Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Mountain Villa Nursing Center
(CCN: 67-5768),

Petitioner

v.

Centers for Medicare and Medicaid Services.

Docket No. C-10-726

Decision No. CR2506

Date: February 22, 2012

DECISION

Petitioner, Mountain Villa Nursing Center, was not in substantial compliance with program participation requirements from February 5 through March 19, 2010. There is a basis for the imposition of enforcement remedies. The following enforcement remedies are reasonable: a civil money penalty (CMP) of $5,550 per day from February 5 through 10, 2010, and $600 per day from February 11 through March 19, 2010, a total of $55,500; and a denial of payment for new admissions (DPNA) for March 18 and 19, 2010. Petitioner was also ineligible to conduct a nurse aide training and competency evaluation program (NATCEP) for a period of two years.

I. Background

Petitioner is located in El Paso, Texas, and participates in Medicare as a skilled nursing facility (SNF) and the state Medicaid program as a nursing facility (NF). On February 10, 2010, the Texas Department of Aging and Disability Services (state agency) completed a survey of Petitioner's facility and found Petitioner not in substantial compliance with program participation requirements. Joint Stipulations (Jt. Stip.); Centers for Medicare and Medicaid Services (CMS) Exhibit (Ex.) 2; Petitioner Exhibit (P. Ex.) 2. CMS notified Petitioner by letter dated March 3, 2010, that CMS concluded that Petitioner no longer met the requirements for participation in Medicare and Medicaid

based on the February 10 survey. CMS advised Petitioner that it was imposing the following enforcement remedies: termination of Petitioner's provider agreement August 10, 2010, if Petitioner did return to substantial compliance before that date; a per instance CMP (PICMP) of $8,500 for the alleged noncompliance with 42 C.F.R. § 483.13(c)(1)(ii)-(iii), and (c)(2)-(4); and a DPNA beginning March 18, 2010, unless Petitioner returned to substantial compliance before that date. CMS also advised Petitioner that it was ineligible to conduct a NATCEP for two years. CMS Ex. 1, at 1-3. CMS notified Petitioner by letter dated March 31, 2010, that it was revising the enforcement remedies as follows: the PICMP was rescinded; and CMS imposed a CMP of $5,550 per day from February 5 through 10, 2010, and $600 per day beginning February 11, 2010. CMS Ex. 1, at 4-5. CMS notified Petitioner by letter dated April 28, 2010, that: the state agency determined that Petitioner returned to substantial compliance as of March 20, 2010; the termination of Petitioner's provider agreement was rescinded; the $5,550 per day CMP was in effect from February 5 through 10, 2010; the $600 per day CMP was in effect from February 11 through March 19, 2010; the total CMP was $55,500; and the DPNA was in effect from March 18 through 19, 2010. CMS Ex. 1, at 6-7; Jt. Stip.

On May 25, 2010, Petitioner requested a hearing. On May 28, 2010, the case was docketed as C-10-726; assigned to me for hearing and decision; and an Acknowledgment and Prehearing Order was issued at my direction. On January 4, 2011, I notified the parties that the case was scheduled for hearing from February 8 through 11, 2011, in El Paso, Texas. On January 24, 2011, the parties filed a joint motion by which Petitioner waived oral hearing and the parties agreed to a decision on the briefs and documentary evidence. On January 28, 2011, I accepted Petitioner's waiver of oral hearing and set a briefing schedule. On March 2, 2011, CMS filed its opening brief (CMS Br.) with exhibits marked CMS Exs. 1 through 10. CMS also filed three declarations that CMS failed to mark as exhibits. I have marked the CMS declarations as follows: the declaration of state surveyor Jessica Aguilar is marked CMS Ex. 11; the declaration of the state program manager Rosa Hinojos is marked CMS Ex. 12; and the affidavit of CMS nurse consultant Susana Cruz, RN, is marked CMS Ex. 13. CMS waived filing a reply brief. On February 28, 2011, Petitioner filed its opening brief (P. Br.), with P. Exs. 1 through 19. Petitioner filed its reply brief (P. Reply) on March 25, 2011, with P. Exs. 20, 21, and 22. No objections have been made to my consideration of the exhibits submitted and CMS Exs. 1 through 13 and P. Exs. 1 through 22 are admitted.

II. Discussion

A. Issues

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

Whether the remedy imposed is reasonable.

B. Applicable Law

The statutory and regulatory requirements for participation of a SNF in Medicare are found at section 1819 of the Social Security Act (Act) and at 42 C.F.R. Part 483.[1] Section 1819(h)(2) of the Act authorizes the Secretary of Health and Human Services (Secretary) to impose enforcement remedies against a SNF for failure to comply substantially with the federal participation requirements established by sections 1819(b), (c), and (d) of the Act.[2] The Act requires that the Secretary terminate the Medicare participation of any SNF that does not return to substantial compliance with participation requirements within six months of being found not to be in substantial compliance. Act § 1819(h)(2)(C). The Act also requires that the Secretary deny payment of Medicare benefits for any beneficiary admitted to a SNF, if the SNF fails to return to substantial compliance with program participation requirements within three months of being found not to be in substantial compliance – commonly referred to as the mandatory or statutory denial of payments for new admissions (DPNA). Act § 1819(h)(2)(D). The Act grants the Secretary discretionary authority to terminate a noncompliant SNF's participation in Medicare, even if there has been less than 180 days of noncompliance. The Act also grants the Secretary authority to impose other enforcement remedies, including a discretionary DPNA, CMPs, appointment of temporary management, and other remedies such as a directed plan of correction. Act § 1819(h)(2)(B).

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

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

The Secretary has delegated to CMS and the states the authority to impose remedies against a long-term care facility that is not complying substantially with federal participation requirements. "*Substantial compliance* means a level of compliance with the requirements of participation such that any identified deficiencies pose no greater risk to resident health or safety than the potential for causing minimal harm." 42 C.F.R. § 488.301 (emphasis in original). A deficiency is a violation of a participation requirement established by sections 1819(b), (c), and (d) of the Act or the Secretary's regulations at 42 C.F.R. Part 483, subpart B. Noncompliance refers to any deficiency that causes a facility not to be in substantial compliance. 42 C.F.R. § 488.301. 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 CMPs, $50 per day to $3,000 per day, is reserved for deficiencies that do not pose immediate jeopardy, but either cause actual harm to residents, or cause no actual harm but have the potential for causing more than minimal harm. 42 C.F.R. § 488.438(a)(1)(ii). A CMP of $1,000 to $10,000 for each instance of noncompliance is also authorized. 42 C.F.R. § 488.438(a)(2).

