Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Woodland Hills Healthcare and Rehabilitation
Center of Jacksonville, LLC,
(CCN: 04-5378),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-11-734

Decision No. CR2780

Date: May 9, 2013

DECISION

Following a June 15, 2011 complaint investigation survey, the Arkansas Department of Human Services, Office of Long-Term Care (state agency) determined that Woodland Hills Healthcare and Rehabilitation Center of Jacksonville, LLC, (Petitioner or facility) was not in substantial compliance with Medicare participation requirements for skilled nursing facilities, and that its noncompliance posed immediate jeopardy to the health and safety of its residents. Specifically, the state agency determined that Petitioner's facility did not report or investigate two rape allegations in accordance with federal requirements. Based on the state agency's survey findings, the Centers for Medicare & Medicaid Services (CMS) imposed a $5,000 per-day civil money penalty (CMP) for one day, June 10, 2011, and a $300 per-day CMP for 31 days, from June 11, 2011 to July 11, 2011, for a total CMP of $14,300.

For the reasons explained below, I find and conclude that Petitioner's reporting and investigation of the two rape allegations at issue was appropriate and reasonable in light of the circumstances surrounding the allegations. Petitioner remained in substantial compliance with Medicare participation requirements at all times relevant to this case.

Accordingly, there is no basis for an enforcement remedy, and the per-day CMPs imposed by CMS are reversed.

I. Case Background and Procedural History

Petitioner is a long-term care facility in Jacksonville, Arkansas that participates in the Medicare and Medicaid programs. As stated, two rape allegations and the facility's response to those allegations are at the center of the deficiencies that the state agency cited. The basic facts and timeline of events set forth below are generally undisputed.

Resident 1 was an 87-year-old female who suffered from, among other things, dementia. She frequently made untrue statements when suffering from a urinary tract infection (UTI), which she was experiencing at the time of the incident giving rise to this case. On June 5, 2011, at approximately 8:30 p.m., a male certified nursing assistant (CNA 1) entered the room of Resident 1 to provide peri-care. The door to the room remained open; the charge nurse, a licensed practical nurse (LPN 1) was outside the room and could hear inside. CNA 1 exited the room shortly thereafter and requested assistance from LPN 1 to change Resident 1's leaking colostomy bag. While LPN 1 gathered the supplies needed, a laundry attendant entered Resident 1's room along with CNA 1. Soon after the laundry attendant left the room, LPN 1 returned, entered the room, and began to assist CNA 1 with changing Resident 1's colostomy bag. Resident 1 was agitated, waving her hands and scratching while CNA 1 and LPN 1 changed her colostomy bag. LPN 1 asked that CNA 1 hold Resident 1's hands to prevent her from hitting LPN 1 during the process. After the colostomy bag was changed, LPN 1 left the room while CNA 1 remained inside the room to finish providing peri-care. LPN 1 stayed outside the room; the door remained open. Two minutes later, CNA 1 exited the room, approached LPN 1, and told her that Resident 1 was "saying that [he] raped her." LPN 1 then entered the room, evaluated the circumstances in the room, and asked Resident 1 what happened. Resident 1 responded "I don't know; I don't understand you." LPN 1 determined that the rape allegation was unfounded. Nevertheless, LPN 1 and CNA 1 each completed separate incident reports. Another staff member placed the two incident reports in the facility administrator's inbox. The following day, on June 6, 2011, at 4:30 p.m., the facility administrator found the incident reports and initiated an internal investigation along with the director of nursing (DON). The day after, on June 7, 2011, at 11:00 a.m., the facility reported the incident to the state agency.

Resident 2 was an 89-year-old female resident who suffered from, among other things, dementia, hallucinations, frequent yelling, cellulitis, and delirium when suffering from a UTI. On June 7, 2011, at 4:00 p.m., a male CNA (CNA 2) and a female LPN (LPN 2) entered the room of Resident 2 to provide peri-care. While CNA 2 was providing care, Resident 2 claimed he was trying to look at her "private area." LPN 2 immediately took over the peri-care. Once peri-care was complete, CNA 2 transported Resident 2 in a wheelchair to the facility's dining area. Resident 2 appeared upset, and the facility's

beautician asked what was wrong. Resident 2 said that a "black man" had tried to rape her in her room. When asked what happened, Resident 2 told the beautician that the man pulled her pants off, lifted her up, and put her pants back on. The beautician reassured Resident 2 that he was likely changing her pants. The beautician immediately notified the DON, who started an internal investigation. The next day, on June 8, 2011 at 11:00 a.m., the facility reported the incident to the state agency.

Beginning June 10, 2011, the state agency conducted a complaint investigation survey of Petitioner's facility. The state agency determined that the facility was not in substantial compliance with Medicare participation requirements, citing three specific deficiencies:

- 42 C.F.R. § 483.13(c)(1)(ii)-(iii), (c)(2)-(4) (Tag F-225) -- failure to investigate or report allegations of abuse of a resident;

- 42 C.F.R. § 483.13(c) (Tag F-226) -- failure to develop and implement abuse and neglect prevention policies; and

- 42 C.F.R. § 483.75 (Tag F-490) -- failure to provide effective administration.

