Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

In the Case of:	
Brookshire Health Care Center (CCN: 01-5127),	Date: November 27 2007
Petitioner,	
- v. -	Docket No. C-06-456
	Decision No. CR1693
Centers for Medicare & Medicaid Services.	

DECISION

I sustain the imposition of civil money penalties (CMPs) by the Centers for Medicare & Medicaid Services (CMS) against Petitioner, Brookshire Health Care Center, Huntsville, Alabama, for failure to comply substantially with federal requirements governing participation of long-term care facilities in Medicare and state Medicaid programs. For the reasons that follow, I uphold the CMP of $3050 per day from January 25, 2006 through February 24, 2006, based on a finding of immediate jeopardy, and the CMP of $50 per day for the period from February 25, 2006 through March 14, 2006. Additionally, I uphold the prohibition on Petitioner's conducting a nurse aide training or competency evaluation program (NATCEP) for a two-year period.

I. Background

On February 25, 2006, the Alabama Department of Public Health (State Agency) completed a complaint and extended complaint survey at Petitioner's facility to determine whether Petitioner was in compliance with participation requirements.[1] CMS exhibits

[1] The State Agency initially surveyed Petitioner on February 8, 2006. This initial (continued...)

(Exs.) 2-4. Petitioner was found out of substantial compliance with three participation requirements. The state agency determined the scope and severity of the deficiencies to be at a "G" Level,[2] but CMS reviewed the survey findings and determined instead that the deficiencies rose to a level of immediate jeopardy, a "J" Level. The State Agency amended the original notice and notified Petitioner on March 14, 2006, of the change and issued a revised statement of deficiencies (SOD) reflecting the immediate jeopardy determination. CMS Ex. 8. On March 23, 2006, CMS notified Petitioner that it was imposing remedies, including a CMP of $3050 per day from January 25 through February 24, 2006, and a CMP of $50 per day from February 25 until substantial compliance was achieved; a mandatory denial of payment for new admissions (DPNA), effective May 25, 2006; mandatory termination of Petitioner's participation agreement on August 25, 2006, if non-compliance persisted; and a prohibition on Petitioner's conducting a NATCEP as a result of the finding of immediate jeopardy. CMS Ex. 9. A May 3, 2006 re-visit found the facility in substantial compliance, effective March 15, 2006. CMS Ex. 11. By letter dated May 9, 2006, CMS notified Petitioner that it was in compliance, effective March

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[1](...continued)
survey found no deficiencies, but, as CMS did not make a finding or impose remedies based on this survey, it is not an "initial determination" or a basis for Petitioner's hearing request. *See* 42 C.F.R. § 498.3(b)(13). The survey concluding on February 25, 2006 found deficiencies, which the State Agency initially cited at a Level G. The fact that CMS directed the State Agency to increase the severity of the deficiency findings to a level of immediate jeopardy is not an issue I can hear. *See Lake Mary Health Care*, DAB No. 2081, at 3-4 (2007). I look only to whether there is a basis for CMS to impose a remedy against Petitioner and whether the immediate jeopardy finding is clearly erroneous.

[2] The scope and severity of a deficiency is determined in accordance with the factors set forth at 42 C.F.R. § 488.404(b). The severity categories range from deficiencies that result in "no actual harm with a potential for minimal harm" to ones that pose "immediate jeopardy" to resident health or safety. 42 C.F.R. § 488.404(b)(1). The scope ranges from "isolated" to "pattern" to "widespread." 42 C.F.R. § 488.404(b)(2). A provider is deemed in substantial compliance if the only deficiencies that exist pose no greater risk than the potential for minimal harm. 42 C.F.R. § 488.301. Letter designations for scope and severity levels (as set forth in the State Operations Manual (SOM), Chapter 7, section 7400.E) range from an isolated incident with no actual harm with a potential for minimal harm (Level A) to widespread immediate jeopardy (Level L). A Level G scope and severity level is an isolated deficiency that constitutes actual harm that is not immediate jeopardy. A Level J is an isolated incident constituting immediate jeopardy.

15, 2006, and thus the DPNA and termination did not go into effect. CMS Ex. 12. Petitioner requested a hearing on May 17, 2006, and the case was assigned to me for hearing and decision.

I held a hearing in this case on June 26 and 27, 2007, in Birmingham, Alabama. Testifying for CMS were Sheila Underwood (a State Agency Surveyor) and Ronald Holland (a State Agency Special Investigator). Testifying for Petitioner were Kathi Duke (Petitioner's parent corporation's Continuous Quality Improvement (CQI) Director); John Wagner, M.D. (Petitioner's Medical Director); Barry Bell (Petitioner's parent corporation's Regional Executive Director and the Interim Administrator at Petitioner's facility); Teresa Jackson (Petitioner's Risk Management Nurse); Tina Townsend (an Administrative Assistant at Petitioner's facility); Douglas Adams, M.D. (Resident 1's psychiatrist); Tonya Powers (a State Agency Surveyor); Rick Harris (Director of the Bureau of Health Providers at the State Agency); Brent B. Davis (an employee of Madison County Mental Health); and John W. Thompson, M.D. (Petitioner's expert witness). At the hearing, CMS offered and I received into evidence CMS Exs. 1-20. Petitioner offered and I received into evidence Petitioner's (P.) Exs. 1-22. Subsequent to the hearing, the parties submitted post-hearing briefs (CMS Br. and P. Br.) and response briefs (CMS Response and P. Response).

Based on the testimony offered at the hearing, the documentary evidence, the arguments of the parties, and the applicable law and regulations, I find that Petitioner was not in substantial compliance on the dates determined by the State Agency and CMS. I further find that CMS was authorized to impose a CMP of $3050 for the period January 25 through February 24, 2006, and $50 per day from February 25 through March 14, 2006, and that Petitioner was prohibited by law from conducting a NATCEP for a two-year period.

