Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Appellate Division

In the Case of:	DATE: March 4, 2008
Beverly Health Care Lumberton, CCN:34-5234, Petitioner,	Civil Remedies CR1626 App. Div. Docket No. A-07-134
	Decision No. 2156
- v. -	
Centers for Medicare & Medicaid Services.	

FINAL DECISION ON REVIEW OF ADMINISTRATIVE LAW JUDGE DECISION

On September 4, 2007, Beverly Health Care Lumberton (Lumberton) requested review of the July 20, 2007 decision of Administrative Law Judge (ALJ) Jose Anglada which sustained the imposition by the Centers for Medicare & Medicaid Services (CMS) of civil money penalties (CMPs). Beverly Health Care Lumberton, DAB CR1626 (2007) (ALJ Decision). The ALJ concluded that, from April 9, 2005 through August 4, 2005, Lumberton was not in substantial compliance with federal requirements governing participation of long-term care facilities in Medicare and State Medicaid programs relating to preventing, reporting, and implementing policies prohibiting resident abuse. The ALJ also concluded that immediate jeopardy was present during the period April 9, 2005 through April 11, 2005. The ALJ upheld a CMP of $3,050 per day during the immediate jeopardy period and a CMP of $1000 per day for the remaining period during which he found Lumberton not to be in substantial compliance.

For the reasons explained below, we sustain the ALJ Decision in its entirety.

Background[1]

Lumberton, a dually-participating long-term care facility in North Carolina, was subject to a complaint investigation ending August 4, 2005 by the North Carolina State Survey Agency (state survey agency). The surveyors determined that Lumberton was not in substantial compliance as a result of three deficiencies: 42 C.F.R. § 483.13(b) (cited as F Tag 223, for failing to provide an environment free of abuse); 42 C.F.R. § 483.13(c) (cited as F Tag 225, for failure to report abuse); and 42 C.F.R. § 483.13(c) (cited as F Tag 226, for staff treatment of residents).

Lumberton had in place a policy forbidding "any form of abuse or willful neglect of a resident." P. Ex. 11, at 6. The policy defined abuse as follows:

> Abuse is the willful infraction [sic] of injury, unreasonable confinement, intimidation or punishment that results in physical harm, pain or mental anguish. . . . This presumes that instances of abuse of any resident – even those in a coma – cause physical harm, pain or mental anguish. . . .
>
> **Physical abuse** includes hitting, slapping, pinching and kicking. It also includes controlling behavior through corporal punishment.

Id. at 7. Under Lumberton's policy, a staff person found to have committed such abuse will be disciplined by action up to and including termination and referral for prosecution. Id. If the suspected abuser is a staff person, the Executive Director (ED), Lumberton's administrator, is to place "the associate on immediate investigatory suspension while completing the investigation." Id. at 4. Lumberton's policy on reporting of abuse required that any staff person "who suspects an alleged violation **immediately** notifies the ED," who then "notifies the appropriate state agency in accordance with state law." Id. at 4 (emphasis added).

It is undisputed that applicable state law required an initial report of any allegation of abuse to the separate state reporting agency charged with monitoring professional licensing within 24

[1] We summarize here the undisputed facts in the record. The background section is meant to provide a general framework for understanding our decision. Nothing in this section is intended to be a substitute for the ALJ's findings.

hours of an incident and a follow-up report of the results of an investigation of the allegation within five working days thereafter. Federal regulations, discussed in the next section, also require a thorough investigation, with the results reported to the state survey agency. 42 C.F.R. § 483.13(c).

