Department of Health and Human Services
DEPARTMENTAL APPEALS BOARD
Appellate Division

Ridgecrest Healthcare
Docket No. A-14-81
Decision No. 2598
October 7, 2014

FINAL DECISION ON REVIEW OF ADMINISTRATIVE LAW JUDGE DECISION

The Petitioner, Ridgecrest Healthcare (Ridgecrest), an Arizona nursing facility, requested review of an Administrative Law Judge's decision sustaining the imposition by the Center for Medicare & Medicaid Services (CMS) of civil money penalties (CMPs) and a denial of payment for new Medicare admissions for failure to comply substantially with Medicare participation requirements in the federal regulations. *Ridgecrest Healthcare*, DAB CR3222 (2014) (ALJ Decision). CMS determined, and the ALJ agreed, that Ridgecrest did not comply substantially with requirements that facilities protect residents from abuse, investigate allegations of abuse, and report allegations of abuse to the state survey agency, and that the noncompliance posed immediate jeopardy.

For the reasons discussed below, we sustain the ALJ Decision.

Legal Background

To participate in the Medicare program, a 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. 42 C.F.R §§ 488.10(a), 488.11; *see also* Social Security Act §§ 1819(g)(1)(A), 1864(a). State survey agencies conduct periodic surveys as well as surveys to investigate complaints that facilities are violating one or more participation requirements. 42 C.F.R. § 488.308.

A state survey agency reports any "deficiencies" it finds in a Statement of Deficiencies (SOD), which identifies each deficiency under its regulatory requirement. 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 facilities with deficiencies, including per-day CMPs for the number of days that the facility is not in substantial compliance, and a denial of payment for new Medicare admissions (DPNA) during the period of noncompliance. 42 C.F.R. §§ 488.402(b),(c), 488.406, 488.408, 488.417(a), 488.430(a). CMS may impose a per-day CMP ranging from $50-$3,000 per day for each day of noncompliance determined to pose less than immediate jeopardy to facility residents, and of $3,050 - $10,000 per day for each day of noncompliance determined to pose immediate jeopardy. 42 C.F.R. §§ 488.408(d)(1)(iii), (e)(1)(iii), 488.438. Those remedies continue until "[t]he facility has achieved substantial compliance, as determined by CMS or the State based upon a revisit or after an examination of credible written evidence that it can verify without an on-site visit . . . ." 42 C.F.R. § 488.454(a)(1).

Case Background

The case involves an incident on November 22, 2012 in which a resident of Ridgecrest sustained a broken finger on his left hand when a certified nursing assistant (CNA) attempted to force the resident to relinquish his grip on a door handle by pressing his own hand against the resident's knuckles.[1]

The resident complained to the state survey agency, which surveyed Ridgecrest on December 6-8, 2012 and February 1-2, 2013. CMS Exs. 1; 32; 34, at 1. The state survey agency found on the first survey that Ridgecrest was not in substantial compliance with regulations requiring that residents be free from physical abuse. CMS Exs. 1, 22. The state agency also found that Ridgecrest was not in substantial compliance with requirements that facilities investigate allegations of abuse, report alleged abuse to the state survey agency, and prevent further potential abuse while the investigation is in progress. *Id.*; 42 C.F.R. § 483.13 (b), (c). The state agency further found that the noncompliance with requirements to investigate allegations of abuse and protect residents during investigations posed immediate jeopardy to resident health and safety.

The state agency found from the February 2013 survey that Ridgecrest was not in substantial compliance with regulations requiring that facilities not employ persons found guilty of abuse by a court of law, or who have had abuse findings entered against them in a state nurse aid registry. The state agency also found again that Ridgecrest was not in substantial compliance with regulations requiring that facilities keep residents free of

[1] The SOD identifies this CNA as "CNA #1" and the resident as "Resident #1" or "resident #1." The ALJ Decision uses the identifier "Resident # 1" for this resident but refers to CNA #1 by his last name. We refer to CNA #1 as "the CNA," except when context requires using the numerical identifier, and to Resident #1 as "the resident."

abuse. The state agency again found that the noncompliance posed immediate jeopardy to resident health and safety. The state survey agency conducted a follow-up survey on April 5, 2013 and determined that Ridgecrest was in substantial compliance with the regulations effective April 5, 2013. CMS Ex. 33, at 6.

CMS adopted the state agency survey findings and imposed CMPs of $5,000 per day for the immediate jeopardy-level noncompliance on December 7, 2012 and $7,200 per day for the immediate jeopardy-level noncompliance on February 1, 2013, and $500 per day from December 8, 2012 through January 30, 2013 and from February 2 through April 4, 2013. CMS Exs. 22, 33. CMS also imposed a DPNA effective February 2, 2013.[2] *Id.*

The ALJ sustained CMS's deficiency determinations and the amount of the CMPs. The ALJ concluded on de novo review and after a hearing that the resident had been abused, that Ridgecrest had not reported alleged abuse to the state agency and had not investigated the alleged abuse. The ALJ also concluded that Ridgecrest was noncompliant with the requirement to protect residents from abuse.

Ridgecrest on appeal repeats arguments the ALJ addressed. We discuss below the ALJ's findings and conclusions and why we agree with those findings and conclusions.

Standard of Review

We review a disputed finding of fact to determine whether the finding is supported by substantial evidence in the record as a whole, and a disputed conclusion of law to determine whether it is erroneous. Departmental Appeals Board, *Guidelines for Appellate Review of Decisions of Administrative Law Judges Affecting a Provider's Participation in the Medicare and Medicaid Programs* (DAB *Guidelines*); *Golden Living Ctr. – Frankfort v. Sec'y of Health & Human Servs.***,** 656 F.3d 421, 426-27 (6th Cir. 2011). Substantial evidence means "such relevant evidence as a reasonable mind might accept as adequate to support a conclusion." *Richardson v. Perales*, 402 U.S. 389, 401 (1971), *quoting Consolidated Edison Co. v. NLRB*, 305 U.S. 197, 229 (1938).

