itself, justifies the finding that the facility was not in substantial compliance with 42 C.F.R. § 483.75.

Moreover, as the above discussion establishes, the failures here were directly attributable to administrative failures. The facility's administration disregarded facility policies when it failed to report to the state agency allegations of resident abuse and when it falsely reported on December 18 that R2 was the only resident with unexplained injuries. The administration also fell short in protecting R2 from a potential abuser. As outlined above, supervisory nurses – particularly LPN Moss – failed in their responsibilities to ensure resident safety.

The facility's administrators were fully aware that LPN Moss was unreliable. For an entire year, they documented instances of her neglecting her duties, violating facility policies, and providing substandard care. Specifically:

- LPN Moss did not attend mandatory in-service training (January 2014). CMS Ex. 21 at 10.

- She did not sign-out narcotics properly (May 2014). CMS Ex. 21 at 9.

- She failed to report an incident when it happened (September 2014). CMS Ex. 21 at 7.

- She did not properly change a fentanyl patch (October 2014). CMS Ex. 21 at 6.

- She failed to document on the medication administration report the medications given (November 2014). CMS Ex. 21 at 5.

- She failed to administer medications (January 2015). CMS Ex. 21 at 2.

Staff members had long complained about the LPN's performance. *See* CMS Ex. 68 at 4-5 (Cole Decl. ¶¶ 18, 19, 20, 21, 22, 23, 24). As they told Surveyor Cole:

- "I told them repeatedly she was a problem and warned them several times she was going to cause us big problems one day[,] and I wanted her gone[.] [N]ow I am right[,] and they see it now."

- "[E]verybody who worked nights knew [she] was impaired and we told anyone who would listen[;] nothing happened til this nightmare happened on New Year's").

CMS Ex. 68 at 4-5 (Cole Decl. ¶¶ 23, 24.

Complaints were also in writing, and some were very specific:

- One employee reported that, on December 24, 2014, LPN Moss came to the nurses' station at about 11:00 p.m. and told the LPN there that she was leaving to get some cigarettes. She did not return until 12:15 a.m. She then took a blanket and pillow and went to the TV room. CMS Ex. 23 at 1. When the employee came to work on December 26, LPN Moss entered the TV room with a blanket and pillow and told staff that she might have a virus. The employee asked her to remove the blanket and pillow from the room when she was finished, which she had not done previously. CMS Ex. 23 at 1.

- The same employee also reported that LPN Moss no longer performed the 5:00 a.m. medication pass. In fact, she was "hardly on C Hall at all except to replace a couple of [fentanyl] patches." CMS Ex. 23 at 2.

- The employee also complained that she had not reported earlier because management did not respond to her complaints. CMS Ex. 23 at 2.

LPN Moss was thus an unreliable employee. Knowing this, management nevertheless assigned her to a critical position in a unit designed for residents requiring a closely-monitored environment. And, even though she was largely responsible for the failures in supervision on the night of the abuse, management assigned her to prepare the investigative reports. Predictably, her reports were inadequate, incomplete, and inaccurate. Yet, no one on the management team seemed to notice.

The facility was therefore not administered in a manner that used its resources effectively to attain or maintain the highest practicable physical, mental, and psychosocial well-being of its residents and was not in substantial compliance with 42 C.F.R. § 483.75.

3. CMS's determination that the facility's substantial noncompliance posed immediate jeopardy to resident health and safety is not clearly erroneous.

Immediate jeopardy. Immediate jeopardy exists if a facility'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 as to the level of a facility's noncompliance (which would include an immediate jeopardy finding) must be upheld unless it is "clearly erroneous." 42 C.F.R. § 498.60(c). The Board has observed repeatedly that the "clearly erroneous" standard imposes on facilities a "heavy burden" to show no immediate jeopardy and has sustained determinations of immediate jeopardy where CMS presented evidence "from which '[o]ne could reasonably conclude' that immediate jeopardy exists." *Florence Park Care Ctr.*,, DAB No. 1931 at 27-28 (2004), *citing Koester Pavilion*, DAB No. 1750 (2000); *Daughters of Miriam Ctr.*, DAB No. 2067 at 7, 9 (2007).

