Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Heather Hill Nursing Home
(CCN: 10-5343),

Petitioner

v.

Centers for Medicare and Medicaid Services.

Docket No. C-08-764

Decision No. CR2298

Date: December 23, 2010

DECISION

Petitioner, Heather Hill Nursing Home, was not in substantial compliance with Medicare participation requirements from June 29, 2008 through August 25, 2008. A civil money penalty (CMP) of $6,550 per day, effective June 29, 2008 through July 31, 2008, is a reasonable enforcement remedy. A CMP of $200 per day, effective August 1, 2008 through August 25, 2008, and a denial of payment for new admissions (DPNA) from July 31, 2008 through August 25, 2008, are also reasonable.

I. Background

Petitioner is located in New Port Richey, Florida, and is authorized to participate in Medicare as a skilled nursing facility (SNF) and in the Florida Medicaid program as a nursing facility (NF). The Florida Agency for Health Care Administration (state agency) surveyed Petitioner on July 11, 2008 and August 1, 2008, and concluded that Petitioner was not in substantial compliance with program participation requirements. Joint Stipulation of Facts and Issues filed December 16, 2008 (Jt. Stip.). A second revisit survey found that Petitioner returned to substantial compliance with program

participation requirements on August 26, 2008. Centers for Medicare and Medicaid Services (CMS) Exhibits (CMS Exs.) 38, 39.

CMS notified Petitioner by letter dated July 29, 2008, that it was imposing the following enforcement remedies based upon the findings of the July 11, 2008 survey: a CMP of $6,550 per day, effective July 11, 2008, continuing until immediate jeopardy was removed or Petitioner's provider agreement was terminated; a discretionary DPNA, effective July 31, 2008, continuing until Petitioner returned to substantial compliance or its provider agreement was terminated; and termination of Petitioner's provider agreement on August 3, 2008, if immediate jeopardy was not removed by that date. CMS also advised Petitioner that it could not be approved to conduct a Nurse Aide Training and Competency Evaluation Program (NATCEP) for two years due to the enforcement remedies imposed and the fact that an extended or partial extended survey was conducted.[1] CMS Ex. 7. CMS notified Petitioner by letter dated August 21, 2008, that: the CMP began accruing at the rate of $6,550 per day on June 29, 2008, rather than July 11, 2008, and continued to accrue through July 31, 2008 when immediate jeopardy was abated; effective August 1, 2008, the CMP was reduced to $200 per day and would continue to accrue until Petitioner returned to substantial compliance; the DPNA that began July 31, 2008 would continue in effect until Petitioner returned to substantial compliance; and discretionary termination on August 3, 2008 was changed to mandatory termination on January 11, 2009, if Petitioner did not return to substantial compliance before that date. CMS Ex. 34. CMS notified Petitioner by letter dated September 19, 2008, that: a revisit survey found that Petitioner returned to substantial compliance effective August 26, 2008; the DPNA was in effect from July 31, 2008 through August 25, 2008; and Petitioner's provider agreement would remain in effect. CMS Ex. 39.

Petitioner requested a hearing before an administrative law judge (ALJ) on September 23, 2008. The case was assigned to me for hearing and decision on October 2, 2008. A hearing was convened in this case on June 16 and 17, 2009, in Tampa, Florida. CMS offered, and I admitted, CMS Exs. 1 through 40. Tr. at 20. Petitioner offered, and I admitted, Petitioner's exhibits (P. Exs.) 1 through 16 and 18 through 23. Tr. at 36. CMS called the following witnesses: Lorraine Marking, a former state agency surveyor; JoAnne Pumphrey, a former state agency surveyor; and Joseph Schuler, a fire protection specialist with the state agency. Petitioner called the following witnesses: Richard Dannenmiller, a building contractor; Laura Siekert, a nurse consultant to Petitioner; Maria Owens-Wicker, a former administrator for Petitioner; and Stephen French, an environmental consultant. The parties submitted post-hearing briefs (CMS Br. and P. Br.) and post-hearing response briefs (CMS Reply and P. Reply).

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[1] Petitioner did not have a NATCEP at the time of the survey. Transcript (Tr.) at 12.

II. Discussion

A. Issues

The issues in this case are:

Whether there is a basis to impose an enforcement remedy; and

Whether the enforcement remedies proposed are reasonable.

B. Applicable Law

The statutory and regulatory requirements for participation by a long-term care facility are found at sections 1819 (SNF) and 1919 (NF) of the Social Security Act (Act) and at 42 C.F.R. Part 483.[2] Section 1819(h)(2) of the Act vests the Secretary of Health and Human Services (Secretary) with authority to impose enforcement remedies against a SNF for failure to comply substantially with the federal participation requirements established by sections 1819(b), (c), and (d) of the Act.[3] Pursuant to section 1819(h)(2)(C), the Secretary may continue Medicare payments to a SNF not longer than six months after the date the facility is first found not in compliance with participation requirements. Pursuant to section 1819(h)(2)(D), if a SNF does not return to compliance with participation requirements within three months, the Secretary must deny payment for all individuals admitted to the facility after that date – commonly referred to as the mandatory or statutory DPNA. In addition to the authority to terminate a noncompliant SNF's participation in Medicare, the Act 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

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[2] References are to the 2007 revision of the Code of Federal Regulations (C.F.R.) in effect at the time of the survey, unless otherwise indicated.

[3] Section 1919(h)(2) of the Act gives similar 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.

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. Part 483, Subpart B. State survey agencies survey facilities that participate in Medicare on behalf of CMS to determine whether the facilities are complying with federal participation requirements. 42 C.F.R. §§ 488.10-.28, 488.300-.335. The regulations specify the enforcement remedies that CMS may impose if a facility is not in substantial compliance with Medicare requirements. 42 C.F.R. § 488.406.

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 a CMP, $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 a CMP, $50 per day to $3,000 per day, is reserved for deficiencies that do not constitute immediate jeopardy but either cause actual harm to residents, or cause no actual harm but have the potential for causing more than minimal harm. 42 C.F.R. § 488.438(a)(1)(ii).

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

Facility Practices), § 483.15 (Quality of Life), or § 483.25 (Quality of Care) that are found to constitute either immediate jeopardy, a pattern of or widespread actual harm that does not amount to immediate jeopardy, or a widespread potential for more than minimal harm that does not amount to immediate jeopardy and there is no actual harm. 42 C.F.R. § 488.301.

