Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Appellate Division

In the Case of:	DATE: March 5, 2009
Singing River Rehabilitation & Nursing Center,	
Petitioner,	Civil Remedies CR1838 App. Div. Docket No. A-09-11
- v. -	Decision No. 2232
Centers for Medicare & Medicaid Services.	

FINAL DECISION ON REVIEW OF ADMINISTRATIVE LAW JUDGE DECISION

On November 3, 2008, Singing River Rehabilitation & Nursing Center (Singing River) appealed the September 2, 2008 decision of Administrative Law Judge (ALJ) Steven T. Kessel that concluded that Singing River failed to comply substantially with a federal regulatory requirement for skilled nursing facilities (SNFs) and imposed a civil money penalty (CMP) of $50 per day beginning April 14, 2007 and continuing through May 25, 2007. Singing River Rehabilitation & Nursing Center, DAB CR1838 (2008)(ALJ Decision). The sole noncompliance at issue on appeal involves Singing River's admitted failure to report to State authorities the results of its investigation of suspected abuse of one resident by another resident. Singing River contends that no report was required because no staff member was implicated and because, in its opinion, state law would not mandate reporting under the circumstances.

For reasons explained below, we conclude that the facility was required to report the results of the investigation under federal

law regardless of whether staff members were implicated in the suspected abuse. We therefore affirm the ALJ Decision.

Applicable legal authority

Federal law and regulations provide for surveys by state survey agencies to evaluate the compliance of skilled nursing facilities (SNFs) with the requirements for participation in the Medicare and Medicaid programs and to impose remedies when a facility is found not to comply substantially. Sections 1819 and 1919 of the Social Security Act; 42 C.F.R. Parts 483, 488, and 498.[1]

"Substantial compliance" is defined as "a level of compliance with the requirements of participation such that any identified deficiencies pose no greater risk to resident health and safety than the potential for causing minimal harm." 42 C.F.R. § 488.301. "Noncompliance" means "any deficiency that causes a facility to not be in substantial compliance." Id.

CMS may impose a CMP for the days on which the facility is not in substantial compliance. 42 C.F.R. §§ 488.404, 488.406, and 488.408. Where the noncompliance does not place residents in immediate jeopardy but has the potential for more than minimal harm, CMS may impose a CMP between $50 and $3,000 per day. 42 C.F.R. § 488.438(a)(1)(i). Where CMS determines that the noncompliance poses immediate jeopardy, CMS may impose a penalty in the range of $3,050 to $10,000 per day. 42 C.F.R. § 488.438(a)(1)(i).

Section 483.13(b) sets out the right of each resident to be "free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion." Section 483.13(c) obliges every facility to "develop and implement written policies and procedures that prohibit mistreatment, neglect and abuse of residents and misappropriation of resident property." Subsection 483.13(c)(4) (with emphasis added) provides as follows:

> The results of all investigations must be reported to the administrator or his designated representative and to other

[1] The current version of the Social Security Act can be found at www.ssa.gov/OP_Home/ssact/comp-ssa.htm. Each section of the Act on that website contains a reference to the corresponding United States Code chapter and section. Also, a cross-reference table for the Act and the United States Code can be found at 42 U.S.C.A. Ch. 7, Disp. Table.

> officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.

Case Background[2]

Singing River is a SNF in Mississippi that participates in the Medicare program and was surveyed for compliance on April 26, 2007. The survey resulted in two deficiency findings.

First, the survey found that Singing River failed to protect residents from abuse by one of the residents and found that this problem posed an immediate jeopardy to the health and safety of residents. Second, the survey found Singing River failed to investigate and report properly an allegation of resident-on-resident abuse. Based on these findings, the Centers for Medicare & Medicaid Services (CMS) imposed a CMP of $3500 per day for April 14, 2007 through April 25, 2007 and a reduced CMP of $50 per day continuing from April 26, 2007 through May 25, 2007.

