Department of Health and Human Services
DEPARTMENTAL APPEALS BOARD
Appellate Division

Leroy Manor
Docket No. A-15-46
Decision No. 2735
September 20, 2016

REMAND OF ADMINISTRATIVE LAW JUDGE DECISION

Leroy Manor (Petitioner), an Illinois nursing facility, appeals the decision of an Administrative Law Judge granting summary judgment in favor of the Centers for Medicare & Medicaid Services (CMS) and imposing civil money penalties (CMPs) for noncompliance with regulatory requirements that facilities keep residents free from, and implement policies to protect residents from, physical abuse. *Leroy Manor*, DAB CR3512 (2014) (ALJ Decision). The ALJ concluded that the noncompliance posed immediate jeopardy and imposed CMPs of $7,000 per day for the period February 23, 2014 through February 25, 2014, and of $200 per day for the period February 26, 2014 that continued through March 6, 2014.

The noncompliance concerned a resident (Resident 4) who assaulted another resident. For the reasons explained below, we conclude that the ALJ erred in concluding that Leroy Manor did not dispute having been on notice that the resident posed a potential danger to other residents prior to the assault. That determination was error because the exhibit on which the ALJ relied was susceptible to more than one reading; Leroy Manor did not have an opportunity to respond to CMS's reading of that exhibit, which the ALJ adopted; and the ALJ drew inferences unfavorable to Leroy and weighed and evaluated other evidence supporting Leroy Manor. In addition, in sustaining the second deficiency based on failure to immediately notify law enforcement of the assault, the ALJ Decision erred in finding it undisputed that Leroy Manor did not comply with its own policy. Accordingly, remand is appropriate.

We therefore vacate the ALJ Decision and remand the case for further development.

Legal background

To participate in the Medicare program, long-term care facilities must be in "substantial compliance" with the requirements in 42 C.F.R. Part 483. 42 C.F.R. §§ 483.1, 488.400. Under agreements with the Secretary of Health and Human Services, state survey

agencies conduct onsite surveys of facilities to verify compliance with the Medicare participation requirements. *Id.* §§ 488.10(a), 488.11; *see also* Social Security Act (Act) §§ 1819(g)(1)(A), 1864(a).

The Secretary contracts with state survey agencies to conduct periodic surveys to determine whether skilled nursing facilities are in substantial compliance. Act § 1864(a); 42 C.F.R. § 488.20. The regulations require that each facility be surveyed once every twelve months, and more often if necessary, to ensure that identified deficiencies are corrected, or to investigate complaints of violations of the requirements for nursing facilities. Act § 1819(g)(2)(A); 42 C.F.R. §§ 488.20(a), 488.308. Survey findings are reported in a Statement of Deficiencies (SOD). A "deficiency" is defined as a "failure to meet a participation requirement specified in the Act or [42 C.F.R. Part 483]." 42 C.F.R. § 488.301. Section 488.301 defines "substantial compliance" as "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." *Id.* Any "deficiency that causes a facility to not be in substantial compliance" constitutes "noncompliance." *Id.* (defining "noncompliance").

CMS may impose various remedies on a facility that is found not to comply substantially with the participation requirements, including per-day CMPs for the number of days that the facility is not in substantial compliance and a denial of payment for new admissions (DPNA) during the period of noncompliance. 42 C.F.R. §§ 488.406, 488.417, 488.430(a). 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. *Id.* § 488.440(a)(1), (b). For deficiencies determined to pose immediate jeopardy, 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," CMS may impose per-day CMPs in amounts ranging from $3,050-$10,000 per day. *Id.* §§ 488.301, 488.408(e)(2)(iii). For noncompliance at less than the immediate jeopardy level, CMS may impose per-day CMPs in amounts ranging from $50-$3,000 per day. *Id.* § 488.408(d)(1)(iii).

Case background[1]

Leroy Manor is a nursing facility located in Illinois that participates in the Medicare program and thus is subject to surveys by the state survey agency on behalf of CMS to assess its compliance with Medicare participation requirements at 42 C.F.R. Part 483. Act §§ 1819, 1866; 42 C.F.R. Part 488, subpart E.

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[1] The following undisputed background facts are taken from the ALJ Decision and the record, and are not intended to serve as new findings of fact.

This case arose from an incident on February 23, 2014 at 1 a.m., when facility staff found Resident 4, a 75-year-old woman with conditions including dementia, anxiety, depression, and altered mental status, lying on top of her roommate, Resident 5, a "frail and demented" 91-year-old woman, and covering Resident 5's nose and mouth with her hands. ALJ Decision at 2, 3, citing CMS Exs. 14; 15; 20, at 1, 3, 7; and P. Exs. 2, at 16; 3; *see also* P. Exs. 7, at 6; 12, at 2.

Resident 4 had resided at Leroy Manor since January 2014. ALJ Decision at 3. Her clinical record "does not describe any incidents of the resident assaulting other residents prior to February 23" although she had expressed "vocalization and complaints" about her roommate. *Id*. at 4. As the ALJ recounted, on February 12, 2014, Resident 4 complained to nursing staff that Resident 5 was disturbing her and, later that day, again complained to nursing staff in a raised voice that "she cannot take her roommate talking, [and] that she does not have to put up with it." *Id*., citing CMS Ex. 14, at 13. Facility staff responded to those complaints by removing Resident 5 from her room to calm Resident 4. *Id*.; CMS Ex. 14, at 13.

Facility staff intervened in the incident on February 23, 2014, removed Resident 4 from atop Resident 5, and moved Resident 4 to a vacant resident room on a different hallway. ALJ Decision at 5, citing P. Ex. 7, at 6, and CMS Exs. 18, at 15, 17; 20, at 4. Staff conducted bed checks of Resident 4 at 15-minute intervals and later placed her on continuous "one-to-one" monitoring. *Id*., citing P. Ex. 7, at 6-7, and CMS Exs. 18, at 15, 17; 20, at 4. Later on during the morning of February 23, 2014, Resident 4 was transported to a hospital for observation, with the assistance of law enforcement who had been called by facility staff. *Id*. at 5-7. Resident 4 was returned from the hospital to Leroy Manor later that day, and she was subsequently discharged from the facility. *Id*. at 7, 5 n.3, citing P. Ex. 7, at 7; *see also* P. Exs. 8, at 1-2; 12, at 6-7; CMS Ex. 14, at 20.

