Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Colonial Hills Nursing Center
(CCN: 44-5181),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-12-357

Decision No. CR3180

Date: March 31, 2014

DECISION

Petitioner, Colonial Hills Nursing Center, was not in substantial compliance with program participation requirements from November 26, 2011 to termination of its participation in Medicare on January 7, 2012, due to violations of 42 C.F.R. §§ 483.10(b)(11) and 483.13(b) and (c)(2).[1] There is a basis for the imposition of enforcement remedies. The following enforcement remedies are reasonable: termination of Petitioner's provider agreement and participation in Medicare effective January 7, 2012; a denial of payment for new admissions (DPNA) effective December 24, 2011 through termination on January 7, 2012; and a civil money penalty (CMP) of $6,000 per day for 43 days, including November 26, 2011 and continuing through termination on January 7, 2012, a total CMP of $258,000.

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[1] Citations are to the 2011 revision of the Code of Federal Regulations in effect at the time of the survey, unless otherwise indicated.

I. Background

Petitioner is located in Maryville, Tennessee, and participated in Medicare as a skilled nursing facility (SNF) and the state Medicaid program as a nursing facility (NF). Petitioner was subject to a complaint investigation by the Tennessee Department of Health (state agency) from December 1 through 15, 2011, and found not in compliance with program participation requirements. The Centers for Medicare & Medicaid Services (CMS) notified Petitioner by letter dated December 22, 2011, that it was imposing the following enforcement remedies: termination of Petitioner's provider agreement and participation in Medicare effective January 7, 2012; a DPNA effective December 24, 2011 through termination on January 7, 2012; and a CMP of $6,000 per day beginning November 23, 2011 and continuing until termination on January 7, 2012. CMS also advised Petitioner that it was ineligible to conduct a nurse aide training and competency evaluation program (NATCEP) for two years. CMS Exhibit (Ex.) 4.

Petitioner requested a hearing before an administrative law judge (ALJ) on February 3, 2012 (RFH). The case was assigned to me for hearing and decision on February 8, 2012, and an Acknowledgement and Prehearing Order was issued at my direction. On January 16, 17, and 18, 2013, a hearing was convened by video teleconference, and a transcript (Tr.) of the proceedings was prepared. CMS offered CMS Exs. 1 through 46 and CMS Exs. 1 through 25 and 27 through 46 were admitted. Tr. 38. Petitioner offered Petitioner's exhibits (P. Exs.) 1 through 19 that were admitted as evidence. Tr. 40. On February 20, 2013, CMS filed an unopposed motion to substitute a more legible copy of CMS Ex. 31; and to have admitted to the record CMS Ex. 47 and CMS Ex. 48. The CMS motion is granted. CMS called the following witness: Surveyor Debra Pannell, RN. Petitioner called the following witnesses: Richard Wyatt Leonard; Darla Parton, RN; Douglas Bryant; Donia Amburn, RN; Denise Patterson, RN; Callie Mahaffey; Jennifer Solomon; and Karen Kirby, Public Health Nurse Consultant Manager, East Tennessee Regional Office. The parties filed post-hearing briefs (P. Br., CMS Br.) and post-hearing reply briefs (P. Reply, CMS Reply).

II. Discussion

A. Issues

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

Whether the remedies imposed are reasonable.

B. Applicable Law

The statutory and regulatory requirements for participation of a SNF in Medicare are at section 1819 of the Social Security Act (Act) and 42 C.F.R. pt. 483. Section 1819(h)(2) of the Act authorizes the Secretary of Health and Human Services (Secretary) to impose enforcement remedies against a SNF for failure to comply substantially with the federal participation requirements established by sections 1819(b), (c), and (d) of the Act.[2] The Act requires that the Secretary terminate the Medicare participation of any SNF that does not return to substantial compliance with participation requirements within six months of being found not to be in substantial compliance. Act § 1819(h)(2)(C). The Act also requires that the Secretary deny payment of Medicare benefits for any beneficiary admitted to a SNF, if the SNF fails to return to substantial compliance with program participation requirements within three months of being found not to be in substantial compliance – commonly referred to as the mandatory or statutory DPNA. Act § 1819(h)(2)(D). The Act grants the Secretary discretionary authority to terminate a noncompliant SNF's participation in Medicare, even if there has been less than 180 days of noncompliance. The Act also grants the Secretary authority to impose other enforcement remedies, including a discretionary DPNA, CMPs, appointment of temporary management, and other remedies such as a directed plan of correction. Act § 1819(h)(2)(B).

The Secretary has delegated to CMS and the states the authority to impose remedies against a long-term care facility that is not complying substantially with federal participation requirements. "*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 causing minimal harm." 42 C.F.R. § 488.301 (emphasis in original). A deficiency is a violation of a participation requirement established by sections 1819(b), (c), and (d) of the Act or the Secretary's regulations at 42 C.F.R. pt. 483, subpt. B. Noncompliance refers to any deficiency that causes a facility not to be in substantial compliance, that is a deficiency that poses a risk for more than minimal harm. 42 C.F.R. § 488.301. State survey agencies survey

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

facilities that participate in Medicare on behalf of CMS to determine whether the facilities are complying with federal participation requirements. 42 C.F.R. §§ 488.10-.28, 488.300-.335. The regulations specify the enforcement remedies that CMS may impose if a facility is not in substantial compliance with Medicare requirements. 42 C.F.R. § 488.406.

CMS is authorized to impose a CMP for the number of days of noncompliance – a per day CMP – or for each instance of noncompliance – a per instance CMP (PICMP). 42 C.F.R. § 488.430. The regulations specify that a CMP that is imposed against a facility on a per day basis will fall into one of two ranges of penalties. 42 C.F.R. §§ 488.408, 488.438. The upper range of CMPs, $3,050 per day to $10,000 per day, is reserved for deficiencies that pose immediate jeopardy to a facility's residents, and, in some circumstances, for repeated deficiencies. 42 C.F.R. § 488.438(a)(1)(i), (d)(2). "*Immediate jeopardy* means a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident." 42 C.F.R. § 488.301 (emphasis in original). The lower range of CMPs, $50 per day to $3,000 per day, is reserved for deficiencies that do not pose immediate jeopardy, but either cause actual harm to residents, or cause no actual harm but have the potential for causing more than minimal harm. 42 C.F.R. § 488.438(a)(1)(ii). The only range for a PICMP is $1,000 to $10,000. 42 C.F.R. §§ 488.408, 488(a)(2).

Petitioner was notified in this case that it was ineligible to conduct a NATCEP for two years. CMS Ex. 4 at 3.[3] Pursuant to sections 1819(b)(5) and 1919(b)(5) of the Act, SNFs and NFs may only use nurse aides who have completed a training and competency evaluation program. Pursuant to sections 1819(f)(2) and 1919(f)(2) of the Act, the Secretary was tasked to develop requirements for approval of NATCEPs and the process for review of those programs. Sections 1819(e) and 1919(e) of the Act impose upon the states the requirement to specify what NATCEPs they will approve that meet the requirements that the Secretary established and a process for reviewing and reapproving those programs using criteria the Secretary set. The Secretary promulgated regulations at 42 C.F.R. pt. 483, subpt. D. Pursuant to 42 C.F.R. § 483.151(b)(2) and (f), a state may not approve and must withdraw any prior approval of a NATCEP offered by a SNF or NF that has been: (1) subject to an extended or partial extended survey under sections 1819(g)(2)(B)(i) or 1919(g)(2)(B)(i) of the Act; (2) assessed a CMP of not less than $5,000; or (3) subject to termination of its participation agreement, a DPNA, or the appointment of temporary management. Extended and partial extended surveys are

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[3] In its brief, Petitioner noted that it did not conduct a NATCEP. P. Br. at 2. Further, because Petitioner's provider agreement was terminated effective January 7, 2012, ineligibility to be approved to conduct a NATCEP is not at issue.

triggered by a finding of "substandard quality of care" during a standard or abbreviated standard survey and involve evaluating additional participation requirements. "Substandard quality of care" is identified by the situation where surveyors identify one or more deficiencies related to participation requirements established by 42 C.F.R. § 483.13 (Resident Behavior and Facility Practices), § 483.15 (Quality of Life), or § 483.25 (Quality of Care) that are found to constitute either immediate jeopardy, a pattern of or widespread actual harm that does not amount to immediate jeopardy, or a widespread potential for more than minimal harm that does not amount to immediate jeopardy and there is no actual harm. 42 C.F.R. § 488.301.

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

The hearing before an ALJ is a de novo proceeding, i.e., "a fresh look by a neutral decision-maker at the legal and factual basis for the deficiency findings underlying the remedies." *Life Care Ctr. of Bardstown*, DAB No. 2479 at 33 (2012) (citation omitted); *The Residence at Salem Woods*, DAB No. 2052 (2006); *Cal Turner Extended Care Pavilion*, DAB No. 2030 (2006); *Beechwood Sanitarium*, DAB No. 1906 (2004); *Emerald Oaks*, DAB No. 1800 at 11 (2001); *Anesthesiologists Affiliated*, DAB CR65 (1990), *aff'd*, 941 F.2d 678 (8th Cir. 1991). The standard of proof is a preponderance of the evidence. CMS has the burden of coming forward with the evidence and making a prima facie showing of a basis for imposition of an enforcement remedy. Petitioner bears the burden of persuasion to show by a preponderance of the evidence that it was in substantial compliance with participation requirements or any affirmative defense. *Batavia Nursing & Convalescent Inn*, DAB No. 1911 (2004); *Batavia Nursing & Convalescent Ctr.*, DAB No. 1904 (2004), *aff'd*, 129 F. App'x 181 (6th Cir. 2005);

Emerald Oaks, DAB No. 1800; *Cross Creek Health Care Ctr.*, DAB No. 1665 (1998); *Hillman Rehab. Ctr.*, DAB No. 1611 (1997) (*remand)*, DAB No. 1663 (1998) (*aft. remand*), *aff'd*, *Hillman Rehab. Ctr. v. United States,* No. 98-3789 (GEB), 1999 WL 34813783 (D.N.J. May 13, 1999).

"Prima facie" means generally that the evidence is "[s]ufficient to establish a fact or raise a presumption unless disproved or rebutted." *Black's Law Dictionary* 1228 (8th ed. 2004). In *Hillman*, the Board described the elements of the CMS prima facie case in general terms as follows:

> HCFA [now known as CMS] must identify the legal criteria to which it seeks to hold a provider. Moreover, to the extent that a provider challenges HCFA's findings, HCFA must come forward with evidence of the basis for its determination, including the factual findings on which HCFA is relying and, if HCFA has determined that a condition of participation was not met, HCFA's evaluation that the deficiencies found meet the regulatory standard for a condition-level deficiency.

DAB No. 1611 at 11. In the final *Hillman* decision after remand, the Board explained:

> The ALJ should be able to determine the existence of a prima facie case at the close of HCFA's presentation. Hence, as we pointed out in our first decision, HCFA would lose even if the provider offered no evidence at all, if HCFA did not come forward with evidence sufficient to support a conclusion in its favor in presenting its prima facie case. Thus, we held that HCFA must make its case "at the outset."
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> Once HCFA has established a prima facie case, the provider may then offer evidence in rebuttal, both by attacking the factual underpinnings on which HCFA relied and by offering evidence in support of its own affirmative arguments. An effective rebuttal of HCFA's prima facie case would mean that at the close of the evidence the provider had shown that the facts on which its case depended (that is, for which it had the burden of proof) were supported by a preponderance of the evidence.
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> The major purpose of requiring HCFA to establish a prima facie case is to assure that the action taken by HCFA has a

> legally sufficient foundation, if the facts are determined to be as alleged by HCFA (since it would be unfair and inefficient to require a provider to defend against a case that, even if proven, would not suffice to support the action taken). In addition, we concluded that fairness requires HCFA to set out evidence of the factual basis for its action in order that the provider not have to offer a shot-gun defense without adequate notice to respond to the case against it. These purposes are accomplished once HCFA has presented a case sufficient, if not effectively rebutted, to sustain its action. At that point, HCFA has established a prima facie case and, to prevail, the provider must proceed to prove its case by the preponderance of the evidence on the record as a whole.

Hillman, DAB No. 1663 (internal citations omitted) at 9-10. HCFA was the predecessor to CMS.

