Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Appellate Division

In the Case of:	DATE: October 5, 2007
Rolling Hills Rehab Center,	
Petitioner,	Civil Remedies CR1484 App. Div. Docket No. A-07-5
- v. -	Decision No. 2119
Centers for Medicare & Medicaid Services.	

FINAL DECISION ON REVIEW OF ADMINISTRATIVE LAW JUDGE DECISION

Rolling Hills Rehab Center (Rolling Hills) appealed the August 4, 2006 decision of Administrative Law Judge (ALJ) Steven T. Kessel upholding a determination by the Centers for Medicare & Medicaid Services (CMS) that Rolling Hills was not in substantial compliance with participation requirements during the period from February 25 through March 1, 2005. Rolling Hills Rehab Center, DAB CR1484 (2006) (ALJ Decision). The ALJ also concluded that CMS's determination that immediate jeopardy was present during that period was not clearly erroneous and that a civil money penalty (CMP) in the amount of $4,150 per day was reasonable. Id.

Rolling Hills conceded before the ALJ that it was out of substantial compliance and that immediate jeopardy existed at its facility on February 25, 2005. On that date, it is undisputed that a nursing assistant sexually assaulted an elderly patient suffering from Alzheimer's and entirely dependent on staff for her needs. Rolling Hills disputed before the ALJ, and argues on appeal, that neither immediate jeopardy nor any lack of substantial compliance continued past that date. Rolling Hills

does not challenge the reasonableness of the per-day amount of the CMP but contends it should be imposed only for one day.

For the reasons explained below, we sustain the ALJ Decision and uphold the imposition of the CMP.

Background[1]

Rolling Hills is a skilled nursing facility in Wisconsin with a locked ward for Alzheimer patients. A complaint survey was conducted at the facility on March 8, 2005. The surveyors determined that Rolling Hills was not in substantial compliance with three participation requirements during the period beginning on February 25, 2005 and continuing through March 1, 2005. CMS Exhibit (Ex.) 1. These three deficiencies were cited at the immediate jeopardy level. The surveyors determined that Rolling Hills was also not in substantial compliance with a fourth requirement, but at a lower scope and severity level. Id. CMS concurred, and imposed the CMP of $4,150 per day for those five days. CMS Ex. 3. CMS also notified Rolling Hills that a CMP of $50 per day would accrue beginning March 2, 2005 and continuing until Rolling Hills achieved substantial compliance. After an April 20, 2005 revisit survey, CMS notified Rolling Hills of its determination that the facility regained substantial compliance as of April 8, 2005.

The parties agreed that the case should be decided based on the written record. ALJ Decision at 2. The ALJ resolved the case based on the deficiency finding under 42 C.F.R. § 483.13(c)(1)(i) alone, which he concluded was sufficient to sustain the $4,150 per day CMP.[2] ALJ Decision at 3. He noted that all three

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[1] The parties do not dispute the central facts relevant to the deficiency, but rather their legal significance. In particular, the actions of the facility staff are not in dispute, but Rolling Hills disputes that those actions demonstrate a failure to understand or implement its anti-abuse policy. We discuss this issue later. We merely summarize briefly here the facts based on the ALJ Decision with additional undisputed details set out in Rolling Hills' brief. None of the statements in this summary should be considered new findings of fact.

[2] Before us, neither party objected to the ALJ's conclusion that it was not necessary to resolve the other immediate jeopardy level deficiencies to sustain the amount

(continued...)

immediate jeopardy findings arose from "essentially the same facts," and that he found it unnecessary to reach any resolution on the two other findings given his conclusion on the one he upheld. Id. at n.1. The ALJ further concluded that CMS had not shown any basis to impose any CMP for dates after March 1, 2005. ALJ Decision at 9.[3]

