Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

In the Case of: The New Homestead Care Center, (CCN: 16-5525), Petitioner, - v. - Centers for Medicare & Medicaid Services.	)	Date: February 25, 2009 Docket No. C-07-293 Decision No. CR1906

DECISION

I sustain the determination of the Centers for Medicare & Medicaid Services (CMS) to impose a civil money penalty (CMP) against Petitioner, The New Homestead Care Center (Petitioner or facility), 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 per instance CMP of $7000, based on a finding of immediate jeopardy.

I. Background

This case is before me pursuant to a request for hearing filed by Petitioner dated March 2, 2007. Petitioner is a long-term care provider located in Guthrie Center, Iowa.

By letter dated January 3, 2007, CMS informed Petitioner that based on an extended survey completed by the Iowa Department of Inspections and Appeals (State Agency) on November 27, 2006, it was imposing a per instance CMP of $7000 due to Petitioner's failure to be in substantial compliance with the applicable federal requirements for long-term care facilities. The CMP was for deficiencies cited at Tag F225 (Staff Treatment of Residents).

On June 15, 2007, CMS filed a motion for summary affirmance. On June 29, 2007, Petitioner filed a brief in response to CMS's motion. On July 27, 2007, CMS filed a supplemental motion for summary affirmance based on newly acquired evidence. On August 10, 2007, I issued an order denying CMS's motion for summary affirmance.

I convened a hearing in this case on June 3, 2008 and June 4, 2008 in Des Moines, Iowa. During the hearing, CMS offered six exhibits identified as CMS Exhibits (CMS Exs.) 1-6. Petitioner objected to CMS Ex. 6 and I overruled Petitioner's objection to this exhibit. I receive CMS Exs. 1-6 into evidence. Petitioner offered ten exhibits, identified as Petitioner Exhibits (P. Exs.) 1-10. I admit these ten exhibits into evidence without objection. In a June 27, 2008 letter issued at my direction, I instructed the parties to submit opening post-hearing briefs (CMS Br. and P. Br.) by July 31, 2008, and post-hearing reply briefs (CMS Reply and P. Reply) by August 15, 2008. The parties subsequently submitted their respective briefs as directed.

Based on 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, and I further find that CMS was authorized to impose a CMP of $7000 for noncompliance.

II. Applicable Law and Regulations

Petitioner is considered a long-term care facility under the Social Security Act (Act) and regulations promulgated by the Secretary of Health and Human Services (Secretary). The statutory requirements for participation by a long-term care facility are found at sections 1819 and 1919 of the Act, and at 42 C.F.R. Parts 483 and 488.

Sections 1819 and 1919 of the Act invest in the Secretary authority to impose CMPs against a long-term care facility for failure to comply substantially with participation requirements.

Facilities that participate in Medicare may be surveyed on behalf of CMS by state survey agencies in order to determine whether the facilities are complying with federal participation requirements. 42 C.F.R. §§ 488.10-488.28; 42 C.F.R. §§ 488.300-488.335. Pursuant to 42 C.F.R. Part 488, CMS may impose either a per day CMP or a per instance CMP against a long-term care facility when a state survey agency concludes that the facility is not complying substantially with federal participation requirements. 42 C.F.R. §§ 488.406, 488.408, and 488.430. The penalty 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 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.

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

1. the facility's history of noncompliance, including repeated deficiencies;
2. the facility's financial condition;
3. the seriousness of the deficiencies as set forth at 42 C.F.R. § 488.404; and
4. the facility's degree of culpability.

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). 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).

In a CMP case, CMS must make a *prima facie* case that the facility has failed to comply substantially with participation requirements. To prevail, a long-term care facility must overcome CMS's showing by a preponderance of the evidence. *Hillman Rehabilitation*

Center, DAB No. 1611 (1997), *aff'd, Hillman Rehabilitation Center v. U.S. Dept. of Health and Human Services*, No. 98-3789 (GEB), slip op. at 25 (D.N.J. May 13, 1999).

