Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Appellate Division

In the Case of:	DATE: May 1, 2009
Columbus Nursing & Rehabilitation Center,	
Petitioner,	Civil Remedies CR1849 App. Div. Docket No. A-09-26
	Decision No. 2247
- v. -	
Centers for Medicare & Medicaid Services.	

FINAL DECISION ON REVIEW OF ADMINISTRATIVE LAW JUDGE DECISION

On December 5, 2008, Columbus Nursing & Rehabilitation Center (Columbus) appealed the September 29, 2008 decision of Administrative Law Judge (ALJ) Jose A. Anglada that concluded that Columbus failed to comply substantially with federal regulatory requirements for long-term care facilities and imposed remedies including two per-instance civil money penalties (CMPs) of $4,150 each and a prohibition on conducting nurse aid training and competency programs (NATCEP). Columbus Nursing & Rehabilitation Center, DAB CR1849 (2008) (ALJ Decision). The incident at issue involved a completely dependent resident found to have a vaginal tear and bleeding in her diaper after a lunch visit from her husband. The ALJ concluded that Columbus was out of substantial compliance with requirements for thoroughly investigating and immediately reporting alleged abuse and protecting residents from the risk of further abuse as set out in 42 C.F.R. § 483.13(c)(2)-(4). In addition, the ALJ concluded that the facility failed to implement its own policy on handling incidents involving possible abuse in violation of requirements at 42 C.F.R. § 483.13(c). The ALJ also concluded that CMS's

immediate jeopardy determination was not clearly erroneous and that the CMPs imposed by CMS were reasonable in amount.

Columbus argues that its investigation was thorough enough to reasonably conclude that the resident's injury was unlikely to be caused by staff abuse, that it protected the resident during the investigation, and that state law did not require the facility to report the incident because no staff persons were implicated.

For reasons explained below, we conclude that Columbus misunderstands its obligations under the applicable regulations. We further conclude that substantial evidence supports the ALJ's findings of noncompliance with both regulatory requirements. We find no error in the ALJ's determination that the amounts of the CMPs were reasonable.

We therefore affirm the ALJ Decision in its entirety.

Case Background[1]

The procedural history of this matter is as follows. On October 4, 2006, the Wisconsin Department of Health and Family Services (State agency) completed a complaint survey of Columbus (complaint survey), which is located in Columbus, Wisconsin. A statement of deficiencies (SOD) set out the allegations on which two findings of noncompliance were based, both relating to the handling of allegations of abuse or neglect or injuries of unknown origin. CMS Ex. 1. The State agency notified Columbus that the two noncompliance findings both rose to the level of immediate jeopardy which began on August 20, 2006 and was removed on September 20, 2006, and that both constituted substandard quality of care. CMS Ex. 2. The State also found continuing noncompliance of a lower scope and severity, and recommended as remedies a discretionary denial of payment for new admissions (DPNA) and two per-instance CMPs of $4,150 each. On October 16, 2006, CMS notified Columbus that it was immediately imposing the two per-instance CMPs and prohibiting Columbus from conducting a NATCEP program based on the State agency's findings and recommendations. CMS Ex. 3.

On November 21, 2006, the State agency completed a revisit survey of Columbus (revisit survey) and found that the facility had

[1] 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.

achieved substantial compliance as of October 27, 2006 and rescinded the DPNA. CMS Ex. 6. CMS issued a letter on December 13, 2006 which summarized its final disposition of remedies resulting from this survey cycle, in which the DPNA was rescinded and the CMPs were confirmed for a total amount of $8,300. CMS Ex. 8.

Columbus first appealed the results of the complaint survey leading to the remedies mentioned above on December 8, 2006. CMS Ex. 7. Columbus then filed a second hearing request on February 8, 2007 in response to CMS's December 13, 2006 notice. CMS Ex. 9. Without objection, the ALJ consolidated Columbus's two appeals under the single docket number on appeal here. Consolidation Order, Docket Nos. C-07-138 and C-07-252 (March 1, 2007). The ALJ held an in-person hearing on May 20-21, 2008.

The ALJ's two findings that Columbus was not in substantial compliance with the regulations arose from events involving a single resident (Resident 1) who was totally dependent on staff for all care. The essential facts of the incident itself are undisputed while the dispute rests on the adequacy of the facility's actions in response to the incident.

Resident 1 could not communicate, was severely mentally impaired and had severe muscle contractions of all her limbs. ALJ Decision at 6, and record citations therein. Shortly before the noon lunch on August 20, 2006, two certified nursing assistants (CNAs) performed incontinence care for Resident 1 and noticed no sign of injury to her vaginal area. Id. Resident 1's husband and guardian regularly visited at lunchtime and fed the resident. Id. On this occasion, he fed her in her room and left at about 1:30 PM. Id. At or before 2 PM, the same two CNAs returned and again cleaned Resident 1. Id. The CNAs observed blood in the resident's adult diaper and, when summoned, the nurse on duty discovered a two centimeter laceration on her labia. Id. at 7. The nurse noted that a large amount of blood was present and still oozing from the wound and that the resident was "agitated and making crying sounds." Id. Neither of the CNAs testified at the hearing, nor did the nurse.

The ALJ reviewed all of the contemporaneous documentation, including a nurse's note recorded at 2 PM on August 20, 2006, brief written statements made by the CNAs during the investigation of the injury, and social service progress notes relating to the investigation. Id. at 7-12. He also observed that written records of interviews with all staff working during the 24 hours before and during the incident could not be located and that no comprehensive report of the investigation or record

of its results was prepared. Id. at 14, n.13.

CMS argued below that the investigation was not thorough for several reasons, including that no physical evidence (such as the bedclothes or bloody diaper) was preserved, no call was made for assistance from the police or the Sexual Abuse Nurse Examiner program, no record was retained of interviews with staff on duty other than the two CNAs who made the discovery, no final report of the investigation could be located, and the facility did not rule out that abuse by either the husband or, conceivably some other person, may have caused the injury.

The ALJ concluded that the record established that the facility did not thoroughly investigate the injury, particularly because it did not fully explore the possibility of sexual abuse by the husband, despite the fact that both the nurse who examined the resident and the social worker involved in the investigation were "extremely suspicious" of his role. ALJ Decision at 16. Instead, the ALJ found, Columbus's administrator ended the investigation without "fully informing himself of the facts." Id. Specifically, the ALJ observed that the administrator accepted the insertion of a catheter as a possible cause of the injury without realizing that the insertion occurred nine days prior to the observation of the fresh wound. Id. Further, the administrator relied on the report of Resident 1's roommate that nothing untoward had happened in their shared room, despite evidence (credited by the ALJ) that the roommate was an unreliable witness who had a legal guardian and suffered from memory deficits and impaired decision-making. Id. at 7, n.6, and 16. The facility failed to call in the police or other outside assistance and did not adequately document its investigation, the ALJ also found. Id. at 14-16.

