Department of Health and Human Services
DEPARTMENTAL APPEALS BOARD
Appellate Division

The Bridge at Rockwood
Docket No. A-18-25
Decision No. 2954
July 15, 2019

FINAL DECISION ON REVIEW OF ADMINISTRATIVE LAW JUDGE DECISION

The Bridge at Rockwood (Petitioner) timely appealed the decision of an administrative law judge (ALJ) upholding sanctions imposed by the Centers for Medicare & Medicaid Services (CMS), which determined that Petitioner's facility was not in substantial compliance with multiple Medicare program requirements and that its deficiencies posed immediate jeopardy to residents. *The Bridge at Rockwood*, DAB CR4978 (2017) (ALJ Decision). The sanctions included civil money penalties (CMPs) of $7,850 per day for 85 days of immediate jeopardy and $300 per day for 67 days of noncompliance that was not immediate jeopardy.

As explained below, we find the ALJ's findings supported by substantial evidence in the whole record and the ALJ's conclusions free of legal error. We therefore sustain the ALJ Decision and uphold the sanctions imposed.

Case Background

Petitioner operates a long-term care facility (LTC) in Tennessee. The state survey agency received complaints about a facility nurse (referred to herein as LPN TM) failing to distribute medications as ordered and falsifying medication records. A complaint survey, ending on March 27, 2015, resulted in multiple noncompliance findings. CMS Ex. 1. CMS concluded that eight noncompliance findings constituted immediate jeopardy to the facility residents. ALJ Decision at 3-4.[1]

[1] As the ALJ identified, Petitioner did not appeal the deficiencies cited at a level lower than immediate jeopardy. ALJ Decision at 3 n.2. The ALJ also noted that none of the deficiency findings was based on the specific complaints about LPN TM that triggered the survey, even though the facts about LPM TM were confirmed by the survey and not disputed by the facility, which had already terminated her employment by the time surveyor arrived. *Id*. at 4 n.3. We need not discuss any deficiencies which were not cited or not appealed.

The facts underpinning all of the immediate jeopardy findings center on a resident (Resident 10) who was physically strong but who suffered from dementia and depression with behavioral issues. Because the parties hotly dispute in their briefs on appeal many facts related to the immediate jeopardy findings, we mention here only the undisputed outline of the events involved and discuss in our analysis the disputed issues. Resident 10 came to the facility's secure unit after a stay in a geriatric psychiatric hospital unit to which he went after behavioral issues in his prior assisted living placement. Resident 10 shared a room with a second resident (Resident 2) who was severely impaired cognitively and suffered from muscle weakness, paralysis, and a range of other medical issues. On December 18, 2014, Resident 2 was noted to have unexplained bruising on his shoulders. Nursing notes show Resident 10 had some scratches on the same date.

Then, very early on January 1, 2015, a certified nurse aide (to whom we refer as CNA JA) found Resident 10 by Resident 2's bed pulling on the roommate's privacy curtain and bed linens. When CNA JA redirected Resident 10 to his own bed, Resident 10 inflicted scratches on CNA JA's neck (the severity of the attack on CNA JA and resultant injuries were disputed). CNA JA left the room; spoke to a nurse (licensed practical nurse (LPN) MC) who was at the nurses' station which oversaw both the secure unit and another unit; and then proceeded outside where he found his own supervising nurse, LPN TM, taking a smoking break. At some point, while CNA JA was out of the building with LPN TM (the time lapse is disputed), LPN MC heard yelling from the residents' room. LPN MC responded to find Resident 10 leaning over Resident 2 and biting him on neck and shoulders (again, the specifics of Resident 10's position and behavior are in some dispute). Resident 10 was pulled away from Resident 2 (how precisely this took place is also disputed). Resident 10 remained in the room (under what supervision is disputed) until he left the facility permanently later that day. Resident 2 went to the hospital emergency room and received antibiotics and other treatment.

The state surveyor determined, based on the view of these events set out in the Statement of Deficiencies (SOD) (CMS Exhibit 1), that the facility's handling of Resident 10 and response to the incidents demonstrated multiple failures to comply with applicable participation requirements for long-term care facilities and created immediate jeopardy to the facility's residents. CMS agreed and proposed sanctions.

Based on the results of a June 10, 2015 revisit, CMS determined that the facility returned to substantial compliance on June 2, 2015. ALJ Decision at 4 (citing CMS Ex. 35, at 1). CMS imposed CMPs of $7,850 per day for 85 days of immediate jeopardy (January l - March 26, 2015), and $300 per day for 67 days of substantial noncompliance that was not immediate jeopardy (March 27 - June l, 2015), for a total of $687,350 in CMPs. *Id.* (citing CMS Ex. 35, at 7).

Petitioner requested review of the immediate jeopardy findings. The ALJ conducted a hearing on July 18, 2017. The ALJ issued the decision on appeal upholding the total CMPs imposed by CMS. ALJ Decision at 22. This appeal ensued.

Applicable legal authorities

To participate in Medicare, an LTC facility must be in "substantial compliance" with the participation requirements in 42 C.F.R. Part 483, subpart B.[2] 42 C.F.R. §§ 483.1, 488.400. A "deficiency" is a "failure to meet a participation requirement." *Id.* § 488.301. An LTC facility is not in "substantial compliance" when it has one or more deficiencies that have the potential for causing more than minimal harm to residents. *Id.* The term "noncompliance," as used in the regulations, is synonymous with lack of substantial compliance. *Id.*

CMS contracts with state agencies to perform onsite surveys to verify an LTC facility's compliance with Medicare participation requirements. *Id.* §§ 488.10(a), 488.11. Such surveys may be triggered by the receipt of complaints. *Id.* § 488.301 (definition of "abbreviated standard survey").

CMS may impose enforcement remedies based on the survey results, including a per-day CMP, on an LTC facility that is not in substantial compliance. *Id.* §§ 488.400, 488.402(b), (c), 488.406. CMS determines the amount of a CMP based on multiple factors, which include the "seriousness" of the noncompliance. *Id.* §§ 488.404(b), 488.438(f). "Seriousness" encompasses scope ("isolated," "pattern," or "widespread") and severity (whether the deficiency constituted no actual harm with a potential for minimal harm; no actual harm with a potential for more than minimal harm that is not immediate jeopardy; actual harm that is not immediate jeopardy, or immediate jeopardy). *Id.* § 488.404(b). "Immediate jeopardy means a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident." *Id.* § 488.301.

An LTC facility may appeal a CMS determination of noncompliance that has resulted in the imposition of a CMP or other enforcement remedy. *Id.* §§ 488.408(g)(1), 498.3(b)(13). During a hearing in such an appeal, an LTC facility may challenge the duration and the reasonableness of the amount of any CMP imposed. *See, e.g., Lutheran Home at Trinity Oaks*, DAB No. 2111, at 21 (2007). A per-day CMP may accrue from

[2] On October 4, 2016, CMS issued a final rule that redesignated and revised the participation requirements for LTC facilities effective November 28, 2016. *See* Final Rule, Medicare and Medicaid Programs; Reform of Requirements for Long-Term Care Facilities, 81 Fed. Reg. 68,688, 68,726 (Oct. 4, 2016). Unless specified otherwise, this decision cites to the version of the regulations in effect on the dates of the surveys that provided the bases for CMS's determination. *See Carmel Convalescent Hosp.*, DAB No. 1584, at 2 n.2 (1996) (applying regulations in effect on the date of the survey and resurvey).

the date the facility was first out of substantial compliance until the date it is determined to have achieved substantial compliance. 42 C.F.R. § 488.440(a)(1), (b). CMS's determination on the level of noncompliance, specifically here whether it constitutes immediate jeopardy, must be upheld unless it is clearly erroneous. *Id.* § 498.60(c)(2).

The participation requirements (and related tag numbers used by the surveyor) cited at the immediate jeopardy level were: 42 C.F.R. § 483.10(b)(11) (Tag F157); 42 C.F.R. §§ 483.13(b) and 483.13(c)(1)(i) (Tag F223); 42 C.F.R. § 483.13(c) (Tag F224); 42 C.F.R. §§ 483.13(c)(1)(ii)-(iii) and 483.13(c)(2)-(4) (Tag F225); 42 C.F.R. § 483.13(c) (Tag F226); 42 C.F.R. § 483.25(h) (Tag F323); 42 C.F.R. § 483.75 (Tag F490) and 42 C.F.R. § 483.75(o)(1) (Tag F520). ALJ Decision at 3-4 (citing CMS Ex. 1).

Section 483.10 imposes on each facility the duty to "protect and promote the rights of each resident." Subsection 483.10(b)(11) deals with required notifications of changes, including in relevant part:

> (i) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is—
>
> (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;
>
> (B) A significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications) . . . .

Section 483.13 addresses resident behavior and facility practices. Subsection 483.13(b) provides that a facility resident "has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion." Subsection 483.13(c) addresses facility policies for treatment of residents and staff standards as well as requirements for investigating and reporting abuse allegations. Specifically, the subsection provides as follows:

> (1) The facility must—
>
> (i) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion;
>
> * * *

> (2) The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).
> (3) The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.
>
> (4) The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.