The most significant survey findings relating to the immediate jeopardy citations centered on an incident that occurred on Saturday night, April 9, 2005, involving Resident 2 (R2). It is undisputed that R2 was a cognitively-impaired 87-year old man with a history of repeated falls resulting in a hip fracture and with a tendency to combativeness. It is also undisputed that R2 was in a wheelchair near the nurses' station and was unfastening and holding his soft waist restraint belt when several staff members responded. Two female nurses, Nurse Marino and Nurse Taylor, sought to prevent R2 from falling. Nursing Assistant (NA) Robinson, a male aide, tried to get the belt away from R2. In that effort, the NA grabbed R2's wrists in a manner repeatedly described as "rough handling" by the facility's own witnesses. See, e.g., Tr. at 137, 140; CMS Ex. 3, at 5-7. Nurse Marino reported in a note which she gave to the Director of Nursing (DON) on Monday that R2 gave the belt to her when she told the NA to let go and then quietly asked R2 to let her hold the belt. CMS Ex. 3, at 5-7. She further reported that, during the incident, R2 became combative with the NA. One of the nurses suggested that R2 might need to go to bed. Nurse Marino reported NA Robinson saying angrily, "He's not going to bed." Id. at 6. At that point, NA Robinson alone took R2 to his room. It is undisputed that the NA changed the resident's soiled diaper and then brought him back to the nurses' station about ten minutes later. When R2 was returned, according to Nurse Marino's note, he was upset, with his eyes watery and his lips quivering. Id. She described him showing her an area of three to four inches on his right wrist displaying redness, scratches and edema, as well as redness and scratches on his hand. The resident verbalized that his wrist was "bad" and had pain when the nurse touched the radial side of his wrist. Id. at 6-7. He also said to the nurse that "you broke my heart." Id. at 6. She also reported that the next morning R2 showed her his arm with bruises now visible and said "that man, bad, bad." Id. at 7.

By the next morning, bruising was visible on his wrists which was reported to the DON on Monday morning, April 11, 2005. She then initiated an investigation of the incident after being informed of the injuries. Tr. at 104. At the time she initiated the investigation, the DON had not been informed of the events of Saturday evening by any of the staff involved; neither had anyone notified the ED. Id. That afternoon, Nurse Marino slipped her

three-page written account of the events under the DON's door while the DON was not in her office. Tr. at 105. NA Robinson had been permitted to continue work on Saturday and had worked the night shift again on Sunday, April 10, 2005 but was not in the facility on Monday. The DON notified him by telephone that day that he was suspended and later terminated his employment. The DON submitted to the state monitoring agency a form, dated April 12, 2005, making an initial 24-hour report. P. Ex. 14, at 1. A five-day follow-up report, dated April 15, 2005 and reviewed by the ED, was sent to the appropriate state reporting agency indicating that abuse was substantiated in the facility investigation. P. Ex. 14, at 2-3; Tr. at 109, 138.

In addition to the incident involving R2, the surveyors pointed to two earlier events as further evidence that Lumberton failed to follow its own policies for reporting and investigating abuse. Those events which were documented in facility complaint files involved allegations of verbal abuse of residents by staff members. In one of them, a family member filed a grievance on March 22, 2005, asserting that a nursing assistant told the resident (R1) that she "better not turn the call light back on again" because they were shortstaffed. CMS EX. 1, at 4. No action was documented until April 8, 2005, and the five-day report to the state agency was not filed until May 24, 2005. By that time the nursing assistant involved no longer worked at the facility. The second incident occurred on April 8, 2005 when a different nursing assistant was reported for having yelled at a resident (R3) according to facility records. Id. The nursing assistant involved was suspended on April 11, 2005 and terminated on April 14, 2005. A 24-hour report in the files was undated and a five-day report was not dated until April 19, 2005.

Applicable legal authority

The statutory and regulatory requirements for participation in the Medicare and Medicaid programs by a long-term care facility are found at sections 1819 and 1919 of the Social Security Act (Act), and at 42 C.F.R. Part 483. Sections 1819 and 1919 of the Act invest the Secretary of HHS with authority to impose remedies of CMPs and denial of payment for new admissions against a long-term care facility for failure to comply substantially with participation requirements.

Participating long-term care facilities are subject to the survey and enforcement procedures set out in 42 C.F.R. Part 488, subpart E, to determine if they are in substantial compliance with applicable program requirements at 42 C.F.R. Part 483, subpart B. "Substantial compliance" means a level of compliance 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. "Noncompliance," in turn, is defined as "any deficiency that causes a facility to not be in substantial compliance." Id.