Under the substantial evidence standard, the Board does not re-weigh the evidence or overturn an ALJ's "choice between two fairly conflicting views" of the evidence; instead, the Board determines whether the contested finding could have been made by a reasonable fact-finder "tak[ing] into account whatever in the record fairly detracts from

[2] The state agency and CMS also alleged that Ridgecrest failed to provide the resident with necessary care and services to address the pain and swelling of his broken finger, in violation of the requirements of 42 C.F.R. § 483.25. The ALJ found it unnecessary to address that deficiency because the other deficiency findings he sustained were "more than adequate to support the remedies that CMS imposed against Petitioner." ALJ Decision at 9. As we sustain the ALJ's other deficiency determinations and his conclusion that the CMP amounts are reasonable, we do not address that alleged deficiency under section 483.25.

the weight of the evidence" that the ALJ relied upon. *Universal Camera Corp. v. NLRB*, 340 U.S. 474, 488 (1951); *see also Allentown Mack Sales & Service, Inc. v. NLRB*, 522 U.S. 359, 377 (1998); *Golden Living Ctr. – Frankfort*, DAB No. 2296, at 9-10 (2009), *aff'd, Golden Living Ctr. – Frankfort v. Sec'y of Health & Human Servs.*

Analysis

Ridgecrest repeats arguments it made before the ALJ, all of which flow from its position that the CNA, in attempting to forcibly break the resident's grip on the door handle, did not abuse the resident but acted reasonably to protect the resident from harming himself or others. Ridgecrest argues that it investigated the incident sufficiently to conclude that there was no abuse, and also that there was no allegation of abuse that Ridgecrest was required to investigate and report to the state survey agency. As it had determined there was not abuse, Ridgecrest argues, it was also not required to keep the CNA from caring for residents.

As discussed below, the ALJ properly rejected Ridgecrest's arguments, and Ridgecrest has shown no grounds to overturn his decision. Any facts Ridgecrest alleges are disputed are not material to the ALJ's determinations and do not demonstrate that the ALJ's findings were not based on substantial evidence.

I. The ALJ's determination that Ridgecrest was not in substantial compliance with the requirement to protect residents from physical abuse is supported by substantial evidence and free of legal error.

A. The ALJ did not err in concluding that Ridgecrest staff's undisputed actions against the resident constituted abuse under the facility's policy and federal regulations.

The relevant provisions of section 483.13(b) and (c) requiring facilities to protect residents from physical abuse state as follows:

> (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; . . .

The ALJ concluded that "Petitioner's staff abused Resident # 1 when [the CNA] forcefully removed the resident's hand from the door handle." ALJ Decision at 5. The ALJ's conclusion was legally correct and supported by substantial evidence for the following reasons stated in the ALJ Decision.

The ALJ found it undisputed that the CNA "forcefully intervened to remove Resident # 1's hand from a door when the resident was resisting being moved from Petitioner's shower area," specifically that "while the resident was being escorted from the shower he grabbed two door handles in an entryway and refused to move." ALJ Decision at 3, citing CMS Ex. 34, at 3, and Tr. at 172-73. At that point the CNA "applied pressure to the fingers of the resident's left hand in order to pry that hand away from the door, and in the process of doing so he broke the resident's finger." *Id*. at 3-4. Ridgecrest does not specifically dispute these material facts.[3]

The ALJ noted that under the federal regulations "Abuse constitutes the willful infliction of injury, among other things." *Id*. at 5, stating that "'[w]illful' means 'deliberate'" and citing 42 C.F.R. § 488.301 ("*Abuse* means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish"). The ALJ also found that the CNA's actions were abuse under Ridgecrest's anti-abuse policy, which "explicitly prohibits its staff from 'Twisting, squeezing or pinching any part of a resident's body with fingers or nails.'" *Id*., citing CMS Ex. 14, at 19-20. The ALJ correctly pointed out that the Board has held that abuse may occur where a staff member takes a deliberate action against a resident that causes the resident harm even if the staff did not intend to harm the resident. *Id*. In *Vandalia Park*, DAB No. 1939, at 12 (2004), the decision cited by the ALJ, the Board held that section 488.301 defining abuse "does not require that the purpose of the actor be to inflict harm, but rather that the action have been undertaken deliberately." *Accord e.g. Merrimack Cnty. Nursing Home*, DAB No. 2424, at 5 (2011) ("as used in section 488.301, the word 'willful' means that the actor must have acted deliberately, not that the actor must have intended to inflict injury or harm (or one of the other specified types of prohibited conduct)").

[3] Ridgecrest "stipulated that it is likely that the Resident's finger was fractured at some point during the incident." RR at 15 n.7. Although Ridgecrest suggests that the fracture may have been caused by some means other than the CNA's application of pressure to the resident's hand, such as by the actions of one of the three other CNAs involved in the incident, *id*., Ridgecrest does not specifically dispute the ALJ's finding that the injury to the resident's left hand was caused by pressure applied to that hand, pressure the CNA involved acknowledges applying, stating he was using a technique designed for self-defense against a person grasping one's hair. No other CNA claimed or was reported to have pressed on the resident's left hand during the incident or to have been in a position to do so. But even assuming it was some other staff member, it would still be abusive conduct. Substantial evidence thus supports the ALJ's finding.

Based on the undisputed facts, we find no error in the ALJ's finding that the CNA had "deliberately squeezed [the resident's] fingers in his attempt to remove the resident's hand from the door" and his conclusion that the CNA's actions constituted abuse under the facility's policy and under the federal regulations. ALJ Decision at 5. That the CNA might not have intended to harm the resident or might even have intended to protect the resident or others, as Ridgecrest seems to contend, is not material since the CNA's undisputed conduct met the federal regulation's and Ridgecrest's definition of abuse.