II. Applicable Law and Regulations

Petitioner is a long-term care facility. Its participation in Medicare and Medicaid is subject to sections 1819 and 1919 of the Social Security Act (Act), and to the regulations at 42 C.F.R. Part 483. Sections 1819 and 1919 of the Act vest the Secretary with authority to impose remedies, including CMPs, against a long-term care facility for failure to comply substantially with participation requirements.

The Secretary has delegated to CMS and the states the authority to impose remedies against a long-term care facility that is not complying substantially with federal participation requirements. The applicable regulations at 42 C.F.R. Part 488 provide that facilities which participate in Medicare may be surveyed on behalf of CMS by state

survey agencies in order to ascertain whether the facilities are complying with participation requirements. 42 C.F.R. §§ 488.10-488.28. The regulations contain special survey conditions for long-term care facilities. 42 C.F.R. §§ 488.300-488.335. Under Part 488, a state or CMS may impose a CMP against a long-term care facility where a state survey agency ascertains that the facility is not complying substantially with participation requirements. 42 C.F.R. §§ 488.406, 488.408, and 488.430. The CMP may start accruing as early as the date that the facility was first out of compliance until the date substantial compliance is achieved or the provider agreement is terminated. 42 C.F.R. § 488.440.

The regulations specify that a CMP that is imposed against a facility on a per day basis will fall into one of two broad ranges of penalties. 42 C.F.R. §§ 488.408, 488.438. The upper range of CMP, of from $3050 per day to $10,000 per day, is reserved for deficiencies that constitute immediate jeopardy to a facility's residents, and, in some circumstances, for repeated deficiencies. 42 C.F.R. §§ 488.438(a)(1)(I), (d)(2). The lower range of CMP, from $50 per day to $3000 per day, is reserved for deficiencies that do not constitute immediate jeopardy, but either cause actual harm to residents, or cause no actual harm, but have the potential for causing more than minimal harm. 42 C.F.R. § 488.438(a)(1)(ii).

The regulations define the term "substantial compliance" to mean:

> [A] level of compliance with the requirements of participation such that any identified deficiencies pose no greater risk to resident health or safety than the potential for causing minimal harm.

42 C.F.R. § 488.301.

"Immediate jeopardy" is defined to mean:

> [A] situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident.

42 C.F.R. § 488.301.

The Act and regulations make a hearing before an administrative law judge (ALJ) available to a long-term care facility against whom CMS has determined to impose a CMP. But the scope of such hearings is limited to whether an *initial determination* made by CMS is correct. Act, section 1128A(c)(2); 42 C.F.R. §§ 488.408(g), 498.3(b)(13). The hearing before an ALJ is a *de novo* proceeding. *Anesthesiologists Affiliated, et al.*, DAB CR65 (1990), *aff'd* 941 F.2d 678 (8th Cir. 1991). A facility has a right to appeal a "certification of noncompliance leading to an enforcement remedy." 42 C.F.R. § 488.408(g)(1); *see also* 42 C.F.R. §§ 488.330(e) and 498.3. However, the choice of remedies by CMS or the factors CMS considered when choosing remedies are not subject to review. 42 C.F.R. § 488.408(g)(2). A facility may challenge the scope and severity level of noncompliance found by CMS only if a successful challenge would affect the range of CMP amounts that could be collected by CMS or impact upon the facility's nurse aide training program. 42 C.F.R. §§ 498.3(b)(14) and (d)(10)(I). CMS's determination as to the level of noncompliance "must be upheld unless it is clearly erroneous." 42 C.F.R. § 498.60(c)(2). This includes CMS's finding of immediate jeopardy. *Woodstock Care Center*, DAB No. 1726, at 9 (2000), *aff'd, Woodstock Care Center v. U.S. Dept. of Health and Human Services*, 363 F.3d 583 (6th Cir. 2003). The Departmental Appeals Board (the Board or DAB) has long held that the net effect of the regulations is that a provider has no right to challenge the scope and severity level assigned to a noncompliance finding, except in the situation where that finding was the basis for an immediate jeopardy determination. *See, e.g.*, *Ridge Terrace*, DAB No. 1834 (2002); *Koester Pavilion*, DAB No. 1750 (2000). Review of a CMP by an ALJ is governed by 42 C.F.R. § 488.438(e).

Pursuant to 42 C.F.R. §§ 483.151(b)(2) and (e)(1), a state may not approve and must withdraw any prior approval of a NATCEP offered by a long-term care facility that: (1) has been subject to an extended or partial extended survey under sections 1819(g)(2)(B)(I) or 1919(g)(2)(B)(I) of the Act; (2) has been assessed a CMP of not less than $5000; or (3) has been subject to termination of its participation agreement, denial of payment, or the appointment of temporary management. Extended and partial extended surveys are triggered by a finding of "substandard quality of care" during a standard or abbreviated standard survey and involve evaluating additional participation requirements. 42 C.F.R. § 488.301. "Substandard quality of care" is identified by the situation where surveyors identify one or more deficiencies related to participation requirements established by 42 C.F.R. § 483.13 (Resident Behavior and Facility Practices), 42 C.F.R. § 483.15 (Quality of Life), or 42 C.F.R. § 483.25 (Quality of Care), that are found to constitute either immediate jeopardy, a pattern of or widespread actual harm that does not amount to immediate jeopardy, or a widespread potential for more than minimal harm that does not amount to immediate jeopardy and there is no actual harm. *Id.* As already

noted, a facility is not normally entitled to ALJ review of a CMS or state agency level of noncompliance determination unless the amount of the CMP might be affected and where there was a finding of substandard quality of care that led to loss of approval of a facility's NATCEP. 42 C.F.R. § 498.3(b)(14).