A long-term care facility found not to be in substantial compliance is subject to various enforcement remedies, including a per-day CMP. 42 C.F.R. §§ 488.402(c), 488.406, 488.408, 488.430. Per-day CMP amounts may be set in the range of $3,050-10,000 for deficiencies that constitute immediate jeopardy and in the range of $50-3,000 where immediate jeopardy is not present. 42 C.F.R. § 488.438(a). The regulations set out a number of factors that CMS considers in determining the amount of a CMP. 42 C.F.R. §§ 488.438(f), 488.404.

"Immediate jeopardy" is defined as "a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident." 42 C.F.R. § 488.301. CMS's determination that a deficiency constitutes immediate jeopardy must be upheld unless it is clearly erroneous. Woodstock Care Center, DAB No. 1726, at 39 (2000) (citing 42 C.F.R. § 498.60(c)), aff'd, Woodstock Care Ctr. v. U.S. Dept. of Health and Human Servs., 363 F.3d 583 (6th Cir. 2003).

Section 483.13 of 42 C.F.R. provides in relevant part 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;
>
> * * *
>
> and

> (iii) Report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.
>
> (2) The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property 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).
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> (3) The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.
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> (4) The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.

"Abuse" is defined at 42 C.F.R. § 488.301 to mean "the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish."

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 in 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), 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. 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) (D.N.J. May 13, 1999).

Analysis

1. Substantial evidence supports the ALJ's findings that the facility failed to provide an environment free of abuse and failed to follow regulations and facility policy to report and investigate allegations of abuse.

The ALJ stated that, in reaching his conclusion that the NA's rough treatment of R2 constituted abuse, he relied heavily on the contemporaneous, detailed written statement of Nurse Marino describing the events of April 9, 2005 to resolve conflicting views of the incident. ALJ Decision at 6. Much of Lumberton's disagreement with the ALJ's conclusion rests on its view that the written statement is ambiguous and should not be read as describing abuse. Lumberton points to the DON's testimony that Nurse Marino told the DON that she (Nurse Marino) had not intended to describe the incident as abuse and that Nurse Taylor also later stated that she did not consider the event to constitute actual abuse. Tr. at 111. According to Lumberton, the ALJ should not have found that the incident amounted to abuse or an allegation of abuse when the staff members who were present later said that they did not consider it abusive.

Our role is not to reweigh evidence or reassess the credibility of witnesses appearing before the ALJ, so long as the ALJ has a reasonable basis for his view of the weight and credibility he accords to the evidence. Here, far from disregarding the conflicting evidence, as Lumberton argues, the ALJ explained clearly why he concluded that the contemporaneous written statement of Nurse Marino was the most reliable account of the events at issue.

As to the DON's report of her conversation with Nurse Marino, the ALJ could reasonably decline to give any weight to the DON's testimony about Nurse Marino's later statement that she did not consider the events abuse. First, the DON reported that the statement was made to her over the telephone when the DON contacted her months later, after the survey was underway, but there was no written documentation of this call. ALJ Decision at 7. Second, as the ALJ pointed out, Lumberton chose not to present testimony by either Nurse Marino or Nurse Taylor who were eyewitnesses to the events, despite having included both in its final witness list. Id.; Petitioner's Final Witness and Exhibit List, dated March 15, 2006. Similar considerations underlie the ALJ's discounting of Nurse Taylor's statement to the surveyor that she did not think the NA's conduct constituted abuse. Tr. at 75.

In any case, the ALJ could reasonably rely, as he did, on a contemporaneous eyewitness description of the actions and emotions of those involved in the incident to form his own conclusion about whether the NA's conduct was abusive. ALJ Decision at 7. He was not required to defer to the conclusions of facility staff about that legal assessment.

