Department of Health and Human Services
DEPARTMENTAL APPEALS BOARD
Appellate Division

Rosewood Care Center of Swansea
Docket No. A-16-35
Decision No. 2721
July 15, 2016

FINAL DECISION ON REVIEW OF ADMINISTRATIVE LAW JUDGE DECISION

Rosewood Care Center of Swansea (Rosewood or Petitioner), an Illinois skilled nursing facility, appeals the decision of an Administrative Law Judge (ALJ) sustaining the determination of the Centers for Medicare & Medicaid Services (CMS) to impose civil money penalties (CMPs) on Rosewood for failure to comply with the requirements for participation in the Medicare and Medicaid programs. *Rosewood Care Ctr. of Swansea*, DAB CR4408 (2015) (ALJ Decision). The ALJ upheld CMPs in the amounts of $6,050 per day for the period May 12 through May 21, 2014 and $200 per day for the period May 22, 2014 through June 16, 2014 based on findings of noncompliance with regulations prohibiting abuse of nursing home residents and requiring nursing homes to investigate and report complaints of alleged abuse. The ALJ also concluded that the noncompliance was at a level that put residents in immediate jeopardy and that the amount of the CMPs was reasonable. For the reasons stated below, we affirm the ALJ Decision.

Legal Background

To participate in the Medicare program, a long-term care facility, including a skilled nursing facility, must be in "substantial compliance" with the requirements in 42 C.F.R. Part 483. 42 C.F.R. §§ 483.1, 488.400. Under agreements with the Secretary of Health and Human Services, state survey agencies conduct onsite surveys of facilities to verify compliance with the Medicare participation requirements. *Id*. §§ 488.10(a), 488.11; *see also* Social Security Act §§ 1819(g)(1)(A), 1864(a).

A state survey agency reports any "deficiencies" it finds in a Statement of Deficiencies (SOD), which identifies each deficiency under its regulatory requirement and the corresponding "tag" number. A "deficiency" is any failure to comply with a Medicare participation requirement, and "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 (also defining "noncompliance" as "any deficiency that causes a facility to not be in substantial compliance").

CMS may impose remedies on noncompliant facilities, including per-day and/or per-instance CMPs. *Id*. §§ 488.402(b)-(c), 488.406, 488.408(d)(1)(iii)-(iv), 488.408(e)(1)(iii)-(iv), 488.430(a). There are two ranges of per-day CMPs, $50-$3,000 per day for noncompliance at a level less than immediate jeopardy and $3,050-$10,000 per day for noncompliance at the immediate jeopardy level. *Id*. § 488.438. "Immediate jeopardy" is "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." *Id*. § 488.301.

Case Background[1]

This case involves findings of noncompliance with three provisions of 42 C.F.R. § 483.13, a regulation that addresses prevention of abuse and neglect of nursing home residents. The three provisions found unmet are the prohibition against abuse, 42 C.F.R. §§ 483.13(b) and (c)(1)(i); the mandate to investigate allegations of abuse and protect facility residents during the investigation, 42 C.F.R. § 483.13(c)(3); and the requirement that the nursing facility report allegations of abuse and misappropriation of resident property to appropriate authorities, 42 C.F.R. § 483.13(c)(2).[2] Surveyors from the Illinois Department of Public Health (IDPH) found this noncompliance during an annual recertification and complaint survey that began on May 13, 2014 and ended on May 28, 2014.[3] CMS Ex. 9, at 1, 3 (survey team leader declaration); CMS Ex. 1, at 1 (SOD). CMS found, and the ALJ sustained, CMS's determination of noncompliance with these requirements based on alleged deficiencies in Rosewood's care of three Rosewood residents documented on the SOD. CMS Ex. 1. The three residents were identified on the SOD as resident 34, resident 6 and resident 28 to protect their privacy. We refer to these residents as R.34, R.6 and R.28 for the same reason.

[1] The facts stated here are taken from the ALJ Decision and/or the record and are not intended to replace any findings by the ALJ. The facts are undisputed unless we indicate otherwise.

