**Department of Health and Human Services**
**DEPARTMENTAL APPEALS BOARD**
**Appellate Division**

Illinois Knights Templar Home
Docket No. A-11-9
Decision No. 2369
March 29, 2011

# FINAL DECISION ON REVIEW OF ADMINISTRATIVE LAW JUDGE DECISION

Illinois Knights Templar Home (Illinois Knights, Petitioner) appealed the August 10, 2010 decision of Administrative Law Judge (ALJ) Steven T. Kessel upholding the imposition of civil money penalties (CMPs) of $3,500 per day for the period March 28 through April 3, 2008 and $300 per day for the period April 4 through April 30, 2008. *Illinois Knights Templar Home*, DAB CR2203 (2010) (ALJ Decision). The Centers for Medicare & Medicaid Services (CMS) imposed the CMPs based on survey findings by the State survey agency that Illinois Knights, a skilled nursing facility, failed to comply substantially with Medicare participation requirements, that this noncompliance posed immediate jeopardy to residents through April 3, and that Illinois Knights did not correct its noncompliance until May 1, 2008. The ALJ concluded that Illinois Knights failed to comply substantially with provisions of 42 C.F.R. § 483.13 prohibiting abuse of residents, requiring that facilities develop and implement policies regarding abuse, and requiring that allegations of abuse be reported immediately to the facility administrator and thoroughly investigated and that the results of the investigations be reported to the State survey agency and others. The ALJ further concluded that Illinois Knights failed to comply substantially with the requirement at 42 C.F.R. § 483.75 governing the administration of a facility. The ALJ also upheld CMS's finding of immediate jeopardy-level noncompliance and its determinations as to the duration of noncompliance and the amount of the CMPs.

For the reasons explained below, we conclude that the ALJ Decision is supported by substantial evidence and free of legal error.

## Case Background

The Social Security Act (Act) and federal regulations provide for state agencies to conduct surveys of Medicare skilled nursing facilities and Medicaid nursing facilities to evaluate their compliance with the Medicare and Medicaid participation requirements. Sections 1819 and 1919 of the Act; 42 C.F.R. Parts 483, 488, and

498.[1] The participation requirements are set forth at 42 C.F.R. Part 483, subpart B. A facility's failure to meet a participation requirement constitutes a "deficiency." 42 C.F.R. § 488.301. "Substantial compliance" means a level of compliance such that "any identified deficiencies pose no greater risk to resident health or safety than the potential for causing minimal harm." *Id*. "Noncompliance" is defined as "any deficiency that causes a facility to not be in substantial compliance." *Id*.

Surveyor findings are reported in a statement of deficiencies (SOD), which identifies each deficiency under its regulatory requirement. 42 C.F.R. § 488.404; *State Operations Manual* (SOM), CMS Pub. 100-07, App. P -- Survey Protocol for Long Term Care Facilities (available at http://www.cms.gov/Manuals/IOM/list.asp), sec. V. A deficiency's scope and severity is designated in the SOD. SOM, Ch. 7, at § 7400.5.1.

A long-term care facility determined to be not in substantial compliance is subject to enforcement remedies, including CMPs. 42 C.F.R. §§ 488.402(c), 488.406, 488.408. A per-day CMP may accrue from the date the facility was first out of compliance until the date it achieved substantial compliance. 42 C.F.R. § 488.440(a)(1), (b). For noncompliance determined to pose less than immediate jeopardy to facility residents, CMS may impose a per-day CMP in an amount ranging from $50-$3,000 per day. 42 C.F.R. § 488.408(d)(1)(iii). For noncompliance determined to pose immediate jeopardy to facility residents, CMS may impose a per-day CMP in an amount ranging from $3,050-$10,000 per day. 42 C.F.R. § 488.408(e)(1)(iii).

The participation requirements at issue in this case include several requirements of 42 C.F.R. § 483.13, Resident Behavior and Facility Practices. Section 483.13(b), captioned "*Abuse*," provides: "The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion." The lead-in language in section 483.13(c), captioned "*Staff treatment of residents*," states: "The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property." Section 483.13(c)(1)(i) states that the facility must "[n]ot use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion[.]"[2] Section 483.13(c)(2)-(4) states as follows:

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[1] The current version of the Social Security Act can be found at http://www.socialsecurity.gov/OP_Home/ssact/ssact.htm.

[2] Illinois Knights argues that the ALJ erred in finding noncompliance with section 483.13(c)(1)(i) because the SOD cited section 483.13(b)(1)(i) instead. RR at 14. However, Illinois Knights was on notice from the regulatory language of section 483.13(c)(1)(i) quoted in the SOD and from CMS's reference to that section in briefs filed with the ALJ that the requirement at issue was section 483.13(c)(1)(i). *See, e.g.*, CMS Ex. 1, at 4; CMS' Post-Hearing Br. at 6 . Accordingly, we reject this claim of error. *See Oak Lawn Pavilion, Inc.*, DAB No. 1638, at 8-12 (1997) (rejecting nursing home's allegation that ALJ erred in considering findings cited in the SOD under the wrong subsection of a regulation or findings cited in the SOD under a regulation other than that which the ALJ found to be violated since the facility had adequate notice of the facts at issue and was not misled by the citation of the wrong section).

