Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Appellate Division

In the Case of:	DATE: May 14, 2007
Lake Mary Health Care Petitioner,	Civil Remedies CR1373 App. Div. Docket No. A-06-39
- v. -	Decision No. 2081
Centers for Medicare & Medicaid Services.	

FINAL DECISION ON REVIEW OF
ADMINISTRATIVE LAW JUDGE DECISION

Lake Mary Health Care (Lake Mary) timely appealed the December 2, 2005 decision of Administrative Law Judge (ALJ) José A. Anglada sustaining the imposition by the Centers for Medicare & Medicaid Services (CMS) of a civil money penalty (CMP) in the amount of $3,050 per day from August 10, 2003 through September 4, 2003 and $100 per day thereafter until October 14, 2003. Lake Mary Health Care, DAB CR1373 (2005)(ALJ Decision). The ALJ concluded that Lake Mary was not in substantial compliance with participation requirements as a result of events surrounding an August 20, 2003 incident in which a resident (R1) suffered a massive fire ant attack. The ALJ concluded that CMS's determination that the situation constituted immediate jeopardy during the first time period was not clearly erroneous.

In its request for review, Lake Mary argues that the ALJ's factual findings were mistaken because he ignored or misconstrued the evidence and that the ALJ erred in concluding that those findings, even if accurate, supported the determination that Lake Mary failed to develop or implement written policies and

procedures against resident neglect. Lake Mary Request for Review (RR) at 1.

For the reasons explained below, we conclude that none of Lake Mary's contentions on appeal is well-founded. We therefore sustain the ALJ Decision in its entirety.

Applicable Legal Provisions

Long-term care facilities participating in the Medicare and Medicaid programs are subject to survey and enforcement procedures set out in 42 C.F.R. Part 488, subpart E, to determine if they are in substantial compliance with applicable program requirements which appear at 42 C.F.R. Part 483, subpart B. "Substantial compliance" means a level of compliance such that "any identified deficiencies pose no greater risk to resident health or safety than the potential for causing minimal harm." 42 C.F.R. § 488.301. "Noncompliance," in turn, is defined as "any deficiency that causes a facility to not be in substantial compliance." Id. "Deficiency" means a facility's failure to meet a participation requirement specified in the Act or in subpart B of 42 C.F.R. Part 483. Id.

A long-term care facility found not to be in substantial compliance is subject to various enforcement remedies, including CMPs. 42 C.F.R. §§ 488.402(c), 488.408. CMS may impose CMPs ranging from $50-$3,000 per day for one or more deficiencies that do not constitute "immediate jeopardy" but that either cause actual harm or create the potential for more than minimal harm, and from $3,050-$10,000 per day for deficiencies constituting immediate jeopardy. 42 C.F.R. § 488.438(a).

"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. In determining the amount of the CMP, the factors specified at 42 C.F.R. § 488.438(f) must be considered.

A per-day CMP may start to accrue as of the date that the facility was first out of compliance, as determined by CMS or the state, and continue until the date the facility achieves substantial compliance. 42 C.F.R. § 488.440(a),(b).

Section 483.70(h)(4) of the regulations requires that a facility maintain an effective pest control program so that the facility is free of pests. 42 C.F.R. § 483.70(h)(4). Section 483.13(c) provides that the facility must develop and implement written policies and procedures that, among other things, prohibit neglect and abuse of residents. 42 C.F.R. § 483.13(c).

Standard of Review

Our standard of review on a disputed conclusion of law is whether the ALJ decision is erroneous. Our standard of review on a disputed finding of fact is whether the ALJ decision is supported by substantial evidence on the record as a whole. Guidelines for Appellate Review of Decisions of Administrative Law Judges Affecting a Provider's Participation in the Medicare and Medicaid Programs, www.hhs.gov/dab/guidelines/prov.html; see also Batavia Nursing and Convalescent Center, DAB No. 1911, at 7 (2004), aff'd, Batavia Nursing & Convalescent Ctr. v. Thompson, No. 04-3687 (6th Cir. Aug. 3, 2005); Hillman Rehabilitation Center, DAB No. 1611, at 6 (1997); aff'd, Hillman Rehabilitation Ctr. v. U.S. Dep't of Health and Human Servs., No. 98-3789(GEB) at 21-38 (D.N.J. May 13, 1999).

Case Background[1]

Lake Mary is a dually-participating long-term care facility located in Florida. It is undisputed that Resident 1 (R1) was a resident of the facility who was bedfast and totally dependent on staff, needing a gastronomy tube for feeding and unable to communicate her needs. Id. at 6. The facility acknowledges that ants were seen in her room on August 10, 2003. Lake Mary Brief in support of request for review (Lake Mary RR Br.) at 2. It is also undisputed that she was found in her room at 4:30 AM on August 20, 2003, with a large number of ants on her face and upper body and with numerous ant stings. Id.; ALJ Decision at 6. Lake Mary reported the ant sting episode to the Florida Agency for Health Care Administration (FAHCA) which conducted a survey on August 22, 2003. The state surveyors found that Lake Mary was not in substantial compliance with 42 C.F.R. § 483.13(1)(i) (cited as Tag F224) and did not cite immediate jeopardy. See Lake Mary RR Br. at 2. CMS issued a revised Statement of Deficiencies (SOD) on October 3, 2003, however, in which Lake

[1] The following background information is drawn from the ALJ Decision and the record before him and summarized here for the convenience of the reader, but should not be treated as new findings.

Mary was also cited under 42 C.F.R. § 483.70 (Tag F469), and both noncompliance findings were raised to the level of immediate jeopardy. The factual findings underlying both tags were essentially the same. CMS Ex. 1. Lake Mary requested a hearing on the noncompliance findings and on the immediate jeopardy determination.

The ALJ conducted a hearing on February 22-23, 2005, at which both parties presented both fact and expert witnesses, and considered that testimony as well as documentary evidence and arguments in the parties' briefs. ALJ Decision at 2. The ALJ reached the following findings of fact and conclusions of law (FFCLs):

> ***A. The facility failed to maintain an effective pest control program so that the facility was free of pests, in accordance with the comprehensive assessment and plan of care as set forth under Physical Environment (Tag F469).***
>
> ***B. The facility failed to develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property as provided by 42 C.F.R. § 483.13(c) (Tag F224).***
>
> ***C. Petitioner was not in substantial compliance with federal participation requirements on August 10, 2003, and continuing through October 14, 2003.***
>
> ***D. CMS's finding of immediate jeopardy was not clearly erroneous.***
>
> ***E. The amount of the penalty imposed by CMS is reasonable.***

ALJ Decision at 5 (bold and italics in original). The ALJ noted that Lake Mary conceded for purposes of this case that the level of harm suffered by R1 was "sufficient to meet the regulatory definition of immediate jeopardy." Id. at 2, citing Tr. at 5.

Issues

Lake Mary excepts to all the FFCLs and makes the following arguments on appeal:

1. The ALJ erred by interpreting the pest control standard to amount to strict liability in finding that the presence of a pest establishes a violation of the regulation and, when the violation presents the potential for more than minimal harm, constitutes noncompliance. Lake Mary Reply Br. at 2.

2. The ALJ erred by considering events "outside the time frame charged in the SOD." Lake Mary RR Br. at 10. In this regard, Lake Mary argues that it lacked notice that CMS's allegations included any events before August 10th, but rather believed that the only issue was whether it failed to respond adequately to the presence of ants on August 10th so as to prevent an incident like that which occurred on August 20th. Further, Lake Mary argues that the other instances of pests in the facility were irrelevant because they were too remote in time.