The introductory language of section 483.25, titled "Quality of care," provides that "[e]ach resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care." The specific relevant requirement provides as follows:

> (h) *Accidents*. The facility must ensure that—
> (1) The resident environment remains as free of accident hazards as is possible; and
> (2) Each resident receives adequate supervision and assistance devices to prevent accidents.

The overarching requirement governing facility administration, set out in the introductory paragraph of section 483.75, provides that a "facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident." CMS also cited the specific provision at subsection 483.75(o)(1) relating to requirements for a quality assessment and assurance committee.

Standard of review

The standard of review on a disputed factual issue is whether substantial evidence in the record as a whole supports the ALJ's decision. The standard of review on a disputed issue of law is whether the ALJ's decision is erroneous. Guidelines - Appellate Review

of Decisions of Administrative Law Judges Affecting a Provider's Participation in the Medicare and Medicaid Programs, https://www.hhs.gov/about/agencies/dab/different-appeals-at-dab/appeals-to-board/guidelines/participation/index.html (last visited July 11, 2019).

Analysis

1. The ALJ's factual findings are supported by substantial evidence in the record as a whole.

A. Our role on reviewing the challenge to the ALJ's findings

Our analysis of Petitioner's arguments first requires resolving the essential disputed facts, especially those regarding the two incidents involving Resident 10 on January 1, 2015. Most of Petitioner's legal arguments depend on accepting Petitioner's version of what occurred and what, therefore, was required of the facility staff. We first analyze Petitioner's challenges to the ALJ's factual findings and address remaining legal questions in the second part of this decision.

Petitioner characterizes these incidents as unfortunate but to be expected or unavoidable in a special unit caring for residents with behavior issues, and denies that the facility's handling of the residents involved was in any way deficient. Thus, Petitioner reasons that CMS (and the ALJ) is (are) effectively making special units themselves impermissible by holding them automatically liable for all unpredictable behavior by demented residents, even if the staff has done everything right and without acknowledging the nature of the residents housed there. *See, e.g.*, Petitioner's Request for Review (RR) at 1, 6-7, 10-11.

CMS (and the ALJ), by contrast, view the facility as having failed in multiple ways to heed warnings about Resident 10's history (and about Resident 2's particular vulnerabilities), not having taken sensible measures to reduce foreseeable risks, and then having responded inappropriately to the escalating agitation and violence of Resident 10 culminating in bloody injuries to Resident 2. Each party accuses the other of mischaracterizing the record evidence or distorting the facts in various ways. *See, e.g.*, RR at 9, 28; Petitioner's Reply Brief (Reply) at 4-5; CMS Br. at 9.

To resolve this dispute, we first lay out the ALJ findings, followed by Petitioner's alternate version of events. We then consider what the record supports about the areas of material dispute. In so doing, we review the ALJ's factual findings, as stated above, to determine if they are supported by substantial evidence in the record as a whole. We do not undertake to weigh the competing versions of events afresh ourselves, as the Board has repeatedly explained:

> When an ALJ has rendered a decision on the evidentiary record, the Board "does not re-weigh the evidence or overturn an ALJ's choice between two fairly conflicting views of the evidence"; instead, "the Board determines whether the contested finding could have been made by a reasonable fact-finder tak[ing] into account whatever in the record fairly detracts from the weight of the evidence that the ALJ relied upon." *River City Care Ctr.* at 4 (citing *Universal Camera Corp. v. NLRB*, 340 U.S. 474, 488 (1951)) (internal quotation marks omitted).

Maysville Nursing & Rehab., DAB No. 2874, at 10 (2018) (emphasis added). Where the ALJ has made credibility determinations and evaluated the weight to assign to conflicting evidence, we will defer to the ALJ as the finder of fact unless Petitioner demonstrates a compelling reason not to do so. *Consolidated Home Health*, DAB No. 2878, at 12 (2018), and cases cited therein.

We address the key disputes of fact below after we summarize the two accounts. As to the main points, we explain why we conclude that substantial evidence fully supports the ALJ's findings. We have examined the record closely even as to those details not fully discussed in this decision. Our review demonstrates that the ALJ findings were supported by substantial evidence and that, where evidence in the record potentially conflicted with or detracted from a finding, the ALJ adequately indicated why she found it less credible or gave it less weight.

B. The ALJ's findings

The ALJ found that the evidence supported the following account of the key events.

> <u>The unexplained injuries - December 18, 2014</u>. On December 18, 20I4, 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.
>
> 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. 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 [CNA JA]. [CNA JA] discovered R10 harassing a sleeping R2, tampering with R2's privacy curtain and bed linens. When [CNA JA] intervened, R10 responded by attempting to choke him and succeeded in scratching his neck, making him bleed. [CNA JA] extricated himself from the resident's grasp and exited the room, leaving R2 alone with R10. [CNA JA] intended to report the attack to his supervisor [LPN TM], but could not find her. She had left the unit without telling anyone where she was going. [CNA JA] reported the incident to [LPN MC], who instructed him to "tell Traci." [CNA JA] 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." . . . He found [LPN TM] 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 [CNA JA].

In the meantime, for another ten minutes or so, [LPN MC] 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. R2 "let out a yell." [LPN MC] left the room and ran up the hall for help. She returned with [CNA AS]. They pulled R10 off R2. [LPN MC] reported that she saw bite marks on R2 and that R2 was "crying tears." They kept the residents separated, and, eventually, [CNA JA] and [LPN TM] reappeared. [CNA JA] confirmed that R2's hand was swollen, and he was crying loudly for his mother.

In a witness statement, dated January 1, 2015, and an undated follow-up statement, [CNA AS] graphically describes the incident: at about 3:00 a.m. (she estimated the time was "about 20 minutes" after [CNA JA] left the building following his conversation with [LPN MC] and his unsuccessful search for [LPN TM]), she heard [LPN MC] 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 MC] was attempting, unsuccessfully, to get R10 off R2. R10's mouth was bloody and he "looked like an enraged zombie cannibal." [CNA AS] 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, [CNA JA] returned to the room, and R10 was "at least" willing to sit on his own bed, so [CNA AS] left to get ice.

> [CNA AS] told Surveyor Cole that she personally observed the assault for "at least" ten minutes; "pillows and side tables were scattered everywhere." She also reported that 25-30 minutes elapsed between the beginning of the attack and the time [LPN TM] finally appeared.
>
> 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. . . . R2 returned at about 6:30 a.m. with a new order for antibiotics. 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.

ALJ Decision at 8-10 (footnotes and record citations omitted). The ALJ also found evidence that the facility knew or should have known, well before these incidents, that R10 was capable of aggression and violence and that R2 was particularly vulnerable. *Id.* at 7-8. Furthermore, she considered the follow-up inadequate in that (1) facility records show only that R10 was on 15-minute checks for 2½ hours but remained in the facility for more than five more hours without documented monitoring and (2) the investigation report filled out by LPN TM was mostly blank and what information was included was inconsistent or inaccurate. *Id*. at 10-12.

C. Petitioner's version of the same events

Petitioner's contrasting account is set out most fully in its initial brief. RR at 8-29. In essence, Petitioner asserts that Resident 10 was an appropriate admission to the secure unit where some behaviors must be expected; that physicians at the psychiatric hospital cleared him for the placement; and that the facility did not receive any information indicating Resident 10 was aggressive or assaultive. *Id*. at 13-16. Moreover, even had the staff learned of combative behavior with staff in prior placement, they would have considered that unrelated to potential aggression toward other residents. *Id*. at 14-15, 17.

Petitioner attributes Resident 2's bruises on December 18, 2014, to the resident crawling under furniture and denies any association to the scratch on Resident 10 on the same date. *Id*. at 18-19. Petitioner calls the findings regarding Resident 10's "attack" on CNA JA "exaggerated" and instead states that Resident 10 was merely "fiddling" with the privacy curtain and that scratching the nurse while being redirected to his own bed was an unremarkable event. *Id*. at 18-19. Petitioner claims CNA JA spent ten minutes with the resident to ensure he was deescalated before leaving to inform his supervisor. *Id*. at 21.

According to Petitioner, LPN TM was taking a brief smoking break nearby (as allowed by facility policy). LPN MC was readily available to consult at the nurses' station. *Id*. at 23-24. LPN MC was not concerned by the report that the confused resident had scratched the CNA. CNA JA knew where to find LPN TM in front of the building, reported to her, and went back in right away when he heard LPN MC yelling for help whereupon he fetched LPN TM. *Id*. at 24-25. LPN MC and CNA SA had separated the residents when CNA JA returned. They reported "they had found Resident #10 kneeling next to Resident #2's bed, apparently biting him on the hand and shoulder." *Id*. at 25. They also said that "when they told [Resident 10] to stop, he simply stood up and sat down on his bed." *Id.* at 26. All of this happened around 3 AM, within moments of when CNA JA was scratched. *Id*.