In challenging the immediate jeopardy determination, Petitioner repeats its arguments that it was in substantial compliance and that there is "no basis whatsoever for" CMS's inference that facility staff were "so clueless and incompetent, that one or more residents remained at risk of 'likely death or serious harm.'" P. Post-hrg. Br. at 30.

I have discussed in detail above why the facility was not in substantial compliance. Here, a reasonably strong, aggressive, and unsupervised resident physically attacked his partially-paralyzed and vulnerable roommate. The victim was crying loudly, from which I can reasonably infer that he was frightened and in pain. He was sent to the emergency room with multiple bruises on his wrist, hand, and chest. His hand was swollen, and he needed antibiotics. The facility's noncompliance thus caused R2 serious injury.

Moreover, by their very nature, incidents of physical abuse are likely to cause serious injury or harm. Beyond that, management's inadequate investigation and its failure to report the allegation of abuse create a dangerous situation for all of the facility residents.

CMS's determination that the deficiencies posed immediate jeopardy to resident health and safety is therefore not clearly erroneous.

4. The penalties imposed are reasonable.

To determine whether the CMPs are reasonable, I apply the factors listed in 42 C.F.R. § 488.438(f): 1) the facility's history of noncompliance; 2) the facility's financial condition; 3) factors specified in 42 C.F.R. § 488.404; and 4) the facility's degree of culpability, which includes neglect, indifference, or disregard for resident care, comfort or safety. The absence of culpability is not a mitigating factor. The factors in 42 C.F.R. § 488.404 include: 1) the scope and severity of the deficiency; 2) the relationship of the deficiency to other deficiencies resulting in noncompliance; and 3) the facility's prior history of noncompliance in general and specifically with reference to the cited deficiencies.

I consider whether the evidence supports a finding that the amount of the CMP is at a level reasonably related to an effort to produce corrective action by a provider with the kind of deficiencies found, and in light of the above factors. I am neither bound to defer to CMS's factual assertions, nor free to make a wholly independent choice of remedies without regard for CMS's discretion. *Barn Hill Care Ctr.*, DAB No. 1848 at 21 (2002); *Cmty. Nursing Home*, DAB No. 1807 at 22 *et seq*. (2002); *Emerald Oaks*, DAB No. 1800 at 9 (2001); *CarePlex of Silver Spring*, DAB No. 1683 at 8 (1999).

Here, CMS imposes a penalty of $7,850 per day for each day of immediate jeopardy, which is in the mid to high range for a per day CMP ($3,050-$10,000). 42 C.F.R. §§ 488.408(e)(1)(iii); 488.438(a)(1)(i). For the period of substantial noncompliance that was not immediate jeopardy, CMS imposes a penalty of $300 per day, which is at the low to very low end of the applicable penalty range ($50-$3,000). 42 C.F.R. § 488.408(d)(1)(iii); 488.438(a)(1)(ii). Considering the relevant factors, these penalties are reasonable.

The facility has a history of substantial noncompliance. In the four surveys completed immediately prior to the March 2015 survey – June 2010, July 2011, February 2013, and May 2014 – the facility was not in substantial compliance with health or life safety code requirements. CMS Ex. 39 at 1, 2. Notably, in 2011, deficiencies were cited under the abuse and neglect regulation, 42 C.F.R. § 483.13(c) (Tag F226). During two of the surveys, 2010 and 2014, deficiencies were cited under the quality-of-care regulation, 42 C.F.R. § 483.25(h) (Tag F323) and the administration regulation, 42 C.F.R. § 483.75(*l*)(1) (Tag F514). CMS Ex. 39 at 1.

Petitioner does not claim that its financial condition affects its ability to pay the CMP.

Applying the remaining factors, I have discussed in some detail the facility's multiple failures here. One of its residents was assessed as a potential risk to any resident who was unable to fight. Yet, he was put in the same room with a partially paralyzed man, who was not even capable of complaining. Management assigned the facility's most unreliable nurse to supervise the unit. Not surprisingly, she left the building without telling anyone where she was going. When the aggressive resident attacked a nurse aide, the aide left him alone with his vulnerable roommate. Unable to find the supervising nurse, the nurse aide reported to another nurse, who took no action until she heard an altercation in progress.

After the attack, the administration assigned the same irresponsible nurse to investigate, and her investigation was, predictably, inadequate. Then, disregarding the policies in place to protect its residents, the facility declined to report the abuse.