The factual allegations underlying both deficiency findings center on an incident on April 14, 2007. It is undisputed that Resident # 1 had an argument with Resident # 2 in which Resident # 1 pulled a folding knife from his pocket and displayed it to the other resident. The Director of Nursing (DON) stated that Resident # 1 told her that he did not intend to use the knife but that he wanted to make Resident # 2 get out of a chair which Resident # 1 considered to be his. P. Ex. 7, at 2-3 (Statement of Kim Kelly). The record contains conflicting evidence about exactly what else Resident # 1 said, did or intended during the altercation. The ALJ excluded late allegations by CMS that prior conduct by Resident # 1 constituted verbal abuse and should have put Singing River on notice of foreseeable risks (ALJ Decision at 5-6), and CMS has not appealed that order. The allegations that the ALJ did address instead related solely to the adequacy of Singing River's response after the incident, including whether all witnesses should have been interviewed and whether the rooms of all residents should have been searched.

The ALJ concluded that Singing River did not fail to meet its obligations under 42 C.F.R. § 483.13(b) and (c) to protect other

[2] The following background information is drawn from the ALJ Decision and the case record and summarized here for the convenience of the reader, but should not be treated as new findings.

residents from abuse in the wake of this incident. ALJ Decision at 9-11. The ALJ found that Singing River took a series of measures in the days following this incident which reasonably protected other residents. The ALJ concluded that Singing River acted diligently and appropriately to protect residents, and that additional steps that CMS contended should have been taken were not justified by the facts as the ALJ found them. Id. at 10-11. In particular, the ALJ put considerable weight on the April 16, 2007 evaluation by a psychiatrist finding Resident # 1 "essentially harmless." Id. at 10. CMS has not appealed the ALJ's conclusions relating to protection from abuse.

The ALJ also rejected CMS's allegation that Singing River failed to comply with the requirement that "all alleged violations" be "thoroughly investigated." ALJ Decision at 13, citing 42 C.F.R. § 483.13(c)(3). The ALJ found that the DON personally conducted interviews with the two residents and with the staff person who reported the incident. ALJ Decision at 14. He concluded the investigation was prompt and sufficient even though the DON did not interview every witness because the information collected was adequate for the facility to take appropriate actions. Id.

The ALJ nevertheless upheld CMS's authority to impose a $50 per day CMP based on the following Finding of Fact and Conclusion of Law (FFCL):

> 2. Petitioner failed to comply with the requirements of 42 C.F.R. § 483.13(c) governing reporting of findings of abuse investigations.

ALJ Decision at 13. It was undisputed that Singing River did not make any report of the result of its investigation to State officials. Singing River argued that no report was required because Resident # 1's conduct did not meet the definition of abuse in Mississippi law as the "willful or nonaccidental infliction of physical pain, injury, mental anguish on a vulnerable adult . . . ." ALJ Decision at 15, quoting Miss. Code § 43-47-5. The ALJ concluded that Resident # 1's conduct met the ordinary meaning of willful, in that his actions were "plainly intended to intimidate Resident # 2," even though Resident # 1 suffered from dementia. ALJ Decision at 15. Hence, he concluded, Singing River should have reported the results of its investigation.

Noting that the remaining CMP is the lowest amount permitted by the regulations and that Singing River did not specifically

challenge the duration of the noncompliance, the ALJ upheld a $50 per day CMP for the full period of noncompliance.[3] Id. at 16. This appeal by Singing River followed.

Standard of Review

Our standard of review on a disputed conclusion of law is whether the ALJ decision is erroneous. Our standard of review on a disputed finding of fact is whether the ALJ decision is supported by substantial evidence on the record as a whole. Guidelines - Appellate Review of Decisions of Administrative Law Judges Affecting A Provider's Participation In the Medicare and Medicaid Programs, http://www.hhs.gov/dab/guidelines/prov.html, (Guidelines); Batavia Nursing and Convalescent Inn, DAB No. 1911, at 7 (2004), aff'd, Batavia Nursing & Convalescent Ctr. v. Thompson, 143 Fed. App'x 664 (6th Cir. 2005); Hillman Rehabilitation Center, DAB No. 1611, at 6 (1997), aff'd, Hillman Rehabilitation Ctr. v. U.S. Dep't of Health and Human Servs., No. 98-3789 (GEB) at 21-38 (D.N.J. May 13, 1999).

