

Department of Health and Human Services
DEPARTMENTAL APPEALS BOARD
Appellate Division

Kindred Transitional Care and Rehab - Greenfield
Docket No. A-16-138
Decision No. 2792
May 18, 2017

**FINAL DECISION ON REVIEW OF
ADMINISTRATIVE LAW JUDGE DECISION**

Kindred Transitional Care and Rehab – Greenfield (Kindred or Petitioner), a skilled nursing facility (SNF), appeals the July 12, 2016, decision of an Administrative Law Judge (ALJ). *Kindred Transitional Care and Rehab – Greenfield*, DAB CR4659 (2016) (ALJ Decision). The ALJ upheld the determination of the Centers for Medicare & Medicaid Services (CMS) to cite Kindred for an immediate-jeopardy-level violation of 42 C.F.R. § 483.13(b) and 483.13(c)(1)(i) and to impose a per-day civil money penalty (CMP) of \$3,550 for the three-day period of immediate jeopardy from September 18 through September 20, 2015. The ALJ, however, found that the facility had returned to compliance as of September 21, 2015 and, accordingly, overturned CMS’s imposition of a \$250 per-day CMP from September 21, 2015 through October 29, 2015. For the reasons set out below, the Board upholds the ALJ Decision.

Legal background

To participate in the Medicare program, a long-term care facility, such as a SNF, must be in “substantial compliance” with Medicare participation requirements in 42 C.F.R. Part 483. 42 C.F.R. §§ 483.1, 488.400.¹ Under agreements with the Secretary of Health and Human Services, state survey agencies conduct onsite surveys of facilities to verify compliance with the requirements. 42 C.F.R. §§ 488.10(a), 488.11; *see also* Social Security Act (Act)² §§ 1819(g)(1)(A), 1864(a).

¹ On October 4, 2016, CMS issued a final rule that amended Medicare requirements for long-term care facilities. Final Rule, *Medicare and Medicaid Programs; Reform of Requirements for Long-Term Care Facilities*, 81 Fed. Reg. 68,688 (Oct. 4, 2016). The Final Rule included revisions to 42 C.F.R. § 483.13, redesignated as 42 C.F.R. § 483.12. *Id.* at 68,726, 68,855. We rely on the regulations in effect when the state agency performed the survey(s) that formed the bases for CMS’s determination of noncompliance. *Carmel Convalescent Hospital*, DAB No. 1584, at 2 n.2 (1996) (the Board applies the regulations in effect on the date of the survey and resurvey).

² The current version of the Act can be found at http://www.socialsecurity.gov/OP_Home/ssact/ssact-toc.htm. Each section of the Act on that website contains a reference to the corresponding United States Code chapter and section. Also, a cross-reference table for the Act and the United States Code can be found at 42 U.S.C.A. Ch. 7, Disp Table.

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”). “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.*

Part 483, subpart B regulations include requirements for the prevention of “abuse” of long-term care facility residents, defined in section 488.301 as “the willful infliction of injury, reasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish.” Section 483.13 provides, in 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[.]

Under authority of 42 C.F.R. Part 488, subpart F, CMS enforces compliance with Part 483, subpart B requirements. Enforcement “remedies” for facilities found to be not in substantial compliance with those requirements include per-day CMP(s) in amounts that vary depending on factors specified in the regulations, which include the “seriousness” of the facility’s noncompliance. 42 C.F.R. §§ 488.404(b), 488.438(f). “Seriousness” is a function of the noncompliance’s scope (whether it is “isolated,” constitutes a “pattern,” or is “widespread”) and severity (whether it has created a “potential for” harm, resulted in “actual harm,” or placed residents in “immediate jeopardy”). *Id.* § 488.404(b). The most serious noncompliance is that which puts one or more residents in “immediate jeopardy.” *See id.* § 488.438(a) (highest CMPs are imposed for immediate-jeopardy-level noncompliance); *Woodland Oaks Healthcare Facility*, DAB No. 2355, at 2 (2010) (citing authorities). A per-day CMP may accrue from the date the facility was first out of substantial compliance until the date it is determined to have achieved substantial compliance. 42 C.F.R. § 488.440(a)(1), (b). CMS’s determination on the level of noncompliance is upheld unless it is clearly erroneous. *Id.* § 498.60(c)(2).

The Act prohibits approval of a nurse aide training and/or competency evaluation program (NATCEP) at any facility participating in Medicare or Medicaid which, within the previous two years, has been subject to an extended survey, triggered by any finding of substandard quality of care. Act §§ 1819(f)(2)(B)(iii)(I), 1919(f)(2)(B)(iii)(I). “Substandard quality of care” means one or more deficiencies related to the requirements of 42 C.F.R. §§ 483.13, 483.15, or 483.25 that “constitute either immediate jeopardy to resident health or safety; a pattern of or widespread actual harm that is not immediate jeopardy; or a widespread potential for more than minimal harm, but less than immediate jeopardy, with no actual harm.” 42 C.F.R. § 488.301.

Case background³

Kindred hired a certified nursing assistant (CNA) on July 28, 2015, after conducting a pre-employment background screening which revealed that the CNA had a few minor traffic citations but no history of sexual offenses. ALJ Decision at 2, citing CMS Exs. 5, at 32 and 7, at 1-4; P. Ex. 1 ¶¶ 10, 11. The CNA had not held a similar position before being hired by Kindred and before then had recently completed his CNA training. P. Ex. 1 ¶ 12. Upon hiring, Kindred trained the CNA on its anti-abuse and reporting policies. *Id.* ¶ 13; CMS Ex. 7, at 8-22.

The CNA worked at Kindred without reported incident until the evening of September 19, 2015 (Saturday), when Resident B reported to a different CNA that, one or two days prior (i.e., September 17 or 18, 2015), the CNA had made “sexual advances” toward her, touched her breasts and nipples when he was assisting her with taking her shirt off while getting ready for her evening cares, exposed himself to her, asked her to touch his penis, and briefly climbed on top of her. Resident B yelled “no” twice in protest. CMS Ex. 2, at 2-3; CMS Ex. 3, at 1-2. The CNA worked at Kindred on September 17 and 18. CMS Ex. 7, at 24-25; CMS Ex. 8, at 16. Resident B’s complaint of attempted abuse was then reported up the chain, to a licensed practical nurse and to Kindred’s executive director. CMS Ex. 2, at 3-4. Kindred also notified its senior clinical staff, Resident B’s family, and the Indiana State Department of Health (ISDH) of the allegations. *Id.* Kindred provided all notices described in this paragraph on September 19, within a span of about three and one-half hours after Resident B reported the alleged abuse. *Id.*; CMS Ex. 8, at 16.

On September 19, Kindred also began investigating Resident B’s report by attempting to contact the allegedly abusive CNA and by interviewing the licensed practical nurse as well as the certified nursing assistant to whom Resident B reported the alleged abuse. The next day, Sunday, September 20, Kindred interviewed all alert and oriented female

³ The factual information in this section is drawn from the ALJ Decision and, unless otherwise indicated, undisputed facts in the record. It is presented to provide a context for the discussion of the issues raised on appeal.

residents in its long-term care unit and conducted head-to-toe skin assessments of the non-alert and non-oriented female residents in the unit. During the course of the interviews and assessments, Resident C reported that the CNA had previously exposed himself to her and asked her to touch his penis. ALJ Decision at 2, citing CMS Exs. 2, at 4 and 3, at 2; CMS Ex. 2, at 6-7; CMS Ex. 8, at 16-17. Resident C, too, reportedly told the perpetrator to stop and he left her room. CMS Ex. 3, at 2; CMS Ex. 2, at 7. When Resident C first recounted the incident she was not certain about the date of the incident, but later, on October 1, she told a surveyor that it had occurred over a month ago. CMS Ex. 2, at 6. Kindred was able to make contact with the CNA the afternoon of September 20, at which time Kindred informed him that he was suspended. CMS Ex. 8, at 17. Kindred also reported the abuse allegations to the local police on September 20. *Id.* On Monday, September 21, Kindred interviewed the CNA regarding the abuse allegations. *Id.* at 18-19. The CNA initially denied the allegations.⁴ *Id.* On September 21, 2015, Kindred terminated the CNA effective immediately and prohibited him from entering the facility or communicating with any staff or residents. CMS Ex. 5, at 34; CMS Ex. 8, at 19.