The state agency further determined that all of Petitioner's deficiencies posed immediate jeopardy to the health and safety of the facility's residents. The state agency cited each deficiency at a "K" level, meaning the surveyor found a pattern of immediate jeopardy. However, the state agency also determined that the facility had abated the immediate jeopardy as of June 10, 2011, but remained out of substantial compliance at a lower scope and severity until July 11, 2011. CMS adopted the state agency's findings, and imposed two levels of per-day CMPs: (1) a $5,000 per-day CMP for one day, June 10, 2011; and (2) a $300 per-day CMP for 31 days, from June 11, 2011 through July 11, 2011, when a revisit survey determined that Petitioner had returned to substantial compliance.

Petitioner requested a hearing to challenge the state agency's finding of noncompliance, the scope and severity of noncompliance, and the enforcement remedies imposed. After the parties submitted pre-hearing briefing, I held a hearing from May 21-23, 2012, in Little Rock, Arkansas, where I admitted CMS Exhibits (CMS Exs.) 1-10 as well as Petitioner's Exhibits (P. Exs.) 1-67. Each party also presented testimony from several witnesses. A transcript of the proceedings (Tr.) is incorporated into the record. Each party has submitted a post-hearing brief (Br.) and a reply brief (Reply Br.).

II. Statutory and Regulatory Framework

The Social Security Act (Act) establishes the requirements that a long-term care facility must meet to participate in the Medicare and Medicaid programs, and authorizes the Secretary of Health and Human Services (Secretary) to promulgate regulations

implementing those statutory requirements. Act §§ 1819, 1919.[1] Specific Medicare participation requirements for long-term care facilities are at 42 C.F.R. Part 483. A long-term care facility must remain in substantial compliance with program requirements to participate in Medicare. 42 C.F.R. § 483.1(b). "Substantial compliance" means "a level of compliance with the requirements of participation such that any identified deficiencies pose no greater risk to resident health or safety than the potential for minimal harm. 42 C.F.R. § 488.301. By contrast, "noncompliance" means "any deficiency that causes a facility not to be in substantial compliance." *Id.* A "deficiency" is a violation of a statutory or regulatory participation requirement. *Id.*

The Act authorizes the Secretary to impose enforcement remedies against a long-term care facility for failure to comply substantially with the federal participation requirements. *See* Act § 1819(h); 42 C.F.R. § 488.402. The Secretary may not continue Medicare payments to a long-term care facility for more than six months after the facility is first found not to be in substantial compliance. Act § 1819(h)(2)(C). If a facility does not return to substantial compliance within three months, the Secretary must deny payments for all individuals admitted to the facility after that date – commonly referred to as the mandatory or statutory denial of payments for new admissions (DPNA). *See* Act § 1819(h)(2)(D).

The Secretary has delegated to CMS and the states the authority to impose remedies against a long-term care facility not in substantial compliance with program participation requirements. State agencies survey facilities on behalf of CMS to determine whether the facilities comply 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. *See* 42 C.F.R. § 488.406.

CMS may impose a per-day CMP for the number of days a facility is not in substantial compliance or a per-instance CMP for each instance of the facility's noncompliance. 42 C.F.R. § 488.430(a). A per-day CMP, which CMS imposed in this case, has an upper and lower range, depending on the severity of a facility's noncompliance. The upper range is from $3,050 to $10,000 per day for noncompliance that constitutes immediate jeopardy. 42 C.F.R. § 488.438(a)(1)(i). The lower range is from $50 to $3,000 per day for noncompliance that does not constitute immediate jeopardy. 42 C.F.R. § 488.438(a)(1)(ii).

A long-term care facility may request a hearing before an administrative law judge (ALJ) to challenge a noncompliance finding and enforcement remedies. Act §§ 1128A(c)(2),

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[1] The Act, as amended, is available at http://www.ssa.gov/OP_Home/ssact/ssact.htm. On this website, each section of the Act contains a reference to the corresponding chapter and code in the United States Code.

1866(h); 42 C.F.R. §§ 488.408(g), 498.3(b)(13). The hearing before an ALJ is *de novo*. *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 (2001); *Anesthesiologists Affiliated*, DAB CR65 (1990), *aff'd*, 941 F.2d 678 (8th Cir. 1991). The choice of remedies or factors CMS considered when choosing remedies is not subject to review. 42 C.F.R. § 488.408(g)(2). A facility may only challenge the scope and severity level of noncompliance if a successful challenge would affect the range of the CMP that may be imposed or impact the facility's authority to conduct a nurse aid training and competency evaluation program (NATCEP). 42 C.F.R. § 498.3(b)(14), (d)(10)(i).

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 Ctr.*, DAB No. 1904 (2004), *aff'd*, 129 F. App'x. 181 (6th Cir. 2005); *see Hillman Rehab. Ctr.*, DAB No. 1611 (1997), *aff'd*, No. 98-3789, 1999 WL 34813783 (D.N.J. May 13, 1999).