The crucial events from which this case arises occurred on February 25, 2005 and are not disputed. ALJ Decision at 5. At about 2 A.M., a female certified nursing assistant (CNA-1) on the locked Alzheimer unit went to look for another CNA on that unit at the time, a male whom we refer to hereafter as the "assailant," to notify him that she needed to use the bathroom on the unit so he could cover for her.[4] Rolling Hills Br. (RH Br.) at 5. She was looking for him when she noticed that the door to the room of one female resident, referred to as R1, was, surprisingly she thought, closed. Id. R1 was 73 years old, suffered from end-stage Alzheimer's disease, and was unable to defend herself. CMS Ex. 1, at 2; ALJ Decision at 5. CNA-1 looked into the room through a peephole and saw R1 on the bed with her diapers at her ankles. RH Br. at 5-6. She saw the assailant from the back standing with his legs spread wide and R1's legs in between his. Id. CNA-1 felt that the assailant appeared to be behaving in an inappropriate manner while alone in the room with R1 with the door closed and lights off. Id. The assailant ultimately confessed, was convicted of sexual assault, and sent to prison. ALJ Decision at 5, n.3.

CNA-1 reported that she then panicked. ALJ Decision at 6, and record citations therein; RH Br. at 5-6. Her first step was to

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[2](...continued)
of the CMP. Rolling Hills further concedes that it was not in compliance on February 25th but challenges the continuation of any CMP after that date. RH Br. at 13-14, 19-20.

[3] CMS did not appeal this conclusion and we therefore do not address it further.

[4] Rolling Hills' practice was to have three CNA's on the night shift in the locked unit. RH Br. at 4. One was assigned to each of the two wings and the third was a "floater" to assist in both and cover during breaks. Id. At the outset of these events, CNA-1 was assigned to the first wing, the CNA on the second wing was on break, and the assailant was acting as floater. Id.

call another female CNA (CNA-2) who was then on break in a separate part of the facility. RH Br. at 6. CNA-2 advised CNA-1 to call the supervising nurse (RN) on duty right away. Id. CNA-1 called the RN around 2:15 A.M.. ALJ Decision at 6. The RN asked CNA-1 to come to see her (the RN) as soon as CNA-2 returned to the unit. RH Br. at 6-7. The RN then went to the break room to ask CNA-2 whether she believed what CNA-1 was describing to be true. Id. at 7. The RN instructed CNA-2 to return to the unit and to send CNA-1 to the RN's office to speak to her.

Around 2:45 A.M., the RN called the facility administrator (NHA). ALJ Decision at 6; RH Br. at 8. The NHA advised the RN to find the assailant and place him on administrative leave and escort him off the unit. RH Br. at 8. Before the RN did that, the NHA called her back and told her to call the social worker and ask her to come in early (by 6 A.M.) to interview R1. RH Br. at 9. The assailant was sent away from the locked unit at about 3 A.M.. ALJ Decision at 6. Sometime after 6 A.M., the NHA reported the incident to a police recording and then spoke to a detective at 8:30 A.M..

As of February 25, 2005, Rolling Hills' anti-abuse policy included the following language quoted by the ALJ:

> 2. If the concern or complaint is regarding an issue of caregiver misconduct (abuse, neglect, or misappropriation of property), the staff person is required to take action immediately to protect the resident and/or stop the occurrence.
>
> 3. The staff member must then report the incident to either the nurse on duty on the resident's floor or the floor where the incident occurred, which ever is appropriate immediately.
>
> 5. The nurse on duty must take action to determine how to protect the resident while the incident is being investigated (*i.e.*, staff person being reassigned, etc.).
>
> 6. The nurse **must** notify the Administrator or Acting Administrator of the alleged incident/complaint immediately after ensuring the safety of the resident.
>
> 15. At any point in the initial learning of the incident and/or during investigation

> (depending upon the incident itself) the incident and the accused staff may be reported to local law enforcement authorities.

ALJ Decision at 5, quoting CMS Ex. 17, at 1 (emphasis in original).

Applicable Law

Rolling Hills' participation in Medicare is governed by sections 1866 and 1819 of the Social Security Act and by federal regulations at 42 C.F.R. Parts 483 and 488.