On September 21, Kindred's management interviewed all staff and reviewed facility abuse policies with them. CMS Ex. 2, at 4. That day Kindred also interviewed all alert and oriented male residents in the long-term care unit and conducted head-to-toe assessments of all non-alert and non-oriented male residents in that unit. *Id.* at 5. It was during this time that Resident D, who is described as "moderately cognitively impaired," reported that he and the CNA previously had multiple sexual encounters, though he could not state the number of encounters or when they had occurred. *Id.* at 4-5, 7-8; CMS Ex. 3, at 2. Resident D later told a surveyor that that he and the CNA "had a relationship"; that the CNA initiated the encounters;⁵ that he and the CNA were involved for "a week or two"; and that they saw each other only during the CNA's work hours. CMS Ex. 2, at 7-8; CMS Ex. 5, at 5-6; CMS Ex. 14 ¶ 12.

⁴ The CNA has since admitted the abuse and pled guilty to felony battery against a disabled person. CMS's Response at 7, citing CMS Ex. 10.

⁵ Kindred maintains that Resident D consented to sex with the CNA, evidently relying on Resident D's characterization of the encounters as having been consensual. RR at 6. Noting Resident D's cognitive deficit, CMS, however, states that Kindred "should not assume that under these circumstances [Resident D] had the capacity to consent." CMS's Response at 5 n.6. We need not and do not reach here the issue of whether Resident D had the capacity to give valid consent to engage in sex with the CNA. At bottom, neither party disputes that the CNA inappropriately touched Resident B and attempted to engage Residents B and C in sexual activity during the time the CNA was in Kindred's employ, and that neither Resident B nor Resident C wanted to engage in a physical relationship with the CNA.

On October 8, 2015, the state agency, ISDH, completed its investigation of the incidents, identifying three deficiencies:

Tag F223 – in violation of 42 C.F.R. § 483.13(b), (c)(1)(i); immediate jeopardy (scope and severity level “J”)

Tag F225 – in violation of 42 C.F.R. § 483.13(c)(1)(ii)-(iii), (c)(2)-(4); scope and severity level “D” for isolated but with potential for more than minimal harm

Tag F226 – in violation of 42 C.F.R. 483.13(c); scope and severity level “D”

CMS Ex. 2, at 2-21. The immediate-jeopardy-level deficiency finding, Tag F223, was determined to have started on September 18, 2015, and “removed” on September 21, 2015 upon the CNA’s termination from employment with Kindred. *Id.* at 9. Upon a revisit to Kindred, the ISDH determined that Kindred had returned to substantial compliance as of October 30, 2015. CMS Ex. 1, at 2. Based on the ISDH’s findings, CMS cited Kindred for violating section 483.13, and assessed per-day CMPs of \$3,550 for the three-day period from September 18 through September 20, 2015, and per-day CMPs of \$250 for the period from September 21 through October 29, 2015. *Id.*

ALJ Decision

On Kindred’s appeal before the ALJ,⁶ CMS expressly withdrew the deficiency cited as Tag F225. CMS Memorandum in Support of its Motion for Summary Judgment or, in the Alternative, CMS’ Pre-Hearing Brief (CMS MSJ) at 2 n.1. CMS pursued summary judgment only for the deficiencies cited as Tags F223 and F226.

The ALJ found no evidence of other abusive acts committed by the CNA or other individuals at Kindred, or evidence that Kindred’s management knew or should have known that the CNA had the propensity to engage in sexual abuse. ALJ Decision at 2. The ALJ found, moreover, that there were no reports of sexual abuse or attempted sexual abuse by the CNA during his employment at Kindred from July 28, 2015, through September 19, 2015.⁷ *Id.*; P. Ex. 1 ¶ 14. Further, the ALJ said, “The undisputed facts establish . . . that Petitioner has in place extensive anti-abuse policies” and “has identified procedures to identify abuse that include pre-employment screening of prospective employees, training of employees on how to recognize and report abuse, and advising residents as to how to report allegations of abuse.” *Id.* at 3, citing CMS Ex. 8, at 76-78.

⁶ The parties filed cross-motions for summary judgment. Although the ALJ determined that there were no factual disputes, he nevertheless found it unnecessary to decide the case on summary judgment. He also noted that neither party had requested an in-person hearing, and decided the case based on the written submissions. ALJ Decision at 2.

⁷ Before Resident B reported the alleged abuse, one resident reportedly had expressed that she did not want the CNA to provide her care. However, that resident reportedly made that request about all male employees at Kindred; she did not single out the CNA or previously complain about the CNA. CMS Ex. 5, at 8.

The ALJ went on to state, “I do not find that Petitioner failed to implement its anti-abuse policies. The undisputed facts establish that Petitioner established and implemented these policies.” *Id.*

The ALJ nevertheless upheld the immediate jeopardy citation. Rejecting Kindred’s arguments to the effect that the abuse incidents were “isolated” or a “collection of incidents attributable to one individual” for which CMS was seeking to impose a CMP on Kindred under an impermissible strict liability standard and that the independent informal dispute resolution (IIDR) process found Kindred “blameless,” *id.*, the ALJ said:

The undisputed facts establish persuasively that Petitioner failed to comply with these regulations’ [i.e., §§ 483.13(b) and 483.13(c)(1)(i)] proscriptions against abuse of residents. In fact, there were multiple incidents of sexual abuse of residents at Petitioner’s facility during the period from September 18 through September 20, 2015.

* * *

I do not find the incidents of abuse to be so isolated as Petitioner contends. There was a pattern of abuse committed by the CNA. The CNA in question sexually assaulted two female residents and engaged in sex with a third and cognitively impaired resident. That said, I would find a violation here if there had been only a single episode of sexual abuse. The governing regulations make it plain that a facility is liable for *any* sexual abuse committed by a member of its staff.

Id. at 3-4 (ALJ’s italics). The ALJ noted, moreover, that the applicable regulations “do not incorporate civil tort liability into their prohibitions against abuse” and instead “make a facility liable for any abuse committed by it or its agents.” *Id.* at 4. Accordingly, the ALJ found, the CNA’s actions committed while he was on duty at Kindred became the act of Kindred. As a consequence, the ALJ determined, the CNA’s abuse is attributable to Kindred “even if it is isolated and even if it runs contrary to facility policy.” *Id.* The ALJ said, “Any other holding would strip the anti-abuse regulations of their force and effect.” *Id.* Citing three Board decisions, the ALJ noted that appellate panels of the Board “have considered and rejected essentially the same argument,” that is, “the facility itself was not negligent or indifferent to the care provided by its staff.” *Id.*, citing *Springhill Senior Residence*, DAB No. 2513 (2013); *N.C. State Veterans Nursing Home, Salisbury*, DAB No. 2256 (2009); *Life Care Ctr. of Gwinnett*, DAB No. 2240 (2009).