The Act and regulations make a hearing before an ALJ available to a long-term care facility against which CMS has determined to impose an enforcement remedy. Act §§ 1128A(c)(2), 1866(h); 42 C.F.R. §§ 488.408(g), 498.3(b)(13). The hearing before an ALJ is a *de novo* proceeding. *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). A facility has a right to appeal a "certification of noncompliance leading to an enforcement remedy." 42 C.F.R. § 488.408(g)(1); 42 C.F.R. §§ 488.330(e), 498.3. However, the choice of remedies or the factors that 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 that CMS determined if a successful challenge would affect the range of the CMP that may be imposed or impact the facility's authority to conduct a NATCEP. 42 C.F.R. §§ 498.3(b)(14), (d)(10)(i). The CMS determination as to the level of noncompliance, including the finding of immediate jeopardy, "must be upheld unless it is clearly erroneous." 42 C.F.R. § 498.60(c)(2). *Woodstock Care Ctr.*, DAB No. 1726, at 9, 38 (2000), *aff'd*, 363 F.3d 583 (6th Cir. 2003). The Departmental Appeals Board (the Board) has long held that the net effect of the regulations is that a provider has no right to challenge the scope and severity level assigned to a noncompliance finding, except in the situation where that finding was the basis for an immediate jeopardy determination. *See, e.g., Ridge Terrace*, DAB No. 1834 (2002); *Koester Pavilion*, DAB No. 1750 (2000). ALJ Review of a CMP is subject to 42 C.F.R. § 488.438(e).

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

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

My conclusions of law are set forth in bold text followed by my findings of fact and analysis.

CMS alleges based upon the survey that ended July 11, 2008, that Petitioner was not in substantial compliance with program participation requirements due to the following regulatory violations: 42 C.F.R. §§ 483.10(e) (Tag F164, scope and severity (s/s) D); 483.13(a) (Tag F221, s/s G); 483.13(b) and (b)(1)(i)[4] (Tag F223, s/s J); 483.13(c)(1)(ii)-(iii) and (c)(2)-(4) (Tag F225, s/s L); 483.13(c) (Tag F226, s/s L); 483.15 (Tag F240, s/s D); 483.15(h)(2) (Tag F253, s/s J); 483.20(g)-(j) (Tag F278, s/s D); 483.20(d) and 483.20(k)(1) (Tag F279, s/s J); 483.20(k)(3)(i) (Tag F281, s/s D); 483.25(h) (Tag F323, s/s D); 483.25(k) (Tag F328, s/s D); 483.35(i)(2) (Tag F371, s/s F); 483.60(b), (d), (e) (Tag F431, s/s D); 483.65(a) (Tag F441, s/s F); 483.70 (Tag F454, s/s F); 483.70(c)(2) (Tag F456, s/s D); 483.70(h)(4) (Tag F469, s/s D); and 483.75 (Tag F490, s/s L). CMS Ex. 3. Petitioner was also surveyed on July 11, 2008, for compliance with the National Fire Protection Association's Life Safety Code (Life Safety Code) and found not to be in compliance with Tags K025 (s/s D), K062 (s/s D), and K067 (s/s F), which are violations of 42 C.F.R. § 483.70. CMS Ex. 5. A revisit survey that ended on August 1, 2008, concluded that immediate jeopardy was abated, but Petitioner continued to be in violation of: 42 C.F.R. §§ 483.13(b) and (c)(1)(i) (Tag F223, s/s D); 483.13(c)(1)(ii)-(iii) and (c)(2)-(4) (Tag F225, s/s F); 483.13(c) (Tag F226, s/s F); 483.15(h)(2) (Tag F253, s/s D); 483.20(d) and (k)(1) (Tag F279, s/s D); and 483.75 (Tag F490, s/s F). CMS Ex. 33.

Petitioner requested review by an ALJ only as to the deficiency citations from the July 2008 survey that allegedly posed immediate jeopardy, Tags F223, F225, F226, F253, F279, and F490. Petitioner did not appeal any non-immediate jeopardy tags from either the July or August surveys. Petitioner agreed that the deficiencies not appealed provide a sufficient basis for a CMP in the lower range of authorized CMPs. Tr. at 10-13; P. Br. at 1; P. Br., Appendix A, at 1; P. Reply at 2. Petitioner did not request review as to, and, therefore, waived any dispute of, the violations cited by the July survey under Tags F164, F240, F278, F281, F323, F328, F371, F431, F441, F454, F456, and F469, or that all posed a risk for more than minimal harm without actual harm or immediate jeopardy.

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[4] The reference to 42 C.F.R. § 483.13(b)(1)(i) is in error, as there is no such subsection. The surveyors recite the language of 42 C.F.R. § 483.13(c)(1)(i) under Tag F223, and I recognize that the surveyors' reference to 42 C.F.R. § 483.13(b)(1)(i) was a clerical error. The erroneous citation caused no prejudice to Petitioner, as the language of the correct subsection is recited in the SOD. All references in this decision to Tag F223, as cited by the SOD of July 11, 2008, refer to 42 C.F.R. § 483.13(b) and (c)(1)(i).

Petitioner did not request review and waived any dispute of the violation cited by the July survey under Tag F221, or that it caused actual harm. Petitioner did not dispute the Life Safety Code violations. Petitioner did not request review and therefore waived any dispute of the violations cited by the August survey under Tags F223, F225, F226, F253, F279, and F490 or that they posed a risk for more than minimal harm without actual harm or immediate jeopardy.[5] Petitioner does not dispute that these violations are an adequate basis for the imposition of enforcement remedies for the period June 29 through August 25, 2008, specifically a CMP in the lower range up to $3,000 per day, and a DPNA from July 31, 2008 through August 25, 2008.[6]

I have carefully considered all the evidence, including the documents and the testimony at hearing, 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.[7] 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.

I conclude that: (1) Petitioner violated 42 C.F.R. §§ 483.13(b) and (c) (Tags F223, F225, and F226) and 483.75 (Tag F490); (2) Petitioner has failed to show that the declaration of

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[5] It could be argued that Petitioner effectively waived any challenge to the violations cited under Tags F223, F225, F226, F253, F279, and F490 by both the July and August surveys by not specifically challenging those deficiencies as alleged by the August survey. The same examples, conduct, and events from the July survey are cited by the August survey as the basis for the surveyors' conclusions that there were continuing deficiencies under all six Tags. However, I am not willing to extend the doctrine of waiver that far in this case, as it is clear that Petitioner intended to obtain review as to whether or not the deficiencies were properly cited.

[6] Petitioner stated at hearing that it intended to show that it returned to substantial compliance on a date earlier than that alleged by CMS. Tr. at 14. However, Petitioner does not provide me any discussion in its briefs on that issue, and I conclude that the issue is waived.

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

immediate jeopardy based on these violations was clearly erroneous; and (3) these violations are a sufficient basis for the imposition of a CMP of $6,550 per day, effective June 29, 2008 through July 31, 2008, and that it is, therefore, not necessary to for me to address the alleged immediate jeopardy violations cited under Tags F253 and F279.