Resident 2 had only a "bite mark on a finger," and "[b]oth Residents were monitored throughout the remainder of the night – Resident #10 never came out of his room, where he remained alone – and nothing further of note occurred." *Id*. at 26-27. Resident 2 went to the hospital at 4:30 AM and returned "with no serious injuries noted and an order for prophylactic antibiotics." *Id*. at 27 (record citations omitted). He had no memory of the incident and no sign of fear. Facility management reviewed the investigation and incident report by LPN TM later the same day and determined it was sufficient. *Id.* at 27-28. Staff determined the incident did not need to be reported to the state agency because Resident 10 was incapable of intentional abuse. *Id*. at 28-29.[3]

D. The ALJ's findings did not overlook the context of secure units in evaluating foreseeable risks of accidents and the prevention of resident-on-resident abuse.

Petitioner argues that the existence of special care units entails accepting a "*potential* risk of behavioral incidents" in order that agitated confused residents have somewhere to go, and that facilities cannot be expected to "predict and prevent all instances of unwanted behavior" in such units. RR at 30 (italics in original). Petitioner states that the "appropriate threshold question" in a secure unit situation is whether the facility enhanced, or failed to mitigate, this unavoidable level of risk. *Id*.

We disagree. The correct question, however, is not whether a facility avoided all "potential" risk nor whether it failed to mitigate risk below some "unavoidable" level. The correct question is whether the facility did what it reasonably could to ensure that all residents received supervision needed to "mitigate foreseeable risks of harm" based on what it knew about the residents, their care needs, and the conditions in the facility. *See Owensboro Place & Rehab. Ctr*., DAB No. 2397, at 8 (2011); 42 C.F.R § 483.25(h). While specific resident needs, foreseeable risks, and reasonable preventive measures may

[3] Notably, much of Petitioner's factual discussion in its brief lacks clear citations to specific record evidence, making it difficult to determine the basis for its assertions.

vary in the multitude of situations presented in different long-term care facilities and are judged by the corresponding standards of care, the underlying regulatory responsibilities are defined no differently for secure or special units.

E. The facility knew or should have known that Resident 10 had a history of and potential for aggressive behaviors toward others well before the relevant incidents.

The ALJ began answering the question of what risks were foreseeable and whether the facility responded with all reasonable measures by looking at what the facility knew about these two residents, so we turn to Petitioner's challenges to those findings. The ALJ found that the facility had access to information that Resident 10 posed a foreseeable risk to others because the psychiatric hospital had documented a significant history of aggressive behavior of which the facility learned or should have learned during extensive pre-admission communications. ALJ Decision at 7.

As the ALJ noted, Resident 10 went to the psychiatric hospital from an "assisted living situation 'due to behavior issues and vascular dementia,'" after hitting a nurse there, and "was described as paranoid, occasionally combative, and non-cooperative," having "recently become more violent and aggressive." *Id*. (citing CMS Ex. 11, at 1, 4) (records of the psychiatric hospital). He was documented to be "an elopement risk and a fall risk and he *could be a risk to other residents who cannot fight.*" *Id.* (citing CMS Ex. 11, at 2, 4-5). He was "physically and verbally abusive to staff" in the psychiatric hospital. *Id*. (citing CMS Ex. 11, at 43).

Petitioner asserts that its staff probably did not see the psychiatric hospital's assessments so it should not be charged with knowledge of that evaluation of the resident's risks. RR at 13, 16, 31. Petitioner admits, however, that its staff had multiple contacts with the hospital before agreeing to accept the transfer (RR at 15-16), and the record includes facility requests to the hospital for updated notes on the resident before acceptance. *See, e.g*., CMS Ex. 11, at 7. Petitioner's Admission Director (KP) testified that she spoke numerous times with the discharging psychiatric hospital and that an admission person (KN) from a related facility nearer the hospital visited and saw the resident. Petitioner Ex. 20, at 1. KN was allegedly only made aware of "exit-seeking" behavior which made Resident 10 appropriate for a locked setting. *Id*. at 2. Director KP stated hospital staff said that Resident 10 had "no behaviors." *Id*. at 1. Petitioner's prescreening form checks "wandering or elopement behavior" but not "combative behavior." CMS Ex. 11, at 8.

In an interview with the surveyor, however, KN said that, although she read some of the medical records, she is not a nurse (her degree is in marketing) and she only skimmed the medical notes, finding no information about behavioral issues. CMS Ex. 3, at 115. In her own interview, Director KP said that "aggressive behaviors towards others" and medical documentation of "psychosis paranoia or delusions" would be "red flags" for

non-admit or additional inquiry for pre-screening, and that she should have seen the relevant documents. *Id.* at 116. Petitioner implies in its briefing and questioning that the psychiatric hospital may have withheld relevant information, even that the hospital statement that the resident was "as stable as he could get" might be "code for 'we wanted to get him out and good luck to the next place.'" RR at 16; Tr. at 48-49.[4] In her written direct testimony, Director KP acknowledges that the manager of the psychiatric hospital unit told the surveyor that Resident 10 had "had prior incidents that required restraint" but denied that she was given that information prior to accepting him for admission. Petitioner Ex. 20, at 2; Tr. at 47 (surveyor testified the hospital records KN skimmed show Resident 10 "had been restrained during his psychiatric hospitalization for violent behaviors towards others . . . .").

The ALJ could reasonably infer that Petitioner had, or should have had with due diligence, sufficient information to be on notice to plan for a resident whose physical and mental condition posed a risk of abuse to other residents. Evaluating Petitioner's claims that it did not know, despite its many communications with the psychiatric unit and access to review his records from his two-week stay there, that Resident 10 was prone to aggressive or violent behaviors is precisely the kind of fact-finding for which deference is due to the ALJ who conducted the hearing. Petitioner has shown no compelling reason to disturb the ALJ's determination that the facility's after-the-fact denials of awareness were either not credible, or at best reflected a failure to fully assess or plan for the placement.

Although Petitioner insists the ALJ is effectively saying that no such resident can ever be admitted to any nursing home, the ALJ in fact made clear that the requirement instead is simply that a facility undertaking such care must take reasonable steps to forestall and mitigate foreseeable harm when caring for a potentially aggressive, physically strong resident with dementia. ALJ Decision at 14.[5] The surveyor did opine that Resident 10 was an inappropriate admission to Petitioner's facility, as Petitioner notes. RR at 14;

[4] Despite its suggestions that the psychiatric hospital may not have provided it accurate information, Petitioner still insists the ALJ should have rejected the surveyor's opinion that Resident 10 was an inappropriate admission to Petitioner's facility on the grounds that hospital approval for discharge to the nursing home amounted to a medical opinion approving the placement. RR at 14. The ALJ was not obliged to infer from the hospital clearing the resident for discharge to a secure unit that Petitioner was prepared to care for him.

[5] The Board has rejected similar contentions in the past. For example, the petitioner in one case argued that facilities would have to reject all residents who had even one instance of inappropriate behavior or would have to isolate them completely based on that ALJ's application of regulatory standards. *Somerset Nursing & Rehab. Ctr.*, DAB No. 2353, at 7 (2010), *mod. on other grounds*, *Somerset Nursing & Rehab. Facility v. U.S. Dep't of Health & Human Servs.*, 502 F. App'x 513 (6th Cir. 2012). The ALJ in that case, as in this one, imposed no standard that would require such drastic consequences. The ALJ found that the facility "was, or should have been, aware of" the resident's long history of sexual aggression, saw evidence of "volatile and violent behavior" after admitting the resident, and yet "Somerset failed to plan adequately or implement adequate supervision to manage the resident's behavioral problems or to institute effective interventions to protect other residents." *Id.* The Board upheld the ALJ's findings.

Reply at 16. That opinion did not reject the hospital physician's assessment of the level of care Resident 10 needed, however. He based it on his conclusion that the survey showed that Petitioner's facility was "not equipped to provide adequate care to a resident who exhibited violent and aggressive behavior with severe cognitive impairment and in order to protect other secured unit residents." CMS Ex. 68, at 7 (surveyor testimony). He never said, in other words, that Resident 10 could not be properly cared for in **any** secured nursing home placement but that **this** facility was not prepared to care for him adequately. In any case, the ALJ did not find fault with Petitioner having admitted Resident 10 at all, but instead faulted it for admitting him without planning for and providing adequate supervision and environmental measures to avoid him causing harm to himself or other residents from the behavioral manifestations of his illnesses.

Moreover, even had the facility not had access to information before admission that Resident 10's behaviors could present a danger to others (which, as we have said, it did have), the ALJ credited considerable additional evidence that put the facility on notice of that fact after admission but well before the January 1, 2015, incident. ALJ Decision at 7-8. For example, the facility's care plan conference notes dated December 10, 2014, record that Resident 10 "can be phy[sically] abusive at times per family." CMS Ex. 14, at 19. A December 18, 2014, quarterly assessment for continuing use of psychotropic medication finds that Resident 10 is "verbally and phys[ically] abusive toward staff." *Id*. at 21. An assessment, dated December 20, 2014, documents that Resident 10 had suffered "delusions" and, in the past week, exhibited "verbal behavioral symptoms directed toward others" and "physical behavioral symptoms directed toward others" (defined to include "hitting, kicking, pushing, scratching, grabbing, abusing others sexually"). *Id*. at 38; *see also id.* at 9 (care plan for Resident 10's behavioral issues with goal that he not harm himself or others).