The ALJ further found that Columbus failed to take appropriate measures to protect Resident 1, and other residents, until the possibility of abuse was resolved. Id. at 16-17. The ALJ concluded that Columbus's failure to report the incident to the state agency violated regulatory reporting requirements. Id. at 17-18. The ALJ concluded that these events demonstrated that Columbus had failed to implement written policies and procedures to prohibit abuse of residents. Id. at 18-19.

Finally, the ALJ concluded that CMS's determination of immediate jeopardy was not clearly erroneous and that the amounts of the remedies imposed were reasonable under the circumstances.

Applicable legal authority

Federal law and regulations provide for surveys by state survey agencies to evaluate the compliance of long-term care facilities with the requirements for participation in the Medicare and Medicaid programs and for CMS to impose remedies when a facility is found not to comply substantially. Sections 1819 and 1919 of the Act; 42 C.F.R. Parts 483, 488, and 498.[2]

"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. "Immediate jeopardy" means a "situation in which the provider's noncompliance . . . has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident." Id.

CMS may impose a CMP when a facility is not in substantial compliance. 42 C.F.R. §§ 488.404, 488.406, and 488.408. A CMP of between $1,000 and $10,000 may be imposed for each instance of noncompliance. 42 C.F.R. § 488.438(a)(2).

Section 483.13(c), under which both deficiencies were cited, reads in relevant part as follows:

> (c) Staff treatment of residents. The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.
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> * * *
>
> (2) The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source . . . are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).
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> (3) The facility must have evidence that all alleged

[2] The current version of the Social Security Act (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.

> violations are thoroughly investigated, and must prevent further abuse while the investigation is in progress.
> (4) The results of all investigations must be reported to the administrator . . . and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.

Surveyors use a system of tag numbers to identify deficiencies under particular regulatory requirements in preparing the SOD. See ALJ Decision at 2, n.2, for an explanation of this system. Here, surveyors cited noncompliance under Tag F 225 for failure to thoroughly investigate and properly report the injury and to protect the residents in the meantime in violation of 42 C.F.R. § 483.13(c)(2)-(4) and noncompliance under Tag F 226 for failure to develop and implement written anti-abuse policies in violation of 42 C.F.R. § 483.13(c).

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 F.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

Columbus argues that any obligation to investigate and report allegations of abuse arises only when staff members are credibly implicated, and that it should not be held to any higher standards voluntarily adopted in its internal policies. Columbus Request for Review Br. (RR Br.) at 7-8, 11. Columbus takes the position that it exceeded its obligations by nevertheless conducting a thorough investigation "as far as was necessary to determine that there was a plausible explanation for the resident's injuries that did not include abuse," which Columbus characterized as being "as far as a thorough investigation need

go." Id. at 20. Columbus contends that no authority requires it to preserve the scene or conduct a "`CSI'" level investigation." Id. at 26.

Columbus also argues that it was required to protect the resident from further abuse only during the pendency of its investigation and that it fulfilled that requirement by restricting the husband's visits to public areas during the eight days "until the administrator had determined that there was insufficient evidence to conclude that abuse had occurred." Id. at 29. According to Columbus, it could not interfere further with visits by the resident's husband, who was also her guardian, without risking a violation of regulatory requirements for access by family members and for personal privacy for family meetings. Id., citing 42 C.F.R. § 483.10(e) and (j)(1).

Columbus further argues that it was not required to report the injury to the state agency because Wisconsin State law did not mandate reporting incidents which did not implicate staff. RR Br. at 32-33. In this regard, Columbus asserts that the ALJ committed prejudicial error by taking judicial notice of certain documents submitted with CMS's posthearing reply brief. RR Br. at 36-39.

Columbus denies that it failed to implement its anti-abuse policies and procedures on the grounds that (1) Columbus was in fact in compliance and (2) a "failure to comply with one more elements of its internal anti-abuse policy" in regard to single event cannot suffice to show lack of implementation.

In addition, Columbus challenges the immediate jeopardy determination as clearly erroneous and the amounts of the per-instance CMPs as unreasonable.

Analysis

1. We uphold the ALJ's conclusion that Columbus was not in substantial compliance with regulatory requirements cited under Tag F 225.

A. The ALJ's finding that Resident 1's injury was not thoroughly investigated is supported by substantial evidence.

i. The duty to investigate does not end upon finding a plausible alternative explanation to staff abuse.

Columbus's arguments throughout its request for review are

informed by an erroneous understanding of the facility's regulatory responsibilities. Columbus views its obligations as limited to investigating and reporting allegations of abuse when staff members are credibly implicated. RR Br. at 7-8. Relying on prior ALJ decisions, Columbus questions whether facilities have any further obligations to investigate or report an incident once they decide that facility staff is not implicated.[3] Columbus asks the Board to "address and identify just what the further investigation and reporting requirements are when a facility rules out staff abuse, but suspects that abuse may have been committed by non-staff." Columbus Reply Br. at 9. Columbus takes the position that it actually exceeded its obligations by nevertheless conducting a thorough investigation "as far as was necessary to determine that there was a plausible explanation for the resident's injuries that did not include abuse," which Columbus characterized as being "as far as a thorough investigation need go." RR Br. at 20.

Columbus argues that, because Resident 1's injury could have occurred during peri-care "and gone undetected for a period of time," an explanation other than abuse was plausible. RR Br. at 14. Columbus describes its investigation as beginning upon notice to the administrator, and including written statements by the two CNAs involved in the resident's care and interviews with the "staff working in the area that day" and with the resident's roommate. RR Br. at 17-18. According to Columbus, the fact that the resident's husband and roommate were in her room between noon and 1:30 PM "precluded any reasonable possibility that sexual assault by a staff member or visitor to the facility" took place. RR Br. at 18. Columbus asserts that its investigation resulted in a decision that, due to the resident's severe contractures, the "more logical" explanation for the injury was inadvertent

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[3] Throughout its request for review, Columbus cites, discusses at length, and quotes extensively from multiple decisions by ALJs in other cases. We note that ALJ decisions are not precedential and are relevant to a Board analysis only for the inherent value of any persuasive analysis therein. Singing River, DAB No. 2232, at 11 n.7. The cases cited involve different factual scenarios than that presented here, do not in a number of instances support the propositions for which Columbus relies upon them, and, to the extent that any comments made in them might be read to be inconsistent with our decision here, we have not found them persuasive. We do not, therefore, discuss or distinguish in any detail the individual ALJ decisions mentioned by Columbus.

injury during care rather than abuse, with "no probability" of caregiver abuse. RR Br. at 21.[4]