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

Also at issue is the requirement in section 483.75 that a "facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident."

The ALJ Decision is the second ALJ decision upholding the CMPs based on the ALJ's conclusion that Illinois Knights failed to comply substantially with these participation requirements. In the first decision, DAB CR1879 (2009), the ALJ granted CMS's motion for summary judgment. Illinois Knights appealed, and the Board remanded the case to the ALJ, finding that there were disputed issues of material fact and that Illinois Knights was entitled to a hearing. DAB No. 2274 (2009). The ALJ then held a hearing and issued the decision that is the subject of the current appeal.

## Standard of Review

The Board's standard of review on a disputed conclusion of law is whether the ALJ decision is erroneous. Guidelines – Appellate Review of Decisions of Administrative Law Judges Affecting a Provider's Participation in the Medicare and Medicaid Programs, http://www.hhs.gov/dab/divisions/appellate/guidelines/prov.html; *Batavia Nursing and Convalescent Inn*, DAB No. 1911, at 7 (2004), *aff'd*, *Batavia Nursing & Convalescent Ctr. v. Thompson*, 143 F. App'x 664 (6th Cir. 2005). The Board's standard of review on a disputed finding of fact is whether the ALJ decision is supported by substantial evidence on the record as a whole. *Id*.

## Analysis

*A. The ALJ's conclusion that Illinois Knights failed to comply substantially with the requirements of 42 C.F.R. §§ 483.13(b) and (c)(1)(i) is based on the correct legal standards and is supported by substantial evidence in the record as a whole.*

The ALJ found that an incident involving abusive behavior by facility staff against residents occurred on September 9, 2007, in violation of the requirements of sections 483.13(b) (prohibiting abuse) and 483.13(c)(1)(i) (requiring that a facility develop and implement a policy on abuse). The ALJ Decision states in relevant part that--

> very early on the morning of September 9, 2007, H and two other nursing assistants were in a room shared by two of Petitioner's residents who are identified as Resident # 4 and Resident # 17. The nursing assistants were providing care to Resident # 17 while Resident # 4, who is nearly blind, slept. While the three nursing assistants were in the room, H began repeatedly hitting his leg against Resident # 4's bed. The two nursing assistants who were with H at that time, Olha York and Kathy Arends, respectively described what H was doing as either "bouncing" the bed or "tapping" on it. CMS Ex. 41 at 1-2. These nursing assistants described H's behavior as joking. *Id*. However, H refused to cease his behavior when Resident # 17 and the two nursing assistants asked him to stop. *Id*. That refusal provoked a confrontation between H and the other nursing assistants. Ms. York raised her hand as if to indicate that she would push H away from Resident #4's bed. *Id*. That gesture caused H to become angry and he threatened to harm Ms. York if she ever touched him. *Id.* at 1. H then became very agitated, began yelling; and left the room. *Id*; CMS Ex. 16 at 22.

ALJ Decision at 3.

Additional details are in the written statements made by CNAs York and Arends dated September 9 and 10, 2007, respectively (CMS Exhibit 41, at 1-2) and the surveyor's notes of her interview with CNA York on March 27, 2008 (CMS Exhibit 16, at 22), to which the ALJ cites. Notably, according to both CNA York's contemporaneous statement and the surveyor's interview notes, after CNA York raised her hand as if to move H away from the bed, H told York that if she ever touched him, he would hurt her. CNA York's statement further states that "I didn't take it seriously so I just joked to him saying that if he would do so I would just slap his butt," and that H then "got very aggitated [sic] and went away using some bad words." CMS Exhibit 41, at 1.

The ALJ concluded that H's continuing to tap or bounce Resident 4's bed when asked by a resident to stop itself constituted abusive behavior. The ALJ further concluded that "H's explosive reaction to the other nursing assistants' requests that he cease his abusive behavior, in the presence of residents, was abusive in its own right. He subjected residents who are by definition individuals who are frail and ill to his outburst and this behavior clearly had the likelihood of causing the residents to suffer from anguish." ALJ Decision at 5. The ALJ concluded on this basis that Illinois Knights failed to comply substantially with the regulatory requirements that residents be free from abuse and that the facility not use any type of abuse.

On appeal, Illinois Knights takes exception to these conclusions on two principal grounds. First, Illinois Knights argues that the ALJ's findings about what occurred in the residents' room on September 9 are not supported by substantial evidence. Second, Illinois Knights argues that the regulatory definition of "abuse" was not met on the facts of this case. We discuss these arguments in turn below.

*1. The ALJ's findings about what occurred in the residents' room are supported by substantial evidence in the record as a whole.*

According to Illinois Knights, the ALJ's findings are contrary to the written direct testimony of its administrator. The administrator's description of the events in the room differs from the descriptions in the exhibits on which the ALJ relied principally in that the administrator testified that H's knee tapped Resident 4's bed as the result of a "nervous tic." P. Ex. 7, at 4. [3] In addition, the administrator stated that, when CNA York gestured toward him, H "indicated to Ms. York that he did not like to be touched," but the administrator's testimony does not identify the precise language H used. *Id*. The administrator did not state that H then began cursing but merely that he "became agitated and left the room." *Id*. Finally, the administrator stated that the "entire incident lasted less than a minute." *Id*. The administrator was not present in the room or even in the facility when the incident occurred but claimed that the next morning she interviewed CNAs York and Arends, Resident 17, and the nursing supervisor to whom CNAs York and Arends reported the incident. *Id*.