B. The ALJ properly rejected Ridgecrest's arguments that the use of force against the resident was appropriate.

Ridgecrest argues that no abuse occurred and that the ALJ "utterly ignored the context of the interaction in question." RR at 2. As to context, Ridgecrest notes that, as is not disputed, the resident in question was "a relatively young, vigorous resident" with serious chronic mental illness and behavioral disorders and documented history of challenging and self-destructive behaviors who resided in a locked "behavioral unit" at Ridgecrest reserved for individuals with psychiatric and behavioral problems. RR at 7, 22; *see* ALJ Decision at 2 (resident was at the time of the incident "a relatively young and physically healthy individual whose primary medical problems consist of a chronic schizoaffective disorder and a bipolar disorder"). Ridgecrest points out that the resident's behaviors sometimes centered around bathing and included having recently wrapped a shower hose around his neck, an incident witnessed by the CNA in question. RR at 10-11; CMS Resp. at 17-18. Ridgecrest argues that this history is particularly relevant here because the incident occurred in a shower room.

Ridgecrest also cites the following details of the incident which, as the citations indicate, are largely undisputed. On November 22, the resident had showered and dressed and was being escorted out of the shower room by the CNA when, according to the CNA, he reached for nearby open "cubbies" containing resident toiletry and bathing items. RR at 11,13; CMS Resp. at 3-4, citing P. Ex. 34, at 2-3. The CNA, at least initially, stood between the resident and the cubbies with his arms extended, and the resident took hold of two nearby doors, one leading back to the shower room and the other to the hallway. RR at 13; CMS Resp. at 4. (The room with the cubbies was between the hallway and the shower room; the door to the hallway and the door to the room containing the shower each opened into the room with the cubbies and, according to Ridgecrest's witnesses, were close enough to make contact. RR at 12, citing P. Exs. 35, at 3; 36, at 2; 42, at 8-9; CMS Resp. at 3-4.) At this point, according to the CNA, the resident, while holding the door handles, pushed backwards against the CNA and pinned him against the wall to the shower room. RR at 13, citing Tr. at 173-82; CMS Resp. at 4, citing P. Ex. 34, at 3. The CNA and another who was nearby called for assistance and two other CNAs responded. RR at 14; CMS Resp. at 4, 9.

At some point, the parties agree, the CNA who had been escorting the resident out of the shower room freed himself from being pinned against the wall of the shower room and used his hand to apply pressure to the resident's left hand in an effort to get the resident to relinquish his grip on the door handle to the room containing the shower. RR at 15, citing Tr. at 172; CMS Resp. at 4, citing P. Ex. 34, at 3. At that point or shortly thereafter the resident released the doors and was escorted away from the shower room area. RR at 15. Some minutes later the resident was seen to have pain and swelling in his finger, and some of the CNAs present at the incident reported it to the nurse in charge of the behavioral unit. P. Exs. 35, at 4; 39, at 2-3; CMS Ex. 9.

Based on the details stated above and the resident's history, Ridgecrest argues that staff were justifiably concerned that the resident could injure himself by attempting to ingest items from the cubbies. Ridgecrest argues that the CNA who broke the resident's finger acted appropriately to remove the resident from a situation where he posed a danger to himself or others, by acting to move him away from the cubbies containing the toiletry items the resident was attempting to grab. Ridgecrest states that when the CNA applied pressure to the resident's left hand, he used "'crisis prevention' techniques" that staff had been taught, "including the proper use of physical interventions in appropriate circumstances to de-escalate behavioral incidents, and to assure resident and staff safety." RR at 8.

The ALJ considered Ridgecrest's arguments about the resident's history and the circumstances of the incident on November 22 and concluded that they did not justify the CNA's use of force against the resident. We agree. We concluded above that the CNA's use of force against the resident here – pressing on the resident's knuckles with his hand while the resident was grabbing the door handle – was abuse as defined in federal law and, indeed, in the facility's own policies. The aide's subjective intent alone does not remove the inappropriate use of force on a resident from those definitions of "abuse." Moreover, there was no credible showing of actual, imminent danger to this or other residents or to the staff involved. Rather, the force applied here was a coercive response to Resident 1's resistant behavior. Thus, claims that the CNA's actions were justified by an intention to protect individuals are entirely unpersuasive.

Furthermore, the ALJ correctly rejected Ridgecrest's assertion that the use of force was reasonably necessary to keep the resident from grabbing items out of the cubbies with which he might have injured himself or others. The ALJ found particularly instructive, and so do we, the testimony of one of Ridgecrest's witnesses, the clinical director of the behavioral unit where the resident lived. This witness testified that after the incident, he had inquired as to "why staff had to use that technique rather than simply standing between the Resident and the cubbyholes and waiting for him to release the door handles, which I thought was likely to happen fairly soon given the Resident's short attention span." ALJ Decision at 4, quoting P. Ex. 40, at 7-8; *see also* CMS Ex. 6, at 5 (surveyor notes from December survey reporting that the facility administrator stated that the

incident could have been prevented by "just backing away"). The clinical director "expressed concern" to the director of the behavioral unit "about the staff's technique of trying to remove the Resident's hands from the door handles (even before I learned that the Resident's finger had been injured)." P. Ex. 40, at 7. We note that on November 29, 2012, an interdisciplinary team amended the resident's "Behavior Plan" to reflect the clinical director's opinion that staff should not have applied force to the resident when he grabbed hold of the door handles. CMS Ex. 13, at 5. The testimony and the change made to the resident's behavior plan consistent with that testimony strongly support the ALJ's conclusion that the actions by the CNA to try to forcibly remove the resident's hands from the door handles were not justified techniques, even if the facility was concerned about the safety of the resident or other residents or staff.