3. The ALJ erred by faulting the facility for lack of knowledge of pest control practices given that Lake Mary contracted with a licensed pest control company and given that no published or accepted standards exist for pest control practices in nursing homes. Lake Mary RR Br. at 17.

4. The ALJ's factual findings and discussion "either misrepresent, skew, or ignore" evidence in the record. Lake Mary RR Br. at 12-17. Further, the ALJ's findings of fact in relation to tag F224 lack supporting evidence and are not legally sufficient to state a violation of the cited regulation. Id. at 19-22.

5. The ALJ erred by ignoring evidence of Lake Mary's interventions to control ants between August 10th and August 20th, 2003. Lake Mary RR Br. at 7.

6. Even if Lake Mary was not in substantial compliance with either of the cited tags, any noncompliance was immediately corrected on August 20, 2003, and should not have formed the basis for any immediate jeopardy determination nor for any continuing CMP after August 20, 2003.

Analysis

1. Lake Mary's assertions about FAHCA's position on how noncompliance should have been cited are irrelevant.

As a preliminary matter, we address a recurrent point made by Lake Mary in various parts of its briefs. Lake Mary repeatedly points out that FAHCA surveyors, who under section 1819(g) of the

Social Security Act (Act)[2] conducted the survey both on behalf of the state regulatory agency and as agents for CMS, did not consider the situation in the same serious light in which CMS now portrays it. Lake Mary RR Br. at 2-3; Lake Mary Reply Br. at 1-2. The surveyors originally cited Lake Mary only under tag 224 (relating to anti-neglect policies) and at the "G" level which means the noncompliance was determined to be isolated and involve actual harm that is not immediate jeopardy.[3]

Lake Mary contends that CMS should not (or perhaps legally could not, the argument is not entirely clear) have determined that noncompliance existed under the additional tag (relating to pest control) or have determined that immediate jeopardy was present. Lake Mary Reply Br. at 1. Lake Mary complains that the changes were made by "CMS personnel who are not in Florida and who were not on any survey of the facility." Id. In addition, according to Lake Mary, the FAHCA surveyors are "surely more familiar with the standards of pest control practices in Florida nursing homes." Id. FAHCA furthermore withdrew the additional charge and the immediate jeopardy determination for state purposes in state administrative appeals of the penalties under Florida law which were imposed after the survey, thereby, according to Lake Mary, rejecting "not once, but twice, the substantive charge which CMS pursued in this case." Lake Mary RR Br. at 3.

Thus, Lake Mary implies, the state surveyors did not consider the fire ant problem as serious or Lake Mary's approach to it as inadequate as did CMS reviewers. Lake Mary suggests that, in such a difference of opinion, the overriding weight should be given to the evaluation of the state surveyors who conducted the survey, as first-person witnesses. Where, as here, most of the factual findings arise from review of documentary evidence and facility records, there is no factual basis for presuming that the surveyors are in a better position to determine noncompliance than the CMS reviewers. More importantly, however, this

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

[3] The FAHCA allegations were based on Lake Mary's failure to call the pest control company and to increase monitoring of R1 after ants were seen in her room on August 10, 2003. Lake Mary RR Br. at 2.

suggestion erroneously assumes that the governing law permits the State's finding of compliance to override CMS's finding of noncompliance.

Ultimate responsibility for the interpretation and enforcement of federal participation requirements lies with CMS, not with the state surveyors who conduct surveys under an agreement with CMS. Any greater familiarity that FAHCA may have with practices in Florida nursing homes cannot override the expertise of federal regulators in the nationally-applicable regulations involved in this matter. Federal law makes clear that, in a situation such as that presented here, CMS's finding of noncompliance and imposition of remedies for a determination of immediate jeopardy not only is legally permissible but must take precedence over the state's position. The statute and regulations contemplate the possibility that state and federal findings and choice of remedies may not always be in accord. Thus, section 1919(h)(6)(B) of the Act provides that, in the case where CMS finds noncompliance (but no immediate jeopardy) but the state makes no finding of noncompliance, CMS may nevertheless "impose any remedies specified in paragraph (3)(C)," which include civil money penalties up to $10,000 per day.[4] See also §§ 1819(h)(2)(A) and 1919(g)(3)(A) of the Act; 42 C.F.R. § 488.452(a)(2) (CMS findings of noncompliance take precedence over state findings of compliance); 59 Fed. Reg. 56,116, at 56,129 (Nov. 10, 1994). Where either CMS or the state finds immediate jeopardy, section 1919(h)(5) of the Act provides that the entity finding immediate jeopardy shall notify the other and take "immediate action to remove the jeopardy and correct the deficiencies" by applying the legal remedies available in immediate jeopardy situations.

We therefore find no merit to Lake Mary's arguments that FAHCA's findings on noncompliance or scope and severity should have controlled here.

2. The ALJ did not erroneously impose strict liability in interpreting the pest control regulation.

Lake Mary contends that CMS sought to impose strict liability by contending that the presence of pests suffices to demonstrate that a facility's pest control program is ineffective and, whenever the pests' presence poses more than a minimal risk of

[4] Section 1919(h)(6)(A) of the Act provides that where the state but not CMS finds noncompliance, the state's findings control and the state's remedies apply.

harm, the facility is not in substantial compliance. Lake Mary Reply Br. at 2. We find that the ALJ did not apply the standard Lake Mary describes, however, as Lake Mary itself acknowledged. Id. at 3. We need not therefore consider what position CMS took below, as CMS makes no such argument on appeal.

The ALJ points out that Lake Mary conceded below that CMS established a prima facie case that the facility "failed to maintain a pest control program so that the facility was free of pests," based on the repeated presence of ants in R1's room on dates prior to the August 20th incident. ALJ Decision at 7. Lake Mary summarized its understanding of the regulation and case law to mean that the "appearance of pests in the facility may be prima facie evidence of a violation," but that this prima facie case may be rebutted if the facility shows "that the appearance of the pests occurred in spite of diligent efforts at prevention." Lake Mary Post-Hearing Br. at 12.

The ALJ found that, far from having made diligent efforts at prevention, Lake Mary was "culpable" in its ineffective efforts to control ants. ALJ Decision at 7. He specified ways in which Lake Mary fell short of taking proper action even after repeated ant sightings. Id. at 7-11. He found that Lake Mary failed to follow its own pest control policy which required that, when any insects are found, they are to be reported on the maintenance log, the staff is to clean and spray, and the pest control company is to be "called to provide call back service." P. Ex. 1, referenced at ALJ Decision at 12-13. He noted the facility administrator's statement to the surveyors that "every time an ant is found in the facility, an immediate call in to the contracted pest control company is done," but found that it was a "gross contradiction" to her later testimony that the staff did not really have to follow that practice, when confronted with evidence that no call-in was made after multiple sightings. CMS Ex. 1, at 3; ALJ Decision at 8, 12-13. He found that, on August 10th when ants were seen in R1's room, Lake Mary staff did not preserve a sample of the ants and the pest control company did not follow the extensive procedures that its owner testified would have been called for in the case of fire ants. ALJ Decision at 9-10, citing Tr. at 144-46. The ALJ concluded that the pest control company should have taken all the precautions it outlined since it could not rule out that the ants were fire ants, but did not do so. Id. He also concluded that the repeated sightings of ants in the facility during five months in 2003 should have led Lake Mary to consider additional measures, yet "the facility continued to routinely spray and clean the rooms without notifying the pest control provider," and, in fact,

decided to reduce maintenance rounds to check for ant nests from daily in 2002 to weekly in 2003. Id. at 10.