[2] CMS cited additional deficiencies, but the ALJ found these deficiencies "administratively final" since Rosewood "has not offered evidence or argument addressing them." ALJ Decision at 3. Rosewood does not challenge this finding on appeal.

[3] IDPH received the complaint, which involved the alleged mental abuse of R.6, on May 8, 2014. CMS Ex. 15. The surveyors extended the survey, as they were required to do, after finding substandard quality of care. CMS Ex. 6, at 1; 42 C.F.R. § 488.310.

Facts Regarding R.34

R.34 was 92 years old, suffered from end-stage dementia, had severe cognitive impairments and was totally dependent on Rosewood staff for showers, transfers to and from his bed and all other activities of daily living. ALJ Decision at 3-4, citing CMS Ex. 1, at 3. Two people were required to assist R.34 in these activities, and he resisted assistance at times, "almost certainly as a consequence of his advanced dementia," the ALJ stated. *Id*. at 4. Two Rosewood nursing assistants assigned to care for R.34 were involved in a verbal altercation with each other while assisting R.34 with his shower the evening of May 12, 2014. *Id*., citing CMS Ex. 21, at 15; and CMS Ex. 24, at 8. One of the nursing assistants "cursed loudly as she attempted to shower [R.34]."[4] *Id*., citing CMS Ex. 24, at 5; and CMS Ex. 20, at 4. Later that evening, one of the nursing assistants treated R.34 roughly while turning him in bed, with the result that R.34 nearly rolled out of bed onto the floor. *Id*., citing CMS Ex. 24, at 4, 7, 8. Staff reported the alleged abuse to a supervisor on the evening of May 12, but the supervisor discounted the allegations and failed to report or immediately investigate them based on her conclusion that the allegations were the result of a feud between the two nursing assistants. *Id*., citing CMS Ex. 24, at 8; CMS Ex. 21, at 15; and CMS Ex. 9, at ¶ 16. The supervisor also allowed the nursing assistants to continue working despite the uninvestigated allegations of abuse. *Id*.

Facts Regarding R.6

The wife of R.6 complained that a female member of Petitioner's staff had mentally abused R.6 by kissing him more than once and telling him she loved him. *Id*. at 5, citing CMS Ex. 15, at 1. The wife complained that although she had reported this to Rosewood's administrator, Rosewood had not immediately investigated her complaint. *Id*. Rosewood conducted no investigation until after IDPH initiated a complaint investigation. *Id*., citing CMS Ex. 23, at 1. The ALJ found the investigation "palpably incomplete," noting that while Rosewood interviewed and obtained statements from three staff members who denied seeing anyone kiss the resident, and also interviewed R.6, Rosewood did not obtain a statement from R.6 or his wife. *Id*., citing CMS Ex. 23, at 2-11. Rosewood did not report the allegations of mental abuse to State authorities until May 14, 2014 (twelve days after the alleged incident). *Id*., at 6, citing CMS Ex. 23. Subsequently Rosewood filed follow-up reports, including one filed on May 26, 2014 "when Petitioner's management learned that a staff member had in fact kissed [R.6] (although, the purported intent was benign)." *Id*., citing CMS Ex. 26.

[4] We refer to the nurse aide alleged to have abused R.34 as T.S. and the nurse aide who witnessed and reported the incidents underlying the allegation as E.S. On the SOD T.S. was referred to as employee (E) 27, and E.S. as E 28. CMS Ex. 1, at 4.

Facts Regarding R.28

On December 27, 2013, R.28's family reported that his rings were missing, but staff did not report these allegations to Rosewood's administrator until December 30, 2013. *Id*., citing CMS Ex. 21, at 17.

The ALJ Findings and Decision

With the parties' agreement, the ALJ decided the case on the written record, which included the parties' briefs, CMS Exhibits (Exs.) 1-61 and Petitioner (P.) Exs. 1-6. *Id*. at 1-2. The ALJ concluded that the evidence of noncompliance with the requirements under section 483.13 "is mostly uncontroverted and strongly supports CMS's allegations." *Id*. at 3. The ALJ found that staff abused R.34 – by cursing and rough handling directed at him and/or by putting him in the middle of a feud between two nurse aides caring for him – and that Rosewood did not follow federal regulations when it failed to timely report and investigate the allegations by Rosewood staff that he had been abused. *Id*. at 4, 6. With respect to R.6, the ALJ found "unequivocal" the evidence that Rosewood "failed to investigate thoroughly and to report complaints that a member of Petitioner's staff abused the resident [by improperly kissing him]."[5] *Id*. at 4. The ALJ also found "uncontroverted" the facts concerning the alleged misappropriation of R.28's rings and Rosewood's failure to immediately investigate and report the misappropriation. *Id*. at 6.