The relevant participation requirement states that a facility "must develop and implement policies and procedures that prohibit mistreatment, neglect, and abuse of residents . . . ." 42 C.F.R. § 483.13(c). Subsection (1)(i) of the same regulation specifies that the facility must "not use verbal, mental, sexual, or physical abuse . . . ."[5]

Under applicable regulations an "immediate jeopardy" deficiency is one that causes, or is likely to cause, a resident or residents of a facility to experience serious injury, harm, or death. 42 C.F.R. § 488.301. CMS's determination that a deficiency constitutes immediate jeopardy "must be upheld unless it is clearly erroneous." Woodstock Care Center, DAB No. 1726, at 9 (2000) (citing 42 C.F.R. § 498.60(c)(2)), aff'd, Woodstock Care Center v. Thompson, 363 F.3d 583 (6th Cir. 2003).

Standard of review

Our standard of review on a disputed conclusion of law is whether the ALJ decision is erroneous. Our standard of review on a disputed finding of fact is whether the ALJ decision is supported by substantial evidence on the record as a whole. Guidelines -- Appellate Review of Decisions of Administrative Law Judges Affecting a Provider's Participation in the Medicare and Medicaid Programs (Guidelines), ¶4(b), (at http://www.hhs.gov/dab/guidelines/prov.html); Batavia Nursing and Convalescent Inn, DAB No. 1911, at 7 (2004), aff'd, Batavia Nursing & Convalescent Ctr.

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[5] Although the ALJ did not mention it specifically, the same regulation also provides, in subsection (2), that a facility must "ensure that all alleged violations involving mistreatment, neglect or abuse . . . are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures."

v. Thompson, 143 F. App'x 664 (6th Cir. 2005); Hillman Rehabilitation Center, DAB No. 1611, at 6 (1997), aff'd, Hillman Rehabilitation Ctr. v. U.S. Dep't of Health and Human Servs., No. 98-3789 (GEB) at 21-38 (D. N.J. May 13, 1999).

Analysis

1. Basis of ALJ Decision

The ALJ concluded that the events set out above demonstrated that Rolling Hills did not "implement effectively its anti-abuse policy in the wake of a sexual assault that had been witnessed by a member of [its] staff." ALJ Decision at 6, and record citations therein. Specifically, the ALJ found that CNA-1 did not "take action immediately to protect the resident and/or stop the assault," or even "cry out for help." Id. She did not "report what she had seen immediately to the nurse on duty," but did so only after calling CNA-2 who advised CNA-1 to call the RN, the ALJ noted. Id. The ALJ found that the RN failed to call the NHA "immediately to report the assault," and assumed at first that CNA-1 "was kidding." Id. The ALJ further found that Rolling Hills staff "failed to take immediate action to protect [its] residents from the assailant," in that the assailant was not told to leave the facility until an hour after the assault and no special surveillance of him or protections for residents were put in place in the interim. Id. Finally, the ALJ stated that the NHA failed to report "the incident to local law enforcement officials until between 6:00 and 8:00 on the morning of February 25." Id. The ALJ characterized the staff's actions as "a series of failures" that "encompassed more than the actions of one nursing assistant" and showed that the "staff – and not just one employee – was not capable of implementing the anti-abuse policy effectively in a crisis situation." Id. at 7.

Based on his assessment of the nature of the staff failures, the ALJ concluded that the immediate jeopardy "was not cured by the removal of the assailant from its premises nor was it cured by simply counseling" CNA-1. Id. Because the ALJ found "manifest incompetence" in the handling of this episode, he considered these events "strong evidence" that the staff would have been incapable of properly dealing with any future episode of abuse until they were retrained in the proper responses to abuse. Id. at 8, n.4. Since that training was not completed, even for the principals involved in the incident, before March 2, 2005, the ALJ concluded that the immediate jeopardy could have not been abated or substantial compliance achieved at any earlier date. Id.