Lake Mary disputes the ALJ's factual findings about many of these matters, as we discuss later in this decision, but it is evident that the ALJ relied on shortcomings in Lake Mary's attempted rebuttal of CMS's prima facie case. He did not find noncompliance with this tag based merely on the presence of one insect or even on the fact that the pests involved turned out to be fire ants. He found noncompliance based on his conclusions that Lake Mary failed to show by the preponderance of the evidence that it took appropriate pest control measures in light of the circumstances as the ALJ found them to have been at the facility. See Tri-County Extended Care Center, DAB No. 2070 (2007) (ALJ did not apply strict liability where he "held the facility to the standards enunciated in the relevant participation requirement and its own policies and care plans and found noncompliance by applying the 'substantial compliance' standard mandated by the regulations"). We see no basis to characterize the ALJ's reasoning as in the nature of strict liability. Furthermore, the ALJ correctly pointed out that concepts like "strict liability" belong to tort law, not to the federal regulation of nursing facilities choosing to receive payments from federally-funded health care programs. ALJ Decision at 7, citing Guardian Health Care Center, DAB No. 1943 (2004).

We therefore find no merit in Lake Mary's arguments about strict liability.

3. The ALJ did not commit legal error by considering events that occurred before August 10, 2003.

Since Lake Mary acknowledged that CMS had made a prima facie case of noncompliance with the pest control requirements and that the injuries to R1 were serious enough to meet the definition of immediate jeopardy, the ALJ's analysis on this tag centered on whether Lake Mary presented evidence sufficient to demonstrate by a preponderance of the evidence that Lake Mary was nevertheless in substantial compliance with the pest control provision. Among the evidence which the ALJ weighed were facility records showing repeated ant sightings during the months leading up to the attack on R1. Thus, the ALJ found that –

> Petitioner's records reveal that its pest control program was ineffective in maintaining the facility free of pests on January 16, 2003 (ants in closet and drawers of Room 413B); May 22, 2003 (ants were sprayed in Room

> 401B, but kept coming back); June 10, 2003 (ants observed on baseboard in nurse's toilet in Williamsburg wing); July 3, 2003 (ants were observed in Room 412A and 450B); July 20, 2003 (ants were observed by the window in Room 420B) and on August 20, 2003 (ants were observed in Room 438). P. Ex. 10, at 2; P. Ex. 14, at 2; P. Ex. 15, at 2; P. Ex. 16, at 2, 3; P. Ex. 17, at 4, 5.

ALJ Decision at 7-8.

Lake Mary makes two arguments about why the ALJ should instead have restricted his inquiry in this regard to events that occurred after August 10, 2003.[5] First, Lake Mary contends that none of the earlier events had any relevance to the question of whether inadequacies in Lake Mary's pest control program resulted in the fire ant attack on August 20th. Second, Lake Mary suggests that the SOD created an expectation that the allegations were limited to that time frame and that, therefore, Lake Mary was not provided with fair notice that any other time frame was at issue.

The Board has repeatedly rejected arguments that an ALJ should not be permitted to rely on past events to determine whether noncompliance existed at the time of a survey. Thus, the Board explained:

> The Board previously has held that a deficiency may be evidenced by events that occurred prior to the actual survey dates. Regency Gardens Nursing Center, DAB No. 1858 (2002). As explained there, particular events disclosed by the facility records may evidence noncompliance with participation requirements, but "the noncompliance - the failure to meet the participation requirement - is what constitutes the deficiency, not any particular event that was used as evidence of the deficiency." Id. at 21, citing 42 C.F.R. § 488.301. Similarly, the observations made on May 8th during the

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[5] On August 10, 2003, ants were seen in R1's room. CMS determined that noncompliance began as of that date. Lake Mary's position is that nothing that occurred prior to the date on which noncompliance allegedly began is relevant as a matter of law. CMS determined that immediate jeopardy had been abated on September 4, 2003. Lake Mary's position is that any noncompliance was cured entirely on the date of the survey by its efforts after the August 10th sighting. We discuss this argument in a later section.

> monitoring visit, as well as the records relating to the fall and transfer, were relevant to determining whether the facility notified family members as required. Nothing in the regulations suggests that only a failure to notify that occurs precisely on the days surveyors are present in the facility may be considered in assessing compliance with this provision. In fact, such an interpretation would be inconsistent with the regulations overall which, for example, expressly permit imposition of a CMP for the "number of days of past noncompliance since the last standard survey." 42 C.F.R. § 488.430(b).

Beechwood Sanitarium, DAB No. 1906, at 40 (2004) (emphasis in original).

In this case, the ALJ did not rely on events prior to August 10, 2003, as a basis for citing past noncompliance prior to that date. He did consider the history of ant sightings and staff responses leading up to August 10th as part of the context of evaluating the adequacy of Lake Mary's pest control program and the consistency with which the policy was followed. See, e.g., ALJ Decision at 7-9, 11. While Lake Mary calls this "clear error," it cites no authority for that proposition. Instead, Lake Mary asserts that CMS could not "impose remedies prospectively if a facility is in compliance as of the date of the remedies' inception and thereafter," and argued, therefore, that whether its pest control policy was ineffective or inadequately implemented prior to August 2003 did not matter if any issues were corrected by the initial date of the remedies. This formulation is equally unavailing.

First, the legal citation which Lake Mary offers for this proposition is to the ALJ Decision in Emerald Shores Health & Rehabilitation Center, DAB CR1385 (2006). That decision was reversed on appeal to the Board. Emerald Shores Health & Rehabilitation Center, DAB No. 2072 (2007). Second, the ALJ found that Lake Mary's pest control problems were not corrected by August 10th, when the remedies began to run, nor by August 20th, when R1 was severely stung, nor by August 22nd, when the surveyors arrived. The problems, the ALJ found, were not resolved even by September 4th, when CMS determined that the threat to residents was reduced below immediate jeopardy. Since we conclude below that the ALJ's findings were supported by substantial evidence, the premise of Lake Mary's contention has not been established. Finally, we see no reason that the ALJ could not consider the recent pest control experiences at the facility in analyzing the context in which the events from August

10-20 occurred. It was reasonable for the ALJ to infer that the need for major changes should have been more obvious given a repeated history of ant sightings (rather than an isolated sighting on August 10th alone). It also was reasonable for the ALJ to infer that Lake Mary's policy on calling the pest control company after every sighting was not a reliable indicator of actual practices when staff repeatedly failed to call the company after sightings. Further, it was reasonable for the ALJ to infer from that history of tolerated failures to abide by one aspect of the pest control policy that changes in policy statements might not ensure changes in practice.

Finding no merit to Lake Mary's argument that any consideration of events prior to August 10th constituted clear legal error, we turn to Lake Mary's additional claim that no adequate notice was provided by the SOD that any prior dates were at issue. The Board has long rejected the suggestion that all evidence supporting a noncompliance finding must be set out in the SOD.