The ALJ found CMS’s determination of immediate-jeopardy-level noncompliance not to be clearly erroneous since “[t]here was a likelihood of severe psychological injury to those residents who were sexually assaulted.” *Id.* The ALJ upheld the imposition of a per-day CMP of \$3,550 for an immediate-jeopardy level noncompliance with 42 C.F.R. §§ 483.13(b) and 483.13(c)(1)(i) for the three-day period from September 18 through September 20, 2015, finding the amount reasonable. *Id.* at 5. As the ALJ noted, as a consequence of the immediate-jeopardy-level noncompliance, Kindred loses its authority to conduct a NATCEP for two years. *Id.* at 1. The ALJ did not uphold the imposition of a \$250 per-day CMP from September 21 through October 29, 2015, finding no noncompliance after September 20, 2015. *Id.* at 5. The ALJ stated, “Petitioner terminated the employment of the offending CNA on September 22, 2015 and the record is devoid of any evidence to show that there was continuing abusive behavior after that date. The only conceivable basis for imposition of additional penalties would be alleged failure by Petitioner to implement its anti-abuse policies. However, and as I have discussed, the record does not support a finding that Petitioner failed to implement these policies.” *Id.*⁸

Standard of review

The Board’s standard of review on a disputed conclusion of law is whether the ALJ’s decision is erroneous. The Board’s standard of review on a disputed finding of fact is whether the ALJ’s finding is supported by substantial evidence in the record. *Guidelines – Appellate Review of Decisions of Administrative Law Judges Affecting a Provider’s Participation in the Medicare and Medicaid Programs (Guidelines)*, accessible at <http://www.hhs.gov/about/agencies/dab/different-appeals-at-dab/appeals-to-board/guidelines/index.html?language=en>.

Analysis

Kindred argues that it did not violate 42 C.F.R. § 483.13(b) and (c)(1)(i). It disputes the citation of an immediate jeopardy violation (Tag F223) and the corresponding per-day CMPs. According to Kindred, it is not culpable because it did not commit abuse; the CNA was the wrongdoer. The following captures the essence of Kindred’s various arguments disputing Tag F223: “Ultimately, the [Board] is being asked in this appeal to determine whether a nursing facility must automatically and necessarily be found deficient at an immediate jeopardy level following an incident of staff-to-resident abuse

⁸ The ALJ Decision, page 5, states that the CNA was terminated on September 22, 2015. Kindred terminated the CNA on September 21, 2015. CMS Ex. 5, at 34; CMS Ex. 8, at 19. The ALJ’s reference to September 22 as the termination date is not consequential, however, since there is no dispute that as of September 21, the CNA was not involved in the care of any Kindred resident, and the ALJ upheld only the finding of immediate jeopardy for the three-day period ending September 20 and the per-day CMP for this period.

committed by a single rogue employee, even though the facility has developed and implemented adequate policies and done everything reasonably possible to avoid the incident of abuse.” Brief in support of request for review (RR) at 1-2. Kindred asks that Tag F223 be “removed entirely” as contrary to law, *id.* at 12, or, in the alternative, that the scope and severity level for Tag F223 be lowered, *id.* at 27.

The central issue is whether Kindred has shown that CMS’s determination of immediate-jeopardy-level noncompliance was clearly erroneous. We conclude that the ALJ Decision, which upheld CMS’s determination as not clearly erroneous, is supported by substantial evidence and is without legal error. Before we turn to our rationale for upholding the ALJ Decision, we first explain the status of the deficiency finding under Tag F226.

A. The deficiency cited as Tag F226 (alleged failure to develop and implement policies and procedures to prohibit resident abuse in accordance with section 483.13(c)) is not before the Board since the ALJ determined, and CMS does not now dispute, that Kindred did not violate this requirement.

As noted, Kindred was cited under Tags F223, F225, and F226. As also noted, CMS withdrew Tag F225, leaving Tags F223 and F226. The ALJ Decision did not refer to the Tags; however, the ALJ reversed that part of CMS’s determination that imposed a per-day CMP of \$250 for September 21 through October 29, 2015, finding “no basis” for the additional penalties because “the record is devoid of any evidence to show that there was continuing abusive behavior” after September 20, 2015 (when immediate jeopardy ended). ALJ Decision at 5. The ALJ wrote, “The only conceivable basis for imposition of additional penalties would be alleged failure by Petitioner to implement its anti-abuse policies. However, and as I have discussed, the record does not support a finding that Petitioner failed to implement these policies.” *Id.* at 5; *id.* at 3 (“I do not find that Petitioner failed to implement its anti-abuse policies. The undisputed facts establish that Petitioner established and implemented these policies.”).

Kindred initially asked the Board for “reversal” and “removal” of Tags F223 and F226. Letter accompanying RR at 2; RR at 12. In response, CMS acknowledged the ALJ’s determination that Kindred was “in substantial compliance with” the part of section 483.13(c) corresponding to Tag F226. CMS’s Response at 20, quoting parts of aforementioned language in pages 3 and 5 of the ALJ’s decision. CMS stated that Kindred’s “request and arguments to ‘remove’ F226 are moot because the ALJ did not find noncompliance with this regulatory provision.” *Id.* In reply, Kindred explained that,

because the ALJ did not refer to the Tags, it was not clear which Tag(s) (F223 or F226 or both) or violations remained in dispute following the ALJ's review⁹; nor could it have anticipated when it appealed whether CMS would dispute that part of the ALJ's decision that was favorable to Kindred. For these reasons, Kindred said, it had specified that it was seeking a "revers[al]" and "remov[al]" of both Tags. Reply brief at 1 and 1 n.1.

We find that Tag F226 is no longer in dispute based on the ALJ Decision. Kindred stated, "[A]s CMS has now conceded that the F226 Tag has been removed and does not apply, Kindred acknowledges that the issue of the F226 Tag is now moot on appeal." Reply brief at 1 n.1; Transcript of the March 15, 2017 oral argument (Tr.) at 8-9 (similar statement). Accordingly, we analyze below only the remaining disputes concerning the two regulatory provisions, 42 C.F.R. § 483.13(b) and 42 C.F.R. § 483.13(c)(1)(i), on which the citation of Tag F223 is based.

B. The ALJ Decision, upholding CMS's determination to cite Kindred for noncompliance with 42 C.F.R. § 483.13(b) and (c)(1)(i) (Tag F223), is supported by substantial evidence and is free of legal error.

1. Kindred's assertion that CMS's interpretation of 42 C.F.R. § 483.13(b) in citing Tag F223 was contrary to authorities is without merit.

Kindred asserts that CMS erred in "unilaterally" construing section 483.13(b) to mean that a facility "automatically" violates the regulation "anytime" "staff-to-resident abuse occurs, regardless of the circumstances." RR at 14-15. Kindred takes issue with what it characterizes as a "common theme" in both CMS's position and the ALJ Decision, i.e., that section 483.13(b) "ensures an absolute right" of a resident to be free from abuse such that "any" infringement of that right or incidence of abuse necessarily must result in a deficiency citation. Kindred suggests that CMS's position is somehow inconsistent with treating "staff-to-resident" abuse differently from "resident-to-resident" abuse. Yet CMS, according to Kindred, holds a facility "automatically" liable "irrespective of facts and circumstances" where staff abuse is involved but, conversely, looks at the circumstances in "resident-to-resident" abuse situations. The distinction, Kindred says, finds no support in the regulation, since the regulation includes no qualifying language concerning the "source" (or perpetrator) of the abuse. Therefore, Kindred argues, to apply the regulation consistently, CMS must either find facility liability in both "staff-to-resident" and "resident-to-resident" abuse situations or read the regulation differently. Reply brief at 3-4 (Kindred's emphases). Kindred suggests that a "better reading of § 483.13(b)" is one that takes into consideration in both situations whether the facility

⁹ We note, however, that the ALJ specifically cited 42 C.F.R. § 483.13(b) and (c)(1)(i) (ALJ Decision at 3, 4) – the regulations that formed the basis for Tag F223.

knew or had reason to know about the potential for resident abuse occurring and whether the facility took reasonable actions to prevent abuse from occurring. RR at 14-15; Reply brief at 4-6. Consistent with such a reading, Kindred says, where, as here, the facility has “sufficiently done everything that can be done, [it] should be found in substantial compliance” RR at 2.

