Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Meridian Care
(CCN: 67-5171),

Petitioner

v.

Centers for Medicare and Medicaid Services.

Docket No. C-10-50

Decision No. CR2438

Date: September 29, 2011

DECISION

Petitioner, Meridian Care, was not in substantial compliance with program participation requirements from July 10 through July 29, 2009, due to violations of 42 C.F.R. §§ 483.13(b) and (c)(1)(i), 483.13(c)(2)-(4), 483.13(c), and 483.75.[1] There is a basis for the imposition of enforcement remedies. The following enforcement remedies are reasonable: a civil money penalty (CMP) of $6,550 per day from July 10 through July 22, 2009, and a CMP of $900 per day from July 23 through July 29, 2009. Petitioner was also ineligible to conduct a Nurse Aide Training and Competency Evaluation Program (NATCEP) for a period of two years.

I. Background

Petitioner is located in San Antonio, Texas, and participates in Medicare as a skilled nursing facility (SNF) and the state Medicaid program as a nursing facility (NF). From

---

[1] References are to the 2008 revision of the Code of Federal Regulations (C.F.R.), which was in effect at the time of the survey, unless otherwise indicated.

July 20 through 29, 2009, Petitioner was subject to complaint and incident investigations by the Texas Department of Aging and Disability Services (state agency) and found not in substantial compliance with program participation requirements. The Centers for Medicare and Medicaid Services (CMS) notified Petitioner by letter dated August 21, 2009, that it was imposing the following enforcement remedies: termination of Petitioner's provider agreement on December 29, 2009, unless Petitioner achieved substantial compliance prior to that date; a CMP of $6,550 per day from July 10 through July 22, 2009, and $900 per day beginning on July 23, 2009, and continuing until termination of Petitioner's participation or return to substantial compliance; and a denial of payment for new admissions (DPNA) effective September 5, 2009, if Petitioner did not achieve substantial compliance before that date. CMS also notified Petitioner that it was ineligible to conduct a NATCEP for two years. CMS notified Petitioner by letter dated November 4, 2009, that: the state agency determined that Petitioner returned to substantial compliance; the termination and DPNA enforcement remedies were not effectuated; and the $900 per day CMP stopped accruing on July 29, 2009. Request for Hearing; Joint Stipulation;[2] CMS Exhibits (CMS Exs.) 1, 4.

Petitioner requested a hearing before an administrative law judge (ALJ) by letter dated October 9, 2009. The case was assigned to me for hearing and decision on October 21, 2009, and an Acknowledgement and Prehearing Order was issued at my direction. On July 7 and 8, 2010, a hearing was convened in San Antonio, Texas, and a transcript (Tr.) of the proceedings was prepared. CMS offered CMS exhibits 1 through 11, and exhibits 1 through 10 were admitted. Tr. at 31. Petitioner offered Petitioner exhibits (P. Ex.) 1 through 13, all of which were admitted as evidence. Tr. at 35-36. CMS called the following witnesses: Surveyor Lillian Horton, Registered Nurse (RN); and Daniel McElroy, RN, Nurse Consultant for CMS. Petitioner called the following witnesses: Veronica Benitez, RN, Petitioner's Director of Nursing (DON); Christina Johnson, Certified Nurse Assistant (CNA); Susan Rubio, MSW (Master of Social Work), Petitioner's social worker; Sally Enriquez, Petitioner's business office manager; and Katherine Thurman, Petitioner's Administrator and Regional Director. The parties filed post-hearing briefs and post-hearing reply briefs.

---

[2] The parties' Joint Stipulation of Facts incorrectly states that the $900 per day CMP stopped accruing on July 22, 2009, and the stipulation was amended at hearing to correct the date to July 29, 2009. Tr. at 44.

II. Discussion

A. Issues

Whether there is a basis for the imposition of an enforcement remedy; and,

Whether the remedy proposed is reasonable.

B. Applicable Law

The statutory and regulatory requirements for participation of a SNF in Medicare are found at section 1819 of the Social Security Act (Act) and at 42 C.F.R. Part 483. Section 1819(h)(2) of the Act authorizes the Secretary of Health and Human Services (Secretary) to impose enforcement remedies against a SNF for failure to comply substantially with the federal participation requirements established by sections 1819(b), (c), and (d) of the Act.[3] The Act requires that the Secretary terminate the Medicare participation of any SNF that does not return to substantial compliance with participation requirements within six months of being found not to be in substantial compliance. Act § 1819(h)(2)(C). The Act also requires that the Secretary deny payment of Medicare benefits for any beneficiary admitted to a SNF, if the SNF fails to return to substantial compliance with program participation requirements within three months of being found not to be in substantial compliance – commonly referred to as the mandatory or statutory DPNA. Act § 1819(h)(2)(D). The Act grants the Secretary discretionary authority to terminate a noncompliant SNF's participation in Medicare, even if there has been less than six months of noncompliance. The Act also grants the Secretary authority to impose other enforcement remedies, including a discretionary DPNA, CMPs, appointment of temporary management, and other remedies such as a directed plan of correction. Act § 1819(h)(2)(B).

The Secretary has delegated to CMS and the states the authority to impose remedies against a long-term care facility that is not in substantial compliance with federal participation requirements. A facility is in "substantial compliance" so long as no identified deficiency poses a greater risk to resident health or safety than the potential for causing minimal harm. 42 C.F.R. § 488.301. "Noncompliance" is any deficiency that

---

[3] Participation of a NF in Medicaid is governed by section 1919 of the Act. Section 1919(h)(2) of the Act gives enforcement authority to the states to ensure that NFs comply with their participation requirements established by sections 1919(b), (c), and (d) of the Act.

causes a facility to not be in substantial compliance. 42 C.F.R. § 488.301. A deficiency is a violation of a participation requirement established by sections 1819(b), (c), and (d) of the Act or the Secretary's regulations at 42 C.F.R. Part 483, subpart B. 42 C.F.R. § 488.301. CMS or state survey agencies survey facilities that participate in Medicare on behalf of CMS to determine whether the facilities are complying with federal participation requirements. 42 C.F.R. §§ 488.10-.28, 488.300-.335. The regulations specify the enforcement remedies that CMS may impose if a facility is not in substantial compliance with Medicare requirements. 42 C.F.R. § 488.406.

A CMP that is imposed against a facility on a per day basis will fall into one of two ranges of penalties. 42 C.F.R. §§ 488.408, 488.438. The upper range of CMPs, $3,050 per day to $10,000 per day, is reserved for deficiencies that pose immediate jeopardy to a facility's residents and, in some circumstances, for repeated deficiencies. 42 C.F.R. § 488.438(a)(1)(i), (d)(2). "Immediate jeopardy means a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident." 42 C.F.R. § 488.301. The lower range of a CMP, $50 per day to $3,000 per day, is reserved for deficiencies that do not constitute immediate jeopardy, but either cause actual harm to residents or cause no actual harm but have the potential for causing more than minimal harm. 42 C.F.R. § 488.438(a)(1)(ii).

Petitioner was notified that it was ineligible to conduct a NATCEP for two years. Pursuant to sections 1819(b)(5) and 1919(b)(5) of the Act, SNFs and NFs may only use nurse aides who have completed a training and competency evaluation program. Sections 1819(e) and 1919(e) of the Act impose upon the states the requirement to specify what NATCEPs they will approve that meet the requirements that the Secretary established and a process for reviewing and re-approving those programs using criteria the Secretary set. Pursuant to sections 1819(f)(2) and 1919(f)(2) of the Act, the Secretary was tasked to develop requirements for approval of NATCEPs and the process for review of those programs. The Secretary promulgated regulations at 42 C.F.R. Part 483, subpart D. Pursuant to 42 C.F.R. § 483.151(b)(2) and (e)(1), a state may not approve, and must withdraw, any prior approval of a NATCEP offered by a SNF or NF that has been: (1) subject to an extended or partial extended survey under sections 1819(g)(2)(B)(i) or 1919(g)(2)(B)(i) of the Act; (2) assessed a CMP of not less than $5,000; or (3) subject to termination of its participation agreement, a DPNA, or the appointment of temporary management. Extended and partial extended surveys are triggered by a finding of "substandard quality of care" during a standard or abbreviated standard survey and involve evaluating additional participation requirements. "Substandard quality of care" is identified by the situation where surveyors identify one or more deficiencies related to participation requirements established by 42 C.F.R. § 483.13 (Resident Behavior and Facility Practices), § 483.15 (Quality of Life), or § 483.25 (Quality of Care) that are found to constitute either immediate jeopardy, a pattern of or widespread actual harm that does not amount to immediate jeopardy, or a widespread potential for more than minimal

harm that does not amount to immediate jeopardy and there is no actual harm. 42 C.F.R. § 488.301.