Based on the plain language of the regulations as a whole, the Board has long held (and recently reaffirmed) 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).'" Singing River Rehabilitation & Nursing Center, DAB No. 2232, at 7 (2009). Columbus bases its position in part on its interpretation of the term "violations" as used in section 483.13, i.e., that a facility must "ensure that all alleged violations involving . . . abuse" are reported immediately, and must "have evidence that all alleged violations are thoroughly investigated . . . ." 42 C.F.R. § 483.13(c)(2) and (3) (emphasis added). Columbus's theory is that the "violations" referred to are only those arising under section 483.13(c)(1), which states that the facility must "[n]ot use . . . physical abuse . . . ," and must take measures to avoid employing and to report to the state agency individuals with a

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[4] Columbus also claims that a surveyor conceded on cross-examination that no further investigation was required if Columbus "was able to come to a reasonable conclusion that no caregiver was involved." RR Br. at 18, citing Tr. at 59. The cited colloquy does not support Columbus's contention:

> Q. . . . If they believed that they had enough information . . . to conclude that no other caregiver was involved, they could have moved on, correct, to the next possible hypothesis?
> A. . . . Correct.
> Q. So given the - you don't believe that given the window of time that was available for this injury to occur, that they could reasonably conclude that it was more likely than not that this did not happen from a caregiver?
> A. There's no - they have shown me no evidence that they reached that conclusion because they didn't do the investigation. I don't know how they got to that conclusion, if indeed they did.

Tr. at 59. The surveyor merely agreed that, if staff abuse were eliminated (which it was not here), the investigation could move on to the "next possible hypothesis," not that the investigation should halt at that point.

history of substantiated abuse. RR Br. at 8. Therefore, Columbus reasons, the only violations requiring reporting and investigating are those committed by facility staff.

In context, however, the regulatory reference to "alleged violations" cannot reasonably be read to be limited only to violations of the prohibitions in section 483.13(c)(1) that apply to actions of facility staff. As relevant here, section 483.13(b) establishes the right of all residents to "be free from verbal, sexual, physical, and mental abuse . . . ." This goal would be meaningless if the regulation is not read as imposing on the facility a duty to take action, in the form of reporting, investigating, preventing risks of further abuse, and taking appropriate corrective actions under section 483.13(c) whenever an allegation or an injury of unknown origin raises the possibility that the resident's right may have been violated.

Columbus acknowledges that facilities have been held responsible for failing to prevent abuse by non-staff, such as other residents, under section 483.13, but contends that "those cases would have been more properly addressed under 42 C.F.R. § 483.25(h)(2)(Accidents)." RR Br. at 8, n.8. Columbus thus argues that treating potential abuse by anyone other than staff as subject to the requirements for investigation, protection and reporting is unnecessary because the provisions of section 483.25(h)(2) against accidents are sufficient to protect residents from future harm in such situations.

We disagree. First, the relevant provisions of 483.13 are not limited to abuse by facility staff, as discussed below. Second, the anti-accident provision does not serve the same purpose, even though some incidents may trigger responsibilities under both. Section 483.25(h)(2) requires facilities to ensure that each resident "receives adequate supervision and assistance devices to prevent accidents." The Board has held that this requirement is breached where a facility fails to take action to prevent foreseeable aggressive conduct by mentally impaired residents that impacts other residents. Woodstock Care Center, DAB No. 1726 (2000), aff'd, Woodstock Care Ctr. v. Thompson, 363 F.3d 583 (6th Cir. 2003). The focus of section 483.13(c)(2)-(4), on the other hand, is on how the facility responds when it appears that one of its residents may have been abused, not on whether the incident raising concern was reasonably foreseeable or whether the conduct was unintended from the point of view of the caregivers. While the Board has held that harmful behavior by a resident may be the source of a foreseeable accident risk for other residents, the Board has never held that abuse by non-staff members may be cited only under section 483.25(h)(2).

In any case, the plain language of section 483.13(c)(2)-(4) governs regardless of whether Columbus considers it unnecessary. Columbus had sufficient reason to know that its responsibilities in preventing and responding to abuse of its residents extended beyond abuse by its own staff, and that all injuries of unknown origin required further investigation.

Columbus also suggests that a Board case cited by CMS actually supports its position that no report was required of non-staff abuse in Wisconsin. Columbus RR Br. at 33, citing Britthaven, Inc., d/b/a Britthaven of Smithfield, DAB No. 2008 (2006). In Britthaven, the Board addressed a facility's claim that no report was required where the facility did not find allegations of staff abuse to be supported. The Board rejected that claim, as it had earlier in Cedar View Good Samaritan, DAB No. 1897, at 11 (2003), and held that any allegation implicating staff must be reported regardless of whether it is substantiated because federal law gives state agencies and facilities "concurrent responsibility for investigating allegations of abuse by staff." Section 1819(g)(1)(C) of the Act; 56 Fed. Reg. 48843-48844 (Sept. 26, 1991) ("Once a facility's preliminary investigation implicates staff, the facility is responsible for notifying the State survey and certification agency."). Neither Cedar View nor the regulatory preamble state that facilities need not report allegations of abuse of facility residents by non-staff perpetrators to the state agency. As the Board explained in Singing River, regulations require that state agencies "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. Singing River, at 12, quoting 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 for allegations that implicate staff is that then "the State must investigate the allegation" itself. 42 C.F.R. § 483.335(a)(2). Furthermore, as noted already, Columbus was dealing with an injury of unknown origin, which would require investigation and reporting even had there not been indications of sexual abuse.

ii. Columbus's investigation also fell short of the requirements of its own policy.

Columbus further contends that no authority requires it to preserve the scene or conduct a "`CSI'" level investigation." RR Br. at 26. We need not decide whether the facility had to take every measure suggested by the surveyors to preserve the scene in order to find that Columbus failed to take appropriate measures under any reasonable standard, including the requirements of its own policy on abuse.

Columbus's parent company's policy on investigating and reporting abuse requires that all injuries of unknown origin be reported to the facility administrator who is to initiate an immediate investigation. CMS Ex. 26, at 574-575.[5] The administrator or designated investigator is instructed to interview the resident (if possible), the involved staff members, and "persons named as having further information regarding the alleged incident," and to obtain written statements from them "in order to complete a thorough investigation." Id. at 576. The policy further specifies that the investigator "shall also collect any physical evidence that is relevant to the incident" and that "each step, as well as the results, must be documented during the investigation." Id.

Yet, the facility made no effort at all to preserve any physical evidence. The facility suggests that calling the Sexual Assault Nurse Examiner (SANE) Program for a full rape kit and examination might have been traumatic and that treating the injury was more important than freezing the scene for police investigation. RR Br. at 26. These after-the-fact explanations do not address why the staff did not retain the bloodied diaper or the resident's bedclothes as obviously relevant physical evidence. To have collected such evidence would have been consistent with the facility policy without risking further trauma or delaying treatment.