The ALJ determined that the administrator's testimony that H touched Resident 4's bed as the result of a "nervous tic," that the incident lasted less than a minute, and that H's actions did not constitute abuse was not credible. *See* ALJ Decision at 7-8. According to Illinois Knights, this credibility determination was in error because a witness' credibility cannot be determined without observing the witness' demeanor and the ALJ did not allow Illinois Knights' witnesses to testify in person unless CMS chose to cross-examine them, which, in the case of Illinois Knights' administrator, CMS did not. RR at 11-12.[4] We agree with the ALJ that it was not necessary that he observe a witness' demeanor in order to make a credibility finding. As the ALJ correctly stated, "[c]redibility may be

[3] All references to Petitioner's exhibits are to exhibits Illinois Knights submitted to the ALJ on remand from DAB No. 2274 (CRD Docket No. C-09-774) except in one instance in which we indicate the docket number for the earlier stage of the proceeding.

[4] Illinois Knights alleges that the ALJ made a "prejudicial error of procedure" in remarks made to CMS counsel in the prehearing conference regarding whether CMS should cross-examine Illinois Knights' witnesses. Illinois Knights Reply Br. at 5. A review of the tape recording of the prehearing conference indicates that the ALJ noted that, in his prior summary judgment ruling, he had accepted as true the statements made by Illinois Knights' witnesses. He then stated he did not know whether CMS felt a need to cross-examine any of Illinois Knights' witnesses generally or, in particular, those for whom Illinois Knights sought subpoenas because they were no longer in its employ. Counsel for CMS stated an intent to cross-examine two of Illinois Knights' witnesses, both still employed by it. The ALJ concluded that no subpoenas were necessary. We find no prejudice reflected in the ALJ's comments, or his mention of his original grant of summary judgment of which both parties were well aware.

based on many factors other than demeanor," e.g., that the testimony is "not supported by the record" or "inconsistent with other evidence," including eyewitness accounts. ALJ Decision at 7. Moreover, we defer to the ALJ's credibility determination since Illinois Knights pointed to no compelling reason for disturbing that determination. *See Woodland Oaks Healthcare Facility*, DAB No. 2355, at 7 (2010) (stating that "[i]n general, the Board defers to an administrative law judge's findings on weight and credibility of witness testimony unless there are 'compelling' reasons not to do so" and that "similar deference is warranted for credibility findings concerning unsworn written statements of facility employees who, for whatever reason, do not testify in-person"); *see also Van Duyn Home and Hospital*, DAB No. 2368, at 10-11 (2011).[5]

Moreover, the administrator's testimony that H "indicated to Ms. York that he did not like to be touched" after she gestured toward him is so vague that it does not undercut the evidence in the record that H told CNA York that if she ever touched him, he would hurt her. Indeed, Illinois Knights does not dispute that H made the "threat" described in CNA York's contemporaneous statement, but merely points out that it "was perceived by her as a joke." RR at 2. In addition, the administrator's testimony that H then became agitated is not inconsistent with CNA York's statement that he began cursing.

Illinois Knights objects to the ALJ's characterizing as "explosive" H's reaction to the requests that he stop touching Resident 4's bed and CNA York's gesturing as if to move him away from the bed. *See* ALJ Decision at 5. Illinois Knights points out that the Board's decision remanding the case to the ALJ states that a "reasonable trier of fact could find that H left the residents' presence immediately upon getting upset with CNA York's touching or trying to touch him, that his temper was therefore not 'explosive,' and that he could control his anger in the interest of safeguarding residents." RR at 10, quoting DAB No. 2274, at 11 (our emphasis); *see also* Illinois Knights Reply Br. at 3. The quoted statement from DAB No. 2274 is not dispositive here. The issue in DAB No. 2274 was whether the ALJ properly granted summary judgment in favor of CMS. As the Board noted in that decision, in deciding a summary judgment motion, an ALJ must construe the record in the light most favorable to the nonmovant. DAB No. 2274, at 4 (citing *Kingsville Nursing and Rehabilitation Center*, DAB No. 2234, at 3-4 (2009)). In response to CMS's motion for summary judgment, Illinois Knights had proffered the same document it later submitted as the written direct testimony of its administrator. *See* P. Ex. 7, Docket No. C-08-537. Viewing the record in the light most favorable to Illinois Knights, the Board concluded that an inference could be drawn from that document in Illinois Knights' favor that H's reaction was not explosive; however, the Board did not suggest that this favorable inference was the only reasonable one possible on the record. The case was in a different posture following the Board's remand to the ALJ for a

[5] Illinois Knights also reiterates its argument below that the in-person testimony of Surveyor DeLong (who interviewed CNA York) was not credible, thus impeaching the credibility of her survey notes. Illinois Knights showed no compelling reason why we should not defer to the ALJ's express determination that her testimony was credible. *See* ALJ Decision at 7; RR at 12-13.