The parties do not dispute that while at the hospital after the incident Resident 4 was diagnosed with what the facility described as "homicidal ideation." ALJ Decision at 4 n.1, citing CMS Ex. 21 (facility memo to State survey agency Feb. 24, 2014); *see also* P. Ex. 8, at 1 (hospital emergency department physician discharge orders noting diagnosis of "acute agitation and homicidal thoughts"). The parties do disagree, however, over whether, as the ALJ found, it was undisputed that Resident 4 had been diagnosed with homicidal ideation at the facility on January 8, 2014, shortly after her admission to Petitioner's facility, *before* the February 23, 2014 incident. That disagreement is the crux of the appeal and this remand.

The state survey agency completed a complaint investigation of Leroy Manor on March 6, 2014. CMS Exs. 1; 23, at 2 (surveyor decl.). CMS by letter of April 18, 2014 notified Leroy Manor that it was imposing remedies for five deficiencies in connection with the February 23, 2014 incident, three of which were at the immediate jeopardy level. The

three immediate jeopardy-level deficiencies alleged noncompliance with requirements in Part 483 of 42 C.F.R. that "[t]he resident has the right to be free from verbal, sexual, physical, and mental abuse" (§ 483.13(b)), and that "[t]he facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents . . . . (1) [t]he facility must— . . .[n]ot use . . . physical abuse . . . ." (§ 483.13(c)). CMS Ex. 1; CMS Prehearing Br. & Memorandum in Support of Motion for Summary Judgment (CMS Br.) at 1 n.1, 3. CMS alleged that Leroy Manor and its staff–

- "failed to implement any interventions to address [Resident 4's] behaviors, or to prevent Resident 4 from eventually abusing Resident 5" even though "staff knew, or should have known, on February 23, 2014 that there was a potential for abuse involving Resident 4" and "should have known that Resident 4 could be a risk to Resident 5."

- "lacked knowledge of and failed to enact their policy on resident to resident abuse" because "[t]he Administrator could not recall what procedures were outlined in the policy or what actions should be taken following a witnessed abuse situation" and "Resident 4 should have been placed in 1:1 supervision following the incident and she was not."

- "neglected to 'immediately notify' law enforcement immediately after the assault, until Resident 4 was being transported to the hospital (in violation of its own Abuse Prohibition Policy)."

CMS Br. at 14-18; *see also* CMS Ex. 1, at 4-5, 11, 16.

CMS also alleged two less-than-immediate jeopardy-level deficiencies for noncompliance with requirements that a facility "immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member" of various events including "[a] significant change in the resident's physical, mental, or psychosocial status" (§ 483.10(b)(11)), and that a facility "must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident" (§ 483.75). CMS alleged that Leroy Manor failed "to immediately notify the resident's POA [power of attorney, the legal representative], police and consult with the resident's physician" and that the occurrence of the immediate jeopardy deficiencies showed that the facility "failed to be administered in a manner to maintain the highest practical well-being of each resident." CMS Opposition to P. Cross-Motion for Summary Judgment (CMS Opp.) at 10-11, 14; *see also* CMS Ex. 1, at 1-2, 22-23.

CMS imposed CMPs of $10,000 per day for three days of immediate jeopardy-level noncompliance from February 23 through 25, 2014, and of $200 per day for the period of less-than-immediate jeopardy noncompliance from February 26 through March 6, 2014. ALJ Decision at 1.

Standard of review

Whether summary judgment is appropriate is a legal issue the Board addresses de novo. *1866ICPayday.com, L.L.C*., DAB No. 2289, at 2 (2009), *citing Lebanon Nursing & Rehab. Ctr*., DAB No. 1918 (2004). Summary judgment is appropriate when the record shows there is no genuine issue as to any material fact, and the moving party is entitled to judgment as a matter of law. *See id*. at 2, *citing Celotex Corp. v. Catrett*, 477 U.S. 317, 322-25 (1986).

In *Livingston Care Center*, DAB No. 1871, at 5 (2003), *aff'd*, *Livingston Care Center v. U.S. Department of Health & Human Services*, 388 F.3d 168, 172-73 (6th Cir. 2004), the Board described the parties' respective burdens regarding summary judgment as follows:

> The party moving for summary judgment bears the initial burden of demonstrating that there are no genuine issues of material fact for trial and that it is entitled to judgment as a matter of law. Celotex, 477 U.S. at 323. This burden may be discharged by showing that there is no evidence in the record to support a judgment for the non-moving party. Id. at 325. If a moving party carries its initial burden, the non-moving party must "come forward with 'specific facts showing that there is a genuine issue for trial.'" Matsushita Elec. Industrial Co. v. Zenith Radio, 475 U.S. 574, 587 (1986) quoting Fed. R. Civ. P. 56(e)).[[2]] To defeat an adequately supported summary judgment motion, the non-moving party may not rely on the denials in its pleadings or briefs, but must furnish evidence of a dispute concerning a material fact – a fact that, if proven, would affect the outcome of the case under governing law. Id. at 586, n.11; Celotex, 477 U.S. at 322

[2] Effective December 10, 2010, Rule 56 of the Federal Rules of Civil Procedure was "revised to improve the procedures for presenting and deciding summary-judgment motions and to make the procedures more consistent with those already used in many courts." Committee Notes on Rules – 2010 Amendment, available at http://www.law.cornell.edu/rules/frcp/rule_56. The revisions alter the language of the rule, but the "standard for granting summary judgment remains unchanged." *Id.* The Federal Rules of Civil Procedure are not directly applicable to administrative proceedings as in this case, but together with related case law, they provide guidance for determining whether summary judgment may be appropriate in administrative proceedings.

> (moving party is entitled to summary judgment if the party opposing the motion "fails to make a showing sufficient to establish the existence of an element essential to that party's case, and on which that party will bear the burden of proof at trial").

Summary judgment principles also provide that "[i]n order to demonstrate a genuine issue, the opposing party must do more than show that there is 'some metaphysical doubt as to the material facts . . . . Where the record taken as a whole could not lead a rational trier of fact to find for the non-moving party, there is no 'genuine issue for trial.''" *1866ICPayday.com* at 3, *quoting Matsushita*, 475 U.S. at 586-87. In deciding whether the record taken as a whole could not lead a rational trier of fact to find for the non-moving party, "the reviewer must view the evidence in the light most favorable to the non-moving party, drawing all reasonable inferences in that party's favor." *Id.*, *citing U.S. v. Diebold, Inc.*, 369 U.S. 654, 655 (1962).