We also agree with the ALJ that the crisis prevention training materials on which Ridgecrest relies do not support its contention that the CNA acted appropriately. P. Ex. 34, at 3; Tr. at 176-77 (CNA testimony that in applying pressure to the resident's hand to remove the resident's hand from the door handle, he employed a technique that he and Ridgecrest staff had been taught as part of crisis prevention training). As the ALJ found, "nothing in the training that Petitioner refers to or in the crisis prevention techniques to which it refers suggests or allows the use of force against residents in circumstances where force is unnecessary." ALJ Decision at 5.

If anything, the crisis prevention training materials demonstrate that the CNA's reported use of a grip-breaking technique from the training was not appropriate. The materials label that technique a "one-hand hair pull release" that a person whose hair has been grabbed may use to "prevent further grabbing of hair and minimize injury." CMS Ex. 15, at 2; Tr. at 176-77 (CNA testimony that the technique is used to release the grip of a person grabbing hair). The training materials do not indicate that this technique may be used for any other purpose. Furthermore, the technique, as described, is one to be used in a very specific situation requiring immediate self-defense. There is no evidence that the situation here was one requiring use of any self-defense techniques, much less the specific situation of hair grabbing for which the technique was suggested. Rather, there is no dispute that the CNA used the pressure on the resident's hand to compel him to release door handles, conduct that not even Ridgecrest suggests posed an immediate threat to anyone.[4] Ridgecrest has also not explained why a technique designed to be used on a hand grasping hair, a soft object, would be appropriate to use on a hand gripping a solid object like a door handle. The training materials thus undermine Ridgecrest's contention that the CNA used appropriate force against the resident.

[4] Ridgecrest states that "[t]here is no evidence that any of the caregivers [at the scene] was angry, scared or emotional; indeed, CMS' witnesses testified that all denied it." RR at 28.

Moreover, Ridgecrest's allegation that the resident's reaching toward the cubbies posed a danger is disputed. The ALJ stated that the CNA was standing between the resident and the cubbies and could thus prevent the resident from grabbing items without having to forcibly remove the resident's hand from the door handle. ALJ Decision at 4-5. Ridgecrest does not deny that the CNA initially blocked the cubbies but says by the time the CNA put his hand on the resident's hand, the CNA was behind the resident with the resident leaning against him. RR at 13. Citing the testimony of some of the CNAs, Ridgecrest also asserts that the resident used his right hand, arm or shoulder to strike at the two CNAs who attempted to remove his right hand from the door, and that he continued to reach toward or into the cubbies with his right hand.[5] RR at 14-15, citing P. Exs. 35-37, and Tr. at 195-96. A state surveyor, who interviewed some of the CNAs and viewed a subsequently-erased video of the incident from a security camera in the hallway outside the room, agreed that the resident used his right hand to strike out at one of the CNAs who attempted to remove his right hand from the door and resisted the efforts of the other CNA to remove his right hand from the door. CMS Ex. 34; Tr. at 40. However, the surveyor also testified that the resident did not reach for the cubbies during the time that staff were attempting to get the resident to release the door handles. Tr. at 47.

Given the surveyor's apparent agreement that the resident removed his right hand from the door on one occasion, the ALJ may have overstated the facts underlying his conclusion that the resident "*could not possibly have harmed himself* at the moment that [the CNA] decided to use force . . . because he had immobilized himself by grabbing door handles with both hands" and "was not actively attempting to grab anything other than the door handles." ALJ Decision at 4 (emphasis in original). Any such overstatement, however, does not undercut the ALJ's conclusion, and ours, that there is no evidence of any imminent threat of harm, or the ALJ's conclusion, which we affirm, that the technique the CNA employed to coerce the resident to remove his left hand from the door handle constituted abuse under the federal regulations and Ridgecrest's policies. The record as a whole simply does not support Ridgecrest's claims that the CNA's actions were a necessary and appropriate response to address the purported risks presented by the resident's alleged reaching toward the cubbies or resistance to being removed from the room.[6]

[5] Some witnesses, including CNA #1, did not testify that the resident had continued to reach for the cubbies after grabbing the door handles. P. Exs. 34, 35, 38. The reports of Ridgecrest's investigations do not reflect that the resident continued to reach for the cubbies after taking hold of the door handles. P. Exs. 18, 19.

[6] The record also does not establish the factual assumption underlying Ridgecrest's argument that there were dangerous objects in the cubbies. *See* Tr. at 101-02 (surveyor testimony that none of the facility staff told her that the cubbies contained sharp objects or prescription medications).

In any event, following our settled precedent, absent compelling reasons for not doing so, we defer to the ALJ's assessment of the credibility of witnesses and weighing of evidence. *See, e.g.*, *Van Duyn Home & Hosp.*, DAB No. 2368, at 10-11 (2011), citing *Koester Pavilion*, DAB No. 1750, at 16, 21 (2000). We find no compelling reason to reject the ALJ's weighing of the evidence on the issues regarding the positioning of the resident and the CNA and whether the resident continued trying to get items from the cubbies after grabbing the door handles. We also note that the CNA testified that after being pinned to the wall by the resident, he "quickly managed to extricate" himself. P. Ex. 34, at 3. Thus, he was "pinned" only briefly and not at the time he applied pressure to the resident's hand, when he could have instead maneuvered to again block the resident's access to the cubbies. The ALJ could reasonably infer based on this testimony that the CNA could have blocked the resident's access to the cubbies even if the resident continued reaching for them while holding onto the door handles.