Facilities are held to a “substantial compliance” standard, which is defined in 42 C.F.R. § 488.301 to mean “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.” CMS explained in the preamble to the participation requirement regulations that “substantial compliance” was intended to meet statutory requirements for the protection of residents’ needs for quality care, as follows:

[W]e have defined “substantial compliance” as a degree of compliance such that any existing deficiencies have not caused actual harm and do not create the potential for more than minimal harm to a resident. This definition is consistent with the statutory focus on resident outcomes as opposed to procedural requirements that do not always accurately measure whether quality care is being furnished. Although [a facility] that falls short of total compliance may escape imposition of a remedy, it still has a duty to provide, to each resident, care that enhances the chances of positive outcomes and avoids negative outcomes. If a single resident experiences any harm, the facility has not satisfied its statutory obligations. Given the statute’s focus on each resident’s right to receive quality care, and the facility’s obligation to provide it, we could not adopt a less rigorous standard of compliance.

62 Fed. Reg. 43,931, 43,932 (Aug. 18, 1997). Thus, while facilities are required to ensure that residents are free from abuse, a failure to prevent abuse constitutes a deficiency only where the abusive situation had the potential to inflict more than minimal harm.

Board precedent supports a distinction between “staff-to-resident” abuse and “resident-to-resident” interactions for purposes of determining compliance with section 483.13(b) for good reason. The Board has said that, because a facility may not disavow the wrongdoing of its staff and may properly be held responsible for its staff’s actions for purposes of section 483.13(b), “considerations of foreseeability are inapposite when [as here] staff abuse has occurred.” *Springhill* at 15, quoting *Gateway Nursing Ctr.*, DAB No. 2283, at 8 (2009). The Board recognizes that residents inflict harm on one another even though they may not be capable of the intentionality implied by abuse, and also recognizes that the responsibility for protecting residents from harmful behaviors by other residents lies with the facility which has undertaken to care for them. In that context, a facility, which acts through its staff, is directly responsible for what the staff

does, but its staff cannot be expected to take protective actions against entirely unforeseeable risks. *See Woodstock Care Ctr.*, DAB No. 1726, at 25-35 (2000) (recognizing that a facility, acting through its staff, cannot be expected to be able to foresee and prevent all possible accidents from occurring, but finding ample evidence that belied the facility’s argument that its staff could not have foreseen or anticipated resident attacks on other residents and resident elopements and, thus, holding that the facility did not meet its affirmative obligation to achieve safety outcomes under section 483.25(h)), *aff’d*, *Woodstock Care Ctr. v. HHS*, 363 F.3d 583 (6th Cir. 2003). It follows, then, that determining whether a facility failed to protect a resident’s right to be free from abuse when another resident behaved harmfully depends on whether the facility staff had a basis to be aware that such behavior might occur and yet left the resident vulnerable to it.

We therefore reject Kindred’s argument that CMS misinterpreted or misapplied section 483.13(b) to wrongfully distinguish a “staff-to-resident” abuse situation from a “resident-to-resident” abuse situation. Applicable Board precedent recognizes such a distinction. Kindred offers no authority in support of the contrary proposition that this case, which involves “staff-to-resident” abuse, must be treated as a “resident-to-resident” abuse situation would be treated, in order to comply with section 483.13(b).

2. *Common law tort doctrines like respondeat superior do not apply; Kindred may be held responsible for the wrongdoing of its employee.*

Kindred argues that CMS’s interpretation of section 483.13(b) is contrary to the express language of section 1128A(l) of the Act, which provides, “A principal is liable for penalties, assessments, and an exclusion under this section for the actions of the principal’s agent acting within the scope of the agency.” Reply brief at 2-3, quoting Act § 1128A(l). According to Kindred, Congress thus “expressly incorporated the doctrine of *respondeat superior* into the laws authorizing CMS to issue penalties for noncompliance.” RR at 20.¹⁰ Kindred argues that the CNA’s misconduct was the “result of his own motivations,” committed outside the scope of his employment at Kindred and, therefore, holding Kindred responsible for his wrongdoing is contrary to Congress’s mandate in section 1128A(l). Reply brief at 3.¹¹ In this vein, Kindred further asserts that

¹⁰ Simply defined, *respondeat superior* is a doctrine where a master (employer) is held legally liable for his servant’s (employee’s) tort committed in the course and scope of his employment. *Burger Chef Systems, Inc. v. Govro*, 407 F.2d 921, 925 (8th Cir. 1969), citing Restatement of Agency, § 219.

¹¹ During the March 15, 2017 oral argument, Kindred, by its attorney, appeared to retreat from its arguments based on *respondeat superior*. Tr. at 40-41 (“[W]ith respect to the respondeat superior and whether the facility is disowning or disavowing the actions of its employees . . . further analysis, further research has led [Kindred] to the point today of recognizing that that’s not a well-received position for the [Board]. Clearly, the facility acts through its employees.”). In any event, based on further argument on March 15 (Tr. at 41) and briefing, we understand Kindred’s position to be that the issue of whether the CNA was acting within the course and scope of his employment remains in dispute. We therefore address Kindred’s arguments on this issue and *respondeat superior*, as briefed, in full, for completeness.

the ALJ's rejection of its argument based on section 1128A(l) of the Act is erroneous because, while a facility "may often" be held liable for abuse committed by its employees, the statutory language necessarily restricts the meaning and reach of the derivative regulations to abuse committed by a facility's employee acting within the scope of his employment and does not "'make a facility liable for any abuse committed by it or its agents.'" RR at 21, quoting ALJ Decision at 4.

Kindred offers no legislative history or other relevant authority to support its position that Congress deliberately codified a common law tort doctrine into the statute. The Board has interpreted section 1128A(l) – made applicable to CMPs by section 1819(h)(2)(B)(ii) of the Act – to mean that facilities may indeed be held responsible for the actions of their employees in determining whether the facilities have complied with applicable regulations. *Ridge Terrace*, DAB No. 1834, at 7-8 (2002) (quoting Act § 1128(A)(l) and stating that the facility is not excused from providing the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being in compliance with section 483.25 on the basis that it is not "practicable" to monitor staff to ensure compliance). The statute acts to impose responsibility on facilities for the misconduct of their staff and agents in violation of federal participation standards, even that of which facility owners or management may not be aware, to the full extent of their employment or agency, rather than to restrict liability to the terms of an imported tort concept.

More generally, the Board has routinely rejected attempts to import tort principles into federal administrative proceedings involving long-term care facilities that receive federal funding for participating in Medicare and Medicaid. *See, e.g., Lifehouse of Riverside Healthcare Ctr.*, DAB No. 2774, at 19 (2017) (rejecting the argument that the facility was being held to a "strict liability" standard for purposes of compliance with the accident prevention provisions of section 483.25(h)) and cases cited therein; *Beverly Health Care Lumberton*, DAB Ruling 2008-05, Denial of Petition for Reopening of DAB No. 2156, at 6 (May 2, 2008) (rejecting the argument that the Board "imputed liability" on facilities based on the liability of facility employees or agents, in the context of a deficiency based on resident abuse); *Briarwood Nursing Ctr.*, DAB No. 2115, at 11 n.8 (2007) ("strict liability" is a tort concept inapplicable to 42 C.F.R. Part 498 proceedings).

It is well-settled that "congressional enactments can take precedence over principles of common law, including the principle of respondeat superior." *Sentinel Med. Labs., Inc.*, DAB No. 1762, at 14 (2001) (citing *Price v. Westmoreland*, 727 F.2d 494 (5th Cir. 1984)), *aff'd*, *Teitelbaum v. Health Care Fin. Admin.*, 32 F. App'x 865 (9th Cir. 2002). CMS derives its enforcement authority not from common law tort doctrines, but from legislation enacted by Congress and implementing regulations governing participation in

Medicare and Medicaid. *Tri-County Extended Care Ctr.*, DAB No. 2060, at 5 (2007) (requiring a facility to comply with Medicare and Medicaid participation requirements does not mean that it is being held strictly liable). As the Board said in *Beverly Health Care Lumberton*:

A facility that undertakes to receive federal funds for its services . . . commits to meet the applicable requirements to participate in Medicare and Medicaid. Such a facility can act only through its agents and employees who make and implement policies, provide care, and perform the various responsibilities called for by federal programs to protect and ensure the welfare of residents. Therefore, a facility whose administration and staff have been found not to be substantially complying with federal requirements is itself subject to administrative enforcement remedies. The facility cannot avoid such remedies merely by attempting to disown the acts and omissions of its own staff and administration since the facility elected to rely on them to carry out its commitments.