ALJ proceedings and decision

Leroy Manor appealed CMS's imposition of remedies, and CMS moved for summary judgment and filed a combined prehearing brief and memorandum in support of its motion (CMS Br.), 23 proposed exhibits (CMS Exs.), and a list of proposed witnesses. ALJ Decision at 2. Leroy Manor filed a combined pre-hearing brief, opposition to CMS's motion for summary judgment, and cross-motion for summary judgment (P. Br.), along with 17 proposed exhibits (P. Exs.) and a list of proposed witnesses, and CMS filed its opposition to Petitioner's cross-motion for summary judgment (CMS Opp.). The ALJ accepted all of the parties' exhibits into the record. *Id.*

The ALJ granted CMS's motion for summary judgment in part and denied it in part, sustaining two of the three findings of immediate jeopardy-level deficiencies and declining to address the two findings of non-immediate jeopardy-level deficiencies.[3]

The ALJ first concluded that undisputed evidence established that Leroy Manor did not comply with the requirement in 42 C.F.R. § 483.13(b) that a resident be free from physical abuse because, as CMS alleged, "it allowed Resident # 4 to abuse physically Resident # 5." ALJ Decision at 2-3. The ALJ stated that a resident's abuse of another resident "is not in and of itself sufficient to establish that a facility allowed its residents to

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[3] The ALJ found it "unnecessary [to] discuss" the two alleged non-immediate jeopardy-level deficiencies because they provided no basis to increase the immediate jeopardy-level penalties he sustained, and because the deficiencies he did sustain "are sufficient, in and of themselves, to justify [the] $200 per day [CMP] after February 25, 2014." ALJ Decision at 8. Neither party appealed that aspect of the ALJ Decision.

be abused in violation of regulatory requirements" because "[i]n order for the facility to be culpable, the abuse must be *foreseeable and preventable*."[4] *Id*. at 3 (ALJ italics). The ALJ found Resident 4's "assault" on Resident 5 "foreseeable and preventable," making Leroy Manor "liable for not protecting its residents against abuse in contravention of [§] 483.13(b)," because "the undisputed facts establish that Petitioner and its staff were on notice that Resident # 4 manifested homicidal ideation." *Id*.

The ALJ relied on Petitioner's Exhibit 3, a four-page "Observation Report" for Resident 4, as showing that "Petitioner's medical director diagnosed Resident # 4 as manifesting homicidal ideation shortly after her admission to Petitioner's facility" during a "mental status evaluation that the medical director conducted on January 8, 2014." *Id*. at 4, citing P. Ex. 3, at 1. The ALJ rejected the medical director's declaration that "nothing about Resident # 4's behavior . . . would have put Petitioner's staff on notice that she posed a threat to other residents" because "the medical director failed to discuss his own finding, that he made on January 8, 2014, that the resident voiced homicidal ideation." *Id*. at 5, citing P. Ex. 17. While the ALJ "agree[d] that the resident's behavior between January 8 and February 23, 2014, when considered in isolation, did not suggest that she was prone to assault other residents," he found that the diagnosis of homicidal ideation, "coupled with the resident's behavior, put Petitioner and its staff on notice that the resident posed a potential danger to other residents of the facility" and that "staff simply disregarded the medical director's assessment of the resident as having homicidal ideation," which put other residents "at risk for serious harm or worse." *Id*. at 3, 5. The ALJ found that "the fact that she harbored homicidal thoughts certainly was a sufficient basis for the facility to treat the resident as being potentially dangerous to others." *Id*. at 4. He concluded that Resident 4's assault of Resident 5 "was, therefore, foreseeable and preventable, and Petitioner is liable for not protecting its residents against abuse in contravention of 42 C.F.R. § 483.13(b)." *Id*. at 3.

Below we discuss our conclusion that under the circumstances of this case, it was error to conclude, based on Petitioner's Exhibit 3, that it was undisputed that the Resident 4 had been diagnosed with homicidal ideation prior to her assault on Resident 5.

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[4] CMS on appeal argues that it "does not have to present evidence on foreseeability in order to establish a violation of § 483.13(b)" because "the plain language of the regulations prohibiting abuse, 42 C.F.R. § 483.13(b), does not include the element of foreseeability" and "does not mention 'foreseeability' or limit a resident's right to be free of abuse to only those incidents that are foreseeable." CMS Resp. at 2, 11. Before the ALJ, CMS argued that "[a] facility's duty to act arises when the facility knows or should know that a potentially abusive event may occur" and that staff "knew, or should have known, on February 23, 2014 that there was a potential for abuse involving Resident 4." CMS Opp. at 2; CMS Br. at 14. The ALJ may have viewed this as statement of a "foreseeability" standard when he found that CMS "acknowledges that this [foreseeability] is the standard." ALJ Decision at 3. CMS did not request Board review of the ALJ's finding on this legal issue as it had a right to do under section 498.80; accordingly, an appeal of that ALJ finding is not properly before the Board. We therefore do not address this ALJ finding about the legal standard here.

The ALJ next found that Leroy Manor violated the requirement in section 483.13(c) to implement written policies that prohibit abuse of residents because "[t]he undisputed material facts do show . . . that Petitioner failed to comply with its own abuse prevention policy" which "directs Petitioner's management and staff to notify law enforcement immediately in the event of abuse." *Id.* at 6, citing CMS Ex. 22, at 12. The ALJ found that undisputed material facts showed that Petitioner failed to comply with this aspect of its abuse prevention policy because it was "undisputed that Petitioner's staff did not notify law enforcement authorities about Resident # 4 for several hours after she assaulted Resident # 5" and did so only "at the point when its staff determined to transport the resident to a hospital for evaluation." *Id.* at 6-7, citing CMS Ex. 21; P. Br. at 23; and P. Ex. 7, at 6. As we discuss below, we do not agree that there was no dispute as to this alleged policy violation.