The ALJ also found that Rosewood violated various provisions of its own anti-abuse policy which, the ALJ noted, "tracks closely the operative language of the governing regulations." *Id*., citing CMS Ex. 22. Among other things, the policy prohibited staff abuse of residents, a policy "plainly violated," the ALJ found, by the abuse directed at R.34 by a nursing assistant and/or suffered by R.34 as a result of being caught in the middle of a verbal altercation between the two nursing assistants. *Id*. at 7. The policy also required Rosewood's administrator to "immediately" report to appropriate State authorities all allegations of abuse and misappropriation of property. *Id*. at 6, citing CMS Ex. 22, at 1. The ALJ noted, "There is nothing in this policy that gives Petitioner's management discretion to either delay reporting or to make judgments about which allegations are credible (and thus meriting reporting) and which are not (thereby not meriting reporting)." *Id*. Rosewood "plainly violated" this policy, the ALJ concluded, by "not reporting immediately the allegations concerning [R.6]." *Id*. Rosewood's anti-abuse policy also required staff to immediately report allegations of abuse to Rosewood management, a policy violated, the ALJ found, when the supervisor receiving reports of alleged abuse involving R.28 and R.34 did not immediately report these allegations to

[5] The ALJ found the evidence as to whether R.6 was actually abused "equivocal," but he also noted, correctly, that CMS had not contended he was abused, only that Rosewood failed to investigate and report the allegation of abuse. *Id*.

management. *Id*. Finally, the ALJ found that Rosewood violated the requirement in its anti-abuse policy that the facility document concerns expressed by a resident's family when staff failed to thoroughly investigate the complaint by R.6's spouse that a female staff member kissed R.6 inappropriately. *Id*. at 6-7.

Analysis

A. The ALJ's findings are supported by substantial evidence and his conclusion that Rosewood was not in substantial compliance with multiple requirements of 42 C.F.R. § 483.13 is legally correct.

The abuse regulation, 42 C.F.R. § 483.13, provides in relevant part:

> (b) *Abuse*. The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.
> (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.
> (1) The facility must—
> (i) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; . . . .
> (2) The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including . . . misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law . . . ;
> (3) The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.

The ALJ began his decision by noting that it was unclear whether Rosewood was arguing that it was in substantial compliance with these regulatory requirements or, instead, was only challenging the immediate jeopardy level of noncompliance found by CMS and the corresponding CMP amount. *See* ALJ Decision at 2 n.1. Nonetheless, "[o]ut of an abundance of caution," the ALJ addressed both the noncompliance and the level of noncompliance. *Id.*

The ALJ found that Rosewood had allowed R.34 to be physically and verbally abused in violation of sections 438.13(b) and (c)(1)(i) and that Rosewood's failure to take the allegations of abuse against R.34 seriously "contributed to an ongoing climate in which more abuse could have easily occurred." ALJ Decision at 3, 4. The ALJ further found that Petitioner violated section 483.13(c)(3) by failing to investigate allegations of abuse

and protect its residents during the investigations. *Id*. These findings were based on the incident involving R.6 as well the incidents involving R.34. The ALJ also found, as CMS alleged, that Rosewood did not comply with section 483.13(c)(2) "because it failed to report to appropriate authorities allegations of neglect, abuse, and misappropriation of resident property." *Id*. at 3. These findings were based on the allegations involving R.34, R.6 and R.28. Finally, the ALJ found that Rosewood violated section 483.13(c) "because it failed to implement its own anti-abuse policies." *Id*.