hearing. At that point, it was proper for the ALJ to weigh the evidence impartially. *See, e.g., Madison Health Care, Inc.,* DAB No. 1927, at 6 (2004) ("[T]he ALJ deciding a summary judgment motion does not 'make credibility determinations, weigh the evidence, or decide which inferences to draw from the facts,' as would be proper when sitting as a fact-finder after a hearing. . . ."(citation omitted)). He could thus reasonably conclude on remand that the record as a whole establishes that H's reaction was at the very least intimidating from a resident's point of view (which was all that was required).[6]

Illinois Knights also disputes the ALJ's finding that H began "yelling" before he left the residents' room, stating that "[n]o witness identified any yelling or angry outbursts by [H] in the presence of residents." Illinois Knights Reply Br. at 2. According to CNA York's contemporaneous statement, H was "using some bad words" when he left the room; however, there is no indication in her statement whether he raised his voice as he was cursing. Nor is there any indication in the record whether H raised his voice prior to that when he threatened CNA York. Even if H did not raise his voice to the point where he was "yelling," i.e., screaming or shouting, that did not mean that his threatening and cursing did not have the same effect as if he had been yelling.

*2. The ALJ's conclusion that H's conduct constituted abuse is consistent with the definition of abuse in 42 C.F.R. § 488.301 as well as with the definition of abuse in Illinois Knights' own policy.*

Section 488.301 defines abuse as "the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish." Section 483.13(b) specifies that "abuse" includes "verbal" as well as "physical" abuse. We conclude that H engaged in conduct that met this definition of abuse when the incident is viewed as a whole.

H's threat to hurt CNA York if she ever touched him was preceded by requests by Resident 17, as well as both CNAs York and Arends, that H stop bouncing or tapping Resident 4's bed and by CNA York's gesturing as if to move H away from the bed. The fact that H threatened violence in response to reasonable efforts to get him to stop touching the bed could easily intimidate a resident who had requested him to stop and who was dependent on him for care. Such a resident might well fear for her own safety, believing that since H, without any real provocation, threatened to hurt a CNA, H could easily lose his temper and actually hurt a resident who was unable to defend herself. Moreover, the fact that H began cursing in response to CNA York's remark that she would "slap his butt" if he tried to hurt her could also frighten a resident, who might view

[6] The evidence discussed above is corroborated by the ALJ's undisputed findings about what transpired after H left the residents' room. The ALJ found that H, who "remained angry and upset," went to the nurse's station and told a nurse that he wanted to go on a break. ALJ Decision at 4, citing CMS Ex. 16, at 16. When CNA York approached the nurse's station, H "jumped up from his seat and went outside, cussing and saying that he was going home." *Id.* quoting CMS Ex. 41, at 1. If H had instead acted calmly after leaving the residents' room, this might have lent some credence to Illinois Knights' view about his behavior in the room.

the cursing as further evidence that H could not control his temper. Thus, as the ALJ indicated, H's behavior had the potential to intimidate the residents and cause them to suffer mental anguish.

The plain language of section 488.301 requires at least mental anguish from the intimidating behavior. We conclude that this requirement was met here. In a recent decision, the Board upheld a CMP based on a deficiency citation under section 483.13(b) where the ALJ did not make findings that some of the residents in question suffered mental anguish, noting that the ALJ had pointed out that the facility itself failed to promptly investigate the allegations of abuse, so that the actual consequences of the behavior could not be ascertained. *See Somerset Nursing & Rehabilitation* Facility, DAB No. 2353, at 19 (2010). Similarly, here it is reasonable to infer that Resident 17 suffered mental anguish as a result of H's conduct. As discussed in the next section, Illinois Knights did not treat CNA York's or CNA Arends' reports of the incident as allegations of abuse and investigate them as such, making it impossible to ascertain how H's conduct affected either resident. While Illinois Knights argues that, contrary to what the ALJ found, its administrator interviewed Resident 17 about the incident the following day, the only evidence in the record of such an interview is the administrator's testimony, which (even if believed) makes no representation about what, if anything, Resident 17 said at the interview. It is reasonable to presume that, if the administrator did interview Resident 17 about the impact of the incident and concluded from her response that it did not cause her to suffer any mental anguish, the administrator would have said so. Since she did not, the reasonable inference is that either the administrator did not ask or the answer was unfavorable to Illinois Knights.

We are also not persuaded by Illinois Knights' argument that we should infer that Resident 17 was not frightened by H's threatening and cursing from the facts that she did not make any contemporaneous complaint about H or even remember the incident when she was interviewed by the surveyors, but did complain that the surveyors intimidated her during the interview. *See* RR at 5, 14, 19. As the ALJ stated, Illinois Knights' assertion that Resident 17 "would have filed a claim of abuse had she believed that H's conduct was abusive . . . is speculative." ALJ Decision at 6. The interview with the surveyors took place over six months after the September 9 incident so Resident 17's lack of memory at that point does not demonstrate that she was not frightened when it occurred. *See* CMS Ex. 16, at 18-19 (surveyor's notes on 3/25/08 resident interviews). It is also undisputed that Illinois Knights did not interview Resident 4 about the incident. While Resident 4 appeared to be asleep, it is possible that she was partially or even fully awakened at some point. At a minimum, H's persistently bouncing or tapping the bed of a sleeping resident further supports an inference that he was indifferent to the impact of his behavior on residents. That this behavior risked disturbing a helpless, blind resident in her bed, moreover, reinforces the inference that Resident 17 was upset by viewing it.