The ALJ denied summary judgment for CMS on the third immediate jeopardy-level deficiency alleging noncompliance with the requirement to implement written policies that prohibit abuse (§ 483.13(c)) because Leroy Manor's administrator could not recall the specific requirements of the abuse prevention policy and the facility "failed to provide continuous (i.e. one-to-one) supervision" of Resident 4 in the period immediately following her assault on Resident 5. ALJ Decision at 3, citing CMS Ex. 1, at 11, 14; and CMS Br. at 17-18. The ALJ found that the facility's policy, "written in the disjunctive," gave staff the option of "either to supervise continuously or to sequester a resident who is suspected of, or who has committed, an assault." *Id.* at 6, citing CMS Ex. 22, at 14. The ALJ concluded that "mov[ing] Resident # 4 to a vacant resident room on a different hallway in Petitioner's facility from the hallway containing the room in which Resident # 4 had committed the assault" and "initiat[ing] bed checks of Resident # 4 at 15-minute intervals in order to monitor her condition" was "entirely consistent with Petitioner's abuse prevention policy." *Id.* at 5, 6. The ALJ also found the Administrator's inability to recall provisions of the abuse prevention policy was "not proof of a violation" because the issue was "whether the policy [requiring isolation or continuous monitoring] had been implemented" and "[t]he undisputed facts show that it was implemented in the case of Resident # 4 and CMS has offered no evidence to show that the policy was not implemented generally." *Id.* at 6. CMS did not appeal the ALJ Decision with respect to this finding.

The ALJ concluded that CMS's determination that the two deficiencies he sustained on summary judgment posed immediate jeopardy was not clearly erroneous. *Id.* at 5 ("undisputed facts strongly support CMS's finding that Petitioner's noncompliance with 42 C.F.R. § 483.13(b) was at the immediate jeopardy level. . . . staff's failure to guard against the possibility that Resident # 4 might assault others plainly created a likelihood of serious injury, harm, or death to other residents"); 7 (staff "unaware[ness] that it was

mandated to notify law enforcement officials in this case" raised " the probability . . . that it would be unaware of its mandate in other cases of assault and that certainly would lead to residents being placed in jeopardy" and "CMS's determination of immediate jeopardy level noncompliance [is] not . . . clearly erroneous for this reason").[5]

The ALJ found the $10,000 per-day CMP for the three days to be unreasonable because Leroy Manor manifested two immediate jeopardy-level deficiencies, making the noncompliance "less egregious than CMS determined it to be" in finding three immediate jeopardy deficiencies. *Id*. at 7. The ALJ thus imposed CMPs of $7,000 per day as a reasonable amount for the two immediate jeopardy-level deficiencies. *Id*. The ALJ also found the CMPs of $200 per day for the period February 26 through March 6, 2014, or "only slightly more than six percent of the maximum daily penalty amount" authorized by regulation, to be "a minimal amount" justified by Leroy Manor's non-immediate jeopardy-level noncompliance with section 483.13(c). *Id*. at 8, citing 42 C.F.R. § 488.438(a)(1)(ii). The ALJ also noted that Leroy Manor "does not contend that it abated its deficiencies – assuming that it was deficient – at a date that is earlier than March 7," meaning that the "duration of noncompliance is not at issue in this case." *Id*.

Leroy Manor requested Board review of the ALJ Decision. CMS did not request review of the ALJ Decision and, in response to Leroy Manor's appeal, CMS did not allege any error in the ALJ's determinations to deny summary judgment for CMS on one immediate jeopardy-level deficiency, to reduce the CMP amounts, or to decline to address the two non-immediate jeopardy-level deficiencies.

Leroy Manor's arguments

Leroy Manor argues that the ALJ's determination that Leroy Manor knew or should have known that Resident 4 posed a threat to other residents was "based upon a misunderstanding of when R4 was diagnosed with homicidal ideation and should be reversed." P. Request for Review (RR) at 11. Leroy Manor argues that the ALJ "mistakenly believed that R4 was diagnosed with homicidal ideation at the time of her admission to LeRoy Manor on January 8, 2014" and that this diagnosis "was not made until AFTER the incident on February 23, 2014, when R4 was admitted to the hospital." RR at 1. Leroy Manor asserts that "when R4 [was] admitted to LeRoy Manor, she had not been diagnosed with 'homicidal ideation'" and "was not assessed, evaluated or otherwise diagnosed with homicidal ideation until February 23, 2014" when she was at

[5] CMS's determination as to the level of noncompliance must be upheld unless it is clearly erroneous. 42 C.F.R. § 498.60(c)(2).

the hospital after the assault of Resident 5. RR at 6, citing P. Exs. 8; 15-17; and CMS Ex. 18, at 8. Leroy Manor explains that the "homicidal ideation" diagnosis listed on its Exhibit 3 was part of general demographic and diagnostic information about the resident shown at the top of the exhibit that was current as of when the exhibit was printed in October 2014 for use in Leroy Manor's appeal and was not the product of the cognitive assessment shown on the rest of the exhibit. RR at 12-13.

Leroy Manor on appeal also moved to file an additional exhibit, Petitioner's Exhibit 18, a "Diagnoses Face Sheet" for Resident 4 listing the dates of her diagnoses including "homicidal ideation" diagnosed on February 23, 2014, which Leroy Manor says "proves that R4 was diagnosed with 'homicidal ideation' . . . ***after*** the occurrence in issue." P. Motion to Supp. Exs. at 2. CMS objects on grounds including that the diagnosis dates shown may be edited on the computer. CMS Response to RR (CMS Resp.) at 16. The Board may admit additional evidence it considers relevant and material to an issue before it. 42 C.F.R. § 498.86(a).[6] As we explain below, we need not resolve the issue of when Resident 4 was diagnosed with homicidal ideation in order to conclude that this case should be remanded to the ALJ. Consequently, we decline to admit Petitioner's Exhibit 18 but retain it in the administrative record. The ALJ on remand may determine whether or not to admit the exhibit.

Leroy Manor also disputes that it violated its abuse prevention policy or any state requirement or CMS policy by not notifying the police of the assault until later on the morning of February 23 when Resident 4 was taken to the hospital. Leroy Manor asserts that its abuse prevention policy did not require immediate notification of the police absent serious bodily injury and that Resident 5 was not seriously injured by the assault. RR at 5, 18-19. Leroy Manor thus argues that the ALJ's determination that a $7,000 per day CMP is reasonable "is not supported by substantial evidence and should be reversed." RR at 5.[7]

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[6] In deciding whether to admit evidence, the Board considers whether the party that proffers the evidence has demonstrated good cause for not producing the evidence during the ALJ proceedings. *Guidelines – Appellate Review of Decisions of Administrative Law Judges Affecting a Provider's Participation in the Medicare and Medicaid Programs*, available at http://www.hhs.gov/dab/divisions/appellate/guidelines/prov.html.