Issues on appeal

The current posture of this case is quite narrow. Singing River takes exception only to FFCL 2. Request for Review (RR) at (unnumbered page) 4. The only remaining issue is whether the facility had an obligation to report the results of its investigation to the state survey agency under the circumstances here.

In arguing that it did not, Singing River relies on a 2003 decision by another ALJ as establishing that a facility must first investigate "if staff is implicated" in an abuse allegation. RR at 4-5, citing Cedar View Good Samaritan, DAB

[3] In explaining why he found the amount of the CMP reasonable, the ALJ stated that the seriousness was very low and that the only risk was the possibility that the DON's misunderstanding of the reporting requirements might affect "some future instance of abuse." ALJ Decision at 16. The ALJ described this risk as "at best, hypothetical" and as posing "only the most minimal possibility of potential harm" for residents. Id. We presume that the ALJ intended an evaluation of the risk consistent with his conclusion that noncompliance was present, i.e., that it posed a potential for more than minimal harm, and we conclude that this misphrasing was harmless error. We therefore consider below whether substantial evidence supports a finding of a potential for more than minimal harm.

CR997 (2003), aff'd, DAB No. 1897 (2003). If staff is indeed implicated, according to Singing River, then the facility must immediately report the incident to the state survey agency, but, if no staff is implicated, then a duty to report to state authorities "arises only if mandated by state law." RR at 5.

Having found no implication that staff behaved inappropriately in regard to the April 14th incident here, the ALJ erred, according to Singing River, in holding that Singing River was required, and failed, to report the investigation results to appropriate Mississippi authorities, because Singing River contended that the conduct did not meet a State law definition of abuse requiring reporting. The Mississippi Code Section 43-47-5 on which Singing River relies defines "abuse" as "the willful or nonaccidental infliction of physical pain, injury or mental anguish on a vulnerable adult . . . ." RR at 6. Singing River contends that the DON reasonably determined that Resident # 1 was incapable of willful conduct because of his dementia and that Resident # 2 was unharmed. Id. She therefore concluded that no report was required because of the absence of both willful conduct and actual harm. Id.

Further, Singing River argues that the ALJ held it to a reporting standard that was not laid out clearly in either federal or state law. RR at 7, citing Emerald Shores Health Care Associates, LLL d/b/a Emerald Shores Health and Rehabilitation Center, Civ. No. 07-12404 (11th Cir. Oct. 22, 2008). According to Singing River, the ALJ's interpretation of the meaning of "willful" in the state provision to encompass any deliberate behavior represented a legal standard of which it had no notice prior to the ALJ's issuance of the decision and for which the ALJ did not cite any supporting state law. In addition, Singing River argues that substantial evidence does not support the ALJ's characterization of Resident # 1's conduct as willful in that Resident # 1 displayed his knife deliberately to intimidate Resident # 2 because the ALJ failed to recognize that dementia made it impossible for the resident to act deliberately. Id. at 6-7.

Analysis

1. The plain language of section 483.13(c)(4) requires facilities to report results of all investigations of suspected abuse to state officials including the state survey and enforcement agency.

Singing River does not question that section 483.123(c)(4) requires facilities to protect residents from abuse and to investigate thoroughly all allegations of abuse, not only those

which allege that a staff person committed the abuse or those in which abuse by a staff person has been substantiated. Indeed, it is well-established that the responsibility of the facility and its staff extends beyond refraining from committing abuse to protecting residents from abuse from whatever source, whether privately hired caregivers, family members, visitors or other residents. See, e.g., Western Care Management Corp., d/b/a Rehab Specialties, Inc., DAB No. 1921, at 12-13 (2004). Further, Singing River acknowledges that the results of investigations of abuse must be reported to state officials, but insists that the scope of its reporting obligation is different for investigations that implicate staff as opposed to those that do not implicate staff. Specifically, Singing River contends that, whereas all investigations which do implicate staff must be reported to the state survey agency (and any other appropriate officials), investigations into suspected abuse by non-staff perpetrators are reportable only to the extent that state law defines the conduct involved as "abuse."