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

appointment of temporary management. Extended and partial extended surveys are 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 Administrative Law Judge (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. *The Residence at Salem Woods*, DAB No. 2052 (2006); *Cal Turner Extended Care*, DAB No. 2030 (2006); *Beechwood Sanitarium*, DAB No. 1906 (2004); *Emerald Oaks*, DAB No. 1800, 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 CMS considered when choosing remedies, are not subject to review. 42 C.F.R. § 488.408(g)(2). A facility may only challenge the scope and severity level of noncompliance determined by CMS if a successful challenge would affect the range of the CMP that may be imposed or impact the facility's authority to conduct a NATCEP. 42 C.F.R. § 498.3(b)(14), (d)(10)(i). The CMS determination as to the level of noncompliance, including the finding of immediate jeopardy, "must be upheld unless it is clearly erroneous." 42 C.F.R. § 498.60(c)(2); *Woodstock Care Ctr.*, DAB No. 1726, at 9, 38 (2000), *aff'd*, 363 F.3d 583 (6th Cir. 2003). The Departmental Appeals Board (the Board) has long held that the net effect of the regulations is that a 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 evidence and making a prima facie showing of a basis for imposition of an enforcement remedy. Petitioner bears the burden of persuasion to show by a preponderance of the evidence that it was in substantial compliance with participation requirements or any affirmative defense. *Batavia Nursing & Convalescent Inn*, DAB No. 1911 (2004); *Batavia Nursing & Convalescent Ctr.*, DAB No. 1904 (2004), *aff'd*, *Batavia Nursing & 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); *Hillman Rehab. Ctr.*, DAB No. 1611 (1997), *aff'd, Hillman Rehab. Ctr. v. United States*, No. 98-3789 (GEB), 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. I have carefully considered all the evidence and the arguments of both parties, though not all may be specifically discussed in this decision. In this decision, I discuss the credible evidence given the greatest weight in my decision-making.[3] 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.

CMS alleges, based upon the survey completed on February 10, 2010, that Petitioner was not in substantial compliance with program participation requirements from February 5, 2010 to Petitioner's return to substantial compliance on March 20, 2010. It is alleged in the Statement of Deficiencies (SOD) for the survey completed on February 10, 2010, that Petitioner violated the following participation requirements: 42 C.F.R. § 483.12(a)(2) (Tag F201 at a scope and severity level (SS) D, indicating a risk for more than minimal harm); 42 C.F.R. § 483.13(b), (b)(1)(i)[4] (Tag F223, SS L, indicating immediate jeopardy); 42 C.F.R. § 483.13(c)(1)(ii)-(iii), (2), (3), (4) (Tag F225, SS L); 42 C.F.R. § 483.13(c) (Tag F226, SS L); and 42 C.F.R. § 483.75 (Tag F490, SS L). Petitioner contests all the deficiencies. Jt. Stip.

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

[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 refer to 42 C.F.R. § 483.13(b) and (c)(1)(i). *Illinois Knights Templar Home*, DAB No. 2369, at 2 n.2 (2011).

I conclude that Petitioner did not violate 42 C.F.R. §§ 483.12(a)(2) (Tag F201) or 483.13(b) and (c)(1) (Tags F223 and F225). However, Petitioner was not in substantial compliance as alleged by CMS due to the violations of 42 C.F.R. §§ 483.13(c)(2)-(4) (Tags F225 and F226) and 483.75 (Tag F490); and Petitioner has failed to show that the determination that those violations posed immediate jeopardy was clearly erroneous. The violations provide a sufficient basis to impose a CMP of $5,550 per day from February 5 through 10, 2010, and $600 per day from February 11 through March 19, 2010, totaling $55,500, a DPNA from March 18 through 19, 2010, and cause the loss of eligibility to conduct a NATCEP.

1. Petitioner did not violate 42 C.F.R. § 483.12(a)(2) (Tag F201).

The Secretary has defined the phrase "transfer and discharge" to be the "movement of a resident to a bed outside of the certified facility whether that bed is in the same physical plant or not. Transfer and discharge does not refer to movement of a resident to a bed within the same certified facility." 42 C.F.R. § 483.12(a)(1). A facility may not transfer or discharge a resident except when:

> (i) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;
> (ii) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility;
> (iii) The safety of individuals in the facility is endangered;
> (iv) The health of individuals in the facility would otherwise be endangered;
> (v) The resident has failed, after reasonable and appropriate notice, to pay for . . . [the resident's] stay . . . .; or
> (vi) The facility ceases to operate.

42 C.F.R. § 483.12(a)(2).

The State Operations Manual (SOM),[5] Tag F177, further defines transfer to be the movement of a resident from a facility to another legally responsible institution. The SOM characterizes discharge as moving the resident to a non-institutional setting and the facility ceases to be responsible for the resident's care. The regulation establishes, and the SOM discusses, specific documentation and procedures necessary for a transfer or discharge initiated by a facility rather than a resident. 42 C.F.R. § 483.12(a)(3)-(8); SOM, Tags F177, F201-F204.

The surveyors allege in the SOD that Petitioner violated 42 C.F.R. § 483.12(a)(2) in the case of Resident 2. It is alleged in the SOD, and it is not disputed, that on January 5, 2010, Resident 2 received a discharge letter from the facility dated December 30, 2009, notifying her that she was to be discharged on or before January 31, 2010. The letter cited as grounds that Petitioner was unable to meet the needs of the resident and the expectations of the resident's family. CMS Ex. 10, at 15. The surveyors concluded that the resident's discharge was not necessary for her welfare and the facility could not show that the resident's needs could not be met. The surveyors found that there had not been any documented change in the resident's condition since her admission; the facility did not document in her clinical record why she was given a 30-day discharge notice; and Resident 2 expressed to the surveyors that she liked the facility and did not want to leave. CMS Ex. 2, at 1-3. There is no dispute that, as alleged in the SOD, Resident 2 received many phone calls on the telephone intended for use by all residents, which required that staff carry the cordless phone to the resident's room. Petitioner apparently believed the use of the phone was excessive and gave the resident the 30-day discharge notice. The resident appealed to the state as authorized by the regulation and the Ombudsman suggested that the family install a phone in the resident's room, but the family refused. CMS Ex. 2, at 3-4. Surveyor Jessica Aguilar testified in her declaration that she cited Petitioner for the violation because she concluded that Petitioner did not have a reason recognized by the regulation to discharge Resident 2. CMS Ex. 11.

I conclude that CMS has failed to make a prima facie showing of a violation of 42 C.F.R. § 483.12(a)(2) as CMS has failed to present any evidence that Resident 2 was transferred or discharged from Petitioner's facility.

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[5] Although the SOM does not have the force and effect of law, the provisions of the Act and regulations interpreted clearly do have such force and effect. *State of Indiana by the Indiana Dep't of Pub. Welfare v. Sullivan*, 934 F.2d 853 (7th Cir. 1991); *Northwest Tissue Ctr. v. Shalala*, 1 F.3d 522 (7th Cir. 1993). Thus, while the Secretary may not seek to enforce the provisions of the SOM, she may seek to enforce the provisions of the Act or regulations as interpreted by the SOM.

The Board has been consistent in its view that CMS has the burden of coming forward with evidence to establish a prima facie case that Petitioner was not in substantial compliance with federal participation requirements to justify the imposition of an enforcement remedy. The Board has stated that CMS must come forward with "evidence related to disputed findings that is sufficient (together with any undisputed findings and relevant legal authority) to establish a prima facie case of noncompliance with a regulatory requirement." *Evergreene Nursing Care Ctr.*, DAB No. 2069, at 7 (2007); *Batavia Nursing and Convalescent Ctr.*, DAB No 1904. Only when CMS makes a prima facie showing of noncompliance, is the facility burdened to show, by a preponderance of the evidence on the record as a whole, that it was in substantial compliance or had an affirmative defense. *Evergreene Nursing Care Ctr.*, DAB No. 2069, at 7.