III. Issues

A. Whether the facility was complying substantially with federal participation requirements.

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 federal participation requirements under 42 C.F.R. § 483.13(c)(2)-(4) (Tag F225).

From April 2005 to November 2006, there were a number of complaints and allegations involving residents at Petitioner's facility. The Statement of Deficiencies listed a total of eight examples under Tag F225 and eight corresponding residents. All of the allegations of abuse and mistreatment involved the same certified nurse aide (CNA), Juan Bautista-Meraz (Meraz). CMS contends that the facility failed to identify possible abuse, make an initial report to the administrator and to State officials, conduct a thorough investigation and issue a post-investigation report. CMS Br. at 7.

Resident 2

CNA Mary Busse identified Resident 2 as stating that, in April or May 2006, CNA Meraz was rough with her, and when she told CNA Meraz he was too rough and that she would complain to management, he took away her call light. CMS Ex. 1, at 5; Tr. at 28, 140. CNA Busse stated that she reported the incident to charge nurse Patty Clark. Nurse Clark told the surveyor on November 2, 2006, that she could not recall knowing about this incident. Tr. at 31.

Petitioner asserts that during the interview conducted by Surveyor Sharon Benson of Resident 2, the resident indicated in various ways that she liked CNA Meraz caring for her and that she had no problem with the way he treats her. P. Br. at 20-21; *see* Tr. at 341, 342, 361, 362. Petitioner also makes light of the fact that Surveyor Benson did not make a determination of abuse for this particular resident. Tr. at 106.

Resident 3

Resident 3 told Surveyor Benson that, shortly after April 2005, CNA Meraz was assisting her with transferring from the toilet and that he rubbed his body against hers. Resident 3 explained that this was done in a sexually suggestive and offensive way, with the resident and CNA facing each other. Tr. at 6; CMS Ex. 2, at 43, CMS Ex. 3, at 144. According to CNA Marlene Stearns, Resident 3 told her that she was afraid of CNA Meraz and that he "had touched ladies inappropriately." Tr. at 12. According to CNA Busse, Resident 3 told her about this incident and at the time Resident 3 was tearful and she stated that she was afraid of Mr. Meraz. CNA Busse explained that Resident 3 was alert at the time she was telling her about the incident. According to testimony, CNA Busse reported the substance of the conversation to the charge nurse, Cheryl Hughes.

Resident 3 also told Surveyor Benson that CNA Meraz would run a wheelchair into her leg. According to testimony, as recently as a day before Surveyor Benson interviewed Resident 3, CNA Meraz ran a wheelchair into Resident 3's leg. Surveyor Benson's interview of CNA Stearns revealed similar information including that Resident 3 stated she was upset and fearful of Meraz. Tr. at 12, 13. CNA Stearns told Surveyor Benson that she reported Resident 3's complaint about the wheelchair to the charge nurse and the resident reported these incidents to the charge nurse, but nothing was done. Tr. at 14, 159.

Petitioner's contention with respect to Resident 3 was that she required a staff member to be in close proximity to her with the staff member's arm around her, according to charge nurse Rosella Hanson. Tr. at 356-7. Petitioner points to testimony that despite Resident 3's assertions of CNA Meraz rubbing up against her, Surveyor Benson testified that there were no allegations that CNA Meraz groped or fondled Resident 3, or that CNA Meraz had an erection. Tr. at 96-97. Petitioner also highlights various instances where Resident 3 has had negative behaviors toward staff, including male staff. P. Br. at 18. Ms. Hanson testified that Resident 3 was not an accurate historian. Tr. at 357-358.