Beverly Health Care Lumberton, DAB Ruling 2008-05, at 6-7; *see also Gwinnett* at 13 n.9 (quoting with approval the ALJ's decision, DAB CR1846, at 7 (2008), in stating that "the Act and regulations make a facility responsible for the actions of its staff because 'it is those actions which comprise the care the residents receive.'").

Furthermore, in rejecting a facility's argument that its responsibility should be limited to those factors that are within the facility's control and that sanctions for employee wrongdoing serve no regulatory purpose, the Board said:

While we do not disagree that facilities face a risk that some employees may prove to be incompetent or dishonest, we disagree that no policy purpose is served by holding facilities responsible for incompetent or dishonest staff conduct. Facilities are responsible for providing care in accordance with federal participation requirements. Facilities perform carry out this responsibility in part through their selection, training and supervision of their staff. Therefore, only facilities are able to take action to prevent incompetent or dishonest individuals from harming residents. Sanctions on facilities for failing to implement policies and procedures to prohibit neglect or abuse through their staff serve the obvious goal of encouraging facilities to maintain hiring, training and supervision practices that protect residents. To hold otherwise would permit facilities to cut corners on staffing, training or supervision and to escape responsibility for resulting shortfalls in care by blaming (and perhaps terminating) individual staff members without making changes that would prevent recurrence.

Gwinnett at 12-13; accord *N.C. State Veterans Nursing Home* at 12 (“The rationale for holding a facility accountable for the actions of its staff applies equally to all staff members who, in the course of carrying out their assigned duties, fail to act in a manner consistent with the regulations and the facility’s policies pertaining to resident abuse.”); *Royal Manor*, DAB No. 1990, at 12 (2005) (“It is the facility that executes a provider agreement and undertakes to provide services of the quality mandated by the participation requirements. If the professional staff hired by the facility is . . . not adequately skilled, trained, or equipped to provide those services, the facility must answer for, and correct, that failure”); *Cherrywood Nursing & Living Ctr.*, DAB No. 1845, at 10 (2002) (rejecting the argument that a nurse aide, unlike a professional (e.g., nurse), had no discretion and acted contrary to written instructions, which the facility could not have foreseen, because the “facility’s responsibility for the actions of its employees” is not “dependent on the hierarchy of the employees”); *Emerald Oaks*, DAB No. 1800, at 7 n.3 (2001) (The facility, as “[the nurse’s] employer[,] cannot disown the consequences of the inadequacy of the care provided by the simple expedient of pointing the finger at [the nurse’s] fault, since she was the agent of her employer empowered to make and carry out daily care decisions.”).

Accordingly, consistent with applicable precedent, facilities shoulder the burden to comply with the applicable participation requirements. Kindred is properly held responsible for the acts of abuse by the CNA, its (former) employee, by virtue of the obligations it assumes as a condition for receiving federal healthcare program monies. It is not being illegally cited for the wrongful actions of its former employee through the application of respondeat superior or another tort liability concept.

Moreover, we disagree with Kindred’s argument (RR at 21-22) that the CNA was not acting within the scope of his employment when he sexually abused or attempted to sexually abuse Residents B, C and D. The CNA was in the facility and had access to the residents because the facility placed in him in the position to provide personal care to the residents, in the course of which he committed these acts. Kindred’s attempt to distinguish the cited facility employee misconduct as described in *Springhill, North Carolina*, and *Gwinnett* (cited in the ALJ Decision) from the CNA’s conduct in the instant case is unconvincing. Kindred argues that, in those cases, the employees were providing care but simply performed “their delegated patient care tasks in an excessive or otherwise improper manner,” whereas in contrast the CNA’s conduct at Kindred “was not incidental or related to his employment, but was instead the result of his own motivation.” *Id.* While *Springhill, North Carolina* and *Gwinnett* did not involve sexual abuse, the CNA here, like the employees in those cases, was able to physically gain access to the residents only by virtue of his employment with the facility. His employment with Kindred as a caregiver to residents provided the CNA with the means and opportunity to abuse or attempt to abuse the residents in the course of providing the care that Kindred hired him to provide.

Likewise we are not convinced by the attempt to distinguish *Springhill* and *North Carolina* on the ground that multiple employees were involved in those cases. RR at 18-19. That *Springhill* and *North Carolina* happened to involve multiple incidents of misconduct or failings by multiple individuals does not then mean that a facility can only be responsible for staff abuse if it is committed by multiple employees.¹²

Further, the ALJ's factual findings here are well supported. In our view, the ALJ rightly rejected Kindred's attempt to cast the CNA's misdeeds as an "isolated" incident. ALJ Decision at 3. The CNA committed or attempted to commit multiple acts of abuse, on multiple residents, on different occasions, and during a relatively brief period of employment. Based on undisputed evidence of the timeline of events, the abusive incidents began about a month or so into the CNA's employment. Given repeated incidents with different residents over a period of time, we consider the ALJ's characterization of the incidents in this case as presenting a "pattern of abuse" to be apt. *Id.* The ALJ was correct, too, however, that one episode of abuse would be sufficient to cite the facility. *Id.* Nothing in section 483.13's language contemplates that finding a violation turns on the number of incidents or perpetrators, or pervasiveness of abuse.¹³

3. *Kindred's assertion that there is no ground for citing it with Tag F223 based on a violation of 42 C.F.R. § 483.13(c)(1)(i) is without merit.*

Kindred argues that the State Operations Manual (SOM), CMS Pub. 100-07, Appendix PP, mentions section 483.13(c)(1)(i) only in relation to Tag F226, concerning a facility's failure to develop and implement abuse-prevention policies and procedures, and does not mention it in relation to Tag F223. The ALJ found, and CMS concedes, that Kindred did not fail to develop or implement abuse-prevention policies and procedures and

¹² As a general matter, the more pervasive, widespread, numerous, and egregious the violations, the greater the likelihood the violations would be graded higher in terms of scope and severity level and that the facility would be assessed higher penalties. We are not stating that the degree of noncompliance in terms of, e.g., isolated versus widespread, has no relevance in the assessment of facility performance. We are simply making the point that the specific question of a facility's liability or not based on the misconduct of its staff does not turn on whether multiple staff persons were involved or the number of incidents.

¹³ While CMS cited Tag F223 at level J, which is isolated immediate jeopardy, we do not believe that implies any error in the ALJ's description of the CNA's actions here as going beyond a single or isolated incident of abuse.

accordingly Tag F226 was “removed” and is a “moot” issue. Therefore, Kindred argues, there is “no basis to transform [section] 483.13(c)(1)(i) . . . into an F223 Tag deficiency.” Reply brief at 1 n.1 and 6; *see* RR at 17, citing Appendix PP pages 78-79.¹⁴

While the SOM provisions provide CMS’s interpretive guidance to surveyors on the applicable law and regulations, they are not themselves substantive authorities with the force and effect of law. *Cedar Lake Nursing Home*, DAB No. 2344, at 6 (2010); *Foxwood Springs Living Ctr.*, DAB No. 2294, at 9 (2009); *Beverly Health & Rehabilitation Services v. Thompson*, 223 F.Supp.2d 73, 99-106 (D.D.C. 2002), *aff’g* *Beverly Health & Rehabilitation – Spring Hill*, DAB No. 1696 (1999).

Moreover, nothing Kindred identified in the SOM¹⁵ precludes CMS from considering violations of section 483.13(c)(1)(i) when reviewing compliance under Tag F226 since that regulation includes elements that go beyond the policy-and-procedure requirements captured under Tag F223. Section 483.13(c) provides:

- (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[.]