2. Rolling Hills' arguments on appeal

Rolling Hills argues that the only breach of policy was that CNA-1 did not immediately act to protect R1 but instead panicked due to "fear for her own safety and the safety of the other residents on the Unit who might have been vulnerable had [the assailant] attacked her once he knew she had seen his abuse" of R1. RH Br. at 6, 13; RH Ex. 1, at 4-5. At the same time, Rolling Hills contends that CNA-1 was "confused" about what she saw and therefore did not clearly inform CNA-2 or RN initially. RH Br. at 6.

Rolling Hills denies that the other staff members violated the anti-abuse policy or showed any misunderstanding of its requirements. Id. at 2. To the extent that brief delays occurred, Rolling Hills attributes them to the RN's lack of clarity and doubt "about the accuracy and contents of [CNA-1's] account" or the "fact of an abuse." Id. at 2, 16. Rolling Hills contends that certain actions (or inactions), such as escorting the assailant off the property entirely instead of merely off the unit, that CMS alleged are not required by anything in the terms of the anti-abuse policy. Finally, Rolling Hills simply suggests that the staff acted quickly enough to meet the terms of the policy. For example, Rolling Hills argues that removing the assailant from patient care within an hour of the incident being reported was sufficient to meet the terms of its policy. RH Reply Br. at 5.

3. Our basis for rejecting Rolling Hills' arguments

Even if we accepted Rolling Hills' contention that "only" one staff member violated its anti-abuse policy (which we do not), it would not follow that no deficiency situation existed after the day of the occurrence. The burden was on Rolling Hills to show that it had regained substantial compliance. At a minimum, given that the facility's anti-abuse policy failed when tested under real-world stress, CMS could reasonably have expected to see assurances that the rest of the staff was better prepared should such a situation recur. Given the seriousness of the risk to patients not protected from sexual abuse despite its being witnessed by a staff member, furthermore, we could not find that CMS committed clear error by determining that an immediate jeopardy condition was not abated as long as such retraining was not done, even if a single staff person had actually acted in violation of the policy.

We find, however, that substantial evidence in the record supports the ALJ's findings that multiple Rolling Hills staff

members failed to conform to its anti-abuse policy in multiple ways. CNA-1 not only failed to intervene at once to stop the ongoing abuse when she observed it. She also failed to call the RN immediately as specified in paragraph 3 of the anti-abuse policy. ALJ Decision at 6, and record citations therein. It does not undercut this finding that CNA-2, whom CNA-1 did call, was sufficiently conscious of the policy to instruct CNA-1 to contact the RN next, as Rolling Hills argues. RH Reply Br. at 3. CNA-2's instruction only confirms that CNA-1's action did not conform to Rolling Hills' policy. Although Rolling Hills denies that its staff failed to understand and implement what was required of it under the anti-abuse policy, CNA-1 actually stated that she did not know if she should confront the assailant or turn him in to the head nurse. RH Ex. 1, at 4.[6]

Rolling Hills' argument that CNA-2 actually demonstrated her accurate understanding of the policy by advising CNA-1 to call the RN and by offering to return immediately from her break overlooks the undisputed fact that CNA-2 did not advise her panicked colleague to immediately protect R1 or the other residents or ensure that the assailant did not have further access to them. RH Br. at 3, 14-15. Thus, CNA-2's reported advice to CNA-1, rather than proving her accurate knowledge of the policy, proves that her understanding of what to do was also incomplete.[7]

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[6] In briefing, the parties couched much of their argument in terms of whether or not Rolling Hills' staff "understood" the anti-abuse policy before their retraining. We do not see that the policy was ambiguous about many of the obligations which the staff failed to implement, particularly the need to act to protect the victim and the requirement to immediately notify the RN and then the NHA. Whether the staff members failed to act properly because they failed to understand the policy or because they understood but failed to do their duty is not important here. Either way, CMS could reasonably conclude that an assurance of proper implementation of anti-abuse policies in the future by this staff required, at a minimum, retraining.