The Act and regulations make a hearing before an ALJ available to a long-term care facility against which CMS has determined to impose an enforcement remedy. Act §§ 1128A(c)(2), 1866(h); 42 C.F.R. §§ 488.408(g), 498.3(b)(13). The hearing before an ALJ is a *de novo* proceeding. *The Residence at Salem Woods*, DAB No. 2052 (2006); *Cal Turner Extended Care*, DAB No. 2030 (2006); *Beechwood Sanitarium*, DAB No. 1906 (2004); *Emerald Oaks*, DAB No. 1800, at 11 (2001); *Anesthesiologists Affiliated,* DAB CR65 (1990), *aff'd*, 941 F.2d 678 (8th Cir. 1991). A facility has a right to appeal a "certification of noncompliance leading to an enforcement remedy." 42 C.F.R. §§ 488.408(g)(1); 488.330(e), 498.3. However, the choice of remedies and the factors CMS considered when choosing remedies are not subject to review. 42 C.F.R. § 488.408(g)(2). A facility may only challenge the scope and severity level of noncompliance determined by CMS if a successful challenge would affect the range of the CMP that may be imposed or impact the facility's authority to conduct a NATCEP. 42 C.F.R. § 498.3(b)(14), (d)(10)(i). The CMS determination as to the level of noncompliance, including the finding of immediate jeopardy, "must be upheld unless it is clearly erroneous." 42 C.F.R. § 498.60(c)(2); *Woodstock Care Ctr.*, DAB No. 1726, at 9, 38 (2000), *aff'd,* 363 F.3d 583 (6th Cir. 2003). The Departmental Appeals Board (the Board) has long held that the net effect of the regulations is that a provider has no right to challenge the scope and severity level assigned to a noncompliance finding, except in the situation where that finding was the basis for an immediate jeopardy determination. *See, e.g.*, *Ridge Terrace*, DAB No. 1834 (2002); *Koester Pavilion*, DAB No. 1750 (2000). ALJ review of a CMP is subject to 42 C.F.R. § 488.438(e).

The standard of proof, or quantum of evidence required, is a preponderance of the evidence. CMS has the burden of coming forward with the evidence and making a *prima facie* showing of a basis for imposition of an enforcement remedy. Petitioner bears the burden of persuasion to show by a preponderance of the evidence that it was in substantial compliance with participation requirements or any affirmative defense. *Batavia Nursing & Convalescent Inn*, DAB No. 1911 (2004); *Batavia Nursing & Convalescent Ctr.*, DAB No. 1904 (2004)*, aff'd, Batavia Nursing & Convalescent Ctr. v. Thompson*, 129 F. App'x 181 (6th Cir. 2005); *Emerald Oaks*, DAB No. 1800; *Cross Creek Health Care Ctr.*, DAB No. 1665 (1998); *see Hillman Rehab. Ctr.*, DAB No. 1611 (1997), *aff'd, Hillman Rehab. Ctr. v. U.S.,* No. 98-3789 (GEB), 1999 WL 34813783 (D.N.J. May 13, 1999).

C. Findings of Fact, Conclusions of Law, and Analysis

My conclusions of law are set forth in bold text followed by my findings of fact and analysis. The surveyors allege in the Statement of Deficiencies (SOD) for the survey, which ended July 29, 2009, that Petitioner was not in substantial compliance with

program participation requirements due to violations of 42 C.F.R. §§ 483.13(b) and (b)(1)(i)[4] (Tag F223); 483.13(c)(1)(ii)-(iii) and (c)(2)-(4) (Tag F225); 483.13(c) (Tag F226); and 483.75 (Tag F490), all at a scope and severity (s/s) of K, which indicates that the surveyors determined that there was a pattern of immediate jeopardy to resident health and safety. The surveyors allege that the immediate jeopardy identified on July 23, 2009, was removed on July 24, 2009, but the facility did not return to substantial compliance. CMS Ex. 1, at 14, 33; CMS Ex. 4, at 1. Counsel for CMS stated at hearing that immediate jeopardy was abated on July 23, 2009, rather than July 24, 2009, as indicated in the SOD. Tr. at 47; CMS Ex. 1, at 14, 33. The enforcement remedy at issue is a CMP accruing at the rate of $6,500 per day from July 10 through 22, 2009, and $900 per day from July 23 through 29, 2009. Petitioner also lost its NATCEP as a result of the CMP. Tr. at 44-45.

I have carefully considered all the evidence and the arguments of both parties, though not all may be specifically discussed in this decision.[5] I discuss in this decision the credible evidence given the greatest weight in my decision-making. The fact that evidence is not specifically discussed should not be considered sufficient to rebut the presumption that I considered all the evidence and assigned such weight or probative value to the credible evidence that I determined appropriate within my discretion as an ALJ. There is no requirement for me to discuss the weight given every piece of evidence considered in this case, nor would it be consistent with notions of judicial economy to do so.

---

[4] The reference to 42 C.F.R. § 483.13(b)(1)(i) is in error, as there is no such subsection. The surveyors recite the language of 42 C.F.R. § 483.13(c)(1)(i) under Tag F223, and I recognize that the surveyors' reference to 42 C.F.R. § 483.13(b)(1)(i) was a clerical error. The erroneous citation caused no prejudice to Petitioner, as the language of the correct subsection is recited in the SOD. All references in this decision to Tag F223, as cited by the SOD of July 29, 2009, refer to 42 C.F.R. § 483.13(b) and (c)(1)(i).

[5] "Credible evidence" is evidence that is worthy of belief. *Black's Law Dictionary* 596 (18th ed. 2004). The "weight of evidence" is the persuasiveness of some evidence compared to other evidence. *Id.* at 1625.

1. Petitioner violated 42 C.F.R. § 483.13(b) and (c)(1)(i) (Tag F223).

2. Petitioner violated 42 C.F.R. § 483.13(c)(2)-(4) (Tag F225).[6]

3. Petitioner violated 42 C.F.R. § 483.13(c) (Tag F226).

4. Each of the regulatory violations posed a risk for more than minimal harm.

5. Petitioner has not shown that the declaration of immediate jeopardy was clearly erroneous.

The alleged deficiencies are all based upon the same alleged incidents involving Resident 3 and Resident 9 and the alleged perpetrator, Licensed Vocational Nurse (LVN) Miguel Avila. Hence, the deficiencies are discussed together.

a. Facts

The incident involving Resident 9 occurred in February 2009, and the incident involving Resident 3 occurred in June 2009.

(i) Resident 9 – Incident of February 12, 2009

Resident 9 was 75 years old on February 12, 2009, the date of the alleged incident involving LVN Avila. She suffered from, among other things, depression, dementia, and schizophrenia. She was assessed as having moderately impaired cognitive skills, but she usually understood others and could be understood. CMS Ex. 6, at 8, 9-10. Resident 9 did not have a treatment relationship with LVN Avila. Tr. at 288.

---

[6] The SOD also alleges under Tag F225 that Petitioner violated 42 C.F.R. § 483.13(c)(1)(ii) and (iii). Subsection 483.13(c)(1)(ii) provides that a facility may not employ individuals who have either been found guilty of abusing, neglecting, or mistreating residents, or who have been listed on a state nurse aide registry for abuse, neglect, mistreatment of residents, or misappropriation of resident property. Subsection 483.13(c)(1)(iii) requires that a facility report to the state nurse aide registry or licensing authority any knowledge the facility has of court actions against an employee that indicates unfitness for service as a nurse aide or other facility staff. The SOD alleges no facts showing a potential violation of 42 C.F.R. § 483.13(c)(1)(ii) or (iii), and I do not discuss those subsections further.

A Resident Grievance/Complaint Investigation Report Form, dated February 12, 2009, signed by Susan Rubio, MSW, states that, on February 12, 2009, Resident 9 reported that LVN Avila: commented that her skin was soft; asked if he could kiss her; and stated that he dreamed of her. The form states that there were no witnesses, other than Resident 9 and LVN Avila. The form shows that LVN Avila was interviewed, and he stated that Resident 9 was shaking. LVN Avila stated that he rubbed her arm to calm her down, but he denied the other allegations by the resident. The form indicates that Ms. Rubio concluded that the allegations were unconfirmed. However, the form also shows that LVN Avila was counseled not to enter Resident 9's room again. P. Ex. 1, at 1. The clinical records in evidence contain no other contemporaneous entries regarding the incident or any notes reflecting care and treatment of Resident 9 related to the incident. After the survey in July 2009, Ms. Rubio completed eight Social Progress Notes, all dated August 27, 2009, each of which indicates that it is a late entry for February 12, 2009. The entries on the various forms describe the complaint of Resident 9 and Ms. Rubio's interviews of a number of residents, all of whom are reported to have stated that no staff member had ever said or done anything inappropriate to them. P. Ex. 1, at 2-9; P. Ex. 2, at 2. There is no evidence that Ms. Rubio interviewed the sister of Resident 9 who made the initial complaint to the DON and was a witness to part of LVN Avila's interaction with Resident 9.