The preponderance of the evidence standard will be applied to resolve disputed issues of fact, except as provided by 42 C.F.R. § 498.60(c)(2), which states that in CMP cases CMS's determination as to the level of noncompliance of a facility must be upheld unless it is clearly erroneous. CMS bears the burden of coming forward with evidence sufficient to establish a *prima facie* case that Petitioner was not in substantial compliance with the participation requirements at issue. Once CMS has established a *prima facie* case, Petitioner has the ultimate burden of persuasion: to prevail, Petitioner must prove by a preponderance of the evidence that it was in substantial compliance with each participation requirement at issue. *Evergreene Nursing Care Center*, DAB No. 2069, at 7-8 (2007).

III. Issues

A. Whether the facility was complying substantially with federal participation requirements on the dates CMS determined to impose a CMP.

B. Whether CMS's determination of immediate jeopardy was clearly erroneous.

C. Whether the amount of the penalty imposed by CMS is reasonable, if noncompliance is established.

IV. Findings and Discussion

The findings of fact and conclusions of law noted below, in italics, are followed by a discussion of each finding.

A. Petitioner was not in substantial compliance with the participation requirement at 42 C.F.R. § 483.15(g)(1) based on its care of Resident 1.

CMS asserts that Petitioner was not in substantial compliance with three participation requirements at the immediate jeopardy level: 42 C.F.R. § 483.15(g)(1) (Social Services, F Tag 250); 42 C.F.R. § 483.25(f)(1) (Mental and Psychosocial Functioning, F Tag 319); and 42 C.F.R. § 483.75(h) (Use of Outside Resources, F Tag 500). In the interest of judicial economy, I do not address and make no findings concerning the alleged violations of 42 C.F.R. § 483.25(f)(1) or 483.75(h). The violation at 42 C.F.R.

§ 483.15(g)(1) provides a sufficient basis for the enforcement remedies proposed by CMS. *Beechwood Sanitarium*, DAB No. 1824 (2002). Moreover, since the CMP amounts are at the minimum level for both noncompliance at the immediate jeopardy and non-immediate jeopardy level for per day CMPs, the amount of the per day CMP would not change whether I substantiated one deficiency or all three cited deficiencies.

The regulation at 42 C.F.R. § 483.15(g)(1) requires:

> (g) *Social Services.* (1) The facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.

CMS alleges that, based on interviews and medical record review, Petitioner failed to assess Resident 1, an individual who was exhibiting illicit behaviors. Specifically, the SOD asserts that Resident 1, a 54-year-old alert and oriented resident, exhibited aggressive behaviors beginning one month after admission to the facility on August 17, 2005. CMS asserts that the facility failed to address these behaviors before they began to escalate in January 2006. The resident committed suicide in the facility on February 7, 2006. Based on the State Agency findings, CMS asserts that the facility failed to:

> 1. Assess Resident 1 for appropriate placement in a nursing home to meet the resident's needs.
>
> 2. Follow through with the September 1, 2005 care plan to investigate the resident's statements and speak to Resident 1 about the facility's expectations and limits.
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> 3. Inservice staff as to how to work with a resident with manipulative behaviors.
>
> 4. Follow through with Resident 1's behavior management plan and review and change interventions that were not effective.
>
> 5. Investigate the causal factors for the resident's behavior.

CMS Ex. 4, at 1-2. I do not address or find that Petitioner failed to assess Resident 1 for appropriate placement. As CMS recognizes, Resident 1's physician certified Resident 1 for admission to the facility and, while CMS argues that it may not be "unreasonable" for me to look beyond this certification, I decline to do so here as I find it unnecessary given the other areas of noncompliance cited by CMS under this section. CMS Br. at 21-23; *see* P. Ex. 4, at 1, 4. I address issues 2, 3, and 5 together, as I find what CMS is asserting is

that Petitioner failed to review its care and behavior management plans and change interventions that were not effective when the resident's behaviors escalated in January 2006. I briefly address also whether Petitioner inserviced its staff on how to work with a resident with manipulative behaviors. Finally, although Resident 1 committed suicide, and the suicide triggered the investigation here, I do not address whether or not Petitioner's failure to provide social services and activities and to coordinate with outside physicians caused Resident 1's suicide. I am addressing solely whether or not Petitioner was out of substantial compliance with the regulation at issue based on the facility's planning and responses to this resident's behaviors.

The SOM, at Appendix PP, requires surveyors to "aggressively identify the need for medically-related social services, and pursue the provision of these services." It is "the responsibility of the facility to identify the medically-related social service needs of the resident and assure that the needs are met by the appropriate disciplines." Such "medically-related social services" are those "provided by the facility's staff to assist residents in maintaining or improving their ability to manage their everyday physical, mental, and psychosocial needs." Such services might include "[d]ischarge planning services (e.g., helping to place a resident on a waiting list for community congregate living, arranging intake for home care services for residents returning home, assisting with transfer arrangements to other facilities)"; "[p]roviding or arranging provision of needed counseling services"; "[t]hrough the assessment and care planning process, identifying and seeking ways to support residents' individual needs"; "[f]inding options that must meet the physical and emotional needs of each resident." The SOM notes that the types of conditions that a facility should respond to with social services by staff or referral include, among other conditions, behavioral symptoms, presence of a chronic disabling medical or psychological condition, depression, chronic or acute pain, difficulty with personal interaction and socialization skills, and abuse of alcohol or other drugs. The SOM notes that "[t]he facility is responsible for the safety of any potential resident victims while it assesses the circumstances of [a] residents behavior."