Illinois Knights also argues that there was no abuse because abuse necessarily involves conduct directed at a resident whereas the incident in question here involved an

"altercation" or "disagreement" between staff of the facility. RR at 6, 15, 17. Section 488.301 does not expressly state that conduct must be directed at a resident in order to constitute abuse.[7] In any event, H's conduct can reasonably be viewed as directed at Resident 17 and Resident 4 as well as CNAs York and Arends. Like those CNAs, Resident 17 requested that H stop tapping or bouncing Resident 4's bed. Moreover, although H's subsequent threat was addressed specifically to CNA York, there is no evidence that H's cursing was addressed to anyone in particular.[8]

Illinois Knights also argues that H's threat to CNA York did not constitute abuse because it was perceived by her as a joke. Illinois Knights Reply Br. at 2. It is irrelevant how CNA York perceived the threat, however. The salient issue is how this threat and H's cursing were perceived by Residents 17 and 4.

Even absent a finding that H's conduct intimidated Resident 17 and/or Resident 4, causing them to suffer mental anguish, or that H's conduct was directed at one or both of them, H's conduct still constituted abuse within the meaning of Illinois Knights' own policy on abuse. That policy defined "verbal abuse" as used in section 483.13(b) as—

> the use of oral, written or gestured language that willfully includes disparaging and derogatory terms to residents or their families, or within their hearing distance, regardless of their age, ability to comprehend, or disability. Examples of verbal abuse include, but are not limited to: threats of harm; or saying things to frighten a resident . . . .

P. Ex. 6 (also submitted as CMS Ex. 40) at 1 (Policy and Procedures for Identification, Investigation, and Protection of Residents and Reporting of Abuse, Neglect, Involuntary Seclusion and Misappropriation of Resident Property Allegations") (emphasis added). Illinois Knights' policy also stated that there is a presumption that "instances of abuse of all residents, even those in a coma, cause physical harm, or pain or mental anguish." *Id*. Illinois Knights' policy is undated, but Illinois Knights does not dispute CMS's assertion that the policy was in effect on September 9, 2007 (the date of the incident in question). *See* CMS Br. at 11. Indeed, Illinois Knights' policy quoted above is identical in both

[7] Illinois Knights argues that the Board and ALJ decisions cited by CMS all involve situations where there was an "action or statement directed toward a resident[.]" RR at 9; Illlinois Knights Reply Br. at 4. To the extent that these decisions are even precedential (the ALJ decisions are not), they do not stand for the proposition that abuse could be present only in such situations.

[8] Illinois Knights also argues that H's tapping or bouncing Resident 4's bed was the result of a "nervous tic" and therefore not "willful" within the meaning of section 488.301. RR at 9. However, Illinois Knights does not take exception to the ALJ's conclusion that once H refused "to stop engaging in the conduct when asked to stop," his actions were not "inadvertent." ALJ Decision at 5. Moreover, it is not necessary to find that H's tapping or bouncing the bed itself constituted abuse since H's reaction to attempts to stop him from doing so constituted abuse. In any event, Illinois Knights relies on the administrator's testimony that the tapping or bouncing was the result of a "nervous tic," which the ALJ found not credible.

respects to a provision in CMS's State Operations Manual (SOM) that was published well before September 9, 2007. SOM, Appendix PP, interpretive guideline on section 483.13(b) (F223).[9] In any case, Illinois Knights was bound by its own policy.

Under Illinois Knights' policy, a resident can be abused regardless of her ability to comprehend and a threat of harm or other utterance that could frighten a resident in hearing distance constitutes abuse. Thus, to establish that abuse occurred, it is not necessary to show that either Resident 17 or Resident 4 was in fact intimidated and suffered mental anguish as a result of H's conduct or that his conduct was directed at them. Instead, it is sufficient Resident 4 (even if not awake and conscious) and Resident 17 were in the same room as H when he told CNA York that he would hurt her if she ever touched him and when he began cursing. Moreover, as discussed later, by not recognizing H's conduct as abuse within the meaning of its policy, Illinois Knights failed to comply substantially with the requirement at section 483.13(c) that a facility implement its policy on abuse.

Accordingly, the ALJ did not err in concluding based on the September 9 incident that Illinois Knights violated the regulatory prohibitions on abuse of residents.

*B. The ALJ's conclusion that Illinois Knights failed to comply substantially with the requirements of 42 C.F.R. §§ 483.13(c) and (c)(2)-(4) is based on the correct legal standards and is supported by substantial evidence in the record as a whole.*

The ALJ found that there were allegations that abuse occurred on September 9, 2007 and in October 2007 which were not handled in accordance with the requirements in section 483.13(c)(2)-(4) and with Illinois Knights' policy on abuse, which section 483.13(c) required Illinois Knights to implement. Like section 483.13(c)(2)-(3), Illinois Knights' policy requires that allegations of abuse be reported immediately to the facility administrator and that they be thoroughly investigated. CMS Ex. 40, at 2. Illinois Knights' policy goes beyond the requirement in section 483.13(c)(3) that the facility "must prevent further potential abuse while the investigation is in progress" by specifying that employees alleged to have been involved in abuse will be immediately suspended pending the outcome of the investigation. *Id.* Section 483.13(c)(4), but not the policy, requires reporting of the results of all investigations to the administrator and others,

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[9] As CMS points out, this provision is consistent with CMS's response, in the preamble to the final regulations, to a comment suggesting that the definition of the term "abuse" in section 488.301 (which CMS stated is the applicable definition for purposes of section 483.13(b)) require that the resident perceive the conduct as abusive. CMS responded to this comment as follows:

> We do not accept this comment. Our obligation is to protect the health and safety of every resident, including those that are incapable of perception or are unable to express themselves. This presumes that instances of abuse of any resident, whether cognizant or not, cause physical harm, pain, or mental anguish.