DON Benitez testified that in February 2009, Resident 9's sister called her and complained that her visit with Resident 9 was delayed because LVN Avila was in the resident's room holding Resident 9's hand. DON Benitez testified that she assured the sister that she would speak with the employee and look into the matter. She testified that she tasked Ms. Rubio to investigate. DON Benitez testified that, after learning the details from Ms. Rubio, she spoke with LVN Avila about the incident, and she informed him that: the matter would be put in writing; he should be careful about how he speaks to residents; and he should know his boundaries and be careful. She testified that LVN Avila denied asking to kiss Resident 9 but stated that, as he walked by her room, he had noticed her trembling, he thought from Parkinson's disease, so he held her hand and rubbed it. DON Benitez testified that she did not write the counseling for LVN Avila; it was written by LVN Avila's supervisor. Tr. at 231-39, 243, 284-85, 299-300; P. Ex. 11, at 1.

Ms. Rubio testified that the DON advised her of the complaint by Resident 9, and she completed the Resident Grievance/Complaint Investigation Report Form, dated February 12, 2009, in evidence as P. Ex. 1, at 1. Tr. at 379; P. Ex. 12, at 1. She explained that she interviewed Resident 9 and other residents and staff when she did her investigation in February 2009, but she did not obtain written statements or otherwise make a record of the statements. She prepared the summaries of the statements, all dated August 27, 2009, in evidence as P. Ex. 1, at pages 2 through 9, and P. Ex. 2, at page 2. She testified that she believed LVN Avila did nothing wrong. Tr. at 379-88. Ms. Rubio testified that the incident was not reported to the state. Tr. at 431.

Administrator Thurman testified that Petitioner had a policy in effect since 2005, which prohibits abuse, neglect, and mistreatment of residents and sets forth the procedures for conducting investigations of allegations, a copy of which is in evidence as CMS Ex. 7, at pages 11-16. She testified that there was no definition of abuse in the policy and that the facility used the definition of abuse from the federal regulations and the State Operations Manual (SOM). Tr. at 453-54, 457-58, 488-89. Administrator Thurman testified the incident involving Resident 9 was not reported to the state. Tr. at 457. She testified that she believed that Resident 9's allegations were without merit, that she was not subject to sexual abuse or harm, and that there was no need for steps to ensure her safety. Tr. at 480-82. She testified that the allegation by Resident 9 was not treated as an abuse allegation and that there was no physical assessment of Resident 9. Tr. at 457, 490-91.

The evidence offered by Petitioner includes records of verbal counseling of LVN Avila by his supervisor on February 16, 2009, related to an incident of inappropriate touching on February 12, 2009. LVN Avila was instructed not to go into Resident 9's room and to avoid any contact with her. The records of verbal counseling state that the complaint was unsubstantiated. P. Ex. 6, at 1-2; CMS Ex. 7, at 17; Tr. at 537-38.

(ii) Resident 3 – Incident of June 28, 2009

Resident 3 was 76 years old on June 28, 2009, the date of the alleged incident involving her and LVN Avila. Her diagnoses included: Alzheimer's disease; dementia; fibromyalgia; major depression; generalized anxiety disorder; panic disorder; histrionic features; hypertension; gastroesophageal reflux disease (GERD); and a history of left hip replacement. CMS Ex. 5, at 1, 8, 28, 33, 54. Resident 3's Minimum Data Set (MDS) with an assessment reference date of February 9, 2009, reflects that Resident 3 had moderately impaired cognitive skills for daily decision-making, but she was usually able to make herself understood and she usually understood others. CMS Ex. 5, at 4. LVN Avila provided respiratory therapy to Resident 3, related to her complaints of shortness of breath. Tr. 251-52, 288; P. Ex. 9, at 1; P. Ex. 11, at 1; CMS Ex. 5, at 11.

A Nurse's Notes entry dated June 29, 2009 at 2:00 p.m., records that the nurse was approached by Resident 3 who asked to speak with her in private. Resident 3 told the nurse that a staff member touched her "private area," touched her breasts, and kissed her neck and lips. Resident 3 reported that she told the staff member to stop, and he would not. Resident 3 identified the perpetrator as "Miguel, the tall Hispanic guy." The note indicates that she stated that this was not the first incident and that she had not reported as she feared he would hurt her. The nurse recorded in the note that she notified the DON, the social worker, and Resident 3's primary care physician and that she would monitor. CMS Ex. 5, at 57, 121; P. Ex. 4, at 18. A Nurse's Notes entry dated July 5, 2009 at 9:00 p.m. indicates that at 3:00 p.m., Resident 3 told the charge nurse that she had filed a complaint against Miguel, the respiratory therapist, but the note states that she did not elaborate. CMS Ex. 5, at 120.

A Social Progress Note signed by Susan Rubio indicates that on June 29, 2009: she was told by staff that Resident 3 had reported that LVN Avila had made inappropriate sexual comments; she reported the allegation to the state and the family; and an investigation was being conducted, and the results would be reported to the state. CMS Ex. 5, at 113; P. Ex. 4, at 2. A Social Progress Notes entry by Ms. Rubio, dated June 30, 2009, indicates that the DON and Administrator came to her office with Resident 3, who stated that she wanted to drop the allegations against LVN Avila. Resident 3 refused to state a reason for dropping the allegations when asked by Ms. Rubio. Ms. Rubio's note states that she reported Resident 3's request to the family and the state. CMS Ex. 5, at 119, 183; P. Ex. 4, at 3. On July 24, 2009, during the period of the survey, Ms. Rubio made a series of "late entry" Social Progress Notes for June 29 through July 20, 2009. P. Ex. 4, at 4-5; CMS Ex. 5, at 114-15. The notes indicate that on June 29, 2009, Ms. Rubio discussed the allegations with Resident 3's therapist, who opined that the resident was up to her manipulative ways to get attention. The same notes indicate that no other female residents reported any inappropriate behavior by staff, which is inconsistent with evidence in Petitioner's records that shows that there was an allegation by a third female resident who is not cited as an example by the surveyors. On July 10, 2009, LVN Avila made a written statement denying the allegation of a third female resident that he had made an inappropriate sexually-oriented comment. CMS Ex. 5, at 185. Furthermore, in the same written warning in which he was told to stay away from Resident 3, LVN Avila was given a written warning to stay away from the third resident. P. Ex. 6, at 2. Ms. Rubio's notes also did not mention the allegation of Resident 9 from February 2009. In a Social Progress Note, which was a late entry for June 30, 2009, Ms. Rubio wrote that when Resident 3 recanted her allegation against LVN Avila, she also stated that he had always been nice to her. The other late entries indicate that Resident 3 was suffering no residual effects from any incident other than her conflict with her own family. CMS Ex. 5, at 114-15; P. Ex. 4, at 4-5. Ms. Rubio also made notes on July 24 and 26, 2009, in which she portrayed Resident 3 as being mostly concerned with conflict in her family, obtaining cigarettes, being lonely, and trying to avoid another resident. P. Ex. 4, at 6-7. On August 17, 2009, a different social worker, R. Milligan, entered a Social Progress Note at 6:00 p.m. The note indicates that R. Milligan asked Resident 3 about her care at the facility, and the resident responded that she felt very safe and well cared for. However, Resident 3 mentioned that there was an incident that the facility resolved, and she felt very safe at the time of R. Milligan's interview. R. Milligan did not include in the note any details related to the incident. P. Ex. 4, at 16. Ms. Rubio testified, in response to my questions, that Robert Milligan was a regional social worker who was specifically interviewing Resident 3 about the incident with LVN Avila. Tr. at 428-31.