Columbus also justifies not calling for an examination by a SANE Program abuse specialist on the grounds that the resident's own

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[5] The policy is titled Policy E-22, "Investigation and Reporting of an Allegation of Misconduct (defined as Abuse, Neglect, or Misappropriation of a Client's Property) and Injuries of Unknown Origin," and is issued by Heyde Health System, Inc., as part of a Human Resources Policy Manual, with the most recent version date of July 7, 2005. Columbus does not dispute that this policy was applicable at all relevant times.

physician was qualified to "detect trauma associated with abuse." RR Br. at 27, n.13. The record does not show, however, that the resident's physician performed an examination to detect such trauma. Instead, the physician entered a progress note three days after the incident in which he noted the nurse's report of the laceration and bleeding. CMS Ex. 12, at 20. The physician reports that he spoke with the Director of Nursing, learned that an abuse investigation was underway, and opined that, until it was completed, restricting the husband to lobby visits was "an appropriate action to take." Id.

> iii. The requirement to report the results of investigations within five days does not imply that no investigatory steps need be taken if they might take more than five days for final resolution.

Columbus further argues that the regulations could not have intended any such measures because section 483.13(c)(4) -

> requires the "results" of investigations to be reported to the required officials "within 5 working days." The idea that this regulation contemplates the packing up of a "crime scene," sending it off to have DNA, fiber, hair and fingerprint analysis performed, all possible perpetrators tested, and the results of all these tests returned to the facility so that the "results" could be reported "within 5 working days" is preposterous.

RR Br. at 27.

Columbus misreads the regulation to mean that all investigations must be entirely completed within five working days, and then extrapolates that the sorts of investigative steps undertaken must be limited to those likely to yield results that quickly. See RR Br. at 31. The regulation does require that a report be made of the results that have been generated by the facility investigation within five days. This timely report provides the state agency with a prompt opportunity to intervene, if necessary. As explained in Singing River, state agencies have an independent obligation to investigate allegations of staff abuse and a responsibility to decide whether to undertake a complaint investigation in response to other possible abuse or misconduct. Singing River, DAB No. 2232 at 12-13; see also section 1819(g)(1)(C) of the Act; 42 C.F.R. § 488.335. It does not follow that the facility should not undertake any appropriate investigatory steps merely because they may not yield final results until after five days.

iv. Columbus did not adequately document what information was obtained during the investigation or what conclusions were reached.

Further, the facility's investigation was largely undocumented contrary to its policy cited above. As the ALJ pointed out, no written records could be located of interviews that supposedly were taken of all staff working around the time of the incident, nor was any comprehensive report of the results of the investigation prepared. ALJ Decision at 14, and n.13, and record citations therein. The administrator did not document the basis of his decision to end the investigation without resolving how the injury happened. The evidence supports the ALJ's finding that the administrator's explanation at the hearing of his reasoning depended on his ignorance of important facts, such as not knowing about resident's roommate's questionable ability to remember and report events reliably or that the catheterization was performed nine days earlier and was unlikely to have caused this fresh bleeding. ALJ Decision at 16.

Columbus argues that its policy did not require creation of written statements for incidents that did not involve a report to the state agency. RR at 41-42. Since Columbus did not report this incident because, according to Columbus, it quickly ruled out caregiver abuse, no written incident statements were required under the policy. Id. We explain below why a report to the state agency was required without regard to whether Columbus believed it had ruled out caregiver abuse. We note here that Columbus's argument does not accurately portray its own policy. That policy expressly requires that, in the case of "non-reportable" incidents, the investigator (or administrator) must "document the decision-making process and maintain it in a file along with the "investigation documentation." CMS Ex. 26, at 575.[6] Columbus produced no such documentation and hence provided

[6] Columbus also attached to its policy a state form which was to be used to document investigations of injuries of unknown origin. CMS Ex. 27, at 582-84. The form calls for attaching "written, signed, and dated statements" from staff members interviewed, as well as family or visitors. It also requires conclusions about the probable cause of the injury, or the inability to determine the cause, signed by the charge nurse and director of nursing, with signatures from the administrator and medical director that indicated that they each reviewed the report and determined that further action is or is not indicated. Id. Despite this, as discussed in the text, Columbus proffered no written report evidencing how the investigation was concluded

(Continued . . .)

no support for the claim that it, in fact, had ruled out the possibility of staff abuse. Even if the facility had ruled out the possibility of staff abuse, moreover, it could not reasonably have ruled out abuse by the husband based merely on his claim of innocence, particularly in light of other documented incidents of the husband's behaviors.

Columbus also argues that its administrator and the staff person delegated to do the investigation did not actually have a consistent practice of taking and preserving interview notes, so their absence is "hardly surprising." Columbus Reply Br. at 4. This argument merely admits without justifying the administrator and staff's failure to follow the facility policy to gather written statements and prepare documentation of each step of the investigation. The resulting absence of contemporaneous documentation of what investigation was performed and with what results supports the ALJ's conclusion that Columbus did not demonstrate that a thorough investigation was conducted.[7]

Columbus also argues that the regulations do not expressly lay out what steps must be taken in an investigation and that it should not be held to any higher standards voluntarily adopted in its internal policies. RR Br. at 11. The Board has explained previously that the current regulations governing long-term care facilities are based on an outcome-oriented approach. Lake Mary Healthcare, DAB No. 2081, at 17 (2007) and authorities cited therein. The essence of this approach is that the regulations establish the outcomes which facilities must achieve but provide each facility with flexibility to select methods to achieve them that are appropriate to its own circumstances and needs. A facility's policy generally reflects the methods it has chosen to accomplish the outcomes contemplated under the regulations.

A facility might in theory be able to show that, even though it deviated from its own policies in a particular situation, it nevertheless took other measures sufficient to achieve the

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(Continued . . .)
or whether further action was determined not to be indicated.

[7] Columbus also points to the existence of some documentation, such as CNA statements and nursing notes (Columbus Reply Br. at 6-7) as sufficient to document the investigation. See CMS Ex. 12. The ALJ reasonably considered those scattered notes inadequate to establish that whatever investigation was done was thorough under the circumstances.

regulatory requirements. Columbus has not, however, made any such showing here. The evidence shows both that Columbus fell short of its own policies for dealing with suspected abuse and injuries of unknown origin and that Columbus did not substitute other adequate methods.

For all the reasons discussed above, we find substantial evidence in the record in support of the ALJ's finding that the investigation was not thorough, as required by the regulations.

B. The ALJ's finding that Columbus failed to take adequate protective measures is supported by substantial evidence.

Columbus argues that the evidence shows it acted reasonably to protect Resident 1 and other residents because of the "fact that there were no similar injuries to R1 or any other resident." Columbus Reply Br. at 13. Further, Columbus contends that the "regulations only require the facility to take steps to protect the resident from further abuse during its investigation." RR Br. at 29 (emphasis in original). Since the facility restricted the husband's access to Resident 1 until the administrator terminated the investigation, in Columbus's view, the facility had done all that was required. Id.