When a penalty is proposed and appealed, CMS must make a prima facie case that the facility has failed to comply substantially with federal participation requirements. "Prima facie" means generally that the evidence is "(s)ufficient to establish a fact or raise a presumption unless disproved or rebutted." *Black's Law Dictionary* 1228 (8th ed. 2004). In *Hillman Rehabilitation Ctr.*, the Board described the elements of the CMS prima facie case in general terms as follows:

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

DAB No. 1611, at 11. Thus, CMS has the initial burden of coming forward with sufficient evidence to show that its decision to impose an enforcement remedy is legally sufficient under the statute and regulations. To make a prima facie case that its decision was legally sufficient, CMS must: (1) identify the statute, regulation or other legal criteria to which it seeks to hold the provider; (2) come forward with evidence upon which it relies for its factual conclusions that are disputed by the Petitioner; and (3) show how the deficiencies it found amount to noncompliance that warrants an enforcement remedy, i.e., that there was a risk for more than minimal harm due to the regulatory violation.

In *Evergreene Nursing Care Ctr.*, the Board explained its "well-established framework for allocating the burden of proof on the issue of whether a SNF is out of substantial compliance" as follows:

> CMS has the burden of coming forward with evidence related to disputed findings that is sufficient (together with any undisputed findings and relevant legal authority) to establish a prima facie case of noncompliance with a regulatory requirement. If CMS makes this prima facie showing, then the SNF must carry its ultimate burden of persuasion by showing, by a preponderance of the evidence, on the record as a whole, that it was in substantial compliance during the relevant period.
>
> CMS makes a prima facie showing of noncompliance if the evidence CMS relies on is sufficient to support a decision in its favor absent an effective rebuttal. A facility can overcome CMS's prima facie case either by rebutting the evidence upon which that case rests, or by proving facts that affirmatively show substantial compliance. "An effective rebuttal of CMS's prima facie case would mean that at the close of the evidence the provider had shown that the facts on which its case depended (that is, for which it had the burden of proof) were supported by a preponderance of the evidence."

DAB No. 2069, at 7-8 (citations omitted).

The regulation gives Petitioner notice of the criteria or elements it must meet to comply with the program participation requirement established by the regulation. 5 U.S.C. §§ 551(4), 552(a)(1). Therefore, in order to make a prima facie showing of noncompliance, CMS must show that Petitioner violated the regulation by not complying with one or more of the criteria or elements of the regulation and that the violation posed a risk for more than minimal harm. The Board's prior decisions seem to be consistent with this construction. Whether CMS makes a prima facie showing is determined by review of the credible evidence CMS presents to establish each element necessary to show that a facility is not in substantial compliance with a statutory or regulatory requirement of participation. To establish a prima facie case of noncompliance, the required basis for imposition of an enforcement remedy, CMS must show that the participation requirement was violated and that one or more residents suffered or were exposed to a risk for more than minimal harm. Petitioner disputes the factual basis for the CMS prima facie case. *See Jennifer Matthew Nursing & Rehab. Ctr.*, DAB No. 2192, at 20 n.12 (2008).

The regulation at issue, 42 C.F.R. § 483.12(a)(2), gave Petitioner notice that it is prohibited from transferring or discharging a resident except in certain circumstances. In this case, the surveyors focused upon whether Petitioner had proper grounds under the regulation for transferring or discharging the resident. The surveyors overlooked, however, that they had no evidence that Resident 2 was ever transferred or discharged

from the facility. The 30-day discharge notice letter advised the resident she was to be discharged on or before January 31, 2010. CMS Ex. 2, at 2. However, the SOD clearly states that the resident was interviewed by the surveyors on February 4, 2010, at 11:30 a.m. CMS Ex. 2, at 3. I infer, based on the surveyor notes at CMS Ex. 4, at 23, that the interview of Resident 2 was at the facility. The nurse's notes for Resident 2 introduced as evidence also shows that the resident remained at the facility after January 31, 2010. CMS Ex. 10, at 13. The SOD also reports that Resident 2's appeal of the discharge was pending and a hearing was set for March 1, 2010, and the Ombudsman expressed hope that the discharge notice would be withdrawn. CMS Ex. 2, at 3.

The SOD fails to allege that Resident 2 was ever discharged, a required element of the CMS prima facie case. In fact, the SOD shows that during the survey Resident 2 continued to reside at the facility and that she had not been discharged or transferred. CMS argues to me that it has met its burden to make a prima facie showing but never addresses the fact that Resident 2 was not transferred or discharged. CMS Br. at 5-7. Because the SOD does not allege evidence that Resident 2 was not discharged or transferred, there is no prima facie showing that Petitioner violated 42 C.F.R. § 483.12(a)(2).

Even if one concluded that CMS made a prima facie showing of a deficiency without showing an actual transfer or discharge of the resident, Petitioner has rebutted the prima facie showing. Petitioner's unrebutted evidence shows that Resident 2 continued to be a resident at Petitioner's facility as of February 14, 2010. P. Ex. 20. Furthermore, Petitioner's assertions that Resident 2 had a telephone installed in her room and that she continues to reside at Petitioner's facility are not disputed by CMS. P. Ex. 21; P. Reply at 2-4.

Accordingly, I conclude that Petitioner did not violate 42 C.F.R. § 483.12(a)(2) as alleged by the survey completed on February 10, 2010.

2. Petitioner did not violate 42 C.F.R. § 483.13(b) and (c)(1)(i) (Tag F223).

3. Petitioner did not violate 42 C.F.R. § 483.13(c)(1)(ii)-(iii) (Tag F225).

The surveyors allege a violation of 42 C.F.R. § 483.13(b) and (c)(1)(i) (Tag F223) on grounds that Petitioner failed to: (1) investigate and act on allegations of physical, verbal, and mental abuse of residents by a staff member; and (2) to supervise staff to prevent abuse. The surveyors cited examples involving four residents. CMS Ex. 2, at 5-17. However, the surveyors do not specifically allege that they found or concluded that abuse actually occurred.

The surveyors record in the SOD numerous allegations by confidential sources, staff members, and residents of physical or verbal abuse or mistreatment of four residents by a certified nursing assistant (CNA) identified as "CNA F" and a Medicare Coordinator (MC) identified as "MC L." CMS Ex. 2, at 7-14, 20-23, 30-36. There is no dispute that CNA F is CNA Pedro Arellanes. P. Ex. 15, at 1. The surveyors do not report that they observed any incident of abuse. The majority of the allegations reported by the surveyors in the SOD and surveyor notes are not verifiable through documents made contemporaneously with the alleged incidents or through the testimony of eyewitnesses and I consider the allegations to be unreliable hearsay. Petitioner objects generally to the hearsay nature of the allegations, but failed to pose any objection to the admissibility of the SOD or the surveyor notes in this case. However, I am required to evaluate the credibility and weight of any evidence I rely upon for my decision even absent a specific objection. I do not find that the surveyor notes at CMS Exs. 4, 5, and 6 are entitled to much if any weight in this case as evidence of actual incidents of abuse. While surveyor notes are a usual and important part of surveying a facility, I do not find the surveyor notes sufficiently reliable to corroborate the allegations and establish a regulatory violation providing a basis for an enforcement remedy in this case. The surveyor notes lack specificity as to the dates of the occurrence of alleged incidents. The surveyor notes are only notes rather than complete summaries of statements received by the surveyors and are mostly indecipherable, absent surveyor testimony explaining them. The declarations of Surveyor Aguilar and Program Manager Hinojos authenticating their surveyor notes are conclusory at best and do not clarify or elaborate upon their notes. CMS failed to even submit a declaration from Surveyor Golden. The declarations of the surveyors are not helpful for understanding their notes. The surveyor notes merely summarize the questions that the surveyors asked staff and residents and the surveyors' perception of the responses received. The notes do not summarize the actual questions asked and answers received. The surveyor notes do not reveal how the individuals interviewed obtained the information they shared with the surveyors. The surveyor notes do not describe the ability of the individuals interviewed to perceive what they alleged. The surveyor notes do not reflect that the individuals interviewed reviewed the notes and agreed that the surveyor accurately summarized what was said. I find the surveyors' notes are simply too unreliable to be considered as weighty evidence to support a conclusion that abuse actually occurred. I conclude that the allegations reflected in the surveyor notes and the SOD are insufficient and do not constitute the competent evidence necessary to meet CMS's burden to make a prima facie showing under 42 C.F.R. § 483.13(b) and (c)(1)(i) (Tag F223) that abuse occurred. Accordingly, I conclude that no violation of 42 C.F.R. § 483.13(b) and (c)(1)(i) (Tag F223) is shown by the evidence before me.