III. Issues

This case presents the following three issues:

1. whether, from June 10, 2011 through July 11, 2011, Petitioner was in substantial compliance with Medicare participation requirements;

2. if Petitioner was not in substantial compliance during the period cited, whether the facility's noncompliance posed immediate jeopardy to the health and safety of its residents on June 10, 2011; and

3. if Petitioner was not in substantial compliance during the period cited, whether the per-day CMPs imposed are reasonable.

As explained below, Petitioner was in substantial compliance with Medicare participation requirements for the period cited. Therefore, the second and third issues are moot.

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

I make five findings of fact and conclusions of law (FFCL) to support this decision. Each FFCL is set forth as a separate heading in bold and italics, followed by a discussion for that FFCL.

1. *Petitioner substantially complied with the abuse reporting requirements at 42 C.F.R. § 483.13(c)(2).*

By regulation, a facility must report all allegations of resident abuse:

> The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source . . . 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).

42 C.F.R. § 483.13(c)(2). The regulations do not provide a time frame for reporting an abuse allegation "immediately," but Appendix PP of the State Operations Manual (SOM), a non-binding guidance manual that CMS publishes for surveyors of long-term care facilities, defines "immediately" to mean "as soon as possible, but ought not exceed 24 hours after discovery of the incident, in the absence of a shorter State time frame requirement." SOM, app. PP, Guidance for F225.

Here, staff reported the rape allegations by Residents 1 and 2 to the facility administrator and the DON. *See* P. Exs. 7, 14. CMS does not argue that the substance of the reports was improper or insufficient, but rather that staff did not "immediately" report the incident involving Resident 1 to the facility administrator. CMS Br. at 3; CMS Reply Br. at 2-3. CMS argues that Petitioner's staff had to report the rape allegation by Resident 1 well before 4:30 p.m. the day after it occurred, but cites nothing other than the surveyor's belief that "immediately" means only "as soon as possible." *See* Tr. 121; CMS Br. at 3; CMS Reply Br. at 1-3. Petitioner aptly cites CMS's own guidance — of which the surveyor had no apparent knowledge (Tr. 122) — that says reporting an incident "immediately" may include reports made up to 24 hours after the incident is discovered. *See* SOM, app. PP, Guidance for F225. Here, Petitioner's staff successfully reported Resident 1's allegation to the facility administrator within 21 hours of its occurrence. While the means of reporting the allegation, placing two incident reports in the administrator's inbox, were perhaps more passive than might be desirable in other circumstances not present here, the critical fact remains that the administrator had knowledge of the incident within the range that CMS set as a guideline.[2] CMS has not

[2] CMS argues that its guideline for surveyors does not apply because the definition of "immediately" refers to a "shorter State time frame requirement." CMS Reply Br. at 2. According to CMS, this definition of "immediately" only applies with reference to when the facility must notify the state agency. CMS's position, however, is unreasonable and legally untenable, as it would result in one word, "immediately," having two meanings in

(*continued . . .*)

offered any basis for why its current *ipse dixit* position of what "immediately" means should have more weight than its own published guidelines. Moreover, LPN 1's immediate assessment of the allegation, which determined it to be unfounded, demonstrates that the slight delay in reporting the incident to the facility administrator, even if deficient, did not create a potential for even minimal harm to Resident 1 or other residents. *See* P. Ex. 7, at 5-6; Tr. 289. CMS, therefore, has not established a *prima facie* case that the facility staff failed to report the rape allegation "immediately" in accordance with Medicare participation requirements and its own guideline for applying the applicable regulatory requirement.[3] CMS cannot meet its burden by ignoring its own published guidance manual and substituting the unsupported belief of a surveyor. Even if CMS had met its burden, Petitioner has come forward with ample evidence — certainly more than a preponderance — showing that staff reported the incident to the administrator within an appropriate time for doing so based on the circumstances of the rape allegation. Additionally, to the extent it may be perceived as a deficiency, the minor delay in reporting the rape allegation did not result in actual harm and, based on the immediate assessment of the allegation by the charge nurse, did not have the potential to cause more than minimal harm. Therefore, Petitioner substantially complied with the regulation.

The facility administrator reported the June 5, 2011 incident to the state agency on June 7, 2011, the morning after he received the staff reports and initiated an internal investigation. Indeed, CMS has not argued that Petitioner's notice to the state agency was deficient in its timeliness. CMS Br. at 2-7; CMS Reply Br. at 2 ("This case involves Petitioner's failure to immediately report allegations of abuse to its Administrator. CMS'[s] Guidelines regarding reporting allegations to state officials are therefore not applicable."). The state agency requires that a facility report an incident to the state agency by 11:00 a.m. the following business day. Tr. 141-142. Here, while evidence shows that the facility did not report the incident until the second business day, and thus did not comply with the state agency's reporting requirements, *see* P. Ex. 7, that showing does not equate to a *prima facie* case of noncompliance with the regulatory requirement the state agency cited. To show "noncompliance," CMS must make a *prima facie* showing of "any deficiency that causes a facility not to be in substantial compliance." 42 C.F.R. § 488.301. As noted above, "substantial compliance" means "a level of compliance with the requirements of participation such that any identified deficiencies pose no greater risk to resident health or safety than the potential for minimal harm." *Id.*

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the same regulation. Under CMS's position, "immediately" with reference to reports to an administrator means "as soon as possible," while "immediately" with reference to reports to the state agency means "within 24 hours."