Furthermore, the written statement was far from the only evidence on which the ALJ could rely in evaluating the nature and seriousness of the NA's conduct. The contemporaneous actions and investigation results of the DON and administrator provide ample corroboration. When the DON became aware of the reported events the following Monday, she immediately suspended NA Robinson. She told the surveyor that she would have suspended the NA at the time of the events, in accordance with the facility abuse policy, had she been aware of the allegations. CMS Ex. 1, at 3. Clearly, the administrator understood that the allegation involved abuse, since she signed a verification of investigation describing the event as "alleged physical abuse," identifying the injury to the resident as bruises and contusions to the wrists, referring to the attached written statement of Nurse Marino as an investigative interview, attaching photographs of the injured wrists and forearms, and noting contact with the resident's physician and family representative on the afternoon of Monday, April 12, 2005. P. Ex. 13. The 24-hour report[2] prepared by the DON and submitted to the state agency on April 12, 2005 identified the allegation as one of "resident abuse." P. Ex. 14, at 1. The follow-up five-day report form from the state agency asked whether the allegation had been substantiated by the facility and whether the accused's employment had been terminated. Id. at 2-3. In response to both questions, the

[2] The 24-hour and five-day reports to the state reporting agency were untimely in relation to when the incident of alleged abuse occurred even though the DON acted within the prescribed time periods after she learned of the allegation. The main concern, however, raised by CMS, and expressed by the ALJ, about the treatment of R2 was that the nurses who observed the NA's conduct did not act immediately to notify the DON or ED and to protect the residents by removing the NA from the environment.

facility checked the "yes" box. Id. at 3.[3] Consistent with that report, the NA was indeed fired on April 14, 2005.

Lumberton acknowledges that neither nurse reported the incident "to anyone else at the time it occurred," despite the facility's policy. Lumberton Br. at 13. Lumberton even suggests that the nurses' failure to act promptly should be taken as evidence that they did not believe that any abuse occurred. Id. It is undisputed, however, that Nurse Marino did begin recording her observations that same Saturday evening, and those observations, as discussed above, describe abuse on their face. Her failure to complete and submit that report before the following Monday afternoon was itself a breach of facility policy to report suspected abuse immediately to the ED, and the other nurse's complete silence is even more disturbing.

Lumberton argues that the facility should not have been cited by the state survey agency because the state reporting agency did not act immediately on the facility's report of these events and ultimately concluded that it could not substantiate that the NA had abused R2. Lumberton Br. at 23-24, 36; P. Ex. 16, at 2,4. This argument fails because the issue in this proceeding is not the competence or actions of the state reporting agency but rather the compliance of the facility with federal law. Whether or not the state reporting agency was staffed on the weekend or responded promptly when notified of the allegation of abuse makes no difference to the facility's duty to identify and report abuse allegations. Nurse Marino's note makes clear that she was disturbed by the NA's treatment of R2 and sets out a description of potential abuse. Under the facility's own policy and the governing law, she was required to report this episode immediately to management. Although she began writing it up that

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[3] The DON also checked this box on the form relating to the investigation of verbal abuse of R1. P. Exs. 21, 22. Lumberton argues that the DON's findings that these abuse allegations were substantiated should be disregarded because she merely meant to indicate that the specific factual "allegations" were substantiated, not that they amounted to abuse. Lumberton Br. at 16, 24. This argument is without merit. The forms in each case plainly identify the nature of the allegation as "resident abuse," with the handwritten note "verbal" added in the case of R1. P. Ex. 14, at 2 (R2); P. Ex. 22, at 1 (R1). The DON could not reasonably have thought that, by indicating to the state reporting agency that the allegations were substantiated, she was expressing no opinion about whether the allegations constituted abuse.

Saturday evening, she waited until the next Monday afternoon to alert the DON. The fact that the state reporting agency was not able to substantiate the abuse when it performed its review for purposes of evaluating the NA's licensing based on whatever information the agency then gathered does not alter the contents of Nurse Marino's account of the events (which the ALJ credited) or retrospectively exempt the facility from its duties to create an abuse-free environment and to identify and report abuse allegations.