Petitioner dismisses the information from the resident's family (which it says was received only after admission) because it did not specifically warn of "abusive behavior *toward other residents*." RR at 16 and n.8 (emphasis in original). Petitioner argues that references to abusive or combative behavior toward staff or non-residents are irrelevant to assessing whether a resident might display such behavior toward another resident. RR at 14-15 (citing Petitioner Ex. 20, at 2). Petitioner cites the testimony of its admission director for this proposition, but she merely opines that many dementia patients are combative to caregivers and that having a history of such behaviors would not have been a reason to reject Resident 10. Petitioner Ex. 20, at 2. This opinion is well short of claiming that a history of combativeness with caregivers has no bearing on assessing the potential for aggressive behaviors that may impact other residents.

And, contrary to Petitioner's argument (RR at 14), CMS did offer conflicting evidence on which the ALJ could reasonably rely. On cross-examination, the surveyor was asked whether, in his opinion, "as a trained psychiatric nurse," there was "a difference between residents being aggressive towards staff and being aggressive towards each other." Tr. at 66. He responded: "Aggression is aggression no matter who it's directed toward. It's a form of violence. . . . And whether it's directed at staff or whether it's directed at other residents in terms of the potential harm, you know, violence is violence, sir." *Id*.

Petitioner sought to impeach the surveyor's testimony on the grounds "he had some experience in acute psychiatric care, but none in long term care;" and that his views arose from his "personal opinion that there is no functional, practical or legal difference between patients in *acute* psychiatric facilities, and patients in nursing facilities who suffer from dementia with behaviors." RR at 8, 10 (emphasis in original). This misstates both the surveyor's background and his testimony.

His direct testimony was that he had been a registered nurse since 1994 and had "17 years of clinical experience in geriatric psychiatric ('Geri-Psych') care including experiences in locked secure units in acute psychiatric hospitals, assisted living facilities and residential homes for the aged, as well as extensive experience in the management of dementia and related medical and behavioral issues in the home health setting." CMS Ex. 68, at 1. That experience included "behavioral symptom assessment and management" and "pre-screening of individuals for admission to assisted living center secure units," as well as follow-up evaluation of the appropriateness of the placements. *Id*. Director KP testified as to her background and training only that she had been in the same position at the facility for 33 years. Petitioner Ex. 20, at 1.

On cross-examination, the surveyor had declined to agree with the counsel's blanket assertion that "the patient population in acute psychiatric facilities is different from skilled nursing facilities," responding: "Not necessarily." Tr. at 40. We fail to see why the ALJ should find that answer unreasonable, when the record here shows that geriatric dementia patients may indeed move between the two kinds of facilities. We see no reason that the ALJ could not reasonably give greater weight to the surveyor's expertise.

In short, we determine that the ALJ's findings concerning the risks presented by Resident 10 of which the facility should have been aware and for which it should have planned reasonable measures to prevent harm to him or other residents are supported by substantial evidence in the record as a whole.

F. The facility had reason to know that Resident 2 was especially vulnerable as a roommate for Resident 10, should have recognized that both had unexplained injuries on December 18, 2014, and should have considered these facts in care-planning for them.

Resident 2 who was placed in the same room as Resident 10 was, as noted, severely cognitively impaired. ALJ Decision at 7 (citing CMS Ex. 4, at 18, 24). He was partially paralyzed, used a wheelchair, and was at risk of abnormal bleeding due to use of anticoagulant medication. *See* CMS Ex. 4, at 7 (admission record), 9-12 (nursing notes), 13 (weekly assessment), 20 (care plan).[6] The ALJ commented that no one explained the decision to place these residents together when one was "aggressive and potentially violent" and the other was "vulnerable and effectively defenseless." ALJ Decision at 8. Petitioner responded that no clear standard of care precluded the facility from making Resident 2 and 10 roommates or required completely isolating Resident 10. RR at 17. This response, like so many of Petitioner's arguments, misconstrues the facility's regulatory responsibilities and the point the ALJ was making.

The facility was required to make professional judgments on supervision and environment (including room placements) with a view to mitigating foreseeable accidents or hazards, preventing abuse, and providing care needed for all residents to reach their "highest practicable physical, mental, and psychosocial well-being." 42 C.F.R. § 483.25. The ALJ's point is that Petitioner identified nothing in the care plans or records of the two residents showing any thought was given to whether this particular pairing was appropriate given the disparities she noted or how to mitigate problems that might arise. The Board has found in the past that failure to consider roommate selection (where pairing a resident with known potential to abuse with a particularly vulnerable resident) may be evidence of inadequate risk assessment in identifying reasonable steps to protect residents from abuse. *Countryside Rehab. & Health Ctr*., DAB No. 2853 (2018).

Petitioner argues that Resident 10's prior combativeness with staff was insufficient to be a "clear predictor of imminent violence *toward his roommate*." RR at 17 (emphasis in original). A facility should not require a clear prediction of imminent violence to consider whether a mobile, physically active resident with a history of acting out aggressively would be better paired with a resident capable of moving easily to leave a situation, capable of remembering and communicating about untoward events, and/or capable of some self-protection (and perhaps not also prone to dangerous bleeding).

[6] Petitioner suggests that Resident 2 "was not necessarily as 'defenseless' as the ALJ posits" because Resident 2's dementia also had "*behavioral manifestations.*" RR at 18 (emphasis in original). Resident 2's care plan indicates that one behavior he manifested was to get on the floor and "work" on things like toilets or air conditioners as a former engineer, and advised plans to offer safe things for him to work on. CMS Ex. 4, at 21. Petitioner does not explain how this would make him any less vulnerable to aggressive behavior from a stronger, more mobile resident. Nor is it evident how his other manifestation of "exit-seeking" behavior would make him less defenseless. *Id*. at 22.

Foreseeability of risk does not mean that the specific timing or targeting of an episode must be apparent in advance or imminent. *See, e.g.*, *Countryside* at 16-17.

This issue became more concrete on December 18, 2014, when Resident 2 was found with unexplained bruising. The facility reported the bruising discovered on both his shoulders as being of unexplained origin after an investigation in which "staff examined all residents and found no other injuries of undetermined origin." ALJ Decision at 8 (citing CMS Ex. 4, at 10; CMS Ex. 7, at 6-7; CMS Ex. 9, at 1-2, 6-9). The ALJ found that this investigative report to the state agency was "wrong" because in fact staff found other unexplained injuries on Resident 10 (scratches on his chest) on the same day. *Id*. (citing CMS Ex. 10).

Petitioner calls the ALJ's concern about this "particularly bizarre," saying it "seems to suggest that any and all of [Resident 2's] bruises over the months of his stay were of 'unknown origin' and thus could have been the result of abuse," perhaps by Resident 10 although he arrived "only in December, 2014." RR at 18-19. (Petitioner also hints, a bit inconsistently that an altercation in which Resident 10 got scratched conflicts with the view of Resident 2 as "passive." *Id*. at 19 n.10.) According to Petitioner, the facility ultimately found that the bruises resulted from Resident 2's habit of crawling on the floor on his back. *Id*. at 19 (citing CMS Ex. 3, at 46; CMS Ex. 4, at 25; CMS Ex. 7, at 6-16).

The ALJ nowhere suggested that all episodes of bruising in prior months implied abuse, nor did she determine that Resident 2's bruises on December 18 were caused by an altercation with Resident 10 or could not have been caused by crawling on the floor. The ALJ did point out correctly that the facility failed to report that Resident 10 also had injuries on the same date. A careful review of the record generally supports the ALJ's findings. Nursing notes show bruising to Resident 2's bilateral shoulders on December 18, 2014, still "continuing to heal" through December 25, 2014. CMS Ex. 4, at 10, *see also id.* at 95-96 (skin check assessments). The report of the bruising says only that the bruises were noted while changing his gown and that no cause was identified. CMS Ex. 7, at 6-7. The state investigative report specifically states the facility reported conducting "full skin assessments on every resident in the facility at the time and no other injuries of unknown origin were identified." CMS Ex. 9, at 2 (despite the actual assessment at CMS Ex. 10 showing Resident 10's unexplained injuries). Staff did inform the investigators about Resident 2's behavior of getting on the floor to tinker with things, although staff said he was not seen doing that on December 18 and that ultimately no conclusion was reached about the actual cause for the bruises. *Id*. at 3, 6-9.

We find that the ALJ could reasonably infer that the fact that "each of the two roommates presented with unexplained injuries on the same day," which was not disclosed to the state agency, called for more inquiry and at least some "greater vigilance to ensure that the roommates were not injuring each other." ALJ Decision at 8.

Here again, we find no reason to disturb the ALJ's findings about the vulnerability of Resident 2 as a roommate to Resident 10, and the facility's treatment of the injuries of December 18. These facts are relevant to whether the facility took all reasonable steps in planning and care to ensure as much as practicable that Resident 10's behavioral manifestations not cause harm to Resident 2 or others.