The facility is culpable for all of these very serious failings.

For these reasons, I find that the relatively modest CMPs are reasonable.

5. CMS's determinations as to the duration of the facility's substantial noncompliance and immediate jeopardy are consistent with statutory and regulatory requirements.

Finally, Petitioner suggests that the duration of the penalties is unfair. However, although it characterizes as "illogical" CMS's underlying "inferences," which led to its finding substantial noncompliance and immediate jeopardy, Petitioner has not argued that it corrected its deficiencies any earlier than the dates determined by CMS (March 26 and June 1).

Once a facility has been found to be out of substantial compliance (as Petitioner was here), it remains so until it affirmatively demonstrates that it has achieved substantial compliance once again. *Ridgecrest Healthcare Ctr.*, DAB No. 2493 at 2-3 (2013); *Taos Living Ctr.* , DAB No. 2293 at 20 (2009); *Premier Living & Rehab Ctr.*, DAB No. 2146 at 23 (2008); *Lake City Extended Care Ctr.*, DAB No. 1658 at 12-15 (1998). The burden is on the facility to prove that it is back in compliance, not on CMS to prove that deficiencies continued to exist. *Asbury Care Ctr. at Johnson City*, DAB No. 1815 at 19-20 (2002). The facility must show that the incidents of noncompliance have ceased *and* that it has implemented appropriate measures to insure that similar incidents will not recur. *Libertywood Nursing Ctr.* , DAB No. 2433 at 15 (2011), *citing Life Care Ctr. of Elizabethton*, DAB No. 2367 at 16 (2011); *accord*, 42 C.F.R. § 488.456(a) and (e); *Hermina Traeye Memorial Nursing Home*, DAB No. 1810 at 12 (2002) (holding that, to be found in substantial compliance earlier than the date of the resurvey, the facility must supply documentation "acceptable to CMS" showing that it was in substantial compliance and *was capable of remaining in substantial compliance* on the earlier date);

Cross Creek Health Care Ctr., DAB No. 1665 (1998). A facility's return to substantial compliance usually must be established through a resurvey. 42 C.F.R. § 488.454(a); *Ridgecrest* at 2-3.

Similarly, CMS's determination that a facility's ongoing noncompliance remains at the level of immediate jeopardy during a given period "is subject to the clearly erroneous standard of review under [42 C.F.R. §] 498.60(c)(2)." *Life Care Ctr. of Elizabethton*, DAB No. 2367 at 16, *quoting Brian Ctr. Health & Rehab./Goldsboro*, DAB No. 2336 at 7-8 (2010). Further, if CMS accepts a deficient facility's plan of correction, the facility must then timely implement all of the steps that it identified in the plan as necessary to correct the cited problems. *Cal Turner Extended Care Pavilion*, DAB No. 2030 at 19 (2006); s*ee also Meridian Nursing Ctr.*, DAB No. 2265 (2009); *Lake Mary Health Care*, DAB No. 2081 at 29 (2007).

Here, Petitioner's problems were not limited to one bad employee or one exceptionally aggressive resident. They reflect systemic problems with management, staffing, and staff training. These are precisely the types of deficiencies that the regulators contemplated when they specified that a facility's return to substantial compliance would usually be established through a resurvey. 42 C.F.R. § 488.454(a)(1). The facility has not met its burden of establishing that it alleviated the immediate jeopardy nor that it returned to substantial compliance any earlier than March 26 and June 1. In fact, the facility explicitly advised the state agency (and CMS) that it would complete correcting its deficiencies on *June 2, 2015*. CMS Ex. 1 at 17, 38, 61, 78, 91, 98, 114. When surveyors revisited the facility on June 10, they determined that the facility returned to substantial compliance on June 2. Nothing in this record suggests that the facility corrected any earlier than that date.

Conclusion

From January 1 through June 1, 2015, the facility was not in substantial compliance with Medicare program requirements and, from January 1 through March 26, 2015, its deficiencies posed immediate jeopardy to resident health and safety. The penalties imposed – $7,850 per day for 85 days of immediate jeopardy and $300 per day for 67 days of substantial noncompliance that was not immediate jeopardy – are reasonable.

/s/
Carolyn Cozad Hughes
Administrative Law Judge