[7] Leroy Manor does not argue that the CMP the ALJ imposed would be unreasonable if the deficiencies were sustained.

Analysis

I. The ALJ erred in finding that Leroy Manor did not dispute that its staff diagnosed Resident 4 with homicidal ideation on January 8, 2014, prior to her assault on Resident 5.

The ALJ's conclusion that Resident 4's assault on her roommate was "foreseeable and preventable" rests entirely on his reading of Petitioner's Exhibit 3 as establishing that "Petitioner's medical director diagnosed Resident # 4 as manifesting homicidal ideation shortly after her admission to Petitioner's facility." According to the ALJ, this conclusion is not independently supported by other undisputed evidence. ALJ Decision at 4, citing P. Ex. 3 at 1. The ALJ found, for example, that Resident 4's "vocalization and complaints prior to February 23 do not, in and of themselves, signify any propensity on Resident # 4's part for violent behavior" and "show her merely to be argumentative and unreasonable"; that "the resident's behavior between January 8 and February 23, 2014, when considered in isolation, did not suggest that she was prone to assault other residents"; that only when "coupled with" the knowledge that Resident 4 manifested homicidal ideation did her behavior prior to February 23 "put Petitioner and its staff on notice that the resident posed a potential danger to other residents of the facility"; and that "everything Resident # 4 said and did after January 8 should have been viewed by Petitioner through the lens of that resident's homicidal thoughts." *Id*. at 3-5.

The record shows that Leroy Manor did not have the opportunity to dispute that Petitioner's Exhibit 3 showed that Resident 4 had been diagnosed with homicidal ideation at the facility prior to her assault on Resident 5. Accordingly, the ALJ's finding that Leroy Manor did not dispute having been on notice that Resident 4 manifested homicidal ideation prior to her assault on Resident 5, making the assault foreseeable and preventable, was error.

Petitioner's Exhibit 3 is a four-page "Observation Report" for Resident 4 that at the top of the first page presents information about the resident including her "Status" (shown as "Discharged") and 20 diagnoses, of which one is homicidal ideation, and, below the information about the resident, the results of an "Admission Cognitive Assessment" of Resident 4. We discuss the exhibit in greater detail later, but here we first explain why we conclude that Leroy Manor did not have the opportunity to dispute that the exhibit showed that it diagnosed Resident 4 with homicidal ideation on January 8, 2014, prior to her assault on her roommate.

Leroy Manor filed its Exhibit 3 with its combined pre-hearing brief, which included its brief in opposition to CMS's motion for summary judgment and its own cross-motion for summary judgment (P. Br.). Leroy Manor cited its Exhibit 3 to show that "[t]he facility performed its first cognitive assessment of R4 on January 9, 2014" and "[n]o psychiatric

or behavior issues were noted as a result of that assessment"; and that it "had no reason to suspect that R4 would engage in a behavior of physical aggression towards R4 on February 23, 2014 [because] [p]rior to that date, LeRoy had no information or documentation to suggest that R4 was likely to engage in any physical aggression towards a resident." P. Br. at 7, 15.

In its combined pre-hearing brief, Leroy Manor did not refer to or discuss the homicidal ideation diagnosis shown on its Exhibit 3. It did, however, assert that homicidal ideation was diagnosed when Resident 4 was at the hospital after her assault on her roommate, and that "the facility, in fact, was *not* aware of that diagnosis until *after* the occurrence" on February 23, 2014. P. Br. at 11, 15, citing P. Ex. 8, at 1 (hospital emergency department physician discharge orders noting diagnosis of "acute agitation and homicidal thoughts"). Leroy Manor made those assertions in response to CMS's assertion that "[a]s of February 23, 2014, per hospital evaluation, her diagnosis included homicidal ideation." CMS Br. at 8.[8] In light of Leroy Manor's statements and CMS's silence on Petitioner's Exhibit 3 to this point, we cannot conclude that Leroy Manor should have anticipated that its Exhibit 3 might be construed as establishing a diagnosis of homicidal ideation prior to February 23, 2014.

Later, when CMS opposed Leroy Manor's cross motion for summary judgment, it argued that Petitioner's Exhibit 3 showed that homicidal ideation had been diagnosed in Resident 4 by the facility's medical director during a "Cognitive Assessment" conducted "*as early as January 8, 2014 . . . .*" CMS Opp. at 4-5, citing P. Ex. 3, at 1 (CMS's italics).[9] CMS's opposition to Leroy Manor's cross motion for summary judgment was the last briefing filed by the parties, and the procedures the ALJ established by order did not provide for Leroy Manor to reply to CMS's opposition. ALJ Pre-Hearing Order at 4. The ALJ Decision was issued 12 days after the DAB Civil Remedies Division received CMS's opposition.

[8] In support, CMS cited a February 24, 2014 memorandum from the Leroy Manor Administrator to the Illinois Department of Public Health reporting the February 23, 2014 incident and stating that "[a]s of February 23, 2014, per hospital evaluation, resident has [a] *new* diagnosis of homicidal ideation." CMS Ex. 21 (emphasis added). The ALJ rejected CMS's argument that Leroy Manor was thus "on notice that Resident # 4 was a danger to others" because the exhibit on which CMS relied reported the findings of "a hospital evaluation made of Resident #4 *after the events of February 23*" and "in the wake of, and not prior to, Resident # 4's assault of Resident # 5." ALJ Decision at 4 n.1 (ALJ italics).

[9] CMS also cited "CMS Ex. 14, Resident 4 Progress Notes, Pet. Ex. 2, Discharge Records from OS St. Joseph Medical Center, p. 16, Pet. Ex. 4, MDS Assessment p. 19." *Id*. The cited exhibit pages do not reflect any diagnoses of homicidal ideation.

We conclude based on this litigation history that Leroy Manor did not have the opportunity before the ALJ to dispute CMS's claim that Petitioner's Exhibit 3 showed that Resident 4 had been diagnosed with homicidal ideation at Leroy Manor as early as January 8, 2014, prior to the assault on Resident 5. Absent that opportunity, and given that Leroy Manor had asserted that the hospital's post-assault diagnosis of homicidal ideation was the first diagnosis of aggressive tendencies, it was error to find that Leroy Manor did not dispute that its Exhibit 3 established that the medical director diagnosed Resident # 4 as manifesting homicidal ideation shortly after her admission to Petitioner's facility. Accordingly, the ALJ's conclusion that the assault on Resident 4 was foreseeable and preventable, which rested entirely on Petitioner's Exhibit 3, was error. ALJ Decision at 3-5.