Our analysis begins, as it must, with a careful reading of the applicable federal requirement. In this case, the regulation requires that the "results of all investigations" of alleged abuse "must be reported" to the facility's administrator and to State officials "in accordance with State law (including to the State survey and certification agency)." 42 C.F.R. § 483.13(c)(4) (emphases added). The most striking feature of the plain language is that the phrasing is both very inclusive (all investigations) and mandatory in nature (must be reported). This broad and imperative approach to the disclosure of abuse allegations to, at a minimum, State survey and certification agency officials is consistent with the strong emphasis on protection of residents in the regulations.

The applicable regulation provides that residents have an affirmative right to be free from any "verbal, sexual, physical and mental abuse . . . ." 42 C.F.R. § 483.13(b). Subsection (c) addresses the obligations of the facility to develop and implement policies and procedures to "prohibit mistreatment, neglect and abuse" of residents generally and to "ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source" are thoroughly investigated and are reported to the facility administrator and to state officials. 42 C.F.R. § 483.13(c)(2)-(4).[4] The inclusion of

[4] The title to subsection (c) is "staff treatment of residents" but it is undisputed that the responsibilities imposed on the facility by the provisions in that subsection are not (continued . . .)

injuries of unknown source as "alleged violations" requiring investigation and reporting further reinforces the understanding that the focus is on the potential impact of suspected abuse on residents rather than on whether facility staff members are the alleged perpetrators. This context further indicates that, even if there were ambiguity in the regulation (which there is not), the regulation should be construed consistently with the purpose of resident protection. Adoption of Singing River's argument would require us to add a limitation to the regulation that is inconsistent with both its plain language and its overarching purpose of protecting residents from being subjected to any incidents of abuse.

In addition, the regulation explicitly requires reporting of the results of all investigations of abuse, not merely those that substantiate abuse. Thus, facilities are not free to view their internal investigations as an opportunity to "pre-screen" whether an alleged or suspected instance of abuse is substantiated or involves specific bad actors, i.e., staff. Indeed, the regulation states that all investigations are to be reported and "if the alleged violation is verified appropriate corrective action must be taken." 42 C.F.R. § 483.13(c)(4)(emphasis added). It follows that the regulation contemplates reporting of the results of investigations even when the alleged violation is not verified. Therefore, the investigation of any alleged or suspected abuse should timely and thoroughly collect relevant evidence both to allow the administrator to determine what corrective measures, if any, are called for and to provide a basis to identify which state officials, beyond the survey and certification agency, should be notified, but not to determine whether to report the investigation results. The nature of the results (i.e., whether abuse is substantiated or whether staff actors or facility practices are implicated based on the investigation) has no bearing on whether those results must be reported.

Furthermore, we conclude that the structure of the regulatory language indicates that the phrase "in accordance with state law" clearly does not define which investigations results must be

---

(continued . . .)
limited to instances of staff mistreatment of residents but extend to staff duties to protect residents from abuse from any source.

reported.[5] The modifying phrase is not near the term, "all investigations," but rather appears immediately after "state officials." The parenthetical requiring that reports be made to the state survey and certification agency appears after the phrase "in accordance with state law" and is not modified by it. This location in the sentence implies that the antecedent reference is to the "officials" to whom the report must be made. This grammatical observation in turn leads to the conclusion that state law is relevant to defining which officials, in addition to the State survey and certification agency, must receive the report, and perhaps to what procedures to use in making reports, but that state law has no relevance to determining whether a report must be made at all once an abuse investigation has taken place, at least to the state survey and certification agency.