Furthermore, as we indicated earlier, the surveyor who viewed the video of the incident testified that the resident did not reach for the cubbies during the time that staff were attempting to get the resident to release the door handles. Tr. at 47. The ALJ, who observed the surveyor testify at the hearing, found her testimony to be "the best evidence" of what that video showed. ALJ Decision at 7 n.2. We note that the surveyor's testimony is consistent with the absence, from the testimony of the two Ridgecrest witnesses who viewed the video with the surveyor, of any statements indicating that they saw the resident attempting to reach the cubbies with his right hand. P. Ex. 41, at 8 (testimony of facility administrator that the video showed a CNA other than CNA #1 trying to get the resident to release his hand from the door); P. Ex. 42. Thus, we find no basis to disturb the ALJ's finding that the resident was not actively attempting to grab anything from the cubbies after he had taken hold of the door handles.

We conclude that substantial evidence supports the ALJ's findings that Ridgecrest staff did not need to apply force to the resident's hand – force that the ALJ found caused the resident to complain of pain almost immediately thereafter and was sufficient to fracture the resident's finger – in order to prevent him from accessing allegedly dangerous items in the cubbies and that "Petitioner's assertion that it used appropriate techniques is unavailing." ALJ Decision at 5 and at 5 n.1.

C. The ALJ did not err in not addressing Ridgecrest's argument that CMS could not find abuse because the state board of nursing dismissed abuse complaints brought against Ridgecrest staff.

Ridgecrest argues that there was no abuse because the state board of nursing dismissed complaints of abuse against the CNAs involved in the incident and the nurse who witnessed it. RR at 6, 35-36, citing P. Ex. 30. Ridgecrest also states that the state survey agency initiated "a parallel State licensure action" based on the incident but "withdrew

and dismissed its action" and issued a revised SOD after the state nursing board dismissed the abuse complaints against Ridgecrest staff. RR at 6, citing P. Exs. 30, 31. Those arguments provide no basis to overturn the ALJ's determinations.

As the Board pointed out in *Britthaven of Chapel Hill*, DAB No. 2284, at 6-7 (2009), a state agency merely recommends findings of compliance or noncompliance, and it is CMS that ultimately determines whether the facility is in substantial compliance and whether immediate jeopardy exists. *See also Lake Mary Health Care*, DAB No. 2081, at 5-7 (2007) (ultimate responsibility for the interpretation and enforcement of federal participation requirements lies with CMS, not with the state surveyors, and CMS's finding of noncompliance and imposition of remedies for a determination of immediate jeopardy take precedence over the state's position). The Board has also held, moreover, that determinations of compliance by state agencies are not binding on the ALJ, who is charged with making a de novo determination based on the record before him as to whether the facility was in substantial compliance with the requirements in the federal regulations. *See, e.g.*, *Grand Oaks Care Ctr.*, DAB No. 2372, at 15 (2011) ("The authority for deciding substantial compliance lay with the ALJ.").

Those principles are even more applicable here, where the findings of the state board of nursing and the SOD that Ridgecrest cites addressed only state requirements and did not apply, or even mention, the federal regulations in sections 488.301 and 483.13 defining abuse and requiring facilities to protect residents from abuse and to promptly report and investigate allegations of abuse. P. Exs. 30-33. Those federal regulations, and not state laws governing facility licensure or when sanctions can be taken against CNAs, determine whether a facility has committed abuse.

We thus sustain the ALJ's determination that Ridgecrest failed to comply substantially with the requirement to protect residents from physical abuse.

II. The ALJ's determination that Ridgecrest failed to investigate timely and thoroughly the November 22 incident is supported by substantial evidence and free from legal error.

The regulation requiring facilities to investigate alleged violations of facility anti-abuse policies states that facilities must "thoroughly" investigate allegations of violations of facility policies barring physical abuse and report the "results of all investigations" to the state survey and certification agency (and other state agencies as required by state law) "within 5 working days of the incident." 42 C.F.R. § 483.13(c)(3), (4). While the Board has declined to hold that the regulation means that all investigations must be entirely completed within five working days, the Board has held that the regulation "does require that a report be made of the results that have been generated by the facility investigation

within five days" and that "[t[his timely report provides the state agency with a prompt opportunity to intervene, if necessary." *Columbus Nursing & Rehab. Ctr.*, DAB No. 2247, at 13 (2009) (emphasis added).[7] As the ALJ concluded, this regulation requires that a facility's investigation be both thorough and timely. ALJ Decision at 6, 9.

Similarly, Ridgecrest's policies required that the facility "promptly and thoroughly" investigate any report of "an incident or suspected incident of resident abuse" and protect residents from harm during the investigation. CMS Ex. 14, at 21-22.

CMS found Ridgecrest not in substantial compliance with the requirement to investigate because during the December survey, two weeks after the incident, the facility, it is not disputed, provided documentation consisting of only one page of handwritten notes prepared by the director of the behavioral unit, who, Ridgecrest states, had begun an investigation before going on leave. CMS Ex. 1, at 9-11, 14-17; RR at 19-20. The one-page document consists of the names and notes of recollections of the CNAs involved in the incident, but not of the nurse who witnessed a portion of the incident. CMS Ex. 24, at 1; P. Ex. 38.