Resident 4

According to the SOD, CNA Stearns told Surveyor Benson that around August or September of 2006, Resident 4 complained about CNA Meraz. CNA Stearns said that Resident 4 was crying and she said that she did not want a man caring for her. CNA Stearns stated that she told the Director of Nursing (DON), Amy Gettler, about the incident. CMS Ex. 1, at 5. According to testimony at the hearing, Resident 4 told Surveyor Benson that CNA Meraz insisted that she get out of bed even when she was not feeling well and that he told her to undress while watching her do so. She told Surveyor Benson that CNA Meraz would jerk the covers off her and he would say "Get up." Resident 4 told Surveyor Benson that CNA Meraz was rude to her, and that she felt

embarrassed and uncomfortable when CNA Meraz made her undress in front of him, and she felt that he stared at her while she would undress. Tr. at 31, 32, 33. By a form dated October 27, 2006, the DON stated that she did not know of the incident involving Resident 4 and CNA Meraz. CMS Ex. 1, at 5.

According to Petitioner, Resident 4 required assistance during the dressing process. P. Br. at 21-22. Petitioner pointed to testimony at the hearing that Ms. Benson did not recall the resident telling CNA Meraz to leave the room inferring that Resident 4 could not have been very embarrassed or uncomfortable with CNA Meraz in the room while she was getting dressed. *See* Tr. at 108. P. Br. at 22.

Resident 6

According to the SOD, CNA Michel Smith told Surveyor Benson that Resident 6 expressed fear of CNA Meraz. According to CNA Smith, Resident 6 told Ms. Smith that she was afraid of CNA Meraz and what he was going to do to her. Tr. at 46, 76; CMS Ex. 2, at 55. CNA Smith stated that she reported the incident to Nurse Wilson, but no investigation was initiated. Tr. at 47, 75.

Petitioner's contention with respect to Resident 6 is that she suffered from a long history of delusional behaviors. P. Br. at 10. Petitioner questions CMS's assertion that because the resident appeared afraid, the facility should have opened an abuse investigation. P. Br. at 11. Petitioner contends that even though CNA Smith reported the incident involving Resident 6 to another staff member, the incident does not equate to an allegation of abuse. Petitioner argues that "clearly not every resident response or comment that is reported to nursing staff constitutes abuse that must be investigated." P. Br. at 11.

Resident 8

According to the SOD, CNA Lois Eivans identified Resident 8 as "scared" and "upset" one day. CNA Eivans stated that Resident 8 told her that CNA Meraz was mean. CNA Eivans asserted that she reported Resident 8's concerns to the social worker, Nancy Wells. According to testimony, nothing happened after Resident 8's concerns were reported and Ms. Wells told Surveyor Benson that she did not recall the report from CNA Eivans concerning Resident 8. CMS Ex. 1, at 3; Tr. 45, 89, 90.

Petitioner points out that with respect to Resident 8, CNA Eivans was the sole source of the allegations involving this particular resident. Petitioner asserts that the social worker, Ms. Wells, denied CNA's assertions that she was told of Resident 8's comments regarding CNA Meraz. According to Petitioner, CNA Eivans had credibility issues and Ms. Wells' recollection of whether she was told about Resident 8's comments should be believed instead of CNA Eivans' version of events. P. Br. at 15.

Resident 9

According to the SOD, CNA Eivans told Surveyor Benson that CNA Meraz placed a chair against the door of Resident 9's room and when she entered the room Resident 9 was not covered and a bloody vaginal discharge was evident. As CNA Eivans entered the room, CNA Meraz was leaning over Resident 9. According to CNA Eivans, CNA Meraz said he was cleaning the resident, but CNA Eivans did not observe any supplies or wash cloths. CMS Ex. 1, at 8. According to testimony, CNA Eivans said she had to gather cleaning supplies and clean Resident 9 herself. Tr. at 26. CNA Eivans said that she reported this incident to charge nurse Hughes. Tr. at 27.

According to Petitioner, CNA Eivans indicated that she never reported any assertions or allegations relating to Resident 9 to any staff members at the facility. Petitioner contends that CNA Eivans only reported her observations to Surveyor Benson during the survey. P. Br. at 7. Petitioner points to testimony from Nurse Smith that it was not unusual to place the Geri chair against the door in Resident 9's room. Tr. at 345. Petitioner also argues that a bloody discharge coming from Resident 9's vaginal area was not uncommon since she had abdominal cancer and occasionally had urinary and rectal bleeding as a result of her illness. Petitioner argues that the inference that CNA Meraz abused Resident 9 based on CNA Eivans' observations of the bleeding is unsupported by the evidence. P. Br. at 8.