1. Petitioner violated 42 C.F.R. § 483.13(b) (Tag F223, s/s J).[8]

2. Petitioner violated 42 C.F.R. § 483.13(c)(2)-(4) (Tag F225, s/s L).[9]

3. Petitioner violated 42 C.F.R. § 483.13(c) (Tag F226, s/s L).

4. Petitioner did not show that the determination that the deficiencies posed immediate jeopardy was clearly erroneous.

Section 1819(c)(1)(A)(ii) of the Act requires that a SNF protect its residents and promote their "right to be free from physical or mental abuse, corporal punishment, involuntary seclusion, and any physical or chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms." The Act provides that restraints may only be applied to ensure the physical safety of a restrained resident or other residents and may only be imposed upon a written physician's order except in emergency circumstances specified by the Secretary. The Secretary has provided by regulation that a "resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion." 42 C.F.R. § 483.13(b). The regulations define "abuse" to be "the willful infliction of injury,

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[8] The SOD also alleges under Tag F223 that Petitioner violated 42 C.F.R. § 483.13(b)(1)(i) (CMS Ex. 3, at 13), which I have recognized was intended to refer to 42 C.F.R. § 483.13(c)(1)(i). However, 42 C.F.R. § 483.13(c)(1)(i) is more appropriately considered under Tag F226, as I have done.

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

unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish." 42 C.F.R. § 488.301. A facility is required to develop and implement written policies and procedures prohibiting mistreatment, neglect, and abuse of residents and the misappropriation of residents' property. 42 C.F.R. § 483.13(c)

The deficiencies alleged under Tags F223, F225, and F226 are closely related, and, for that reason, I discuss them together. The surveyors cited an example related to Resident 2 under all three deficiencies, and examples related to Residents 1, 3, and 4 under Tags F225 and F226. After careful review of the evidence, I conclude that the examples of Residents 2 and 3 are sufficient to show that the deficiencies existed as alleged, and I conclude it is not necessary to discuss the examples of Residents 1 and 4 to further illustrate the violations.

The July 11, 2008 SOD alleges that Petitioner violated 42 C.F.R. § 483.13(b) (Tag F223), because Petitioner did not provide Resident 2 an environment free of physical abuse and/or involuntary seclusion. The surveyors allege that staff failed to recognize an incident of abuse of Resident 2 and failed to timely report the incident. The surveyors cited the deficiency as an isolated event that posed immediate jeopardy. CMS Ex. 3, at 13. The surveyors allege as a violation of 42 C.F.R. § 483.13(c)(2)-(4) (Tag F225) that, in the case of Residents 2 and 3: Petitioner failed to ensure that staff immediately reported abuse or alleged abuse to the administrator and other officials as required by law; Petitioner failed to have evidence to show that alleged incidents of abuse were thoroughly investigated; and Petitioner failed to have evidence to show that during the investigation measures were implemented to ensure no further abuse occurred. The surveyors cited the deficiencies under Tag F225 as widespread and posing immediate jeopardy to residents. CMS Ex. 3, at 22-23. The surveyors cited Petitioner for violation of 42 C.F.R. § 483.13(c) (Tag F226) on the theory that the violations cited under Tags F223 and F225 show that Petitioner failed to implement its policy and procedures prohibiting mistreatment, neglect, abuse, and misappropriation of resident property. The deficiency is cited as posing widespread immediate jeopardy. CMS Ex. 3, at 52-53. I conclude that Petitioner did violate the regulations as alleged and that Petitioner has failed to show that the declaration of immediate jeopardy was clearly erroneous.

a. Facts

Resident 2 suffered from dementia and resided in a locked unit. Tr. at 89, 203; CMS Ex. 18, at 25, 56, 61. Her Minimum Data Set (MDS), with an assessment reference date of May 22, 2008, assessed her as: moderately impaired with long and short term memory deficits; totally dependent on staff for transfer and locomotion on the unit; unable to walk in her room or the corridor; and having functional limitation in range of motion of both hands, with associated partial loss of voluntary movement. CMS Ex. 18, at 19-22. A wheelchair was her primary mode of locomotion, and she could wheel herself. CMS Ex. 18, at 50, 87. She was assessed as requiring a one person physical assist for locomotion

on or off the unit but as being self-sufficient once in her wheelchair. CMS Ex. 18, at 20-21, 50, 87. Resident 2 exhibited repetitive verbalizations almost daily. CMS. Ex. 18, at 31, 51, 87.

It is not disputed that on June 29, 2008, at about 8:45 p.m., a certified nursing assistant (CNA) found Resident 2 in her wheelchair with the wheelchair tied by a garbage bag to a handrail in the hall. The wheelchair was tied in such a manner that Resident 2 could not untie the garbage bag to free herself. Because the resident could not free her wheelchair and could not ambulate without the wheelchair, her freedom of movement was restricted, she was effectively restrained or confined to the location in the hall, and she was involuntarily secluded from the rest of the population and the areas of the facility to which she would normally wheel herself. It is not disputed that Resident 2 repeatedly asked the CNA to help her with her chair, and the CNA then cut the garbage bag, freeing Resident 2. The CNA asked other staff who tied Resident 2 to the handrail, and no one confessed. However, the CNA also reported that maintenance men were in the hall doing the floors, reflecting her suspicion that the maintenance men did it. CMS Ex. 18, at 101.

Petitioner's Director of Nursing (DON) interviewed another CNA by telephone on July 3, 2008, at noon, and recorded that the CNA told her she saw the resident in the hall when she went to the laundry and the resident was not tied to the railing but when she returned ten minutes later she learned that another CNA found the resident tied to the railing. CMS Ex. 18, at 102. There are no nurse's notes dated June 29 or 30, or July 1 or 2, 2008 that describe the incident or the action of staff in response to the incident. CMS Ex. 18, at 37-39. A nurse's note entered on July 3, 2008, reflects that the resident was assessed on June 29, 2008, and found to have no signs or symptoms of distress. CMS Ex. 18, at 39.

Petitioner admits that the CNA reported the matter to her supervisor, but the incident was not reported to the administrator until the evening of July 2, 2008. P. Br. at 6. The DON did not complete the investigation until July 3, 2008. The DON concluded based upon her investigation that Resident 2 suffered no injury, though she did complain that she was unable to move her wheelchair. She noted in her report that maintenance men were cleaning the floor but without any allegation that they tied the resident to the handrail. The DON also concluded that there was potential abuse. The only corrective action noted was that the evening supervisors discussed abuse guidelines with staff. CMS Ex. 18, at 96-97.

On July 3, 2008, Petitioner's Director of Social Services submitted the report to the state agency as a substantiated incident of abuse without a determination as to who tied-up the resident. The report noted that corrective actions by Petitioner included: contacting the abuse hotline; contacting the resident's daughter; notifying the resident's physician; and immediately untying the resident from the handrail. The evening supervisor RN discussed abuse guidelines with staff on the date of the incident. CMS Ex. 18, at 99-100.

During a subsequent investigation by the nurse consultant, Laura Siekert, she interviewed all staff members identified as being in the unit at the time of the incident, including the licensed practical nurse, the two men doing the floor, and five or six CNAs. No staff admitted to tying the resident's chair to the railing, and Nurse Siekert could not determine how the incident occurred. Nurse Siekert testified that Resident 2 could not have tied herself to the handrail. She opined that Resident 2 was probably tied-up only about ten minutes. Tr. at 203-10. There is no evidence that another resident was capable of tying Resident 2's wheelchair to the handrail.