The ALJ concluded that the regulation obliges a facility to investigate thoroughly and timely any incident that might involve abuse, and that "[e]ven the remote possibility that a resident has suffered abuse triggers the duty to conduct a full and thorough investigation." ALJ Decision at 6; see also *id.* at 9 ("failure to investigate timely and thoroughly the November 22 incident . . . contravened regulatory requirements"). Ridgecrest does not dispute the ALJ's statement of the regulation's requirements. *See, e.g.*, RR at 8 (Ridgecrest had "typical abuse prevention policies, and abuse reporting and investigation procedures, including initiation of an immediate investigation upon any 'allegation of abuse'"). Nor do we find any error in the ALJ's statement of the regulation's requirements or his application of those requirements. The ALJ found that the one-page documentation of an investigation provided to the surveyor was inadequate because it contained "no summary of the events, no analysis of what happened, no reference to facility policies, no discussion of the Resident and his condition, and no conclusions as to whether the actions taken by staff were appropriate or not." ALJ Decision at 6. The ALJ also determined that Ridgecrest's "failure to investigate timely

[7] The Board has held that requirement to report alleged abuse and investigation results "to other officials in accordance with State law" refers to the state law designation of which officials receive reports of abuse and not to the obligation to report abuse, and that the regulation requires facilities to report investigation results to the state survey and certification agency, regardless of whether state law requires reporting. *Singing River Rehab. & Nursing Ctr.*, DAB No. 2232, at 9 (2009) ("state law is relevant to defining which officials, in addition to the State survey and certification agency, must receive the report [but] has no relevance to determining whether a report must be made at all once an abuse investigation has taken place, at least to the state survey and certification agency") (emphasis in original).

and thoroughly the November 22 incident not only contravened regulatory requirements that it conduct such an investigation but it contravened Petitioner's own policy governing abuse." *Id*. at 9, citing CMS Ex. 14. Ridgecrest's policy requires that it "promptly and thoroughly" investigate an incident, or "suspected" incident, of abuse. CMS Ex. 14, at 21.

Ridgecrest argues that it investigated the incident shortly after it occurred and concluded that there was no abuse and that it was not required to conduct a "further formal investigation" because "no one had made an 'allegation of abuse' — indeed, all witnesses denied that they thought anything improper had happened." RR at 18-19; *see also* CMS Ex. 1, at 14-16 (SOD alleging that during the survey the facility administrator stated that the incident had not been reported to the state agency because it was not considered abuse). Neither the record nor the law supports those arguments.

A. Reports of the November 22 incident constituted allegations of abuse.

Implicit in Ridgecrest's argument that "no one . . . made an 'allegation of abuse'" is the notion that allegations of abuse are limited to staff reports of their conclusions that abuse has occurred and do not include allegations of circumstances that, by their nature, raise the possibility that abuse has occurred. Ridgecrest cites no authority for that concept, which is contrary to the Board's reading of the regulation. *See, e.g.*, *Grace Healthcare of Benton*, DAB No. 2189, at 6 (2008) ("broad language" of section 483.13(c) requiring reporting and investigation of alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source "encompasses not only a direct allegation that the resident has been abused, but also an allegation of facts from which one could reasonably conclude that the resident has been abused"), *rev'd on other grounds, Grace Healthcare of Benton v. U.S. Dep't of Health & Human Servs., Ctrs. for Medicare & Medicaid Servs.*, 589 F.3d 926 (8th Cir. 2009), *modified on reh'g*, 603 F.3d 412 (8th Cir. 2010); *see also Ill. Knights Templar Home*, DAB No. 2369, at 11 (2011) ("the reporting requirements are triggered by an allegation of abuse whether or not it is recognized as such by the facility").

Here, the ALJ could reasonably conclude that abuse was alleged where staff reported an incident with a resident in which the resident sustained a broken bone during a physical confrontation with multiple staff members who were attempting to forcibly control the resident; the injury resulted from staff's use of a grip-breaking technique intended for personal self-defense to instead remove the resident's hand from a door handle; and the application of force meets the definition of abuse in the regulations and the facility's policy. As the ALJ observed at the hearing, the occurrence of an injury "that could, conceivably, have resulted from abuse . . . triggers the facility's duty to investigate" and "where an injury is sufficiently serious to require x-rays and treatment, and that injury results from an altercation or an involvement between staff and a resident, that is highly

likely to trigger the duty to conduct an investigation." Tr. at 15-16. There was thus an allegation of abuse that the facility was obliged to investigate thoroughly and timely (and promptly under its policies).

Ridgecrest's argument that it could rely on the opinion of staff who witnessed the incident that it was not abuse also ignores the fact that the witnesses stated that they did not see the resident's left hand, the one that was injured, due to their position, and could thus not describe precisely how the hand was injured. P Exs. 35, at 3-4; 36, at 2; 37, at 2; *see also* Tr. at 25, 32, 39, 44 (resident's left hand not visible in the video). That limitation undermines any reliance on their opinions in determining whether they were alleging abuse or whether abuse occurred. We agree with the ALJ that the circumstances here leave no doubt that the facility should have determined that there was an allegation of abuse.

B. Ridgecrest has shown no error in the ALJ's determination that it did not conduct an adequate investigation.

Having before it a situation of alleged abuse, Ridgecrest had a clear duty under the federal regulation to conduct an adequate investigation. We agree with the ALJ that Ridgecrest did not fulfill this duty. Ridgecrest argues that the ALJ "disregarded the material evidence" that the single page of notes shown to the surveyor did not "constitute the entirety of [the unit director's] investigation." RR at 18, 19. Ridgecrest asserts that the unit director "did undertake *some* investigation of the incident before she left for vacation the day before the survey started, and that she and [the administrator] determined that the incident did not involve resident abuse and so [the unit director] could draft a written report after she returned from vacation" on December 10. RR at 19, 31. Ridgecrest states that the behavioral unit director "interviewed all of the witnesses regarding the incident, and discussed with the witnesses and others possible alternatives in the circumstances, including simply withdrawing and letting the Resident calm down by himself." RR at 18, citing P. Ex. 43.