This reading makes sense because abuse reports may appropriately be received by different officials depending on the source of the alleged abuse, the organizational structure of a particular state and the purpose of the report in a given instance.[6] For example, abuse by a family member might need to be reported to an adult protective services agency while abuse by a professional (whether employed by the facility or privately) might need to be reported to a licensing agency, depending on state law. The plain language of the federal regulation expressly requires, however, that, regardless of which officials are designated by state law to receive various abuse reports, the results of all investigations of suspected abuse at SNFs must be reported to the state survey and certification agency. That agency is the one on which the federal authorities rely to monitor the compliance of

[5] It is even less plausible to construe the reference to state law here, as Singing River seems to do, as implying that state definitions of what conduct constitutes "abuse" should be applied to govern what "abuse" investigations are subject to the federal reporting requirement. Nothing in subsection (c)(4) discusses the nature of conduct to be considered abuse, so the phrase "in accordance with state law" cannot reasonably be read as modifying the appropriate definition of abuse to be applied, whether to staff or non-staff conduct.

[6] Any attempt to read the phrase as modifying which investigations are to be reported would compel the illogical conclusion that federal participation requirements were intended to defer to the varying state laws to determine which investigatory results must be reported even to the facility administrators who are responsible for ensuring appropriate corrective measures are taken.

SNFs, including ensuring that residents are adequately protected from neglect and abuse. It is thus reasonable that the regulation would defer to state law on how and where to report abuse to state authorities generally, but would not provide for the varying laws of multiple jurisdictions to impose different concepts of what constitutes suspected abuse and whether to investigate and report it to the state agency mandated by federal law to survey the performance of SNFs.

Finally, Singing River's purported distinction, i.e., applying state definitions of abuse to determine whether the results of an abuse investigation must be reported to the State only when the alleged perpetrator is not a staff person, has no support whatsoever in the regulatory language. The requirement to report is expressly the same for all investigations, without distinction as to whether a staff person is implicated.

To the extent that the ALJ appeared to apply state law here by discussing whether Resident # 1's conduct was willful, such application was an error of law since the federal reporting requirements rather than state law apply to all investigations. State law is only relevant to identifying appropriate state officials besides the state survey and certification agency and to determining the procedures to be followed in reporting.

We therefore conclude that the regulation on its face provides that all investigations of alleged abuse (as well as neglect or misappropriation of property) must be reported to the state survey agency, in addition to any other appropriate state officials. The obligation arises whether or not the investigation finds that the allegations implicated a staff person or were even substantiated at all.

2. Singing River's reliance on dicta in an earlier ALJ decision as showing that investigations that do not implicate staff need not be reported unless required by state law is misplaced.

The only "authority" which Singing River cites for the proposition that, despite the plain meaning of the regulatory language, state law governs whether abuse must be reported where no staff member is implicated, is an analysis in an earlier ALJ decision by ALJ Keith Sickendick. RR at 4-5, citing Cedar View Good Samaritan, DAB CR997, at 12-15 (2003), aff'd, DAB No. 1897 (2003). To the extent that ALJ Sickendick's reasoning was considered by the Board on appeal, neither that reasoning nor the Board's decision upholding the ALJ's decision supports Singing

River's position.[7] ALJ Sickendick never draws the conclusion which Singing River would have us reach. To the extent that Singing River reads ALJ Sickendick's discussion as providing a rationale for its theory, we find no merit in that position.