On appeal, as before the ALJ, it is unclear whether Rosewood is challenging the findings of noncompliance or only the findings regarding the immediate jeopardy level of noncompliance. Rosewood points to no affirmative evidence of compliance but, instead, cites alleged flaws in the survey process which it contends "materially affected the objectivity of the investigation and the reasonable conclusions to be drawn therefrom." Given these alleged flaws, Rosewood asserts, "the Board should reduce the scope and severity findings in this survey and reduce the CMP." Request for Review (RR) at 4. Nonetheless, our review assumes, as did the ALJ's, that Rosewood is challenging the ALJ's findings and conclusion that Rosewood was not in substantial compliance with the regulatory requirements cited as well as the immediate jeopardy determination. As discussed below, we find no merit to either challenge.

1. *The record and law support the ALJ's conclusions that Rosewood staff abused R.34 physically and verbally in violation of sections 483.13(b) and (c)(1)(i) and that Rosewood violated sections 483.13(c)(2) and (3) by not timely investigating and reporting the allegations of that abuse.*

The ALJ concluded the evidence of record established that Rosewood staff verbally and physically abused R.34. ALJ Decision at 3, 8. Evidence cited by the ALJ included written statements attached to Rosewood's report of its investigation into the allegations that R.34 was abused during his shower and bedtime care the evening of May 12, 2014. *See Id*. at 4, citing CMS Ex. 24. According to these statements, E.S., one of two nurse aides caring for R.34 that evening, alleged that T.S., the other nurse aide caring for the resident, cursed at R.34 during the shower and handled him so roughly when putting him to bed that he almost fell out of the bed. CMS Ex. 24, at 3-5. A statement by a licensed practical nurse (LPN) on duty that night confirmed that E.S. reported to her T.S.'s alleged rough handling of R.34. *Id*., at 8. A registered nurse (RN) stated that E.S. later reported the incidents to her and complained that the LPN had taken no action on the allegations. *Id*., at 7. The evidence relied on by the ALJ also included statements made by E.S. and the LPN during interviews, including a statement by the LPN that she did not tell anyone about the allegation. CMS Ex. 21, at 15; CMS Ex. 9, at 3, ¶ 16.

Rosewood does not dispute this evidence but argues that the written statement of T.S., the alleged perpetrator of the abuse, supports a different version of the events in question.[6] RR at 5, citing CMS Ex. 24, at 9. Rosewood faults the surveyor for not interviewing T.S, as well as E.S., whose account the surveyor found "credible because her written statement and her interview with me were detailed and consistent." *Id*. at 6, citing CMS Exs. 9, 21. We find no merit to this argument. The ALJ correctly observed that "as a matter of law, inadequate performance of a survey does not excuse a skilled nursing facility from its duty to comply with regulatory requirements." ALJ Decision at 7, citing 42 C.F.R. § 488.318(b)(1),(2).

Rosewood has the ultimate burden to show that it was in substantial compliance with section 483.13. *E.g. W. Tex. LTC Partners, Inc., d/b/a Cedar Manor*, DAB No. 2652, at 6 (2015), citing *S. Valley Health Care Ctr*., DAB No. 1691 (1999), *aff'd, S. Valley Health Care Ctr. v. Heath Care Fin. Admin*., 223 F.3d 1221 (10th Cir. 2000). That burden endures even if we were to conclude, as we do not, that the survey process was flawed.[7]

Rosewood is correct that making credibility determinations and weighing competing evidence is an integral part of an ALJ's decision-making process. RR at 6. However, we reject Rosewood's suggestion that the absence of an interview with T.S. somehow tainted the ALJ's analysis. *Id*. Rosewood, as the ALJ noted, "has not shown how any alleged defects in the conduct of the survey . . . undercut or impeach the evidence of noncompliance offered by CMS." ALJ Decision at 7. Furthermore, although the ALJ did not specifically discuss T.S.'s written statement, he repeatedly cited the CMS Exhibit (Rosewood's belated internal investigation report) which included that statement along with E.S.'s statement and the statements of the two nurses to whom she reported the alleged abuse. Thus, it is a fair inference, and Rosewood does not contend otherwise, that the ALJ was aware of T.S.'s statement but simply gave more credit to E.S.'s account, which is supported in all material respects by the statements of the nurses. The Board defers to an ALJ's determinations of credibility and weighing of the evidence absent a compelling reason to do otherwise. *E.g. Ridgecrest Healthcare*, DAB No. 2598, at 10 (2014). The ALJ here credited the evidence, including E.S.'s statements, that T.S. abused R.34, and we find no reason to disturb that determination.