Resident 3 was admitted to the facility on December 13, 2007, from a hospital where she had been admitted for generalized weakness and falls with pain in her right hip due to a fall. Her medical history included hypertension, anxiety, abnormal liver function tests due to alcohol abuse, hypercholesterolemia, noncompliance with medication and follow-up, and macular degeneration. She had a history of a right hip fracture with prosthesis and a plate and screws. She drank four to six glasses of wine a day and smoked a pack of cigarettes a day. CMS Ex. 19, at 10-12, 53. The resident was noted to be confused upon admission on December 13, 2007, possibly due to alcohol withdrawal, but with no hallucinations or delusions noted in her record. CMS Ex. 19, at 10, 12, 20.

On December 14 through 19, 2007, she was reported to be alert, responsive, and capable of making her needs known, but sometimes confused and resistive of care. CMS Ex. 19, at 20-26. A nurse's note dated December 19, 2007, at 4:00 p.m., states that Resident 3 told her visiting spouse and another family member that she was raped by a male, CNA and the husband reported the complaint to the day supervisor. The nurse's note states that the resident was experiencing confusion, and, for the first time, there is a statement that the resident was suffering delusions. The note states that attempts to redirect and reassure the resident that she was safe were not successful, and the resident did not want a male CNA in her room. The note indicates that: the family was "spoke[n] to;" pain management would continue; therapy would continue as ordered; the call bell was placed in reach; side rails were put up; and the resident's appetite was fair, when she was taken to the dining room. CMS Ex. 19, at 27. The nurse's note does not show that any action was taken to address the complaint or protect the resident. In fact, nurse's notes from December 19, 2007 through January 15, 2008, when Resident 3 was discharged from the facility, reflect no action by staff based upon the resident's complaint. CMS Ex. 19, at 27-46.

However, a nurse's note entry dated January 28, 2008, thirteen days after Resident 3's discharge, states that, on December 19, 2007, when Resident 3 alleged rape by a CNA, Resident 3's spouse told the nurse that he knew the resident's allegation was untrue. CMS Ex. 19, at 47. It is undisputed that no investigation of the incident was done, and no

report regarding the incident was made to the State. On May 5, 2008, the state agency: completed a complaint survey of Petitioner related to Resident 3;[10] and substantiated the complaint that Petitioner had failed to prevent, investigate, and report the allegation of abuse on December 19, 2007. However, the state agency did not cite a deficiency "because the facility [was] in their period of correction for deficiencies related to this allegation." P. Ex. 23, at 3. The complaint survey discovered that the January 28, 2008 nurse's note was written after a nurse consultant preparing for Petitioner's annual survey discovered the nurse's note from December 19, 2007. The complaint survey also confirmed that even after the discovery of the incident by the nurse consultant in January, no action was taken to investigate or report the incident. P. Ex. 23.

Petitioner had a policy that provided that abuse would not be tolerated and made the administrator responsible for assuring patient safety, including freedom from abuse. The policy is in evidence. CMS Ex. 25. Though not clearly stated, I read the policy to **prohibit** not only **abuse** in all its forms but also neglect, involuntary seclusion or unreasonable confinement, and misappropriation of resident property. CMS Ex. 25, at 21, 26. Petitioner's policy provided that any report to staff by a resident, family member, another staff member, or other person would be considered possible abuse if it involved, *inter alia*, unreasonable confinement, including unwanted restriction of access to all patient areas, and any complaint of sexual assault. The policy requires that staff observing or hearing of such events report the event immediately to the central abuse registry, the immediate supervisor, the center social worker, the DON, and the administrator. The supervisor is required to initiate an investigation. CMS Ex. 25, at 23, 25. The policy requires that residents be protected during the investigation and that staff suspected of abuse must be suspended immediately pending investigation. CMS Ex. 25, at 24-25.

b. Analysis

On June 29, 2008, at about 8:45 p.m., Resident 2 was found in the hall with her wheelchair tied to the handrail in such a manner that she could not free herself. Because she could not free herself and could not ambulate without her wheelchair, her freedom of movement was restricted, i.e. she was restrained.[11] There is no evidence that a physician ordered the restraint, or that it was permissible because there was an emergency that required imposition of the restraint to protect the resident or other residents. Because Resident 2 could not free her wheelchair and she could not ambulate without her

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[10] Resident 3 was designated Resident 1 in the May 2008 complaint survey. P. Ex. 22.

[11] Petitioner agrees that there was an improper restraint of Resident 2. P. Br. at 7-8.

wheelchair, she was effectively confined to the location in the hall, and she was involuntarily segregated from the remainder of the facility and residents. Petitioner concluded after its investigation that the incident constituted abuse, a conclusion with which I agree.

Although the evidence shows that the incident of abuse was reported by the CNA to her supervisor on June 29, 2008, the evidence does not show that the incident was reported by the supervisor to the abuse registry, the social worker, the DON, or the administrator. The evidence shows that no immediate investigation other than the questioning of other staff by the CNA was conducted, as the DON was first advised on July 2, 2008, and the investigation was not initiated until July 3, 2008. The evidence does not show that any action was taken to protect Resident 2 from further abuse either before or during the investigation.[12] Based upon the evidence, I conclude that there is a *prima facie* showing of a violation of 42 C.F.R. § 483.13(b) (Tag F223),[13] because Resident 2 was abused and subjected to involuntary seclusion and improper restraint by being prevented from moving freely about the locked ward in which she resided. I also conclude that there is a *prima facie* showing of a violation of 42 C.F.R. § 483.13(c)(2) and (3) (Tag F225), because Petitioner failed to ensure the alleged violation was immediately reported to the administrator and to other officials; in addition, there is no evidence that Petitioner took action to protect Resident 2 from further abuse before and during the investigation. I also conclude that there is a *prima facie* showing of a violation of 42 C.F.R. § 483.13(c), as the undisputed facts show that Petitioner's staff did not follow or apply Petitioner's policy and procedures when the CNA recognized that abuse had occurred (Tag F226).

I would not normally accept a single failure to follow a policy or procedure as sufficient to establish a *prima facie* showing under this regulation that the policy or procedure was not implemented. However, in the case of Resident 2, the evidence shows that there was a failure to follow the requirements of Petitioner's policy and procedures in multiple respects, at least until July 3, 2008. Even after the investigation was initiated on July 3, 2008, the evidence does not show that Resident 2 was protected from further abuse.

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[12] Petitioner presents no evidence to show, and makes no specific argument, that action was taken to protect Resident 2 from further abuse during the investigation and fails to even allege that it was in compliance with the requirement of 42 C.F.R. § 483.13(c)(3).

[13] There is also a violation of section 1819(c)(1)(A)(ii) of the Act, which requires that a SNF protect and promote the right of a resident to be free of physical abuse, mental abuse, physical and chemical restraints (except as ordered by a physician to treat medical symptoms or for the protection of residents), involuntary seclusion, and corporal punishment.