The ALJ's failure to give Leroy Manor an opportunity to dispute that its Exhibit 3 shows that the facility diagnosed homicidal ideation in Resident 4 shortly after her admission might be harmless error if the exhibit were sufficiently clear on its face as to preclude a reasonable contrary finding. As we discuss next, however, the exhibit is susceptible of reasonable contrary readings, including that it did not show that Resident 4 was diagnosed with homicidal ideation either during the cognitive status examination of the resident conducted shortly after her admission or prior to the February 23, 2014 assault. By selecting one possible interpretation of the exhibit over others, and, as we discuss later, using that reading to discount other evidence indicating that homicidal ideation was diagnosed after the assault, the ALJ weighed evidence and drew inferences to the detriment of Petitioner, the non-moving party, which an adjudicator may not do in granting summary judgment.

II. The ALJ erred in drawing inferences from Petitioner's Exhibit 3 unfavorable to Leroy Manor in granting summary judgment.

In *Illinois Knights Templar Home*, DAB No. 2274 (2009), the Board summarized how it "has explained in prior decisions how an ALJ's role in deciding a summary judgment motion differs from the role of an ALJ resolving a case after a hearing (whether an in-person hearing or on the written record)":

> [I]n *Madison Health Care, Inc.*, DAB No. 1927, at 6 (2004), the Board stated that "the ALJ deciding a summary judgment motion does not 'make credibility determinations, weigh the evidence, or decide which inferences to draw from the facts,' as would be proper when sitting as a fact-finder after a hearing, but instead should 'constru[e] the record in the light most favorable to the nonmovant and avoid[] the temptation to decide which party's version of the facts is more likely true.' *Payne v. Pauley*, 337 F.3d 767, 770 (7th Cir. 2003)." In that process, the ALJ should not be assessing credibility or evaluating the weight to be given conflicting evidence.

DAB No. 2274, at 8. The ALJ here erred in drawing inferences about Petitioner Exhibit 3 that were unfavorable to Leroy Manor when he awarded summary judgment to CMS. Review of Petitioner's Exhibit 3 does not compel any one finding as to when Resident 4 was diagnosed with homicidal ideation. Instead, we conclude that the exhibit is susceptible to more than one interpretation depending on what inferences are drawn from its contents. The ALJ erred in granting summary judgment in favor of CMS by drawing inferences that were favorable to CMS and unfavorable to Leroy Manor.

As noted, Petitioner's Exhibit 3 is a four-page "Observation Report" for Resident 4. A line of text at the bottom of each page shows a "Run Date" of "10/27/2014," the date Leroy Manor says the exhibit was printed "for production for this case." P. Ex. 3; RR at 12. In the top portion of the first page of the exhibit is information about the resident, and below that, over the rest of the exhibit and under the heading "Special Care Unit -- Cognitive Assessment," are the results of an "Admission Cognitive Assessment" of Resident 4.

The information about Resident 4 in the top portion of the exhibit includes, in designated spaces, her age, her diagnoses (20 in all) listed with diagnostic codes, her allergies, the name of her physician (the facility's medical director), her "Room/Bed" and "Unit" (those spaces are blank), and her "Status," which is shown as "Discharged." The first diagnosis included in the list is "V62.85 Homicidal ideation," and the other 19 include six that could relate to her mental status ("294.1 Dementia, unspec w/ behav disturb"; "780.52 Symptom, insomnia NOS,"; "780.97 Status, mental, altered"; "296.00 Depression, major NOS"; "290.0 Senile dementia"; and "300.00 Anxiety state NOS"). P. Ex. 3, at 1. According to Leroy Manor, the top portion of the Observation Report comprises "demographic and diagnostic information . . . set forth in the top quarter of the [first] page" that "includes . . . all of the diagnoses that had been entered into R4's record through the date of printing (i.e., October 27, 2014)." RR at 13. Leroy Manor asserts that this portion of the Observation Report "is continuously updated and reflects the most current information when it is printed" and thus "shows R4's status as discharged." *Id.*

The next portion of the exhibit, which begins with the heading "Special Care Unit -- Cognitive Assessment," shows the results of an "Admission Cognitive Assessment" of Resident 4. P. Ex. 3, at 1. This portion first shows information about the assessment including an "Observation Date" and "Date Recorded" of January 8, 2014, a "Completed Date" of January 9, 2014, and has the name of an "LPN" (licensed practical nurse) as the entries for "Creator" and "Completed By." *Id.* The cognitive assessment portion is divided into five sections: Orientation, Location, Memory, Concentration, and Evaluation, each with preprinted, multiple choice observations. *Id.* at 1-4.

According to Leroy Manor, the "observation information" in this cognitive assessment portion of the exhibit "is static and reflects the information gathered on the date of the observation (i.e., January 8, 2014)." RR at 13. Leroy Manor states that the ALJ "mistakenly believed that the demographic and diagnostic information" at the top of the first page, which includes the "homicidal ideation" diagnosis, was, like the observation information, "also static and reflected R4's diagnoses at the time of admission." *Id.*

The ALJ Decision describes Petitioner's Exhibit 3 as follows:

> Petitioner's medical director diagnosed Resident # 4 as manifesting homicidal ideation shortly after her admission to Petitioner's facility. P. Ex. 3 at 1.
>
> The medical director's diagnosis of the resident's homicidal ideation is laconic comment, grouped with multiple other diagnoses, to a much lengthier mental status evaluation that the medical director conducted on January 8, 2014, around the date of the resident's admission to Petitioner's facility. There is no elaboration of this comment. P. Ex. 3 at 1. What the resident may have said that triggered the medical director's finding is, therefore, unknown.

ALJ Decision at 4 (footnote omitted).

The ALJ Decision does not explain why the ALJ concluded that the exhibit's contents necessarily show that the facility's medical director diagnosed homicidal ideation in Resident 4 on January 8, 2014. Petitioner's Exhibit 3, on its face, reasonably establishes that Leroy Manor's medical director was Resident 4's physician and that the resident's 20 diagnoses as of her discharge from the facility included homicidal ideation, but it does not establish that the diagnosis was on January 8, 2014.