[6] The written statement by T.S. upon which Rosewood relies as well as the written statements of E.S. and the nurses to whom E.S. reported the alleged abuse were all attached to the internal investigation report of the incident that Rosewood submitted to IDPH on May 16, 2014 after the survey had begun.

[7] We also note it is not clear from the record whether T.S. was even available for an interview during the survey since Rosewood terminated her employment by May 21, 2014, and the survey did not conclude until May 28, 2014.

In any event, while T.S.'s account of the incident differs in some respects from E.S.'s account, it does not contradict E.S.'s account or tend to undercut the ALJ's findings. Although T.S. did not admit to cursing at R.34 in the shower, she did, as Rosewood acknowledges, confirm that she pulled the pull sheet in R.34's bed hard enough that R.34 "rolled close to the edge of the bed." CMS Ex. 24, at 9. Rosewood does not explain why this admission is not essentially an admission to rough handling and physical abuse, especially since T.S. stated that R.34 was resisting care at the time. Nor does Rosewood explain why T.S.'s statement about what occurred in the shower room should be credited when Rosewood concluded based on its own investigation that T.S. "did raise voice to resident" and terminated T.S.'s employment based on that conclusion. *Id*. at 4.

The ALJ concluded that the record evidence established abuse of R.34 even if the "cursing and verbal outbursts" and "physical abuse" suffered by R. 34 "may not have been directed at the resident so much as they were an element of a verbal altercation between [E.S. and T.S]." ALJ Decision at 4. Rosewood disputes this conclusion, arguing that "[a]t the most, the only evidence of any animosity between the two CNAs is the statement made by [the LPN to whom the CNA reported the incidents] that it was common knowledge the two CNAs argued and sniped at each other." RR at 7, citing CMS Ex. 1, at 10; CMS Ex. 21, at 15; and CMS Ex. 24, at 8. This is not an accurate characterization of the LPN's statement. The LPN did use the phrase "snipping and sniping" in her written statement, but she also said in that statement that the verbal altercations had been going on "for the better part of three weeks" and, in an apparent reference to the intensity of the feud, that both aides had been threatening to quit "for at least as long as well." CMS Ex. 24, at 8. In addition, as Rosewood acknowledges, the LPN told the surveyor that it was "common knowledge these two girls argue." CMS Ex. 21, at 15. The ALJ could reasonably infer from these statements an ongoing feud that was sufficiently serious to interfere with the nurse aides' ability to provide quality care to R.34 and other residents.

Moreover, the ALJ found with respect to R.34 not only a violation of the prohibition against abuse but, also, violations of the requirements that allegations of abuse be investigated and reported. These are requirements of section 483.13 that, as the ALJ noted, were mirrored in Rosewood's policies. It is undisputed that the LPN did not report E.S.'s allegations of T.S.'s abuse of R.34 to either the facility administrator or appropriate state authorities and did not investigate the allegations until after the survey had begun. Indeed, while arguing that the evidence did not support the ALJ's finding of abuse, Rosewood "concedes as it did in its Prehearing Brief that [E.S.]'s report of abuse of R34 to [the LPN] was not handled properly. [The LPN] should have reported the alleged abuse as reported by [E.S.] to the facility Administrator . . . ." RR at 7. Thus,

even if we had concluded that the ALJ erred by finding that Rosewood violated sections 483.13(b) and (c)(1)(i) by not keeping staff from abusing R.34, which we did not, we would conclude that Rosewood violated the requirements of 42 C.F.R. §§ 483.13(c)(3) and 483.13(c)(2), as well as its own policies, by not timely investigating and reporting the allegations of abuse of R.34.

2. The record and law support the ALJ's conclusion that Rosewood violated sections 483.13(c)(2) and (3) by not timely investigating and reporting the alleged emotional abuse of R.6.