Ms. Rubio's investigation of the alleged incident involving Resident 3 and LVN Avila was placed in evidence by Petitioner. P. Ex. 3. A statement signed by LVN Carpena indicates that Resident 3 gave her a note on June 28, 2009 to place under the door of Ms. Rubio. The note requested that Ms. Rubio see Resident 3 in the resident's room. P. Ex. 3, at 1. A Resident Grievance/Complaint Investigation Report Form, dated June 29,

2009, and signed by Ms. Rubio, indicates that, on June 28, 2009, Resident 3 reported that LVN Avila made inappropriate statements to her and touched her inappropriately and had been doing so for some time. Resident 3 reported that LVN Avila had said that he dreamed of making love to Resident 3. Resident 3 reported that she said no to his actions but that LVN Avila just smiled and continued to touch her. Resident 3 alleged that LVN Avila kissed her all over her face, neck, and lips. The form indicates that LVN Avila denied the allegations. Under the "findings" section of the form, Ms. Rubio wrote only that Resident 3 recanted her statement. Ms. Rubio recommended follow-up counseling with LVN Avila and a change in his assignments to prevent any future incidents. She noted on the form that the incident was reported to the state. P. Ex. 3, at 2. Ms. Rubio completed a note on August 24, 2009 as a late entry for June 30, 2009, in which she records that she interviewed various staff who reported no observation of inappropriate activity and who reported that LVN Avila was professional, polite, nice, caring, and a hard worker. P. Ex. 3, at 3. Included with the investigative materials are eight Social Progress Notes dated by Ms. Rubio on August 27, 2009, and purportedly late entries for June 29, 2009. The late entries reflect that Ms. Rubio interviewed residents and some family members, all of whom reported witnessing no inappropriate behavior by staff. P. Ex. 3, at 4-11.

DON Benitez testified that Resident 3 was alert and oriented and able to make her needs known, but she was always seeking medication and was manipulative of staff. Tr. at 244. She testified that Resident 3 had falsely accused staff of stealing from her. Tr. at 246-47. She testified that Resident 3 was a heavy smoker and had been caught smoking in her room, though Resident 3 denied it. Tr. at 248. Resident 3 also had much conflict with her family. Tr. at 249-50. Resident 3 had first contact with LVN Avila when she started receiving respiratory therapy from him in March 2009. Tr. at 251. Ms. Rubio told her and Administrator Thurman about the abuse allegation by Resident 3 on June 29, 2009. She and the Administrator instructed Ms. Rubio to ensure she interviewed staff and residents. Ms. Rubio reported the incident to the state agency. DON Benitez testified that pursuant to the facility abuse protocol, LVN Avila had to be suspended during the investigation, the state agency had to be notified, and the investigation had to be completed in five days and all information submitted to the state agency. DON Benitez testified that on June 29, 2009, LVN Avila was suspended for three days by his supervisor and told that he should return in three days with his written statement addressing the allegations. LVN Avila did not return at the end of his suspension but returned with his statement a few days later. DON Benitez testified that it was decided on July 10, 2009, that LVN Avila would continue as an employee. Tr. at 253-59. She testified that Resident 3 was not credible, and she concluded that LVN Avila posed no risk to residents and had done nothing wrong. Tr. at 265, 293-94. She testified that she did not call the police, but they came to the facility on July 19, 2009, the day before the survey began. Tr. at 269, 270. On July 23, 2009, LVN Avila was interrogated at the facility by police and state surveyors, and he had to be taken to the hospital by emergency medical services. Tr. at 274-79. DON Benitez testified that Resident 3 came to her and

recanted her allegations against LVN Avila, and she directed the resident to see Ms. Rubio. Tr. 299.

CNA Christina Johnson testified that she recalled that, at about 6:10 a.m. on an unspecified day in June 2009, Resident 3 stopped her as she entered the building and told her that she was afraid of a respiratory therapist who had been touching her and making sexual advances. CNA Johnson testified that she reported the information to LVN Reed who then interviewed Resident 3, and Resident 3 elaborated more. CNA Johnson testified that she was also present when Resident 3 was interviewed by Ms. Rubio. CNA Johnson testified that she felt Resident 3's demeanor was fine throughout the interviews, and she opined that Resident 3 was a very manipulative resident. CNA Johnson testified that she also reported the incident to Administrator Thurman, the facility abuse coordinator. Tr. at 363-74.

Social Worker Rubio testified that Resident 3 was brought to her on a day in late June 2009, and she interviewed Resident 3 for about 40 minutes. She then interviewed LVN Avila, and he denied the allegations of Resident 3. She could not recall whether or not she interviewed LVN Avila the same day. Ms. Rubio testified that she also interviewed other alert residents and staff who had contact with LVN Avila, and none had any complaints or had observed anything inappropriate. She testified that initially she took no written statements and made no summaries because no one had anything negative or significant to say, and she later made the delayed entries to record that she had done interviews of staff and residents. She testified that she reported the results of her investigation to the DON, Administrator Thurman, and the state agency. Ms. Rubio did not call the treating physician, as she believed that the nurse usually did that, and she could not recall notifying the family. She testified that LVN Avila was suspended during the investigation, but that was not her action. She testified that, the day after Resident 3 made her complaint, the DON brought Resident 3 to Ms. Rubio's office, and Resident 3 wanted to recant her allegations. Resident 3 would not say why. Tr. at 388-409; P. Ex. 4. Ms. Rubio testified that Administrator Thurman was the abuse coordinator. Tr. at 415.

Administrator Thurman testified that the social worker had served as the abuse coordinator for eleven years. Tr. at 478. She testified that Ms. Rubio was the abuse coordinator at the time of the incident involving Resident 3. She testified that she told Ms. Rubio to interview residents, employees, and coworkers. She testified that she did not personally call the state agency. Tr. at 466-67. Administrator Thurman testified that she believed LVN Avila and not Resident 3. Tr. at 471. She testified that the family of Resident 3 asked if she was going to call the police, and she told them no. Tr. at 472, 504. The police did come to investigate, and they were either called by the family or the surveyors, she did not know which. Tr. at 473-74. Administrator Thurman opined that there was no deficiency because she followed protocol, and neither Resident 3 nor Resident 9 suffered any abuse or harm. Tr. at 481-82. She testified that she did not know whether Resident 3 was assessed by a nurse. Tr. at 491-92. She testified that there was a

psychiatric assessment, but it is not in the evidence before me. Tr. at 492-93. She agreed that the facility policy requires that police be called if there is an allegation of abuse, neglect, or exploitation of a resident. Tr. at 505. She testified that her understanding of the policy, based on their customary practice, is that if there is an allegation, they have 24 hours before they are required to call the state during which they conduct a preliminary investigation to determine whether the allegation is one of abuse or neglect. Tr. at 510, 517-18.

Petitioner's employee disciplinary records show that, on June 29, 2009, Miguel Avila received a written warning for an incident of "inappropriate touching" on June 28, 2009, and he was suspended for three days. P. Ex. 6, at 2. The warning states:

> In regards to [Resident 3's] allegations of being touched inappropriately by employee Miguel Avila. Mr. Miguel was counseled to refrain contact with such resident, and including [a third resident not cited as an example by the surveyors]. Mr. Miguel was suspended for three days pending investigation. [Resident 3] did withdraw her complaint.

P. Ex. 6, at 2. LVN Avila was instructed to bring a written statement when he returned to work after his three-day suspension, but he failed to return when instructed to. P. Ex. 6, at 2. A Social Progress Notes form was used to record a statement allegedly made by LVN Avila on July 10, 2009, at 11:00 a.m., in which he denies any inappropriate actions toward Resident 3 and states he has always been nice to her and helped her by going to the store across from the facility when needed. CMS Ex. 5, at 184; P. Ex. 8, at 1. A second Social Progress Notes form contains a second statement purportedly by LVN Avila, same date and time, in which he denies the allegation of a third resident (not cited as an example by the surveyors) that he made an inappropriate sexual comment. CMS Ex. 5, at 185. LVN Avila was then placed on probation for ninety days, not for inappropriate conduct with residents, but because he failed to return to work after his three-day suspension. P. Ex. 6, at 2. On July 23, 2009, LVN Avila was terminated, and a notation was made that he was not eligible for rehire based on information obtained during interrogation by police and surveyors on that day. P. Ex. 6, at 2, 3.