[3] The SOM does not establish requirements that a facility must follow, nor is CMS bound by it. However, its application here is particularly useful because there is no other guidance as to what "immediately" means in 42 C.F.R. § 483.13(c)(2).

CMS offered no evidence showing that the delay in reporting to the state agency caused actual harm to Resident 1 or had the potential to cause more than minimal harm to residents. Merely demonstrating that the facility did not meet a reporting deadline with the state agency by one day is insufficient to show noncompliance with the Medicare participation requirement because it is not clear on its face how failing to meet that deadline was likely to cause more than minimal harm, especially when, as here, the facility immediately assessed the resident and began an investigation of the incident.[4] *See* P. Ex. 7, at 2-3. Petitioner correctly pointed out at the hearing that if the incident occurred on a Saturday rather than a Sunday, the period in which Petitioner would have been permitted to make a timely report (Saturday to Monday at 11:00 a.m.) would have been the same period as what actually happened here (Sunday to Tuesday at 11:00 a.m.). *See* Tr. 223. Therefore, any possibility of more than minimal harm associated with the reporting delay is unsupported because the state agency's own reporting requirements permit the same reporting period as happened here without imposing a *per se* finding of harm. Moreover, CMS did not suggest in its briefing how this technical deficiency with the state agency reporting requirements posed the possibility of more than minimal harm. Even the state agency did not find that the facility's delayed incident report showed that "harm could have or may have occurred" because the state agency waited an additional three days before entering the facility.[5] *See* Tr. 215-216.

CMS also relies on certain subsequent acts of the facility administrator to support its position that facility staff did not immediately report the rape allegations to the administrator. *See* CMS Br. at 4; Tr. 32, 304. CMS and the surveyor repeatedly refer to a written warning that the administrator issued to LPN 1 for not immediately reporting the rape allegation or suspending CNA 1. CMS Ex. 10, at 137. Under CMS's theory, the administrator's warning shows that he understood LPN 1 did not comply with the regulatory reporting requirement. *See* CMS Br. at 4. But CMS overlooks two critical points: first, this warning was given on June 11, 2011, after the state agency had begun its survey and informed the facility of its immediate jeopardy determination; and second,

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[4] CMS could, for example, show that the administrator took no action, and that a delay in reporting to the state agency likely exposed residents to a risk of more than minimal harm as a result. CMS did not make such a showing here, but rather submitted evidence that demonstrated the facility took steps to prevent further abuse and start an internal investigation. By contrast, not reporting an incident to a facility administrator could be, on its face, enough to demonstrate the potential for more than minimal harm because it may prolong possible abuse or put other residents for similar types of abuse. The facility administrator has the ability to respond immediately to such reports, making immediate notification critical. A delay in reporting to a state agency does not implicate the same potential for harm to residents.

[5] The surveyor testified that if the state agency finds that "harm could have or may have occurred," it will enter a facility within two days. Tr. 215-216.

the facility administrator's conduct is not a legal determination that must be afforded deference when determining the facility's compliance. The written warning carries little weight here because it was most likely prompted by the presence of the state agency in the facility, not the administrator's independent belief that staff had failed to report the incident immediately. The administrator likely felt pressured into taking the action he did in light of the scrutiny with which the state agency was reviewing the facility's actions as well as the state agency's determination of immediate jeopardy on June 10, 2011.[6] *See* Tr. 373 (testimony of administrator, stating he did not find anything that "warranted [CNA 1's] suspension"). It is unreasonable for CMS to prompt a facility into taking action that it deems necessary to abate an immediate jeopardy determination, and then rely on that act as evidence the facility knew it was not in substantial compliance. Such reliance is more unfounded when, as here, the basis for finding immediate jeopardy was erroneous. Thus, the written warning to LPN 1 does not support CMS's case here.

CMS does not allege that Petitioner failed to comply substantially with participation requirements based on its reporting of the incident involving Resident 2 on June 7, 2011. Tr. 40; CMS Br. at 5. Therefore, I need not address Petitioner's reporting practices for that rape allegation.

2. *Petitioner substantially complied with the abuse investigation requirements at 42 C.F.R. § 483.13(c)(3).*

Once an allegation of abuse has occurred, the regulations require that the facility investigate the allegation thoroughly while protecting residents from any further potential abuse. The applicable regulation states:

> (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.

42 C.F.R. § 483.13(c)(3).[7]

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[6] The state agency advised Petitioner of the noncompliance notification by letter dated June 27, 2011, though the surveyor testified that she told the facility about the immediate jeopardy determination on June 10, 2011, while she was conducting the survey. Tr. 32.

[7] The F-Tag that CMS cited here (F-225) includes 42 C.F.R. § 483.13(c)(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

(*continued* . . .)