Lumberton suggests that this case differs from prior Board decisions in that a facility staff person is, allegedly for the first time, being cited for abuse when he was "touching a resident for an appropriate therapeutic purpose, but in a manner that allegedly was clumsy or rough." Lumberton Br. at 1, 25-27. According to Lumberton, the problem was merely that NA Robinson's "technique" was "not very good." Id. at 12. Lumberton arrives at this conclusion by painting the scenario found by the ALJ as "wildly exaggerated," while relying on its own rewriting of the events, often without any record citations. Lumberton also seeks to reinterpret the actions of administrative staff in suspending and firing the NA and filing a report of substantiated abuse as merely expressions of disapproval of technique. Lumberton compares its version of events here with a number of ALJ decisions involving various resident-staff interactions in nursing homes and draws the conclusion that the present case should have been treated more like those in which ALJs did not find abuse.

Lumberton's comparisons are ill-founded (and inaccurately summarize the cited cases). Cf. Lumberton Br. at 25, citing Anchorage of Bensenville Home, DAB CR1376 (2005) and Heritage Manor of Columbia, DAB CR995 (2003). In Anchorage, ALJ Blair did not hold that merely feeling humiliated during an "apparently clumsy" lift demonstration did not constitute abuse, as Lumberton asserts. Lumberton Br. at 25. Rather, the ALJ there found that multiple, more objective accounts of the events of the demonstration and of the resident's more contemporaneous descriptions of them undermined the resident's later claims that she had been treated in a humiliating manner. DAB CR1376 passim. Similarly, in Heritage, ALJ Kessel did not hold, as Lumberton claims, that "improper administration of insulin to a resident (without accompanying food) may have been poor nursing technique . . . but it was not 'abuse,' since the necessary regulatory element of 'willful' infliction of injury was absent." Lumberton Br. at 25. Rather, the ALJ there rejected as unreliable uncorroborated hearsay from impaired residents. The ALJ also concluded that no evidence suggested that the aide whose timing

in feeding a diabetic patient was questioned had any negative intent at all. DAB CR995. The referenced cases which found no proof of abuse thus in no way suggest that willful infliction of harm that occurs during the provision of care does not constitute abuse.

Here, the ALJ found both actual injury to R2 and "intentional and retaliatory" conduct on the part of the NA. ALJ Decision at 7. The situation in the present case bears more resemblance to the two cases which Lumberton sought to distinguish in which abuse was found. In Shiawassee County Medical Center, DAB CR989 (2002), a NA twisted a resident's hand and finger in response to a slap by the resident.[4] In Britthaven, Inc., DAB No. 2018 (2006), the Board upheld an ALJ decision finding abuse by a NA cutting a resident's fingernails after the resident scratched the NA's face, where the fingernails were cut so short they bled. In both of these instances, a NA providing care to a combative resident became angry and used unnecessary force in retaliation just as the ALJ found here that NA Robinson acted out of anger at R2 for swinging his fists and resisting restraint.

The ALJ summed up his response to the argument that the NA merely displayed inadequate caregiving skills as follows: "Roughly handling in anger an 87 year-old fragile resident cannot be considered a mere inappropriate care technique . . . ." ALJ Decision at 7. We agree. And when such handling resulted in redness, swelling, scratches and pain, the ALJ could reasonably conclude, as he did, that it constituted abuse. Lumberton

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[4] Lumberton actually quoted the ALJ's explanation of why this "spontaneous twist" constituted abuse in that "whether intended as corporal punishment, or as a restraint, [the action] amounted to willful abuse and infliction of pain upon a vulnerable resident." Lumberton Br. at 26, quoting Shiawassee. Lumberton comments that the ALJ here did not "address this precedent . . . so it is impossible to tell whether he thinks the situation here was similar." Lumberton Br. at 26. While the ALJ did not, and need not, address a prior decision by another ALJ, he did in fact make it perfectly clear that he thought the situation here "similar." The ALJ noted that the facility's anti-abuse policy included within the definition of abuse "controlling behavior through corporal punishment" as well as any willful infliction of "injury, unreasonable confinement, intimidation or punishment that results in physical harm, pain or mental anguish." ALJ Decision at 6, citing P. Ex. 7, at 7. He concluded that the NA's treatment of R2 "would constitute 'abuse' under any reading of the facility's policy." ALJ Decision at 6.

asserts that recognizing abuse that occurs during "otherwise appropriate" care would be too broad and subjective a definition. Lumberton Br. at 28-29. On the contrary, immunizing abuse that occurs in the course of resident care would exempt the willful infliction of harm in the most likely context for it to occur in a nursing facility. The circumstances which the ALJ found here fall precisely in the categories which Lumberton seeks to distinguish, i.e., retaliation against a resident for striking out or soiling himself or frustration vented against a helpless victim. Cf. Lumberton Br. at 29.