As noted, the "Cognitive Assessment" portion of the exhibit nowhere mentions homicidal, assaultive or aggressive thoughts or ideation, and none of the pre-printed, multiple-choice options used to report the results of the assessment address aggressive, assaultive or homicidal ideations or behaviors. Thus, one could reasonably infer from the fact that the diagnosis of homicidal ideation appears only in the top portion of the exhibit describing Resident 4's "Status" as "Discharged," with no entries for her "Unit" and "Room/Bed," that this diagnosis was made after the assessment and perhaps not until she was discharged from Leroy Manor, i.e., after she assaulted Resident 5. RR at 12-13.

Thus, finding that Petitioner's Exhibit 3 established that the resident was diagnosed with homicidal ideation at Leroy Manor prior to her assault on Resident 5 required drawing inferences unfavorable to Leroy Manor, and rejecting reasonable inferences in its favor, which was error in granting summary judgment against the facility. The Board has held

that "in the context of summary judgment . . . an ALJ must draw all reasonable favorable inferences on behalf of the nonmoving party." *E.g. Venetian Gardens*, DAB No. 2286, at 16 (2009). In addressing findings that turned on the disputed interpretation of a resident's progress notes, for example, the Board held that "[d]rawing an inference from or determining the interpretation of these notations is precisely the kind of thing that the ALJ was not permitted to do on summary disposition so long as alternative inferences or interpretations existed that were more favorable to" the facility against CMS seeking summary judgment. *Madison Health Care, Inc.*, DAB No. 2049, at 10 (2006). The Board thus "reversed the summary disposition essentially because the ALJ failed to draw all reasonable inferences in favor of the non-moving party when evaluating a contested summary disposition request." *Id.* at 6.

The ALJ compounded the error involving his inference from Petitioner Exhibit 3 by discounting the credibility of the medical director's declaration testimony based on finding that testimony inconsistent with the diagnosis of homicidal ideation in Petitioner Exhibit 3, that the ALJ inferred was made on January 8, 2004. The medical director testified that "[f]rom the time of her admission until February 23, 2014," the date of the assault, "I did not identify any behavioral issues for R4," and "did not feel R4 needed any psychological evaluation," and "was not aware of any instances of physical aggression towards others and did not feel that R4 posed a threat to any other residents in the facility." P. Ex. 17, at 2. He also testified that "[a]t no time during her admission, did I have concerns that R4 would engage in any physical aggression towards another resident" and that "[t]he behavior by R4 during that occurrence" on February 23, 2014 "was a new behavior and could not have been anticipated by the LeRoy Manor Staff." *Id.* In an apparent reference to the diagnosis listed in Petitioner's Exhibit 3, the ALJ discredited this testimony because "the medical director failed to discuss [in his declaration] his own finding, that he made on January 8, 2014, that the resident voiced homicidal ideation. That omission is significant." ALJ Decision at 5. Discrediting on summary judgment testimony that created a dispute about when R4 was diagnosed with homicidal ideation, a fact that was material to the ALJ's decision, was error.

The ALJ also addressed, but apparently discounted, additional evidence favorable to Leroy Manor on the issue of the timing of the diagnosis of homicidal ideation, the February 24, 2014 memorandum from the Leroy Manor Administrator to the Illinois Department of Public Health (IDPH) reporting the assault. The Administrator stated in the memorandum that "[a]s of February 23, 2014, *per hospital evaluation*, resident has [a] *new diagnosis* of homicidal ideation." CMS Ex. 21, at 1 (emphasis added). As noted above, the ALJ rejected CMS's citation of this exhibit as showing that Leroy Manor was "on notice that Resident # 4 was a danger to others" because it referenced findings "made of Resident #4 *after the events of February 23*" and "in the wake of, and not prior to,

Resident # 4's assault of Resident # 5." ALJ Decision at 4 n.1 (ALJ italics). However, the ALJ failed to consider that his conclusion that this document related to findings made after the alleged assault on R4 tended to support the existence of a dispute of fact as to when R4 was diagnosed, contrary to the ALJ's treatment of January 8, 2014 as the undisputed date of that diagnosis.

Thus, a genuine dispute exists as to when Resident 4 was diagnosed with homicidal ideation, and the ALJ regarded the date of that diagnosis as material to his conclusion that Resident 4's actions early in the morning on February 23, 2014 were foreseeable and preventable, which the ALJ concluded was a prerequisite for finding the facility liable for resident abuse under section 483.13(b) when the abuse is attributable to the actions of another resident. ALJ Decision at 3. We therefore conclude that the ALJ erred in granting summary judgment on this deficiency finding without permitting an evidentiary hearing (or, if the parties waived a hearing, to make arguments as to the weight of the evidence beyond those in support of summary judgment). Remand of the appeal to the ALJ for further proceedings is thus appropriate. *See, e.g., Va. Highlands Health Rehab. Ctr.*, DAB No. 2339, at 6 (2010) (remanding case where ALJ in granting summary judgment failed to view evidence in record in light most favorable to facility). In addition to further proceedings to resolve material factual disputes, if on remand the ALJ continues to hold that to establish resident-to-resident abuse under section 483.13(b), CMS must show that the abuse was foreseeable and preventable, the ALJ needs to explain and cite authority for that holding.

The ALJ may well find Leroy Manor's arguments, evidence and witnesses less credible or persuasive than those presented by CMS, "but where such evaluation of credibility or comparison of competing evidence is called for, summary judgment is inappropriate" and "where the record evidence is susceptible of a rational interpretation which would preclude summary judgment against the non-movant party, the case must go forward for a thorough evaluation of what the most reasonable inferences and the preferable interpretations are based on all credible evidence" in the record. *Madison Health Care, Inc.*, DAB No. 1927, at 14.

III. <u>The ALJ erred in finding that it was undisputed that Leroy Manor did not comply with its abuse policy in notifying the police of the February 23, 2014 incident and, on remand, should also address the regulatory requirement for reporting alleged abuse.</u>

The ALJ sustained "an additional immediate jeopardy level violation of 42 C.F.R. § 483.13(c) in that Petitioner allegedly failed – in contravention of its abuse prevention policy – to notify law enforcement officials immediately of the assault of Resident # 5 by Resident # 4." ALJ Decision at 3. The ALJ found that "[t]he undisputed material facts do show . . . that Petitioner failed to comply with its own abuse prevention policy [that]

directs Petitioner's management and staff to notify law enforcement immediately in the event of abuse" because it was "undisputed that Petitioner's staff did not notify law enforcement authorities about Resident # 4 for several hours after she assaulted Resident # 5." ALJ Decision at 6-7, citing CMS Ex. 22, at 12, and P. Br. at 23.