The surveyors allege a violation of 42 C.F.R. § 483.13(c)(1)(ii)-(iii), (2), (3), and (4) (Tag F225). Subsection 483.13(c)(1)(ii) provides that a facility may not employ individuals who have either been found guilty of abusing, neglecting, or mistreating residents, or who have been listed on a state nurse aide registry for abuse, neglect, mistreatment of

residents, or misappropriation of resident property. Subsection 483.13(c)(1)(iii) requires that a facility report to the state nurse aide registry or licensing authority any knowledge the facility has of court actions against an employee that indicates unfitness for service as a nurse aide or other facility staff. The SOD alleges no facts showing a potential violation of 42 C.F.R. § 483.13(c)(1)(ii) or (iii). Accordingly, I find no violation of those provisions.

4. Petitioner violated 42 C.F.R. § 483.13(c)(2), (3), and (4) (Tag F225).

5. Petitioner violated 42 C.F.R. § 483.13(c) (Tag F226).

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

The surveyors allege under Tag F225, that Petitioner failed to ensure that: (1) all allegations of abuse were reported to the state agency as required by 42 C.F.R. § 483.13(c)(2) and (4); (2) all allegations of abuse were thoroughly investigated as required by 42 C.F.R. § 483.13(c)(3); and (3) further potential abuse was prevented while the investigation was in progress as required by 42 C.F.R. § 483.13(c)(3). The surveyors also cited examples related to the same four residents as cited under Tag F223. CMS Ex. 2, at 17-27.

The surveyors allege a violation of 42 C.F.R. § 483.13(c) (Tag F226) on grounds that Petitioner failed to develop and implement policies and procedures that prohibit mistreatment, neglect and abuse of residents. The surveyors cited examples related to the same four residents as under Tags F223 and F225. CMS Ex. 2, at 27-38.

The surveyors declared immediate jeopardy on February 5, 2010, at 3:30 p.m., and determined that the immediate jeopardy was abated on February 10, 2010, at 2:40 p.m., after Petitioner implemented its action plan. CMS Ex. 2, at 6.

Petitioner denies knowledge prior to the survey of any of the allegations of abuse cited by the surveyors, except two. The first allegation was made on February 3, 2009, during a resident council meeting at which a resident reported that he witnessed CNA Arellanes verbally abuse a resident. The second allegation is documented on a facility complaint form dated October 30, 2009, in which a Licensed Vocational Nurse (LVN) reported that Resident 12 reported to her that CNA Arellanes had been cursing and calling the resident names. P. Br. at 3, 5, 19-20; P. Reply at 4; P. Ex. 12, at 1, 7; P. Ex. 13, at 1, 7-8, 13; CMS Ex. 2, at 14, 23-24, 36. Petitioner concedes that the two incidents it acknowledges were reported to Petitioner's managers prior to the survey. Petitioner asserts that neither of the alleged incidents involved an allegation of physical abuse. P. Reply at 4. The evidence related to Petitioner's handling of the two allegations establishes a prima facie showing of violations of 42 C.F.R. § 483.13(c) and (c)(2)-(4) that Petitioner has failed to

rebut. The evidence also shows that when Petitioner investigated the allegations raised by the surveyors, Petitioner learned that staff failed to report prior instances of suspected abuse in violation of Petitioner's abuse prevention policy and procedures, showing that Petitioner's policy and procedures were not implemented. I conclude that it is unnecessary to discuss every incident and example alleged in the SOD.

a. Facts

(i) The February 3, 2009 Allegation of Verbal Abuse

During a resident council meeting on February 3, 2009, the council president, Resident 13, reported that he witnessed "verbal abuse" of another resident by CNA Pedro Arellanes. CMS Ex. 10, at 38. A Nurse Notes form, dated February 3, 2009, records that at a resident council meeting at 10:30 a.m. on February 3, 2009, Resident 13 reported that on Saturday, January 31, 2009, CNA Arellanes called Resident 8 "momia." Resident 13 also reported that Resident 8 was showing CNA Arellanes what the resident called a ticket, which CNA Arellanes told him was a plain hand towel. The document also shows that CNA Arellanes denied working Saturday, January 31, 2009, but stated that he did work on Sunday, February 1, 2009. CNA Arellanes stated that he and another CNA call each other "momia" on a daily basis. CNA Arellanes stated he never called a resident a "momia." CNA Arellanes stated that during the last week of January 2009, Resident 8 did show him a hand paper towel, stating that it was a lottery ticket. CNA Arellanes stated that he told Resident 8 that it was a hand paper towel. The form indicates that the investigator concluded that the allegation of verbal abuse was unfounded. The form indicates that staff was advised to refrain from using the nickname "momia" while on the floor. The investigator noted that residents might mistake the CNAs' use of "momia" for something else. P. Ex. 12, at 1.

CNA Luis Juarez corroborated that he was present when the resident had the paper towel and claimed it was a lottery ticket. He also corroborated that he and CNA Arellanes had nicknames for each other, including "momia," which CNA Juarez clarified means mummy. P. Ex. 9, at 15-16; P. Ex. 12, at 3-5.

In an affidavit dated February 22, 2011, Petitioner's Director of Nursing (DON), Lillian Jabines, states that she was aware of the verbal abuse allegation made against CNA Arellanes during the February 3, 2009 resident council meeting. She states that Petitioner's activities director, Fermin Chavez, conducted the investigation. DON Jabines states that she read the report and concurred with the finding that no verbal abuse occurred. She states she interviewed the two CNAs involved and counseled them to be more careful with their language in front of residents. P. Ex. 9, at 13; P. Ex. 12, at 7.

There is no evidence that CNA Arellanes was suspended or that Resident 8 was otherwise protected from potential abuse during the investigation. There is no evidence that the

complaint was reported to the administrator. There is no evidence that the complaint was reported to the state agency. There is no evidence that the results of the investigation were reported to the administrator or the state. Petitioner's Administrator, Dionicio Rivera, states in his affidavit executed on February 22, 2011, that he reviews all complaint forms generated in the facility and ensures that a full and proper investigation is done. P. Ex. 9, at 5-6. However, Administrator Rivera does not mention that he received the February 3, 2009 allegation of verbal abuse. Petitioner's Assistant Administrator (AA), Donovan Rivera, states in his affidavit that when he received notice from the surveyors that there was immediate jeopardy due to allegations of abuse against CNA Arellanes, he immediately suspended CNA Arellanes who never returned to work. AA Rivera does not mention the February 3, 2009 allegation of abuse. P. Ex. 9, at 7-8.