The ALJ provided a process for clarifying issues and exchanging exhibits and witness lists in advance of the in-person hearing. ALJ Order (Dec. 1, 2003); ALJ Order for Exchange of Documents (Feb. 13. 2004). CMS's prehearing brief and exhibits disclose that CMS planned to show that "[a]nts were a problem in the facility well before Resident 1 was attacked." CMS Prehearing Br. at 3, citing CMS Ex. 7 (Lake Mary's pest control log). Further, the ALJ granted Lake Mary's motion to amend its exhibits and witness list to include, among other things, testimony by Administrator Maureen Kehoe "as to the specific actions nursing staff took in responding to certain identifications of ants in the facility in 2002" and testimony by owners of the pest control and lawn companies that provided services to Lake Mary in 2002 and 2003. ALJ Summary of Prehearing Conference and Ruling on Petitioner's Motion, at 3-4 (February 16, 2005). Lake Mary plainly had adequate notice of the fact that its pest control experience prior to August 2003 was at issue and had adequate opportunity to respond to CMS's contentions about the prior history of sightings and the adequacy of the facility's response to them.

Finally, Lake Mary's premise that the SOD limited the period of concern to August 10-20, 2003 is not entirely true. The pest control tag does allege that R1 was bitten ten days "after facility's staff discovery of ants in the resident's room on 8/10/03." CMS Ex. 1, at 5. Additional findings under that tag, however, also report interviews with residents and visitors revealing that "the ant problem had been ongoing" and that "ant mounds 'can be found in the courtyard frequently,'" but that no

aggressive treatment of the problem had been observed. Id. at 8. Also, the surveyors reported that their interviews with staff "confirmed that ant problems were on-going due to the rainy season" and that record review showed monthly treatment by a pest control company. Id. at 9. While these findings do not include information about the dates and details of particular sightings, they suffice to provide some notice to Lake Mary that evidence on its history of ant problems might be presented if Lake Mary challenged the noncompliance determination.

We therefore reject Lake Mary's claim that the ALJ erred in considering evidence of events that occurred prior to August 10, 2003.

4. Lake Mary retained responsibility to implement an effective pest control program.

Lake Mary suggests at several points that it should not be held responsible for any shortcoming in pest control at the facility because (1) the facility properly relied on the expertise of the pest control company with which it contracted and had no reason to doubt its competence, and (2) no accepted guidelines or standards of practice (in the industry or in CMS publications) exist to define exactly what must be included in an effective pest control program. See, e.g., Lake Mary RR Br. at 15-16. Given those premises, Lake Mary characterizes as "Monday morning quarterbacking" suggestions that, for example, the facility should not have reduced monitoring of its grounds for signs of ant activity from daily to weekly prior to the attack on R1. Id. at 16. We disagree that Lake Mary can deflect responsibility here to its pest control company or to CMS.

> A. Contracting with a pest control company was a reasonable step in implementing such a program but did not absolve Lake Mary of responsibility to ensure that it was providing effective services.

Although Lake Mary asserts that the ALJ required that "nursing homes must develop pest control expertise and second guess" pest control operators, we find no such requirement in the ALJ Decision (nor does Lake Mary specifically point to where it appears). Lake Mary RR Br. at 4.

Lake Mary presented evidence tending to show that fire ants were ubiquitous (and hence, in its view, could not reasonably be controlled) and also asserts that no fire ants were seen in the building prior to August 20th (and hence Lake Mary had no reason to think its pest control inadequate). See, e.g., Lake Mary RR

Br. at 4. A certain unacknowledged inconsistency exists between these two threads of argument. If Lake Mary claims that the fire ant problem was so massive that no methods could successfully keep them out of the building, how can Lake Mary also credibly claim that fire ants were successfully kept out of the building except on the single day on which the fire ants mounted a massive attack on a resident? In any case, Lake Mary failed to provide sufficient evidence to make credible its assertions about not having had any prior incursions by fire ants. The many prior ant sightings were not identified as fire ants. The facility staff was shown by substantial evidence to be unable to identify fire ants and also to be in the habit of spraying ants without summoning the pest control professionals (or preserving samples of the ants when they did call their pest control company at the time, Hollywood East). Given those well-supported findings, there is no evidentiary basis to conclude that none of the prior sightings involved fire ants.

The resolution which the ALJ reached was essentially that Lake Mary did not aggressively monitor for, identify, or use available methods to treat for fire ants and therefore did not know whether or when fire ants were in the facility prior to the attack. ALJ Decision at 8-11. The ALJ made clear that his conclusion did not depend on whether the ants sighted on the various dates before August 20, 2003 were fire ants, but rather on the failure of the facility to act on the assumption that, given "their prevalence and elusive nature," fire ants were among the ants gaining access, absent some basis for definitely concluding that they were not. ALJ Decision at 11.

It was undisputed that no methods have been developed to completely eliminate fire ants from an infested area. ALJ Decision at 11, citing Tr. at 85 (Dr. Merchant). Lake Mary's expert witness on fire ants, Dr. Walter Tschinkel, reported that, on the day before the hearing, he laid out baited test tubes in various areas around the courtyard and perimeter of the facility building and collected fire ants. Tr. at 209-10. Despite recent inspections and treatments by the "lawn person," Dr. Tschinkel found six undetected nests (in addition to two visible ones treated already) and found ants "essentially everywhere." Tr. at 210-11. Thus, substantial evidence, including testimony by Lake Mary's own expert, supports the ALJ's finding about the prevalence of fire ants on the grounds and near the building.

Dr. Merchant testified that effective methods do exist to control fire ants in nursing facilities. Tr. at 85. Despite the well-known harm of ant stings for individuals like R1, Lake Mary did not adopt the methods delineated by Dr. Merchant. Dr. Merchant

described six ways in which he concluded that Lake Mary fell short of an effective program to control fire ants. Tr. at 55. Furthermore, the ALJ rejected Lake Mary's reliance on the argument that fire ants may still gain access to a building despite use of appropriate techniques on the ground that Lake Mary did not present "persuasive evidence that it employed all appropriate techniques to maintain the entry of fire ants into its facility under control." ALJ Decision at 12. Lake Mary responds by pointing to its contract with a professional for pest control. Under the circumstances here, we agree with the ALJ that merely hiring a pest control company did not meet the requirements of effective pest control.

First, the contract which Lake Mary signed with Hollywood East specifically covered pharaoh ants, house ants, and carpenter ants, but did not specifically cover fire ants. CMS Ex. 10, at 2. The significance of this omission is not that the operator would necessarily decline to respond to fire ant sightings or would not use chemicals that also affect fire ants.[6] The significance is that the company might be less alert to search for signs of fire ants, less proactive in prevention efforts, and less aggressive in trying to eliminate access points than had its contractual obligation singled out fire ants as one of the pests it must control. ALJ Decision at 9; Tr. at 140.[7] This concern

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[6] Mr. Day from Hollywood East testified that the omission of fire ants from the list of covered pests did not mean that no services were provided "that would address fire ants," and asserted that two products, Talstar granules and Demon EC, killed fire ants and were used in and around the perimeter of the building. Tr. at 126-27.

[7] Notably, the pest control company which was hired to replace Hollywood East shortly after the survey covered all ants and charged twice the initial service fee ($200 instead of $100) and undertook to "eliminate all pests listed above from the facility" through an intensive treatment program. CMS Ex. 11, at 1. Further, its ongoing maintenance program included regular service twice, instead of once, per month and was billed at $350 instead of $100 per month. Id. Lake Mary argues that this increase should be viewed as a matter of taking "extraordinary measures" in response to or anticipation of a survey. Lake Mary Reply Br. at 7, n.4. The ALJ could, however, reasonably infer that the fact that the original service was so much cheaper suggested that it did not include the same level of protection against fire ants as was offered under this more expensive

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is confirmed by Mr. Day's testimony that, had they recognized a "fire ant problem," the pest control operators would have had to take a much more thorough approach than they actually did. Tr. at 145-46.