The thoroughness of a facility's investigation of potential abuse must be assessed in light of all relevant facts and the steps the facility took based on those facts. The evaluation is not meant to pinpoint diversions from the facility's internal investigation policies, but to determine whether the facility took reasonable steps to investigate the potential abuse thoroughly based on the surrounding circumstances. *See, e.g., Amboy Care Ctr.*, DAB CR1411 (2006). In addition, to ensure no further instances of potential abuse occur, the facility must take some preventative measures to protect the resident from the alleged cause of the abuse. *See, e.g.*, *Somerset Nursing & Rehab. Facility*, DAB CR2166, at 7-9 (2010), *aff'd*, DAB No. 2353 (2010). In the specific context of the circumstances presented here, the two investigations Petitioner undertook were thorough and substantially complied with the Medicare participation requirement, and Petitioner took adequate preventative measures to protect Residents 1 and 2 from further potential abuse during the investigations.

a. *Investigation into the allegation by Resident 1*.

After CNA 1 relayed the rape allegation Resident 1 had made against him — moments after the allegation — LPN 1 immediately interviewed Resident 1. Tr. 287-288. LPN 1 determined that the rape allegation was unfounded, which the surrounding circumstances at the time confirm: Resident 1 was confused about the rape allegation she just made against CNA 1 (Tr. 288; P. Ex. 7, at 6); CNA 1 and LPN 1 had provided Resident 1 with intimate care in the minutes before the allegation (P. Ex. 7, at 5-6); Resident 1 had a UTI that made her delirious (Tr. 238; CMS Ex. 7, at 138); Resident 1 had a history of making accusations against staff in the past (Tr. 442); and LPN 1 was just outside the room when the alleged act occurred (P. Ex. 7, at 5). The following day, the administrator and DON learned of the incident, prompting them to interview Resident 1 immediately. Tr. 367; P. Ex. 7, at 2. Resident 1 expressed her satisfaction with CNA 1 and never repeated the rape allegation or any other inappropriate behavior by CNA 1. Tr. 369. The administrator did not ask pointed questions, but made them "as open-ended as possible . . . without putting any particular thoughts in her head." Tr. 368. During the interview, the DON conducted a full body audit, but discovered no unexplained bruises or injuries. P. Ex. 7, at 2. The administrator then interviewed CNA 1, who explained that he provided peri-care to Resident 1 and changed her colostomy bag, consistent with his statement at the time of the incident. Tr. 370. Next, the administrator reviewed surveillance video footage of the hallway outside Resident 1's room, and determined there was no suspicious activity at the

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> of the incident, and if the alleged violation is verified appropriate corrective action must be taken.

CMS has not argued or presented any evidence that Petitioner violated this specific regulatory requirement. Rather, the evidence here demonstrates that Petitioner timely submitted investigation reports to the state agency as required. CMS Ex. 10, at 52, 486.

time of the allegation. Tr. 370-371; CMS Ex. 10, at 53; *see* P. Ex. 65. The administrator then interviewed a generally coherent and reliable resident, referred to at hearing as "M.V.," who was seen in the video just outside Resident 1's room at the time of the allegation. Tr. 280-281, 371; P. Ex. 65. M.V. denied noticing any unusual activity in or around Resident 1's room at that time. Tr. 371; CMS Ex. 10, at 53. The administrator also interviewed other residents that CNA 1 had cared for around the time of the allegation to determine if he was ever inappropriate with them. Tr. 373. All of the residents denied that CNA 1 was ever inappropriate. Tr. 373; CMS Ex. 10, at 54. The facility staff contacted local police, who initiated their own investigation of the rape allegation. *See* P. Ex. 7, at 4. Staff also contacted Resident 1's primary care physician and her family to notify them of the rape allegation. CMS Ex. 10, at 53. The family's reaction was not one of immediate concern: "Yeah, she says a lot of things." CMS Ex. 10, at 53.

The next day, the facility notified the state agency of the allegation and initiated a broader investigation. P. Ex. 7. The administrator and DON obtained witness statements from numerous staff members and residents regarding CNA 1's behavior. *See* CMS Ex. 10, at 142-176. All of the statements denied witnessing or being aware of inappropriate behavior by CNA 1. CMS Ex. 10, at 54, 142-176. The facility also performed follow-up staff in-services about the proper procedures for handling and reporting abuse allegations. CMS Ex. 10, at 54.

The facility's investigation included immediate interviews of the alleged victim, the alleged perpetrator, and a critical witness (LPN 1) to the alleged act. The facility's investigation also consisted of reviewing video footage of the area outside Resident 1's room, which alerted the facility administrator to another possible witness, M.V., the coherent and reliable resident-witness mentioned above, who was passing by the room at the time of the alleged incident. The facility staff performed a body audit within 24 hours of the alleged incident and found no unexplained injuries. The facility notified Resident 1's family and primary care physician. All of these steps reflect a thorough investigation of an incident that, from the outset, seemed implausible and unfounded. Based on Resident 1's history of dementia, delusions, and making allegations against staff when suffering from a UTI, as she was on June 5, 2011, as well as the assessments and interviews conducted within 24 hours of the incident, Petitioner's staff took reasonable measures to investigate the rape allegation and complied with the regulatory requirement that investigations be done thoroughly.