(ii) The October 30, 2009 Allegation of Abuse

A facility complaint form dated October 30, 2009, states that Resident 12 notified LVN Gonzalez that he was not feeling good, and, when she asked him what was wrong, he stated that "[t]hose two guys were cussing and calling me names." He told her the two guys were "Luis and Pedro." The comments section of the form, states that witness statements from Maria Mott and Veronica Hermosillo (also known as Veronica Jaramillo) are attached. A note at the bottom of the form indicates that "Luis and Pedro" were verbally counseled to be more careful with how they "verbally and physically" interact with residents. The note states that observation shows that staff was following through and there were no further complaints. CMS Ex. 8, at 1; P. Ex. 13, at 1. In a written statement dated March 8, 2010, after the survey, LVN Gonzalez clarified her prior statement on the complaint form. LVN Gonzalez clarified that CNAs Mott and Hermosillo did not witness the alleged incidents of rude acts or rough handling, rather, they witnessed Resident 12 make his complaint. P. Ex. 13, at 2.

DON Jabines states in her affidavit dated February 22, 2011, that she did not receive the October 30, 2009 complaint as she was on vacation. She states that LVN Rae Michelle Thweatt and Norma Rivera handled Resident 12's verbal abuse allegation. P. Ex. 9, at 13. Norma Rivera, Petitioner's Admissions and Medicare Coordinator, did not mention the October 30, 2009 allegation in her affidavit dated February 22, 2011. P. Ex. 9, at 21. LVN Thweatt stated in her affidavit dated February 24, 2011, that on October 30, 2009, she received a complaint form completed by LVN Elizabeth Gonzalez. LVN Thweatt states that she interviewed Resident 12 and the two CNAs. There were no witnesses to the alleged verbal abuse and the two CNAs denied verbally abusing Resident 12. LVN Thweatt states that she knew Resident 12 sometimes had bad days and got confused and he also sometimes used "very bad language on the CNAs." She states she counseled the two CNAs to be careful how they "talk and kid" with Resident 12 and to be "respectful" of him. She observed the two CNAs the following week and saw they were treating the residents appropriately, and there were no further complaints. She concluded that the

allegation of verbal abuse was unfounded, based on her own interaction with Resident 12 and his history at the facility. P. Ex. 13, at 5-6; P. Ex. 9, at 19-20.

CNA Juarez denies in his affidavit that he used abusive language with Resident 12. He also stated that he did not witness CNA Arellanes using abusive language. CNA Juarez states that Resident 12 has called him a "wetback" or "Mexican." CNA Juarez states that if he did something wrong, Resident 12 would say, "[i]t had to be a Mexican" or he would threaten CNA Juarez with deportation. P. Ex. 13, at 7-8.

There is no evidence that CNA Arellanes was suspended or that Resident 12 was otherwise protected from potential abuse during the investigation. There is no evidence that the complaint was reported to the administrator. There is no evidence that the complaint was reported to the state agency. There is no evidence that the results of the investigation were reported to the administrator or the state. Administrator Rivera states in his affidavit executed on February 22, 2011, that he reviews all complaint forms generated in the facility and ensures that a full and proper investigation is done. P. Ex. 9, at 5-6. However, Administrator Rivera does not mention that he received the October 30, 2009 allegation of abuse. AA Rivera also fails to mention the October 30, 2009 allegation in his affidavit. P. Ex. 9, at 7-8.

(iii) Petitioner's Abuse Policy

There is no dispute that Petitioner had a policy that required that its residents be free from abuse and neglect and that imposed upon all personnel the obligation to report to proper authorities an incident of abuse, mistreatment, or neglect. The policy is set forth in several different documents issued by Petitioner that are in evidence. CMS Ex. 9, at 9-21; P. Ex. 8; P. Ex. 16, at 2. The surveyors do not allege under Tag F226 that Petitioner did not have the policies and procedures required by 42 C.F.R. § 483.13(c). Rather, the surveyors allege that Petitioner failed to implement the policies and procedures that prohibit mistreatment, neglect, and abuse of residents. CMS Ex. 2, at 27.

Petitioner's policy defines abuse as any "act, failure to act, or incitement to act done willfully, knowingly, or recklessly through words or physical action which causes or could cause mental or physical injury or harm or death to a resident." Verbal abuse is defined as using oral, written or gestured language which includes terms disparaging or derogatory to a resident or within the resident's hearing distance without regard to the resident's age, ability to comprehend, or disability. Mental or psychological abuse involves mistreatment that does not result in physical harm and may include humiliation, harassment, threats of punishment, deprivation, and intimidation. CMS Ex. 9, at 9-10.

Petitioner's abuse policy provides that facility residents will be free from abuse. Personnel are required to report any incident pertaining to abuse or neglect to the proper authorities and failure to report subjects the employee to criminal prosecution. Any

facility owner or employee having cause to believe that a resident's physical or mental health or welfare has been, or may be, adversely affected by abuse by another person must report the abuse immediately. Petitioner's procedure for an employee witnessing resident abuse is for the employee to immediately report the incident to the charge nurse, DON, administrator, state agency, or local law enforcement. The facility requests that if an employee reports to the state agency or law enforcement, the employee inform the administrator or DON so that they can take necessary and immediate remedial measures. Petitioner's policy requires that an oral report by the administrator or designee to the proper authorities must be performed immediately upon learning of the abuse, followed by a written report within five days. All reports must contain the name and address of the facility and of the employee accused. The administrator, the DON, or charge nurse will conduct the investigation immediately. CMS Ex. 9, at 9-10.

Petitioner's policy and procedures in evidence are inconsistent regarding the protection of residents during an investigation. The July 1, 2000 revision of the policy, a "Personnel Policy – Revision/Clarification," and a "Patient Abuse Investigation" policy or procedure specify that an alleged perpetrator will be suspended during the investigation of an abuse complaint. CMS Ex. 9, at 16, 18. 21. The form that employees signed that sets forth the policy only provides that an employee may be suspended. CMS Ex. 9, at 10; P. Ex. 8, at 8-41. The August 15, 2000 revision of the policy also indicates that an accused employee may be suspended, and not that the employee will be suspended. The revised policy provides that to protect a resident in a case when an employee is not suspended following an abuse allegation, the employee will be transferred during that shift to another wing or asked not to handle the affected resident to prevent further contact between the employee and resident. CMS Ex. 9, at 11-12. If the employee involved was a nurse aide, the incident was to be reported to the nurse aide registry and could result in suspension of the employee's license. CMS Ex. 9, at 9-21.

CNA Maria V. Mott states in her affidavit executed on February 24, 2011, that one time she worked with CNA Arellanes and she thought he handled a resident too roughly. She did not report the incident and stated that she did not know if it was abuse, but she did not like it. P. Ex. 9, at 29-30; P. Ex. 13, at 3-4. Her affidavit is consistent with her February 3, 2010 statement during Petitioner's investigation of the allegations identified during the survey. P. Ex. 7, at 24-26; CMS Ex. 8, at 41. CNA Veronica Jaramillo (P. Ex. 15, at 1) also reported on February 3, 2010, that she had seen CNA Arellanes treat residents badly, saying bad words and hitting a resident on the head, but she had not reported her

observations because she had heard someone had reported in the past and nothing was done.[6] P. Ex. 7, at 24-25; CMS Ex. 8, at 41-44.

b. Analysis

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 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 require that a facility 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 facility must "[n]ot use verbal, mental, sexual, or physical abuse, corporal punishment or involuntary seclusion." 42 C.F.R. § 483.13(c)(1)(i). The facility "must ensure that all alleged violations involving mistreatment, neglect, or abuse . . . are reported immediately to the administrator of the facility and to other officials in accordance with State law." 42 C.F.R. § 483.13(c)(2). The facility "must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse" during the investigation. 42 C.F.R. § 483.13(c)(3). The facility must ensure that the results of all investigations are "reported to the administrator or his designated representative and to other officials in accordance with State law . . . within 5 working days of the incident." 42 C.F.R. § 483.13(c)(4). The regulations define "abuse" to be "the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish." 42 C.F.R. § 488.301.