Resident 1 was admitted to Petitioner's facility on August 17, 2005, with diagnoses of, among other things, myositis ossificans right hip with ankylosis right ankle[3], peripheral vascular disease, chronic obstructive pulmonary disease (COPD), Hepatitis C, and depressive disorder. CMS Ex. 19, at 98; P. Ex. 4, at 4. Prior to his admission, Resident 1 resided at the Salvation Army and was under the care of Dr. Marco Ortega. P. Ex. 4, at 8.

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[3] As CMS notes in its brief, myositis ossificans is inflammation of a muscle marked by bony deposits or by ossification of muscle, and ankylosis is immobility and consolidation of a joint due to disease, injury or surgical procedure. CMS Br. at 12 n. 6. Ms. Duke testified that this condition caused Resident 1 to be in a wheelchair. Tr. 107.

Resident 1 had a history of alcohol, cannabis, and narcotic addiction. CMS Ex. 19, at 80-81. Resident 1 was described in an August 25, 2005 Minimum Data Set (MDS) as having a “sad, pained worried facial expression at least five times per week.” CMS Ex. 19, at 97. The Resident Assessment Protocol (RAP) worksheet indicated that Resident 1 had a problem in the area of Mood State, in that he had “a sad facial affect.” CMS Ex. 19, at 84. Resident 1’s Initial Nursing Assessment dated August 17, 2005, described him as “incooperative” [sic] and “dissatisfied,” and he refused to allow the nurse to complete an examination of his abdomen. P. Ex. 4, at 90, 92. Another RAP worksheet stated that Resident 1 had “persistent mood problems [related to] depressive disorder” and “firmly refuses to walk.” CMS Ex. 19, at 87. Petitioner’s “Social Service History, Information and Basic Social Assessment Form” dated August 24, 2005, stated that Resident 1 was a Marine veteran, liked gun collecting, and did not have a diagnosis of mental illness (which conflicts with Dr. Ortega’s medical history, where Dr. Ortega noted Resident 1 had a depressive disorder). CMS Ex. 19, at 80, 90, 116-17. The Social Service History form also noted that Resident 1 made negative statements, had difficulty sleeping, and did not easily adjust to change. CMS Ex. 19, at 120-21. Dr. Ortega noted that Resident 1 had right hip pain and was wheelchair dependent. CMS Ex. 19, at 80. Upon admission to the facility, Resident 1 was prescribed Ativan (an anti-anxiety agent), Fentanyl patches (also known as Duragesic, the patches deliver a continuous dose of narcotic painkiller for three day periods), Oxycontin (a controlled release form of the narcotic painkiller Oxycodone) and Remeron (prescribed for the treatment of major depression). CMS Ex. 19, at 81; CMS Br. at 13.

On August 18, 2005, shortly after Resident 1’s admission, Dr. Robert Williams, Petitioner’s physician at the facility, wrote a progress note on Resident 1. He noted that Resident 1 had been in a car accident in April 2004 and had suffered traumatic injuries to his lower extremities, which resulted in his myositis ossificans right hip and ankylosis right ankle. He lived at the Salvation Army prior to his admission to Petitioner’s facility. Dr. Williams noted that since his admission to the facility there were “a number of problems both with staff and apparently with Dr. Wagner, (his initial physician at Petitioner’s facility), who has dismissed him as a patient. Yelling, cursing and so forth have been addressed and at least for the time being not such a problem. The mental health therapist believes this is a situational problem.” Dr. Williams’ assessment concluded “I suspect his problems are largely related to excessive narcotics.” CMS Ex. 19, at 81-82. The record does not reflect an attempt by Dr. Williams or the facility to address problems related to narcotics.

Facility documentation following Resident 1's admission depicts the resident as manipulating staff, violating the facility smoking policy,[4] seeking pain patches, cursing and yelling at staff and arguing with other residents, and verbally threatening another resident on October 9, 2005 (Petitioner's goal, as noted in the care plan, was that the resident "will not harm self or others thru next review"). CMS Ex. 19, at 122, 125, 126, 127, 193-96, 198, 200, 204, 215. Petitioner scheduled a mental health consultation for Resident 1 on October 11, 2005, because Resident 1 was "exhibiting maladaptive behaviors such as cursing and yelling at staff . . . . " CMS Ex. 19, at 176. Resident 1 told the therapist that he did not want any services other than to see a prescribing psychiatrist. He then stated "his problems stemmed from lack of adjustment to the nursing home since he was still relatively new." *Id*. There is nothing in the record to show that the facility referred Resident 1 to a "prescribing psychiatrist" or asked Resident 1 his preference. Although on October 18, 2005, Resident 1 did report to Petitioner's administrator that "things were getting better, adjusting to a new place," (CMS Ex. 19, at 203) there is no documentation demonstrating Petitioner did anything further from a mental health perspective to assess Resident 1's problems and what could be done to help Resident 1 adjust to the facility. And, the facility did not provide documentation that it tried to get mental health services for him in January 2006.

Petitioner's Behavior Management Policy and Procedure requires the facility to identify residents with new or worsening behaviors who are in need of specific behavioral interventions in order to "bring dangerous or disruptive behavior under control." CMS Ex. 19, at 144. In response to Resident 1's behaviors (apparently dangerous/disruptive or both), Petitioner instituted a behavior management program, including requiring behaviors to be recorded on a behavior log. CMS Ex. 19, at 53. However, there are only three entries between September 28, 2005 and October 11, 2005 and no other entries in the record until January 10, 2006. CMS Ex. 19, at 142; P. Ex. 4, at 385-86. The facility also care planned in response to the problem of the resident cursing staff, seeking pain patches, being non-compliant with the facility's smoking policy, being easily agitated when the staff did not meet his demands, complaining about meals, and threatening