Leroy Manor concedes that it contacted the police nine hours after the assault but argues that it "notified the police consistent with its own policy[.]" RR at 18, 19. That policy, titled "Abuse Prohibition," provides in relevant part as follows:

> 3. The administration shall ***immediately contact local law enforcement authorities in the following situations***: . . . .
>   - Physical abuse involving physical injury inflicted on a resident by a staff member or visitor;
>   - Physical abuse ***involving physical injury inflicted on a resident by another resident,*** except in situations where the behavior is associated with dementia or developmental disability;. . .
>
> 4. If the event that caused reasonable suspicion ***result[s] in serious bodily injury***, the report to IDPH and local law enforcement will be made immediately (no later than two hours after forming the suspicion). ***Otherwise it will be made within 24 hours after forming the suspicion.***

CMS Ex. 22, at 12-13 (emphasis added).

Apparently relying on the second prong of its policy (addressing "serious bodily injury" as opposed to simply "physical injury"), Leroy Manor argues that "[i]n this case, there was no serious bodily injury and all reports were made within 12 hours, which is consistent with the applicable law and Leroy Manor's policy."[10] RR at 19.

These provisions from Leroy Manor's policy, which Leroy Manor quoted below, on their face state different time lines for reporting abuse or reasonable suspicion of abuse depending on the circumstances. On remand, the ALJ may determine on the full record what time frame applied to the circumstances here and whether Leroy Manor complied with it. The ALJ Decision does not note or address these specific policy provisions for reporting abuse involving actions of a resident, and this was error.

The ALJ, for example, did not address whether Resident 5 was injured in the assault. CMS argues that "Petitioner may not objectively argue that there was no physical injury to R5, obviating its need to immediately notify law enforcement under its policy" because

[10] Leroy Manor quotes but does not discuss the first prong.

"[i]t is undisputed that R5 was slow to respond for about thirty seconds following the incident, evidencing potential of physical distress." CMS Resp. at 14; *see* P. Ex. 12, at 2 (progress notes stating Resident 5 "was slow to respond for 30 seconds after incident").

Leroy Manor asserts that Resident 5 "was assessed immediately following the incident and never showed any signs or symptoms of distress or injury." RR at 17, citing P. Ex. 7, at 2. The exhibit Leroy Manor cites, which it also cited below, is an "Event Summary List" for Resident 4 that does not contain information about Resident 5. Progress notes for Resident 5 state that a "head to toe skin assessment" at 11:30 am in the morning following the assault found "a pinpoint area to her chin on her right that is pink" that "does not look to be related to any traumatic event," and entries over the next two days noting no signs or symptoms of distress and no adverse effects. P. Ex 11, at 2. It is not clear how Leroy Manor could have complied with its policy's requirement to immediately notify police of abuse by a resident that results in injury if Leroy Manor did not conduct any assessment at all until some 10 hours after the assault. On remand, the ALJ may develop the record as to whether the resident sustained any injury, including whether the skin assessment would necessarily suffice to identify any injuries that might result from the actions of her roommate.

The parties and the ALJ also did not address whether Resident 4's behavior in assaulting her roommate was associated with dementia or developmental disability, one of the considerations Leroy Manor's policy cites in determining when to notify law enforcement. CMS Ex. 22, at 12-13. We note that the record is not clear on that question. On one hand, facility records for Resident 4 show that when questioned by staff after the assault, she stated that she knew what she had done and that her actions could have caused injury to Resident 5. P. Ex. 7, at 6. On the other hand, it is not disputed that Resident 4's diagnoses included dementia, anxiety, depression, and altered mental status, and that during the assault she was heard reprimanding Resident 5 for not hanging up Resident 4's clothes, and calling Resident 5 a name that Leroy Manor reports was actually the name of Resident 4's daughter in law. ALJ Decision at 3; CMS Br. at 9; P. Br. at 8.

Thus, whether Leroy Manor was required by its abuse prevention policy to notify police of the assault immediately entails resolution of disputed or unaddressed issues of fact. It is not the Board's role, in reviewing a grant of summary judgment, to resolve disputed issues of fact where the record has not been fully developed. We accordingly vacate the ALJ's conclusion that it was undisputed that Leroy Manor did not comply with its policy for reporting abuse to law enforcement and remand to permit development of the record to resolve this disputed deficiency.

Additionally, a provision of section 483.13(c) not addressed in the ALJ Decision requires facilities to "ensure that all alleged violations involving mistreatment, neglect, or abuse" are "reported immediately" to the facility administrator and "to other officials in accordance with State law through established procedures (including to the State survey and certification agency)." 42 C.F.R. § 483.13(c)(2).

Leroy Manor argues that it "self-reported the incident to IDPH within 24 hours as required by law," citing a "State Report of Patient Incident" with a fax cover sheet showing transmission on February 23, 2014 at 12:02:38 p.m. RR at 19, citing P. Ex. 14 (at 1-2). Leroy Manor cites CMS guidance for surveyors of long term facilities that it claims interprets "immediately" as meaning "as soon as possible, but ought not exceed 24 hours after discovery of the incident, in the absence of a shorter State time frame requirement."[11] RR at 17, citing State Operations Manual, App. PP.[12] CMS on appeal did not respond to Leroy Manor's arguments that cite this provision of the State Operations Manual.

As the issue of compliance with section 483.13(c)(2) has not been developed by the parties, we decline to comment further on it. On remand the ALJ should provide the parties an opportunity to fully develop this issue so that he can address it in his decision.

[11] Leroy Manor seems to have been aware that the issue of reporting the February 23, 2014 incident implicated requirements beyond its own policy, as it asserted before the ALJ as it does on appeal that it "self-reported the incident to IDPH within 24 hours as required by law." P. Br. at 24, citing P. Ex. 14. On appeal, Leroy Manor identifies the referenced law as including 42 C.F.R. § 483.13(c)(2). RR at 17-19.

[12] https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf, accessed Sept. 9, 2016.

Conclusion

We vacate the ALJ Decision and remand this case to the ALJ for further proceedings consistent with the above discussion.

/s/
Sheila Ann Hegy

/s/
Leslie A. Sussan

/s/
Susan S. Yim
Presiding Board Member