Thus, CMS has the initial burden of coming forward with sufficient evidence to show that its decision to impose an enforcement remedy is legally sufficient under the statute and regulations. CMS makes a prima facie showing of noncompliance if the credible evidence CMS relies on is sufficient to support a decision in its favor absent an effective rebuttal. To make a prima facie case that its decision was legally sufficient, CMS must: (1) identify the statute, regulation or other legal criteria to which it seeks to hold the petitioner; (2) come forward with evidence upon which it relies for its factual conclusions that are disputed by the petitioner; and (3) show how the deficiencies it found amounted to noncompliance that warrants an enforcement remedy, i.e., that there was a risk for more than minimal harm due to the regulatory violation.[4] In *Evergreene Nursing Care Ctr.*, the Board explained its "well-established framework for allocating the burden of proof on the issue of whether [a] SNF [is] out of substantial compliance" as follows:

> CMS has the burden of coming forward with evidence related to disputed findings that is sufficient (together with any undisputed findings and relevant legal authority) to establish a prima facie case of noncompliance with a regulatory requirement. If CMS makes this prima facie showing, then the SNF must carry its ultimate burden of persuasion by

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[4] The regulation gives Petitioner notice of the criteria or elements it must meet to comply with the program participation requirement established by the regulation. 5 U.S.C. §§ 551(4), 552(a)(1).

> showing, by a preponderance of the evidence, on the record as a whole, that it was in substantial compliance during the relevant period.

Evergreene Nursing Care Ctr., DAB No. 2069 at 7 (2007). A facility can overcome CMS's prima facie case either by rebutting the evidence upon which that case rests, or by proving facts that affirmatively show substantial compliance. "An effective rebuttal of CMS's prima facie case would mean that at the close of the evidence the provider had shown that the facts on which its case depended (that is, for which it had the burden of proof) were supported by a preponderance of the evidence." *Id.* at 7-8 (citations omitted).

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

My conclusions of law are set forth in bold text followed by my findings of fact and analysis. I have carefully considered all the evidence and the arguments of both parties, though not all may be specifically discussed in this decision. I discuss in this decision the credible evidence given the greatest weight in my decision-making.[5] I also discuss any evidence that I find is not credible or worthy of weight. The fact that evidence is not specifically discussed should not be considered sufficient to rebut the presumption that I considered all the evidence and assigned such weight or probative value to the credible evidence that I determined appropriate within my discretion as an ALJ. There is no requirement for me to discuss the weight given every piece of evidence considered in this case, nor would it be consistent with notions of judicial economy to do so. Charles H. Koch, Jr., *Admin. L. and Prac*. § 5:64 (3d ed. 2013).

CMS alleges based upon the survey that ended December 15, 2011, that Petitioner was not in substantial compliance with program participation requirements from November 23, 2011 to termination of its participation in Medicare on January 7, 2012, based upon violations of 42 C.F.R. §§ 483.10(b)(11); 483.13(b) and (c); 483.20(k)(3)(i); 483.25; 483.30(b); 483.35(e); 483.75; and 483.75(e)(8). Petitioner's theory is that there was no noncompliance, but, if there was, there was no immediate jeopardy and Petitioner returned to substantial compliance in December 2011, well before the termination date. P. Br. at 30; P. Reply at 20.

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

1. Petitioner suffered no prejudice or violation of its due process rights related to review of agency action in this case.

The parties were notified on December 12, 2012, that this case was scheduled for hearing from January 16 through 18, 2013. On January 11, 2013, two working days prior to the scheduled hearing in this case, CMS notified me that Wanda Julian, RN, one of the two surveyors who conducted the complaint investigation in issue, was unavailable to testify at hearing on any of the scheduled dates, January 16, 17, or 18, 2013. CMS advised me that Surveyor Julian was unavailable because the state agency granted her leave due to difficulty she was experiencing related to her mother's death. Surveyor Julian was scheduled to return to work on January 22, 2013, the next working day after the last day scheduled for hearing. On January 14, 2013, CMS submitted as evidence a physician's statement that Surveyor Julian was under his care from January 14, 2013 to January 18, 2013, and that she was able to return to work on January 21, 2013, which happened to be the Martin Luther King federal holiday. CMS offered no evidence to show when Surveyor Julian's mother died; why Surveyor Julian was unable to return from leave one working day early to provide testimony in this case; or that Surveyor Julian was incompetent or otherwise medically unable to testify during the scheduled hearing. CMS did not request a subpoena to compel Surveyor Julian's attendance at the scheduled hearing.

CMS requested by its motion on January 11, 2013, that I continue the hearing to a date after January 22, 2013, to permit CMS to produce the testimony of Surveyor Julian. On January 14, 2013, I issued an order deferring ruling upon the motion for a continuance until the hearing. At the hearing, I discussed the matter with counsel on the record and explained the factors that would influence a ruling on whether or not to continue the hearing to a date after January 22, 2013. Tr. 64-75, 211-26. CMS placed in evidence the Statement of Deficiencies (SOD) (CMS Ex. 3) drafted at least in part by Surveyor Julian; Surveyor Julian's surveyor notes (CMS Ex. 29); and the testimony of Surveyor Pannell who also participated in the survey. Petitioner offered as evidence the deposition of Surveyor Julian taken as part of state administrative enforcement proceedings. P. Ex. 14. CMS renewed its request for a continuance to receive the testimony of Surveyor Julian at the conclusion of its case-in-chief. Counsel for CMS could not proffer what Surveyor Julian would testify to that was not cumulative of the evidence already in the record. Tr. 220-22.

Counsel for Petitioner did not object to the admission of the SOD (CMS Ex. 3) or Surveyor Julian's surveyor notes (CMS Ex. 29), both of which include statements of Surveyor Julian. Counsel for Petitioner indicated that, considering the SOD, the surveyor notes, and the deposition, Petitioner had an adequate opportunity to cross-examine Surveyor Julian. Tr. 213-15. Accordingly, I ruled that Surveyor Julian's testimony was not necessary to complete the record as it was cumulative and the CMS motion for a continuance to permit Surveyor Julian to testify was denied. Tr. 226.

In post-hearing briefing, Petitioner alludes to unspecified due process issues because Ms. Julian did not appear for cross-examination at hearing. P. Br. at 3. Petitioner did not raise that objection at hearing, although given ample opportunity to do so. I also advised Petitioner at hearing that if cross-examination was desired, I would continue the hearing to another date to permit cross-examination and Petitioner specifically stated that was not necessary. Therefore, any objection by Petitioner that it did not have an adequate opportunity to examine Surveyor Julian was waived.

Petitioner also conceived a new argument after the hearing that, because Surveyor Julian did not testify, CMS had no witness to explain why CMS elected to impose termination on "short notice" and without a revisit. P. Br. at 4. Petitioner knows as well as I that it was a CMS official, not Surveyor Julian, who approved and decided to proceed with the termination. Surveyor Julian was not the decision-maker, and contrary to Petitioner's unsupported assertion, Petitioner has no "Constitutional right to confront the Government's decision maker." P. Br. at 4.[6] Rather, as already discussed, Petitioner has the due process right to my de novo review as to two issues, i.e., whether CMS had a basis to impose enforcement remedies, including termination, and whether the remedies imposed are reasonable. I have no jurisdiction to review and Petitioner has no right to seek review of the internal decision-making of CMS, including such things as the selection of remedies. 42 C.F.R. § 488.408(g)(2) (choice of remedies and the factors CMS considered when choosing remedies are not subject to review).

Furthermore, the events that are the factual underpinning for the cited deficiencies occurred on November 23, 2011, and between November 26 and December 1, 2011,

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[6] Petitioner cites *Melendez-Diaz v. Massachusetts*, 557 U.S. 305 (2009) and *Morrissey v. Brewer*, 408 U.S. 471, 489 (1972) as supporting its position. In *Melendez-Diaz*, the Supreme Court held that in a criminal drug trial, the admission of laboratory certificates of analysis that the materials seized from the accused was cocaine of a certain quantity without producing the certifying laboratory analysts to testify in court violated the accused's Sixth Amendment right to confront the witnesses against him. *Melendez-Diaz,* 557 U.S. at 305. In *Morrissey* the Court identified the due process requirements for parole revocation, which is a non-criminal proceeding. The Court listed, among other things, "the right to confront and cross-examine adverse witnesses (unless the hearing officer specifically finds good cause for not allowing confrontation)." *Morrissey v. Brewer* 408 U.S. at 489. Neither case cited by Petitioner supports an argument that in a criminal, civil, or administrative proceeding, the target of government action has the right to confront the government decision-maker unless, of course, that decision-maker is also an adverse witness. Petitioner does not argue that the CMS official who approved termination was an adverse witness and that the right to cross-examine was triggered.

before the abbreviated survey to investigate the complaint began. Therefore, Surveyor Julian did not personally witness the incidents that are the bases for the deficiency citations and her factual findings are based on her review of resident records, staff interviews, and her observations of the facility. I am not bound by Surveyor Julian's factual findings, and, to ensure no prejudice to Petitioner, I put her factual findings aside and review the contemporaneous documentary evidence de novo. Thus, Surveyor Julian's absence caused no prejudice to Petitioner.[7] I conclude that in this case the most credible information regarding the events is found in the contemporaneous documents and that the next most credible evidence is the testimony received in open session and subject to cross-examination. I am also not bound by Surveyor Julian's legal conclusion but conduct a de novo review to determine whether there was a basis for enforcement remedies in this case and the reasonableness of the enforcement remedies.

2. Petitioner violated 42 C.F.R. § 483.10(b)(11) (Tag F157).

3. Petitioner violated 42 C.F.R. § 483.13(b) (Tag F223).

4. Petitioner violated 42 C.F.R. § 483.13(c)(2) (Tag F225).[8]

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[7] Arguably, if either party was prejudiced by Surveyor Julian's absence, it was CMS. However, the prejudice, to the extent it existed, does not entitle CMS to a remedy as CMS failed to insist that its contractor, the state agency, make Surveyor Julian available or, at least provide some sufficient and reasonable justification for her absence other than she was not coping well with her mother's death. The implication that her inability to cope from January 16 through 18 would be resolved by January 22, 2013, so that she could then testify strains credibility and common sense.

[8] The SOD also alleges under Tag F225 that Petitioner violated 42 C.F.R. § 483.13(c)(1)(ii) and (iii), and (c)(4). Subsection 483.13(c)(1)(ii) provides that a facility may not employ individuals who have either been found guilty of abusing, neglecting, or mistreating residents, or who have been listed on a state nurse aide registry for abuse, neglect, mistreatment of residents, or misappropriation of resident property. Subsection 483.13(c)(1)(iii) requires that a facility report to the state nurse aide registry or licensing authority any knowledge the facility has of court actions against an employee that indicates unfitness for service as a nurse aide or other facility staff. Subsection 483.13(c)(4) requires a facility to report the results of all investigations "to the administrator or his designated representative and to other officials in accordance with State law . . . within 5 working days of the incident." 42 C.F.R. § 483.13(c)(4). The SOD alleges no facts showing a potential violation of 42 C.F.R. § 483.13(c)(1)(ii) or (iii), or of 42 C.F.R. § 483.13(c)(4), and I do not discuss those subsections further.

The deficiency citations are divided into three groups for purposes of analysis. The "abuse tags" are the alleged violations of 42 C.F.R. §§ 483.10(b)(11) (Tag F157[9]); 483.13(b) (Tag F223) and (c) (Tag F225) related to the alleged abuse of two residents by the son of another resident. The "abuse tags" allegedly posed immediate jeopardy that was ongoing on December 15, 2011, when the survey ended. CMS Ex. 3 at 1-38. The "salty beets tags" are the alleged violations of 42 C.F.R. §§ 483.20(k)(3)(i) (Tag F281); 483.25 (Tag F309); and 483.35(e) (Tag F367) related to the allegation that staff fed seven residents 25 pounds of salt mixed with approximately 12 pounds of pureed, canned beets. The "salty beets tags" allegedly posed immediate jeopardy that was abated on December 6, 2011. CMS Ex. 3 at 38-71. The "administration tag" is an alleged violation of 42 C.F.R. § 483.75 (Tag F490) that derives from both the abuse and the salty beets allegations and is also alleged to have posed immediate jeopardy. CMS Ex. 3 at 71-78. Two alleged deficiencies are not related to either the abuse tags or the salty beets tags. The alleged violation of 42 C.F.R. § 483.30(b) (Tag F354) alleges that the Director of Nursing (DON) could not also serve as Acting Administrator of the facility and that there was a risk for more than minimal harm due to this regulatory violation. CMS Ex. 3 at 68-69. The alleged violation of 42 C.F.R. § 483.75(e)(8) (Tag F497) is that Petitioner failed to ensure nurse aides received required training, which posed a risk for more than minimal harm. CMS Ex. 3 at 78-80.