As discussed under Conclusion of Law 2 related to Tag F223, it is not possible given the quality of the evidence to determine whether any abuse actually occurred in this facility. However, a conclusion that abuse occurred is not a threshold requirement for a finding that Petitioner violated the regulations in issue.

I conclude that CMS has made a prima facie showing of violations of 42 C.F.R. § 483.13(c) that Petitioner has not rebutted. The evidence shows that Petitioner's staff failed to report the allegations of abuse from February and October 2009 to the state agency. Petitioner has also failed to produce evidence that it protected its residents during investigation of the alleged abuse in February and October 2009. The evidence

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[6] CNA Jaramillo's statement is unsigned. However, it is offered as evidence by both parties and is therefore not disputed.

also shows that Petitioner failed to implement its abuse policy. Petitioner does not deny that allegations were made in February and October 2009, regarding CNA Arellanes. Petitioner argues that both of these complaints were fully investigated and resolved in accordance with applicable law and Petitioner's internal policies. P. Br. at 3, 19; P. Reply at 4. The evidence, however, does not support Petitioner's argument.

It is undisputed that during the resident council meeting on February 3, 2009, a resident reported that he witnessed CNA Arellanes verbally abuse a resident. CMS Ex. 10, at 38; P. Ex. 9, at 13; P. Ex. 12, at 1, 7. Whether or not the resident correctly interpreted the incident as one of verbal abuse is not the issue. In fact, it was Petitioner's activities director that characterized the incident as verbal abuse in her notes from the resident council meeting. CMS Ex. 10, at 38. Thus, at least Petitioner's activities director recognized an allegation of potential abuse. The issue is whether Petitioner responded to the allegation as required by law. DON Lillian Jabines' affidavit shows that an investigation was conducted by Petitioner's activities director with the conclusion that there was no verbal abuse. P. Ex. 9, at 13; P. Ex. 12, at 7. The fact that Petitioner's staff concluded after investigation that there was no verbal abuse did not relieve Petitioner of the obligation to comply with the requirements of 42 C.F.R. § 483.13(c).

There is no evidence that Petitioner complied with 42 C.F.R. § 483.13(c)(3) as there is no evidence that CNA Arellanes was suspended or that Resident 8 was otherwise protected from potential abuse during the investigation. There is no evidence that Petitioner complied with 42 C.F.R. § 483.13(c)(2) as there is no evidence that the allegation was immediately reported to the administrator or the state agency. Administrator Rivera states in his affidavit executed on February 22, 2011, that he reviews all complaint forms generated in the facility and ensures that a full and proper investigation is done. P. Ex. 9, at 5-6. However, Administrator Rivera does not mention that he received the February 3, 2009 allegation of verbal abuse. AA Donovan Rivera also does not mention the February 3, 2009 allegation of abuse in his affidavit. P. Ex. 9, at 7-8. There is also no evidence that Petitioner complied with the requirement to report the results of its investigation to either the administrator or the state. The regulation clearly imposes upon Petitioner the burden to document its investigation and compliance with 42 C.F.R. § 483.13(c). Petitioner has not presented evidence establishing compliance with the regulation. I conclude Petitioner violated 42 C.F.R. § 483.13(c) based upon the February 2009 incident.

The evidence shows that on about October 30, 2009, Resident 12 complained to LVN Gonzalez that CNA Arellanes and CNA Juarez were cussing and calling him names.[7] Whether or not the resident correctly interpreted the incident as one of verbal abuse is not the issue. The evidence shows that LVN Gonzalez interviewed a couple witnesses and then verbally counseled CNA Arellanes and CNA Juarez that they need to be more careful of both their verbal and physical interaction with residents. P. Ex. 13, at 1. DON Jabines testified in her affidavit that she believed LVN Thweatt and Ms. Rivera handled Resident 12's allegation of abuse. P. Ex. 9, at 13. Ms. Rivera did not mention participating in any investigation related to the October 2009 incident in her affidavit. P. Ex. 9, at 21. LVN Thweatt testified in her affidavit that she interviewed Resident 12 and the two CNAs and concluded that Resident 12 had bad days and was sometimes abusive of CNAs. She stated that she counseled the CNAs to be more careful of how they speak to the resident. She stated that she observed the two CNAs for the following week and observed no problem and received no complaint. P. Ex. 13, at 5-6; P. Ex. 9, at 19-20.

As with the February 2009 allegation of abuse, there is no evidence that Petitioner complied with 42 C.F.R. § 483.13(c)(3) as there is no evidence that CNA Arellanes or CNA Juarez were suspended or that Resident 12 was otherwise protected from potential abuse during the investigation. There is no evidence that Petitioner complied with 42 C.F.R. § 483.13(c)(2) as there is no evidence that the allegation was immediately reported to the administrator or the state agency. Administrator Rivera states in his affidavit executed on February 22, 2011, that he reviews all complaint forms generated in the facility and ensures that a full and proper investigation is done. P. Ex. 9, at 5-6. However, Administrator Rivera does not mention that he received the October 30, 2009 allegation of verbal abuse. AA Rivera, also does not mention the October 30, 2009 allegation of abuse. P. Ex. 9, at 7-8. There is also no evidence that Petitioner complied with the requirement to report the results of its investigation into the allegation of abuse

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[7] A hand-written, unsigned statement dated February 8, 2010, purports to be a statement of Elizabeth A. Gonzalez. CMS Ex. 8, at 45. I do not give this statement any weight as it is unsworn and without other sufficient indicia of reliability. Petitioner did not offer a copy of the statement with its evidence or otherwise indicate it did not contest the content of the statement. I note the statement suggests that Nurse Gonzalez personally observed CNA Arellanes speak to residents in an "undermining manner." The statement also indicates that Resident 12 claimed that CNA Arellanes handled him roughly, which is potentially an allegation of physical abuse. More thorough investigation and documentation by the surveyors and their testimony or the testimony of LVN Gonzalez at hearing may have permitted consideration of this evidence. Nevertheless, CMS satisfies its burden to make a prima facie showing even without consideration of this evidence.

to either the administrator or the state. The regulation clearly imposes upon Petitioner the burden to document its investigation and compliance with 42 C.F.R. § 483.13(c). Petitioner has not presented evidence to establish compliance with the regulation. I conclude Petitioner violated 42 C.F.R. § 483.13(c) based upon the October 2009 incident.