CMS does not offer any additional action that Petitioner could have taken to make its investigation more thorough, other than an intrusive pelvic examination, commonly called a "rape kit." The surveyor testified that a proper investigation would "entail immediately doing a body audit, questioning the resident, [and] perhaps getting a rape kit." Tr. 29. It is beyond question that the facility questioned Residents 1 and 2 and performed body audits immediately after their allegations. P. Exs. 7, 14. The "rape kit"

that the surveyor referred to as a helpful and possibly-productive step for a thorough investigation is simply too extreme — too traumatic, too intrusive, and too likely to exacerbate Resident 1's emotional distress — in the context of this incident. CMS has offered no authority for the very dangerous assertion that all rape allegations — even when a full and carefully-conducted investigation of the circumstances surrounding the allegation determines it to be unfounded — must have a rape kit to be considered "thorough" under the regulation. Petitioner, however, has provided credible testimony that a rape kit would have been much more detrimental to Resident 1 in light of the circumstances surrounding the allegations. Tr. 448 (testimony of Resident 1's physician, stating that a rape kit exam "probably would cause a significant emotional distress for the patient because she wouldn't be able to understand the nature of the exam and what exactly is happening to her . . ."). The surveyor also testified that the thoroughness of an investigation depends on the facility following its internal investigation policy, though neither she nor CMS cites authority to support that argument. *See* Tr. 210-211. Rather, the applicable regulatory standard only requires that an investigation must be done "thoroughly" without reference to the facility's investigation policy. 42 C.F.R. § 483.13(c)(2); *see Amboy Care Ctr.*, DAB CR1411, at 10-11.

The investigation of Resident 1's allegation is consistent with other cases where an ALJ has found a facility performed a thorough investigation of potential abuse. In *Amboy Care Center*, *supra*, the ALJ found an investigation was thorough because the facility interviewed all persons who could have had knowledge of the alleged abuse. DAB CR1411, at 11. Similarly, Petitioner here interviewed all witnesses — and even uncovered through the video footage a previously unknown witness — who could have had knowledge of the alleged rape. Also, in *Singing River Rehabilitation & Nursing Center*, DAB CR1838 (2008), the ALJ found an investigation was thorough when facility staff interviewed two witnesses who corroborated what the DON had learned by interviewing the principals in the incident. DAB CR1838, at 14. Like in *Singing River*, Petitioner here interviewed Resident M.V., who was in the hallway at the time of the alleged rape, and who corroborated the LPN's and CNA's statement that nothing unusual had occurred in or around the room.

By contrast, this case is not at all like those where the ALJ has found an investigation failed to be thorough. In *New Homestead Care Center*, DAB CR1906 (2006), the ALJ found a facility's investigation was not thorough simply because it interviewed the resident and alleged perpetrator and determined the allegation unfounded. DAB CR1906, at 10. Here, unlike in *New Homestead*, the facility interviewed many more witnesses than just Resident 1 and CNA 1. As stated, the facility reviewed video footage, interviewed other staff members and residents, conducted a body audit, and notified police. Therefore, the investigation Petitioner performed in this case is more like those in *Amboy Care Center* and *Singing River*, rather than *New Homestead*. Accordingly, Petitioner has shown that its investigation of the allegation by Resident 1 was thorough under the requirement at 42 C.F.R. § 483.13(c)(2).

b. *Investigation into the allegation by Resident 2.*

Immediately after the facility's beautician reported the rape allegation by Resident 2, the DON interviewed Resident 2, CNA 2, and the other female staff member present in the room during the alleged incident. P. Ex. 14, at 2. The DON also performed a body audit and found no unexplained bruises or injuries. CMS Ex. 10, at 487. The DON and administrator reviewed the video footage of Resident 2 with CNA 2 moments after the rape allegedly occurred. Tr. 389. Based on statements by Resident 2 and the witnesses, the body audit, and the video showing Resident 2's demeanor, the DON determined the rape allegation was not true. At hearing, the surveyor acknowledged that the DON immediately investigated the rape allegation by Resident 2 and that the DON talked to "every relevant witness."[8] Tr. 110, 113. In a similar case, *Westview Manor*, DAB CR1308 (2005), the ALJ determined an investigation was thorough even though it was limited to those witnesses with knowledge of the alleged incident. DAB CR1308, at 10. Consistent with *Westview*, as well as the cases cited above, the interviews the DON conducted here, as well as the body audit and review of video footage, amounted to a thorough investigation in light of all the circumstances presented.

CMS implies that the beautician tainted the investigation by reassuring Resident 2 she had not been raped, but that CNA 2 was simply changing her pants. CMS Br. at 7. According to CMS, that reassurance resulted in Resident 2 believing she had not been raped and therefore not repeating the allegation to the DON when asked. But CMS overlooks that a female staff member who was in the room at the time the rape allegedly occurred stated that no such rape or abuse occurred. CMS Ex. 10, at 487. The statements Resident 2 made after her initial investigation were not the only means of investigating that allegation. The facility took additional steps to investigate the claim, including interviews with other witnesses who would have knowledge of the alleged incident and a body audit shortly after the alleged incident occurred; none of these steps depended upon Resident 2's statements after her initial allegation. Therefore, it is unreasonable for CMS to claim that the facility's beautician tainted the investigation and resulted in the facility's noncompliance when she was doing a commendable job of calming an agitated and anxious resident. CMS has offered nothing more than its speculation — entirely unbuttressed by any objective evidence or logical support — to advance its position that the beautician's conduct actually hindered the investigation or delayed other steps' being taken. Such speculation will not stand to establish or support a noncompliance finding.