Cedar View involved allegations of sexual abuse of a resident by a nurse aide. DAB No. 1897, at 2. Accordingly, the case cannot be viewed as authority for any distinction between allegations of abuse by staff and allegations of abuse by others. The ALJ concluded, and the Board agreed, that Cedar View was required by federal law to report the results of all investigations of alleged staff abuse without regard to whether the allegations were substantiated. Id. at 10-12. The Board noted, however, that the ALJ's discussion of whether Cedar View also violated state law was not relevant, because the "ALJ did not determine that Kansas law governed here instead of federal law, but simply that reporting would have also been required under Kansas law if it were applicable," and that "determination is dicta, since the ALJ did not rely on it." Id.[8]

The discussion to which Singing River points in the Cedar View ALJ decision focused on the relationship which the ALJ perceived between regulatory section 483.13 and section 1819(g)(1)(C) of the Act. That statutory provision imposes a duty on states participating in the Medicare program to provide, through their state survey and certification agencies, "for a process for the receipt and timely review and investigation of allegations of neglect and abuse and misappropriation of resident property by a nurse aide of a resident in a nursing facility or by another individual used by the facility in providing services to such a resident." ALJ Sickendick observed that this provision addresses

[7] We note that an ALJ decision is not itself precedential, and has relevance to a Board analysis only for the inherent value of any persuasive analysis therein. Furthermore, a subsequent Board decision affirming the ALJ should not be assumed to imply approval of all language in the ALJ decision where the language was not necessary to the outcome and was not directly addressed by the Board. The language in the ALJ's Cedar View decision which Singing River reads as supporting its position was mere dicta and was not adopted by the Board on appeal.

[8] Similarly, passing references in the ALJ's decision to how state law reporting requirements might affect cases where abuse is alleged by "someone other than facility staff" are dicta since, as the ALJ pointed out, "those are not the facts" of the case before him in Cedar View. CR997, at 19 n.9.

only investigations of neglect, abuse, or misappropriation by a nurse aide or other facility caregiver, and not violations of resident's rights by other residents or by persons from outside the facility. Cedar View, DAB CR997, at 14.

This observation cannot be viewed as circumscribing the Secretary's authority to require facilities to report the results of abuse investigations involving persons not on their staff to state survey agencies. Indeed, ALJ Sickendick recognized that the regulations impose duties on the state survey agency and the facility broader than this statutory mandate in section 1819(g)(1)(C). Id. at 15. Section 1819(d)(4) expressly requires SNFs to comply with all applicable federal and state law and regulations and to meet "such other requirements relating to the health, safety, and well-being of the residents . . . as the Secretary may find necessary." Section 483.13 is part of the regulatory scheme implementing sections 1819(a)-(d) of the Act by setting out participation requirements for long term care facilities. Section 483.13 thus does not actually implement section 1819(g)(1)(C) of the Act, which addresses instead the duties imposed on states.

Furthermore, 42 C.F.R. § 488.335, which does implement section 1819(g)(1)(C), does not support the concept that the statutory focus on state maintenance of nurse aide registries implies that SNF's reporting requirements are different depending on whether the suspected perpetrator is a staff member. Instead, the regulation mandates that that the "State must review all allegations of resident neglect and abuse, and misappropriation of resident property and follow procedures specified in § 488.332," which sets out the process for complaint investigation surveys of facilities. 42 C.F.R. § 488.335(a)(1) (emphasis added); see also 42 C.F.R. § 488.335(a)(3)(state must have "procedures for the timely review and investigation of allegations" of resident abuse). The only distinction made regarding staff and non-staff abuse is in section 483.335(a)(2), which provides that, when evidence suggests that an individual "used by a facility to provide services" could have abused a resident, then "the State must investigate the allegation" itself.

In light of our conclusion that the federal regulation plainly requires reporting of the results of Singing River's investigation of suspected resident-on-resident abuse, we need not address in any detail the parties' briefing about whether the ALJ erred in interpreting "willful" in the state regulation to include "deliberate" action or whether Resident # 1's mental condition precluded "willful" conduct. We note, however, that

Singing River appears to ignore that including "nonaccidental" conduct in the definition of abuse in the state code defining abuse implies that behavior that is less than willful may still be abusive. Cf. RR at 5-7; Miss. Code § 43-47-5. Singing River makes no argument that Resident # 1 acted by accident and the record could not support such a claim. We thus agree with the ALJ that Singing River would have been obliged to report the results of this investigation even under the terms of the state law on which it relied.[9]

Thus, the regulation requires the state agency to conduct an investigation itself whenever abuse allegations implicate facility staff and to review all other allegations to determine whether to follow up with a complaint survey of the reporting facility. In order for the state agency to fulfill these requirements, facilities must in turn be required to report all allegations and the results of all investigations. That is the parallel requirement embodied in 42 C.F.R. § 483.13, as discussed in the previous section.