I conclude that Petitioner violated 42 C.F.R. §§ 483.10(b)(11) (Tag F157), 483.13(b) (Tag F223), and 483.13(c)(2) (Tag F225); Petitioner failed to show that the declaration of immediate jeopardy was clearly erroneous as to those deficiencies; and Petitioner failed to show that it remedied those deficiencies prior to its termination in Medicare. Therefore, I need not further consider the remaining deficiency citations. Counsel for Petitioner used a shotgun approach to defending this case, raising numerous fact issues and legal arguments. I conclude that it is not necessary to discuss and attempt to resolve every issue raised by Petitioner as this case must be resolved against Petitioner on the specific grounds discussed hereafter.

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[9] This is a "Tag" designation as used in CMS Publication 100-07, State Operations Manual (SOM), Appendix PP – Guidance to Surveyors for Long Term Care Facilities (http://www.cms.hhs.gov/Manuals/IOM/list.asp). The "Tag" refers to the specific regulatory provision allegedly violated and CMS's policy guidance to surveyors. Although the SOM does not have the force and effect of law, the provisions of the Act and regulations interpreted clearly do have such force and effect. *Ind. Dep't. of Pub. Welfare v. Sullivan*, 934 F.2d 853 (7th Cir. 1991); *Northwest Tissue Ctr. v. Shalala*, 1 F.3d 522 (7th Cir. 1993). Thus, while the Secretary may not seek to enforce the provisions of the SOM, she may seek to enforce the provisions of the Act or regulations as interpreted by the SOM.

a. Facts

Petitioner provides a concise description of the facts on which the abuse tags are based in its post-hearing brief. Paul McKee was a middle–aged man known to staff as the frequent visitor of his mother who was a resident of Petitioner's facility. The incident involving McKee and two female residents occurred on Saturday, November 26, 2011 at around 6:00 p.m. A certified nursing assistant (CNA) saw McKee sitting with a group of female residents playing cards in a public area of the facility referred as the café. The CNA saw McKee touch one of the card players, Resident 1, who was an alert and oriented female resident, on the thigh or upper leg in a way that the CNA deemed inappropriate. The CNA intervened by removing Resident 1 to her room and by notifying a nursing supervisor. McKee was left alone with the three remaining residents, and Resident 2 reported that he put his hand on her back and may have been attempting to put his hand under her shirt. Resident 2 was also alert and oriented and removed herself from the situation by leaving the area to smoke a cigarette. However, McKee followed her to the outdoor smoking area where, with staff supervision present, Resident 2 and McKee smoked a cigarette. P. Br. at 5-6. The incident was reported to Petitioner's Assistant Director of Nursing (ADON), Lida Rose Keller, RN, who confronted McKee, told him he could not touch residents, and that he would not be allowed in any resident's room but his mother's. McKee subsequently left the facility. ADON Keller also called Petitioner's Executive Director (Administrator), William "Rick" Sharpe, and reported the incident. ADON Keller did not believe that Administrator Sharpe was taking her report seriously. ADON Keller did begin to investigate the incident on November 26, 2011, by taking witness statements. P. Br. at 6-7. The following Monday, November 28, 2011, Administrator Sharpe had the social worker interview the two residents and the social worker reported that the matter was serious. P. Br. at 7.

Petitioner cites the testimony of Darla Parton, RN, Regional Director of Clinic Services for Life Care Services of America, Petitioner's operator, as support for its summary of the facts. RN Parton was called during the evening of Wednesday, November 23, 2011,[10] regarding the salty beets incident which occurred at dinner-time that day. She arrived at the facility on Monday, November 28, 2011, specifically to address the salty beets

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[10] Dates are important to understanding the sequence of events in this case. I advised the parties that I would take administrative notice of the U.S. government calendar for 2011. Tr. 315. The specific calendar used is the payroll calendar for 2011 available at www.gsa.gov/graphics/staffoffices/payroll-calendar-2011.pdf. I note that November 23, 2011 was Wednesday; Thursday, November 24, 2011, was the Thanksgiving holiday; November 25, 2011 was Friday; November 26, 2011 was Saturday; November 27, 2011 was Sunday; and November 28, 2011 was Monday.

incident. Tr. 308-17, 404, 415. While working on the salty beets incident on November 28, 2011, ADON Keller, who was covering for the DON, approached RN Parton and asked her if she knew about the alleged touching of Residents 1 and 2 by McKee. RN Parton advised the ADON she did not know what incident the ADON was referring to and the ADON related what she knew about the alleged abuse.[11] RN Parton testified that she immediately contacted her supervisor to advise that there was a serious allegation that required further investigation. RN Parton was instructed by her supervisor to start investigating the incident and ensure proper notification of authorities. RN Parton testified that she initiated an investigation using the work of ADON Keller who had begun investigating on November 26, 2011, the date of the incident. RN Parton reviewed the statements already collected by the ADON and then proceeded to interview staff. ADON Keller had spoken to the residents involved, the alleged perpetrator, Petitioner's Administrator, and some staff on duty at the time of the incident. RN Parton testified that at the time she understood that the incident involved inappropriate touching of residents by the family member of another resident. More specifically, she understood that the allegation was that the son of another resident rubbed the leg of one resident and attempted unsuccessfully to put his hand under the shirt of a second resident. RN Parton testified that such allegations would normally trigger a report to the state agency but, as of Monday, November 28, 2011, no report had been made to the state because the investigation was not complete. She contacted her supervisor to report what she had learned; she began writing an action plan to address the incident; in-servicing, that is, training, for staff to address the incident was started; she advised the Administrator, Rick Sharpe, that the police had to be called; he did so and the police came to the facility on Monday, November 28, 2011. Tr. 317-22, 408-10. Petitioner states that there is no dispute that the local Ombudsman was also called during the afternoon of Monday, November 28, 2011. P. Br. at 7. RN Parton testified that she was concerned that the ADON had not contacted her, but she expressed no concern that the state agency was not notified on November 26, 2011. Tr. 324. There is no evidence that RN Parton immediately reported the matter to the state agency; to the contrary she testified that that was not her duty. She testified that it was her understanding that Petitioner had five working days to report an incident. Tr. 415-17. There is also no evidence that ADON Keller reported the incident to the state agency on November 26, 2011. Administrator Sharpe and ADON Keller were suspended for not complying with corporate reporting policies; ADON Keller did not return from her suspension as she had already given notice that she was leaving; and Administrator Sharpe was terminated on November 29, 2011, for not following internal reporting requirements. P. Br. at 9, n. 10.

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[11] Petitioner asserts that ADON Keller complained to RN Parton on Monday, November 28, 2011, that Administrator Sharpe was not taking the matter seriously. P. Br. at 7.

Petitioner offered as evidence a collection of documents marked P. Ex. 2, which were admitted without objection. RN Parton identified the document as the performance improvement plan for the abuse allegation that she prepared. Tr. 323. In fact, only pages 1 through 5 of P. Ex. 2 are documents with the heading "Quality Assurance and Performance Improvement Plan." Page 6 of P. Ex. 2 is a witness statement dated December 5, 2011, that RN Parton used to document a telephone conversation with Administrator Sharpe, ADON Keller, and others, regarding her performance improvement plan. Page 7 of P. Ex. 2 is a notice that indicates it was posted at 8:00 on November 28, 2011, that describes Paul McKee and directs that police be called if he entered Petitioner's facility. P. Ex. 2 pages 8 and 9, is a form titled "Managing Incidents of Alleged Abuse & Neglect." The form is undated and unsigned so it is not clear when the form was completed or by whom. However, because Petitioner offered the document, I interpret the document to be Petitioner's concession of facts as to the events reflected on the form. According to the form, Resident 1 was immediately removed from the scene but Resident 2 made her allegation later. After Resident 1 was removed, McKee was under constant staff supervision. P. Ex. 2 at 8. The statement that McKee was under constant staff supervision is inconsistent with the testimony of RN Parton. RN Parton testified that she understood that the CNA who witnessed the touching of Resident 1 by McKee, escorted Resident 1 from the area but left the other residents with McKee with no other staff present. Tr. 325-26. I conclude that the testimony of RN Parton is more credible than the form regarding the fact that residents were left alone with McKee when the CNA removed Resident 1, as RN Parton's testimony is based on her investigation and consistent with the fact that McKee has the opportunity to attempt to place his hand under the shirt of Resident 2. The statement that McKee was under constant staff supervision is also inconsistent with the admission of Petitioner in its post-hearing brief that McKee was left alone with the remaining card players for at least a few moments. P. Br. at 5. The form indicates that the Executive Director (Administrator Sharpe) and DON were notified immediately; the residents notified their own families; physicians were not notified until November 28, 2011; medical assessments of the residents were not done or documented until November 28, 2011; the police were notified by Administrator Sharpe on November 28, 2011; and the regional or divisional vice president was not notified until November 28, 2011. P. Ex. 2 at 8-9. RN Parton's improvement plan lists the observation "[f]ailure to follow abuse policy" but she does not state specifically how the facility abuse policy was violated. P. Ex. 2 at 1. The form, which states that the action plan was completed on November 28, 2011 at 7:00 p.m., lists eight actions:

1. All department heads in-serviced on abuse investigation and procedures to protect residents.
2. All staff in-serviced on abuse policy and procedures and reporting.
3. Police notified of the alleged incident for investigation.
4. Residents to be in-serviced regarding resident's rights and reporting alleged incidents.

5. Families to be in-serviced regarding resident rights and reporting of alleged incidents.
6. Staff members to be in-serviced to call for help from other staff members if more than one resident is involved so that a staff member will be present with remaining residents as residents are removed.
7. The perpetrator will be asked to immediately leave the facility pending investigation.
8. There will be communication not to allow the alleged perpetrator back into the facility.

P. Ex. 2 at 1-5; Tr. 324-26. RN Parton identified P. Exs. 4 and 6 as documenting the training of staff. Tr. 326-29. P. Ex. 4 consists of 15 "Education Acknowledgement Forms," 14 of which list the training topic "[h]ow to initiate an abuse investigation" and are dated November 28, 2011, and the remaining form lists the training topic "[f]ront window coverage and visitor sign-in" and is dated December 5, 2011. P. Ex. 6 includes staff training forms dated November 28, 29 and 30, 2011, which list: training on Petitioner's abuse policy; discussion of the incident involving McKee and Residents 1 and 2; the need to protect multiple residents at risk for abuse; abuse reporting and investigation; and completion of forms. P. Ex. 6 at 1-40. P. Ex. 6 at 114 is an in-service training form dated December 16 through 22, 2011, which indicates that staff received one-on-one education regarding situations involving the abuse of multiple residents; how to handle individuals who pose a possible threat; staff smoking; the front door security guard; the prohibition against propping a door open and that all doors have alarms; and that McKee was no longer permitted in the building. P. Ex. 6 also includes training forms from 2010 reflecting abuse and neglect training prior to the November 26, 2011 incident. P. Ex. 6 at 91-112. P. Ex. 6 includes copies of Petitioner's policies titled "Reporting Alleged Abuse" (P. Ex. 6 at 2-4, 42-44, 84-86), "Abuse and/or Neglect Investigation" (P. Ex. 6 at 5-10, 45-50, 87-89). Tr. 327-29.

P. Ex. 3 includes in-service training records for December 2, 2011. The topics were abuse; visitor badges and sign-in; staff name badges; handling inappropriate behavior by staff, resident family member, or visitors and reporting it; and keeping McKee out of the facility. P. Ex. 3 at 8. P. Ex. 7 includes training records dated December 2, 6, and 7, 2011, related to new security procedures.

P. Ex. 8 includes more in-service training forms for training between December 1 and 13, 2011, that reflect a discussion of abuse; use of visitor badges and signing-in; reporting inappropriate behavior; intervention to stop abuse; reporting abuse; protecting residents; and keeping McKee out of the facility. P. Ex. 8 includes copies of Petitioner's "Reporting Alleged Abuse" policy which was revised in February 2009, that differs from

the copies of the "Reporting Alleged Abuse" policy in P. Ex. 6, as the copy of the policy in P. Ex. 8 addresses the federal requirement to ensure that all allegations of abuse and neglect are reported immediately to the state survey agency but the copies in P. Ex. 6 do not. Compare P. Ex. 6 at 6 and P. Ex. 8 at 7.

P. Ex. 9 includes one-on-one in-service training records dated December 5 and 6, 2011, regarding coverage of the front door and visitor sign-in. P. Ex. 10 reflects in-service training December 16 through 22, 2011, regarding abuse (including multiple residents at risk and handling intruders); staff smoking; door codes and locks; door alarms and the prohibition on propping doors open; and that McKee was not to be allowed in the building. P. Ex. 10 at 2 is a notice to employees that they could not clock-in after December 16 if they had not received training on the foregoing topics. P. Ex. 10 also reflects that nurses were trained on notification of physician and family related to change in resident condition and transfers. P. Ex. 10 at 60 and 66, both dated December 16, 2011, reflect that nurses were taught that family and physician were to be notified of a change in a resident's status within 24 hours. P. Ex. 11 includes in-service training documents for the period December 15 through 19, 2011. Staff members were instructed on building security, including not propping open doors, and were informed that if they did so, they were subject to discipline including termination. P. Ex. 11 at 1.