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[4] Resident 1 had many problems at the facility related to his smoking behaviors. On a September 27, 2005 care plan, the facility stated as a problem that Resident 1 was an unsafe smoker who was non-compliant with the facility's smoking policy and refused to give up lighters or cigarettes. The facility had a number of approaches to deal with the problem, including educating the resident and family, having staff supervising the resident when smoking and lighting his cigarettes, having the resident attend smoker's meetings, having the resident smoke in designated smoking areas and putting a smoke detector in his bedroom. CMS Ex. 19, at 151. Smoking remained an issue throughout the resident's tenure at the facility.

another resident. The care plan identifies that the staff approaches should be to: encourage the resident to follow facility rules and regulations and policies; inform the resident of the consequences of not following the rules, regulations and policies; when the resident began to curse at a staff member, to have the staff member get another staff member to assist the resident and allow time for both parties to calm down; follow doctor's orders; document the resident's behavior in a log book; refer to mental health/social services as needed; encourage the resident's sponsor to visit to reinforce the facility's policies, rules and regulations; institute 15 minute checks; separate the resident from other residents; and get mental health to evaluate the resident. CMS Ex. 19, at 125. A data collection form for programmed behavior identifies staff interactions for behaviors such as cursing at staff, complaints about food, seeking pain patches and arguing with other residents to be: ask another staff member to assist the resident if he was cursing at the first staff member; to document behaviors; to inform the resident that the nurse and doctor will be notified [about the behaviors]; to offer an alternate meal if the resident was complaining about his food; to separate the resident if he was arguing with another resident, and to inform the resident of the time frame in which his medication could be given. CMS Ex. 19, at 122.

Resident 1's behaviors seemed to subside in November and December 2005, although a November 21, 2005 activity note indicates that he was still making attempts to adjust to the facility and normally displayed a flat affect. He spent most of his time in the designated smoking room or outside smoking cigarettes and voiced his dissatisfaction with facility routines. CMS Ex. 19, at 189-90. Social Service Progress Notes indicate that as of November 21, 2005, Resident 1 had no behavioral problems and, on November 29, 2005, no episodes noted of "cussing" others. Nurses Summary Sheets from November 21, 2005, December 5, 2005, December 12, 2005, December 19, 2005, December 26, 2005, January 1, 2006, and January 23, 2006, however, paint a different picture, noting his mood and behavior patterns as variously "angry," "sad pained worried facial expression," "reduced socialization," "withdrawal for interests," and "depressed." CMS Ex. 19, at 227, 308, 310, 312, 314, 316, 318. On January 23, 2006, the resident was noted to be verbally abusive to other residents and staff. CMS Ex. 19, at 320. This is indicative of Resident 1's escalating behaviors in January 2006, described more fully below.

Dr. Williams' writes in a January 29, 2006 physician progress note that staff had noticed an escalation of disruptive behaviors, non-compliance, and angry outbursts from Resident 1. These incidents included reports of threats against staff and residents; empty bottles of Jack Daniels found in a brown bag in Resident 1's room; entering and refusing to leave

restricted areas; smoking in non-smoking areas; a strong marijuana odor in the resident's room and on the front porch when he and his roommate were there alone; cursing and abusive language to staff and residents. CMS Ex. 19, at 83.

A Social Service Progress Note dated January 12, 2005, notes a staff member reported Resident 1 was under suspicion for smoking marijuana. The smell was present and Resident 1 was the only one there. The social worker spoke with Resident 1's sponsor, who said he would speak to Resident 1. The social worker tried to speak with the resident, but he was resting when she went to talk to him and he asked her to come back. The social worker also spoke with the Ombudsman. CMS Ex. 19, at 230. A Social Service Progress Note dated January 26, 2006 reflects a conversation the social worker had with an attorney. The social worker writes, "I explained to her [Resident 1's] behavior of threatening staff stating 'I'll take all of you out,' cursing staff, threatening another resident to do bodily harm - rolled into the other [resident's] room & cursed at other [resident]. [The attorney] stated that we would not be able to have him committed because . . . no signs or symptoms of psychosis." CMS Ex. 19, at 231-32. The social worker also reviewed the behavior log on January 30, 2006, noting that the resident silenced another resident's IV pump, and smoked something that smelled like marijuana on the front porch . CMS Ex. 19, at 232.

Petitioner uses behavior logs to track residents with problem behaviors. The behavior logs are set up to state a given behavior, note why it occurred, the approach used by staff to address the behavior, whether the approach was successful and, if not, why not, and then note the resident's behavior after the intervention. Although Resident 1 had been placed on behavior management in October, there are no log entries between October 11, 2005 and January 10, 2006. Here I note that in January 2006 Petitioner's staff did not fully fill out these behavior logs for Resident 1, really only stating Resident 1's behaviors. The logs are, however, reflective of Resident 1's escalating behaviors during that time, noting,

- On January 10, 2006, Resident 1 stated he was "getting meds from VA Drs. he don't care what facility Drs. say wants to fire those Drs." It also notes that staff's approach to managing the behavior was not successful.

- On January 13, 2006, staff documented that a large sum of money (folded $100 bills) was found lying on his bed. Resident 1 was in the smoking room. Social services was notified of the incident.

- On January 21, 2006, Resident 1 wanted the nurse practitioner's phone number. He went behind the nurse's station looking through papers for her number and went into the cigarette container to find his cigarettes. He "continue[d] to get loud. He was determine[d]. He did what he wants." The log documented that the phone listings and cigarettes were removed from the desk. The log also notes that staff's approach to managing the behavior was not successful.

- On January 25, 2006, at 5:30 p.m., Resident 1 unplugged a cordless phone while another resident was on the phone. He then took the phone and used it.

- On January 25, 2006, at 7:25 p.m., Resident 1 went behind the nurse's desk into the cigarette box. He denied doing this but two other residents watched him do it.

- On January 25, 2006, at 8:00 p.m., Resident 1 continued to complain about another resident using the phone. He was yelling and cursing at the nurse, wanting something. The nurse told Resident 1 that the other resident could speak for himself. Resident 1 stated "It is my business I speak for everyone."