Furthermore, according to Columbus, the facility could not further restrict the husband without affirmative proof in light of the resident's rights to access by family members and to privacy in meeting with family. Id., citing 42 C.F.R. § 483.10(e) and (j)(1). In addition, Columbus cites regulations providing that a guardian recognized under state law (as was Resident 1's husband) may exercise the resident's rights to the extent provided by state law. Id. at 31, citing 42 C.F.R. § 483.10(a)(3)-(4).

The fact that no "similar injuries" were noted does not in itself establish that sufficient protections were in place to prevent abuse of this or other residents. Other possible explanations for the absence of such injury findings would include the abuser refraining from repeating the actions, abuse occurring but not causing similar injuries, injuries occurring that were not detected, and so on. The relevant questions instead are what protections were undertaken and whether they were reasonably calculated to "prevent further potential abuse." 42 C.F.R. § 483.13(c)(3).

The only protective measure taken, i.e., restricting Resident 1's husband to visiting in public areas, was removed by the administrator after eight days. CMS has not argued that this

restriction was not a reasonable measure to have adopted in response to the injury, but instead that termination of the restriction was premature in the absence of a thorough investigation. The ALJ concluded that Columbus's failure to thoroughly investigate meant that Columbus "should not have dropped those restrictions." ALJ Decision at 17. We agree that the information gathered by Columbus was insufficient to justify ending the protective measure.

Columbus's arguments downplay the possibility that the husband sexually abused Resident 1 and emphasize the husband's role as family member and guardian of Resident 1. It is not disputed that the husband had access to the resident in her room during the period between peri-care cleanings (the first showing no injury and the second showing fresh bleeding). Columbus states that the presence of the resident's roommate who later reported nothing unusual indicated that abuse was unlikely. RR Br. at 24. The record contains evidence, however, that the roommate had significant cognitive and memory problems and was under guardianship so her report may not have been reliable. Tr. at 89-90. Further, the record reflects that the resident had privacy curtains that could be closed around her bed. Tr. at 120.

Columbus also points to the resident's severely contracted limbs as making it more likely that an injury during peri-care might go unnoticed at the time and less likely that sexual activity could have occurred.[8] RR Br. at 24-25. Columbus cites for this proposition only a police report (dated September 26, 2006) prepared after the survey when Columbus finally reported the incident which had occurred more than a month before. Id., citing CMS Ex. 19, at 2. The officer merely records that the "nursing staff" told him that peri-care is difficult "since her

[8] There is other evidence in the record which tends to undercut the likelihood of this alternative, in that caregivers customarily wear gloves during peri-care that would minimize the chances of inadvertent scratches. Tr. at 66, 81. Furthermore, Columbus's suggestion that the injury occurred while its staff was providing care to the resident, either during peri-care or during the catheterization, itself presents additional concerns. If Columbus, in fact, believed that the resident was injured during care, Columbus should have investigated how this occurred and considered corrective measures to prevent recurrence, such as training its CNAs in caring safely for residents with contractures. Yet, Columbus points to no evidence that it took such measures.

legs are hard to separate" and she "does resist being cleaned." CMS Ex. 19, at 2. The officer also notes that staff told him that it would not be possible for the resident to have scratched herself or for someone to "reach into her pants and scratch her where she was scratched" if she "was sitting in a wheelchair." Id. She was also told that the facility "had looked into the matter and that there was no one else in the room who could possibly have caused the injury" besides the husband, and that the husband's behavior with the resident was "appropriate" although he was intimidating to the staff, but not "physical." Id. The officer does not indicate any independent evaluation of any of these assertions and, by the time she talked to the nursing staff, the facility was well aware of the surveyor's concerns.

Columbus's administrator testified that he did initially treat the incident as possible abuse and that he imposed the restrictions on visitation to protect the resident from her husband. Tr. at 153-54. He based his suspicions on the husband's presence at the relevant time and possibly on his awareness "that there had been previous restrictions on this gentleman." Tr. at 154; see also Tr. at 29. In fact, the record indicates that this episode was far from the first episode of inappropriate behavior on the part of the resident's husband. A county social worker interviewed by the surveyor reported that the husband had "a long history of inappropriate incidents" and that she had believed that restrictions on visitation were "still in place." Tr. at 91. Columbus had previously sought a restraining order unsuccessfully after an incident in 2003 where his rough handling of the resident was suspected of causing a leg fracture. CMS Ex. 16. Columbus adopted a safety plan for the resident in 2003 that included visit restrictions, and Columbus has not submitted any evidence of when or why the restrictions were lifted. CMS Ex. 17, at 1-2. In 2001, Resident 1's husband forcibly broke into the facility at 1 AM and was then limited to visiting between 8 AM and 8 PM. CMS Ex. 17, at 3. The county social worker also informed the surveyor of incidents in which the husband threw a fork at the resident, called her names, and took pictures of her "down her shirt." Tr. at 92.

In short, we agree with the ALJ that Columbus had good reason for concern that sexual abuse by the husband caused the injury. The facility clearly determined initially that the concern was significant enough to restrict the husband's access. We also agree that Columbus's investigation was not thorough enough to support a reasonable conclusion that abuse by the husband was not involved. For that reason, we, like the ALJ, are not persuaded that Columbus was not required to extend its protective measures

beyond eight days. See ALJ Decision at 17. In any event, the protection to be provided during the investigation is an interim requirement while a thorough investigation is completed. Once the investigation is completed, the facility must also take "appropriate corrective action" if an "alleged violation is verified." 42 C.F.R. § 483.13(c)(4). Since, as we have found, the investigation was inadequate to determine that no "violation" of the resident's right to be free from abuse occurred, protective measures should have remained in place until either abuse was ruled out or corrective action was taken. Columbus has not shown that it could reasonably remove that protective measure after eight days without exposing the resident to further danger.

We are not persuaded that the facility's obligation to protect the resident was negated by the regulatory requirements for family access and privacy, or by the husband's status as guardian. 42 C.F.R. § 483.10(e) and (j)(1); 42 C.F.R. § 483.10(a)(3)-(4). Despite Columbus's reliance on these provisions now, the facility obviously felt able to restrict the husband's access for eight days. Columbus does not explain why it believed that such restrictions were legal for eight days but not permissible for any longer. Had the facility acted properly to preserve evidence and to complete a thorough and timely investigation, eight days might have sufficed to resolve the situation and determine whether corrective action was needed and, if so, what form it should take. Had the facility immediately notified the state agency of the alleged violations, it might have sought and received assistance in dealing with the husband, in handling an investigation of possible sexual abuse, and in balancing the resident's rights to family access and privacy with her right to be free of abuse.

We conclude that the ALJ's conclusion that Columbus failed to protect the resident from potential abuse is supported by substantial evidence.