Douglas Bryant, Petitioner's director of human resources during the relevant period, testified that he learned of the alleged improper touching of residents at the staff meeting during the morning on Monday, November 28, 2011, when the Administrator instructed the Director of Social Services to check the two residents. Later that day, he was meeting with RN Parton when the Director of Social Services reported that the alleged incident was a problem and "more than just an incident" and RN Parton started directing action, including setting up a meeting of department heads and in-service training. He testified that he was directed to get the training materials together, which included Petitioner's abuse policy and abuse investigation procedures. Tr. 333, 339-41, 355-56. In-service training began on Monday, November 28, 2011. Tr. 342-44.

Donia Amburn, RN, Petitioner's DON, testified that if there is an allegation of abuse, the administrator is required to report to the state. Tr. 365-66, 396-97. She did not mention that she also had a duty to report under federal and state law.

Denise Patterson, RN, Regional Director of Clinical Services for Life Care Centers of America, testified that Petitioner was a facility for which she was responsible. RN Parton was covering for her at the time of the alleged abuse of Residents 1 and 2 and she was not at the facility until Tuesday, November 29, 2011. Tr. 420-22. She testified that the Administrator told her he did not feel that there was abuse because he understood the touching was on the shoulder. Tr. 427-28. She testified that Administrator Sharpe was instructed to report the incident to the state on Monday, November 28, 2011. She

testified that the report of an allegation of abuse may be made on-line or by phone. Tr. 430-33. In this case, she testified that she determined on November 29, 2011, that Administrator Sharpe failed to submit the report on-line, apparently because he did not know how, and so the DON completed the report to the state. Tr. 434.

Jennifer Solomon, Regional Vice President, Appalachian Region, Life Care Centers of America, testified that she learned of the alleged abuse incident between 2:00 and 4:00 p.m. on Monday, November 28, 2011. The incident was reported to her by a division director and she then discussed with Administrator Sharpe who had concluded that there was no abuse. She testified that it was also her opinion that the incident did not amount to sexual abuse. Tr. 550-51, 560-63. However, in response to my questions, she agreed based on what the CNA reported, that there was an allegation of abuse. Tr. 590. She testified that she terminated Administrator Sharpe because he did not report the "inappropriate touching" to her. Tr. 565. She testified that Petitioner submitted a plan of correction to the state agency but no revisit survey was conducted prior to termination. Tr. 579-80.

Petitioner's records obtained by the surveyors during the survey show that Residents 1 and 2 did not display signs of physical injury following the inappropriate touching by McKee, which is characterized as a sexual crime by Petitioner's social worker. However, both residents experienced emotional distress, including fear that continued after the incident, which required therapy.[12] CMS Ex. 33 at 10, 12, 13, 16-17, 19, and 22; CMS Ex. 34 at 10-11, 13-18, and 21.

Petitioner called Karen Kirby, Public Health Nurse Consultant Manager of the East Tennessee Regional Office of the state survey agency, to testify. Tr. 641. Ms. Kirby had oversight responsibility for the survey. Tr. 641-42. Ms. Kirby testified in response to my question that no revisit survey was conducted because the allegation of compliance and plan of correction were not acceptable and Petitioner's staff was so advised. Tr. 663-70. Jennifer Solomon testified that Petitioner received five written rejections of its allegations of compliance from the state agency and Petitioner received no response regarding its sixth allegation of compliance or the plan of correction submitted on December 28, 2011. Tr. 678-83.

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[12] A nurse note dated November 28, 2011 at 9 p.m., states that Resident 1 denied any anxiety or concerns and declined counseling services. I have no evidence that Resident 1 understood what the term "anxiety" means or that the nurse who prepared the note was qualified to assess whether or not Resident 1 was experiencing any anxiety at that the time of the interview.

Petitioner offered its December 28, 2011, plan of correction for my consideration marked as P. Ex. 1. The plan of correction for Tag F157 does not show that staff and management were trained on the requirement of 42 C.F.R. § 483.10(b)(11) that "[a] facility must immediately inform the resident; consult with the resident's physician; and, if known, notify the resident's legal representative or an interested family member" when there is an accident that may require physician intervention or a significant change in the resident's mental, physical or psychosocial condition. The plan of correction states that Residents 1 and 2 notified family members of the incident that occurred on November 26, 2011, but the plan of correction does not acknowledge that resident notification of their families does not satisfy the regulatory requirement. The plan of correction states that all department heads and staff were educated on the policy regarding family and physician notification. The plan of correction does not state that management and staff were trained regarding the requirement for physician consultation. P. Ex. 1 at 8-10. Furthermore, P. Ex. 10 at 60 and 66, both pages dated December 16, 2011, reflect that nurses were taught that family and the resident's physician were to be notified of a change in a resident's status within 24 hours, which, as discussed hereafter, is not compliant with the federal regulatory requirement that family be notified and the physician be consulted immediately. Because management and staff were not, according to the plan of correction, educated on the correct regulatory requirement, future compliance would be unlikely, if not impossible. The plan of correction also does not establish any process to ensure future compliance with 42 C.F.R. § 483.10(b)(11) by management and staff. Under Tag F223, it is alleged by the surveyors that Petitioner failed to remove a male from the facility after he allegedly sexually abused one resident, allowing him to sexually assault another resident and place others at risk. The plan of correction does not describe a plan or training of management and staff regarding the immediate removal of an alleged perpetrator from the facility or to otherwise immediately prevent his or her access to other residents. P. Ex. 1 at 16-22. The plan states that staff members were instructed that if McKee was found in the facility, the police were to be called; however, the plan does not instruct staff members what to do in the case of other alleged perpetrators. Petitioner also describes a plan referred to as "code security" under which if McKee or any "unwanted" visitor or family member was present, "code security" was to be announced and all "available" associates were to respond. P. Ex. 1 at 20. The plan does not describe what staff members were to do when they responded or what would happen if no staff were available at the time to respond. The plan of correction refers to security guards but does not describe what, if any, responsibilities they had in the event a "code security" was announced. Tag F225 alleges that Petitioner failed to immediately report allegations of sexual abuse to law enforcement and the state agency. But, the plan of correction does not address the training of staff or management, particularly the Administrator and DON or their designees, regarding the requirement of 42 C.F.R. § 483.13(c)(2) that all allegations of "mistreatment, neglect, or abuse, including injuries of unknown source, and

misappropriation of resident property" be immediately reported to officials in accordance with state law. The plan of correction also fails to address how Petitioner will ensure proper and timely reporting in the future. The plan of correction also does not address educating staff and management regarding state reporting requirements. P. Ex. 1 at 29-34.

b. Analysis

(i) The violation of 42 C.F.R. § 483.10(b)(11) (Tag F157).

The regulation requires:

> (11) *Notification of changes*. (i) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal respresentative (sic) or an interested family member when there is –
>
> (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;
> (B) A significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);
> (C) A need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or
> (D) A decision to transfer or discharge the resident from the facility as specified in § 483.12(a).

42 C.F.R. § 483.10(b)(11)(i). The regulatory language is clear but has often been misconstrued. Therefore, further analysis of the regulation and its history is appropriate, not because interpretation is required but for the sake of clarity in application. Residents in long-term care facilities have the rights enumerated in 42 C.F.R. § 483.10. Among the rights listed are the right to notice of rights and services, including the right to have the facility give immediate notice of significant changes in the resident's condition to the resident, the resident's physician, and the resident's legal representative or interested family member. The language of the regulation is very specific that the facility "**must immediately inform** the resident; **consult** with the resident's physician; and . . . **notify** the resident's legal representative or an interested family member." 42 C.F.R. § 483.10(b)(11)(emphasis added). The regulation creates a distinction between informing the resident and family and the requiring that Petitioner "**must immediately . . . consult**

with the resident's physician" when there is a significant change in the resident's physical, mental, or psychosocial status (meaning a deterioration in the resident's condition); an accident that may require physician intervention; a need to alter treatment; or a decision to transfer or discharge the resident to another facility or institution. *Id.* (emphasis added). It is clear from the regulatory language that the requirement to consult is not discretionary and requires more than merely informing or notifying the physician. The preamble to the final rule reflects the drafters' specific intention that the facility should "inform" the resident of the changes that have occurred but should "consult with the physician about actions that are needed." 56 Fed. Reg. 48,826, 48,833 (Sept. 26, 1991). Thus, it is clear from the language of the regulation and its history that the requirement of the regulation to consult with the physician means more than to simply notify the physician. Consultation implies the requirement for a dialogue with and a responsive directive from the resident's physician as to what actions are needed; it is not enough to merely notify the physician. Nor is it enough to leave a message for the physician. The regulation also requires notification and consultation "immediately" upon discernment of a significant change in condition of the resident or the occurrence of an accident that may require physician intervention, or the occurrence of any of the other triggers in the regulation. The use of the term "immediately" in the regulatory requirement indicates that consultation is expected to be done as soon as the change is detected, without any intervening interval of time. It does not mean that the facility can wait hours or days before notification of the resident and his or her representative and consultation with the physician. The preamble to the final rule indicates that originally the proposed rule granted the facility up to 24 hours in which to consult with the resident's physician and to notify the legal representative or family. However, after the receipt of comments that time is of the essence in such circumstances, the final rule amended that provision to require that the physician be consulted and the legal representative or family be notified immediately. 56 Fed. Reg. 48,826, 48,833 (Sept. 26, 1991). The point of using the word "immediately" recognized that in such situations a delay could result in a situation where a resident is beyond recovery or dies. The Board has been consistent in its interpretation of the regulation that consultation with a physician must occur immediately, that is, without delay, after a significant change is detected or observed. *Magnolia Estates Skilled Care*, DAB No. 2228 at 9 (2009). Furthermore, if we balance the relative inconvenience to a physician and the facility staff to consult with the possibility for dire consequences to the resident if the physician is not immediately consulted, it seems that any inconvenience certainly is inconsequential and outweighed by the potential for significant harm if the facility fails to immediately consult the physician. The regulation at 42 C.F.R. § 483.10 is entitled "Resident rights" and the requirements of this specific regulation provide that every resident has the right, among other things, to a dignified existence and access to and communication with persons and services inside and outside the facility. Therefore, the regulatory requirements make inconsequential any inconvenience under the regulation to the resident's physician or to the facility staff when compared to the protection and facilitation of the rights of the resident. *See* 56 Fed. Reg. at 48,834. Finally, the

regulation does not allow the facility to pick and choose whom to notify and whom to consult. Rather, it requires the facility to immediately inform the resident, consult the physician and notify the resident's legal representative or interested family member. The regulation also directly burdens the facility to consult and notify and does not permit a facility to rely upon a notification or consultation being accomplished by the resident or a third-party such as an emergency room.

In this case, the first question is whether or not 42 C.F.R. § 483.10(b)(11) applies to Residents 1 and 2 and the inappropriate touching by McKee. Petitioner argues that the regulation does not apply to Residents 1 and 2 as there was no significant change in their condition. The mere fact that a resident may have experienced abuse or have been subject to some conduct that was perceived to be abusive does not trigger an inference that there has been a significant change that triggers Petitioner's duty to notify and consult. There must be some evidence of an actual significant change to trigger 42 C.F.R. § 483.10(b)(11)(i)(B). *Cedar View Good Samaritan*, DAB 1897 at 21 (2003). The regulation provides that a facility must immediately consult and notify when there has been "[a] significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental or psychosocial status in either life-threatening conditions or clinical complications)." 42 C.F.R. § 483.10(b)(11)(i)(B). CMS provides further interpretation of the regulation in its instructions to surveyors in the SOM, app. PP, Tag F157, which provides that "life-threatening conditions are such things as a heart attack or stroke" and "clinical complications are such things as development of a stage II pressure sore, onset or recurrent periods of delirium, recurrent urinary tract infection, or onset of depression." Clearly this list is not exhaustive and simply provides examples to guide surveyor analysis. The evidence does not show any physical injury to Residents 1 and 2. However, when finally evaluated on November 28, 2011, they both expressed that they suffered mental anguish in the form of fear. The evidence does not show that either was evaluated by a psychiatrist or psychologist and no qualified diagnoses were made based upon the resident's experience or residual emotional trauma. But the evidence shows that continuing therapy was required due to the incidents, such as might be required for either anxiety or depression provoked by such experiences.