Resident 11

Resident 11 told CNA Eivans that CNA Meraz had reached around and rubbed Resident 11's breast. CMS Ex. 1, at 2. According to CNA Eivans, she reported the incident to the DON. According to testimony at the hearing, Resident 11 told Surveyor Benson that CNA Meraz grabbed her breast once or twice while assisting her ambulating. Tr. at 39. Resident 11 signed a statement that recited her allegations. Tr. at 41; CMS Ex. 3, at 263. Later, Resident 11 denied any problem with CNA Meraz. Tr. at 41, 43; CMS Ex. 3, at 264; CMS Ex. 2, at 41. When interviewed, the DON stated that she investigated the incident of July 14, 2006, and the resident denied the incident, so CNA Meraz was not disciplined. CMS Ex. 1, at 2. According to testimony at the hearing, no report was immediately made to the state of possible abuse, no further investigation was conducted, and CNA Meraz was not separated from Resident 11.

Petitioner contends that immediately after the incident was reported to Ms. Gettler, the DON, regarding Resident 11, she conducted an interview with CNA Eivans as well as with Resident 11. Petitioner maintains that during the investigation of the alleged incident with CNA Meraz and Resident 11, Resident 11 did not corroborate any portion of the allegations made by CNA Eivans. P. Br. at 13; *see* Tr. at 200. Subsequent to the

investigation, Ms. Gettler concluded that there was no reasonable basis to believe that CNA Meraz had abused Resident 11. Two months after the conclusion of Ms. Gettler's investigation, prompted by the State, she initiated a second investigation. During the second investigation, Resident 11 recalled an incident involving similar occurrences, but according to Ms. Gettler the Resident was unable to identify the staff member involved. Also, according to Ms. Gettler, subsequent investigations were initiated and Resident 11 had inconsistent remembrances of the incident. Tr. at 81, 82; P. Br. at 14. Petitioner also argues that it is not uncommon for a caregiver to inadvertently come in contact with a resident's breast while attempting to ambulate her. P. Br. at 14.

<u>Resident 15</u>

According to the SOD, on October 25, 2006, Resident 15 stated that CNA Meraz grabbed his shoulder to get him dressed and he was too rough. Resident 15 said that the incident occurred approximately a year earlier. Resident 15 stated that he informed his physician of the incident. CMS Ex. 1, at 6, 7. According to Resident 15, it was his right arm and he had to start taking multiple dosages of Tylenol daily after this incident. Tr. at 22, 68, 72. According to the December 12, 2005 nurses' notes, Resident 15 started complaining of increased pain in his arm. CMS Ex. 3, at 333, 334. According to the testimony of Surveyor Benson, the facility did not investigate why Resident 15 had increased pain in his right arm.

Petitioner contends that Resident 15 never alerted facility staff of the incident where CNA Meraz allegedly jerked Resident 15's arm. Petitioner argues that because the facility had not been made aware of Resident 15's complaint, either from Resident 15 himself or Resident 15's physician, the facility should not have been required to report possible abuse regarding Resident 15. P. Br. at 9. Also, Petitioner argues, Resident 15's complaints of pain do not constitute an "injury," and that Resident 15 has had chronic shoulder pain dating back to at least September 2004. P. Br. at 8-9; *see* P. Ex. 7, at 5, 18-23. Petitioner contends that Surveyor Benson concluded that the allegation asserted by Resident 15 against CNA Meraz did not constitute abuse. P. Br. at 10; *see* Tr. at 73.