Most importantly, section 483.13(c)(1)(i) requires development and implementation of policies against abuse and neglect and explicitly prohibits facilities from using sexual abuse, among other abusive practices. We are not persuaded by Kindred’s claims that this express prohibition is somehow limited in its scope because it appears in the context of language about developing policies against abuse. RR at 17. Read as Kindred suggests, subsection (c)(1)(i) would seem to add nothing to the overall requirement that

¹⁴ The current version of Appendix PP (Rev. 168, eff. March 8, 2017), available in PDF format on the CMS website, addresses Tag F226 in pages 87-90. (CMS manuals, including the SOM and its appendices, are available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/index.html>.) Possibly, in referring to pages 78-79, Kindred was relying on an earlier version of Appendix PP. We note that Kindred submitted SOM, Appendix Q (Rev. 102, issued Feb. 14, 2014) in its entirety as its exhibit 3 in support of arguments addressed elsewhere herein; it has not, however, submitted any part of the version of Appendix PP upon which it relies. We also note that while the current version of Appendix PP does instruct the use of Tag F226 for deficiencies concerning a facility’s development and implementation of policies and procedures, it does not expressly refer to section 483.13(c)(1)(i), and instead refers to a number of other regulations, including section 483.12(b) (apparently for consistency with the October 2016 Final Rule, which, among other things, redesignated section 483.13 to section 483.12) and 483.95(c). Appendix PP, pages 87-88.

¹⁵ The current version of Appendix PP available on the CMS website (Rev. 168, eff. March 8, 2017) expressly refers to the provisions of section 483.12 in addressing Tag F223. *See* Appendix PP pages 83-86.

facility policies prohibit all forms of mistreatment, neglect and abuse. We read it instead to add affirmative prohibitions against the use of specific egregious practices which the drafters treated as particularly subject to misuse in the setting of dependent, vulnerable nursing home residents.

Kindred nevertheless argues, even if section 483.13(c)(1)(i) could be a basis for Tag F223, *Kindred* has not actually violated the regulation because the word “use” (i.e., that a facility must not “use” sexual abuse) is defined in the dictionary to mean to take, hold, employ or deploy something to accomplish a result or purpose. RR at 16. Thus, Kindred contends, in forbidding *the facility* from using abusive practices in caring for its residents, “the word ‘use’ does not simply mean ‘engage in.’” *Id.* Kindred argues that it was only the CNA, not the facility, who could be said to have “used” abuse in violation of the regulations. *Id.*

This argument misses the mark. In urging the Board to strictly employ a dictionary definition of the word “use” in interpreting section 483.13(c), Kindred attempts to distance itself from the reach of the regulation’s language, reasserting that it bears no culpability because it “did everything right” in terms of developing and implementing anti-abuse policies and procedures. However, again, by its terms, 42 C.F.R.

§ 483.13(c)(1)(i) requires not only that the facility develop and implement anti-abuse policies and procedures (which Kindred has done here), but also that *the facility* not “use” abuse in providing care to its residents. As we have discussed earlier, a facility provides care and services through its staff. Indeed, any action a facility takes necessarily must be accomplished through its personnel. It follows, then, where, as here, the facility’s staff person, the CNA, “used” abuse, that wrongful act, committed while the CNA was providing care to facility residents, effectively “becomes the act of the facility” (ALJ Decision at 4) for purposes of establishing a violation of section 483.13(c)(1)(i).

Kindred also asserts, again, that “isolated” incidents perpetrated by one person, the CNA, acting outside the scope of his employment, may not be grounds for citing Kindred with a violation of section 483.13(c)(1)(i). RR at 12, 16-17. According to Kindred, applicable precedent, including the Board’s decisions in *Gwinnett* and *Emerald Oaks*, support its position because therein the Board rejected the notion that isolated misconduct supports a deficiency, “instead reading . . . [section 483.13(c)(1)(i)] as addressing the sufficiency and implementation of facility policies and procedures.” RR at 16-17. In *Gwinnett*, the Board said, “We agree with [the facility] that the terms of section 483.13(c) concern more than whether an individual staff member committed an individual act of neglect, mistreatment or abuse. The Board has previously stated that section 483.13(c) ‘addresses a deficiency related to lack of effective policy as opposed to one directed at the occurrence of neglect itself.’” *Gwinnett* at 14, quoting *Emerald Oaks* at 17. In support of

its argument Kindred quotes the first sentence of this statement from *Gwinnett* (at 14) and that part of *Emerald Oaks* (at 18) in which the Board said that section 483.13(c)(1)(i) “addresses adopting effective anti-neglect and abuse policies, not targeting isolated events.” RR at 16-17.

These arguments, relying on selected language from Board decisions, also miss the mark. We must consider, in context, the specific language that Kindred quotes from *Emerald Oaks* and *Gwinnett*. In *Emerald Oaks*, issued in November 2001, more than seven years before *Gwinnett*, the Board addressed a question that appeared to have been one of first impression: whether sufficient evidence of neglect of residents may be the basis for inferring failure to comply with section 483.13(c)’s requirement to develop and implement policies and procedures prohibiting neglect. *Emerald Oaks* at 17-18. In upholding the ALJ’s determination that such evidence may be the basis for drawing such an inference, the Board said:

[I]mplementing policies clearly means something more than maintaining a paper file of documents without actually regulating staff actions. A pattern of recurring neglect can reasonably raise the inference drawn by the ALJ that no policy against neglect has been systematically implemented at the facility. . . .

We conclude that the ALJ made no error in drawing the inference that sufficient examples of neglect can demonstrate lack of implementation of an anti-neglect policy.

Id. at 18. The Board then examined the evidence and agreed with the ALJ that there was substantial evidence supporting a violation of section 483.13(c)(1)(i) based on resident neglect. *Id.* at 14, 19. Similarly, in *Gwinnett*, the Board determined that the facility was responsible for failing to implement anti-neglect policies as demonstrated by the failures of its staff. *Gwinnett* at 12-14.

The instant case, however, does not involve an issue of facility neglect of residents, much less the question of whether the evidence presented supports an inference that the facility failed to develop and implement policies and procedures (whether those policies and procedures concern abuse or neglect). The ALJ found, and CMS does not dispute, that Kindred had no failure in terms of developing and implementing policies and procedures. This case is about abuse of residents; it is not about implementation of policies and procedures. And, here, the ultimate question we must answer is whether Kindred may be held responsible for abusive acts committed by its (former) employee. As we have explained, Kindred indeed may be held responsible because under section 483.13(c)(1)(i) it is the facility that is prohibited from “using” abuse and Kindred, as any other facility, can only act through the individuals it hires to provide care and services to the residents it

serves. Where, as here, the facility’s (former) employee abused residents, those abusive acts are effectively the acts of the facility on which a violation of section 483.13(c)(1)(i) may be found. Whether or not the CNA’s actions may be characterized as “isolated” as Kindred asserts (and as we address elsewhere herein we agree with the ALJ that they were not “isolated”) has no bearing on this ultimate question.¹⁶

4. *Kindred has not proven that CMS’s determination to cite it with immediate-jeopardy-level noncompliance with 42 C.F.R. § 483.13(b) and (c)(1)(i) was clearly erroneous.*

a. SOM, Appendix Q

Kindred points to the SOM, Appendix Q (P. Ex. 3), as showing that harm, immediacy, and culpability constitute three required components of immediate jeopardy, and asserts that CMS must show at minimum “*some culpability*” to find immediate jeopardy. RR at 23 (Kindred’s emphasis). Kindred argues that, regardless of the likely or actual harm that has occurred, Appendix Q bars an immediate-jeopardy-level citation where, as here, the facility had “no reason to know of the abuse and took all reasonable steps to avoid and then respond to the abuse.” *Id.* at 25. Quoting Appendix Q, Kindred asserts that Appendix Q instructs that immediate jeopardy should not be cited where the incident “could not have been predicted or prevented” and “[t]he facility reacted appropriately.” *Id.*, quoting P. Ex. 3, at 19. The quoted language is found within a case example discussed in Appendix Q. P. Ex. 3, at 18-19. As CMS points out, the example concerns an intruder (not a facility employee) who breaks into the facility at night unobserved and rapes a resident (CMS’s Response at 22), which is hardly the scenario at issue here. Kindred asserts that section 483.13(b)’s language does not distinguish staff abuse of residents and abuse by an outsider and, in any case, through Appendix Q guidance, CMS has instructed surveyors not to cite immediate-jeopardy-level deficiencies in the absence of some level of facility failure. Reply brief at 7-8.