Petitioner had a "Facility Abuse Prohibition Policy and Procedure" (Petitioner's abuse policy) that had been in effect since 2005. CMS Ex. 7, at 11-16; Tr. at 488-89. The policy does not define the terms "abuse" or "neglect." Petitioner's abuse policy required that any allegation involving abuse, neglect, or exploitation of a resident be reported immediately to the Administrator. If the alleged perpetrator was an employee, the immediate or ranking supervisor was to place the employee on suspension, obtain the employee's written statement, and then remove the employee from the facility. If the employee had to wait for transportation, the employee was to be placed on direct supervision away from residents until transportation arrived. The policy specified that

the facility charge nurse should complete a Resident Accident or Incident Report documenting the resident's clinical condition and any signs or symptoms of abuse or neglect. The policy required that the Nurse Manager conduct a full body audit, noting any physical signs of neglect or abuse, if appropriate. The Nurse Manager was to obtain written statements from all parties and any witnesses. The Charge Nurse was to notify the attending physician and responsible party of the incident. The Social Services or the Activity Department was to conduct resident interviews regarding staff treatment of residents to identify other potential abuse situations. All written statements, incident reports, and other investigative materials were to be given to the Administrator or designee. The policy required that the Administrator or designee immediately report all allegations of abuse, neglect, or exploitation to the state agency and any other appropriate state or local agency. The policy required that the investigation begin with the reporting by the Administrator and that the investigation should normally be completed within five days. The policy required that corrective action was to be taken and documented immediately in case of a substantiated complaint. CMS Ex. 7, at 11-16.

b. Analysis

Section 1819(c)(1)(A)(ii) of the Act requires that a SNF protect its residents and promote their "right to be free from physical or mental abuse, corporal punishment, involuntary seclusion, and any physical or chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms." The Secretary has provided by regulation that a "resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion." 42 C.F.R. § 483.13(b). The regulations require that a facility develop and implement written policies and procedures prohibiting mistreatment, neglect, and abuse of residents and the misappropriation of residents' property. 42 C.F.R. § 483.13(c). The facility must "[n]ot use verbal, mental, sexual, or physical abuse, corporal punishment or involuntary seclusion." 42 C.F.R. § 483.13(c)(1)(i). The facility "must ensure that all alleged violations involving mistreatment, neglect, or abuse . . . are reported immediately to the administrator of the facility and to other officials in accordance with State law." 42 C.F.R. § 483.13(c)(2). The facility "must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse" during the investigation. 42 C.F.R. § 483.13(c)(3). The facility must ensure that the results of all investigations are "reported to the administrator or his designated representative and to other officials in accordance with State law . . . within 5 working days of the incident." 42 C.F.R. § 483.13(c)(4). The regulations define "abuse" to be "the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish." 42 C.F.R. § 488.301.

(i) Tag F223

The surveyors allege in the SOD under Tag F223 that Petitioner violated 42 C.F.R.

§ 483.13(b) and (c)(1)(i) because Petitioner: failed to protect Resident 3 and Resident 9 from sexual abuse by staff; failed to recognize that the residents were abused; and failed to protect the residents by monitoring staff. CMS Ex. 1, at 1-2. I conclude based upon the facts set forth above that CMS has made a *prima facie* showing of the alleged violation and the risk for more than minimal harm beginning as early as February 12, 2009, based upon both examples. The noncompliance continued through July 29, 2009, the day on which the survey concluded and the date the CMP stopped accruing.

The undisputed evidence is that Resident 9's sister complained to DON Benitez about LVN Avila being in Resident 9's room and holding her hand. It is also undisputed that when Resident 9 was interviewed by Ms. Rubio, Resident 9 reported that LVN Avila told her that her skin was soft, he asked to kiss her, and he told her he dreamed of her. Although there is evidence from July 24, 2009, during the survey, that Resident 9 did not believe she had been touched inappropriately by LVN Avila (P. Ex. 2, at 1), the resident's recollection of her perception five months after the incident is not considered weighty. Even if the resident was not offended by the touching or even if she consented to the touching at the time of the incident, the resident's perception would not be controlling of the determination of whether there was abuse, neglect, or mistreatment. Rather, the resident's perception or consent is evidence to be considered in determining whether or not there was abuse, neglect, or maltreatment and whether or not there was any harm. There is no dispute that in February 2009, Petitioner's staff did not recognize or treat Resident 9's report as an allegation of abuse or mistreatment that triggered Petitioner's abuse policy and the regulatory requirements for handling such complaints.

I am satisfied that the conduct of LVN Avila amounted to: physical or mental abuse under section 1819(c)(1)(A)(ii) of the Act; or sexual, physical, or mental abuse within the meaning of 42 C.F.R. § 483.13(b); or mistreatment within the meaning of 42 C.F.R. § 483.13(c) and (c)(1). I also find that there was willful intimidation and resulting mental anguish within the meaning of 42 C.F.R. § 488.301.

Resident 9 was elderly with moderately impaired cognitive skills, but she could understand and be understood. Her version of what occurred is not inconsistent with her sister's observation that LVN Avila was holding her hand, despite the fact he had no treatment relationship with Resident 9 and had no reason to be in her room. I have no reason to discount the credibility of the statement of Resident 9 documented by Ms. Rubio in February 2009. LVN Avila's denial is self-serving and not credible particularly because he had no treatment relationship with Resident 9, he had no reason to be in her room or observing her from the hall, and any legitimate concern based upon observing Resident 9 should have been directed to the appropriate caregiver rather than addressed by hand-holding and arm-rubbing. Petitioner's inadequate investigation and failure to assess Resident 9, as required by its policy, limits the available facts. But I infer from the content of Resident 9's statement, as recorded by Ms. Rubio, that the resident suffered intimidation and/or mental anguish as the result of the statements of LVN Avila. *See*

Somerset Nursing & Rehab. Facility, DAB No. 2353, at 19 (2010). Furthermore, a showing of actual harm is not required to establish a deficiency; a showing of a risk for more than minimal harm is sufficient. *Id.;* 42 C.F.R. § 488.301.

The language of 42 C.F.R. § 483.13(b) and (c)(1)(i) does not establish "foreseeability" as an element of the CMS *prima facie* case. The Board has specifically declined to decide whether there is an element of foreseeability that must be established for a *prima facie* showing of a violation of 42 C.F.R. § 483.13(b) and (c)(1)(i). *Lakeridge Villa Healthcare Ctr.*, DAB No. 2396, at 5 (2011); *Gateway Nursing Ctr.*, DAB No. 2283, at 8-9 (2009). The plain language of a regulation provides a regulated party notice of action that is required or prohibited. Thus, the plain language of the regulation should establish all the elements necessary to determine whether or not the regulation is violated, except in the case where some overarching statutory or regulatory provision establishes a required element. For example, the conditions for participation in 42 C.F.R. Part 483 do not specify that a deficiency amounts to noncompliance only if there is a risk for more than minimal harm, and that element is added by the definitions found at 42 C.F.R. § 488.301. I am not convinced that Congress did not impose upon long-term care facilities, through section 1819(c)(1)(A)(ii) of the Act, the absolute responsibility or duty to protect its residents from abuse, in which case foreseeability would not be an element necessary for a *prima facie* showing of a violation. The evidence before me does not show that it was foreseeable that LVN Avila might abuse Resident 9. However, the evidence does show that, after the allegation by Resident 9, it was foreseeable that LVN Avila might be the perpetrator of abuse, and Petitioner, thereafter, failed to protect Resident 9 and other residents from potential abuse. The failure to protect Resident 9 from further abuse and the failure to protect other residents after the allegations by Resident 9 also constitute a *prima facie* showing of a violation of 42 C.F.R. § 483.13(b) and (c)(1)(i) with a risk for more than minimal harm to residents.

Therefore, the burden is upon Petitioner to rebut the *prima facie* showing or to establish an affirmative defense. Petitioner argues that the incident did not occur as described by Resident 9, and, if it did, it was not abuse. Petitioner argues that Resident 9 was assessed as needing a hearing aid, and it was possible she misunderstood LVN Avila. Petitioner's Post-Hearing Brief (P. Brief) at 4. Petitioner presented no evidence to show the degree or amount of Resident 9's hearing loss, to support an inference that she did not hear or that she misunderstood LVN Avila. Petitioner does agree that Resident 9 was, at the time, alert, outspoken, and able to communicate. Petitioner's Post Hearing Rebuttal Brief (P. Reply) at 2. Petitioner argues that conduct alleged by Resident 9 did not amount to abuse under state law. P. Br. at 6-7. However, the federal regulations take precedence over state law in this enforcement proceeding. *Cedar View Good Samaritan*, DAB No. 1897, at 12-13 (2003). Petitioner also argues that the allegations of Resident 9 do not meet the definition of "abuse" under 42 C.F.R. § 488.301 and the SOM, app. PP, Tag F223. Petitioner notes that "sexual abuse" and "sexual harassment" are not defined in either the regulations or the SOM. Thus, Petitioner relies upon a dictionary definition that sexual