C. The ALJ's conclusion that Columbus failed to comply with requirements for reporting abuse investigations is not legally erroneous and is supported by substantial evidence.

Columbus does not dispute that it made no report to the state agency about Resident 1's injury and potential abuse. Instead, Columbus argues that no report was necessary because the state agency did not require reporting where no credible allegation of abuse by a staff member is determined to be present. Id. at 33. According to Columbia, abuse by a staff member "was reasonably ruled out within the 24 hours (and abuse by the husband was ruled out in 5 days)," so no report was necessary. Id. at 33-34.

Columbus relies in part on a decision tree which Columbus asserted was distributed to nursing homes by the state agency. Id. at 33; P. Ex. 4. Columbus contends that the state reporting requirements in Wisconsin define abuse to include only actions "by a caregiver," and that federal regulations only require reporting of abuse "in accordance with state law."

Columbus is wrong on both the law and the facts.

> i. Facilities must report all alleged violations and the results of their investigations regardless of whether staff members are implicated or abuse is substantiated.

As the Board recently explained in detail, the plain language of the federal regulation requires that the results of all investigations of alleged abuse or injuries of unknown origin must be reported to the state agency within five days (and all allegations and injuries of unknown origin must be reported immediately). Singing River, DAB No. 2232, at 7-10. The reference to reporting to State officials "in accordance with State law (including to the State survey and certification agency)" does not adopt state law definitions of abuse or more limited state reporting requirements. 42 C.F.R. § 483.13(c)(4). Instead, state law is cited only to ensure that facilities are also responsible under federal law for complying with any state requirements for reporting to other officials in addition to the state Medicaid agency. Singing River, DAB No. 2232 at 8-10. As the Board pointed out, the "inclusion of 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." Id. at 7-8. The same considerations apply to the requirement in section 483.13(c)(2) that all "alleged violations" involving abuse or injuries of unknown source must be reported immediately to the state agency.

The Board also rejected in Singing River the argument that facilities need only report allegations of abuse that are substantiated. The regulation expressly requires reporting all investigations and specifies that, "if the alleged violation is verified, appropriate corrective action must be taken." 42 C.F.R. § 483.13(c)(4). The Board pointed out that this provision clearly contemplates "reporting of the results of investigations even when the alleged violation is not verified" and timely and thorough investigation of any alleged or suspected abuse to "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." Singing River, DAB No. 2232 at 8; see also Vandalia Park, DAB No. 1939 (2004) (the results of all investigations must be reported regardless of whether abuse is substantiated). Plainly, given that the results of investigations that find no abuse must be reported, facilities are not excused from reporting the alleged violations themselves merely because their preliminary view is that abuse is not the most likely explanation of the injury. We adopt the rationale explained in detail in Singing River to conclude that the regulatory reporting obligations are triggered by any suspected abuse or injury of unknown origin whether or not a staff person is implicated and whether or not abuse is substantiated.

Clearly, not only must the results of all investigations involving alleged abuse or injury of unknown origin be reported within five days as required by section 483.13(c)(4), the allegation or injury must itself be immediately reported under section 483.13(c)(2). Columbus hence had ample notice that failing to report the allegations of abuse and the results of the investigation here was not justified under the regulations.

Federal law requires state agencies responsible for operation of Medicaid and Medicare participating facilities to act on all abuse allegations, either by conducting their own investigation when facility staff are implicated or, in all other cases, by considering whether to follow up with a complaint survey of the reporting facility. Sections 1819(g)(1)(c) and 1919(g)(1)(c) of the Act; 42 C.F.R. §§ 488.332 and 488.335. In order for state agencies to fulfill these requirements, facilities must be (and are) required to report to them all allegations and the results of all investigations.

ii. Columbus's reliance on an outdated state "decision tree" is misplaced.

Columbus nevertheless argues that it could rely on a "decision tree" that it had received from the state agency as allowing it to not report the injury or suspicion of abuse, if it ruled out staff abuse within 24 hours.[9] RR Br. at 33-34. Social Worker

[9] The full title of the document to which Columbus refers is "Caregiver Misconduct and Injuries of Unknown Source Entity Investigation and Reporting Requirements." P. Ex. 4, at 1.

Sharkey stated that Petitioner's Exhibit 4 contains the form which Columbus used, and also contains a highlighted line tracing down the "tree" that shows the analysis by which Columbus determined that the incident was not reportable. P. Ex. 16, at 3 (Sharkey statement); P. Ex. 4.

CMS responds that Wisconsin state law, since at least 2005, has required all nursing homes participating in the federal health care programs to report all cases of abuse regardless of the perpetrator. CMS Br. at 30. In support of this contention, CMS proffered with its reply brief to the ALJ a declaration by Shari Busse, Director of the Office of Caregiving Quality, Division of Quality Assurance, Wisconsin Department of Health Services. Three documents were attached to that declaration: (1) a December 2004 CMS document clarifying that the phrase "in accordance with State law" modifies only state "officials" (Ex. A); and (2) two notices (dated March 23, 2005 and October 26, 2005) sent to all nursing homes by the Wisconsin state agency communicating this clarification and specifically indicating that the use of its decision tree must be appropriately adjusted (Exs. B and C). ALJ Decision at 3, n.3.

The ALJ excluded Ms. Busse's declaration as untimely. ALJ Decision at 3, n.3. The ALJ did not admit the attached documents as exhibits, but found that they constituted public issuances by CMS or the state agency and, as such, could be considered by him. Id. Consequently, the ALJ took "judicial notice" that the state agency's prior decision tree process has been "superseded by CMS and state agency notices in calendar year 2005." Id. at 17.

Columbus argues that this was prejudicial error because CMS did not show it could not have presented the documents earlier and because Columbus did not have an opportunity to rebut them. RR Br. at 36-39. CMS responds that these documents were simply a source of legal standards, not evidence of any facts at issue. CMS Br. at 32-33.

CMS also notes that the State Operations Manual (SOM), published on the CMS website, provides the same information in its guidelines to surveyors on the relevant regulatory requirement. CMS Br. at 31; SOM, Pub. No. 100-07, App. PP, accessible at http://cms.hhs.gov/manuals/Downloads/som107ap_pp_guidelines_ltcf.pdf. The relevant SOM language, in effect at the time of the incident, reads:

> The phrase "in accordance with State law" modifies the word "officials" only. As such, State law may stipulate that alleged violations and the results of the investigations be

> reported to additional State officials beyond those specified in Federal regulations. This phrase does not modify what types of alleged violations must be reported or the time frames in which the reports are to be made. As such, States may not eliminate the obligation for any of the alleged violations (i.e., mistreatment, neglect, abuse, injuries of unknown source, and misappropriation of resident property) to be reported, nor can the State establish longer time frames for reporting than mandated in the regulations at §§483.13(c)(2) and (4). No State can override the obligation of the nursing home to fulfill the requirements under §483.13(c), so long as the Medicare/Medicaid certification is in place.