- On January 25, 2006, at 9:00 p.m., Resident 1 went into another resident's room who had just turned on his light. Resident 1 came out yelling and cursing at the nurse saying his light has been on for 30 minutes. When Resident 1 was told it was not his concern he said "everything is [my] concern. I speak for everyone."

- On January 28, 2006, at 11:00 a.m., Resident 1 went into another resident's room and turned off that resident's IV pump, stating it was beeping. The nurse explained to him the reason for the pump noise and that he has no rights when it comes to other resident's medications.

- On January 28, 2006, at 5:30 p.m., Resident 1 went out on the front porch. When the nurse asked him to come in he stated "I don't have to . . . I can do anything I want."

- On January 28, 2006, at 6:00 p.m., a nurse found a resident "sloppy drunk" who had been visiting Resident 1. She found a fifth of Jack Daniel's empty in Resident 1's room.

- On January 29, 2006, Resident 1 was found on the front porch smoking a "blunt." Resident 1 refused to take a drug test.

- On February 1, 2006, at 8:00 a.m., Resident 1's nurse was going to change his Duragesic patch. The old patch was not on his back. Resident 1 stated he had taken it off when he took a shower. The nurse told him to let a nurse take it off as it needs to be properly disposed of.

- On February 1, 2006, at 9:00 p.m., Resident 1 was asking for information about another resident's medication. He was told the nurse could not give him such information by state law. Resident 1 was insistent on being answered. Resident 1 "wrote this nurse up" putting a note regarding his complaint about the nurse under the facility's administrator's door.

- On February 2, 2006, Resident 1 came to the nurse's desk to ask about a noise. He was told it was an IV pump. Resident 1 stated "who's is it, why don't you turn it off instead of sitting on your lazy butt & do something. R. was informed that nursing staff was aware of the IV pump & were actually in the middle of report . . ." and knew about the need to address the matter. Resident 1 wheeled down the hallway to the smoking room making rude statements about staff. Staff approach was not successful.

CMS Ex. 19, at 141-43; *see* CMS Ex. 19, at 214, 215, 218, 221, 348, 350.

Not all behaviors were placed in the log. Nurse's notes from January 20, 2006, indicate that the resident wanted to sign out two hours in advance of going out. The nurse explained that he could sign out, but needed to wait. Resident 1 apparently stated "I have rights & I will do what I damn well please." CMS Ex. 19, at 215. Later that day the resident stated he understood and would sign out before going out of the facility. *Id.* Nurse's notes from January 21, 2006, reflect the behavior log entry where the resident was non-cooperative in going behind the nurse's station to look for the nurse practitioner's number and refused to leave the area. The nurse noted he was "loud and rude." CMS Ex. 19, at 217-18. Nurse's notes from January 23, 2006, reflect that the resident wanted to use the portable phone. The nurse informed him another resident was using it and she would bring it to him when the other resident finished, as all residents had the right to use the phone. Resident 1 stated "I bet I know who is on the phone, the same SOB that is always on the phone" and "I'll go in that punks room & take it. I need to use the phone!" Nurse's notes also reflect the January 28, 2006 log entry where Resident 1 entered another resident's room and silenced the IV pump alarm. It reflects the nurse educating the resident on reporting the noise if an IV pump was beeping and

that the Resident was not to touch the pump. CMS Ex. 19, at 218. Further notes from January 28, 2006, at 5:30, reflect the behavior log entry where Resident 1 did not come in from the front porch and finding the fifth of Jack Daniel's in the resident's room. CMS Ex. 19, at 219-20.

Perhaps most unsettling, however, is that, on January 25, 2006, Nurse's notes prepared by Ms. Duke state that at:

> 10:00 a.m. Resident asked to speak at morning meeting stated he was concerned about medical visits. I told him that he [should] call [to] discuss that without involving the entire dept head group. He also stated that staff was not honoring smoking times. He left meeting stating "I could take 10 of you out."
>
> 10:30 a.m. Resident came to DON office. I told him I would be glad to address his concerns, however I did think he did not need to threaten staff. He stated "It is not a threat. I can take them out anytime I want to."
>
> 10:45 a.m. Resident came back to DON office and apologized for remarks.

CMS Ex. 19, at 219; *see* Tr. 122-23.

On February 5, 2006, Nurse's Notes indicate that Resident 1 stated he was going out. When staff inquired when he would be back, he stated "When I get back." CMS Ex. 19, at 222.

The facility attempted to discharge Resident 1. An initial discharge letter was issued on January 30, 2006. It was rescinded and a new discharge letter was issued on February 6, 2006. It gave the resident 30 days notice of discharge and was sent to his sponsor, Craig Abercrombie. Mr. Abercrombie was notified that Resident 1 was being discharged for failure to abide by facility rules of conduct. Specifically, Petitioner noted that Resident 1's smoking an unlawful substance and drinking alcohol on the premises was against the well-being of the resident and others. The letter also stated that Petitioner had found the resident an alternative placement in Tennessee. CMS Ex. 19, at 269; Tr. 214.

On February 7, 2006, Resident 1 was found on the floor next to his bed with blood around his head and he died after transport to the emergency room. CMS Ex. 1; CMS Ex. 18, at 27. Resident 1 had shot himself. Police investigation revealed that Resident 1 had purchased two guns from a local pawn shop, which he picked up on February 3, 2006. P. Ex. 7, at 1; CMS Ex. 19, at 71-72.