Second, according to her August 25, 2003 letter, the facility administrator fired Hollywood East precisely because there had "been significant problems getting an ant problem under control." CMS Ex. 10, at 1. The ALJ concluded that this reason placed in doubt the effectiveness of the pest control program and that he found less than credible the administrator's attempts at the hearing to explain this letter in any other way. ALJ Decision at 13.

Third, the facility did not follow its own policy to call back the pest control company whenever a pest was sighted in the facility. The effect was that the professional pest control company was not placed in a position to assess the nature of the pests or to develop a complete awareness of pest control problems. The ALJ's comments on the ignorance of staff in failing to correctly identify species of ants and understand fire ant architecture[8] are in this context. Since its staff merely

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[7](...continued)
program.

[8] Thus, Lake Mary argues that there "cannot possibly be" a requirement that nursing home staff know about "fire ants architecture in Florida," because only a few experts actually know about such architecture. Lake Mary RR Br. at 15. Lake Mary points out that even Dr. Merchant (CMS's expert) "was unaware of how fire ant mounds would appear in Florida." Id. Dr. Merchant's testimony was that he found the ant mounds less prominent in the sandy soil at the facility location than in the heavy clay soil in his area of Texas. Tr. at 53. Nothing about this observation implies that Dr. Merchant lacked awareness of fire ant mound architecture. Furthermore, we disagree with Lake Mary's contention that the lower visibility meant that less frequent monitoring of the grounds was justified because "if the mounds are not visible, then it is illogical to conclude that more frequent monitoring would have located them." Lake Mary RR Br. at 15. On the contrary, the ALJ could reasonably conclude that the difficulty of spotting some mounds made it all the more important that careful inspections occur regularly using personnel trained to watch for fire ant activity. Furthermore, neither expert testified that no visible surface mounds appear
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sprayed household pesticides on ants when seen (without retaining samples of the ants or calling the pest control company), Lake Mary did not in fact use its pest control company to discern how serious ant infestations were, whether fire ants were involved or whether a fire ant problem required professional treatment. Instead, the staff made those decisions despite the staff's ignorance of fire ant identification, habits, or treatment. In a fire-ant infested area, the ALJ reasonably concluded that such decisions demanded at least some clarity and training for the staff about the appearance and behavior of fire ants as opposed to more harmless species.

Fourth, in addition to using its own staff (who admittedly lacked any training in pest control) to apply pesticides indoors, Lake Mary employed a lawn care service which was not licensed in pest control. Tr. at 63-64. Lake Mary nevertheless relied on this lawn care service to apply outdoor pesticide. Such pervasive use of unlicensed persons to treat for pests was problematic and undercut Lake Mary's claims that it reasonably relied on professionals to provide effect pest control.

We thus conclude that Lake Mary's contract with a pest control company did not suffice to relieve Lake Mary of its responsibility for having an effective program to control fire ants.

B. Regulations permit Lake Mary flexibility to design its own pest control program, but Lake Mary has the responsibility to make that program effective.

The federal government has established a regulatory regime using survey, certification and enforcement actions to make sure that federal funds are directed to high quality facilities providing appropriate care to some of our most vulnerable citizens. Two general approaches have been tried in evaluating nursing home performance that can be summarized as either rule-based or outcome-based. Congress has concluded that the outcome-based approach offers the better alternative to ensure quality care for nursing home residents. Thus, in the Omnibus Budget Reconciliation Act of 1987 (OBRA '87), Congress moved away from checklists of actions that facilities must take toward a central focus on the actual care received by patients, leaving facilities

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[8](...continued)
above fire ant nests in Florida, only that not all nests can be seen, at least by untrained observers. See, e.g, Tr. at 53, 184, 211.

with flexibility to select the most appropriate methods but the corresponding responsibility to ensure that the selected methods are effective for achieving the outcomes specified in the statute and implementing regulations. 42 U.S.C. §§ 1395i-3 and 1396r.[9] The legislative history regarding the nursing home reform provisions of OBRA '87 reinforces Congress's intention to create a resident-centered, outcome-oriented survey and enforcement program. See H.R. Rep. No. 391, 100th Cong., 1st Sess., pts. 1 & 2 (1987), reprinted in 1987 U.S. Code Cong. & Admin. News 2313-1; and H.R. Conf. Rep. No. 495, 100th Cong., 1st Sess. (1987), reprinted in 1987 U.S. Code Cong. & Admin. News 2313-1245.

Lake Mary turns this approach on its head in arguing that it should not be responsible for the ineffectiveness of its pest control program because neither the federal nor state authorities "have published any guidelines for effective pest control, and there are no procedures or measures taught to nursing home administrators or nurses during their education and licensing processes that might provide insight as to what is considered standard practice for pest control." Lake Mary RR Br. at 15 (record citations omitted). While guidance may often be provided by industry, state or federal sources and may be helpful as a way of sharing the fruits of experience, the ultimate responsibility for selecting an effective program lies at all times with the facility. The regulations did not require Lake Mary to adopt a pest control program with predefined content or to have its program preapproved, but rather demanded that, in selecting its own approach to pest control, Lake Mary choose a program effective to address pest control problems confronting the facility. It is hard to imagine a facility located in a part of Florida which all agree is heavily infested with fire ants capable of doing serious harm to (and even of killing) helpless nursing home residents not placing a high priority on preventing access by and effectively treating for fire ants.[10]

In any case, this facility had ample notice of the regulatory approach in effect. The regulations make very clear that those who choose to participate in Medicare were obliged to provide

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[9] As CMS pointed out in issuing regulations implementing the new approach, under either regulatory scheme, "the facility was responsible for fully complying with all requirements." 56 Fed. Reg. 48,827 (Sept. 6, 1991).

[10] Lake Mary's expert acknowledged that nursing home deaths had occurred from fire ant stings, but contended that such events were rare.

many specific services and to do so in a manner calculated to achieve specific outcomes. As one of those services, the facility must have in place a pest control system, and that system must be effective to keep the facility free of pests. If the facility found these requirements unattainable or unclear, the time to have made that decision was before signing a participation agreement.

We thus conclude that the absence of additional guidance on how to control pests effectively did not relieve Lake Mary of its responsibility for having an effective program to control fire ants.