Just as Lumberton mischaracterized prior ALJ decisions and the evidence in the record in its efforts to dispute the ALJ's factual findings, its brief similarly misrepresents the ALJ's rationale in its efforts to contest his legal conclusions. In one example of this, Lumberton asserts that the ALJ "never actually made clear in his Decision what definition of 'abuse' he was applying in this case" and "specifically held that he 'found no basis or support for Petitioner's argument' that the description in CMS's Interpretive Guidelines is a useful guide for the analysis." Lumberton Br. at 20, quoting ALJ Decision at 5. In fact, what the ALJ found lacked any basis or support was Lumberton's claims that "witnesses for both parties agreed that the incident involving R2 does not fall into any of the categories of 'physical abuse'" in either the guidelines or the facility policy. ALJ Decision at 5. The ALJ concludes that, to the contrary, either definition fits the case here, stating as follows:

> When Petitioner alleges that physical abuse did not occur in this case because there was no hitting, slapping, pinching or kicking, it overlooks the mandate of the applicable federal regulations. It is clear from the federal regulation . . . that "abuse" is not limited to physical abuse such as willful hitting, slapping, pinching, or kicking. Therefore, intentional actions such as forceful grabbing and rough handling of a resident also constitute abuse.

ALJ Decision at 5. The ALJ went on to point out that the facility's own policy incorporated this standard. Id., citing P. Ex. 7, at 7.

Further, a finding that actual abuse occurred is not necessary to conclude that the facility was not in compliance with the requirement that it develop and implement policies and procedures to prohibit abuse. 42 C.F.R. § 483.13. As the Board held in a prior case, "the salient question is not whether any abuse in

fact occurred or whether [a facility] had reasonable cause to believe that any abuse occurred, but whether there was an allegation that facility staff had abused a resident." Cedar View Good Samaritan, DAB No. 1897, at 11 (2003), citing 56 Fed. Reg. 48,843-844 (Sept. 26, 1991); see also Beverly Health and Rehabilitation Center - Williamsburg, DAB No. 1748 (2000).

The ALJ here concluded that the events demonstrated a pervasive failure of Lumberton's staff to implement the facility's policy calling for immediate actions to remove the suspected abuse and alert the administration. ALJ Decision at 12. Undisputed evidence in the record supports the ALJ's findings that NA Robinson was permitted to work again on Sunday and that no report was made to the DON until Monday contrary to the facility's abuse policy. The ALJ found that both nurses who witnessed the events involving R2 failed to implement the policy's direction on immediate reporting to administration.

Nor was a finding that abuse actually occurred necessary to the ALJ's conclusion that the facility failed to report all abuse allegations to the facility administrator and to appropriate state officials. ALJ Decision at 8. As noted, R2's suspected abuse was not reported immediately to the ED. Furthermore, undisputed evidence in the record supports the ALJ's finding that the facility's reports about the alleged verbal abuse of R1 and R3 were not made within the required time frames.

In attempting to justify the belated reports of the events involving R1 and R3, Lumberton contends that the DON was "over-reporting" because she was newly hired. Lumberton Br. at 7. She reviewed facility records on abuse allegations and determined that these matters were not fully documented and proceeded to file the reports with the state. Lumberton contends that finding noncompliance based on her overaggressive reporting of past incidents in a "gray area" would only serve as a "disincentive to conduct audits, or to file reports following audits, in close or questionable cases." Id. The risk of such a disincentive could not serve as a defense against a well-supported deficiency finding. Moreover, since surveyors routinely conduct record reviews, it is unclear that facilities would somehow benefit from failing to audit their own records and correct their own errors before they are unearthed in a survey. In any case, as we pointed out above, even an allegation of abuse that turns out to be unsubstantiated (or in a "gray area") must be reported and investigated.