1. Petitioner did not review and change interventions that were not effective.

Resident 1's care plan dated September 1, 2005, states as a goal that manipulative behaviors, cursing, and stating things that are unfounded or unreasonable would occur no more than one time a month through the next review period. Approaches listed were to: give praise and positive reinforcement when the resident told the truth and not to appear to agree with the resident's untruth; to investigate the resident statement as quickly as possible and document the behavior in the behavior management book and the resident's chart; and to state the facility's expectations and limits with the resident and what is expected. Staff were not to debate, argue, rationalize or bargain with the resident. Staff was to be consistent with the resident. CMS Ex. 19, at 152. An October 10, 2005 care plan entry, discussed above, notes approaches to Resident 1's behaviors for dealing with the resident's problem of cursing staff, seeking pain patches, being non-compliant with the facility's smoking policy and being easily agitated when staff did not meet his demands, complaining about meals and threatening other residents (CMS Ex. 19, at 125), and a data collection form for programmed behavior for October 2005 suggested approaches for Resident 1's cursing staff and residents, complaining about food, seeking pain patches and arguing with other residents. CMS Ex. 19, at 122.

Petitioner asserts that it followed through with its care plans for dealing with Resident 1's behaviors. Petitioner asserts that it addressed its expectations with the resident, not only in response to the resident's behaviors, but also with regard to the facility's policies and expectations in the normal course of interacting with him. In its brief, Petitioner presents a chart listing the Date, Behavior, and Facility Response to some of Resident 1's behaviors. Petitioner did not cite to specific instances in the record, instead referring generally to P. Ex. 4, its submission of Resident 1's facility records. Petitioner's chart for January states that on January 12, 2006, Resident 1 was suspected of smoking marijuana. Petitioner called Resident 1's sponsor and ombudsman, Social Services tried to speak with the resident, and the Administrator spoke to the resident; on January 20, 2006, when the resident attempted to sign out two hours before leaving, the nurse explained the policy of checking out at an appropriate time, approached the resident an hour later to discuss the check out, and the resident expressed his understanding and agreed to check out at the appropriate time; on January 21, 2006, the resident went behind the nurse's station and staff explained he could not come behind the desk; on January 26, 2006, Resident 1 threatened staff and the CQI director met with the resident to discuss concerns; on January 27, 2006, department heads discussed the incident of the previous day and determined the situation was under control; on January 28, 2006, Resident 1 informed the nurse he had turned off an IV pump and the nurse went to that resident's room and found the nursing supervisor attending to the pump and then educated Resident 1 on the

importance of not interfering with the care of other residents; on January 29, 2006, when Resident 1 was suspected of smoking marijuana the facility began discharge proceedings; and, on January 30, 2006, they communicated the discharge decision to Resident 1 and re-instituted 15 minute checks. P. Br. at 11-12.

While I accept Petitioner's assertions that it addressed Resident 1's behaviors, the problem for Petitioner is that when Resident 1's behaviors escalated in January 2006 Petitioner did not change its approach to addressing these behaviors and its approaches were not working. It was Petitioner's duty under the regulations to aggressively address Resident 1's behavioral symptoms. Ms. Underwood, the State Agency Surveyor, testified that there was no documentation that the approaches were successful or revised to incorporate additional approaches. Tr. 16. Although Petitioner asserts that Resident 1's behaviors were not escalating in January (P. Br. at 12) this characterization is belied by Dr. Williams' note of January 29, 2006, that staff had noted an escalation of disruptive behaviors, non-compliance and angry outbursts. CMS Ex. 19, at 83. Petitioner notes the testimony of Ms. Duke that in her opinion as a registered nurse his behaviors were not escalating (Tr. 163) and asserts that the resident simply changed the type and manner in which he chose to act out. P. Br. at 12. However, if Resident 1 was changing the type and manner in which he chose to act out, it was up to Petitioner to come up with new approaches to manage that behavior. Petitioner has not adduced evidence that it did so. And, if it was only the type and manner of Petitioner's behaviors that changed, why was Petitioner trying to find an alternative placement for the resident? The February 6, 2006 care plan entry for Resident 1 states that "Resident behaviors inappropriate for nursing home setting." Petitioner's goal was to "find placement suitable to meet needs." Petitioner's approaches were to present a discharge letter to Resident 1 with numbers to call to appeal and to meet with the resident to discuss placement plans on February 7, 2006. CMS Ex. 19, at 149. There is nothing in the plan about how to manage the resident's behaviors, especially how to manage his behaviors for the 30 days pending his removal.

2. Petitioner did not inservice staff about how to work with a resident with manipulative behaviors.

Surveyor notes indicate that Ms. Underwood asked the Petitioner's Social Services Director, Sherry Brown, if she inserviced staff on how to work with Resident 1 and Ms. Brown's response was "no." CMS Ex. 4, at 12; CMS Ex. 19, at 58. Ms. Duke testified that staff was inserviced on behaviors on dates from September 2005 to February 2006, and that the inservices related to behaviors. Tr.114. Ms. Duke refers to inservice training records found at P. Ex. 20. These records indicate training by date and topic. On February 9, 2006, after Resident 1's suicide, staff was inserviced on, among other things, watching residents for an increase in anxiety, nervousness, sad expression, any

verbalization of suicidal thoughts, report any abuse, and to offer spiritual counseling and a mental health counseling if needed. P. Ex. 20, at 2. Since this training occurred after Resident 1's suicide, it is not relevant. Moreover, even if it was, it does not reference an inservice about how to work with a resident with Resident 1's behaviors. Prior to Resident 1's suicide, staff was inserviced on the following dates: January 11, 2006-documentation of residents' behavior needs to be in behavior logbook; November 2, 2005-state reporting- the policy and procedure on reporting alleged violations; November 2, 2005-resident abuse; October 25, 2005-resident rights; October 19, 2005-resident abuse and misappropriation of resident property; September 2, 2005-resident abuse and reporting. P. Ex. 20, at 1, 3-12. The only inservice that could be of any relevance here might be the January 11, 2006 inservice regarding documentation of residents' behavior needing to be placed in a behavior logbook. P. Ex. 20, at 1. However, there is nothing in this record, and nothing in Ms. Duke's testimony, that staff were inserviced on how to work with Resident 1, or with any resident displaying the manipulative behaviors Resident 1 displayed.