59 Fed. Reg. 56,116, 56,130 (Nov. 10, 1994).

including the State survey agency, within five working days of the incident. We discuss the two incidents at issue here in turn below.

The September 9 incident

The ALJ found, and Illinois Knights does not dispute, that CNAs York and Arends reported what had occurred in the residents' room to the supervisory nurse shortly after H left the room. ALJ Decision at 4, 6. Illinois Knights argues that there were no allegations of abuse since "[n]one of the three individuals who observed [H's] behavior characterized it as abuse or even potentially abusive." RR at 5. Addressing the same argument below, the ALJ found that "there was an allegation of abuse because the two nursing assistants who were witnesses to H's conduct had reported it in terms that described abuse by any objective measure." ALJ Decision at 6. Illinois Knights does not dispute the underlying principle, also articulated in Board decisions, that the person who reports a situation need not characterize it as abuse in order for the report to constitute an allegation of abuse. *See, e.g.*, *Grace Healthcare of Benton*, DAB No. 2189, at 6 (2008), *rev'd on other grounds*, *Grace Healthcare of Benton v. U.S. Dep't of Health & Human Servs., Ctrs. for Medicare & Medicaid Servs.*, 589 F.3d 926 (8th Cir. 2009), *modified on reh'g*, 603 F.3d 412 (8th Cir. 2010), (the "broad language" of section 483.13(c) "encompasses not only a direct allegation that the resident has been abused, but also an allegation of facts from which one could reasonably conclude that the resident has been abused."). Instead, Illinois Knights disputes the ALJ's finding on the ground that CNAs York and Arends "each characterized the situation as 'joking.'" *Id*. However, neither CNA indicated that they believed H was joking by the time he was agitated and cursing. Accordingly, the ALJ did not err in finding that they made allegations of abuse.

There was also no error in the ALJ's finding that Illinois Knights did not handle these allegations of abuse in accordance with the regulatory requirements. Illinois Knights acknowledges that it did not report the results of its investigation of this incident to the State survey agency and that H continued to work at the facility until October 19, 2007, when he was terminated for other reasons. RR at 6-7. Illinois Knights asserts that it did not thereby violate the applicable regulations or its policy on abuse because the incident was properly investigated "as a disagreement among staff." RR at 6.[10] However, the reporting requirements are triggered by an allegation of abuse whether or not it is recognized as such by the facility. Moreover, it is irrelevant whether, as Illinois Knights argues, it complied with these requirements in other instances where abuse was alleged.

[10] Illinois Knights notes that the State code was amended in 2009 "to eliminate the requirement of reporting incidents or accidents when, as here, there is no harm or injury to a resident." RR at 6, n.3, citing P. Ex. 19 (77 Ill. Admin. Code Section 200.690). We do not admit this exhibit, submitted for the first time with Illinois Knights' request for review, since Illinois Knights does not explain why it was not provided to the ALJ and, in any case, the code provision is not relevant to incidents that took place before its effective date. *See* 42 C.F.R. § 498.88(a). Regardless, the federal regulation at issue still governs the facility's responsibility to report an allegation of abuse to the State survey agency.

Illinois Knights' failure to recognize reports of H's actions as allegations of abuse is inconsistent with its own policy on abuse. As discussed previously, under the definition of abuse in Illinois Knights' policy, H's conduct clearly constituted abuse since it had the potential to intimidate and cause mental anguish to the two residents who were within hearing distance. Furthermore, any issue about whether the behavior caused actual mental anguish to the residents could only have been conclusively resolved by a proper investigation. As we discuss below, the Board has held that even an allegation of abuse not ultimately substantiated must be fully investigated.

The October incident

The ALJ found, and Illinois Knights does not dispute, that, on an unspecified date in October 2007, CNA Mandy Ebert alleged that she had witnessed H verbally abuse another resident identified as Resident 13. Nor does Illinois Knights dispute the ALJ's finding that another CNA, who is not identified by name in the ALJ Decision and to whom we refer as "CNA D.H.," heard CNA Ebert make this allegation but did not report the allegation to the administrator until later that month, on October 18. *See* ALJ Decision at 4. Indeed, Illinois Knights expressly concedes that CNA D.H. "did not immediately report the allegation" made by CNA Ebert. Illinois Knights Reply Br. at 8. Accordingly, there is substantial evidence in the record to support the ALJ's conclusion that Illinois Knights violated the requirement in section 483.13(c)(2) and in Illinois Knights' policy on abuse that allegations of abuse be reported immediately to the administrator.