Furthermore, the incident in December 2007, involving Resident 3, when there was a complete failure to follow Petitioner's policy and procedures, also supports my conclusion that the policy and procedures were not actually implemented to the extent that staff complied with their provisions.

The surveyors do not allege the example of Resident 3 under Tag F223, and I make no findings or conclusions that Resident 3 was raped on December 19, 2007. The surveyors do cite the example of Resident 3 in support of the allegation that Petitioner was not in substantial compliance with 42 C.F.R. § 483.13(c)(2), (3), and (4) (Tags F225 and F226). I note that there is no requirement in law, and Petitioner cites no authority for a requirement, that a resident must actually suffer abuse or that Petitioner be charged with failure to prevent abuse to trigger the requirements of 42 C.F.R. § 483.13(c)(2), (3), and (4), or Petitioner's policy.

Indeed, the law and Petitioner's policy and procedures are consistent in that they require immediate action when there is alleged abuse. Neither the law nor Petitioner' policy and procedures give Petitioner or its staff the discretion to determine whether or not to act based upon their view of whether an allegation is true or not. The regulation requires that "all alleged violations" be immediately reported to the administrator and that they be investigated and reported. 42 C.F.R. § 483.13(c)(2), (3), and (4). Petitioner's policy is even more specific than the statute or regulations in that it requires that staff treat as possible abuse any event that fits within a list in the policy, including unreasonable confinement or restriction or any complaint of sexual assault. Petitioner's policy specifies that "[s]taff observing or hearing about [possible abuse] will report the event immediately to the central abuse registry. . . . the immediate supervisor, center social worker, Director of Nursing, or Administrator." CMS Ex. 25, at 23. I conclude that the evidence related to Resident 3 does amount to a *prima facie* showing that Petitioner violated 42 C.F.R. § 483.13(c)(2), (3), and (4) (Tag F225), because: Petitioner failed to ensure that the alleged sexual assault by a staff member was immediately reported to the administrator and to other officials; there is no evidence that Petitioner took action to protect Resident 3 from further abuse; there is no evidence that any investigation was conducted at the time the allegation was made; and there is no evidence that the results of the investigation were reported to the administrator and other officials as required by law. I also conclude that there is a *prima facie* showing of a violation of 42 C.F.R. § 483.13(c), based on the example of Resident 3, as the undisputed facts show that Petitioner's staff did not follow or apply Petitioner's policy and procedures to protect, report, and investigate.

Petitioner argues several theories in its defense, all of which are without merit.

Petitioner does not deny in the case of Resident 2 that, while the CNA reported the incident to her supervisor, there was a two to three day delay before the administrator was made aware of the incident. P. Br. at 6. Thus, Petitioner concedes the incident was not

immediately reported to the administrator and other officials in accordance with law and Petitioner's policy – all the facts necessary to conclude that Petitioner violated 42 C.F.R. § 483.13(c)(2). Petitioner argues that, when the administrator did receive the report, there was immediate action to file the incident report, staff was counseled, in-service training was conducted, and a thorough investigation was done. P. Br. at 6. Petitioner cites no authority to support a conclusion that its violation of 42 C.F.R. § 483.13(c)(2) is excusable because appropriate action may have been taken when the administrator finally received notice of the incident.

Petitioner argues that tying Resident 2's wheelchair to the handrail had the same effect as if the brake on her wheelchair had been locked. P. Br. at 6. Whether or not using a garbage bag to secure the wheelchair has the same effect as engaging the wheelchair brake is not the issue. The issue is whether or not the conduct was abuse, and either act could be abuse. Locking the brakes on the wheelchair is readily distinguished from tying the resident's wheelchair to the handrail. A wheelchair brake is a safety device that can be locked to minimize or prevent unwanted or unnecessary movement of the wheelchair. If the brake had been locked on Resident 2's wheelchair, it would not be a simple matter to determine whether the act was abuse, as locking the brake might have had a proper purpose.[14] It would be necessary to examine the reason the party locked the brake to decide whether or not the act amounted to abuse.

The situation is significantly different when a garbage bag is used to tie the wheelchair to the handrail. A garbage bag is not standard wheelchair equipment and, I infer, not a device intended to be used to prevent wheelchair movement. The resident obviously did not tie herself to the handrail, and, just as obviously, some other person did tie her to the handrail. The use of the garbage bag was clearly a willful act, not due to negligence or an accident. The willful act triggers an inference that whoever tied the chair to the handrail intended to prevent the resident from freeing herself, which is improper restraint or confinement that amounts to abuse. The garbage bag was probably used, because the perpetrator did not know the resident could not release her wheelchair brake. Petitioner presented no evidence of any lawful purpose for securing an occupied wheelchair to a handrail. Petitioner states that tying a resident's wheelchair to an object to prevent tracking in fresh wax may not be unreasonable. P. Br. at 7. To the contrary, not only is it unreasonable to treat a resident in such a manner, I conclude it is unlawful.

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[14] Nurse Siekert testified that Resident 2 was incapable of operating the brake mechanism on her wheelchair. Tr. at 239. I have no reason to doubt Nurse Siekert is correct in this regard.

Petitioner argues that, because Resident 2 was tied-up across from the nurse's station, there was no possibility that the resident would be unseen for any extended period. P. Br. 6. Petitioner points to no authority to support a proposition that abuse may be excused or that Petitioner has a defense to a charge of not preventing abuse, because the abuse only lasted for a brief period. If Petitioner intends to suggest by its argument that the risk for harm to Resident 2 was minimal due to the brief duration of the abuse, I am not persuaded. Petitioner presented no evidence in support of an argument that the brevity of a period of abuse minimizes that harm suffered by the one abused. Petitioner cited no authority that recognizes such defenses.

Petitioner acknowledges that tying the resident to the handrail was not acceptable but asserts it was not abuse. Petitioner also argues that, while the incident involving Resident 2 was treated and reported as abuse, it does not rise to that level. Petitioner's theory is that an act does not amount to abuse unless there is a harmful effect, and Resident 2 suffered no harmful effect. P. Br. at 7. Clearly, Resident 2 was intentionally tied to the handrail, though the purpose for the act is not evident. The facts show that Resident 2 was repeatedly asking for assistance (CMS Ex. 18, at 101), from which I infer that she was suffering some emotional distress due to being unable to freely move about in her wheelchair. Emotional distress is actual harm. Petitioner has not submitted any evidence that Resident 2 did not suffer harm. Thus, I conclude that Resident 2 suffered sufficient harm to satisfy the regulatory definition of abuse.

Petitioner argues that even if I find abuse did occur, its only failing was the delay in reporting to the administrator. Petitioner argues that, once the report was made, the administrator acted appropriately. P. Br. at 7. Petitioner's argument ignores its other failings, as shown by the evidence that also supports my conclusion that Petitioner was not in compliance with 42 C.F.R. § 483.13(c), including its staff's failure to comply with Petitioner's policy to report to the state, and its failure to take action to protect Resident 2 from further abuse during the investigation.