As discussed, the SOM is not binding authority; it provides interpretive guidance for surveyors. The example to which Kindred cites specifically involved an actor who was in no sense an agent of the facility. We do not find that the language in Appendix Q is properly read to exempt facilities from responsibility for the harmful actions of their own employees that create immediate jeopardy. While the facility here may have developed

¹⁶ As we have explained, Kindred’s reliance on specific language from *Gwinnett* and *Emerald Oaks* is misplaced in the instant case. We observe, however, that, even in the context of development and implementation of anti-neglect policies and procedures for purposes of section 483.13(c), in *Gwinnett* and *Emerald Oaks*, the Board determined that it is the facility that shoulders the burden to ensure appropriate implementation of neglect policies via the actions of its employees. In that sense, whether the issue is one of neglect or abuse, the ultimate question is whether the facility is responsible for ensuring that its staff does not violate anti-neglect or anti-abuse provisions.

and implemented an adequate anti-abuse policy, that does not mean that the facility here (unlike the one in the example) had no control over events and no opportunity to affect the acts of the CNA because the facility chose the CNA, placed him in a position of access to and authority over dependent, vulnerable residents whom the facility had undertaken to protect, and was responsible for supervising the CNA.

We also disagree with Kindred's suggestion that facility culpability is a necessary element of immediate jeopardy *based on Appendix Q's discussion of culpability*. The Board rejected the same argument in *North Carolina* at 17, relying upon binding (regulatory) authority, stating that "the definition of immediate jeopardy in section 488.301 does not support [the facility's] reading of Appendix Q as providing that culpability is a necessary component of immediate jeopardy." *Accord Pinecrest Nursing & Rehab. Ctr.*, DAB No. 2446, at 19 (2012) ("Appendix Q's purpose is to guide surveyors in applying a regulatory standard, not to define that standard. The immediate jeopardy standard is defined by regulation in 42 C.F.R. § 488.301, and the regulatory definition, not the SOM instructions, binds the Board."). It is important to bear in mind that Appendix Q is intended to aid surveyors on how to identify immediate-jeopardy situations by discussing immediate jeopardy in terms of harm, immediacy, and culpability. *See* P. Ex. 3, at 2 (Preamble to Appendix Q), 14 (harm, immediacy, culpability are "components" of immediate jeopardy). Saying that culpability is one component of evaluating immediate jeopardy does not necessarily imply that immediate jeopardy can only exist where culpability is proven. This discussion in the SOM is based on the regulations, under which CMS considers multiple factors, one of which is the facility's "degree of culpability," to assess the appropriate penalty. *See* 42 C.F.R. §§ 488.438(f), 488.404(b). Moreover, the regulations specifically state that, while degree of culpability is a relevant factor, "[t]he absence of culpability is not a mitigating circumstance in reducing the amount of the penalty." 42 C.F.R. § 488.438(f)(4). The SOM must be read consistently with the governing regulation.

b. ISDH newsletter

Kindred argues that the immediate-jeopardy citation conflicts with interpretive guidance of the ISDH, the state agency charged with overseeing regulatory compliance of long-term care facilities in Indiana. That guidance is in the form of the ISDH's November 30, 2009 "Long Term Care Newsletter" which, Kindred says, explains that how staff abuse of residents is cited depends on how the facility implemented its abuse policies and reacted to the abuse. According to Kindred, if, as here, a facility had an appropriate abuse policy in place and properly administered that policy, but a "rogue" employee without prior history of abuse committed abuse, and the facility appropriately responded to the incident with thorough investigation, protected the resident from further abuse, disciplined the perpetrator, and retrained staff, a "substantial compliance level deficiency would be warranted[.]" RR at 25-26, citing CMS Ex. 11, at 79, 87; Reply brief at 8-9 (similar argument).

We reject the suggestion that CMS is bound by a state agency newsletter (issued some eight years ago). State agencies, like ISDH, perform compliance surveys of facilities under agreement with the federal government, but it is CMS that enforces compliance with applicable federal law and regulations. Kindred offers no reasoned explanation bolstered by authority for the proposition that CMS's actions are limited by an ISDH newsletter article. As we have discussed, binding authority and applicable precedent govern a determination of whether Kindred was or was not properly cited with Tag F223.

c. Independent Informal Dispute Resolution (IIDR)

Kindred urges the Board to consider as persuasive an IIDR reviewer's opinion that, under the circumstances of this case, Kindred should not be cited with any violation, let alone an immediate-jeopardy finding, noting that "no [facility] failures are illustrated within the F223 deficiency." RR at 8, quoting CMS Ex. 11, at 86. Kindred takes issue with the ALJ's characterization of its arguments concerning the IIDR review. *Id.* at 8 n.3, quoting ALJ Decision at 4 ("I find no merit to Petitioner's assertion that CMS's determination is unlawful in light of the decision made at [I]IIDR."). Kindred states that it does not contend that the IIDR's decision is "mandatory" authority, but rather that the IIDR reviewer's "well-reasoned opinion [is] persuasive support to explain why CMS's position . . . is unsupported by and contrary to governing authority and precedent." *Id.*; Reply brief at 7 n.5 (similar statement).

The informal dispute resolution process (which includes IIDR) offers facilities an informal opportunity to dispute survey findings. *See generally* 42 C.F.R. §§ 488.331, 488.431; SOM, Ch. 7, §§ 7212, 7213. CMS has the ultimate authority for the survey findings and imposition of CMPs. 42 C.F.R. § 488.431 (IIDR); SOM, Ch. 7, § 7213.3 (IIDR). *See also Columbus Park Nursing & Rehab. Ctr.*, DAB No. 2316, at 10 (2010) (*appeal dismissed, Columbus Park Nursing & Rehab. Ctr. v. Sebelius*, 940 F. Supp.2d 805 (N.D. Ill. 2013)); citing *Rafael Convalescent Hosp. v. Shalala*, 1998 WL 196469 (N.D. Cal. Apr. 15, 1998); *Britthaven of Chapel Hill*, DAB No. 2284 (2009); and *Capitol House Nursing & Rehab Ctr.*, DAB No. 2252, at 5-8 (2009) (CMS is not required to accept informal dispute resolution results, and a revised SOD issued by a state agency based on informal dispute resolution does not trigger appeal rights under Part 498); SOM, Ch. 7, § 7213.4 (IIDR "is not intended to be a formal or evidentiary hearing nor are the results of the [IIDR] process an initial determination that gives rise to appeal rights pursuant to [42 C.F.R. § 498.3(b)]. The [IIDR] results are recommendations to the State and CMS and are not subject to formal appeal.").