[7] Rolling Hills suggests that, by heading back to the unit early, CNA-2 discharged any duty she had to ensure that R1 was protected during the investigation under paragraph 5 of the policy. RH Br. at 14-15. Paragraph 5 refers to the RN determining how to protect the resident while the incident is being investigated. The duty here was

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The RN also did not follow the policy. The policy required the RN to "take action to determine how to protect the resident while the incident is being investigated (*i.e.*, staff person being reassigned, etc.)" and instructed her that she "**must** notify the Administrator . . . of the alleged incident/complaint immediately after ensuring the safety of the resident." ALJ Decision at 5, quoting paragraphs 5 and 6 of the anti-abuse policy. The RN did not promptly perform either of these steps.

It is uncontested that the RN's first action on hearing from CNA-1 that the assailant had molested R1 was to consult CNA-2 about whether to believe this report. Her second action was to instruct CNA-2 to return to the unit and send CNA-1 to her. Under the policy, the RN's first obligation at that stage was not to decide whether the report was credible or the abuse occurred, but to ensure that the victim and other residents were safe. Yet, the RN neither went to the unit to deal with the assailant herself nor provided any instructions to CNA-2 about what actions she should take to protect the resident or deal with the assailant. Rolling Hills suggests that the RN did take action to protect the resident, apparently referring to the fact that CNA-2 was sent to the unit to replace CNA-1. RH Reply Br. at 4. While obviously it would be an even more appalling breach if the RN had summoned CNA-1 without providing any staff person for the unit other than the accused assailant, it hardly constitutes protective action to simply maintain the same staffing level on the unit with no other special measures. As a consequence of RN's inaction, as the ALJ found, the staff "undertook no special surveillance or protective actions for the residents of the facility during the period between 2:00 a.m., when the assault occurred, and 3:00 a.m., when the assailant was sent away . . . ." ALJ Decision at 6.

The RN's second responsibility was to call the NHA immediately. Instead, she spent time talking to CNA-2 about the credibility of the report, waiting for CNA-1 to come to her office, and then interviewing CNA-1 about what she observed before deciding that she had enough clarity that abuse had occurred. Only then, at about 2:45 A.M. did she call the NHA. The RN explained that she "was in some doubt that [CNA-1's] perception of what she saw was

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[7](...continued)
for the staff person on the scene to "take action immediately to protect the resident" under paragraph 2. Since CNA-2 was in a break room three buildings away, her plan to come back to the unit could hardly substitute for instructing CNA-1 to remedy this omission immediately.

the reality." RH Ex. 3, at 1. Rolling Hills argues that the RN notified the NHA as soon as she "understood sufficiently what had happened." RH Reply Br. at 5. According to Rolling Hills, the record incontestably shows that CNA-1's initial explanations to CNA-2 and the RN were "not comprehensible," so that they understood she "was upset and scared but not why." Id.

This is not a fair description of the evidence in the record. The statements submitted by Rolling Hills certainly support the conclusion that CNA-1 was panicked and very upset, which is to be expected since she had observed the sexual abuse of a helpless elderly resident. RH Exs. 1, at 4-5; 2, at 2; 3, at 1. Nevertheless, CNA-2's statement also makes clear that she understood that CNA-1 was alleging that she observed the assailant behaving inappropriately with R1 while R1's diapers were pulled down. RH Ex. 2, at 2-3. CNA-2 also stated that CNA-1 told her on the phone that she was afraid that the assailant "might hurt her" if she "confronted him." These are all indications that, even though CNA-1 was indeed upset, she communicated clearly that she had seen inappropriate behavior by an employee with a resident so serious as to make CNA-1 afraid for her own safety. CNA-2 reported that she thought that CNA-1 might have misinterpreted something and doubted that the assailant would do what he was accused of. Id. at 3. Such doubts, however, certainly do not amount to having no idea why CNA-1 was upset and scared. She was plainly upset about the assailant's treatment of R1. It was not necessary to be certain that that treatment would meet the definition of abuse to understand that action must be taken under the anti-abuse policy.