Appendix PP of the SOM contains interpretive guidelines on how CMS has interpreted statutory and regulatory provisions applicable to long-term care facilities. The Board has repeatedly explained that the SOM does not itself have the force of law, but may be "useful guidance as to CMS' interpretations of applicable law." Cal Turner Extended Care Pavilion, DAB No. 2030, at 13 (2006), and cases cited therein; cf. The Laurels at Forest Glenn, DAB No. 2182, at 11 (2008) (referencing the SOM as CMS's "official interpretation" of a regulation). The quoted SOM language does articulate CMS's interpretation that the regulatory provisions require reporting of all alleged violations (including allegations of unknown source) to the state agency and that any instructions from a state inconsistent with the federal requirements (such as the decision tree here) should not be relied upon. This source of information about CMS's understanding of its regulation was publicly available and independent of the notices attached to the excluded Busse declaration.

In any case, in our view, the ALJ used the notices merely as a source of information about legal standards, or at most "legislative facts," rather than as evidence relating to "adjudicative facts." These distinctions are explained in the 1972 Advisory Committee Note to Rule 201 of the Federal Rules of Evidence, [10] as follows -

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[10] The Board is not subject to the Federal Rules of Evidence but often looks to them for helpful guidance in considering evidentiary issues. Florence Park Care Center, DAB No. 1931, at 13-14 (2004); Omni Manor Nursing Home, DAB No. 1920, at 14 (2004).

> This is the only evidence rule on the subject of judicial notice. It deals only with judicial notice of "adjudicative" facts. . . . No rule deals with judicial notice of "legislative" facts. The omission of any treatment of legislative facts results from fundamental differences between adjudicative facts and legislative facts. Adjudicative facts are simply the facts of the particular case. Legislative facts, on the other hand, are those which have relevance to legal reasoning and the lawmaking process, whether in the formulation of a legal principle or ruling by a judge or court or in the enactment of a legislative body.

As relevant here, the ALJ did not take "judicial notice," for example, that Columbus had actual notice of the Wisconsin or CMS issuances, which could be viewed as a factual matter relevant to the adjudication. Instead, the ALJ relied on the documents only as evidence that the decision tree proffered by Columbus was out-of-date and inconsistent with not only federal law but also with the policies of the state agency at the time in question. ALJ Decision at 17-18.

Columbus argues that the state issuances could not establish any "state law" because they were not adopted under state rulemaking procedures, nor could the federal "clarification" alter the federal regulation. Columbus Reply Br. at 16-17. Columbus fails to understand that the purpose for which these issuances were proffered was not to establish the existence of new "law" in 2005, but rather to demonstrate interpretation of the existing law by the federal agency charged with its implementation, and to show that the state agency with enforcement responsibilities under that law understood it correctly at least by 2005. In part, Columbus's position is driven by its view that "the regulation in question [had] already been judicially construed in a manner different from the interpretation being advanced by CMS in its letter." Id. at 17. Our rejection of that position is informed by our conclusions above that the CMS interpretation follows the plain language of the regulation and that none of the cited ALJ decisions constitute binding precedent to the contrary.

We turn to Columbus's argument that the late submission of this material by CMS was prejudicial to it because Columbus had no opportunity to respond before the ALJ issued his decision. The record does not reflect that Columbus ever requested that the ALJ reopen the record for it to submit responsive materials or provide it with a further opportunity to respond after CMS submitted its posthearing reply brief with the Busse declaration and its attachments.

Moreover, on appeal, Columbus has had ample opportunities to submit briefing. Under the appeal regulations, the Board may admit additional evidence into the record, if it is relevant and material. 42 C.F.R. § 498.86. Columbus has not proffered before us any additional evidence or documents in response to those attached to the declaration. Columbus has not questioned that the documents are what they purport to be or challenged their authenticity. To the extent that Columbus had contrary legal arguments to make, we presume they have been fully articulated in its request for review with accompanying brief and its reply brief before us.[11] Therefore, any prejudice that may have ensued from the late inclusion of these documents in the record below has been effectively cured. Fairness would not be served by excluding from consideration authentic issuances of the relevant state and federal agencies in discerning the meaning of applicable regulations.

Finally, we note that we would have found Columbus noncompliant with even the limited reporting requirements which it does not dispute. We find substantial evidence in the record, including the evidence discussed above, that Columbus never conducted an investigation adequate to "rule out" sexual abuse, by Resident 1's husband or any other person, as the cause of her injury. Its claim that caregiver abuse was ruled out within 24 hours is completely undocumented. The decision tree on which Columbus puts so much weight requires that the facility first protect its residents from further injury and "immediately conduct a thorough internal investigation and document your findings for all incidents," before beginning the steps to decide if reporting is mandatory. P. Ex. 4, at 1. Columbus never met these prerequisites. Therefore, Columbus is not in a position to claim that it could reasonably have relied to its detriment on this superseded form.

2. We uphold the ALJ's conclusion that Columbus was not in substantial compliance with the regulatory requirements cited under F Tag 226.

The focus of this deficiency finding is on whether the facility has both developed and implemented written policies and procedures to prohibit abuse. The ALJ rejected Columbus's

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[11] We note, however, that even on appeal, Columbus has not explicitly denied that it received the October 26, 2005 state notice to all Wisconsin nursing homes which itself cited CMS's clarification. RR Br. at 1, 36-39.

argument that this single incident could not establish a prima facie case of failure to implement anti-abuse policies. ALJ Decision at 18. The ALJ reasoned that the regulation does not necessarily require multiple incidents to demonstrate lack of implementation. Id. He found that Columbus had failed to carry out its responsibilities under the regulations and its own policy under circumstances that demonstrated a "systemic failure."

Columbus argues that CMS cannot make a prima facie case under this regulation by merely relying on a single, isolated instance "where a facility has deviated from its internal abuse policy." RR Br. at 39-40. Columbus also relies on its contentions, rejected above, that its actions fulfilled all the requirements for handling alleged abuse under the circumstances.[12] Id.

Columbus's arguments lack merit. The evidence relating to this noncompliance finding is not limited to the fact that an incident of alleged abuse occurred at Columbus. Instead, the salient evidence on which the ALJ relied demonstrates that the management and multiple staff members did not know how to respond properly to an injury of unknown origin under circumstances suggesting sexual abuse. The facility used an outdated decision tree and failed to follow the action steps set out in it before prematurely abandoning any effort to determine whether the injury was the result of abuse. The record shows that the nurse and the social worker had serious misgivings about allowing Resident 1's husband to resume private visits, yet the administrator acted without fully informing himself. CMS Ex. 1, at 10, 11, 16; Tr. at 40, 150, 152. The facility's policy clearly called for preserving evidence, obtaining written statements, and documenting the investigatory steps and resolution, among other things. Yet multiple staff members failed to conform to that policy.