Petitioner does not discuss whether the conduct of McKee might meet the definition of an accident that may have required physician intervention; thus, triggering Petitioner's duty to notify and consult under 42 C.F.R. § 483.10(b)(11)(i)(A). The regulations do not define the term "accident," but CMS has provided a definition in interpretive guidance found in the SOM, app. PP, Tag F323. The SOM provides that "'[a]ccident' refers to any unexpected or unintentional incident, which may result in injury or illness to a resident." McKee's touching of Residents 1 and 2 was an unexpected incident, which the evidence shows resulted in psychological injury that had the potential to require physician intervention and did require therapy.

Similarly, Petitioner failed to discuss the application of 42 C.F.R. § 483.10(b)(11)(i)(C), which requires consultation when there may be a need to alter treatment significantly, such as the commencement of a new form of treatment. The evidence before me does not show either Resident 1 or 2 required mental health interventions prior to the incident of abuse on November 26, 2011. However, the evidence clearly shows that the abuse incident required a change in their treatment by the addition of therapy to address emotional trauma due to the incident.

I conclude that the evidence is sufficient to show a substantial change, an accident requiring physician intervention, or a need to alter treatment significantly that triggered the notice and consultation requirements of 42 C.F.R. § 483.10(b)(11)(i). Residents 1 and 2 did not display signs of physical injury following the inappropriate touching by McKee, which is characterized as a sexual crime by Petitioner's social worker, but both residents experienced emotional distress including fear that continued after the incident, that required therapy. CMS Ex. 33 at 10, 12, 13, 16-17, 19, and 22; CMS Ex. 34 at 10-11, 13-18, and 21.

Resident 1, who was almost 81 years old at the time of the abuse incident, was interviewed by a nurse on November 26, 2011, at about 6:25 p.m. regarding the incident with McKee. The statement of the nurse who conducted the interview records that Resident 1 told her that a man rubbed her leg "in places he should not have been;" Resident 1 did not like what he was doing; and it made her uncomfortable. CMS Ex. 33 at 10, 22. Although the nurse clearly states the resident told her she was uncomfortable, the nurse's statement does not reflect that she did any assessment of Resident 1's condition, either physical or mental, at that time or attempt to consult with a physician for assessment and possible treatment of the resident. The evidence shows that it was not until November 28, 2011, that Resident 1 was assessed and treated. A physician's progress note dated November 28, 2011, and a nurse's note dated November 28, 2011 at 9:00 p.m., record that a nurse practitioner examined Resident 1 related to the November 26 incident. The notes record that Resident 1 stated that she was very frightened following the incident and told her husband. Resident 1 stated she did not sleep well the night of the incident. The nurse practitioner noted that Resident 1 denied any physical injury or pain; denied any anxiety or concerns at the time of the examination; and declined the offer for counseling services. The nurse practitioner assessed Resident 1 as alert and oriented, and able to give clear details, and she found no bruises or open areas or evidence of physical harm. CMS Ex. 33 at 13, 19. A social service progress note by the Director of Social Services, Kristie Klagges, dated November 28, 2011, records that Resident 1 stated that she was touched inappropriately by a male visitor and that it scared her. Ms. Klagges recorded in her note that she discussed with Resident 1 the emotions and feelings she may experience as the victim of a sexual crime, and that she would setup an appointment with the therapist to ensure that Resident 1 could process the incident. The social worker stated further that she had spoken to the Ombudsman to ensure that everything was being done to help Resident 1 feel safe. CMS Ex. 33 at 16. Ms. Klagges'

progress note dated November 29, 2011, documents that Resident 1 reported that she was still upset and shocked. Ms. Klagges recorded that she spoke at length with Resident 1 about being the victim of a sexual crime and she told the resident that the therapist would be in to speak with her. CMS Ex. 33 at 16-17. On November 29, 2011, Resident 1 participated in a group counseling session with the therapist from Psychiatric Services, Pat Abbarno, LCSW, DCSW, and two other residents. Resident 1 stated during the session that she had been touched sexually by a family member of another resident during the preceding weekend. CMS Ex. 33 at 12.

Resident 2, who was 77 years old at the time of the abuse incident, was interviewed by a nurse on November 26, 2011, around 6:50 p.m. regarding the incident with McKee. Resident 2 stated McKee tried to put his hand under her shirt and tried to rub her leg. She stated that when she told him to quit he tried to push his chair closer to hers. When she left to go to the smoking area, he followed. Resident 2 stated that she would not want to be alone with him. CMS Ex. 34 at 13, 21. Although Resident 2's statement to the nurse clearly shows that she was fearful on November 26, 2011, the evidence shows no consultation with a physician or attempt to treat Resident 2 for her fear until November 28, 2011. A physician's progress note dated November 28, 2011, shows that a nurse practitioner examined Resident 2 on that date. The nurse practitioner documented that Resident 2 told her that McKee rubbed Resident 1's leg up her thigh. Resident 2 stated that after Resident 1 was removed by a CNA, McKee came to her, lifted her shirt in the back, and tried to put his hand up her shirt; and when she knocked him away he tried to put his hand on her leg. Resident 2 reported that McKee followed her to the smoking area. Resident 2 stated that after she finished smoking, she hid in her room because she was scared. The nurse practitioner assessed Resident 2 as alert and oriented, with no bruises or marks. The nurse practitioner noted that Resident 2 declined to have a psychiatric consult at that time. CMS Ex. 34 at 14. Ms. Klagges, the Director of Social Services, interviewed Resident 2 on November 28, 2011, at 12:30 p.m. Ms. Klagges documented on a witness interview form that Resident 2 told her that McKee started to rub Resident 2's leg and in between her legs; she elbowed him to make him stop, but he put his hand up the back of her shirt. Resident 2 reported that she then wheeled herself to the smoking area and McKee followed her. Resident 2 stated that she went back inside the facility a different way because she was afraid McKee might follow her to her room. Resident 2 stated that "she was so scared that she hid in the corner of her room" for fifteen minutes. CMS Ex. 34 at 10-11. Ms. Klagges' Social Service progress note dated November 28, 2011, records that she was informed of an incident that caused Resident 2 to be uncomfortable and she would investigate to assure that Resident 2 was okay. Ms. Klagges recorded that she told Resident 2 that she would arrange for the therapist to see Resident 2. CMS Ex. 34 at 15. On November 29, 2011, Resident 2 participated in a group counseling session with Ms. Abbarno, Ms. Klagges, and two other residents. In her progress note dated December 5, 2011, related to the November 29 session, Ms. Abbarno recorded that Resident 2 had no change in her mental or emotional state but that she would provide weekly contact for a month to assess any changes in mood and

behavior. CMS Ex. 34 at 17. On November 30, 2011, Ms. Klagges and Ms. Abbarno spoke to Resident 2 and she reported that she was doing fine, everyone was supportive, and she felt safe and secure. CMS Ex. 34 at 16. In another progress note dated December 8, 2011, Ms. Abbarno wrote that Resident 2 reported feelings of sadness and self-blame daily, but she was able to maintain interest in usual activities. Resident 2 reported positive reactions from peers, family, and staff about the assault. Resident 2 reported feeling safe and that she trusted staff but that she was conflicted emotionally. Ms. Abbarno stated in her note that she had had two sessions with Resident 2 since November 29, 2011, and that Resident 2's thoughts and feelings about the sexual assault on November 26, 2011, were not going away. The note states that Resident 2 agreed to continue counseling. CMS Ex. 34 at 18.

Whether one treats McKee's unwanted sexual touching of Residents 1 and 2 as an accident that resulted in mental injury that potentially required physician intervention; as causing a significant change in the condition of Residents 1 and 2 in the form of a clinical complication that required physician intervention similar to the onset of depression or similar mental injury; or as the cause of altering treatment significantly by the addition of a new form of treatment, the analysis has the same result. McKee's unwanted sexual touching of Residents 1 and 2 caused both women emotional trauma or injury that triggered the requirement for staff to immediately, that is, without delay, consult with the residents' physicians and notify their families. Petitioner's arguments to the contrary are without merit. Both these cognitively intact women recognized and understood what happened. The fact that Petitioner's staff and Administrator did not appreciate the trauma associated with unwanted sexual touching is no defense for Petitioner.

Accordingly, I conclude that CMS made a prima facie showing that Petitioner violated 42 C.F.R. § 483.10(b)(11) (Tag F157), which Petitioner has not rebutted. Petitioner has also failed to establish any affirmative defense.

The evidence shows that Residents 1 and 2, who both expressed fear of McKee on November 26, 2011, following the unwanted sexual touching, received no counseling or therapy to address their fears until November 28, 2011. I conclude that the delayed availability of treatment resulted in mental suffering that amounted to more than minimal harm. Furthermore, I conclude as discussed in detail under Conclusion of Law 5, that Petitioner has failed to meet its burden to show that the violation of 42 C.F.R. § 483.10(b)(11)(i) did not pose immediate jeopardy.

Petitioner argues that it corrected this deficiency prior to termination of its provider agreement and participation in Medicare on January 7, 2012. However, the plan of correction for Tag 157 does not show that staff and management were ever properly trained on the requirement of 42 C.F.R. § 483.10(b)(11) that "[a] facility must immediately inform the resident; consult with the resident's physician; and, if known, notify the resident's legal representative or an interested family member" when there is

an accident that may require physician intervention; a significant change in the resident's mental, physical, or psychosocial condition; or a need to alter treatment significantly. The plan of correction states that Residents 1 and 2 notified family members of the incident that occurred on November 26, 2011, but the plan of correction does not acknowledge that the regulatory requirement is for staff to notify the resident's legal representative or family member and that resident notification does not satisfy the regulatory requirement. The plan of correction states that all department heads and staff were educated on the policy regarding family and physician notification. The plan of correction does not state that management and staff were trained regarding the requirement for physician consultation. P. Ex. 1 at 8-10. Furthermore, P. Ex. 10 at 60 and 66, both pages dated December 16, 2011, reflect that nurses were taught that family and the resident's physician were to be notified of a change in a resident's status within 24 hours, which does not comply with the federal regulatory requirement that family be notified and the physician be consulted immediately, that is, without delay. Because management and staff were not, according to the plan of correction, educated on the correct regulatory requirements for immediate notification and consultation, future compliance would be unlikely, if not impossible. The plan of correction also fails to establish any process to ensure future compliance with 42 C.F.R. § 483.10(b)(11) by management and staff.

(ii) The violation of 42 C.F.R. § 483.13(b) (Tag F223).

Abuse is defined in the federal regulations as "the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish." 42 C.F.R. § 488.301. Pursuant to 42 C.F.R. § 483.13(b), a "resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion." CMS explains the intent of the regulation as follows:

> Each resident has the right to be free from abuse, corporal punishment, and involuntary seclusion. Residents must not be subjected to abuse by anyone, including, but not limited to, facility staff, other residents, consultants or volunteers, staff of other agencies serving the resident, family members or legal guardians, friends, or other individuals.

SOM, app. PP, Tag F223. CMS instructs surveyors that sexual abuse includes sexual harassment, sexual coercion, or sexual assault and mental abuse includes humiliation, harassment, or threats of punishment or deprivation. SOM, app. PP, Tag F223.

The surveyors alleged in the SOD under Tag F223, that the facility violated the regulation as follows:

> 1. Petitioner failed to protect Residents 1 and 2 from sexual assault; and
>
> 2. Petitioner failed to protect Resident 2 and placed other female residents at risk for sexual assault because Petitioner failed to immediately remove McKee from the facility.

CMS Ex. 3 at 10.

The allegations clearly are that Petitioner failed to protect the residents from abuse. The facts show that Residents 1 and 2 were subject to unwanted touching by McKee that was considered by the residents and staff to be of a sexual nature. Residents 1 and 2 did not consent to the touching. The evidence shows that they suffered mental anguish as a result. The facts show that Residents 1 and 2 were subject to abuse, whether characterized as sexual or mental or both. It is also undisputed that after McKee touched Resident 1, a CNA removed her but left McKee with the three remaining female residents. The credible evidence is that McKee was unsupervised with the three female residents, at least long enough for him to touch Resident 2. Accordingly, I conclude that there is a prima facie showing of a violation of 42 C.F.R. § 483.13(b) because Residents 1 and 2 were not free from sexual or mental abuse as was their right. Petitioner has not rebutted the prima facie showing or established an affirmative defense. Petitioner suggests that it "would be a stretch" to hold Petitioner responsible for the sexual abuse of Resident 1 because prior to McKee abusing Resident 1, it was not foreseeable that he would commit abuse. P. Br. at 6. The regulation does not limit the resident's right to be free from foreseeable abuse and no such reading is reasonable. 42 C.F.R. § 483.13(b). Thus, foreseeability is not an element of the CMS case on which CMS must present evidence. Petitioner cites no authority, statutory, regulatory, or case law, that recognizes a foreseeability defense to a violation of a resident's right to be free from abuse. However, even if I accepted Petitioner's foreseeability defense, as soon as the CNA saw McKee abuse Resident 1, it was foreseeable that he might abuse another female resident. Therefore, at that point, the foreseeability defense is no longer available to Petitioner. Petitioner does not deny that staff failed to protect Petitioner's other female residents from abuse because McKee was not immediately removed from the facility or otherwise limited in his access to other female residents. Petitioner does not rebut and offers no defense to the prima facie showing of the regulatory violation based on the abuse of Resident 2 and the potential for abuse of the two other female residents who remained after Resident 1 was removed. P. Br. at 23.