Rosewood acknowledges that R.6 and his spouse reported to Rosewood's administrator that a staff member had inappropriately kissed R.6 following a physical therapy session. RR at 8. Rosewood further acknowledges that although the administrator's initial investigation found no evidence to support this allegation, a staff member ultimately admitted to kissing R.6, although she denied doing so inappropriately. *Id*. Rosewood, however, denies that the kiss was abusive and cites the ALJ's statement that the evidence of actual abuse was "equivocal." *Id*. at 9. Rosewood is correct that the ALJ made a statement to this effect. *See* ALJ Decision at 4 ("The evidence is equivocal as to whether Petitioner's staff abused [R. 6.]."). However, the ALJ went on to state that CMS was not "contending that the resident was abused" but "[r]ather . . . that Petitioner's management failed to investigate thoroughly and to report complaints that a member of Petitioner's staff abused the resident . . . [and] [t]he evidence is unequivocal as to these allegations." *Id*. Rosewood notes this further statement by the ALJ but disputes the ALJ's findings that the administrator's investigation was not thorough because, although the administrator interviewed physical therapy staff and residents, he did not obtain statements from R.6 or his spouse. RR at 9-10. Rosewood states, "Contrary to [the ALJ]'s assessment, it is a fact that no interview or statement of R6 or his wife would have yielded any information that would have furthered the investigation." *Id*. at 10. As the ALJ said, "that is simply speculation on [Rosewood's] part," not fact. ALJ Decision at 5. Rosewood has no way of knowing what useful information the administrator might have gathered from these individuals had he obtained statements from them. Rosewood notes that neither R.6 nor his spouse was able to identify the staff member involved at the time they reported the alleged inappropriate kissing. RR at 8. Nonetheless, it is certainly possible that questioning by the administrator might have uncovered information enabling him to identify the individual, especially since the nurse who later came forward to acknowledge kissing R.6 had had previous interactions with the spouse. *See id*. ("Later . . . a . . . nurse c[a]me forward and indicated that she had kissed R6 on the forehead in a congratulatory manner about him doing so well in physical therapy. That nurse . . . had previously spoken with R6's wife about R6's condition . . . .").

Rosewood once again does not deny the facts relied on by the ALJ but criticizes the survey process, asserting that the surveyor should have interviewed the nurse who came forward after the administrator's investigation to admit having kissed R.6. We have already explained, in our discussion of R.34, why Rosewood cannot prevail by citing alleged survey imperfections instead of rebutting the evidence of noncompliance, and we reject Rosewood's argument here for the same reasons. Moreover, the reason Rosewood gives for why it was important to interview this employee – the fact that none of the other employees who were interviewed corroborated the abuse allegations – is irrelevant. As indicated, CMS did not cite Rosewood for abusing R.6; rather, CMS cited Rosewood for not thoroughly investigating and reporting the alleged abuse. Although Rosewood disputes the ALJ's finding that the administrator's investigation was not thorough, Rosewood does not dispute his finding that the administrator "did not file a report of the investigation [to appropriate State authorities] until May 14, 2014, twelve days after the incident allegedly occurred." ALJ Decision at 6. Section 483.13(c)(2) provides that the facility "must ensure that all alleged violations involving mistreatment, neglect, or abuse, . . . and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law." (emphasis added) Thus, the regulation does not permit a facility to decline to report or delay reporting based on its own evaluation that an allegation is not credible. As the ALJ noted, the facility's own policies also allowed no such discretion. ALJ Decision at 6, citing CMS Ex. 22. In addition, as the ALJ noted, the facility's investigation of this incident did not begin until after IDPH initiated the complaint investigation. *Id*. at 5, citing CMS Ex. 23, at 1. Clearly, the administrator had no basis for concluding that the allegation was not credible when he had not even begun an investigation.

3. The record and the law support the ALJ's conclusion that Rosewood violated section 483.13(c)(2) by not reporting the alleged misappropriation of R.28's rings.