Kindred's argument is unavailing. An IIDR reviewer's opinion is just that. Ultimately, because CMS is not bound to follow or defer to an IIDR determination, let alone the opinion of an IIDR reviewer, it is inconsequential that an IIDR reviewer expressed an opinion favorable to Kindred. Importantly, we note that the state agency's final IIDR

decision recommended no changes to the deficiency findings as initially made and therefore effectively rejected the IIDR reviewer's opinion that Kindred should not be cited. *See* CMS Ex. 11, at 1, 82-89. Moreover, once CMS proceeds with enforcement action following completion of state agency level investigation, on the facility's appeal of CMS's deficiency citation to the ALJ, the outcome of the informal dispute resolution process is no longer the issue. On appeal, the ALJ does not review CMS's conclusions or determinations about earlier state agency-level review, but rather reviews de novo the entire record and determines whether the facility was or was not in substantial compliance with applicable regulations. *See Britthaven of Chapel Hill* at 4-6 (discussion in context of informal dispute resolution).

d. Policy considerations

Kindred urges the Board to consider the implications of tarnishing the reputation of a facility that has "do[ne] everything right" with the stigma of an immediate-jeopardy citation, stating that following the "approaches required by Appendix Q and described by ISDH . . . makes good policy sense." RR at 26. Kindred suggests that disregarding Appendix Q and the facility's record of having done everything correctly "will result in an increased failure to report abuse" and would discourage facilities from developing and implementing abuse-prevention policies and procedures. *Id.* Kindred suggests, moreover, that state criminal law enforcement processes and professional licensure disciplinary authority afford sufficient protection from abuse, neglect and other forms of mistreatment of facility residents. *Id.* at 27.

We have addressed Kindred's reliance on Appendix Q and the ISDH newsletter above and need not repeat that discussion here. It is not for the Board to weigh policy considerations. *See Med-Care Diabetic & Med. Supplies, Inc.*, DAB No. 2764, at 20 (2017). Moreover, Kindred does little more than speculate that citing it with an immediate-jeopardy violation would somehow lead to widespread or pervasive violations of abuse-prohibition requirements. Facilities have a vested interest in complying with, and indeed are obligated to comply with, the requirements for participating in Medicare and Medicaid as a condition for receiving federal funding, irrespective of whether *based on the facts of this case* the ALJ and the Board uphold CMS's determination to cite an immediate-jeopardy violation. The Medicare and Medicaid programs, too, have a vested interest in ensuring that participating facilities maintain high standards of quality in providing care. That interest endures regardless of any additional benefits the programs, the facilities, and their residents may enjoy in terms of quality care delivered by quality personnel due to the efficacy of parallel state criminal law enforcement and professional licensure disciplinary actions. Requirements like those in section 483.13 are in place to further that interest.

- e. The ALJ did not err in determining that the violation cited as Tag F223 posed immediate jeopardy.

Immediate jeopardy, the most serious level of noncompliance, 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’s determination of immediate jeopardy must be upheld unless it is clearly erroneous. *Id.* § 498.60(c)(2). The “clearly erroneous” standard in section 498.60(c) is highly deferential and imposes a heavy burden on the facility to upset CMS’s finding on the level of noncompliance. *Springhill* at 18 and *Gwinnett* at 19 (and cases cited in both decisions).

For purposes of immediate jeopardy, the likely or actual serious harm or injury need not be physical in nature. Psychological harm is a cognizable form of injury for purposes of an abuse violation. 42 C.F.R. § 483.13(c)(1)(i) (the facility must not use “mental” abuse); 42 C.F.R. 488.301 (“abuse” is defined to include “mental anguish”); *Springhill* at 18; *see also* P. Ex. 3 (SOM, Appendix Q) at 3 (“[p]sychological harm is as serious as physical harm”), 4-6 (“Immediate Jeopardy Triggers” include failure to protect from psychological harm). Moreover, section 488.301’s definition of “immediate jeopardy” focuses not only on the occurrence of harm, but also the likelihood of or potential for harm. And, consistent with section 488.301, Appendix Q provides, “**Serious harm, injury, impairment, or death** does **NOT** have to occur before considering Immediate Jeopardy. The high potential for these outcomes to occur in the very near future also constitutes Immediate Jeopardy.” P. Ex. 3, at 3 (bolding and capitalization in original). Therefore, by the regulation’s terms, considered together with the aforementioned authorities and guidance, actual, physical harm need not have taken place for an actionable immediate-jeopardy abuse deficiency.

The ALJ determined that CMS’s immediate-jeopardy citation was not clearly erroneous in light of the “likelihood of severe psychological injury” to Residents B and C. ALJ Decision at 4. We concur with the ALJ’s determination because it comports with the authorities and guidance set out above and is amply supported by the evidence. The two residents plainly did not want the CNA’s advances as they protested when the CNA attempted to engage them in inappropriate contact with him. *E.g.*, CMS Ex. 11, at 27-29, 32-34; CMS Ex. 5, at 5. All three residents (Residents B, C and D) were diagnosed with psychological disorders. CMS Ex. 3, at 1, 2; CMS Ex. 6, at 12 (all three have depression; Residents B and C have anxiety; Residents B and D have insomnia and dementia; Resident D has schizophrenia). After the incidents came to light, Kindred staff identified concerns about the potential for decline in all three residents’ psychosocial well-being

related to the CNA's actions and made plans for appropriate intervention. CMS Ex. 6, at 4, 11, 16. Thus, while we recognize that Kindred took appropriate action in attempting to mitigate the potential for any additional harm to the residents once it learned of the incidents, Kindred's own records raise a reasonable question about the residents' susceptibility or vulnerability to exacerbated psychological harm attributable to the CNA's actions.

As noted, the recurrent theme in Kindred's appeal is that it should not be penalized with a violation, particularly one cited at the immediate-jeopardy level, because it bears "*zero . . . culpability[.]*" RR at 12 (Kindred's emphasis). Kindred's position is that for the citation to lie against it there must be some finding of fault on the part of the facility as an institution and, because it it "did everything right" in terms of developing and implementing abuse-prevention procedures and policies, there is, and can be, no basis for the citation. It is true that the ALJ found, and CMS does not dispute, that Kindred established and implemented abuse-prevention policies. But development and implementation of abuse-prevention procedures and policies, even if executed without any shortcoming such that the facility arguably is not "culpable" in the sense that it did not neglect or disregard or act indifferently to its residents' needs,¹⁷ do not necessarily shelter the facility from citation for immediate jeopardy. Nevertheless, Kindred failed to comply with the requirements it undertook in participating in Medicare – specifically, the requirements to protect residents' rights to be free of abuse and to ensure that sexual abuse is not "used" at Kindred. Those failures may constitute deficiencies without regard to any finding about institutional culpability, the seriousness of which depends on the level of harm or potential harm. And, the touchstone for immediate jeopardy in particular is the degree of or potential for *serious* harm, whether psychological or physical or both. In consideration of the serious nature of the abusive actions of the facility's former employee in this case, committed against more than one resident and on multiple occasions and, as the ALJ aptly noted, the "likelihood of severe psychological injury" to the residents (ALJ Decision at 4), we fully concur with the ALJ that an immediate-jeopardy citation was warranted.

Since we find that immediate jeopardy (Tag F223, scope and severity level "J") was properly cited (not clearly erroneous), we reject Kindred's alternative request for relief that in the event the Board finds no basis to "remove" Tag F223, the scope and severity level should be lowered to "A" (meaning isolated in scope but substantially compliant in severity) or "D" (meaning isolated in scope but that in terms of severity there was potential for more than minimal harm). RR at 27; Reply brief at 1. Kindred raises no specific argument concerning the ALJ's determinations on the reasonableness of the per-day CMP amount for immediate jeopardy (\$3,550) or the duration of immediate jeopardy (three days). ALJ Decision at 5. We therefore summarily affirm those determinations.

¹⁷ "Culpability" includes neglect, indifference, or disregard for resident care, comfort or safety. 42 C.F.R. § 488.438(f)(4).

Lastly, since we (like the ALJ) have concluded that CMS did not err in determining that Kindred's noncompliance with section 483.13 posed immediate jeopardy, we also conclude that the noncompliance constitutes substandard quality of care (*see* 42 C.F.R. § 488.301), a consequence of which, as the ALJ indicated, is that Kindred loses the authority to conduct a NATCEP for a two-year period.

Conclusion

Based on the foregoing reasons and bases, the Board upholds the ALJ Decision.

/s/
Christopher S. Randolph

/s/
Leslie A. Sussan

/s/
Susan S. Yim
Presiding Board Member