The record, however, supports the ALJ's determination that Ridgecrest did not conduct the investigation the regulations require. Ridgecrest, as noted, admits that the unit director had not completed her inquiries before leaving for vacation and did not intend to do so until after her return on December 10. RR at 19, 31. While Ridgecrest states that the unit director interviewed "all of the witnesses regarding the incident," as CMS noted she did not interview the resident, notwithstanding that he reported pain in his finger to a CNA and a nurse shortly after the incident and told the CNA that he thought his finger was broken, and that the CNA observed the finger to be swollen. RR at 18; CMS Resp. at 22, Tr. at 237-38; P. Exs. 18, at 2-3; 35, at 4; 39, at 2-3. The report of the initial investigation, the unit director's testimony, and her single page of handwritten notes, also do not state that she interviewed a nurse who witnessed at least part of the incident. P. Exs. 18; 38, at 1-2; 43.

Moreover, the facility administrator explained during the hearing that the unit director was not conducting "an abuse investigation" but rather "like a review . . . [s]ometimes we call it a post-intervention where we . . . do a review of a behavioral incident because there's always a chance to look at how we did; what can we do better; what can we do different; how can we prevent it from happening again." Tr. at 266.

Ridgecrest also concedes that it did not undertake any additional investigation activities until after the surveyors informed Ridgecrest during the December survey of their conclusion that Ridgecrest had not adequately investigated the incident. RR at 20; Tr. at 269-70. Only then did Ridgecrest interview the resident, who stated that the CNA had "grabbed this finger (pointed to bandaged hand) and busted it. He broke my finger." P. Ex. 19, at 3.

Ridgecrest does not specifically argue that the ALJ should have concluded that this belated inquiry it conducted at the behest of the surveyors constituted the investigation the regulations require. Ridgecrest does state that its administrator, based on this investigation, "again concluded that [the CNA] had employed appropriate technique" and "that the incident did not constitute abuse" of the resident. RR at 20, citing P. Exs. 18-20, 41. This assertion does not accurately depict the results of that subsequent investigation. The report of that investigation does not conclude that the CNA "had employed appropriate technique" during the incident and indeed acknowledges that "[t]he technique used by staff is not taught as a method to remove a person's hand from a metal door handle," which supports our earlier determination that this technique was not appropriate for that purpose.[8] P. Ex. Ex. 19, at 4.

The report of the subsequent investigation also mischaracterizes what constitutes "abuse" for federal long-term care enforcement purposes. The report states that Ridgecrest was "unable to substantiate the allegation of abuse because the definition of abuse is the willful infliction of injury" and concludes that the incident "was not a willful infliction of injury but an accident that occurred trying to keep [the Resident] safe." P. Exs. 19, at 4; 20, at 3. As we stated earlier, the federal definition of abuse in 42 C.F.R. § 488.301 as, among other things, "the willful infliction of injury" does not mean that the purpose of the actor must be to inflict harm, but rather that the action have been undertaken deliberately, i.e., that the actor must have acted deliberately but not necessarily with intent to do harm. There is no question here that the CNA deliberately applied pressure to the resident's hand. The facility's failure to comprehend that such deliberate action was within the definition of abuse undermines the conclusions of the belated investigation. Ridgecrest could not have trained its staff (including the CNA) in the correct definition of abuse when it did not understand that definition and thus did not comprehend why staff's actions in the November 22 incident constituted abuse.

[8] That statement was omitted from the version of the report that Ridgecrest submitted to the state survey agency. P. Ex. 20, at 3.

The record thus shows that Ridgecrest did not conduct the thorough and timely investigation of an incident of alleged abuse required by the regulations and its own policies. CMS Ex. 14, at 21. Substantial evidence supports the ALJ's determination that "[t]he cursory 'investigation' that Petitioner's management conducted of the November 22 incident fell far short of what it was obligated to do and constituted a substantial violation of regulatory requirements." ALJ Decision at 6.

III. The ALJ's determination that Ridgecrest failed to substantially comply with the requirement to report allegations of abuse to the state survey agency is supported by substantial evidence and free from legal error.

Section 483.13(c)(2) states that a facility "must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source . . . are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency)" (emphasis added).

Ridgecrest does not dispute the ALJ's finding that it "did not notify appropriate State officials of the November 22 incident" as required by the regulations. ALJ Decision at 7; RR at 18-19. Ridgecrest argues that it was not required to report the November 22 incident because its officials had determined to their satisfaction that the incident did not rise to the level of abuse, and because, as noted above, Ridgecrest maintains that there was not an allegation of abuse. RR at 18-19.

We have already concluded above that the incident did constitute an allegation of abuse and that Ridgecrest should have recognized it as such. Thus, Ridgecrest had a duty under federal regulations to both timely and thoroughly investigate the alleged abuse and report the alleged abuse to the appropriate state authorities. We thus sustain the ALJ's determination that Ridgecrest was not in substantial compliance with the requirement to immediately report alleged violations of facility policy prohibiting abuse. 42 C.F.R. § 483.13(c)(2).

IV. The ALJ's determination that Ridgecrest failed to comply substantially with the requirement to protect residents from abuse by continuing to employ the CNA in patient care without assuring that he understood why his conduct was inappropriate and abusive is supported by substantial evidence and free from legal error.

The ALJ agreed with Ridgecrest that noncompliance in this case cannot be based on a violation of regulations prohibiting employment of a person who has been convicted of abuse or had a finding of abuse entered against him in a state nursing registry, because

none of the CNAs were convicted of abuse or had abuse findings entered against them in the state nursing registry.[9] ALJ Decision at 8; 42 C.F.R. § 483.13(c)(1)(ii). The ALJ found, however, that Ridgecrest continued to employ the CNA "as a caregiver without assuring that he understood why his conduct on November 22 was inappropriate and abusive." *Id.* The ALJ concluded that Ridgecrest thus violated the "provisions of 42 C.F.R. § 483.13(c)(1) barring facility abuse of residents, because there remained a high likelihood of continuing abuse so long as [the CNA] remained employed as a caregiver without correcting his faulty understanding of when it might be appropriate to use force." *Id*.