G. The ALJ's material findings as to Resident 10's attack on CNA JA are supported by substantial evidence in the record.

As an overarching observation, we note that Petitioner's account of this interaction, as well as of the subsequent assault on Resident 2, relies heavily on its position that the ALJ could not properly reject the credibility of its "undisputed eyewitness testimony" presented in the form of written direct statements. *See, e.g.*, RR at 21 and n.13. Petitioner argues the ALJ lacked the "usual means" to evaluate the witnesses in person (since CMS did not ask to cross-examine Petitioner's witnesses) and that she improperly simply dismissed all Petitioner's testimony as not credible. *Id*. We reject this position.

First, Petitioner is mistaken that the fact that a witness is not cross-examined somehow makes the witness unimpeachable or the content of the testimony undisputed. A witness may be found less than credible, for example, based on evidence of prior inconsistent statements, based on internal indicia of reduced reliability or plausibility in the testimony, or based on contrary evidence from other witnesses or documents.

Second, the ALJ did not reject all of Petitioner's witnesses out of hand or ignore their testimony. She found the direct testimony of the eyewitnesses to the events of January 1, 2015, mostly consistent with their contemporaneous statements. ALJ Decision at 12-13. She concluded, however, that where the testimony prepared for the litigation minimized or downplayed aspects of the events or omitted telling details, she gave more credence to the more "contemporaneous statements" as "the most reliable accounts of the event." *Id*. at 13 (citing *Cedar Lake Nursing Home*, DAB No. 2390, at 9 (2011), *aff'd Cedar Lake Nursing Home v. U.S. Dep't of Health & Human Servs.*, 481 F. App'x 880 (5th Cir. 2012); *accord, Woodland Oaks Healthcare Facility*, DAB No. 2355, at 8 (2010)).

For example, Petitioner claims in briefing (with no citations to the record) that there is "no evidence that Resident #10 was touching, or trying to touch, Resident #2 himself at this point" (during the first interaction in which the CNA was scratched) and that CNA JA "wrote immediately after the event, and testified, that Resident #10 was *not* being aggressive toward Resident #2 . . . ." RR at 20 (emphasis in original). Petitioner also says CNA JA testified that "he probably spent 'ten minutes or more'" at Resident 10's bedside after the attack before leaving to make his report. *Id*. at 21.

But CNA JA's handwritten statement from the facility's own investigation actually says that he told LPN TM that Resident 10 had "attacked me as I tried to get [Resident 10] away from [Resident 2]." CMS Ex. 15, at 1. LPN MC's statement to the facility investigation reports that CNA JA came to her at the nurses' station to say Resident 10 "attacked" him. CMS Ex. 16, at 1. Asked what happened, CNA JA told her that "he was trying to get [Resident 10] away from [Resident 2] because he was trying to get [Resident 2] out of bed." *Id*. Even in his later handwritten statement to the surveyor in March 2015, CNA JA states that he found Resident 10 "messing with" Resident 2's bedding and the privacy curtain, "tried to redirect him[,] and he physically attacked my neck and made me bleed." Petitioner Ex. 2, at 3. Only in his testimony prepared for litigation does CNA JA refer to the first encounter as merely finding Resident 10 "fiddling" with the curtain and pulling on blankets on his sleeping roommate's bed. Petitioner Ex. 23, at 2. In that testimony, he also minimizes the attack on him somewhat, saying Resident 10 "yanked away without warning" and "put his hand" to the aide's neck and scratched it "drawing some blood." *Id*. The ALJ reasonably credited the aide's earlier statements which show Resident 10's initial behavior as directed at interfering with his roommate and as escalating to violent action to attack the aide when he intervened.

Similarly, CNA JA's investigatory statement says only he was attacked by Resident 10 when trying to get him away from Resident 2 and says nothing about taking any further measures to control Resident 10 before heading to the nurses' station. CMS Ex. 15, at 1-2. In his later statement to the surveyor, CNA JA then asserts that he made sure Resident 2 was "ok" and Resident 10 was "in the bed" before he left to find his supervising nurse. Petitioner Ex. 2, at 3. Only in the testimony prepared for litigation does he suggest, rather vaguely, a longer stay: "When I left, Resident #10 was settling himself in his bed. He had de-escalated and was no longer a problem. I do not know precisely how long I was in the room after the scratch, but it could very well have been ten minutes or more . . . ." Petitioner Ex. 23, at 2.[7] In no statement does CNA JA make the claim asserted in the brief that "he probably spent 'ten minutes or more'" in the room. RR at 21. Here, again, the ALJ was not obliged to accept the later embellishments over the witnesses' starker accounts given closer to the events and before the stakes for the witnesses' employer became clear, much less counsel's further elaborations beyond the evidence. *See, e.g.*, ALJ Decision at 15.

Given the facts the ALJ found, Petitioner's argument that "there was nothing improper about a CNA simply calming and redirecting a confused resident who has a history of wandering in the middle of the night back to his bed," even if the resident happened to scratch the CNA while being redirected, is a non sequitur that completely fails to address

[7] The relevance of adding the "ten minutes" timeframe may be that the facility policy for de-escalating agitated residents requires staff to stay "with the resident for **at least** 10 minutes after the incident" and never leave them alone if agitated. CMS Ex. 30, at 4 (emphasis added).

the real situation. RR at 22. The scenario Petitioner paints may not be improper, but the same cannot be said of a CNA leaving a resident with a history of aggressive behavior who attacked you and drew blood as you tried to divert him from pulling at his roommate in bed alone with that helpless roommate.

The ALJ also found that, after he was attacked, CNA JA went to LPN MC who was located at the shared nurses' station because he did not know where the nurse assigned to the secure unit (LPN TM) had gone. ALJ Decision at 8-9. LPN MC instructed him to tell LPN TM what happened but took no further action herself at that point. *Id*. CNA JA found LPN TM, according to the ALJ's findings, on the front porch smoking, where both remained for some time. *Id*. at 9.[8]

Petitioner denies that LPN TM had left her post without telling anyone and claims that CNA JA wrote at the time (as well as testifying later) that he simply "went to the front of the building where I know that [LPN TM] takes a smoke break." RR at 25 (quoting Petitioner Ex. 23) (internal quotation marks omitted). After all, Petitioner states, facility nurses could take two 15-minute breaks so long as the other nurse "stayed at or near" the nurses' station. *Id*. at 24 (citing CMS Ex. 19, at 2). Petitioner misrepresents the record.

CNA JA's contemporaneous statement says nothing about knowing where LPN TM was when Resident 10 attacked him. CMS Ex. 15, at 2. LPN MC's contemporaneous statement says he came to her at the nurses' station and she told him to tell LPN TM. CMS Ex. 16, at 1. The ALJ could reasonably infer from these statements that neither CNA JA nor LPN MC was aware that LPN TM was on a break or knew where she was. The handwritten statement CNA JA made to the surveyor is consistent with this inference. He says he went to tell "my nurse," i.e., LPN TM, about the attack on him; he told LPM MC about it instead, and she said to "find Tracy;" and he then found her "out

[8] Petitioner suggests that the timeframes involved are crucial and that the ALJ believed that the first attack occurred at 1:30 AM and that Resident 10 was left alone until 3 AM. RR at 21; Reply at 9. The ALJ made no such finding. While the surveyor reported some staff said the first attack happened around 1:30 AM or 2 AM (Tr. at 83-84), the ALJ merely found that the first attack happened "[s]ometime in the early hours of January 1, 2015." ALJ Decision at 8. She also found that LPN MC continued working "for another ten minutes or so" after CNA JA talked to her, before she heard yelling. The key eyewitness, CNA JA, put in his original statement to facility investigators that the attack on him occurred at 2:30 – 3 AM. CMS Ex. 15, at 2. He put the time at "around 3" AM when he heard LPN MC "screaming" from the residents' room for him to get LPN TM. *Id*. at 1. CNA AS reported in her original statement in the investigation that about twenty minutes elapsed between when CNA JA was attacked and went to try to find LPN TM and when she heard LPM MC screaming for help from the residents' room. CMS Ex. 17, at 2. In sum, the ALJ did not base her conclusions on finding that more than an hour elapsed and the record does not support Petitioner's claim that everything "unfolded immediately." Reply at 9. It was not necessary (and probably not possible) for the ALJ to determine the precise timeline in order to conclude that CNA JA left the residents alone instead of calling for help and that neither LPN went promptly to check on them after being told of the first attack until the yelling indicated the assault on Resident 2 was in progress.

front." Petitioner's Ex. 2, at 3. Even the written testimony in which CNA JA says he knew that the front porch was where LPN TM took smoke breaks never indicates that he knew LPN TM had taken a break at the time. It appears that when instructed to look further for her, he simply looked where she tended to go.