The ALJ found Rosewood noncompliant with the misappropriation of property reporting requirement of section 483.13(c)(2) because staff failed to timely report to the administrator the a possible theft of R.28's rings. ALJ Decision at 6. He found that although R.28's family reported to staff that the rings were missing on December 27, 2013, staff did not relay this information to the administrator until December 30, 2013, three days later. *Id*. Accordingly, the ALJ found, investigation of the possible misappropriation and reporting of the incident to IDPH was delayed for three days, facts the ALJ concluded put Rosewood in "clear violation of regulatory requirements that allegations of . . . misappropriation of resident property be immediately reported and investigated." *Id*. The ALJ further found that this was a violation of Rosewood's internal anti-abuse policy. *Id*. Rosewood first states that "[t]he facts surrounding the incident are not in dispute" but then states that the fact the rings were missing was reported to the administrator on December 27, 2013, even though he did not begin an

investigation or report to IDPH until December 30, 2013. RR at 11-12. Rosewood cites no evidence of record for its assertion that the administrator learned of the missing rings on December 27 rather than December 30, 2013 as found by the ALJ, and statements on the SOD, and in the surveyor's declaration support the ALJ's finding. CMS Ex. 1, at 12; CMS Ex. 9, at 6, ¶ 30.

Moreover, Rosewood "concede[s] that facility policy and IDPH regulation required [the administrator] to report the 'missing rings' to IDPH in a more timely manner" but argues that the fact R.28 was on hospice, had family visiting and died on December 30, 2013 are mitigating factors that justified the delay. RR at 12-13. Rosewood also notes that even though IDPH received a report of the misappropriation on December 30, 2013, IDPH conducted no investigation in connection with that report prior to the May 2014 survey. Rosewood argues that this "inaction" on the part of IDPH "shows the diminimis nature of the deficiency . . . ." *Id*. at 12.

We agree with the ALJ that for staff receiving a complaint that the rings were missing to delay reporting of that complaint to the administrator for three days – with the result that the required investigation and report to the State were also delayed – is a clear violation of the regulation and of Rosewood's own policies. We need not decide whether CMS could lawfully have considered the circumstances suggested by Rosewood as reasons for not finding noncompliance with respect to the alleged misappropriation of R.28's rings. Our role is to determine whether substantial evidence in the record supports the ALJ's determination that Rosewood was not in substantial compliance with the regulations and whether his decision is free of legal error. We have concluded the ALJ's decision meets the substantial evidence standard and is free of legal error with respect to the incident involving R.28 as well as those involving R.6 and R.34.

B. <u>The ALJ did not err in concluding that CMS's determination of the level of noncompliance – immediate jeopardy – was not clearly erroneous.</u>

CMS cited Rosewood's noncompliance at the level of "immediate jeopardy," which is defined as "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; CMS Ex. 6, at 1. ALJs and the Board may not overturn CMS's determination of the level of noncompliance, which includes immediate jeopardy, unless that determination is clearly erroneous. 42 C.F.R. § 498.60(c)(2). The ALJ did not find CMS's immediate jeopardy determination clearly erroneous. Indeed, the ALJ concluded that Rosewood's noncompliance was "so egregious as to place residents of Petitioner's facility in a state of immediate jeopardy." ALJ Decision at 8.

Although Rosewood seeks to overturn the immediate jeopardy determination, Rosewood does not specifically assert (much less provide any supporting argument) that the determination is clearly erroneous. Instead Rosewood makes sparse, unsupported arguments attempting to minimize the seriousness of its noncompliance. With respect to R.34, Rosewood asserts, "The failure of [the LPN] to report the alleged abuse [to the facility administrator] does not rise to the level of an Immediate Jeopardy" but provides no explanation for this assertion. RR at 7. With respect to its failure to thoroughly investigate and report the alleged mental and emotional abuse of R.6, Rosewood states that the facility "may have been better served if [the administrator] had taken written statements of his interviews with staff and residents and made a formal report to the IDPH but those inactions do not rise to the level of an immediate jeopardy." *Id*. at 10. Again, Rosewood provides no explanation for its assertion. With respect to R.28, Rosewood argues, without further explanation, that the fact that the IDPH did not investigate its belated December 30, 2013 report of the alleged misappropriation of this resident's property until the May 2014 survey "shows the diminimis nature of the deficiency . . . ." *Id*. at 12.