I conclude that the evidence shows that the abuse, whether characterized as sexual or mental abuse, of Resident 2 resulted in more than minimal harm to her, as discussed under Tag F157. The abuse of Resident 1 also caused her more than minimal harm, as discussed under Tag F157. As discussed in more detail under Conclusion of Law 5, Petitioner has failed to meet its burden to show that the violation of 42 C.F.R. § 483.13(b) did not pose immediate jeopardy.

Petitioner has also failed to show that it remedied the deficiency prior to its termination on January 7, 2012. Under Tag F223, it is alleged by the surveyors that Petitioner failed to remove a male from the facility after he allegedly sexually abused one resident, allowing him to sexually assault another resident and place others at risk. The plan of correction does not describe a plan or training of management and staff regarding the immediate removal of an alleged perpetrator from the facility or to otherwise immediately prevent his or her access to other residents. P. Ex. 1 at 16-22. The plan states that staff members were instructed that if McKee was found in the facility, the police were to be called; however, the plan does not instruct staff what to do in the case of other alleged perpetrators. Petitioner also describes a plan referred to as "code security" under which if McKee or any "unwanted" visitor or family member was present, "code security" was to be announced and all "available" associates were to respond. P. Ex. 1 at 20. The plan does not describe what staff members were to do when they responded or what would happen if no staff were available at the time to respond. The plan of correction refers to security guards but does not describe what, if any, responsibilities they had in the event a "code security" was announced. The evidence shows that Petitioner concocted and implemented many interventions to address the abuse of Residents 1 and 2. But the evidence does not show that Petitioner's interventions could successfully protect residents from future abuse under circumstances similar to the incident involving McKee and Residents 1 and 2. Even if McKee had been wearing a name tag, all the doors were locked, and all the other interventions Petitioner devised had been implemented before November 26, 2011, those interventions would not have prevented him from touching Resident 1 and 2 inappropriately. Accordingly, I conclude that Petitioner had not abated immediate jeopardy or corrected the deficiency at the time of termination on January 7, 2012.

(iii) The violation of 42 C.F.R. § 483.13(c)(2) (Tag F225).

Petitioner, as a SNF participating in Medicare, is required to "develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property." 42 C.F.R. § 483.13(c). Petitioner's implemented policies and procedures must accomplish four tasks or requirements enumerated in the regulation, including:

> The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property 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 Tennessee Adult Protection Act, codified at Tenn. Code. Ann. §§ 71-6-101-122 (2013), provides the following regarding reporting:

> Any person, including, but not limited to, a physician, nurse, social worker, department personnel, coroner, medical examiner, alternate care facility employee, or caretaker, having reasonable cause to suspect that an adult has suffered abuse, neglect, or exploitation, shall report or cause reports to be made in accordance with this part.
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> * * * *
>
> An oral or written report shall be made immediately to the [Tennessee Department of Human Services] upon knowledge of the occurrence of suspected abuse, neglect, or exploitation of an adult.

Tenn. Code Ann. § 71-6-103(b)(1), (c). Sexual abuse under the Tennessee law includes sexual contact against the will of a person 18 years of age or over, who is unable to manage his or her own resources, carry out activities of daily living, or protect himself or herself from neglect or hazardous or abusive situations without assistance from others due to mental or physical dysfunction or advanced age (i.e. 60 years or older). Tenn. Code Ann. § 71-6-102(2), (3), and (13). "'Abuse or neglect' means the infliction of physical pain, injury, or mental anguish, or the deprivation of services by a caretaker that are necessary to maintain the health and welfare of an adult or a situation in which an adult is unable to provide or obtain the services that are necessary to maintain that person's health or welfare. Tenn. Code Ann. § 71-6-102(1)(A). Knowing failure to report is a Class A misdemeanor under Tennessee law. Tenn. Code Ann. 71-6-110. Contrary to Petitioner's argument (P. Br. at 24-25), the reporting requirements of 42 C.F.R. § 483.13(c)(2) and the Tennessee Adult Protection Act are clear.

There is no dispute that the CNA who observed McKee touching Resident 1 and removed Resident 1 from the area on November 26, 2011, reported to her supervisor. There is also no dispute that ADON Keller promptly reported the incident to Administrator Sharpe on November 26, 2011. There is no dispute that Administrator Sharpe did not immediately report the matter to the Tennessee state agency on November 26, 2011. Although there is a suggestion that Administrator Sharpe misunderstood the nature of the allegation, there is no question that the CNA who made the observation and removed Resident 1 and ADON Keller both reasonably suspected that abuse had occurred. The CNA did not report the matter to the Tennessee state agency. Although ADON Keller did not believe that Administrator Sharpe was taking the matter seriously, she did not immediately report the matter to the Tennessee state agency on November 26, 2011. P. Br. at 7. Petitioner's witness RN Parton testified that allegations such as those made by the CNA would

normally trigger a report to the state agency. Tr. 321-22. RN Parton testified that she determined that no report had been made to the state agency as of her arrival to the facility on November 28, 2011, because the investigation was not yet complete. Tr. 322. RN Parton did not clarify whether that was the explanation given to her by staff or whether that was her understanding of what the Tennessee law and the federal regulation require. She subsequently testified that she thought Petitioner had five working days to report suspected abuse or neglect. Tr. 416-17. RN Parton's understanding of the state and federal requirements is clearly in error. Both the federal regulation and the Tennessee law are clear that immediate reporting is required and no time for investigation prior to reporting is allowed. The Tennessee statute is very specific, stating that reporting is required immediately upon obtaining knowledge that suspected abuse or neglect has occurred. Tenn. Code Ann. § 71-6-103(b)(1),(c). Given RN Parton's position, it is troubling that her testimony suggested a lack of knowledge and understanding of reporting requirements. DON Amburn was clear in her understanding of the law that when there is an allegation of abuse, it must be reported to the state. Tr. 397. Ms. Solomon agreed on my examination that the CNA report amounted to an allegation of abuse. Tr. 590. Petitioner agreed in post-hearing briefing that the CNA had made an allegation of abuse. P. Br. at 24-26.

The lack of knowledge and understanding about the requirement for immediate reporting of allegations of abuse and neglect under state and federal law may also be based, in part, on the inconsistent versions of Petitioner's policy in circulation that were offered by Petitioner as evidence in this proceeding. P. Ex. 8 includes copies of Petitioner's "Reporting Alleged Abuse" policy, revised in February 2009, which differs from the copies of the "Reporting Alleged Abuse" policy in P. Ex. 6. The copy of the policy in P. Ex. 8 addresses the federal requirement to ensure that all allegations of abuse and neglect are reported immediately to the state survey agency but the copies in P. Ex. 6 do not. Compare P. Ex. 6 at 6 and P. Ex. 8 at 7. Neither version of the policy addresses Tennessee reporting requirements.[13]

I conclude that there has been a prima facie showing of a violation of 42 C.F.R. § 483.13(c)(2). On November 26, 2011, a CNA observed McKee touch Resident 1 and she reported to her supervisors. The CNA's report is recognized by Petitioner's witnesses as being an allegation of abuse. No immediate report of the alleged abuse of Resident 1 or 2 was made to the state agency on November 26, 2011. In fact, it is

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[13] The surveyors did not cite Petitioner for having a defective policy under Tag F226. I do not consider the defects in Petitioner's policy as a separate regulatory violation. Rather, I view the errors, omissions, and inconsistencies in the versions of Petitioner's policy that Petitioner placed in evidence as additional evidence that Petitioner failed to remedy the cited deficiency prior to termination.

undisputed that no report of the alleged abuse was made until November 28, 2011. Petitioner does not rebut the prima facie case or establish any affirmative defense. I also conclude that the evidence shows that both Resident 1 and 2 suffered mental anguish, which amounted to more than minimal harm as evidenced by the duration and the requirement for interventions. As discussed hereafter, Petitioner has failed to meet its burden to show that the declaration that the deficiency posed immediate jeopardy was clearly erroneous.

I conclude that Petitioner's allegation that it remedied the deficiency under Tag F225 prior to termination on January 7, 2012, is unsupported by the evidence. The termination of Administrator Sharpe and the suspension of ADON Keller did not remedy the deficiency as all staff needs to know and understand abuse and neglect reporting requirements. Petitioner's plan of correction does not even address the training of staff or management, particularly the Administrator and DON or their designees, regarding the requirement of 42 C.F.R. § 483.13(c)(2) that all allegations of "mistreatment, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property" be immediately reported to officials in accordance with state law. The plan of correction also does not address educating staff and management regarding the requirements of the Tennessee Adult Protection Act. Finally, the plan of correction fails to address how Petitioner will ensure proper and timely reporting in the future. P. Ex. 1 at 29-34.

Accordingly, I conclude that Petitioner did not show that it abated immediate jeopardy or remedied this deficiency prior to termination on January 7, 2012.

5. Petitioner has failed to show that the violations of 42 C.F.R. §§ 483.10(b)(11); 483.13(b); 483.13(c)(2) did not pose immediate jeopardy or that immediate jeopardy was abated prior to termination on January 7, 2012.

The surveyors allege in the SOD that the violations of 42 C.F.R. §§ 483.10(b)(11) (Tag F157; 483.13(b) (Tag F223); and 483.13(c)(2) (Tag F225), posed immediate jeopardy to Petitioner's residents beginning on November 26, 2011 and continuing through December 15, 2011. CMS Ex. 3 at 3, 10, and 25; P. Ex. 1 at 9, 16, and 31. It is undisputed that none of Petitioner's plans to abate immediate jeopardy were accepted by the state agency and CMS. Tr. 681-82. Therefore, the CMS position is that immediate jeopardy continued through the date of termination on January 7, 2012. Petitioner asserts that there was no immediate jeopardy but, if I should find there was, it was not of the duration alleged by CMS. P. Reply at 20.

The CMS determination of immediate jeopardy must be upheld, unless Petitioner shows the declaration of immediate jeopardy to be clearly erroneous. 42 C.F.R. § 498.60(c)(2). CMS's determination of immediate jeopardy is presumed to be correct, and Petitioner has a heavy burden to demonstrate clear error in that determination. *Yakima Valley Sch.*,

DAB No. 2422 at 8-9 (2011); *Cal Turner Extended Care Pavilion*, DAB No. 2384 at 14 (2011); *Brian Ctr. Health and Rehab./Goldsboro,* DAB No. 2336 at 9 (2010) (citing *Barbourville Nursing Home*, DAB No. 1962 at 11 (2005), *aff'd*, *Barbourville Nursing Home v. U.S. Dep't of Health & Human Srvs.,*174 F. App'x 932 (6th Cir. 2006); *Maysville Nursing & Rehab. Facility*, DAB No. 2317 at 11 (2010); *Liberty Commons Nursing & Rehab. Ctr.– Johnston*, DAB No. 2031 at 18-19 (2006), *aff'd*, *Liberty Commons Nursing & Rehab. Ctr.–Johnson v. Leavitt*, 241 F. App'x 76 (4th Cir. 2007).

Once CMS presents evidence supporting a finding of noncompliance, CMS does not need to offer evidence to support its determination that the noncompliance constitutes immediate jeopardy; rather, the burden is on the facility to show that that determination is clearly erroneous. *Cal Turner Extended Care Pavilion*, DAB No. 2384 at 14-15; *Liberty Commons Nursing & Rehab. Ctr.–Johnston*, 241 F. App'x 76 at 3-4.

"*Immediate jeopardy*" under the regulations refers to a situation "in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident." 42 C.F.R. §§ 488.301, 489.3 (emphasis in original). In the context of survey, certification, and enforcement related to SNFs and NFs under the regulations, a conclusion by the state agency and CMS that noncompliance with program participation requirements poses immediate jeopardy to the facility residents triggers specific regulatory provisions that require enhanced enforcement remedies, including authority for CMS to impose a larger CMP than may be imposed when there is no declaration of immediate jeopardy. 42 C.F.R. §§ 488.408(e), 488.438(a)(1)(i), (c), and (d). The regulations also require termination of the facility's provider agreement on an expedited basis or the removal of the immediate jeopardy through appointment of temporary management. 42 C.F.R. §§ 488.410, 488.440(g), 488.456, 489.53(d)(2)(ii).