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

In arguing that the ALJ Decision was not supported by substantial evidence, Lake Mary parses about a dozen specific statements which the ALJ made (on pages 8-11 of the ALJ Decision) and argues that they demonstrated that the ALJ had misrepresented or ignored record evidence. Lake Mary RR Br. at 12-17. We will not discuss every statement in detail but will provide examples to explain why we do not find any of Lake Mary's arguments in this regard persuasive. Generally, Lake Mary misreads the ALJ's statements and disputes points which he did not make and/or seeks to interpret or weigh conflicting evidence differently than did the ALJ, without showing that the ALJ's interpretation was unreasonable or inconsistent with evidence in the record. Further, in many cases, Lake Mary simply contradicts the ALJ without citing to any specific evidence in the record.[11]

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[11] As an example, Lake Mary points to the ALJ's statement that its "principal argument" was that "fire ants in Florida cannot be eradicated" despite best efforts. Lake Mary RR Br. at 16, quoting ALJ Decision at 11. Lake Mary denies that this assertion was its principal argument, although pressing its truth. Lake Mary then states, with no record citation, that the ALJ's characterization of Lake Mary's position "apparently disregards, without any true consideration, the volume of evidence of the facility's pest control actions." Lake Mary RR Br. at 16. Unsupported claims of this kind are not persuasive and certainly do not establish that the ALJ ignored any of the evidence in the record, especially in light of the ALJ's detailed discussion, with record citations, of Lake Mary's pest control efforts. See ALJ Decision at 7-11. Finally, Lake Mary does not respond to the point made by the ALJ that the very fact that fire

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For example, Lake Mary challenges as "completely unwarranted" speculation the ALJ's statement that it was possible that the pest control company's "actions were governed by the fact that its contract with Lake Mary Health Care did not include fire ants." Lake Mary RR Br. at 14, quoting ALJ Decision at 9. Lake Mary argues that its contract with the pest control company "was a typical pest control contract," that it had been "reviewed and approved by the state of Florida," and that the company nevertheless "provided complete pest control services, including treatments specifically designed to address fire ants, even though the contract did not identify fire ants by name." Lake Mary RR Br. at 14. Lake Mary relied for these claims on testimony by Steven Day, the owner of the pest control company. Id., citing Tr. at 126, 127, 131, and 148.

The ALJ viewed Mr. Day's testimony and was in the best position to evaluate it. That testimony spans approximately 40 pages in the transcript and contains much more than the points relied on by Lake Mary, much of it supportive of the ALJ's views. Cf. Tr. at 118-57. Mr. Day concedes, as indeed Lake Mary must, that the contract (as discussed above) did not specifically cover fire ants. While Mr. Day asserts that Hollywood East used products that include fire ants among their target species, he does not anywhere state that the services provided constituted "complete pest control services, including treatments specifically designed to address fire ants."

Mr. Day acknowledged that his assertion that the pest control contract was "typical" was based only on the fact that it was apparently legal in Florida, in that a state inspector reviewed contracts every few years to "make sure the contracts were within state guidelines," about which guidelines Mr. Day stated that he was "very vague." Tr. at 147-48. In context, it is clear that Mr. Day was not, as Lake Mary implies, asserting that the state of Florida either reviewed this particular contract with Lake Mary or evaluated its appropriateness for a nursing home with residents whose risk from fire ants was, as Mr. Day agreed, much higher than for the average person. Tr. at 149. We therefore disagree with Lake Mary's claim that the omission of fire ants from the species of ants identified as covered is merely "yet another red herring." Lake Mary Reply Br. at 6.

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[11](...continued)
ants cannot be eradicated in Florida "places an onus on long term care providers in that State to have a heightened awareness of the possibility of such insects entering the facility and causing harm to residents." ALJ Decision at 11.

The ALJ did not assert, as Lake Mary implies, that the company never treated with products which were labeled for use with fire ants, as well as other kinds of ants. It was not disputed that the company provided treatment after the August 20th incident which included products effective against fire ants. Nor was it disputed that some of the products used were broad spectrum, and would be expected to kill many insects, from cockroaches to fire ants. Tr. at 141. As the omission of "fire ants" from the contract language indicates, however, fire ant control was not a specific contractual responsibility. The fact that measures taken to control other pests might also have, incidentally, had an impact on fire ants or the fact that the company on a particular occasion used a product directed at fire ants does not change the fact that Lake Mary did not have an effective policy.

The ALJ, also, was entitled to take into account that Mr. Day himself testified that, had he been aware that fire ants had been in the building on August 10 – for example, had the facility retained some of the ants sighted so that their species would have been clear – he would have proceeded very differently. Mr. Day testified that fire ants would cause him to "be reacting differently," by doing "a thorough investigation on where these ant problems are coming from" as "step one," finding the point of entry, and talking to those "who had seen the ants" to obtain details. Tr. at 145. Had he known of a fire ant sighting in a resident's room, he testified, he would "certainly do an extensive crack and crevice interior, investigate the exterior, treat around the area left and right of that room, investigate rooms on both sides. Look in the closets, look for area of where and why this is coming from. Look at potted plants." Tr. at 146. None of this occurred because Lake Mary staff neither knew how to identify fire ants nor retained samples of killed ants from sightings so that pest company personnel could do the identification.

The ALJ was also entitled to consider that Mr. Day, who was not himself a technician applying treatments, had visited Lake Mary only twice, and only to address a termite problem and a "sighting that the facility manager was concerned with, with pharaoh ants," whereupon Mr. Day came in and inspected the facility "to see where our problem was lying with the pharaoh ants." Tr. at 136-37. It was not unreasonable for the ALJ to infer from this testimony that Lake Mary did not direct Mr. Day's attention to any special concern with fire ants. The ALJ was also entitled to take into account the testimony of Mr. Day that he did not know until two weeks before the hearing about the fire ant attack, and that, when asked on cross-examination, admitted that it was "not evidence" of an effective pest control program. Tr. at 138, 140.

In short, more than substantial evidence in the record as a whole supports the ALJ's conclusion that the pest control company did not undertake all necessary measures directed at fire ant control prior to the August 20th attack. His suggestion that the lack of a contractual obligation to do so played a role is not unreasonable.

Lake Mary also disputes the ALJ's statement that, in one ant sighting around a flower pot on May 22, 2003,[12] "there was no indication whether the ants were in the pot prior to being brought to the facility or the ants entered the room from the outside and were attracted to the lilies in the pot." Lake Mary RR Br. at 12; ALJ Decision at 8. Lake Mary argues that the ALJ disregarded testimony of the administrator, "who personally observed the situation . . . that the ants were on the lily in the pot and removal of the lily solved the problem." Lake Mary RR Br. at 12. Lake Mary contends that the ALJ only questioned the administrator's testimony that the details were not documented in writing. Id. at 13, n.5. The maintenance log for May 22, 2003 records the room number and identifies the issue as "small ants — were sprayed then keep coming back." P. Ex. 14, at 2. The administrator testified that, after the nurse found that the ants kept returning despite spraying and cleaning, the administrator went to the room and saw "that these little ants were coming off of this flowering plant that was in the room." Tr. at 324. The plant was then removed, and no further ants were sighted in that room. Id. at 324-25.

We do not see that the ALJ's statement is necessarily inconsistent with testimony of the administrator. The administrator reported seeing ants coming off the lily pot after the nurse had repeatedly attempted to remove the ants from the area by cleaning and spraying. Accepting the observation as accurate in no way establishes how the ants came to be on the plant and the surrounding windowsill. As the ALJ stated, there is simply no indication of whether the ants were brought into the facility on the plant or whether the plant became infested while on the windowsill with ants attracted from outside. ALJ Decision at 8. That removing the plant ended the infestation does not

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[12] Lake Mary erroneously refers to the ant sighting as occurring on May 19, 2003. Lake Mary RR Br. at 12. In fact, Hollywood East performed its monthly pest control services on May 19, 2003. ALJ Decision at 8. Three days later, a nurse noticed that a plant (brought in by a resident's daughter) was sitting on the windowsill in a resident's room surrounded by "little teeny ants." Tr. at 323-24.

answer this question either. Whether the plant was the attractant or the source of the ants, removing it might well help stop the return of the ants.