42 C.F.R. § 483.13(c)(2)-(4) requires a participating facility's staff to:

- Immediately report to the facility's administrator and to other officials in accordance with state law through established procedures (including to the state survey and certification agency), all alleged violations involving mistreatment, neglect or abuse of a resident, including injuries of unknown source;

- Thoroughly investigate all such allegations and prevent further abuse while the investigation is in process;

- Report all investigation results to the administrator or his/her designated representative and to other officials in accordance with State law within five working days of the incident and if the alleged violation is verified appropriate corrective action must be taken.

See 42 C.F.R. § 483.13(c)(2)-(4).

The facts concerning most of the residents in this case are not in dispute. CMS contends that, with one exception, Petitioner's DON and the facility's administrator denied knowing about any of the allegations of mistreatment, neglect or abuse cited in the SOD. CMS Br. at 1. According to CMS, 42 C.F.R. § 483.13(c)(2) is triggered not by the probability of violative conduct, but by the facility's recognition of the *possibility* of violative conduct. CMS argues that the facility did not comply with section 483.13(c)(2) which requires the facility to immediately report all alleged violations involving abuse to the facility administrator and to the State survey and certification agency. According to CMS, harsh or loud statements which cause mental anguish, but no physical injury, can initiate the requirement for a facility to report the alleged violation as possible abuse. CMS Br. at 8.

42 C.F.R. § 488.301 defines neglect as the "failure to provide goods and services necessary to avoid physical harm, mental anguish or mental illness." Abuse is defined as "willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish." 42 C.F.R. § 488.301. With the exception of Resident 15, CMS alleges that the facility should have identified possible neglect or abuse in the form of mental anguish of the residents of Petitioner's facility. Pursuant to 42 C.F.R. § 483.13(c)(2) facility staff has a duty to immediately report to the facility's administrator *all* alleged violations involving mistreatment, neglect or abuse of a resident. This not only includes possible physical abuse, as CMS alleges concerning Resident 15, but also mental aguish as CMS alleges with respect to Residents 2, 3, 4, 6, 8, 9, and 11. *See Hotel Reed Nursing Center*, DAB CR1494 (2006), *aff'd on other grounds*, DAB No. 2154 (2008); *Royal Park Care Center*, DAB CR1493 (2006); *Cedar View Good Samaritan*, DAB CR997 (2003). Also, with respect to Residents 3, 4, 9, and 11 CMS alleges that Petitioner did not investigate possible inappropriate sexually oriented conduct.

Petitioner largely misses the point as to what the regulations require when allegations of abuse have been made. Petitioner argues that residents make statements all the time that could be interpreted as many different things including allegations of abuse. P. Br. at 10. However, Petitioner contends, each resident's credibility, prior history and individual circumstances must be considered before an investigation into allegations of abuse are initiated. Petitioner seemed to operate on the principle that if the allegation of abuse was likely to be deemed not credible, it did not need to be reported. This, however, is a misunderstanding of the regulation. The regulation does not entitle a facility to make a

preliminary investigation involving exclusively lower-level facility staff in order to weed out claims that it thinks do not rise to the level of likely abuse. The regulation is explicit in its direction that *all* alleged violations involving mistreatment and abuse must be immediately reported to facility's administrator and *all* such allegations must be thoroughly investigated.

In seven of the eight Residents listed in the SOD, Petitioner did not show that it made an immediate report to the facility's administrator concerning these residents nor did it provide evidence that it provided the proper report within five working days to the State. Petitioner provides various reasons for not making the required reports to the appropriate representatives, including not knowing about the possible abuse and reasoning that the allegations concerned incidents so common that the actions could not possibly rise to the level of what can be considered as abuse.

The one investigation that the facility did initiate, of the eight that it should have investigated, was lacking in thoroughness and in that the possible abuse was not reported to the State within the specified time required. The DON only chose to interview the Resident, Resident 11, and CNA Eivans. The DON did not interview CNA Meraz, any of the other CNAs or any of the other residents concerning Mr. Meraz. As CMS argues in its brief, if the State had been properly notified, it may have questioned the thoroughness of the facility's investigation and a more complete investigation may have been initiated, if not mandated.