Petitioner identifies no evidence that LPN TM **was** actually on a scheduled break or had notified either the other nurse (LPN MC) who could cover for her or the CNA who needed to report to her.[9] The exhibit Petitioner cites (CMS Exhibit 19, at 2) merely shows that LPNs TM and MC served together on the 7PM to 7AM shift on that wing with two assigned CNAs. Petitioner argues that LPN TM's absence was "immaterial," since the ALJ focuses on the actions of CNA JA and LPN MC. RR at 24, n.15. That focus is inevitable because those were the staff members who were at least present and took some actions.

The layout shows that the secure unit had twelve resident rooms (Petitioner Ex. 17) for which LPN TM was responsible with CNA JA assigned to assist her. Twenty rooms are shown in the rest of the wing for which that nurses' station shared responsibility. The ALJ could reasonably conclude that LPN TM's absence contributed materially to the facility failing to provide adequate supervision, since it left CNA JA alone in the secure unit with only one nurse covering the whole wing, with neither knowing where she would be or for how long. This is especially concerning in the context of the facility's failures discussed above to fully understand Resident 10's history and plan his environment appropriately.

H. The ALJ's material findings as to Resident 10's attack on Resident 2 and its aftermath are also supported by substantial evidence in the record.

Turning to the specifics of the resident-on-resident episode, Petitioner claims that LPN MC and CNA AS "reported – and testified" that Resident 10 was merely "leaning over" Resident 2 and, when they "told him to stop, he simply stood up and sat down on his bed." RR at 26 (citing Petitioner Exs. 1, 18, 21). This account again distorts the record as a whole developed before the ALJ, and she described it as "plainly false." ALJ Decision at 12. Indeed, we agree, as neither of the named witnesses ever reported or testified as Petitioner claims.

[9] Indeed, the surveyor's notes show that LPN MC told him specifically that LPN TM "left the unit without notifying anyone and . . . was located by [CNA JA] who was looking for her." CMS Ex. 3, at 91. In her testimony, LPN MC did not deny making this statement. P. Ex. 18. Petitioner fired LPN TM before the surveyor arrived, for her failure to deliver ordered medication, and did not attempt to subpoena her. LPN TM did not provide direct testimony about her whereabouts nor did she address that question in her minimal investigative report on the incident, as discussed elsewhere in this decision.

LPN MC reported in the facility investigation that she heard a man yell, went down the unit, and found Resident 10 "on top of" Resident 2 "who was laying in bed" and who "let out a yell." CMS Ex. 16, at 1. She stated that she saw "bite marks" on Resident 2, who was "crying tears," and that she and CNA AS "kept them separated until" LPN TM arrived. *Id*. CNA AS reported that Resident 10 "attacked" Resident 2 and was "on top of him naked forearm choking & biting him, very much did not want to stop 'hurting him.'" CMS Ex. 17, at 1. She stated that LPN MC was "trying to get" Resident 10 off Resident 2 and that Resident 10 "had a bloody mouth." *Id.* at 2. In her testimony for the hearing in this case, CNA AS acknowledged that she earlier used "colorful and shocking expressions," such as "enraged zombie cannibal," but wanted to "add" that they were able to separate the residents and Resident 10 did calm down. Petitioner Ex. 21, at 1. In other words, she does not disclaim her earlier language as inaccurate. LPN MC's later testimony comes closest to the version in Petitioner's brief, describing Resident 10 as "kneeling over, biting [Resident 2] on the hand," and saying the two staff members "spoke very quietly" with the residents while separating them. Petitioner Ex. 18, at 2.[10]

Clearly, the versions prepared for litigation are far less, as CNA AS put it, colorful, but none of the accounts accords with the claims made in Petitioner's brief. The ALJ made clear that she compared the direct and dramatic contemporaneous accounts of the event with the diluted versions in the later written direct testimony and, where they differed, found the former much more credible. ALJ Decision at 13. We have no reason to disturb the ALJ's judgment in that regard.

We find the same pattern persists with regard to Petitioner's attacks on the ALJ's findings concerning the aftermath of the attack, i.e., Petitioner recasts elements of its exhibits as exculpatory when they are not, while ignoring record evidence relied on by the ALJ. *See, e.g.,* RR at 26-29. For example, Petitioner asserts that it is "undisputed that the Center's staff confined" Resident 10 to his room until he was discharged, but cites nothing documenting any such confinement. RR at 37; *see also* RR at 27 (He "never came out of his room."). The sole evidence Petitioner cites for these claims is a 24-hour report noting the altercation and stating that Resident 2 was moved to a different room and calling for checks on him each every 15 minutes. CMS Ex. 8.

[10] Petitioner pointed to the surveyor's assertion that staff should have responded with what was termed a "Mr. Strong" technique, as showing the surveyor had an exaggerated view of the incident. RR at 10, 22, 36. Petitioner characterizes this technique as "an 'all hands' response to physically restrain the person." RR at 10. The surveyor in fact defined the technique as far more nuanced, involving training specialized team members to use safe holds, de-escalation interventions, and modalities to reduce risks of harm to all concerned. CMS Ex. 68, at 6; *see also* CMS Ex. 3, at 122 (surveyor noting Petitioner's staff showed "limited knowledge re Dr. Strong process especially after hours. Limited knowledge re team composition, who responds, no recurrent in-services, drills etc, know how to call, nobody knows who responds after hours."). In any case, the ALJ made no findings about whether the staff should have used "Mr. Strong" techniques to deal with Resident 10's attacks. We therefore see no reason to revisit what those techniques involve and whether they should have been employed.

The surveyor testified that the only documentation of actual 15-minute checks on Resident 10 reflected that all such checks were before 7:30 AM (shown on CMS Exhibit 34, at 2), and that he found no evidence of any such monitoring after that (when the shifts changed) until Resident 10 was discharged from the facility later in the afternoon. Tr. at 103-05. Petitioner points to no such documentation and does not identify testimony from any staff member asserting that they performed 15-minute checks on him. Thus, no evidence in the record conflicts with the ALJ's factual findings (ALJ Decision at 11) which show that even after the violent attack on Resident 2, facility staff failed to even carry out the planned monitoring to ensure other residents were protected from potential abuse.

As for the after-care of Resident 2, Petitioner argues that he "left for" the hospital about 4:30 AM, "not, as the ALJ's Decision recites, an hour earlier." RR at 27 (citing ALJ Decision at 10). This assertion misstates both the ALJ's findings and the record. The ALJ found the **call** for the ambulance was made at 3:56 AM. ALJ Decision at 10. The ambulance log (which the ALJ found more reliable than the facility records) shows that the ambulance crew arrived at the facility at 4:03 AM and left with the patient at 4:18 AM. CMS Ex. 6, at 1. Petitioner does not offer any refutation of the ALJ's finding that LPN TM's record of performing checks on Resident 2 every 15 minutes from 4:30 AM to 7 AM is thus patently false. ALJ Decision at 10-11; CMS Ex. 34, at 1.

Petitioner also states that Resident 2 had "no serious injuries noted." RR at 27. Its own nurses recorded that, after return from the emergency room, he had bruising on his left hand at wrist, on his right middle knuckle, and on his chest on the left side of his rib cage, as well as swelling on his left hand; and late that night he was still complaining of pain when moving his left hand. CMS Ex. 4, at 10, 11. The ALJ's findings about the facility's handling of the residents after the attack are supported by substantial evidence.

We come to the same conclusion about the ALJ's findings that the investigation of the episode was "minimal." ALJ Decision at 11. Even a cursory review of the initial investigative report prepared by LPN TM reveals its inaccuracies and glaring omissions, some of them summarized by the ALJ. CMS Ex. 7, at 1-3.

Petitioner argues that incident reports may be revised over several days, but then says that the "Center's managers determined later the same morning that no additional information was needed to address the matter." RR at 28. So it is not merely that the initial report required later additions. Some revisions were actually made, but they do not include providing the missing information and, in some regards, they too are not accurate.[11]

[11] For example, an addendum added January 5, 2015, states that Resident 2's hand injury was assessed and "no orders received according to nursing." CMS Ex. 7, at 3. But it is undisputed that Resident 2 was placed on a course of prophylactic antibiotics to deal with the human bite injuries. A brief undated "synopsis of events" by the Director of Nursing merely reports what LPN TM told him and concludes everyone "responded appropriately" and no changes in policy or procedure were needed. CMS Ex. 18.

Petitioner's argument merely establishes that the administration endorsed the inadequate investigative report prepared by the nurse whose absence from her duty station contributed to the event.

2. Petitioner's remaining legal arguments are without merit and show no error of law in the ALJ Decision.

A. The ALJ did not impose a "strict liability" standard in evaluating Petitioner's noncompliance.

Petitioner argues that the noncompliance findings are based on "impos[ing] obligations on nurses that are indistinguishable from the 'strict liability' and 'clairvoyance' theories of liability the Board has held many times are not incorporated" into the compliance regulations. RR at 1. By "clairvoyance," Petitioner apparently means that "where it is *foreseeable,* if not predictable, that such residents suddenly may act out – then the facility accepts strict regulatory liability for the consequences of any such incident." RR at 33 (emphasis in original).

We first note that the entire concept of strict liability is inapplicable to regulatory enforcement.