I further conclude that the evidence shows that Petitioner had the abuse policy required by 42 C.F.R. § 483.13(c). However, Petitioner failed to implement its policy. Petitioner's errors in addressing the February and October 2009 allegations of abuse clearly establish that Petitioner failed to implement its policy. The affidavit of CNA Mott also shows that the policy was not implemented prior to the survey. CNA Mott states in her affidavit executed on February 24, 2011, that one time she worked with CNA Arellanes and she thought he handled a resident too roughly. However, she did not report the incident as she did not know if it was abuse, but she knew that she did not like it. P. Ex. 9, at 29; P. Ex. 13, at 3. Her affidavit is consistent with her February 3, 2010 statement given during Petitioner's investigation of the allegations identified during the survey. P. Ex. 7, at 24-26; CMS Ex. 8, at 41. CNA Jaramillo's statement also supports the conclusion that Petitioner failed to implement its policy. CNA Jaramillo reported on February 3, 2010, that she had seen CNA Arellanes treat residents badly, saying bad words and hitting a resident on the head, but she had not reported her observations because she had heard someone had reported in the past and nothing was done. P. Ex. 7, at 24-25; CMS Ex. 8, at 41-44.

The inability of staff to identify abuse and to understand and fulfill the requirements to report to the administrator and state officials is credible and weighty evidence that Petitioner failed to implement its abuse policy.

Petitioner asserts that it complied with 42 C.F.R. § 483.13(c)(2) because it investigated the reports regarding the February and October 2009 allegations; it was determined that abuse did not occur; and, therefore, Petitioner was not required to report to the state agency. Petitioner cites its policy and the Texas statutes in support of its argument. P. Br. at 19; P. Reply at 13-15. Petitioner is in error. The federal regulation requires that the facility "must ensure that all alleged violations involving mistreatment, neglect, or abuse . . . are reported immediately to the administrator of the facility and to other officials in accordance with State law." 42 C.F.R. § 483.13(c)(2). All alleged violations must be reported to the administrator. Thus, even if Petitioner is correct in its interpretation of the Texas statute, Petitioner has failed to show that the alleged abuse in February and October 2009 was reported to Administrator Rivera as required by 42 C.F.R. § 483.13(c)(2).

Petitioner also errs in its interpretation of the Texas statutes. The federal regulation requires that all allegations of abuse be reported to officials in accordance with state law. 42 C.F.R. § 483.13(c)(2). The Texas statute provides:

> A person, including an owner or employee of an institution, who has cause to believe that the physical or mental health or welfare of a resident has been or may be adversely affected by abuse or neglect caused by another person shall report the abuse or neglect in accordance with this subchapter.

Tex. Health & Safety Code § 242.122 (1989). The gist of Petitioner's argument is that the Texas code section allows Petitioner to first determine whether or not abuse or neglect occurred before Petitioner's obligation to report to the state agency is triggered. The plain language of the Texas code section indicates that one "who has cause to believe" that a resident "may be adversely affected by abuse or neglect" must report. The code section does not specify how much "cause" is necessary to trigger the reporting requirement. But the language "may be adversely affected" suggests a very low threshold. The remaining language of the Texas statute, including the existence of criminal sanctions for failure to report, strongly supports my interpretation that a mere allegation of abuse with any possible adverse effect triggers mandatory and immediate reporting without any preliminary determination by the owner or operator of a nursing facility. Tex. Health & Safety Code §§ 242.123-.135. However, even if my interpretation of the Texas statute is in error, 42 C.F.R. § 483.13(c)(2) controls and requires that all allegations of abuse be reported to state officials, using the procedures specified under state law. *Britthaven, Inc., d/b/a/ Britthaven of Smithfield*, DAB No. 2018 (2006); *Cedar View Good Samaritan*, DAB No. 1897, at 11 (2003).

Petitioner argues that: it gave staff and residents the opportunity to voice concerns and report staff behavior without fear of retribution; the abuse hotline number and department head telephone numbers were posted; employees could make anonymous reports through the hotline; in-service trainings on abuse and neglect were done during the six months preceding the survey; new employees were trained on the requirements of Petitioner's abuse policy; and an administrator's memorandum stating the abuse and neglect policy was issued to staff and posted on the bulletin board. P. Br. at 21-23; P. Reply at 16-17. Despite Petitioner's efforts to educate its staff, the evidence discussed herein shows that staff failed to recognize potential abuse or allegations of abuse and failed to immediately report to the administrator and the state agency as required by law. Thus, Petitioner fails to rebut the evidence showing that it failed to implement its policy.

Petitioner disputes that its noncompliance posed immediate jeopardy. P. Br. 27-29; P. Reply at 21-23. Petitioner bears the burden of showing that CMS's finding of immediate jeopardy is clearly erroneous. Petitioner argues, referring to the SOM, appendix Q, that the applicable triggers for immediate jeopardy do not exist in this case. Petitioner argues that no substantiated evidence exists of psychological harm to the residents involved. Petitioner argues that the applicable triggers for immediate jeopardy also require a lack of intervention on the facility's part, which it asserts did not occur here because it investigated the two complaints and had no cause to believe that a resident's physical or

mental health or welfare had been or might have been adversely affected by abuse. Petitioner asserts that such adverse affect is the standard for reporting abuse to state authorities, consistent with the Texas statutes and with Petitioner's own abuse and neglect policy. Moreover, Petitioner argues that the scope of any problem at the facility was not widespread. Petitioner also argues that there was not a systemic failure of Petitioner's abuse and neglect policy.

I conclude that Petitioner failed to meet its burden and has not shown that the declaration of immediate jeopardy was clearly erroneous. It is not subject to dispute that residents of nursing homes are susceptible to mental or physical harm from all forms of abuse. Petitioner's failure to implement its policy prohibiting abuse; the failure of Petitioner and its staff to report; and Petitioner's failure to take measures to protect its residents; exposed Petitioner's residents to a high risk for abuse and resulting serious harm or death**.** Petitioner has not presented evidence that would support a conclusion to the contrary.

Petitioner has not presented evidence or argued that it returned to substantial compliance prior to March 20, 2010.

7. Petitioner violated 42 C.F.R. § 483.75 (Tag F490).

8. Petitioner did not show that the determination that the deficiency posed immediate jeopardy was clearly erroneous.

I also conclude based on this record that there is a derivative violation of 42 C.F.R. § 483.75 (Tag F490) as the failure of management to act appropriately in this case is significant evidence that the facility was not being administered so as to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.

The regulation requires that a long-term care facility 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. I have concluded that from at least February 2009 through March 19, 2010, 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.[8] 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 a year. 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 related to the violations of Tags F225 and F226.

9. Petitioner was not in substantial compliance with participation requirements for the entire period beginning February 5, 2010 through March 19, 2010.

10. A CMP of $5,550 per day from February 5 through 10, 2010, and $600 per day from February 11 through March 19, 2010, a total CMP of $55,500; and a DPNA for March 18 and 19, 2010, are reasonable enforcement remedies.

11. Petitioner's ineligibility to conduct a NATCEP is by operation of law.

I have concluded that Petitioner violated 42 C.F.R. §§ 483.13(c) and (c)(2), (3), and (4) and 483.75. I have further concluded that Petitioner has not shown that the declaration of immediate jeopardy was clearly erroneous. 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 per day CMP for the number of days that the facility is not in compliance or a PICMP for each instance that a facility is not in substantial compliance, whether or not the deficiencies pose immediate jeopardy. 42 C.F.R. § 488.430(a). CMS proposes to impose a per day CMP of $5,550 for the period of immediate jeopardy and $600 per day for the period after immediate jeopardy was abated. I have found that there are bases for the imposition of an enforcement remedy, including the CMP and the DPNA. The CMPs proposed by CMS are well within the ranges for authorized CMPs. 42 C.F.R. §§ 488.408, 488.438.