In any case, Lake Mary's dispute about where these particular ants originated misses the point that the ALJ illustrated by referring to this incident along with others that occurred during 2003. The policy required staff to notify the pest control company whenever ants were sighted; yet, the administrator permitted staff to ignore the policy to call the pest control company and, "if it was just a minor problem, to be able to deal with it themselves and report it to maintenance." Tr. at 320. The effect of leaving this discretion in the hands of staff who were unable to recognize fire ants and who had no training in assessing the source of pest problems was that no complete record was made about ant sightings, and the pest control professionals did not obtain a full picture of the ant problems.[13]

The other arguments which Lake Mary makes about statements in pages 8 through 11 of the ALJ Decision are equally unavailing. We reject them without further discussion. We conclude that the challenged ALJ findings are supported by substantial evidence in the record as a whole.

6. The ALJ did not "ignore" evidence of interventions undertaken by Lake Mary between August 10 and August 20, 2003.

Lake Mary argues that the only relevant period of time referenced in the SOD was August 10th through August 20th of 2003 and that the evidence showed that Lake Mary made all reasonable efforts during that time. Lake Mary therefore contends that the ALJ erred because he ignored evidence of the efforts made by Lake Mary to respond to the August 10th sighting in R1's room. Lake Mary asserts that the ALJ "inexplicably" concluded that the pest control company acted on the assumption that the ants seen were not fire ants. Lake Mary Reply Br. at 7-8. In addition, Lake Mary asserts that the ALJ acknowledged only the treatment with

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[13] The ALJ similarly focused on the inadequacies of the information provided to the pest control company when he pointed out that, on July 20, 2003, facility staff observed ants in a resident's room but called the pest control company only about a wasps' nest seen just outside the resident's window. ALJ Decision at 8. Lake Mary again misses the point by arguing that the reason for the call was irrelevant since on arrival the pest control company treated for the ants in the room. Lake Mary RR Br. at 13.

Gourmet Ant Bait Gel while ignoring the use of another pesticide (Demon) which does kill fire ants, as well the "numerous diligent and aggressive measures, in addition to routine cleaning of the room and care and monitoring of the resident . . . ." Id. at 8.

Not only do we disagree with Lake Mary that the only relevant events were those occurring during August 10-20, 2003, for the reasons explained above, we also find no basis for Lake Mary's claim that the ALJ did not understand the events that occurred during that period. The ALJ laid out the details of the actions taken by the facility and by Hollywood East over those eleven days. ALJ Decision at 8-11. On August 10, 2003, ants were sighted in R1's room, and two days later, during its regular monthly visit, the pest control company treated with Gourmet bait and Demon spray, both of which the ALJ named. ALJ Decision at 9. Gourmet was specific to pharaoh ants, not fire ants. Demon was effective against a wide spectrum of pests, including fire ants. Far from being inexplicable, the ALJ's inference that the pest control company believed the problem to be pharaoh ants was based on record evidence. The pest control operator did not have an opportunity to view the ants. Evidence from the record shows that, even after the attack on August 20th, facility staff continued to believe erroneously that the pests involved were not fire ants, because they were "black" and "much larger than fire ants."[14] CMS Ex. 3, at 3 (nurse reporting to R1's son that she was not bitten by fire ants); see also Tr. at 246-47, 344 (son reporting conversation with administrator to same effect), Tr. at 386-89 (administrator almost certain the ants seen on August 10, 2003 were not fire ants based on "communications with staff"). Further, the owner of Hollywood East testified that he depended on accurate information from the facility to tailor the treatment to the type of ant involved and that, as we have noted, had he known fire ants were spotted, the company would have acted much more aggressively. Tr. at 142-46, 150. In this context, it was not unreasonable for the ALJ to conclude that the choice of a bait specific for pharaoh ants reflected the operator's

[14] Dr. Merchant testified that, in fact, the easiest way to identify fire ants is to know that they are generally large with wide individual variation within a group, so that a trail of ants varying in size is recognizable as fire ants. Tr. at 43. Also, they range in color from reddish orange to almost black. Id.

assumption that the pest was not fire ants, even though a wide-spectrum spray was also used.[15]

In addition to the treatment on August 12 by Hollywood East, Lake Mary also points to actions of its staff as establishing its diligent efforts after August 10th. Lake Mary RR Br. at 8-9. The staff inspected room and grounds for entry points and ant mounds, without finding any, and cleaned and sprayed the room with a "common household ant spray." Id. at 8. Staff members "noted the sighting on the facility's 24-hour report" for discussion (but not on its pest control log). Id. at 8; CMS Ex. 7, at 2. On August 12th, "staff also applied 350 points of Talstar, a recognized fire ant control product, to the outside grounds." Lake Mary RR Br. at 9, citing Tr. at 265. On August 13th, staff conducted "walking rounds of the facility grounds" to look for fire ant mounds. Id. at 9, citing Tr. at 307. In addition, daily "guardian angel" rounds were made of residents' rooms. Id. at 9. Thus, Lake Mary contends, the ALJ was wrong to conclude that "nothing was done to address fire ants." Id. at 10.

The ALJ does not conclude that nothing was done between August 10-20 that could have impacted fire ants. The ALJ concludes that, absent assurance that the invaders were not fire ants, the facility and pest control operator should have taken all the steps which were identified as appropriate to address a fire ant infestation, and did not do so. Even assuming the facility did what it stated and even if we conclude that those actions were a reasonable part of a pest control program,[16] Lake Mary's

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[15] Lake Mary itself seems to concede this point by saying that the "technician believed the ants that had been observed by staff were pharaoh ants, a non-stinging ant, because those ants had occasionally been seen in the facility in previous months" and therefore used bait "to attract and kill that type of ant." Lake Mary RR Br. at 10, n.4.

[16] This assumption is not necessarily warranted. For example, an unsuccessful effort to find the entry points is hardly reassuring, since obviously the ants did enter and could again, since the points were not found and sealed. The ALJ pointed out that the guardian angel rounds and administrative morning meetings never resulted in a single report on ants in the facility or fire ant mounds on the grounds despite all the ant sightings. ALJ Decision at 12; Tr. at 309, 318-19. In addition, the administrator admitted that another ant sighting occurred on

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recitation does not undercut other evidence that more was required to appropriately control fire ants. Had the ants on August 10th (or earlier sightings) been identified as fire ants, as we have found, more aggressive actions by the pest control operator would have been necessary and might have forestalled the attack. ALJ Decision at 9-10, 12-13, and record citations therein. Taking some steps that are appropriate as part of a pest control program does not equate to implementing a fully effective program.

We conclude that the ALJ's findings on Lake Mary's pest control activities between August 10-20, 2003 were supported by substantial evidence in the record.

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[16](...continued)
August 15, 2003, resulting in another visit by Hollywood East on August 18, 2003. Tr. at 334. Yet, Lake Mary still did not undertake an inspection that was thorough enough to discover the entry points and sources of the ants. The failure to find fire ant mounds is not surprising given the evidence, discussed elsewhere, that mounds are hard to spot in sandy soil such as that around Lake Mary. Such a failure should not have convinced Lake Mary staff that fire ants were not present, especially given that Lake Mary's own expert on a pre-hearing visit found fire ants everywhere on the grounds during his visit.

7. The ALJ's conclusion that Lake Mary failed to develop and implement written policies to prevent neglect is not erroneous and is supported by substantial evidence.

Lake Mary asserts that the evidence in the record does not support the finding that it was not in substantial compliance under tag 224. Lake Mary RR Br. at 20-22, 24. Lake Mary also contends that the findings made by the ALJ are not legally sufficient to make out a case under 42 C.F.R. § 483.13(c) because Lake Mary did have a proper anti-neglect policy and followed it in the case of R1. Id. at 19-10.