Pursuant to 42 C.F.R. § 498.3(d)(10), a finding by CMS that deficiencies pose immediate jeopardy to the health or safety of a facility's residents is not an initial determination that triggers a right to request a hearing by an ALJ or that is subject to review. Rather, a finding of noncompliance that results in the imposition of an enforcement remedy, except the remedy of monitoring by the state, does trigger a right to request a hearing and is subject to review. 42 C.F.R. §§ 488.408(g); 498.3(b)(8) and (13). Furthermore, the level of noncompliance, i.e., scope and severity, is subject to review only if a successful challenge would: (1) affect the amount of CMP that may be imposed, i.e., the higher range of CMP authorized for immediate jeopardy; or (2) affect a finding of substandard quality of care that rendered the facility ineligible to conduct a NATCEP. 42 C.F.R. § 498.3(b)(14) and (16). Pursuant to 42 C.F.R. § 498.60(c)(2), in reviewing a CMP, the ALJ must uphold the CMS determination as to the level of noncompliance (i.e., the scope and severity), unless it is clearly erroneous. The phrase "clearly erroneous" is not defined by the Secretary.

Many appellate panels of the Board have addressed "immediate jeopardy."[14] In *Miss. Care Ctr. of Greenville*, DAB No. 2450 at 15 (2012), the Board commented:

> CMS's determination that a deficiency constitutes immediate jeopardy must be upheld unless the facility is able to prove that the determination is clearly erroneous. 42 C.F.R. § 498.60(c)(2); *Woodstock Care Center*. The "clearly erroneous" standard means that CMS's immediate jeopardy determination is presumed to be correct, and the burden of proving the determination clearly erroneous is a heavy one. *See, e.g., Maysville Nursing & Rehabilitation Facility*, DAB No. 2317 at 11 (2010); *Liberty Commons Nursing and Rehab Center — Johnston*, DAB No. 2031 at 18 (2006), *aff'd*, *Liberty Commons Nursing and Rehab Ctr. — Johnston v. Leavitt*, 241 F. App'x 76 (4th Cir. 2007). When CMS issued the nursing facility survey, certification, and enforcement regulations, it acknowledged that "distinctions between different levels of noncompliance . . . do not represent mathematical judgments for which there are clear or objectively measured boundaries." 59 Fed. Reg. 56,116, 56,179 (Nov. 10, 1994). "This inherent imprecision is precisely why CMS's immediate jeopardy determination, a matter of professional judgment and expertise, is entitled to deference." *Daughters of Miriam Center*, DAB No. 2067, at 15 (2007).

The Board's statement that the CMS immediate jeopardy determination is entitled to deference is subject to being misunderstood to limit ALJ and Board review of immediate jeopardy beyond what was intended by the drafters of the regulations. In the notice of final rulemaking on November 10, 1994, the drafters of 42 C.F.R. § 498.60(c)(2), discussing the merits of the reviewability of deficiency citations, selection of remedy, and scope and severity, commented:

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[14] Decisions often cited include: *Lakeport Skilled Nursing Ctr.*, DAB No. 2435 at 6-7, (2012); *Liberty Health & Rehab. of Indianola, LLC*, DAB No. 2434 at 13, 18-20 (2011); *Yakima Valley Sch.*, DAB No. 2422 at 8-9; *Lutheran Home at Trinity Oaks*, DAB No. 2111 (2007); *Daughters of Miriam Ctr.*, DAB No. 2067 (2007); *Britthaven of Havelock*, DAB No. 2078 (2007); *Koester Pavilion*, DAB No. 1750 (2000); *Woodstock Care Ctr.*, DAB No. 1726 (2000), *aff'd*, *Woodstock Care Ctr. v. Thompson*, 363 F.3d. 583 (6th Cir. 2003).

> We believe that a provider's burden of upsetting survey findings relating to the level of noncompliance should be high, however. As we indicated in the proposed rule, distinctions between different levels of noncompliance, whether measured in terms of their frequency or seriousness, do not represent mathematical judgments for which there are clear or objectively measured boundaries. Identifying failures in a facility's obligation to provide the kind of high quality care required by the Act and the implementing regulations most often reflect judgments that will reflect a range of noncompliant behavior. Thus, in civil money penalty cases, whether deficiencies pose immediate jeopardy, or are widespread and cause actual harm that is not immediate jeopardy, or are widespread and have a potential for more than minimal harm that is not immediate jeopardy does not reflect that a precise point of noncompliance has occurred, but rather that a range of noncompliance has occurred which may vary from facility to facility. While we understand the desire of those who seek the greatest possible consistency in survey findings, an objective that we share, the answer does not lie in designing yardsticks of compliance that can be reduced to rigid and objectively calculated numbers. Survey team members and their supervisors ought to have some degree of flexibility, and deference, in applying their expertise in working with these less than perfectly precise concepts. **For these reasons, we have revised the regulations to require an administrative law judge or appellate administrative review authority to uphold State or HCFA findings on the seriousness of facility deficiencies in civil money penalty cases unless they are clearly erroneous.**

59 Fed. Reg. 56,116, 56,179 (emphasis added). It is clear from this regulatory history that the drafters of 42 C.F.R. § 498.60(c)(2) ensured that the state agency's or CMS determination that there was immediate jeopardy would receive deferential consideration, by adopting the clearly erroneous standard of review. Thus, caution must be exercised to ensure that the Board's decision in *Miss. Care Ctr. of Greenville*, *Daughters of Miriam Ctr.*, and other decisions that have mentioned deference relative to immediate jeopardy not be read to require deference for the determination that there was immediate jeopardy beyond that imposed by adoption of the clearly erroneous standard. Giving or requiring that the immediate jeopardy determination be given deference in addition to applying the

"clearly erroneous standard" would be contrary to the intent of the drafters of the regulation; would significantly limit the review of the determination by an ALJ and the Board; and would impermissibly deny an affected party the due process right to review intended by the drafters of the regulation.

In the foregoing quotation from *Miss. Care Ctr. of Greenville*, that panel of the Board states that the clearly erroneous standard means that the "immediate jeopardy determination is presumed to be correct, and the burden of proving the determination clearly erroneous is a heavy one." *Miss. Care Ctr. of Greenville* at 15. Similar formulations have been used in other Board decisions when referring to the "clearly erroneous standard." However, the Board's characterization of the "clearly erroneous standard" in *Mississippi Care Ctr.* and other cases does not define the standard. The "clearly erroneous standard" is described in *Black's Law Dictionary* as a standard of appellate review applied in judging the trial court's treatment of factual issues, under which a factual determination is upheld unless the appellate court has the firm conviction that an error was committed. *Black's Law Dictionary* 269 (18th ed. 2004). The Supreme Court has addressed the "clearly erroneous standard" in the context of the Administrative Procedure Act (APA). The Court described the preponderance of the evidence standard, the most common standard, as requiring that the trier-of-fact believe that the existence of a fact is more probable than not before finding in favor of the party that had the burden to persuade the judge of the fact's existence. *In re Winship*, 397 U.S. 358, 371-72 (1970); *Concrete Pipe & Prods. of Cal., Inc. v. Construction Laborers Pension Trust for Southern CA*, 508 U.S. 602, 622 (1993). The "substantial evidence" standard considers whether a reasonable mind might accept a particular evidentiary record as adequate to support a conclusion. *Consol. Edison v. NLRB*, 305 U.S. 197, 229 (1938); *Dickinson v. Zurko*, 527 U.S. 150, 162 (1999). Under the "clearly erroneous" standard, a finding is clearly erroneous even though there may be some evidence to support it if, based on all the evidence, the reviewing judge or authority has a definite and firm conviction that an error has been committed. *United States v. U. S. Gypsum Co.*, 333 U.S. 364, 395 (1948); *Dickinson*, 527 U.S. at 162; *Concrete Pipe*, 508 U.S. at 622. The clearly erroneous standard has been characterized by the Court as being stricter than the substantial evidence test and significantly deferential. The Court stressed in discussing the clearly erroneous standard the importance of not simply rubber-stamping agency fact-finding. The Court also commented that the APA requires meaningful review.[15] *Dickinson*, 527 U.S. at 162 (citations omitted); *Concrete Pipe*, 508 U.S. at 622-23.

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[15] The Board's characterization of the clearly erroneous standard as being highly deferential to the fact-finding by the state agency surveyor and CMS, and even triggering a rebuttal presumption, is entirely consistent with the Supreme Court's characterization of the standard. However, the Court's cautions about ensuring meaningful review rather than rubber-stamping agency decisions show it is important for the ALJ and the Board

(Footnote continued next page.)

Various panels of the Board have recognized other principles applicable to the review of the immediate jeopardy issue. A finding of immediate jeopardy does not require a finding of actual harm, only a likelihood of serious harm. *Dumas Nursing and Rehab., L.P.*, DAB No. 2347 at 19 (2010) (citing *Life Care Ctr. of Tullahoma*, DAB No. 2304 at 58 (2010), *aff'd*, *Life Care Ctr. of Tullahoma v. Sebelius*, 453 F. App'x 610). The definition of immediate jeopardy at 42 C.F.R. § 488.301 does not define "likelihood" or establish any temporal parameters for potential harm. *Agape Rehab. of Rock Hill*, DAB No. 2411 at 18-19 (2011). The duration of the period of immediate jeopardy is also subject to the clearly erroneous standard. *Brian Ctr. Health and Rehab./Goldsboro*, DAB No. 2336 at 7-8 (2010). There is a difference between "likelihood" as required by the definition of immediate jeopardy and a mere potential. The synonym for "likely" is "probable," which suggests a greater degree of probability that an event will occur than suggested by such terms as "possible" or "potential." *Daughters of Miriam Ctr.*, DAB No. 2067 at 10. "Jeopardy" generally means danger, hazard, or peril. The focus of the immediate jeopardy determination is how imminent the danger appears and how serious the potential consequences would be. *Woodstock Care Ctr.*, DAB No. 1726 at 39.

What is the meaning of serious injury, harm, or impairment as used in the definition of immediate jeopardy found in 42 C.F.R. § 488.301? How does serious injury, harm, or impairment compare with "actual harm?" On the first question, the Board recognized in *Yakima Valley Sch.*, DAB No. 2422 at 8, that the regulations do not define or explain the meaning of the term "serious" as used in the definition of immediate jeopardy.[16] The Board suggested that the definitions may be unimportant because the Board has held that, under the clearly erroneous standard, once the state agency or CMS declares immediate jeopardy, there is a presumption that the actual or threatened harm was serious and the

(Footnote continued.)

not to be tempted to simply defer to the surveyor, the state agency, or CMS on the immediate jeopardy issue.

[16] Appendix Q of the SOM also fails to provide surveyors a working definition of the term "serious" that they can use to determine whether harm, injury, or impairment is serious when deciding whether or not to declare immediate jeopardy. The Act does not define the phrase "immediately jeopardize" and does not introduce the concept of serious harm, injury, or impairment as the basis for finding immediate jeopardy. Thus, one is not in error concluding that absent a definition of the term "serious" in the Act, the regulations, the SOM, or decisions of the Board, it is essentially up to individual surveyors, and whatever unpublished guidance they receive from their superiors or CMS officials, to exercise their individual discretion and judgment to decide that there was immediate jeopardy.

facility can only rebut the presumption of immediate jeopardy by showing that the harm or threatened harm meets no reasonable definition of the term "serious." *Id.* at 8 (citing *Daughters of Miriam Ctr.*, DAB No. 2067 at 9). In *Daughters of Miriam Ctr*, the Board discussed that the ALJ attempted to define "serious," finding meanings such as dangerous, grave, grievous, or life-threatening. The Board notes that the ALJ stated that serious harm is outside the ordinary, requiring extraordinary care, or having lasting consequences. The Board further noted that the ALJ stated that a serious injury may require hospitalization, or result in long-term impairment, or cause severe pain, as opposed to harm, injury, or impairment that is temporary, easily reversible with ordinary care, does not cause a period of incapacitation, heals without special medical intervention, or does not cause severe pain. The Board did not endorse or adopt the ALJ's definitional exercise but concluded that it was simply unnecessary in the context of that case. The Board reasoned that the facility bore the burden to rebut the presumption by showing that the actual or threatened harm met no reasonable definition of "serious." *Daughters of Miriam Ctr.*, DAB No. 2067 at 9.