harassment and sexual abuse are "uninvited and unwelcome verbal or physical behavior of a sexual nature." P. Br. at 7. Petitioner's argument that the allegations of Resident 9 do not describe sexual abuse or sexual harassment is not persuasive. The act of holding someone's hand or rubbing their arm is not necessarily sexual in nature and may be acceptable conduct for a caregiver. However, commenting that the person's skin is soft, stating one dreams of another, and asking the other to kiss them has one clear connotation, and it is sexual. The report by Resident 9 to Ms. Rubio shows that the contact was uninvited and/or unwelcome. Petitioner simply discounts the statement of Resident 9, as the misunderstanding of a deaf, demented, schizophrenic resident. The sister's observation of LVN Avila in Resident 9's room, holding her hand and rubbing her arm, when LVN Avila had no treatment relationship with Resident 9, lends credence to Resident 9's allegations. LVN Avila's denial record by Ms. Rubio is self-serving, and its credibility is further diminished by the fact that LVN Avila had no reason to be in Resident 9's room. The fact that the Administrator encouraged a home-like or family-like environment where staff could hug and kiss residents is not a defense or an excuse for LVN Avila's conduct. P. Br. at 7. The facts of each situation must be assessed, and the facts here show that LVN Avila's conduct was unwanted, as demonstrated by the fact that Resident 9 warned LVN Avila that he could get in trouble, and his conduct was sexual in nature. Thus, by the dictionary definition Petitioner proposes, the incident was one of sexual harassment or abuse. Petitioner admits, without acknowledging the inconsistency, that LVN Avila was counseled that he should not be "too touchy" with residents because some might take it the wrong way and that he was also told not to go into Resident 9's room again and to avoid contact with her. P. Br. at 5. The counseling LVN Avila was given clearly shows that Petitioner recognized that the alleged actions of LVN Avila could be construed to be inappropriate. The direction for LVN Avila to stay out of Resident 9's room and to avoid contact also belies Petitioner's assertion that LVN Avila's actions were believed to be totally innocent. I conclude that Petitioner does not meet its burden to rebut the CMS *prima facie* case or to establish an affirmative defense.

In the example of Resident 3, the undisputed evidence shows that Resident 3 had a note placed under Ms. Rubio's door requesting to meet with her. Resident 3 also voiced her complaint to CNA Christina Johnson and to a nurse. A nurse's note shows that, on June 29, 2009, Resident 3 complained that LVN Avila touched her private area, touched her breasts, and kissed her neck and lips. The nurse's note also indicates that Resident 3 was afraid of LVN Avila. CMS Ex. 5, at 57, 121; P. Ex. 4, at 18. Ms. Rubio's subsequent note (CMS Ex. 5, at 113; P. Ex. 4, at 2) states that staff reported that Resident 3 reported that LVN Avila made inappropriate sexual comments. There is no mention in Ms. Rubio's note of the additional details of the nurse's note that the resident had been touched and was in fear. Ms. Rubio's Resident Grievance/Complaint Investigation Report Form (P. Ex. 3, at 2) mentions that the resident alleged LVN Avila made inappropriate statements and that he touched her inappropriately, but there is no mention that the resident was fearful. I am satisfied that the alleged conduct occurred and amounted to physical or mental abuse under section 1819(c)(1)(A)(ii) of the Act; or

sexual, physical, or mental abuse within the meaning of 42 C.F.R. § 483.13(b); or mistreatment within the meaning of 42 C.F.R. § 483.13(c) and (c)(1); and that there was willful intimidation and resulting mental anguish within the meaning of 42 C.F.R. § 488.301. I am also satisfied that it was foreseeable that LVN Avila might abuse residents after the incident with Resident 9 in February 2009, but Petitioner failed to act to protect its residents.

Therefore, the burden is upon Petitioner to rebut the *prima facie* showing or to establish an affirmative defense. The gist of Petitioner's argument is that Resident 3 is simply not credible, and no abuse occurred. P. Br. at 8-15, 20; P. Reply at 9-10. Petitioner advances several arguments in support of its position, none of which are persuasive, including that Resident 3: had a history of manipulative conduct; was attention-seeking and often in conflict with her family; recanted her allegations the day after she made them; and showed no behavioral changes after the alleged incident. There is no dispute that Resident 3 was alert and oriented and that Petitioner had assessed her as being moderately impaired cognitively, but she was able to understand and be understood. Despite the allegations that she was manipulative, Petitioner presented no evidence that her behaviors were so bad as to require care planning by the interdisciplinary team.

Petitioner argues that Resident 3 exaggerated her complaint against LVN Avila. However, Petitioner fails to address the fact that Resident 3 attempted to report her complaint initially by having a note placed under the door of Ms. Rubio, and, before Ms. Rubio read and reacted to the note, Resident 3 made a verbal complaint to CNA Johnson and LVN Reed. The gist of Resident 3's complaint was clear – LVN Avila made sexual advances or comments, and she was afraid of him. Petitioner does not specifically inform me why the initial complaint was not credible. Petitioner's investigation of the complaint was so inadequate that possible motives of Resident 3 for lying about LVN Avila were not developed. Petitioner also failed to develop and document evidence by medical assessment of Resident 3, including psychiatric assessment, which could have revealed her state of mind and a possible motive to fabricate. LVN Avila, on the hand, clearly had motive to deny the allegations. Resident 3's complaint was also not the only complaint against LVN Avila.

Further, considering all the evidence available, I do not find that Resident 3's subsequent withdrawal of her allegations made the initial allegations not credible. The evidence shows that the Administrator and DON brought Resident 3 to Ms. Rubio, for the purpose of Resident 3 recanting the allegations against LVN Avila. Resident 3's motives when she recanted were never determined. However, more than a month later, on August 17, 2009, when being interviewed by a regional social worker from outside the facility, she referred to the incident with LVN Avila as being taken care of by the facility, and, as of August 17, 2009, she felt safe in the facility. P. Ex. 4, at 16; Tr. at 428-31. The social worker's brief note memorializing the interview in August 2009 clearly shows that Resident 3 did believe that there was an incident and that she previously felt unsafe

related to that incident and/or LVN Avila. Ms. Rubio testified that the interview by the regional social worker was specifically related to LVN Avila though that is not reflected by the note. Tr. at 428-31.

I also do not find persuasive the argument that Ms. Rubio and a "Geri-psych" counselor detected no behavior changes. The clinical records in evidence do not show any specific evaluation or assessment for post-traumatic signs or symptoms by one with qualifications to make such an assessment. The mere fact that Resident 3 did not discuss or specifically declined to discuss the incident further does not trigger an inference that her initial complaint was bogus. The resident's refusal could be interpreted many ways other than as evidence of fabrication; for example, her refusal to discuss the incident could also be evidence of repression, fear, or suppression. Petitioner also cites the different version of the incident that Resident 3 related to the surveyors as evidence of fabrication by Resident 3. I note, despite the fact Resident 3 did not want to discuss the matter with Petitioner's staff, that she was willing to discuss the incident with a surveyor who was not part of Petitioner's regular staff, just as she was willing to discuss the matter with the regional social worker, who was also not a regular at the facility. Whether or not Resident 3 truly exaggerated her story to the surveyor is unknowable, due largely to the fact that Petitioner's investigation of the incident was cursory and inadequate. However, even if there was some exaggeration, the initial complaint of inappropriate touching, kissing, comments, and fear remained. CMS Ex. 1, at 2. Petitioner even agrees that "there was some evidence that Resident 3 might have been abused (her allegation appeared credible when made). . . ." P. Reply at 11.

Petitioner faults the surveyors for not exploring possible inconsistencies in Resident 3's complaints and behavior. P. Br. at 12-14. However, the surveyors' ability to investigate was hampered by Petitioner's failure to conduct and document a thorough investigation when the initial complaint was made. I conclude that the preponderance of the evidence supports a conclusion that abuse did occur, though the exact conduct of LVN Avila may be subject to some dispute, a dispute that I need not resolve as this is not a prosecution of LVN Avila. Petitioner has not met its burden.[7]

---

[7] Petitioner notes that LVN Avila subsequently confessed during an interview by police and surveyors at the facility, possibly under intimidation or coercion. I do not consider the alleged confession in reaching my decision. The conduct of the local police and the surveyors in interviewing LVN Avila is, therefore, not relevant to my decision or subject to my review.

(ii) Tag F225

The surveyors allege under Tag F225 that Petitioner violated 42 C.F.R. § 483.13(c)(2)-(4) because Petitioner did not have written evidence that: (1) the alleged incidents of sexual abuse of Residents 3 and 9 were thoroughly investigated; (2) the alleged incidents were immediately reported to the state agency; and (3) Residents 3 and 9 were protected from further abuse during the investigation. CMS Ex. 1, at 16-17. I conclude based upon the facts set forth above that CMS has made a *prima facie* showing of the alleged violation and the risk for more than minimal harm beginning as early as February 12, 2009. The noncompliance continued through at least July 29, 2009.