The Board recently held that whether noncompliance with section 483.70(h)(4) also constitutes noncompliance with section 483.13(c) depends on the facts of a particular case. Emerald Shores Health & Rehabilitation Center, DAB No. 2072, at 21-22 (2007). Specifically, to make that connection, CMS "must establish some relationship between the failure to provide pest control services and a failure to have or to implement policies or procedures designed to prevent neglect."[17] Id. at 22. The ALJ in Emerald Shores had found no such connection, and the Board upheld that determination because it was supported by substantial evidence. Id. at 24. In particular, in that case, CMS based its argument for noncompliance with the neglect requirements on the alleged non-existence of any written policies on pest control, yet the facility proved that it did have such a written policy. Id. at 23-24. The Board indicated in that case that "CMS's case for noncompliance under 483.13(c) might have been more persuasive had CMS admitted that policies and procedures existed but argued and shown that they were not sufficient or adequately implemented." Id. at 23.

The ALJ in the present case, by contrast, found that CMS had established that the pest control failure was the "natural consequence" of the repeated failure to carry out the requirements of its pest control policy. ALJ Decision at 10. He found that the administrator treated the pest reporting policy as "merely a guideline that staff was not really expected to follow." Id. at 13, and record citations therein. The ALJ pointed to the failure of the facility's administration to determine the source(s) of the repeated ant sightings, to require its pest control company to cover fire ants by contract, and to respond aggressively in sealing entry points and increasing

[17] The regulations define "neglect" as "failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness." 42 C.F.R. § 488.301.

inspections and monitoring until R1 had been attacked as demonstrating inadequate policy implementation. Furthermore, the ALJ found that Lake Mary's staff, in fact, "exhibited neglect, indifference, and disregard to resident care and safety" in their failure to have and implement effective control of pests. Id. at 14. The ALJ could reasonably infer from these findings and other facts in the record that the documented pest control problems evidenced a larger breakdown in ensuring effective implementation of policies to ensure that residents received the services they needed to be safe.

We therefore affirm the ALJ's conclusion that Lake Mary was not in substantial compliance with Tag F224, as well as Tag F469.

8. We affirm the ALJ's conclusions on immediate jeopardy and the duration of the CMP.

The standard by which we are guided in reviewing an ALJ's decision to uphold CMS's immediate jeopardy determination is highly deferential. See, e.g., Barbourville Nursing Home, DAB No. 1962, at 11 (2005), aff'd, Barbourville Nursing Home v. Leavitt, 2006 W.L. 908631 (6th Cir., Apr. 6, 2006). Regulations require an ALJ to uphold CMS's determination that the applicable level of noncompliance is immediate jeopardy unless the facility proves that it is "clearly erroneous." 42 C.F.R. § 498.60(c).

Lake Mary does not dispute that the harm caused to R1 was serious enough to justify finding immediate jeopardy if the facility was in noncompliance. Indeed, Lake Mary could hardly fail to admit this in light of the photograph in the record showing the severity of R1's injuries. CMS Ex. 19.

Lake Mary argues, nevertheless, that –

- Its actions as of August 20, 2003 eliminated any deficiency; and

- Citing continuing immediate jeopardy after that date was "blatantly unfair," because the state surveyors did not find (and therefore did not notify Lake Mary about) any immediate jeopardy. Hence, the facility had "no opportunity to address such concerns."

Lake Mary RR Br. at 23.

Lake Mary argues that it implemented 15-minute checks of every resident in the facility on August 20, 2003 to preclude another attack and reinstated daily inspections of the grounds. Id.

Further, Lake Mary contends that the surveyors conceded that "the action plan developed by the administrator was more than adequate to **fully** correct whatever deficiency had been identified." Id. at 23 (bold in original), citing P. Ex. 23, at 76. Lake Mary further argues that the only corrective action not taken until September 5, 2003, caulking of the facility, was actually a "recaulking" done "at the suggestion of a surveyor as a measure above and beyond what was actually necessary." Lake Mary RR Br. at 24. Finally, Lake Mary claims that all measures required by its plan of correction were accomplished by September 20, 2003, so that substantial compliance was achieved and the lower CMP should have ended on that date instead of October 14, 2003 when the revisit occurred. Id.

The Board has repeatedly held that even when a plan of correction is accepted by CMS, that does not suffice to remove noncompliance. The burden is on the facility to show that it timely completed the implementation of that plan and in fact abated the jeopardy (to reduce the applicable CMP range) or achieved substantial compliance (to end the application of remedies). See, e.g., Spring Meadows Health Care Center, DAB No. 1966 (2005). It is not enough that some steps have been taken, but rather the facility must prove that the goal has been accomplished.

Furthermore, some of the measures which Lake Mary cites as eliminating immediate jeopardy were only stopgap measures to prevent other injuries while the underlying problem was being solved. For example, the 15-minute resident checks were only in place for the 48 hours as a "bootstrap" operation before the pest treatments, whereupon the facility reverted to standard two-hour checks. Tr. at 347-49 (Administrator Kehoe). Many of the procedures on which Lake Mary relies as showing its corrective efforts, including the 15-minute checks, are not part of the plan of correction submitted in response to the SOD, but are simply identified on the internal action plan which the administrator prepared and showed to the surveyors at the end of the survey. Compare CMS Ex. 21 with P. Ex. 2. The pest control company did not even come out to begin treatment until August 22, 2003. Tr. at 339-40. The action plan called for many steps that would not be completed until well after August 20, 2003, such as trimming shrubs near the building targeted for August 28, 2003. P. Ex. 2. The administrator admitted that caulking of the windows of residents' rooms was not completed until September 5, 2002. Tr. at 372-72.

In its plan of correction for the SOD, Lake Mary does not allege that it will achieve substantial compliance prior to September

20, 2003. CMS Ex. 21. The surveyors who revisited on October 15, 2003 to determine if the credible allegation of substantial compliance was well-founded concluded that substantial compliance was achieved as of the survey date. CMS Ex. 20, at 5. Lake Mary asserts, without citing to the record, that the required actions were taken by September 20, 2003 and that there was "no evidence to contrary." Lake Mary then cites the regulation that a CMP may "only accrue until the date of correction for which there is written credible evidence." Lake Mary RR Br. at 24, citing 42 C.F.R. § 488.440(h)(1).

Lake Mary's reliance on this regulation is misplaced. The regulation does not require CMS to provide evidence that the facility remained out of compliance on each day on which a CMP accrued. Once CMS finds a facility out of compliance, the facility remains out of compliance (and the CMP continues to accrue) until the date CMS finds the facility in compliance. Generally, that finding requires a revisit survey to determine that a facility has achieved substantial compliance. If the facility submits "written credible evidence" through "documentation acceptable to CMS or the State agency that substantial compliance was achieved on a date preceding the revisit," the CMP stops accruing on the date CMS determines that substantial compliance was achieved. 42 C.F.R. § 488.440(h)(1). Lake Mary has made no showing that this situation exists here.

We conclude that the ALJ correctly upheld both CMS's immediate jeopardy determination and the duration of the CMPs in this matter.[18]

[18] The reasonableness of the amounts of the daily CMPs was not an issue on appeal. As the ALJ noted, the immediate jeopardy CMP was set at the lowest allowable amount and the non-immediate jeopardy CMP was only one step above the lowest allowable amount of $50. ALJ Decision at 14-15.

Conclusion

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

/s/
Judith A. Ballard

/s/
Sheila Ann Hegy

/s/
Leslie A. Sussan
Presiding Board Member