B. CMS's determination that immediate jeopardy existed is not clearly erroneous.

As noted above, "immediate jeopardy" means a situation in which a provider's noncompliance is likely to cause serious injury, harm, impairment, or death to a resident. 42 C.F.R. § 488.301. CMS asserts that immediate jeopardy began when Resident 1 threatened facility staff and that the immediate jeopardy was removed on February 25, 2006, when the facility took corrective action. CMS then asserts that the deficiency remained out of compliance at a lower level of scope and severity and ended when Petitioner completed inservices, audits on all current residents, and educated its alert and oriented residents regarding resident rights and responsibilities. CMS Ex. 4, at 2; CMS Br. at 39.

In its brief, Petitioner contends that it was in substantial compliance and that if, for the sake of argument, I found it not in substantial compliance, the noncompliance would not rise to the level of immediate jeopardy. Moreover, Petitioner argues that even if I found immediate jeopardy to exist, the period of immediate jeopardy would have ended with Resident 1's death on February 7, 2006. P. Br. at 24. In its reply brief, Petitioner amplifies on its argument and asserts that the threat by Resident 1 to "take ten of you out" is not supported by the survey report, because Resident 1 did not harm anyone other than himself and any threat to other residents or staff was purely speculative. P. Reply at 7-8.

CMS's determination concerning a facility's level of compliance must be upheld unless it is "clearly erroneous." 42 C.F.R. § 498.60(c)(2). The clearly erroneous standard puts a heavy burden on providers to overturn CMS's determination. As the Board explained in

Southridge Nursing and Rehabiliation Center, DAB No. 1778, at 12 (2001) "the ALJ should not evaluate immediate jeopardy with the benefit of 20-20 hindsight regarding what actually happened, but should instead evaluate the potential for harm stemming from the generic nature." I must presume that CMS's determination is correct unless Petitioner can prove that the determination was clearly erroneous. *Daughters of Miriam Center,* DAB No. 2067, at 7 (2007), *citing Liberty Commons Nursing and Rehab Center-Johnston*, DAB No. 2031 (2006). Petitioner has failed to do so.

There was potential for harm here. As CMS notes, Resident 1 was an extremely difficult resident, who was allowed to dictate his treatment, violate facility policy, verbally abuse staff, have alcohol and marijuana on the premises and offer it to other residents, bring guns into the facility, threaten staff, and intrude into the care of others, all while he and the facility waited for him to "adjust." CMS Reply at 4. Resident 1 had a history of acting out behaviors that could be perceived as threatening. *See* P. Ex. 15, at 43, 60-61, 105, 127. Petitioner's care plan from October 11, 2005 indicated that he had "threatened another resident." CMS Ex. 19, at 125. The facility goal was that the resident would not harm himself or anyone else. Even Petitioner's expert witness thought that Resident 1 was capable of causing harm to others. Although Petitioner's expert witness testified that from the record he did not see as a risk the resident making a plan and taking his own life, he testified that "I would have suspected if anything would have happened, that he would have maybe punched a nurse because he was getting frustrated from time to time." Tr. 395. Thus, the testimony of Mr. Bell and Ms. Duke that they did not take the threat that he would take ten of them out seriously is not convincing. Petitioner has not proved that CMS's determination of immediate jeopardy was clearly erroneous.

C. The amount of the CMPs imposed by CMS is reasonable.

CMS has imposed CMPs at the minimum level for both immediate jeopardy and non-immediate jeopardy level deficiencies. Thus, if I find that Petitioner was out of substantial compliance with participation requirements for the periods alleged by CMS, I must uphold the amount of the CMPs imposed.

Petitioner contends that CMS did not present sufficient evidence to establish the duration of the CMPs. However, the burden is on Petitioner to show that it had eliminated the noncompliance on any date prior to March 14, 2006. It has not done so. As noted above, CMS asserts that the immediate jeopardy was removed on February 25, 2006, when Petitioner took corrective action and that the facility remained out of compliance at a lower level of scope and severity and ended when Petitioner completed inservices, audits on all current residents, and educated its alert and oriented residents regarding resident

rights and responsibilities. Petitioner has presented no evidence to contest CMS's assertions. I have found CMS out of substantial compliance for the periods and at the scope and severity level alleged by CMS. Thus, I uphold the amount of the CMPs imposed.

D. Petitioner is properly subject to a two-year prohibition on conducting a NATCEP.

The parties did not address this issue directly in their briefing. However, Petitioner cited in its brief all the remedies listed in CMS's notice letter of March 23, 2006, which included the prohibition against Petitioner's conducting a NATCEP, and stated that it was appealing "all the remedies imposed." P. Br. at 5. As I have found Petitioner to be noncompliant at the immediate jeopardy level with a participation requirement under 42 C.F.R. § 483.15, a two-year prohibition of Petitioner's conducting a NATCEP is required by law.

V. Conclusion

Based on the testimony offered at the hearing, the documentary evidence, the arguments of the parties, and the applicable law and regulations, I find that Petitioner was not in substantial compliance at the immediate jeopardy level from January 25, 2006 through February 24, 2006, and that the imposition of a $3050 per day CMP is reasonable. Additionally, I conclude that a CMP of $50 per day is reasonable for deficiencies at the less than immediate jeopardy level based on Petitioner's noncompliance from February 25, 2006 through March 14, 2006. Finally, I uphold the prohibition against Petitioner's conducting a NATCEP.

/s/

José A. Anglada
Administrative Law Judge