It is undisputed that Petitioner's staff did not treat the incident involving Resident 9 in February 2009 as an incident of abuse. Therefore, LVN Avila was not suspended during the investigation of the incident involving Resident 9. Suspension was the protection required by Petitioner's policy. What constitutes a thorough investigation is not specified by the Act, the regulations, or the SOM. Rather, the requirements for an investigation are set forth in Petitioner's abuse policy. Petitioner's policy specified that the written statement of the alleged employee-perpetrator was to be obtained before the employee left on suspension. The required statement was not obtained for either of the incidents involving Residents 3 and 9. A written statement from LVN Avila was only obtained after he returned to the facility following his suspension related to the incident involving Resident 3. Petitioner's policy required that the charge nurse complete a Resident Accident or Incident Report documenting the resident's clinical condition and any signs or symptoms of abuse or neglect. Petitioner has not presented such reports for either incident. Petitioner has also presented no documentary evidence of any assessment of either resident when they made their allegations. Petitioner has not presented documentary evidence that Resident 9's physician or responsible party was notified or that records the substance of what was reported or any orders or requests based on the report. A Nurse's Notes entry in Resident 3's clinical record states that LVN Reed notified Resident 3's primary care physician on June 29, 2009, but the note does not show that there was any contact with the physician, what the physician was told, or whether orders were solicited or received. P. Ex. 4, at 18. Ms. Rubio admitted that she did not document statements of staff or residents, until long after she interviewed them. There is no evidence, written or otherwise, that Ms. Rubio interviewed the sister of Resident 9, who reported that she witnessed LVN Avila holding Resident 9's hand. Petitioner admits that the incident involving Resident 9 was not reported to the state agency or local police officials. Petitioner has not presented documents or other evidence

showing that the allegations of Resident 3 were immediately[8] reported to the state agency, other than a notation by Ms. Rubio, or that it was reported to the local police officials, municipal or county, as required by Texas Health and Safety Code §§ 242.122 (1989) and 242.125(a) (2003) (http://www.statutes.legis.state.tx.us/).[9] Indeed, Administrator Thurman's testimony shows that she erroneously believed that the facility could delay reporting 24 hours while a preliminary inquiry was done to determine if there was abuse. Ms. Rubio testified that, before contacting the state, a preliminary inquiry is made to determine if abuse occurred or not. Tr. at 432-33. Immediate reporting is required when there is an allegation of abuse by staff, and a preliminary inquiry to determine whether or not abuse actually occurred is not allowed. *Cedar View Good Samaritan*, DAB No. 1897, at 11. It is not clear from the evidence that Ms. Rubio did not delay reporting the allegation of abuse by LVN Avila, until she made a preliminary inquiry. Petitioner also produced no evidence that the completed report of investigation for either incident was delivered to the state agency within five working days as required by 42 C.F.R. § 483.13(c)(4). I note that Petitioner's abuse policy is inconsistent with the regulatory requirement as it states that the investigation should normally be completed within five days. The policy does not specify that it must be completed and submitted to

---

[8] Petitioner submitted letters from the state agency to providers dated in 2007 and 2010, which indicate that "immediately" in this context means within 24 hours. P. Brief, app. 1, tabs 3 and 4. This construction of the term "immediately" is inconsistent with the plain meaning of "immediately," which generally means without lapse of time, without delay, instantly, or at once. *See* www.dictionary.com. The construction used by the state agency is also inconsistent with the prior construction of the term as used in the federal regulations. *Cedar View*, DAB No. 1897, at 11. I am not bound by the state's incorrect construction, but I am bound to follow the federal regulations promulgated and interpreted by the Secretary. However, even if I gave credence to the state agency definition of "immediate" as being within 24 hours, it would not affect my conclusion that Petitioner failed to maintain evidence of a thorough investigation performed in accordance with the federal regulations and Petitioner's own policy.

[9] Petitioner argues that staff is only required to report under the Texas statute if there is cause to believe that the health or welfare of a resident may be, or has been, adversely affected by abuse. P. Reply at 8. While it is not for me to declare the meaning of Texas statutes or regulations in this case, it is clear that a report is required if there is any cause to believe that there has been abuse. The statute does not state that a report is only required if there is reasonable cause or probable cause. In this case, the allegations of Residents 3 and 9 were all the "cause" necessary to believe that they may have been affected by abuse and it certainly should not have required 24 hours for Administrator Thurman, DON Benitez, and Ms. Rubio to recognize the allegations for what they were.

the state agency within five working days of the incident, which is the requirement of the regulations. The surveyors' opinion that the violations posed a risk for more than minimal harm is unrebutted. I am satisfied that CMS made a *prima facie* showing of a deficiency under Tag F225.

The burden is upon Petitioner to rebut the *prima facie* showing or to establish an affirmative defense. Petitioner argues that there was no allegation of abuse related to Resident 9 and, therefore, it had no obligations under 42 C.F.R. § 483.13(c)(2)-(4). P. Br. at 8. Petitioner is incorrect as I have explained under Tag F223, as there was an allegation of abuse that was not properly investigated and reported. Petitioner argues that its investigation of the allegations by Resident 3 was adequate and that its protection of Resident 3 was also adequate. P. Br. at 16-19. I find Petitioner's arguments that its investigation was adequate unpersuasive for the reasons already discussed. Petitioner's argument that it protected Resident 3 during the investigation is also not persuasive. LVN Avila was suspended, but the evidence does not show when he left the facility or what was done to ensure he had no contact with Resident 3 or other residents prior to leaving facility grounds. Further, the evidence does not include an assessment of Resident 3 at the time of her complaint to determine what, if any, harm she suffered or what care and treatment might be needed to address residual harm and to protect her from further harm. I conclude Petitioner failed to meet its burden.

(iii) Tag F226

The surveyors allege under Tag F226 that Petitioner violated 42 C.F.R. § 483.13(c) because the facts related to the examples of Resident 3 and Resident 9 show that Petitioner failed to implement its written policy and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. CMS Ex. 1, at 31-32. I conclude, based upon the facts set forth above, that CMS has made a *prima facie* showing of the alleged violation and the risk for more than minimal harm beginning as early as February 12, 2009. The noncompliance continued through at least July 29, 2009.

The conflicting testimony of Administrator Thurman, Ms. Rubio, and CNA Johnson shows that staff and managers did not know who was responsible to conduct investigations under the policy. All three witnesses mentioned the abuse coordinator for the facility – a position not even mentioned in Petitioner's policy – and there was disagreement as to who filled that position. CNA Johnson testified Administrator Thurman was the abuse coordinator. Tr. at 371-74. Ms. Rubio thought the same. Tr. at 415. Administrator Thurman thought Ms. Rubio was the abuse coordinator and testified that the facility's social worker had been the abuse coordinator for eleven years. Tr. at 478.

Although Administrator Thurman testified the policy had been in effect since 2005, her testimony shows that she was not clear on the requirements of the policy regarding reporting and investigation of complaints of abuse. Ms. Rubio, who was new to her job in December 2009, did not know the requirements for conducting abuse investigations in February 2009 or in June 2009. As discussed above, the investigations conducted did not meet the requirements of Petitioner's abuse policy. Neither Ms. Rubio nor Administrator Thurman understood that Petitioner's policy, consistent with the federal regulation, required immediate reporting of an allegation of abuse by staff. I conclude that the evidence shows that Petitioner's abuse policy was not properly implemented by Petitioner. The policy was also inconsistent with the requirements for reporting established by 42 C.F.R. § 483.13(c)(4). I am satisfied that CMS made a *prima facie* showing of a deficiency under Tag F226.

The burden is upon Petitioner to rebut the *prima facie* showing or to establish an affirmative defense. Petitioner argues that CMS did not make a *prima facie* showing. P. Br. at 20-21. Petitioner's argument is not persuasive for reasons already discussed. Petitioner argues, in the alternative, that it rebutted the CMS showing because it had an abuse policy (CMS Ex. 7, at 11-16, Tr. at 453-54). It is not alleged in the SOD that Petitioner did not have a policy. The allegation was that Petitioner failed to implement its policy. CMS Ex. 1, at 32. I agree. I conclude that Petitioner has failed to meet its burden.

(iv) Immediate Jeopardy

The SOD recites that the surveyors advised the Administrator on July 23, 2009, that there was immediate jeopardy. The SOD indicates that the surveyors found that immediate jeopardy was removed on July 24, 2009, but that Petitioner continued not to be in substantial compliance. CMS Ex. 1, at 14. CMS stipulated at hearing that immediate jeopardy was actually abated on July 23, 2009. Tr. at 47. Petitioner argues that there was no immediate jeopardy. P. Br. at 22-25. I am required by regulation to uphold CMS's determination of the level of a petitioner's noncompliance, unless it is "clearly erroneous." 42 C.F.R. § 498.60. Immediate jeopardy is appropriately found when a deficiency has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident. 42 C.F.R. § 488.301. The Board has explained that a presumption exists that CMS's determination is correct, and a petitioner must rebut the presumption by showing the determination to be clearly erroneous. *Daughters of Miriam Ctr.,* DAB No. 2067 (2007); *Liberty Commons Nursing and Rehab Ctr. – Johnston,* DAB No. 2031 (2006). The Board has also held that immediate jeopardy exists under either of the following circumstances: the facility's noncompliance has caused death or "serious" harm to one or more residents; or the facility's noncompliance is or was "likely to cause" death or serious harm. *Daughters of Miriam Ctr.,* DAB No. 2067. I conclude that Petitioner has failed to show that the determination that the violations of various provisions of 42

C.F.R. § 483.13(b) and (c) posed immediate jeopardy to Petitioner's residents was clearly erroneous.