Petitioner argues that an isolated incident of abuse is not a "*per se* failure" of the facility to comply with the requirements of 42 C.F.R. § 483.13(b). Petitioner argues that the issue is not whether an act of abuse occurred but whether there was a deliberate or negligent failure by the facility to protect the resident from abuse. Petitioner argues that CMS made no showing that Petitioner either deliberately or negligently failed to protect Resident 2 from abuse. P. Br. at 7-8. Petitioner's logic is faulty.

CMS made a *prima facie* showing that Resident 2 was abused while the resident was in Petitioner's facility and in Petitioner's care. The evidence also shows that Petitioner failed to implement its policy to prevent abuse; thus no other failing by Petitioner need be shown. The totality of the evidence related to the incidents involving both Resident 2 and 3 shows that Petitioner's staff was not well-trained to either recognize potential abuse or to act appropriately to an allegation of abuse or actual abuse. I need not resolve whether

Petitioner's failings were either deliberate or negligent or whether the abuse of Residents 2 or 3 was foreseeable or not.

Petitioner argues that an investigation was informally conducted, when the incident occurred. P. Br. at 9. Petitioner apparently refers to the questioning of staff by the CNA, after she discovered Resident 2 tied to the handrail. The informal questioning of staff by the CNA (CMS Ex. 18, at 101) was not the investigation by supervisory staff required by Petitioner's policy. CMS Ex. 25, at 24. Furthermore, the inquiries by the CNA were not documented and retained as evidence of a thorough investigation as required by 42 C.F.R. § 483.13(c)(3). Petitioner asserts that there was no likelihood of any harm to Resident 2, or any other resident, but points to no evidence to support that assertion. P. Br. at 9. Petitioner presented no evidence of interventions to protect Resident 2 from further abuse during the investigation, and such interventions are specifically required by 42 C.F.R. § 483.13(c)(3).

The incident involving Resident 3 occurred more than six months prior to the incident involving Resident 2. A nurse's note dated December 19, 2007, at 4:00 p.m., states that Resident 3 told her visiting spouse and another family member that she was raped by a male CNA, and the husband reported the complaint to the day supervisor. The nurse's note states that the resident was experiencing confusion and delusions. The statement that the resident was suffering delusions is the first and only evidence in the clinical record that the resident was delusional. The note states that attempts to redirect and reassure the resident that she was safe were not successful, from which I infer that the resident was suffering some emotional distress. The note also indicates that the resident did not want a male CNA in her room, from which I infer that the resident was fearful.

The note indicates that: the family was "spoke[n] to;" pain management would continue; therapy would continue as ordered; the call bell was placed in reach; side rails were put up; and the resident's appetite was fair when she was taken to the dining room. The nurse's note, dated December 19, 2007, does not mention that the husband stated that he believed the resident's allegation was untrue. CMS Ex. 19, at 27. The nurse's note entry dated January 28, 2008, thirteen days after Resident 3's discharge and more than a month after the alleged rape, is the first statement that Resident 3's spouse told the nurse that he knew the resident's allegation was untrue. CMS Ex. 19, at 47. It is significant that the January 28, 2008 nurse's note was written after a nurse consultant preparing for Petitioner's annual survey discovered evidence of the rape allegation and the absence of appropriate action (P. Ex. 23, at 3), and it is clearly self-serving for Petitioner and not credible.

Petitioner asserts that there were further discussions with the husband and that a review of the facts, including the fact the resident was suffering hallucinations due to her mental condition, led to a determination that the allegation was not even superficially credible, and the husband withdrew the allegation. P. Br. at 11. Petitioner cites P. Ex. 19, the

deposition of Brenda Turner, as the evidence supporting its characterization of the facts. However, Ms. Turner, an employee of the state agency, testified to reviewing Resident 3's clinical record but she professed no recollection of what she found. P. Ex. 19, at 6.[15] Petitioner argues that the allegation of rape was immediately withdrawn and impossible under the circumstances. P. Br. at 11; P. Reply at 4. The evidence before me does not support Petitioner's characterization of the facts. The evidence shows that the resident was confused, not delusional or hallucinating, unless one accepts that the allegation of rape is evidence of delusions or hallucinations. The contemporaneous evidence does not show that the husband withdrew the allegation, and only the nurse's note created weeks later at the behest of a consultant preparing for Petitioner's annual survey indicates that the husband said the allegation of rape was untrue. There is no evidence that the facts related to the allegation were investigated, except to the extent that the consultant examined the clinical record and determined to take remedial action to address the potential deficiency caused by failure of Petitioner to properly respond to the alleged rape in accordance with its policy and the law.

Petitioner asserts that the rape of Resident 3 was impossible but cites no evidence to support the assertion or explain the basis for the assertion. Even if Petitioner produced some evidence to support its assertion that rape by a male CNA was impossible, for example because there were no male CNAs on duty at the time, such evidence would not rule out the possibility of rape by a male the resident confused with a CNA. But there was no investigation, no reporting, and no interventions to protect Resident 3 during the investigation. Rather, staff took no action based, according to Petitioner, upon the conclusion that the resident was delusional or hallucinating. Whether or not staff may have been correct in its conclusion that no rape occurred, the law and Petitioner's policy do not permit Petitioner or its staff the discretion to decide not to protect, investigate, and report when an allegation of abuse is made. The law requires that all allegations be investigated and reported and that the resident be protected from further abuse. 42 C.F.R. § 483.13(c); *Singing River Rehab. & Nursing Ctr.*, DAB No. 2232, at 8-9 (2009); *Cedar View Good Samaritan*, DAB No. 1897, at 11 (2003).

Petitioner asserts that the incident involving Resident 3 had been reviewed by the facility consultant as part of its own quality assurance process. P. Br. at 11; P. Reply at 4. Petitioner cites no authority, and I am aware of none, that supports an argument that Petitioner's failure to comply with 42 C.F.R. § 483.13(b) and (c) is excusable because the facility engaged in a quality assurance review.

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[15] I recognize that Petitioner may have intended to cite CMS Ex. 19 rather than P. Ex. 19. However, the pages of CMS Ex. 19 with the page numbers cited by Petitioner include only the notes of the surveyors from the July 2008 survey. Those notes are no more helpful to Petitioner than the testimony of Ms. Turner.

Petitioner argues that the prior complaint survey on May 5, 2008, found there was no deficiency related to the incident involving Resident 3. P. Br. at 11. Petitioner mischaracterizes the evidence of record. The incident involving Resident 3 occurred on December 19, 2007. The complaint survey on May 5, 2008, considered the Resident 3 incident but did not cite Petitioner for a deficiency, not because the surveyors concluded that Petitioner was in compliance with the requirements of 42 C.F.R. § 483.13(c) but due to a technicality. The documents show that the survey confirmed the complaint allegations that Petitioner failed to file a federal report, prevent abuse and neglect, and follow a plan of care. But, Petitioner was not cited for a deficiency under 42 C.F.R. § 483.13(c), because Petitioner was in its "period for correction." P. Exs. 7, 22, and 23.