Another troubling aspect of the facility's handling of its residents' allegations of abuse is facility staff's general denial that the residents made allegations that would have triggered an investigation. With respect to Residents 2, 4, and 8 the social worker, charge nurse and the DON denied ever knowing or could not recall being told about the relevant allegations. CMS Ex. 1, at 3, 5; Tr. 31, 44, 89, 90. As for Residents 3, 6, 9, and 11, reports were made by CNAs of possible mistreatment or abuse, but no action was taken in the form of an investigation into possible abuse. Tr. at 14, 25, 47, 75, 159. Petitioner attacked the credibility of CNA Eivans, but could not advance any plausible reason why CNA Stearns and CNA Busse should not be believed when they said that they reported incidents of possible abuse involving CNA Meraz. In the case of CNA Eivans, Petitioner's contention that Ms. Eivans had prior personal history with CNA Meraz and could not be believed when she claimed reporting incidents allegedly involving CNA Meraz has no relevance as to whether or not she reported these incidents to her superiors. It would only be relevant as to whether the claims Ms. Eivans made were credible. I find that the statements made by CNA Stearns, CNA Busse, and CNA Eivans, that they reported the various incidents of possible abuse, are more credible than those statements made by the charge nurse, the DON, and the social worker that they could not recall or merely denied these statements were made.

As for Resident 15, a facility has the duty to investigate an injury caused by an unknown origin. I find that Petitioner failed to comply with the requirements of 42 C.F.R. § 483.13(c)(3) because it should have investigated the cause of the pain in the resident's right shoulder as soon as he complained of increased pain on December 12, 2005. The regulation requires that a facility investigate immediately the cause of a resident's injury, including an injury of an unknown origin. On December 12, 2005, facility staff knew that Resident 15 experienced a significant change in his condition, but did not know the cause of Resident 15's increased pain at that time. The fact that Resident 15 may have suffered an unknown injury placed a duty upon Petitioner to investigate the cause. The failure to investigate the cause of Resident 15's injury, and the failure to report its results to the appropriate state officials within five days of December 12, 2005, is a failure to comply with the regulatory requirement. "A facility has an absolute duty to treat every resident injury from an unknown source as evidence of possible abuse, neglect, or mistreatment, until it establishes the injury's cause." *Grace Healthcare of Benton*, DAB CR1676 (2007).

B. CMS's finding of immediate jeopardy was not clearly erroneous.

Immediate jeopardy exists where a 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. For a finding of immediate jeopardy, it is not necessary to show that the noncompliance caused serious injury, harm, impairment, or death. It is sufficient to show that the noncompliance was likely to cause serious injury, harm, impairment, or death. *Fairfax Nursing Home, Inc.*, DAB No. 1794, at 14 (2001).

It is Petitioner's burden to prove clearly erroneous a finding by CMS that a deficiency puts residents at immediate jeopardy. 42 C.F.R. § 498.60(c)(2). Here, CMS established strong prima facie evidence of immediate jeopardy level deficiencies under Tag F225. Petitioner contends in its brief that there were no immediate jeopardy level deficiencies. Petitioner argues that CMS has failed to prove that there was a likelihood of serious injury or harm to the residents cited under F225. Specifically, Petitioner argues that CMS failed to show a potential for more than minimal harm with respect to all the residents. Petitioner also argues that CMS's primary witness, Surveyor Benson, could only substantiate the findings of abuse related to one of the eight residents, Resident 3. According to Petitioner, the only type of harm that Resident 3 experienced was mental anguish. Petitioner contends that Resident 3's mental anguish does not rise to the level of serious injury or harm to the resident. Petitioner asserts that the only physical harm alleged to have occurred was related to Resident 15's arm. Petitioner contends that any harm done to Resident 15's arm or shoulder did not rise to the level of serious injury or harm to a resident.