Singing River denies that the results of investigations that do not implicate staff must be reported to any state agency unless the conduct involved meets state law definitions of reportable abuse. This suggestion, in addition to lacking support in the language or goals of the regulation, flies in the face of the long-established principle that the results of all investigations must be reported regardless of whether abuse is substantiated. Vandalia Park, DAB No. 1939 (2004).

The Board explained in a prior case that the import of Cedar View is that the reporting requirement for abuse is governed by federal not state law and that all investigations must be reported regardless of whether the allegations were substantiated:

> [T]he Board has previously held that federal reporting requirements take precedence over state law and require that "[o]nce a facility's preliminary investigation implicates staff, the facility is responsible for notifying the State

[9] We also find it unnecessary, for the same reasons, to address Singing River's assertions that the state law required a showing of actual harm (including mental anguish) and that Resident # 2 was not harmed because he expressed no fear of Resident # 1 or awareness of the knife when later interviewed by the DON or the surveyor. Cf. RR at 6-7; P. Ex. 7, at 5; CMS Ex. 11, at 4.

> survey and certification agency." [Cedar View, DAB No. 1897, at 11], citing 56 Fed. Reg. 48,843-48,844 (Sept. 26, 1991). We reached this conclusion because Congress gave states and facilities concurrent responsibility for investigating allegations of abuse by staff in long term care facilities. Section 1819(g)(1)(C) of the Act. In order to enable states to fulfill this responsibility, CMS adopted section 483.13(c), which requires facilities to report "all alleged violations." (Emphasis added). Thus, for reporting allegations of abuse to the state, "the salient question is not whether any abuse in fact occurred or whether [a facility] had reasonable cause to believe that any abuse occurred, but whether there was an allegation that facility staff had abused a resident." Cedar View, at 11.

Britthaven, Inc. d/b/a Britthaven of Smithfield, DAB No. 2018, at 15 (2006). While Britthaven, like Cedar View, did involve allegations implicating staff, we conclude that the same analysis implies the primacy of federal law to abuse investigations involving allegations against non-staff perpetrators. The State's concurrent responsibility in such cases is to review the allegations and investigation results, rather than to conduct an independent investigation in every case, but this responsibility would be similarly thwarted if facilities could avoid reporting investigatory results by applying varying state law definitions of abuse.

We conclude that federal law governs the requirement that the results of all investigations of abuse allegations be reported to appropriate state officials.

In addition, we reject Singing River's contention that it lacked notice of this interpretation of the regulations. As the Board noted with approval in Cedar View, the ALJ in that case "concluded that the regulations incorporate state law not with respect to the obligation to report in the first instance but merely with respect to the procedures to be followed once a report of alleged abuse is made." DAB No. 1897, at 13. Our decision in Cedar View is a matter of public record, and, unlike the ALJ decision to which Singing River cites, is entitled to precedential weight.

Singing River's argument that the ALJ Decision constituted its first notice of what the term "willful" in the state law could encompass is thus not only wrong (given the state law inclusion of "non-accidental" actions) but also irrelevant since state law does not apply. The plain language of the regulation, as well as

the Board's prior decisions, sufficed to inform Singing River of its responsibilities.

Conclusion

For the reasons explained above, we uphold the ALJ Decision imposing on Singing River a CMP of $50 per day beginning April 14, 2007 and continuing through May 25, 2007.

_____/s/_____
Stephen M. Godek

_____/s/_____
Sheila Ann Hegy

_____/s/_____
Leslie A. Sussan
Presiding Board Member