Petitioner argues that a revisit survey on May 21, 2008, following Petitioner's annual recertification survey, found that Petitioner was in substantial compliance, and, therefore, Petitioner cannot be found not in substantial compliance based upon the alleged rape of Resident 3. P. Br. at 11; P. Ex. 7, at 4. The state agency notice, dated May 30, 2008, does not specifically refer to the May 5, 2008 complaint survey or violations of 42 C.F.R. § 483.13(b) and (c). P. Ex. 7, at 4-6. The incident involving Resident 2 occurred on June 29, 2008, approximately six months after the Resident 3 incident. The July and August 2008 surveys found that Petitioner was again not in compliance with the requirement to implement its policy and procedures prohibiting abuse, mistreatment, neglect, and misappropriation of resident property.

Based upon the evidence before me and the conduct of Petitioner's staff related to both incidents, I find it highly improbable that at any time during the intervening six month period Petitioner fully implemented its policy or procedures prohibiting abuse. I conclude that Petitioner was not in compliance with 42 C.F.R. § 483.13(b) and (c) from at least December 19, 2007 until it returned to substantial compliance on August 26, 2008. I note that Petitioner did not implement its policy and procedures, despite the fact that a nurse consultant discovered the incident involving Resident 3 during a record review in January 2008, while preparing for Petitioner's annual recertification survey, and despite the fact that the noncompliance was raised to Petitioner's attention again by the May 5, 2008 complaint survey when Petitioner was not cited for the deficiency due to a technicality.

Even if I accept that Petitioner was certified by the state agency to be in substantial compliance based upon the May 21, 2008 revisit, I conclude that I am not bound by that certification as it clearly was in error. The incident involving Resident 2 shows that Petitioner was not in substantial compliance with the abuse prevention requirements of the Act and 42 C.F.R. § 483.13(b) and (c) in June 2008. The allegation of rape of Resident 3, the abuse of Resident 2, and Petitioner's response to both incidents shows that Petitioner was not in substantial compliance with the law in December 2007, and there is no evidence (other than the intervening surveys) that Petitioner actually achieved compliance with 42 C.F.R. § 483.13(b) and (c) between December 2007 and August

2008. I conclude that Petitioner's argument that I cannot consider the alleged rape of Resident 3 as evidence of continuing noncompliance from December 2007 to August 26, 2008 is without merit. However, out of an abundance of caution, I limit my assessment of the reasonableness of the enforcement remedies to consideration of the example of Resident 2 and consider for purposes of assessing the remedy that the example of Resident 3 shows a history of noncompliance with the same conditions of participation.

I also conclude that Petitioner has failed to show that the determination that the violations of 42 C.F.R. § 483.13(b) and (c) posed immediate jeopardy to Petitioner's residents was clearly erroneous. I am required by regulation to uphold CMS's determination of the level of a petitioner's noncompliance, unless it is "clearly erroneous." 42 C.F.R. § 498.60. Immediate jeopardy is appropriately found when a deficiency has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident. 42 C.F.R. § 488.301. The Board has explained that a presumption exists that CMS's determination is correct, and a petitioner must rebut the presumption by showing the determination to be clearly erroneous. *Daughters of Miriam Ctr.*, DAB No. 2067 (2007); *Liberty Commons Nursing and Rehab Ctr. – Johnston*, DAB No. 2031 (2006). The Board has also held that immediate jeopardy exists under either of the following circumstances: the facility's noncompliance has caused death or "serious" harm to one or more residents; or the facility's noncompliance is or was "likely to cause" death or serious harm. *Daughters of Miriam Ctr.*, DAB No. 2067. Petitioner argues that it should not bear the burden of showing that the determination of immediate jeopardy was clearly erroneous. P. Br. at 18-19. I am persuaded by the analysis of the Board in its prior cases that the regulation establishes a presumption in favor of CMS that Petitioner must rebut by a preponderance of the evidence. Petitioner fails to meet its burden in this case.

In this case, the surveyors allege under Tag F223 that the abuse of Resident 2 was an isolated event. But, the surveyors allege under Tags F225 and F226 that the failure of staff to act appropriately to an allegation of abuse in accordance with law and Petitioner's policy was widespread. The evidence shows that Resident 2 and Resident 3 showed signs of emotional distress, and I am satisfied that their emotional distress amounted to actual harm. Petitioner cannot prove the seriousness of the emotional distress suffered by the residents as the evidence of record includes no psychiatric or psychological evaluation of either resident following the incidents. Whether or not Resident 3 suffered any significant physical injury also cannot be shown, as there was no investigation by Petitioner. The CMS determination has also not been shown to be clearly erroneous, as staffs' failure or inability to identify possible abuse or to recognize and respond appropriately to an allegation of abuse places all residents at risk for serious injury, impairment, harm, or death at the hands of an abuser who would not be identified and stopped as intended by Petitioner's policy.

Petitioner argues that, because the deficiency cited by the July 11, 2008 survey as a violation of 42 C.F.R. § 483.13(a) (Tag F221) (CMS Ex. 3, at 5) based upon the improper

restraint of Resident 2 was alleged to have resulted in actual harm to Resident 2 and not immediate jeopardy, it shows that the abuse of Resident 2 should not be cited as posing immediate jeopardy. P. Br. at 8. This argument seems logical at first blush but does not bear up on closer examination. There is nothing inconsistent with the conclusion that a single instance of improper restraint of Resident 2 did not pose immediate jeopardy, while the failure of staff to react appropriately to an incident of abuse did pose immediate jeopardy to Resident 2 and other residents. Whether or not a rapist was roaming the corridors on December 19, 2007, or whether the person who tied-up Resident 2 had a more evil intent than simply preventing the resident from tracking through the new wax, need not be decided. It is sufficient to understand that Petitioner failed to protect its residents' right to be free of abuse by ensuring that its staff was prepared and qualified to recognize possible abuse and to respond to an allegation of abuse by protecting, investigating, and reporting in compliance with 42 C.F.R. § 483.13(c) and Petitioner's policy and procedures. Petitioner has not shown that its failure was not likely to result in serious injury, harm, impairment, or death of a resident. I conclude that Petitioner has failed to show that the determination of immediate jeopardy was clearly erroneous.

5. Petitioner violated 42 C.F.R. § 483.75 (Tag F490, s/s L).

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

> A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.

42 C.F.R. § 483.75. The surveyors cite several deficiencies from the survey that ended on July 11, 2008, as the basis for the alleged violation of this regulation and the determination that it posed immediate jeopardy. CMS Ex. 3, at 141. I conclude that the violations of 42 C.F.R. § 483.13(b) and (c) are sufficient evidence that Petitioner failed to administer its facility to ensure that resources were used to attain the highest practicable well-being of its residents. The alleged rape of Resident 3 occurred in December 2007. The evidence shows that staff did not respond appropriately to protect, report, and investigate the alleged abuse in the manner required by Petitioner's policy and procedures or the regulations. The failure of staff was discovered by a consultant in January 2008, after Resident 3 had departed the facility, but the evidence does not show that the administrator took action to report and investigate as required by the law and Petitioner's policy. The complaint survey in May 2008 again unearthed the alleged rape of Resident 3, and Petitioner has not presented evidence that appropriate actions to investigate and report were taken up to that time. In June 2008, Resident 2 was abused, and the evidence shows that Petitioner's staff did not react appropriately by protecting and reporting.