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[8] CMS misrepresents the surveyor's testimony on this issue, which seriously undermines its overall position. In its brief, CMS claims that the surveyor determined Petitioner "failed to interview key staff and residents." CMS Br. at 5 (citing Tr. 42). CMS, probably neglectfully, omitted the surveyor's acknowledgement that Petitioner's staff interviewed "every relevant witness." Tr. 113.

c. *Prevention of further potential abuse during the investigations*.

The regulation requires prevention of further potential abuse, but it does not articulate specific measures for such prevention. 42 C.F.R. § 483.13(c)(3). Therefore, it is important to consider all of the circumstances surrounding the allegation, as well as the risk of further potential abuse to residents when evaluating the facility's prevention of further potential abuse. Here, facility staff determined soon after the rape allegations that both were unfounded and there was no evidence of rape or any other abuse by CNA 1 or CNA 2. Nevertheless, immediately after Resident 1 accused CNA 1 of rape, LPN 1 directed him not to enter the room without a female staff member present. Tr. 290. The next day, the administrator, the DON, and local police determined the rape allegation was not credible and there was no evidence of abuse by CNA 1. Therefore, it would be unreasonable to require further restrictions of CNA 1 after an investigation concluded he did not commit the acts he was accused of committing. Similarly, a prompt and thorough investigation of Resident 2's allegation revealed that CNA 2 did not abuse her. The regulation simply does not require ongoing segregation or suspension of staff members that a thorough investigation has shown to be innocent.

CMS, however, seeks to impose an unreasonable standard here: that a staff member accused of an unfounded rape must be and must remain suspended until a surveyor or other official determines the investigation was appropriate.[9] *See* Tr. 35-39; CMS Br. at 3-5. Here, the facility conducted a thorough investigation of the rape allegations. Immediately after Resident 1 made the allegation, the facility staff preliminarily determined that the rape allegation was unfounded and did not suspend CNA 1. Tr. 373. The regulation does not require suspension of staff, but the prevention of further potential abuse. 42 C.F.R. § 483.13(c)(2). While the investigation continued, the facility restricted CNA 1's access to female residents by requiring a female staff member to be present while CNA 1 provided care to female residents. Tr. 290. After a more thorough investigation, the facility determined that CNA 1 had not raped or otherwise abused Resident 1. Only then did the surveyor enter the facility. She observed CNA 1 enter the room of a female resident without a female staff member and called immediate jeopardy. Tr. 128-129; CMS Ex. 7, at 138. She did not ask whether the restriction against CNA 1 had been lifted or whether the investigation had returned any conclusive results. The surveyor did not recognize that the facility had already conducted a thorough investigation — at that point five days after the allegation — and determined that CNA 1 was not a threat to female residents. *See* P. Ex. 7. The surveyor overlooked the facility's

[9] As further support of the alleged deficiency under section 483.13(c)(3), CMS relies on the facility's failure to implement its abuse investigation policy, which says that under certain circumstances of alleged abuse, involved staff members will be suspended. CMS Br. at 3; CMS Ex. 5, at 20. But failure to implement an abuse investigation policy is not part of a deficiency under section 483.13(c)(3). Accordingly, that issue is discussed below in reference to the applicable regulatory requirement.

reasonable actions following the rape allegation, and instead seems to have imposed an arbitrary and unarticulated standard related to CNA 1's access to female residents. The cascading acts the facility took after the surveyor called immediate jeopardy, including the suspension of CNA 1 and CNA 2, do not reflect the facility's noncompliance with participation requirements, but show the reactive measures the facility believed it needed to take to comply with the unreasonable standard the surveyor had imposed *sua sponte*. Interestingly, the facility's plan to remove the immediate jeopardy, the plan that the state agency accepted, did not require continued suspension or that male staff members have female staff present when providing care to female residents. CMS Ex. 4, at 55. The accepted plan of removal provides further support that the surveyor's determination of what was needed to protect residents as of June 10, 2011, was arbitrary and unsupported.

3. *Petitioner substantially complied with the general abuse prevention policy requirement at 42 C.F.R. § 483.13(c).*

By regulation, a facility must develop and implement a written abuse prevention policy. 42 C.F.R. § 483.13(c). Consistent with the regulatory requirement, the facility developed two policies related to abuse prevention. The first, titled "Reporting Abuse," says in relevant part that the "administrator/designee should be notified IMMEDIATELY of any potential resident abuse incident." CMS Ex. 5, at 18. The other policy, titled "Resident Abuse," explains that the facility "will insurance [*sic*]that further potential abuse will not occur while the investigation is in progress . . . based upon the results of the quick internal investigation, appropriate action will be taken. If the suspect is an employee of the facility, that employee will immediately be suspended pending the outcome of further investigation." CMS Ex. 5, at 20.