The RN did report that CNA-1 "was very excited and sounded scared so [she] had a difficult time understanding what she was trying to tell [her]." RH Ex. 3, at 1. When she spoke to CNA-2, however, the RN did not ask her what CNA-1 had talked to CNA-2 about, but rather whether CNA-2 believed what CNA-1 had said. Id. at 2. This suggests that the RN understood that CNA-1 was reporting perceived abuse and simply doubted the reliability of CNA-1's perceptions. The concern that the RN expressed about accepting CNA-1's perceptions went to the "seriousness of what she said about" the assailant. Id. at 1-2. This statement further suggests that the RN understood from the first report that an accusation of serious misconduct was being made about the assailant.

We conclude that substantial evidence in the record supports the ALJ's finding that the RN did not act immediately to report this allegation of assault to the NHA as required by the anti-abuse policy. See ALJ Decision at 6.

Rolling Hills discounts the importance of any delays in implementation of the requirements of the anti-abuse policy during the "twenty (20) to thirty (30) minutes following the incident." RH Br. at 2. According to Rolling Hills, the ALJ gave too much importance to the delays because he erroneously attributed to the RN "certainty" about the nature of the incident that CNA-1 reported to her. Id. Rolling Hills argues that the ALJ was judging her actions in the light of his own certainty "derived from the hindsight of [the assailant's] subsequent confession . . . ." Id. We disagree that the ALJ in fact attributed certainty to the RN. He rather concluded that the information she was given sufficed to trigger her responsibilities to act on a complaint of caregiver misconduct under the facility's own anti-abuse plan. The initial steps required of the staff to protect the residents and notify the chain of command are triggered by a "concern or complaint . . . regarding an issue of caregiver misconduct," not by certainty about the fact of an abuse. Further, the ALJ did not judge the staff's conduct based on his later knowledge that the abuse was substantiated but based on their failure to perform the steps mandated by the anti-abuse policy once such a concern or complaint was reported. Rolling Hills' own policy recognized that the very possibility that a resident has suffered from caregiver misconduct (particularly potential abuse) triggers the need to protect residents. There is an obvious reason for this. If a facility waits for an investigation (much less a confession) either the resident at issue or another resident may suffer further harm in the meantime.

The ALJ also faulted the NHA for failing to report the assault allegations to law enforcement "until between 6:00 and 8:00" that morning. ALJ Decision at 6. Rolling Hills argues that the anti-abuse policy makes such reporting "an option, without specification of the timeframe in which the notification can, or should, occur." RH Reply Br. at 2. The language of Paragraph 15 of the anti-abuse policy does give staff some discretion, depending on the nature of the incident, about whether to report a concern or complaint immediately or during the investigation. It is not clear that reporting a complaint of a possible assault is in any sense optional under either the facility's policy or the law, however.[8] The policy's reference to reporting being done in accordance with the "nature of the incident" is most reasonably read to mean that a complaint involving alleged

[8] See, e.g., 42 C.F.R. § 483.13(c)(2)-(4), affirmatively requiring reporting of all abuse to appropriate state authorities in accordance with state law requirements.

criminal conduct such as sexual assault would have to be reported promptly. Certainly, this case illustrates exactly why timeliness is significant. The NHA himself reported that the detective who came on the scene stated that he could only use in court evidence that the police "gathered from scratch," and not items handled or collected by the facility. See CMA Ex. 21, at 2.[9] This raises concerns that the NHA's delay in contacting law enforcement could have prejudiced effective investigation and enforcement. Nevertheless, given the unclear language in the facility's then-applicable anti-abuse policy regarding the timing of reports to law enforcement and the many other ways in which Rolling Hills' response to the incident breached the policy, we need not rely on this aspect in order to sustain the ALJ Decision.