Thus, I have concluded that, from December 2007 through June 2008, Petitioner failed to implement its policy and procedures to protect its residents from physical and mental abuse, corporal punishment, involuntary seclusion, improper chemical or physical restraints, neglect, and misappropriation of their property. Petitioner's obligation to protect its residents is both statutory and regulatory. Petitioner failed to meet its obligation for an extended period of more than six months. I conclude that Petitioner's failure to protect its residents on the facts of this case amounted to a failure of administration and a violation of 42 C.F.R. § 483.75. Petitioner has failed to show that the determination of immediate jeopardy was clearly erroneous under the same analysis as that for the violations of Tags F223, F225, and F226.

7. A CMP of $6,550 per day, effective June 29, 2008 through July 31, 2008, a CMP of $200 per day, effective August 1, 2008 through August 25, 2008, and a DPNA from July 31, 2008 through August 25, 2008, are reasonable enforcement remedies.

I have concluded that Petitioner violated 42 C.F.R. §§ 483.13(b) and (c) and 483.75 and that those violations posed immediate jeopardy for Petitioner's residents. I conclude that Petitioner was not in substantial compliance with program participation requirements from June 29, 2008 through August 25, 2008, and there is a basis for the imposition of enforcement remedies. Petitioner has not offered evidence that it returned to substantial compliance prior to August 26, 2008. If a facility is not in substantial compliance with program requirements, CMS has the authority to impose one or more of the enforcement remedies listed in 42 C.F.R. § 488.406, including a CMP. CMS may impose a CMP for each day that the facility is not in substantial compliance with program participation requirements. A CMP that is imposed against a facility on a per day basis will fall into one of two ranges of penalties. 42 C.F.R. §§ 488.408, 488.438. The upper range of a CMP, $3,050 per day to $10,000 per day, is reserved for deficiencies that pose immediate jeopardy. 42 C.F.R. § 488.438(a)(1)(i), (d)(2). The lower range of a CMP, $50 per day to $3,000 per day, is reserved for deficiencies that do not pose immediate jeopardy but either cause actual harm to residents, or cause no actual harm but have the potential for causing more than minimal harm. 42 C.F.R. § 488.438(a)(1)(ii). Petitioner does not dispute that the deficiencies for which Petitioner did not seek review are a sufficient basis for the imposition of a CMP of $200 per day from June 29, 2008 through August 25, 2008, and a DPNA from July 31 through August 25, 2008. The issue remaining is whether a CMP of $6,550 per day is reasonable for the period of immediate jeopardy, June 29 through July 31, 2008. I conclude it is.

When I conclude, as I have in this case, that there is a basis for the imposition of an enforcement remedy and the remedy proposed is a CMP, my authority to review the reasonableness of the CMP is limited by 42 C.F.R. § 488.438(e). The limitations are: (1) I may not set the CMP at zero or reduce it to zero; (2) I may not review the exercise of discretion by CMS in selecting to impose a CMP; and (3) I may only consider the factors

specified by 42 C.F.R. § 488.438(f) when determining the reasonableness of the CMP amount. In determining whether the amount of a CMP is reasonable, the following factors specified at 42 C.F.R. § 488.438(f) must be considered: (1) the facility's history of non-compliance, including repeated deficiencies; (2) the facility's financial condition; (3) the seriousness of the deficiencies as set forth at 42 C.F.R. § 488.404(b), the same factors CMS and/or the state were to consider when setting the CMP amount; and (4) the facility's degree of culpability, including, but not limited to, the facility's neglect, indifference, or disregard for resident care, comfort, and safety. The absence of culpability is not a mitigating factor.

The factors that CMS and the State were required to consider when setting the CMP amount and that I am required to consider when assessing the reasonableness of the amount are set forth in 42 C.F.R. § 488.404(b): (1) whether the deficiencies caused no actual harm but had the potential for minimal harm, no actual harm with the potential for more than minimal harm, but not immediate jeopardy, actual harm that is not immediate jeopardy, or immediate jeopardy to resident health and safety; and (2) whether the deficiencies are isolated, constitute a pattern, or are widespread. My review of the reasonableness of the CMP is *de novo* and based upon the evidence in the record before me. I am not bound to defer to the CMS determination of the reasonable amount of the CMP to impose but my authority is limited by regulation as already explained. I am to determine whether the amount of any CMP proposed is within reasonable bounds, considering the purpose of the Act and regulations. *Emerald Oaks*, DAB No. 1800, at 10 (2001); *CarePlex of Silver Spring*, DAB No. 1683, at 14–17 (1999); *Capitol Hill Cmty. Rehab. and Specialty Care Ctr.*, DAB No. 1629 (1997).

I treat the alleged rape of Resident 3 as evidence of Petitioner's history of noncompliance with 42 C.F.R. § 483.13(c), for reasons already discussed. Petitioner has not alleged an inability to pay the CMP that CMS proposed in this case and has not presented evidence of its financial condition. I consider that Petitioner's failure to implement it policies and procedures to protect and preserve its residents' right to be free from abuse is an extremely serious deficiency. The deficiency is made even more serious by the fact that Petitioner failed to act during a period of more than six months to ensure its policy and procedures were properly implemented, despite several events that should have alerted Petitioner to its failure. The evidence does not show that Petitioner intentionally failed to implement its policy and procedures, and, therefore, I conclude that it negligently failed to do so. Thus, I consider Petitioner highly culpable. Termination of Petitioner's provider agreement would have been justified on the facts of this case, but CMS did not elect to impose that remedy. Accordingly, I conclude that a CMP of $6,550, for the period June 29, 2008 through July 31, 2008, is a reasonable enforcement remedy to encourage Petitioner to remain in substantial compliance. I also conclude that the undisputed remedies, a CMP of $200 per day from August 1 through 25, 2008 and a DPNA effective from July 31 through August 25, 2008, are reasonable enforcement remedies.

8. The allocation of the burden of persuasion does not affect the decision in this case.

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 *et. seq.*, specifically 5 U.S.C. § 556(d). P. Br. at 4, 18-20. Pursuant to the scheme for the allocation of burdens that the Board adopted 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. 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 that the Board suggested 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. However, the evidence is not in equipoise in this case, and the allocation of the burden of persuasion has no impact upon my decision.

III. Conclusion

For the foregoing reasons, I conclude that Petitioner was not in substantial compliance with program participation requirements from June 29, 2008 through August 25, 2008. Reasonable enforcement remedies are a CMP of $6,550 per day from June 29, 2008 through July 31, 2008, and $200 per day from August 1, 2008 through August 25, 2008, and a DPNA from July 31, 2008 through August 25, 2008.

/s/
Keith W. Sickendick
Administrative Law Judge