Illinois Knights points out that, based on its investigation of the alleged abuse, it determined that CNA Ebert "fabricated the allegation" that H verbally abused Resident 13. RR at 13.[11] Illinois Knights argues that since no abuse occurred, CNA D.H. was not required to report the allegation. Illinois Knights Reply Br. at 8. As the ALJ correctly held, however, "it is no defense to assert that the allegations relating to the October incident may have been 'fabricated' or that they were false. The regulation requires that all allegations of abuse – true or not – be investigated immediately and reported." ALJ Decision at 10; *see also Britthaven, Inc., d/b/a Britthaven of Smithfield*, DAB No. 2008 (2006) (rejecting facility's claim that no report was required where the facility did not find allegations of staff abuse to be supported). As the ALJ further explained, such a requirement is necessary because "[w]hen a facility's management receives an allegation of resident abuse it is placed in a situation where, potentially, there is a conflict of interest" since it "is not in a facility's self-interest to authenticate allegations of resident abuse[.]" *Id*. Requiring all allegations of abuse to be reported

[11] Illinois Knights does not dispute that the facts alleged by CNA Ebert about what H said to Resident 13 when providing care to him would make out a case of abuse but maintains that CNA Ebert misrepresented what was actually said and that any finding by the ALJ that abuse in fact occurred was erroneous. RR at 13. Illinois Knights admits that it is unclear from the ALJ Decision whether the ALJ made such a finding, and we do not find that he did.

"assures that a neutral third party (the State) will be apprised of the allegations and will be in a position to take protective action if necessary." *Id*.

Illinois Knights argues further that it complied with the applicable requirements because once CNA Ebert's allegation of abuse was reported to its administrator, Illinois Knights "immediately and thoroughly investigated" the allegation. RR at 16. However, such an investigation would not excuse Illinois Knights' failure to ensure that the allegation of abuse was reported immediately to its administrator as required by section 483.13(c)(2) and Illinois Knights' policy.[12]

Illinois Knights also asserts that CMS acknowledges in its response to the request for review "that a mere failure to report" is insufficient to establish a violation of the regulations where, as here, the employee has received abuse prevention training, the employee was a good employee, and the employee had no history of engaging in such behavior. Illinois Knights Reply Br. at 8, citing CMS Br. at 15. We do not read CMS's response as acknowledging, nor are we aware of any authority for, such a proposition.

We note that it appears, although it is not entirely clear, that the ALJ may have also treated CNA Ebert's failure to immediately report to the administrator that H abused Resident 13, in addition to CNA D.H.'s failure to report CNA Ebert's allegation to that effect, as violating section 483.13(c)(2). *See* ALJ Decision at 4, 10. We agree with Illinois Knights that there is no basis "to cite a facility for the failure of its employee to 'timely' report a *fabricated* allegation of abuse" at least if the non-reporting employee is the one found to have fabricated the report of past abuse. RR at 16 (emphasis in original). Any holding by the ALJ that CNA Ebert was required to report her allegation to the administrator would be harmless error, however, since, as discussed above, CNA D.H.'s failure to immediately report CNA Ebert's belated allegation violated section 483.13(c)(2).

*C. The ALJ's conclusion that Illinois Knights failed to comply substantially with the requirements of 42 C.F.R. § 483.75 is supported by substantial evidence.*

The ALJ concluded that the "evidence in this case plainly establishes a systemic failure by Petitioner's management to apply its policies to protect residents against abuse," in violation of section 483.75. ALJ Decision at 11. The ALJ pointed specifically to Illinois Knights' "failure to treat the allegations concerning the September 9, 2007 incident as abuse allegations and to implement the full panoply of abuse policies to deal with that incident" as well as "the delayed reporting of allegations pertaining to the October incident[.]" *Id*. at 11-12.

[12] Given this failure, we need not determine whether Illinois Knights also violated section 483.13(c)(4) by failing to report the results of its investigation within five working days of the alleged abuse. Illinois Knights argues that it would have been impossible to comply because the allegation of abuse had not even been reported to the administrator by that time. *See* RR at 16.

Illinois Knights argues that the ALJ erred in concluding that there was a "systemic failure" because the "only event which Illinois Knights failed to treat as an allegation of abuse (thus triggering its abuse investigation policy) was the September 9, 2007 event." RR at 18. Illinois Knights also argues that its handling of this incident does not demonstrate "that the facility was poorly administered." *Id*. Illinois Knights further argues that the two events on which the ALJ relied were "isolated events." *Id*. Finally, Illinois Knights asserts that its prompt response to the report of CNA Ebert's allegation of abuse as well as its response to what it considered Resident 17's allegation of abuse by the surveyors show "that it takes all allegations of abuse seriously[.]" *Id.*

We conclude that the ALJ did not err in concluding that the facility's handling of both the September 9 and October incidents established that Illinois Knights failed to comply substantially with section 483.75. As the ALJ correctly pointed out, "[u]ltimately, the responsibility for implementing and enforcing a facility's policies lies with management." ALJ Decision at 11. Accordingly, the failure of Illinois Knights' staff to understand what constituted abuse and the necessity of immediately reporting an allegation of abuse and, when a report is received, taking the steps required by sections 483.13(c)(2)-(4) and by the facility's policy, showed that the facility was poorly administered. Moreover, the ALJ could reasonably find that Illinois Knights' noncompliance with section 483.13 on two occasions within a period of less than two months, including noncompliance with several requirements on the first occasion and repeated noncompliance with the requirement to report allegations of abuse immediately to the facility administrator, was not isolated. Thus, it is irrelevant whether there were some instances in which Illinois Knights complied with the regulatory requirements at issue here.