> [T]he Board has routinely rejected attempts to import tort principles into federal administrative proceedings involving long-term care facilities that receive federal funding for participating in Medicare and Medicaid. *See, e.g., Lifehouse of Riverside Healthcare Ctr.*, DAB No. 2774, at 19 (2017) (rejecting the argument that the facility was being held to a "strict liability" standard for purposes of compliance with the accident prevention provisions of section 483.25(h)) and cases cited therein; *Beverly Health Care Lumberton*, DAB Ruling 2008-05, Denial of Petition for Reopening of DAB No. 2156, at 6 (May 2, 2008) (rejecting the argument that the Board "imputed liability" on facilities based on the liability of facility employees or agents, in the context of a deficiency based on resident abuse); *Briarwood Nursing Ctr.*, DAB No. 2115, at 11 n.8 (2007) ("strict liability" is a tort concept inapplicable to 42 C.F.R. Part 498 proceedings).

Kindred Transitional Care & Rehab – Greenfield, DAB No. 2792, at 12 (2017). The regulations establish what constitutes substantial noncompliance and reviewers must look, as the ALJ did here, to the specific provisions at issue to evaluate it.

Petitioner specifically argues that the ALJ imposed strict liability because she referred to the facility's "obligation to keep all of their residents safe." RR at 33 (citing ALJ Decision at 14). But the ALJ did not conclude that, if any resident experienced any

mishap, the facility perforce violated regulatory standards. On the contrary, the ALJ made express and detailing findings about the actions and inactions of the facility and its staff, concluding they "fell short in multiple ways." ALJ Decision at 14. These failures included eight examples listed in bullet points. *Id*. at 14-15. Among the listed shortcomings were: disregarding warnings about Resident 10's danger to residents unable to protect themselves; housing Resident 10 with just such a resident; failing to explore why both roommates had unexplained injuries on December 18, 2014; LPN TM abandoning her post in the secure unit; CNA JA leaving Resident 2 alone with Resident 10 after Resident 10 had attacked CNA JA violently; LPN MC failing to check on the residents, or send someone else to do so, after CNA JA reported the attack to her; and staff generally failing to respond to the situation with Resident 10 until it escalated to violent assault on Resident 2. *Id*., and record citations therein.

The ALJ correctly analyzed these multiple failures in terms of the regulatory requirements. In relation to 42 C.F.R. § 483.25(h), the Board has made clear 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.'" *Heritage Plaza Nursing Ctr*., DAB No. 2829, at 6 (2017) (citing inter alia *Briarwood Nursing Ctr.*, DAB No. 2115, at 5 (2007)); *see also Owensboro Place & Rehab. Ctr.* at 8; *Woodstock Care Ctr. v. Thompson*, 363 F.3d 583, at 589 (6th Cir. 2003) (upholding Board and ALJ's finding that the facility "failed to take all reasonable precautions against residents' accidents"). The ALJ clearly identified reasonable steps that the facility could have taken, but did not, to mitigate the foreseeable risk of harm from its care of a resident with Resident 10's history and conditions.

The regulation at section 483.13(b) flatly states that all residents have a right to be free of physical abuse, so theoretically the analysis of noncompliance under that provision could end with the fact that Resident 2 was physically abused. The Board has nevertheless recognized "a distinction between 'staff-to-resident' abuse and 'resident-to-resident' interactions for purposes of determining compliance with section 483.13(b)." *Kindred* at 10. The reason is that a facility "may not disavow the wrongdoing of its staff" and therefore any "considerations of foreseeability are inapposite when . . . staff abuse has occurred." *Id*. (quoting *Springhill Senior Residence,* DAB No. 2513, at 15 (2013) (quoting in turn *Gateway Nursing Ctr.*, DAB No. 2283, at 8 (2009))) (internal quotation marks omitted). By contrast, while residents may harm each other, the facility's responsibility for protecting them from each other cannot extend to "entirely unforeseeable risks." *Id*. at 9-10 (citing *Woodstock Care Ctr.*, DAB No. 1726, at 25-35 (2000), *aff'd, Woodstock Care Ctr. v. Thompson*, 363 F.3d 583 (6th Cir. 2003)). Hence, the Board has held that "determining whether a facility failed to protect a resident's right to be free from abuse when another resident behaved harmfully depends on whether the facility staff had a basis to be aware that such behavior might occur and yet left the resident vulnerable to it." *Id.* at 11.

The ALJ, therefore, was correct in applying the same analysis of whether the facility did all it could to prevent or mitigate risks of harmful resident-on-resident behavior, whether the behavior is viewed as accidental or abusive.

B. Petitioner relies on an inapplicable "causation" requirement.

Petitioner reframes its argument about liability at times in terms of some requirement for CMS to prove the facility's conduct "caused" the bad behavior or its consequences. For example, Petitioner suggests that the "Board's task" is somehow, "short of blessing regulatory 'per se' or 'strict liability,' . . . to determine what manifestations of a resident's illness may be charged to a nursing facility as a violation of its regulatory obligations, and which incidents – if any – do not illustrate any cause and effect relationship between some act or omission by the facility staff, and the unwanted outcome." RR at 6. This statement is less than clear, but to the extent Petitioner suggests that CMS must show that the facility caused Resident 10's behavioral symptoms or caused Resident 10 to attack Resident 2, Petitioner is mistaken (and understandably therefore cites no authority for its proposition as to what the Board's tasks are).

Petitioner attempts to clarify its point with an analogy that it admits is imperfect. The analogy seems to be that, given that the "Board presumably would not ipso facto impose regulatory liability on a facility" just because a resident with cardiac problems suffers chest pains, the Board should similarly not "categorically treat the behavioral manifestations of mental illness any differently." RR at 6-7. As Petitioner states, the ALJ Decision "plainly does not address the record in such terms" (*id*. at 7), and for good reason, because they are inapposite. The only possible analogy here is that, just as the regulations would hold a facility noncompliant if it failed to identify, plan for, and provide appropriate care to a resident with known heart disease, so a facility is equally responsible if it fails to identify, plan for, and provide appropriate care to a resident with behavioral symptoms of dementia known to present dangers to himself or others.

In short, the Board does not undertake to determine whether the facility "caused" a manifestation of a resident's illness or a particular incident but whether the facility met the regulatory requirements for providing compliant care to the resident to maximize as much as practicable the well-being of all residents.

In a different presentation of what appears to be the same argument, Petitioner contends that CMS is not permitted to "impose sanctions simply upon broad critiques of a facility's staff, admission policies, care planning, abuse investigation, and the like, *without* drawing any causal connection between those critiques and the incident that supposedly triggered

the enforcement action." Reply at 4 (emphasis in original). Petitioner suggests that the ALJ is treating its case as if the "only 'causation' necessary to sustain a sanction is that the facility decided to admit a resident who turned out to behave badly a few weeks later." *Id*.

As was abundantly clear in the ALJ's findings (and our discussion above), the facility is not being sanctioned for merely admitting a resident who happened to later "behave badly." The sanction here is not simply because an incident occurred. The Board has repeatedly explained that the occurrence of an accident (of whatever type) is neither necessary nor sufficient to find noncompliance with section 483.25(h). *See, e.g., W. Tex. LTC Partners, Inc., d/b/a Cedar Manor*, DAB No. 2652, at 11 (2015), *aff'd, W. Tex. LTC Partners, Inc. v. HHS*, 843 F.3d 1043 (5th Cir. 2016) (Board long rejected argument that "accident must actually occur before a facility can be cited for noncompliance") (citing *Clermont Nursing & Convalescent Ctr*., DAB No. 1923, at 21 (2004) (Section 483.25(h) calls for a "risk-oriented analysis" and "does not require that either an accident or resident injury actually occur for a violation to exist."), *aff'd, Clermont Nursing & Convalescent Ctr. v. Leavitt*, 142 F. App'x 900 (6th Cir. 2005). The occurrence of an incident or accident may expose the failure of a facility to identify a risk and take reasonable steps to eliminate or minimize it, depending on the factual circumstance. Or such a failure may come to light in a survey despite the residents having fortuitously escaped being subject to an incident. There is no requirement to prove that a specific act or omission by the facility caused a particular adverse outcome.

The regulatory structure under which this case proceeds is indeed "outcome-oriented," in the sense that the regulations focus on what goals facilities are to accomplish while permitting facilities to choose among reasonable means to accomplish those goals to suit their individual setting and residents. *See Lifehouse* at 15 ("regulation broadly prescribes outcomes facilities must meet, facilities have flexibility to choose the specific methods as appropriate to their circumstances and to employ reasonably necessary measures to comply with the regulation), and cases cited therein; *see also* 42 C.F.R. § 488.26(c)(2). But the basis for finding noncompliance here is that the facility failed to take reasonable steps to accomplish the responsibilities it undertook. Hence, the "causation" of the particular outcome is simply not the issue.