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[8] There is evidence that in December 2009, January 2010, and during the survey in February 2010, Petitioner conducted investigations of alleged abuse that were not cited by the surveyors as deficient. CMS Ex. 7; CMS Ex. 8, at 25-36; P. Ex. 7 at 31-41. However, Petitioner does not argue that those investigations show that Petitioner returned to substantial compliance prior to March 2010.

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 noncompliance, 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 and the absence of culpability is not a mitigating factor. The factors that CMS and the state were required to consider when setting the CMP amount and that I am required to consider when assessing the reasonableness of the amount are set forth in 42 C.F.R. § 488.404(b): (1) whether the deficiencies caused no actual harm but had the potential for minimal harm, no actual harm with the potential for more than minimal harm, but not immediate jeopardy, actual harm that is not immediate jeopardy, or immediate jeopardy to resident health 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 14–16 (1999); *Capitol Hill Cmty. Rehab. and Specialty Care Ctr.*, DAB No. 1629 (1997).

CMS initially imposed a PICMP of $8,500 for an instance of noncompliance on February 10, 2010. CMS subsequently revised its remedies and the PICMP was rescinded and a per day CMP was imposed. CMS Ex. 1, at 1-5. Petitioner argues that CMS exceeded its authority in revising the CMP from a per instance to a per day. P. Reply at 23-25. Petitioner argues that 42 C.F.R. §§ 488.430 and 488.444 do not permit CMS to revise a PICMP to a per day CMP. Petitioner's interpretation of the regulations is faulty, as no language in either regulation prevents CMS from exercising its discretion to select the appropriate type CMP. CMS may reopen and revise any initial or reconsidered determination within 12 months after the date of the notice of the initial determination (42 C.F.R. § 498.30), except when the CMS determination is the subject of an ALJ or Board decision (42 C.F.R. §§ 498.74 and 498.90). Petitioner also cites a provision of the SOM in support of it argument. However, the SOM provision cited by Petitioner is within the statement of CMS policies to guide the survey and the enforcement process. The SOM does not limit Secretarial or CMS authority, but must be construed consistent with the Act and regulations. Furthermore, the SOM provision referred to by Petitioner

(currently SOM, Chap. 7, § 7516.3 (eff. Sep. 10, 2010)) does not refer to the reopening and revision of an initial determination by CMS. Rather, the provision of the SOM provides guidance to CMS and the state surveyors for determining whether to change the amount of the CMP when, during the course of the survey cycle, there is an increase or decrease in the number or severity of the cited instances of noncompliance.

Petitioner argues that the amount of the CMP imposed is unreasonable. Petitioner asserts, citing *CarePlex of Silver Spring*, DAB No. 1683, at 8, that I should focus on whether the amount of the CMP imposed is reasonably related to an effort to produce corrective action. P. Br. at 29-30; P. Reply at 25-26. Petitioner's reliance upon the decision in *CarePlex* is at odds with its argument. In *CarePlex*, an appellate panel of the Board found it error for the ALJ to evaluate the evidence related to the reasonableness of the CMP in terms of whether the CMP was remedial or punitive. The Board in *CarePlex* concluded that an ALJ's de novo review is limited to whether the evidence presented supports factual findings as to the regulatory factors.

Petitioner argues that CMS has not established that Petitioner is highly culpable or that Petitioner has a history of repeat deficiencies. Petitioner argues that a per day CMP of $5,550 for six days beginning on February 5, 2010 and continuing through February 10, 2010 is too high, because CNA Arellanes was suspended on February 5, 2010, and afterwards had no access to residents. I conclude, based on my de novo review related to the regulatory factors, that the CMP proposed by CMS is reasonable, even though I have concluded that there was no noncompliance proved under Tags F201 and F223. I find that Petitioner's noncompliance is serious, and Petitioner has not shown that the declaration of immediate jeopardy from February 5 through 10, 2010, was clearly erroneous. I also conclude that Petitioner was very culpable as Petitioner neglected to ensure that its abuse policy was effectively implemented to protect its residents against abuse. Petitioner is obligated by both the Act and the regulations under which it agreed to operate to protect its residents from abuse. The regulations establish a specific scheme for the reporting and investigation of alleged abuse that Petitioner is further obligated to implement through its own policies and procedures. Elderly residents, who are often demented or of limited capacity to understand and cope, are particularly susceptible to mental or physical abuse. Many states, including Texas, impose criminal sanctions against those who fail to report suspected elder abuse in recognition of the vulnerability of that population. Petitioner conceded that allegations of abuse were received by facility management in February and October 2009, but the evidence shows that Petitioner failed to report to the state or take action to protect its vulnerable residents. Although CNA Arellanes was suspended on February 5, 2010, it was not clear until February 10, 2010, that he would not return to the facility or that Petitioner had accomplished all necessary steps to abate the immediate jeopardy. Petitioner was not found in substantial compliance until March 20, 2010, when the state agency determined that the corrective action was implemented and that Petitioner could maintain substantial compliance. Petitioner has not shown that it returned to substantial compliance before March 20,

2010, or that immediate jeopardy was abated prior to February 10, 2010. Petitioner is correct that the evidence does not show a history of noncompliance prior to the survey at issue before me.

Petitioner argues that the total CMP of $55,500 represents a considerable financial burden and that Petitioner cannot pay the CMP without compromising resident health and safety. P. Br. at 30; P. Reply at 27-28. Petitioner submitted five pages of tax records as evidence that it is unable to pay the CMP. P. Ex. 19. The five pages of tax records reflect the taxpayer name as "Maharlika Resources, Inc." The 2005 form reflects a taxpayer address different from the address for Petitioner listed on the SOD. P. Ex. 19, at 1; CMS Ex. 2. However, the tax forms for 2006, 2007, 2008, and 2009 all list a taxpayer address that is the same as that for Petitioner. P. Ex. 19, at 2-5; CMS Ex. 2. CMS did not object to my consideration of the tax forms so I infer that they are what Petitioner represents they are, that is the tax filings for Petitioner for 2005 through 2009. I do not accept, however, Petitioner's representation that I may infer based on these forms that Petitioner is unable to pay the total CMP. The forms show that Petitioner's accountant is skilled at reducing Petitioner's corporate income tax liability to zero. The forms reveal nothing useful related to Petitioner's assets or liabilities from which I may make a reasonable determination regarding Petitioner's ability to pay. Petitioner has not met its burden and proved its inability to pay the CMP without compromising resident health and safety.

Petitioner was notified in this case of the circumstances under which approval of NATCEP would be withdrawn and that its NATCEP was being withdrawn based on a finding of substandard quality of care. P. Ex. 22, at 2-3. I have also concluded that a CMP of more than $5,000 is reasonable. Thus, Petitioner is ineligible to conduct a NATCEP for two years as a matter of law.

III. Conclusion

For the foregoing reasons, I conclude that Petitioner was not in substantial compliance with program participation requirements from February 5 through March 19, 2010. A CMP of $5,550 per day from February 5 through 10, 2010, and $600 per day from February 11 through March 19, 2010, a total CMP of $55,500; and a DPNA for March 18 and 19, 2010, are reasonable enforcement remedies. Petitioner was ineligible to conduct a NATCEP for two years.

/s/
Keith W. Sickendick
Administrative Law Judge