Lumberton further alleges that the ALJ should have discounted the testimony of the surveyor as biased because a sister of the

surveyor was employed in patient care at Lumberton. Since the primary evidence on which the ALJ relied to determine the facts of the NA's interaction with R2 were derived from Nurse Marino's account written well before the surveyor's arrival, it is difficult to see how any such bias had any influence with the ALJ. Most of the other evidence to which the ALJ refers in reaching his factual findings is equally independent of the surveyor's opinions. The surveyor testified that he had not been aware that his sister was working at Lumberton before he arrived and that she had no involvement in the incidents he reviewed. Tr. at 86. Whether or not it was good judgment for the surveyor to complete his work after learning of his sister's employment, Lumberton offers no basis to believe that the surveyor would somehow have been motivated to evaluate the events at the facility more harshly as a result.[5] In any case, the ALJ was aware of the evidence concerning the surveyor's sister and acted within his proper role in deciding how to take that into account in considering the credibility of the surveyor's testimony.

We conclude that the ALJ's findings and conclusions that Lumberton was out of substantial compliance with the three cited regulatory requirements were free of legal error and supported by substantial evidence on the record as whole.

2. CMS's determination of immediate jeopardy was not clearly erroneous.

CMS's determination that a deficiency constitutes immediate jeopardy "must be upheld unless it is clearly erroneous." 42 C.F.R. § 498.60(c) (2); Woodstock, DAB No. 1726, at 9 (2000). The burden thus rested on Lumberton to show that CMS's determination was clearly erroneous, and the ALJ found that Lumberton had not carried that burden.

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[5] Lumberton speculates that the surveyor might have "pulled his punches" regarding a complaint involving a resident to whom Lumberton asserted that the surveyor's sister had provided care and that the surveyor might have chosen instead to find "an alternative citation as a distraction." Lumberton Br. at 40, n.19. This theory makes little sense, since there was uncontradicted evidence at the hearing that the surveyor's sister did not in fact provide care during the relevant time period for the resident about whom the complaint was filed that triggered the survey. Tr. at 86. Hence, the survey results would not have reflected in any way on his sister.

Lumberton acknowledges that "[r]esident abuse is a very serious offense, and it is easy to see how delaying an investigation or report of actual abuse; failing to protect residents or suspend suspected abusers, etc., *could* endanger residents – *if there really was abuse*." Lumberton Br. at 39 (italics in original). Nevertheless, Lumberton asserts, here "CMS bootstrapped 'immediate jeopardy' out of nothing." Id. This position, of course, depends entirely on Lumberton's view of the interaction of NA Robinson with R2 as innocuous, a view which the ALJ rejected for reasons we have already found to be supported by substantial evidence on the record. Furthermore, Lumberton's assertion ignores the requirement, which we have discussed above, that any allegation of abuse must be immediately reported and thoroughly investigated without prejudging its merits. If the system does not function properly in response to an allegation that is subsequently found not to constitute abuse (unlike the situation involving R2 which the DON and ED reported as substantiated and the ALJ found to be abusive), then it is reasonable to conclude, as the ALJ did, that the system is broken and residents who may experience serious abuse cannot rely on that system to protect them. ALJ Decision at 14.

Lumberton also recognizes that a determination of immediate jeopardy, as defined at 42 C.F.R. § 488.301, does not require a finding that actual harm occurred at the level justifying the determination but only that serious harm was likely under the circumstances. Lumberton Br. at 38; see also Brightview Care Center, DAB No. 2131, at 18 (2007). In the present case, R2 indeed suffered physical harm, but the ALJ properly considered the likelihood of other, potentially even more serious events occurring as a result of the recurring failures of multiple staff members (from the nurses involved in the incident with R2, to the staff handling the verbal abuse allegations relating to R1 and R3, to the DON and the ED) to understand the nature of abuse and to act immediately and in compliance with both facility policy and federal regulations to respond effectively to any allegation of abuse.