*D. The ALJ did not err in concluding that Illinois Knights did not show CMS's determination of immediate jeopardy to be clearly erroneous.*

"Immediate jeopardy" is defined in 42 C.F.R. § 488.301 as a "situation in which the facility'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." A determination that immediate jeopardy is present is a determination about the level of noncompliance, and the regulations at 42 C.F.R. § 498.60(c)(2) provide that "CMS's determination as to the level of noncompliance of an SNF or NF must be upheld unless it is clearly erroneous." Under that standard, CMS's determination of immediate jeopardy here is presumed to be correct, and Illinois Knights has a heavy burden to demonstrate clear error in that determination. *See Brian Center Health and Rehabilitation/Goldsboro*, DAB No. 2336, at 6 (2010); *Liberty Commons Nursing & Rehab Center v. Johnston*, DAB No. 2031, at 18 (2006), *aff'd*, *Liberty Commons Nursing and Rehab Center - Johnston v. Leavitt*, 241 F. App'x 76 (4th Cir. 2007).

CMS determined that Illinois Knights' noncompliance with sections 483.13(b), 483.13(c)(1)(i), and 483.13(c)(2)-(4) was at the immediate jeopardy level. CMS Ex. 3,

at 1. The ALJ concluded that the evidence "amply supports" CMS's immediate jeopardy determination and that Illinois Knights did not prove that determination clearly erroneous. ALJ Decision at 12. According to the ALJ, Illinois Knights' failure "to recognize and respond appropriately to abusive behavior by its staff . . . created the likelihood that residents would be subjected to serious injury or harm." *Id*. By way of example, the ALJ stated that Illinois Knights' "failure to suspend H . . . after the September 9, 2007 incident, meant that an employee who demonstrated more than the potential for committing abusive acts was allowed to continue to provide direct resident care." *Id*. The ALJ continued: "The failure to report the September 9 incident to State officials meant that Petitioner's management had stripped residents of a protection that was guaranteed to them by law and, as a consequence, left them vulnerable to the possibility that Petitioner would not treat abuse allegations with the seriousness that they merited." *Id*.

Illinois Knights argues that the ALJ erred in upholding CMS's determination of immediate jeopardy because "there was no suggestion of abuse regarding the September 9, 2007 event, and the October 2007 allegation was immediately investigated and determined to be fictional and unfounded." RR at 19. As discussed above, however, the ALJ's finding that H's conduct on September 9 constituted abuse is supported by substantial evidence. Moreover, we agree with the ALJ that, regardless of whether the allegations of abuse here were substantiated, Illinois Knights' noncompliance with the requirements for reporting allegations of abuse and the related regulatory requirements made it likely that residents would not be protected against other instances of abuse that could cause serious harm. *See* ALJ Decision at 12-13; *see also Beverly Healthcare Lumberton*, DAB No. 2156, at 15 (2008) (in upholding CMS's immediate jeopardy determination where there were allegations of both verbal and physical abuse, "the ALJ properly considered the likelihood of other, potentially even more serious events occurring as a result of the recurring failures of multiple staff members . . . to understand the nature of abuse and to act immediately and in compliance with both facility policy and federal regulations to respond effectively to any allegation of abuse.").

Illinois Knights also notes that the State survey agency made its immediate jeopardy determination one day after Illinois Knights reported Resident 17's complaint that she was intimidated by the surveyors who interviewed her as an allegation of abuse. *See* RR at 19-20. According to Illinois Knights, the "timing of the immediate jeopardy determination is suspicious and suggests that the determination was retaliatory." *Id.* at 19. Illinois Knights' suggestion that the State survey agency had an improper motive for making the determination of immediate jeopardy is highly speculative. In any event, the State survey agency's motive is irrelevant since CMS adopted the determination of immediate jeopardy, which the ALJ concluded based on the evidence in the record was not clearly erroneous. *Cf. Comprehensive Professional Home Visits*, DAB No. 1934, at 13 (2004) ("This Board has frequently pointed out that 'the appeals process is not intended to review the conduct of the survey but rather to evaluate the evidence of compliance regardless of the procedures by which the evidence was collected.'

Beechwood Sanitarium, DAB No. 1906 at 44 (2004). Consequently, the arguments concerning the surveyor's alleged attitude and knowledge of program requirements are unavailing.").

*E. The ALJ did not err in concluding that the amount and duration of the per-day CMPs imposed by CMS were correct.*

Illinois Knights challenges the amount and duration of the per-day CMPs only on the ground that the ALJ erred in concluding that Illinois Knights failed to comply substantially with sections 483.13(b), 483.13(c)(1)(i), 483.13(c)(2)-(4) and 483.75 and that the noncompliance posed immediate jeopardy. *See* RR at 20. Since we have found no error in those conclusions, we further conclude that the ALJ did not err in upholding a $3,050 per-day CMP from March 28 through April 3, 2008 and a $300 per-day CMP from April 4 through April 30, 2008.

## Conclusion

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

/s/
Judith A. Ballard

/s/
Stephen M. Godek

/s/
Leslie A. Sussan
Presiding Board Member