Ridgecrest argues that the ALJ's conclusion was erroneous because the incident on November 22 did not constitute abuse. We rejected that argument above. The evidence shows that the CNA abused the resident by using on him a grip-breaking technique in a situation where it was not appropriate and causing injury. That supports the ALJ's determination that permitting the CNA to continue to care for residents while believing that his actions had been appropriate violated the facility's obligation to keep its residents safe from abuse.

Additionally, the regulation cited in the SOD from the February 2013 survey requires that facilities "prevent further potential abuse" while the investigation required by the regulation is in progress. 42 C.F.R. § 483.13(c)(3); CMS Ex. 32. As discussed above, the facility's failure to understand and apply the correct definition of abuse prevented it from conducting an adequate investigation of the November 22 incident. Permitting the CNA to continue to care for residents absent the completion of an adequate investigation, during which time the CNA (and facility administration) failed to recognize that abuse can encompass deliberate acts not intended to inflict injury, violated this requirement.

For these reasons, we sustain the ALJ's determination that Ridgecrest failed to comply substantially with the requirement to protect residents from abuse by continuing to employ the CNA in patient care without assuring that he understood why his conduct was inappropriate and abusive.

[9] CMS states that the state survey agency "incorrectly cited Ridgecrest [] for a violation of 42 C.F.R. § 483.13(c)(1)(ii)." CMS Resp. at 10 n.2. We note, however, that the SOD from the February 2013 survey cites other provisions of section 483.13(c), including the requirements to implement policies prohibiting abuse and to "prevent further potential abuse" while the required investigation is in progress. CMS Ex. 32. The SOD also does not allege that the CNA was convicted of abuse or had a finding of abuse entered against him in a state registry. *Id*.

V. Ridgecrest has shown no basis to reverse the ALJ's determinations of immediate jeopardy and the CMP amounts.

The ALJ determined that Ridgecrest's failure to protect residents from abuse, to report the allegation of abuse to the state survey agency, to thoroughly investigate the incident, and to keep the CNA from caring for patients without assuring that he understood why his conduct during the November 22 incident was inappropriate and abusive posed immediate jeopardy to resident health and safety. ALJ Decision at 3, 7 ("there was a high probability of harm, not only to Resident # 1, but to all of Petitioner's residents, because in not investigating the November 22 incident, Petitioner's management blinded itself to the probability that further abusive conduct would occur"), 9. The ALJ concluded that CMS's determination of immediate jeopardy was not clearly erroneous and was entirely supported by the evidence. *Id*. at 9; *see* 42 C.F.R. § 498.60(c) (ALJ must uphold CMS's determination of immediate jeopardy unless facility shows that it is "clearly erroneous"). The ALJ also sustained the amounts of the CMPs CMS imposed, because "Petitioner has offered no argument here challenging the penalty amounts." *Id*.

On appeal, Ridgecrest neither challenges the CMP amounts nor argues that CMS's immediate jeopardy determinations were clearly erroneous. Ridgecrest argues that there was no noncompliance and thus no basis for any of the findings of noncompliance. We rejected those arguments above and sustained the ALJ's findings of noncompliance.

Ridgecrest does challenge the duration of the period of noncompliance, arguing that "even if the Board were to sustain one or more of the deficiencies cited following the December 8, 2012 survey" there is evidence "sufficient to demonstrate that Petitioner returned to compliance no later than February 1, 2013." RR at 35 n. 14. Ridgecrest refers to "extensive documentation of [its] corrective actions completed in response to the December 8, 2012 survey . . . *prior to* the February 2, 2013 revisit, following which the State cited continuing immediate jeopardy solely because [the CNA] remained at work." RR at 34 n. 14, citing CMS Ex. 31. The exhibit Ridgecrest cites comprises materials from its corrective action plan, primarily records of in-service training Ridgecrest administered to staff on its abuse policies from December 12, 2012 through February 1, 2013. CMS Ex. 31. Some of these materials state that abuse includes "[t]use of physical force that may result in bodily injury, physical pain, or impairment" including pushing and pinching. *Id*. at 69. However, none of these materials establish that Ridgecrest's management had recognized that it had been acting under a mistaken understanding that "abuse" cannot occur unless the actor intends abuse or injury. Moreover, almost all of the training occurred prior to the February survey (only one out of over 35 sign-in sheets is dated February 1, 2013), when the facility was still harboring that mistaken understanding.

Finally, the Board "has long held that CMS is not obliged to 'provide affirmative evidence of continuing noncompliance for each day that a remedy is in place.'" *Golden Living Ctr. –Frankfort* at 20, citing *Coquina Ctr.*, DAB No. 1860, at 23 (2002), and *Regency Gardens Nursing Ctr.*, DAB No. 1858 (2002). Instead, the statute and regulations "place a burden on the facility to demonstrate not only that an event that exposed its noncompliance is over but that the facility has completed all measures necessary to correct the underlying noncompliance and prevent its recurrence." As indicated above, the exhibit relied upon by Ridgecrest is not sufficient to establish this. Ridgecrest's failure to recognize that abuse may encompass deliberate actions even where the actor did not intend to inflict injury or commit abuse shows that it has not met this burden.

For the foregoing reasons, we need not address further CMS's determination of the CMP amounts or its determination that the noncompliance with the requirements to protect residents from abuse, and investigate and report to the state survey agency allegations of abuse, posed immediate jeopardy.

We accordingly sustain the immediate jeopardy determination and the CMPs. We also sustain the DPNA, which CMS imposed based on 42 C.F.R. § 488.417(a), authorizing a DPNA when a facility is not in substantial compliance with the participation requirements. CMS Exs. 22, at 2; 33, at 2, 3.

Conclusion

For the reasons explained above, we uphold the ALJ Decision.

/s/
Constance B. Tobias

/s/
Leslie A. Sussan

/s/
Sheila Ann Hegy
Presiding Board Member