C. Petitioner was required to report the resident-on-resident attack as abuse.

Petitioner admits that Resident 10's January 1, 2015, attack on Resident 2 was never reported to the state agency. RR at 29; CMS Ex. 3, at 111. The ALJ noted that facilities must report all allegations of abuse, whether or not substantiated. ALJ Decision at 16. The regulations require facilities to report "all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source" to the state agency, as well to

fully investigate, prevent any further "potential abuse" in the meantime, and then to report the results of the investigation within five days and take any "appropriate corrective action." 42 C.F.R. 483.13(c)(2)-(4); CMS Ex. 25, at 3-4 (Petitioner's own policy also requires reporting all allegations of abuse).

Petitioner argues that its administrator decided "the matter did not have to be reported to the State as resident to resident 'abuse,' because [Resident 10] was incapable of forming the intent to abuse." RR at 29 (citing CMS Ex. 3, at 110-11 (surveyor notes of conversation with administrator)). Petitioner also acknowledges it took no corrective action, but says this was because its interdisciplinary team "saw no reason" since "sudden behavioral incidents, while undesirable, were foreseeable on the Bridge unit from time to time because of the nature of the residents' ailments, and staff had already been trained accordingly." *Id*.

These arguments are unsustainable as a matter of both law and fact. The ALJ rejected the idea that a resident with dementia cannot be the subject of an abuse allegation. ALJ Decision at 16. She did so in accordance with longstanding Board decisions analyzing the applicable regulations and concluding that dementia does not necessarily preclude sufficient intent to constitute abuse under the regulatory definition.

The Board has discussed in several cases the meaning of abuse as used in these regulations. Abuse need not be "intentional," i.e. need not involve an intent to cause injury. "The regulation does not use the word 'intentional.' While the word 'willful' can have a number of dictionary definitions, the Board has held that as used in section 488.301, the word 'willful' means that the actor must have acted deliberately, not that the actor must have intended to inflict injury or harm (or one of the other specified types of prohibited conduct)." *Merrimack Cnty. Nursing Home,* DAB No. 2424, at 5 (2011) (citing *Britthaven, Inc., d/b/a/ Britthaven of Smithfield*, DAB No. 2018, at 4 (2006); *Western Care Management Corp., d/b/a Rehab Specialties Inn*, DAB No. 1921, at 14 (2004); *Vandalia Park*, DAB No. 1939, at 9 (2004)).

A resident with cognitive deficits or dementias may nevertheless be capable of directing aggressive actions toward another person by will, as opposed to injuring another resident accidentally, such as by stumbling into them. Where such a resident directs assaultive behavior at another resident, it is not necessary as a matter of law to discern the precise level of active intent on the part of aggressor to conclude that the victim is experiencing abuse from the willful act of the other. As the Board has explained, the goal of section 483.13(b), keeping residents free from abuse, could not be achieved, "if a facility could be found in compliance even though it failed to take reasonable steps to protect residents from potentially injurious acts which it knew or should have known might occur and

which might be willful, in any sense of that word." *Western Care* at 14-15 (footnote omitted). The requirement to keep residents free of abuse extends to protecting them from attack by "a resident with a known propensity to engage in potentially injurious behaviors such as hitting or kicking others, [even where] the resident has cognitive deficits." *Id*. at 14.

Moreover, as a factual matter, the record contains evidence that Resident 10 did in fact act with deliberate will to hurt Resident 2, albeit the intent may have been symptomatic of Resident 10's underlying mental condition. As mentioned earlier, CNA AS reported that, when Resident 10 was told to stop hurting Resident 2 whom he was choking, hitting and biting, Resident 10 made clear that he "very much did not want to stop 'hurting him.'" CMS Ex. 17, at 1.

Furthermore, regardless of whether a full investigation might have concluded otherwise, Petitioner's obligation to investigate and report the results to the state agency did not depend on whether the attack was substantiated as abuse. *Rockcastle Health & Rehab. Ctr.*, DAB No. 2891, at 12 (2018); *Singing River Rehab. & Nursing Ctr.*, DAB No. 2232, at 8 (2009) ("[T]he regulation explicitly requires reporting of the results of ***all*** investigations of abuse, not merely those that substantiate abuse. Thus, facilities are not free to view their internal investigations as an opportunity to 'pre-screen' whether an alleged or suspected instance of abuse is substantiated or involves specific bad actors, i.e., staff." (emphasis in original)).

We conclude that the ALJ correctly rejected Petitioner's claim that it could avoid investigating and reporting the assault on Resident 2 because its Administrator believed Resident 10 incapable of abuse.

D. We uphold the immediate jeopardy determination and the CMP amount.

Petitioner asks us to "set aside" the "lengthy CMP CMS imposed as clearly erroneous." RR at 40. This request appears to conflate contentions that the immediate jeopardy determination was clearly erroneous, that the immediate jeopardy ended at some earlier point than the ALJ found, and that the CMP was unreasonable. Petitioner offers little argument as to why any of the ALJ's conclusions on these issues were wrong.

Petitioner's references to the immediate jeopardy determination and the duration of immediate jeopardy amount to straw-man arguments about their factual underpinnings. For example, Petitioner argues that, "even if [LPN TM] was the worst nurse in history, that fact does not make CMS' allegations of 'systemic' noncompliance true, nor its conclusions about continuing 'immediate jeopardy' – for many weeks after the incident – appropriate." RR at 30; *see also* Reply at 1. Similarly, Petitioner derides the ALJ's

acceptance of "an expansive view of the alleged noncompliance (spiced by additional (uncited) allegations relating to [LPN TM])" to support her determination of immediate jeopardy and continuing noncompliance "for some four months *after* the offending Resident #10 was discharged; and a CMP in the amount of $667,250." RR at 9 (emphasis in original; footnote omitted).

The immediate jeopardy determination was not based on finding LPN TM to be the worst nurse in history and Resident 10 was not the offender in the facility's noncompliance. LPN TM's abandonment of her duty station, repeated false documentation, and inadequate and inappropriate "investigative" report were simply elements of Petitioner's overall failures to identify risk, plan reasonable measures to forestall foreseeable consequences from those risks, protect residents from abuse, respond properly to harmful episodes, and otherwise meet its regulatory responsibilities, as discussed above. Resident 10's behavior caused Resident 2 to experience abuse, but the offender was the facility that failed in its duties to its residents who depended upon its systemic operations.

The Board has held that a facility found to have placed residents in an immediate jeopardy situation is presumed to continue to present immediate jeopardy unless the facility shows that the determination of continued immediate jeopardy is clearly erroneous. *Brian Ctr. Health & Rehab./Goldsboro,* DAB No. 2336, at 7-8 (2010), and cases cited therein. The facility must allege and prove that it has abated the conditions that created the immediate jeopardy and act to prevent their recurrence. *Life Care Ctr. of Elizabethton*, DAB No. 2367, at 16 (2011). Petitioner acknowledges this presumption, yet argues it is inapplicable absent proof that Petitioner's "policies and procedures governing training, admission to and operation of the Bridge Unit, abuse prevention, and the like . . . all were so inadequate, and [its] staff so clueless and incompetent, that one or more residents remained at risk of 'likely death or serious harm' for some three months after the subject incident." RR at 39. We find no support for this argument.

Petitioner's quality assurance group agreed in a meeting on the morning of March 26, 2015, to implement corrective measures to remove the immediate jeopardy. CMS Ex. 44. Those measures were set out in a five-page allegation of removal of immediate jeopardy concluding that the facility "alleges jeopardy removal on 3/26/15." CMS Ex. 46, at 5. Despite the fact that many of the measures set out were only alleged to begin on March 25, 2015 (*id*. passim), the surveyor accepted on March 27, 2015, that Petitioner had abated its immediate jeopardy conditions on March 26, 2015, as alleged. CMS Ex. 1. (Petitioner alleged, and a later revisit confirmed, substantial compliance with the remaining deficiencies, which Petitioner has not contested here, as of June 2, 2015); ALJ Decision at 22 (citing CMS Ex. 1, at 17, 38, 61, 78, 91, 98, 114).

Petitioner has provided no basis for us to conclude that it abated the immediate jeopardy, or even recognized the existence of the problems that caused it, at any date earlier than it alleged. Petitioner has not shown it identified and corrected issues with its handling of potentially aggressive residents, its staff's capacity for and awareness of proper care-planning and incident management, or its understanding of its responsibilities to recognize, prevent, investigate and report resident-on-resident abuse at any point between when the events at issue here occurred and when the surveyor discovered the conditions that they exposed.

We conclude that Petitioner has shown no error in the ALJ's conclusion as to the duration of immediate jeopardy.

The CMP imposed here included $7,850 per day for the duration of the immediate jeopardy. Although Petitioner states it challenged the amount of the CMP in its request for hearing (RR at 7), it offers no argument before the Board as to why this amount is unreasonable. The ALJ provided a detailed analysis of the relevant factors, including Petitioner's extensive prior noncompliance (with the same regulatory provisions and others), the absence of any claim of a relevant financial condition, and its culpability for the staff's failures and its administration's poor decision-making which resulted in serious consequences. ALJ Decision at 20-22. We find no reason to disturb the ALJ's conclusion.

Conclusion

We affirm the ALJ Decision.

/s/
Christopher S. Randolph

/s/
Constance B. Tobias

/s/
Leslie A. Sussan
Presiding Board Member