Again, I am not persuaded by Petitioner's arguments or Petitioner's witnesses' testimony. Petitioner offered no persuasive evidence to show that CMS's determination of immediate jeopardy was clearly erroneous. The allegations concerning CNA Meraz and four of the residents, Residents 3, 4, 9, 11, involved the possibility of sexually oriented conduct. The mental anguish experienced by victims of sexually oriented abuse is very serious and can affect an individual in lasting ways that manifests itself both mentally and physically. CMS has proven that there was a potential for more than minimal harm because there was a likelihood of serious injury or harm to Petitioner's residents if the facility continued its pattern of not investigating possible abuse. Petitioner failed in providing these residents with a level of care that is mandated by the regulations. Petitioner knew or should have known that its reluctance and unwillingness to investigate possible abuse was likely to cause serious injury, harm, impairment, or death to the residents of its facility. Moreover, Petitioner's systemic flaw concerning investigations equally exposed other residents similarly situated to the likelihood of suffering serious injury, harm, impairment, or death. Petitioner has not proved that CMS's determination of immediate jeopardy was clearly erroneous.

C. The amount of the CMP is reasonable.

CMS imposed a $7000 per instance CMP. When an ALJ finds that the basis for imposing a CMP exists, the ALJ may not: (1) set a penalty of zero or reduce the penalty to zero; (2) review the exercise of discretion by CMS to impose a CMP; and (3) consider any factors in reviewing the amount of the penalty other than those specified by regulation. 42 C.F.R. § 488.438(e). I have found that a basis exists for CMS to impose a CMP because I have found that Petitioner was not in compliance with 42 C.F.R. § 483.13(c)(2)-(4). I must, therefore, review de novo whether the amount of the CMP is reasonable by considering four factors specified in 42 C.F.R. § 488.438(f). These four factors are: (1) the facility's history of noncompliance, including repeated deficiencies; (2) the facility's financial condition; (3) the scope and severity of the deficiencies, the relationship of one deficiency to other deficiencies, a facility's prior history of noncompliance with reference to the deficiency at issue (factors specified in 42 C.F.R. § 488.404); and (4) the facility's degree of culpability.

Petitioner has argued that the deficiencies cited as immediate jeopardy do not rise to a level of immediate jeopardy. Petitioner contends that the immediate jeopardy citation in this case is inappropriate because CMS has failed to prove that there was a likelihood of serious injury or harm as a result of the cited deficiency. P. Br. at 23-24. I have already amply discussed the basis for a finding of noncompliance at the immediate jeopardy level. Moreover, CMS may impose a per instance CMP in the range of $1000 to $10,000, regardless of whether or not the deficiencies constitute immediate jeopardy. 42 C.F.R. § 488.430 (a); 42 C.F.R. § 488.438 (a)(2).

Neither party has provided evidence of the facility's history of noncompliance or the facility's financial condition. Petitioner has provided no evidence that the CMP assessed by CMS for this case would put it out of business. *See Kelsey Memorial Hospital*, DAB CR583 (1999); *Capitol Hill Community Rehabilitation and Specialty Care Center*, DAB CR469 (1997), *aff'd* DAB No. 1629 (1997).

The regulations define culpability as neglect, indifference, or disregard for resident care, comfort or safety. 42 C.F.R. § 488.438(f)(4). Petitioner only initiated one investigation for one resident for which there was a possibility of abuse. There were seven other residents for which the facility did not investigate possible abuse involving CNA Meraz. Petitioner did not investigate possible abuse based on an injury of unknown origin, and did not report to the State within the requisite time period for reporting possible abuse of residents by staff. Petitioner did not thoroughly investigate possible abuse as mandated by 42 C.F.R. § 483.13(c)(3). Petitioner displayed indifference and disregard for resident care and safety by not thoroughly investigating each instance of alleged abuse. In view of the foregoing, I find that the amount of the CMP is reasonable.

V. Conclusion

Based on 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 and that the imposition of a per instance CMP of $7000 is reasonable.

/s/

José A. Anglada
Administrative Law Judge