Residents 3 and 9 were subjected to abuse by LVN Avila. Petitioner's staff failed to recognize that the incident involving Resident 9 was abuse. Petitioner's staff did a cursory investigation of the incident involving Resident 3, and determined to return the perpetrator to work in the facility. LVN Avila's continued access to residents in the facility after the incident with Resident 9 made it probable that there would be further abuse which had the potential for both serious mental and physical harm of residents. Petitioner's arguments that it was a busy facility and no resident was alone with staff for long, is belied by the fact that LVN Avila found some private time with both Residents 3 and 9. Because Petitioner failed to recognize potential abuse and failed to report it as required, there was a likelihood of abuse and serious harm. With respect to Resident 9, Petitioner's failure to report her allegations meant that the state agency was prevented from conducting a thorough and independent investigation of the incident in question. *Cedar View Good Samaritan*, DAB No. 1897, at 18-20. The evidence does not show that Resident 3 or Resident 9 suffered actual harm in the incidents described above, but a showing of actual harm is not required. *Id.* Petitioner has not proved that CMS's determination of immediate jeopardy was clearly erroneous.

6. Petitioner violated 42 C.F.R. § 483.75 (Tag F490).

7. The regulatory violation posed a risk for more than minimal harm.

8. Petitioner has not shown that the declaration of immediate jeopardy was clearly erroneous.

The surveyors allege in the SOD that Petitioner violated 42 C.F.R. § 483.75 because the Administrator, DON, and respiratory therapy supervisor failed to manage the facility in an effective and efficient manner to attain or maintain the highest practicable physical, mental, and psychosocial well-being of Resident 3 and Resident 9 by not: implementing Petitioner's Abuse Prohibition Policy; identifying that abuse had occurred; and supervising staff to ensure resident safety. CMS Ex. 1, at 46. CMS relies on the same facts that are the bases for the deficiencies under Tags F223, F225, and F226. The facts I have found are set forth above and need not be restated here.

Petitioner is obliged to administer its facility in

> [A] manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.

42 C.F.R. § 483.75. The Board has previously recognized that a violation of 42 C.F.R. § 483.75 may be derivative of findings of other deficiencies. *Cedar View Good Samaritan*, DAB No. 1897, at 23-24; *Asbury Ctr. at Johnson City*, DAB No. 1815 (2002), at 11. Based on the deficiencies under Tags F223, F225, and F226, I conclude that CMS has made a *prima facie* showing of noncompliance under Tag F490 that Petitioner has failed to rebut. Petitioner's repeated noncompliance with its abuse policy is strong evidence that there was a deficiency in administration. Petitioner relies upon its answers to the deficiencies cited under Tags F223, F225, and F226. P. Br. at 22. Petitioner's arguments are not persuasive. Petitioner has also failed to show that the declaration of immediate jeopardy was clearly erroneous as to this deficiency for the same reasons Petitioner failed to meet that burden as to the other deficiencies.

9. A CMP of $6,550 per day effective July 10 through 22, 2009, and a CMP of $900 per day effective July 23 through 29, 2009, are reasonable enforcement remedies.

I have concluded that Petitioner violated various provisions of 42 C.F.R. §§ 483.13(b) and (c) and 483.75 and that those violations posed immediate jeopardy for Petitioner's residents. I conclude that Petitioner was not in substantial compliance with program participation requirements from July 10 through 29, 2009, and there is a basis for the imposition of enforcement remedies. There is no dispute that on July 10, 2009, LVN Avila returned to work at the facility following his suspension. CMS Ex. 1, at 6; Tr. at 469. There is no dispute that LVN Avila was terminated on July 23, 2009, and departed the facility. The surveyors found that immediate jeopardy was abated on July 24, 2009, but CMS stipulates that it was actually abated on July 23, 2009. CMS Ex. 1, at 14; Tr. at 47. Petitioner has not offered evidence that it returned to substantial compliance prior to July 30, 2009, the date Petitioner alleged it completed its plan of correction. CMS Ex. 1, at 2, 17, 33, 47.

If a facility is not in substantial compliance with program requirements, CMS has the authority to impose one or more of the enforcement remedies listed in 42 C.F.R. § 488.406, including a CMP. CMS may impose a CMP for each day that the facility is not in substantial compliance with program participation requirements. A CMP that is imposed against a facility on a per day basis will fall into one of two ranges of penalties. 42 C.F.R. §§ 488.408, 488.438. The upper range of a CMP, $3,050 per day to $10,000 per day, is reserved for deficiencies that pose immediate jeopardy. 42 C.F.R. § 488.438(a)(1)(i), (d)(2). The lower range of a CMP, $50 per day to $3,000 per day, is reserved for deficiencies that do not pose immediate jeopardy but either cause actual harm to residents, or cause no actual harm but have the potential for causing more than minimal harm. 42 C.F.R. § 488.438(a)(1)(ii).

If I conclude, as I have in this case, that there is a basis for the imposition of an enforcement remedy and the remedy proposed is a CMP, my authority to review the

reasonableness of the CMP is limited by 42 C.F.R. § 488.438(e). The limitations are: (1) I may not set the CMP at zero or reduce it to zero; (2) I may not review the exercise of discretion by CMS in selecting to impose a CMP; and (3) I may only consider the factors specified by 42 C.F.R. § 488.438(f), when determining the reasonableness of the CMP amount. In determining whether the amount of a CMP is reasonable, the following factors specified at 42 C.F.R. § 488.438(f) must be considered: (1) the facility's history of non-compliance, 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(b), the same factors CMS and/or the state were to consider when setting the CMP amount; and (4) the facility's degree of culpability, including, but not limited to, the facility's neglect, indifference, or disregard for resident care, comfort, and safety, and the absence of culpability is not a mitigating factor.

The factors that CMS and the state were required to consider when setting the CMP amount and that I am required to consider when assessing the reasonableness of the amount are set forth in 42 C.F.R. § 488.404(b): (1) whether the deficiencies caused no actual harm but had the potential for minimal harm; no actual harm with the potential for more than minimal harm, but not immediate jeopardy; actual harm that is not immediate jeopardy; or immediate jeopardy to resident health and safety; and (2) whether the deficiencies are isolated, constitute a pattern, or are widespread. My review of the reasonableness of the CMP is *de novo* and based upon the evidence in the record before me. I am not bound to defer to the CMS determination of the reasonable amount of the CMP to impose, but my authority is limited by regulation as already explained. I am to determine whether the amount of any CMP proposed is within reasonable bounds, considering the purpose of the Act and regulations. *Emerald Oaks,* DAB No. 1800, at 10; *CarePlex of Silver Spring*, DAB No. 1683, at 14–16 (1999); *Capitol Hill Cmty. Rehab. and Specialty Care Ctr.*, DAB No. 1629 (1997).

I do not have any information which shows a history of noncompliance, and I have no evidence of a history of violations of 42 C.F.R. § 483.13(b) and (c). Petitioner has not argued that its financial condition affects its ability to pay the CMP. Petitioner is culpable for the deficiencies. Petitioner failed to act aggressively to protect its residents, by failing to implement its policy and procedure when there was an allegation of abuse against a staff member. Prevention of abuse is required by the Act and is a very serious matter. Petitioner's failures must be dealt with seriously with a sufficiently high CMP to ensure future compliance. A per day CMP of $6,500 for the period of immediate jeopardy is in the middle of the authorized range and is reasonable. A per day CMP of $900 per day from July 23, when immediate jeopardy was abated, through July 29, 2009, the day prior to Petitioner's return to substantial compliance, is in the lower third of the lower range, and it is reasonable. Petitioner's loss of its authority to conduct a NATCEP was required by law because the CMP imposed was $5,000 or more, and it is presumptively reasonable.

III. Conclusion

For the foregoing reasons, I conclude that Petitioner was not in substantial compliance with program participation requirements and that the enforcement remedies are reasonable.

/s/

Keith W. Sickendick
Administrative Law Judge