These assertions fall far short of establishing that CMS's determination of immediate jeopardy was clearly erroneous. Rosewood's argument with respect to R.34 does not even address all of the failures underlying the determination of noncompliance involving that resident. The ALJ's determination was based not only on the LPN's failure to report the alleged abuse of R.34 to the administrator but also on the facility's failure to investigate the alleged abuse, to protect R.34 and other residents during an investigation and to report the alleged abuse to IDPH. Regarding R.28, we see nothing *de minimus* about a failure by facility staff to immediately report to the administrator a report by the family of a dying resident of the possible theft of two of the resident's rings. But even if Rosewood's characterization was reasonable, that would not excuse Rosewood's undisputed failure to immediately investigate and report the potential theft. Similarly, although the kiss a nurse gave R.6 might ultimately have been found not abusive, Rosewood was obligated under the regulations to take seriously the abuse allegation and to investigate the allegation and report it to IDPH. The regulations address the nursing facility's obligation to promptly investigate and report to State officials <u>all</u> allegations of abuse or misappropriation of property; they do not address the State's responsibility for processing such allegations, but clearly no processing can occur unless the allegations are reported. The ALJ summarized why Rosewood's noncompliance put residents in immediate jeopardy:

> It is apparent that Petitioner's management did not comprehend the seriousness of the allegations of abuse[;] and so . . . its response to them was lethargic and half-hearted. That had the consequence of leaving residents unprotected against additional instances of abuse, an extremely dangerous situation for the frail and vulnerable individuals who resided at Petitioner's facility.

ALJ Decision at 8. We find this an apt summary of why Rosewood's noncompliance constituted immediate jeopardy and affirm the ALJ's upholding of CMS's immediate jeopardy determination.

C. The ALJ did not err in finding the CMP amounts reasonable.

In determining the amount of a CMP, CMS must consider the facility's compliance history, financial condition and culpability, as well as the seriousness of the deficiencies, that is, the scope and severity of the noncompliance. 42 C.F.R. §§ 488.438(f), 488.404 (incorporated by section 488.438(f)(3)). An ALJ, in turn, must apply the same factors de novo to the facts and evidence of record to determine whether the CMP amounts are reasonable. *Pearsall Nursing & Rehab. Ctr. – N.*, DAB No. 2692, at 10 (2016), citing *Emerald Oaks*, DAB No. 1800, at 11-13 (2001). Applying those factors here, the ALJ found the amounts of the CMPs selected by CMS – $6,050 per day for the period of immediate jeopardy and $200 per day for the remaining period of noncompliance – "entirely reasonable." ALJ Decision at 8. Indeed, after noting the permissible ranges for these CMPs, he found the amounts chosen by CMS "modest given the seriousness of Petitioner's noncompliance." *Id*. He also noted that Rosewood had raised no challenge to the multiple findings of noncompliance underlying the $200 per day amount for the period of noncompliance after the abatement of immediate jeopardy. *Id*.

On review, Rosewood asserts that "the Board should reduce the scope and severity findings in this survey and reduce the CMP." RR at 4. As we concluded, above, Rosewood has not shown that the level of noncompliance determined by CMS and upheld by the ALJ is clearly erroneous; accordingly, there is no basis for disturbing CMS's scope and severity determination. Rosewood also has made no case for reducing the CMP amounts. Rosewood does not specifically challenge any of the ALJ's findings on the amount issue or his finding that Rosewood had not challenged the duration of its noncompliance. *See* ALJ Decision at 8. Rosewood had the burden "to demonstrate through argument and the submission of evidence addressing the regulatory factors, that a reduction is necessary to make the CMP amount reasonable." *Pearsall*, DAB No. 2692, at 11, citing *Pinecrest Nursing & Rehab. Ctr.*, DAB No. 2446, at 23 (2012). Rosewood has not even attempted to meet that burden. Accordingly, we uphold without further discussion the ALJ's determination that the CMP amounts are reasonable.

Conclusion

For the reasons discussed above, we affirm the ALJ Decision.

/s/
Constance B. Tobias

/s/
Susan S. Yim

/s/
Sheila Ann Hegy
Presiding Board Member