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[12] Columbus further asserts that, since the incident involved alleged conduct by a family member not a staff person, "this example" does not meet the definition of "abuse" under section 483.13(c), and hence cannot form the basis of a finding that Columbus failed to implement anti-abuse policies. Id. The premise of this assertion is faulty. The applicable definition of "abuse" in long-term care facilities is "the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish," with no reference to the identity of the perpetrator. 42 C.F.R. § 488.301.

Perhaps the single most telling piece of evidence is a handwritten statement prepared by the charge nurse who was called in by the CNAs when they observed the blood in Resident 1's diaper. CMS Ex. 37, at 5-6. She reports that, when the surveyor asked her if she had any training in "dealing with abuse incidents," the surveyor qualified the question as particularly addressing sexual abuse and issues such as "maintaining the [site] and collecting samples or evidence." Id. at 6. The nurse then avers as follows:

> If it is my responsibility as a nurse to collect evidence, I have never been told or shown in all my 30+ years as a geriatric nurse.

Id. This statement calls into question whether Columbus had adequately trained its staff on the facility's abuse policy, which calls for preservation of evidence of potential abuse. Columbus has not submitted any evidence that other staff were trained on the subject. The ALJ could reasonably infer from this declaration, from the actions of the staff following up on Resident 1's injury, and the pervasive misunderstanding of regulatory obligations on the part of Columbus's management that Columbus had not implemented a written policy or procedures to prohibit abuse.

Contrary to Columbus's arguments, the Board has never required that multiple incidents of abuse have occurred in order for CMS to cite noncompliance with this requirement. The issue is whether the circumstances presented, viewed as a whole, demonstrate a systemic problem in implementing policies and procedures. Liberty Commons Nursing and Rehab Center -Johnston, DAB No. 2031, at 14 (2031), aff'd, Liberty Commons Nursing & Rehab Ctr.-Johnston v. Leavitt, 241 F. App'x 76 (4th Cir. 2007).

We agree with the ALJ that that standard for citing noncompliance was met under the circumstances here.

3. Columbus has not shown any basis for us to revisit the immediate jeopardy determination or the reasonableness of the amount of the CMPs imposed.

CMS's determination as to the level of noncompliance must be upheld unless it is clearly erroneous. RR Br. at 42, citing 42 C.F.R. § 498.60(c)(2). Furthermore, the level of noncompliance is subject to review only if a successful challenge would affect the applicable range of CMP amounts or a finding of substandard quality of care that resulted in the loss of approval of a facility's NATCEP. 42 C.F.R. § 498.3(b)(14). The ALJ pointed

out that per-instance CMPs fall within a single range which is not affected by an immediate jeopardy determination. ALJ Decision at 19. He also noted that CMS's notice explained that the partial extended survey triggered by the immediate jeopardy finding did result in a substandard quality of care finding resulting in the NATCEP suspension. Id. He pointed out, however, that Columbus would be subject to the same result because the total CMP amount exceeded $5,000. Id.; 42 C.F.R. § 483.151(b)(2)(iv), (e)(1).

The ALJ went on to conclude that the immediate jeopardy determination was not clearly erroneous as to either noncompliance finding. Id. He noted that Resident 1's injury was suggestive of sexual abuse, which would be criminal conduct, yet Columbus failed to report immediately, investigate adequately, or provide protection from the likelihood of further injury. Id. at 16, 19. He noted that the resident was "exposed to the likelihood of further injury." Id. at 19. His conclusion is well-founded, and we note further that the lack of competent follow-up also demonstrated that other residents were exposed to likely harm because they could not rely on the facility to act effectively to protect them from abuse and to respond appropriately to any injury or allegation.

Since it is apparent that the immediate jeopardy determination cannot be said to be clearly erroneous, we need not reach CMS's arguments that the immediate jeopardy determination should not have been reviewed at all, on the grounds that, even without the substandard quality of care finding, Columbus would have lost its NATCEP anyway or because the question was moot since the NATCEP suspension period has already expired.

The ALJ reviewed the reasonableness of the amounts of the CMPs considering the relevant factors set out in section 488.438(f) -- the facility's history of noncompliance, including repeated deficiencies; the facility's financial condition; the factors specified in 42 C.F.R. § 488.404 which include the seriousness of the deficiency, the relationship of one deficiency to other deficiencies, and the facility's prior history of noncompliance; and, the facility's degree of culpability. ALJ Decision at 19-20. He found that Columbus had a prior history of noncompliance; that Columbus made no showing of financial hardship; and noted that the deficiencies here were serious involving failure to investigate and report possible sexual abuse. Id. at 20.

Columbus argues on appeal that the amounts of the per-instance CMPs were not reasonable and suggests that any CMP should have been "at or near the minimum per instance CMP of $1,000." RR Br.

at 46-47. Columbus points out that absence of culpability and the seriousness of the deficiencies - i.e., their scope and severity -- are among the factors set out in 42 C.F.R. § 488.438(e) and (f), but recognizes that whether those factors are considered favorable on appeal would "obviously depend on the outcome of this case on the merits." RR Br. at 47. Given our resolution of the merits of this case above, we see nothing that would support that the description of the noncompliance here as "a procedural misstep in an unusual and unlikely-to-be-repeated circumstance" or as reflecting Columbus's "earnest attempt to comply" with the regulations. Id. The failure to investigate thoroughly and report promptly an incident involving a potential criminal act such as sexual abuse is particularly disturbing.

Columbus also makes an argument that, added together, the CMPs total "almost the maximum daily CMP that could have been imposed for the single day the facility was found to be out of compliance."[13] RR Br. at 46. The relevance of this observation is not at all clear. As the ALJ noted, "[e]ach of the CMPs is in the lower half of the range of per instance CMP." ALJ Decision at 20. A per-instance CMP may be imposed for each "instance of noncompliance," not for each day of noncompliance or each incident which evidenced noncompliance with one or more participation requirements. 42 C.F.R. § 488.438(a)(2). Therefore, we see no particular relationship between the sum of per-instance CMPs imposed for noncompliance on a particular date and the amount of a per-day CMP that could have been imposed instead for those noncompliance findings.

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[13] The two CMPs add up to $8,300. The maximum daily amount of a per-day CMP is $10,000. Columbus implies that the amounts should be considered together because they were "based on the same facts." RR Br. at 46. While the same incident was involved in each of the noncompliance findings, the findings were based not merely on the facts of the incident but rather on what those facts along with other evidence established about Columbus's compliance with different regulatory requirements.

Conclusion

For the reasons explained above, we uphold the ALJ Decision in its entirety.

/s/
Judith A. Ballard

/s/
Constance B. Tobias

/s/
Leslie A. Sussan
Presiding Board Member