Applying the clearly erroneous standard to the record before me related to the noncompliance I have found based on the violations of 42 C.F.R. §§ 483.10(b)(11); 483.13(b); and 483.13(c)(2), I have no definite and firm conviction that an error has been committed in CMS's determination that immediate jeopardy existed. Staff and management failure to comply with the requirement of 42 C.F.R. § 483.10(b)(11) to immediately consult with a resident's physician in the event of a significant change in physical, mental, or psychosocial condition or in case of an accident that may require physician intervention, or when a significant change in treatment may be necessary, clearly poses a risk for serious injury, harm, impairment, or death. Similarly, failure to ensure that the perpetrator of an alleged act of abuse or neglect is removed from a facility or isolated from residents to protect residents from further acts of abuse or neglect as required by 42 C.F.R. § 483.13(b), also poses a risk that a resident may suffer serious injury, harm, impairment, or death. It may not be as readily apparent that the failure to immediately report to the state agency as required by 42 C.F.R. § 483.13(c)(2) poses a likelihood for serious injury, harm, impairment, or death. However, failure to immediately report prevents that state from taking immediate action when necessary to protect residents of a facility, which is critically important when staff and management of the facility are unable to protect facility residents. Petitioner's evidence does not show that there was no likelihood for serious (given any accepted definition of that term) injury, harm, impairment or death on account of these deficiencies. Accordingly, I conclude that Petitioner has failed to show that the declaration of immediate jeopardy based on the violations of 42 C.F.R. §§ 483.10(b)(11); 483.13(b); 483.13(c)(2) was clearly erroneous.

6. I have no authority to review CMS's selection of termination as a remedy.

7. Termination on January 7, 2012; a CMP of $6,000 per day for 43 days, from November 26, 2011 through termination, a total CMP of $258,000; and a DPNA effective December 24, 2011 through termination, are reasonable enforcement remedies.

I have concluded that Petitioner was not compliant with 42 C.F.R. §§ 483.10(b)(11); 483.13(b); and 483.13(c)(2) from November 26, 2011 through termination on January 7, 2012. I have also concluded that Petitioner has failed to show that the declaration of immediate jeopardy was clearly erroneous as to those deficiencies. Therefore, CMS has bases to impose enforcement remedies. When there are one or more deficiencies that pose immediate jeopardy, CMS and the state must impose temporary management or terminate the provider agreement. CMS may also impose a CMP in the higher range of authorized CMPs from $3,050 to $10,000 per day. 42 C.F.R. § 488.408(e). CMS's selection of remedies, including termination, is not subject to review by me. 42 C.F.R. §§ 488.408(g)(2), 498.3(d)(11) and (14). *Beverly Health & Rehab. – Spring Hill v. Health Care Fin. Admin.*, DAB No. 1696 (1999), *aff'd*, *Beverly Health & Rehab. Servs. v.Thompson*, 223 F.Supp. 2d 73 (D.D.C. 2002). In this case, the survey ended on December 15, 2011 and termination occurred on January 7, 2012 – 23 days after the end of the survey. CMS Exs. 1, 4; P. Ex. 1. Pursuant to 42 C.F.R. § 488.410, when there is immediate jeopardy the state and CMS either terminate the provider agreement within 23 calendar days of the last date of the survey or appoint temporary management to remove the jeopardy within 23 calendar days or the provider agreement is terminated. 42 C.F.R. § 488.410(a) and (c). This regulatory provision is consistent with the requirement of section 1819(h)(2)(A)(i) of the Act, which requires that when noncompliance with requirements of the Act immediately jeopardizes the health or safety of residents, the Secretary takes immediate action to remove the jeopardy or terminate the facility's participation in Medicare. The Secretary has little discretion under the Act and CMS has little discretion under the regulation when there are deficiencies that pose immediate jeopardy. The election of CMS to terminate rather than first appoint temporary management to attempt to abate immediate jeopardy prior to termination is not subject to my review. Even if there is no immediate jeopardy, CMS has the authority to terminate a provider agreement if a facility is not in substantial compliance or fails to submit an acceptable plan of correction. 42 C.F.R. §§ 488.456(b); 489.53(a). CMS is required to give notice at least 15 days in advance of the effective date of termination, except when there is immediate jeopardy in a SNF, in which case only 2 days advance notice is required. 42 C.F.R. § 489.53(d)(1) and (2)(ii). In this case, the notice is dated December 22, 2011, more than 15 days prior to the effective date of termination. CMS Ex. 4. I conclude that Petitioner was not deprived of any required notice in this case and the imposition of the termination was consistent with the statutory and regulatory requirements and delegated authority.

The remaining issue is whether the DPNA and CMP are reasonable enforcement remedies. Petitioner violated 42 C.F.R. §§ 483.10(b)(11) (Tag F157); 483.13(b) (Tag F223); and 483.13(c)(2)(Tag F225); the violations posed a risk for more than minimal harm to one or more facility residents; and Petitioner has failed to show that the declaration that each of the three deficiencies posed immediate jeopardy was clearly erroneous. When a facility is not in substantial compliance with program requirements, CMS has the authority to impose one or more of the enforcement remedies listed in 42 C.F.R. § 488.406, including a CMP. CMS may impose a per day CMP for the number of days that the facility is not in compliance or a PICMP for each instance that a facility is not in substantial compliance, whether or not the deficiencies pose immediate jeopardy. 42 C.F.R. § 488.430(a). A CMP in the higher range of $3,050 to $10,000 per day is authorized when the deficiencies pose immediate jeopardy. 42 C.F.R. § 488.408(e); 488.438(a)(1)(i). I conclude that there are bases for the imposition of enforcement remedies, including the CMP in the higher range and the DPNA.

If I conclude, as I have in this case, that there is a basis for the imposition of an enforcement remedy and the remedy proposed is a CMP, my authority to review the reasonableness of the CMP is limited by 42 C.F.R. § 488.438(e). The limitations are: (1) I may not set the CMP at zero or reduce it to zero; (2) I may not review the exercise of discretion by CMS in selecting to impose a CMP; and (3) I may only consider the factors specified by 42 C.F.R. § 488.438(f) when determining the reasonableness of the CMP amount. In determining whether the amount of a CMP is reasonable, the following factors specified at 42 C.F.R. § 488.438(f) must be considered: (1) the facility's history of noncompliance, including repeated deficiencies; (2) the facility's financial condition; (3) the seriousness of the deficiencies as characterized by 42 C.F.R. § 488.404(b), the same factors CMS and/or the state were to consider when setting the CMP amount; and (4) the facility's degree of culpability, including but not limited to the facility's neglect, indifference, or disregard for resident care, comfort, or safety, and the absence of culpability is not a mitigating factor. The factors that CMS and the state were required to consider when setting the CMP amount and that I am required to consider when assessing the reasonableness of the amount are set forth in 42 C.F.R. § 488.404(b): (1) whether the deficiencies caused no actual harm but had the potential for minimal harm; no actual harm with the potential for more than minimal harm, but not immediate jeopardy; actual harm that is not immediate jeopardy; or immediate jeopardy to resident health or safety; and (2) whether the deficiencies are isolated, constitute a pattern, or are widespread. My review of the reasonableness of the CMP is de novo and based upon the evidence in the record before me. I am not bound to defer to the CMS determination of the reasonable amount of the CMP to impose but my authority is limited by regulation as already explained. I am to determine whether the amount of any CMP proposed is within reasonable bounds considering the purpose of the Act and regulations. *Emerald Oaks,* DAB No. 1800 at 10 (2001); *CarePlex of Silver Spring*, DAB No. 1683 at 14-18 (1999); *Capitol Hill Cmty. Rehab. & Specialty Care Ctr.*, DAB No. 1629 (1997).

With respect to facility history, CMS has submitted documentation that shows that Petitioner has a significant history of noncompliance prior to the survey at issue. CMS has submitted for my consideration the facility's CASPER (Certification and Survey Provider Enhanced Reports) report, which includes a synopsis of survey findings for the years 2008 through 2011, and another document titled "Division of Health Care Facilities ASPEN: Full Facility Profile (FFP)," which shows Petitioner's compliance history dating back to 2002. CMS Ex. 27. These documents show that since September 2002, Petitioner has been cited by numerous surveys for violations of Medicare participation requirements, including prior deficiency citations under Tag F157 in 2011, 2009, 2008, and 2006 (CMS Ex. 27 at 1, 7, 8, 14, 15, 16); Tag F225 in 2011(CMS Ex. 27 at 13); and Tag F223 in 2006 (CMS Ex. 27 at 20).

Petitioner has not specifically argued that its financial condition affects its ability to pay the proposed CMP, which totals $258,000. At the hearing, Petitioner's Regional Vice President, Jennifer Solomon, testified that Petitioner incurred a loss of "around $14 million" related to the closure of the facility. Tr. 581. Ms. Solomon testified further that Petitioner had intended to renovate the facility and then reopen, but then decided to have the facility demolished. According to Ms. Solomon, Petitioner now intends to build a new facility on a different site. Tr. 581-82. Other than the testimony of Ms. Solomon, Petitioner has offered nothing in the way of documentary evidence regarding its financial condition. Petitioner has not argued an inability to pay. I conclude that Petitioner's financial condition does not preclude it from paying the CMP I approve.

I conclude that Petitioner's noncompliance is serious, and Petitioner has not shown that the immediate jeopardy related to the violations of Tags F157, F223, and F225 was abated prior to termination. I also conclude that Petitioner is culpable as Petitioner failed to immediately consult with the residents' physicians and to protect other vulnerable residents, and failed to immediately report the allegation of abuse to the state authorities. I also consider Petitioner culpable as Resident 1 and Resident 2 were not examined by a nurse practitioner until November 28 and were not seen by a social worker until November 29. By failing to provide immediate care to the residents following the abuse, Petitioner's staff further risked their physical, emotional, and mental health.

CMS proposes a per day CMP of $6,000 from November 23, 2011 through termination on January 7, 2012. The November 23 inception date is based on allegations related to the salty beets, which I find unnecessary to review in this case.[17] The alleged violations

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[17] The potential difference in CMP by beginning the CMP on November 23 rather than November 26, 2011, is $12,000 to $18,000, which is de minimis compared with a total CMP of $258,000. The CMP I approve is sufficient to accomplish the Congressional purpose for authorizing alternative remedies particularly in light of the fact that Petitioner

(Footnote continued next page.)

under Tags F157, F223, and F225 that I have reviewed, began on November 26, 2011. The $6,000 per day CMP proposed falls in the middle of the range of CMPs authorized when there is immediate jeopardy. In light of the relevant factors, I find that the amount of the CMP is reasonable. I also conclude that CMS was authorized to impose a DPNA beginning December 24, 2011 through termination on January 7, 2012, and that the DPNA is a reasonable enforcement remedy.

7. Other issues raised by Petitioner are without merit or are not within my authority to decide.

Petitioner attempts to preserve two additional issues for appeal. Petitioner argues that the allocation of the burden of persuasion in this case, according to the rationale of the Board in the prior decisions cited above, violates the Administrative Procedure Act, 5 U.S.C. §§ 551-59, specifically 5 U.S.C. § 556(d). RFH at 5; P. Brief at 4. Pursuant to the scheme for the allocation of burdens adopted by the Board in its prior cases, CMS bears the burden to come forward with the evidence and to establish a prima facie showing of the alleged regulatory violations in this case by a preponderance of the evidence. If CMS makes its prima facie showing, Petitioner has the burden of coming forward with any evidence in rebuttal and the burden of showing by a preponderance of the evidence that it was in substantial compliance with program participation requirements. Petitioner bears the burden to establish by a preponderance of the evidence any affirmative defense. The allocation of burdens suggested by the Board is not inconsistent with the requirements of 5 U.S.C. § 556(d), as CMS is required to come forward with the evidence that establishes its prima facie case. Furthermore, because the evidence is not in equipoise, this case does not turn upon which party bore the burden of persuasion and Petitioner suffered no prejudice.

Petitioner also argues that the Medicare Act is violated and Petitioner is deprived of due process if CMS is not required to submit evidence to prove it considered the regulatory criteria established by 42 C.F.R. §§ 488.404 and 488.438(f). RFH at 6; P. Prehearing Brief at 10. I reviewed the evidence related to the regulatory factors de novo and I perceive no prejudice to Petitioner because I did not require CMS to submit evidence related to its consideration of the regulatory factors.

(Footnote continued.)

was placed on a fast track for termination of its provider agreement. Accordingly, I conclude that the review of the salty beets tags is simply not necessary for the purpose of possibly extending the duration of the CMP by two or three days.

III. Conclusion

For the foregoing reasons, I conclude that Petitioner was not in substantial compliance with program participation requirements from November 26, 2011 through termination of its participation in Medicare on January 7, 2012. There are bases for the imposition of the following enforcement remedies, which I conclude are reasonable: termination of Petitioner's provider agreement and participation in Medicare effective January 7, 2012; a CMP of $6,000 per day beginning November 26, 2011 and continuing until termination on January 7, 2012; and a DPNA effective December 24, 2011 through termination on January 7, 2012.

/s/
Keith W. Sickendick
Administrative Law Judge