Rolling Hills also argues on appeal that the ALJ erroneously relied on its provision of in-service training to staff as evidence that the staff had previously inadequately understood the anti-abuse policy. RH Br. at 12, 17. Rolling Hills complains that such use of remedial efforts as proof of prior failure violates the rationales behind Federal Rule of Evidence 407. The Board has addressed an analogous argument in a prior case also involving a nursing home, as follows –

> FRE 407 makes inadmissable certain evidence related to actions taken after an injury or harm. Tri-County's argument is without merit for a number of reasons. First, Tri-County does not cite any objection it made to the admission of this evidence . . . . Second, evidence may be received in Part 498 hearings even if inadmissable under the Federal Rules of Evidence. 42 C.F.R. § 498.61. Third, as explained previously by the Board, FRE 407 arises in the context of tort cases and promotes a public policy of not discouraging parties from voluntarily adopting subsequent safety precautions. Part 498 cases differ materially because they arise "in the context of statutory and regulatory obligations of skilled nursing facilities to maintain substantial compliance with Medicare participation requirements." Omni Manor Nursing Home, DAB No. 1920, at 44 (2004), aff'd, Omni Manor Nursing Home v. Thompson, No. 04-3835 (6th Cir. Oct. 11, 2005). Thus, admitting evidence of corrective actions would not have the unintended

[9] Indeed, the detective reported to surveyors that he felt the notification was not timely and the crime scene and evidence were disrupted as a result. CMS Ex. 1, at 20.

> consequence of discouraging facilities from taking such actions. Fairfax Nursing Home, DAB No. 1794, at 9; see also 2 Weinstein's Federal Evidence 407.05[3], p. 407-27 (2nd Ed. 2001) (recognizing an exception to FRE 407 where remedial action is mandated by superior governmental authority.) Fourth, even if the evidence . . . is disregarded, we find that there is still substantial evidence to support the ALJ's finding.

Tri-County Extended Care Center, DAB No. 2060, at 8 (2007) (citations to record in Tri-County omitted). All four of the points made in Tri-County are also applicable here. Most particularly, as noted there, the Federal Rules of Evidence are not binding in Part 498 administrative proceedings.

In any case, Rolling Hills is mistaken in its premise. The ALJ relied on the completion of the in-service training as evidence of the time by which Rolling Hills could show that it had abated the jeopardy to its residents and achieved substantial compliance. ALJ Decision at 8-9. He relied on other evidence going to the inadequacy of the staff members' responses to the report of abuse, for his finding that Rolling Hills was not in substantial compliance. The ALJ noted that the "manifest incompetence" of staff in dealing with the assault that occurred was "strong evidence" that the staff would be incapable of "dealing with future episodes of abuse." Id. at 8, n.4. Therefore, he reasonably concluded that Rolling Hills could not have attained substantial compliance without retraining its staff in implementing the anti-abuse policy. Id.

Whatever Rolling Hills' actual motivation was in scheduling the in-service training, CMS accepted the completed in-service training as sufficient to show that the demonstrated inability of the staff to fully understand and implement the anti-abuse policy had been addressed at least enough to abate the immediate jeopardy. The ALJ concluded that substantial compliance was achieved once the staff members whose conduct was specifically deficient had received in-service training, which was completed on March 2, 2005. Thus, the ALJ held that no CMP was justified after March 2, 2005 since "CMS has not asserted what more Petitioner needed to accomplish after March 2 in order to attain compliance." ALJ Decision at 9.

We conclude that substantial evidence in the record as a whole supports the ALJ's factual findings and that Rolling Hills has not demonstrated any legal error by the ALJ.

Conclusion

For the reasons explained above, we sustain the ALJ Decision in its entirety and uphold the imposition of the $4,150 per day CMP from February 25, 2005 through March 1, 2005.

/s/
Sheila Ann Hegy

/s/
Constance B. Tobias

/s/
Leslie A. Sussan
Presiding Board Member