CMS has not argued that the substance of Petitioner's abuse policies do not comply with the regulatory requirement. Instead, CMS asserts that Petitioner did not implement its policies with regard to the allegations by Residents 1 and 2. The Board has repeatedly stated that "multiple or sufficient examples of neglect may support a reasonable inference that a facility has failed to develop or implement policies and procedures that prohibit neglect."[10] *Oceanside Nursing and Rehab. Ctr.*, DAB No. 2382, at 11 (2011); *Columbus Nursing and Rehab. Ctr.*, DAB No. 2398 (2011). The facts of the case must demonstrate something fairly stark, the "underlying breakdown" of the facility's policies. *Columbus*, DAB No. 2398, at 11.

Here, CMS has not presented sufficient evidence to demonstrate any such "underlying breakdown" of Petitioner's abuse prevention policies. As explained above, the facility

[10] The applicable regulatory provision speaks to policies that prevent both resident abuse and neglect. 42 C.F.R. § 483.13(c). Therefore, the same standard for evaluating the implementation of neglect policies must also apply to implementation of abuse policies.

staff reported the rape allegation to the facility administrator immediately, *i.e.*, within the 24-hour guideline CMS established for surveyors. *See* CMS Ex. 10, at 53. Additionally, Petitioner provided evidence showing that LPN 1 was the charge nurse on duty at the time Resident 1 made her allegation, and was therefore acting as the administrator's designee for purposes of the facility's own abuse reporting policy.[11] Tr. 289; CMS Ex. 10, at 53. CMS has not refuted this evidence. CNA 1 reported the rape allegation to LPN 1, the administration designee, within minutes of it being made. Tr. 286; CMS Ex. 10, at 53; P. Ex. 65. Moreover, it is undisputed that the facility's beautician notified the DON within minutes of Resident 2's rape allegation. P. Ex. 14, at 4. Therefore, the facility complied with its abuse reporting policy.

The facility did not suspend CNA 1 until several days after Resident 1 made a rape allegation against him. *See* CMS Ex. 10, at 54. CMS argues that the delayed suspension violates the facility's abuse prevention policy, resulting in the facility's noncompliance. CMS Br. at 3-5. However, the facility's policy for the suspension of suspected staff members is premised upon "the results of the quick internal investigation," which in this case revealed that the allegation was unfounded. CMS Ex. 5, at 20. LPN 1 immediately assessed the situation and questioned Resident 1 within minutes of the allegation. The administrator and DON also questioned Resident 1 within a day of the incident and performed a body audit that discovered no unusual injuries. The results of the "quick internal investigation," therefore, revealed that appropriate action did not include the suspension of CNA 1. Even if suspension was required, CMS has not shown that the one technical failure to follow the abuse policy demonstrated an "underlying breakdown" of that policy or posed a potential for more than minimal harm. The facility administrator and DON determined after a prompt and thorough investigation that CNA 1 was not a threat to Resident 1 or other residents and based the facility's decision accordingly. Such a reasonable measure is not indicative of "underlying breakdown" in the facility's policies, and Petitioner's conduct did not violate its policies or reflect some "underlying breakdown" thereof.

4. *Petitioner administered its facility in a manner that enabled the effective use of resources and ensured its residents attained or maintained their highest practicable physical, mental, and psychosocial well-being.*

By regulation, "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 psycho-social well-being of each resident. 42 C.F.R. § 483.75. Here, CMS

[11] CMS correctly notes that the reporting regulation does not permit the immediate reporting to an administrator's "designee," but rather directly to the administrator. 42 C.F.R. § 483.13(c)(2). The facility policy, however, states a different standard than in the regulation, and it is that policy standard at issue to determine compliance with the abuse policy provision of the regulation. 42 C.F.R. § 483.13(c).

did not allege any separate facts to support its finding with regard to this regulatory provision that it did not allege to support its findings related to other provisions. Rather, CMS premised its finding on the facility administration's failure to ensure that staff implemented its abuse prevention policies as well as to ensure residents were protected during the investigation. CMS Ex. 2, at 18-19. In essence, CMS presented its noncompliance finding with this regulatory provision as a derivative of Petitioner's alleged noncompliance with other regulatory provisions previously discussed. Having determined that Petitioner remained in substantial compliance with all other regulatory provisions, it follows that Petitioner administered its facility in a manner consistent with regulatory requirements.

5. ***There is no basis for CMS to impose enforcement remedies.***

CMS may impose an enforcement remedy, such as per-day CMP, when a facility is not in substantial compliance with Medicare participation requirements determined during a survey. 42 C.F.R. § 488.402(b). As explained above, Petitioner remained in substantial compliance with Medicare participation requirements at all times relevant to this case. Accordingly, there is no legal basis upon which CMS may impose enforcement remedies against Petitioner. Therefore, the per-day CMPs that CMS imposed against Petitioner between June 10, 2011 and July 11, 2011, are reversed.

V. Conclusion

For the foregoing reasons, Petitioner remained in substantial compliance with Medicare participation requirements at all times related to this case. Therefore, there is no basis for enforcement remedies, and any such remedies imposed are reversed.

/s/
Richard J. Smith
Administrative Law Judge