Lumberton also disputes that the late filing of abuse allegation reports on the incidents involving R1 and R3 supported an immediate jeopardy finding in themselves, and claims that the ALJ "specifically held that all three examples" constituted immediate jeopardy, "a charge never made by CMS." Lumberton Br. at 39. Lumberton mistakes the ALJ's conclusion sustaining CMS's determination that "each of these three deficiencies constitutes immediate jeopardy." ALJ Decision at 13. The three deficiencies are the three cited regulatory requirements with which the ALJ concluded that Lumberton was out of substantial compliance. The

ALJ did not make a holding that each of the three examples (R1, R2, and R3) cited under those requirements independently constituted immediate jeopardy.[6]

We conclude that the ALJ did not err in concluding that CMS's immediate jeopardy determination was not clearly erroneous.

3. The amount and duration of the CMPs imposed by the ALJ were reasonable.

The ALJ found that immediate jeopardy was abated by April 12, 2005, rather than April 14, 2005 as originally determined by CMS. ALJ Decision at 15. He concluded that CMS's determination of immediate jeopardy for the period April 12, 2005 through April 14, 2005 was clearly erroneous. Id. CMS did not appeal this conclusion.[7]

Lumberton contends that CMS had no rationale for when immediate jeopardy began or ended. Lumberton Br. at 39-40. We disagree. The ALJ made clear that he determined that immediate jeopardy began when the facility staff failed to react properly to NA Robinson's treatment of R2 and ended when the NA was "suspended and removed from the facility." ALJ Decision at 15-16. We find no error in the ALJ's conclusion on the period of immediate jeopardy and, since the per-day CMP imposed is the lowest possible for immediate jeopardy, we need not consider the reasonableness of the amount.

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[6] Since we have concluded that Lumberton mischaracterized the ALJ's holding, we need not address whether either of these individual incidents would independently constitute immediate jeopardy. We note that, had such a determination been made, the facility would bear a heavy burden of proving it to be clearly erroneous. Liberty Commons Nursing and Rehab Center-Johnson, DAB No. 2031 (2006), aff'd sub nom, Liberty Commons Nursing and Rehab Center-Johnson v. Leavitt, 241 Fed. Appx. 76 (4th Cir. 2007).

[7] CMS did discuss in its brief its disagreement with the ALJ's reasoning. CMS Br. at 7-9. CMS does not seek to have the Board take any action based on this disagreement, however, concluding only that CMS "respectfully requests that the DAB affirm" the ALJ Decision. Id. at 9. We therefore do not review the ALJ's reduction of the period of immediate jeopardy. We note that CMS's argument on the issues that were in dispute on appeal to us consisted entirely of one sentence referencing the briefs it filed before the ALJ. CMS Br. at 9.

The ALJ also concluded that conditions in the facility after the immediate jeopardy was abated continued to constitute noncompliance, albeit at a lower level than immediate jeopardy. Id. at 16. Lumberton first argues that no systemic breakdown occurred at the facility so that no ongoing noncompliance should have been cited. Lumberton Br. at 40. Substantial evidence in the record as a whole supports the ALJ's finding that the system for preventing, identifying, investigating and reporting abuse had indeed broken down. As Lumberton recognizes, under governing law, a facility that is out of substantial compliance has the burden of demonstrating that it has corrected the noncompliant conditions and returned to substantial compliance before a CMP will be terminated. Id. Nevertheless, Lumberton argues that this burden is unfair here because "no one ever suggested to Petitioner that it was noncompliant" until the survey was triggered by an unrelated matter. Id. This argument is without merit. Lumberton was not entitled to ignore the flaws in implementation of its anti-abuse policies in its facility unless and until an external survey forced it to focus its attention on the situation. Despite its claim that it was "completely unclear" how the facility was "supposed to complete 'corrective action'" before the survey disclosed the events at issue "by happenstance," we find it clear that the facility could have begun enforcing its anti-abuse policies at any point in time and documented such measures as staff retraining and prompt and effective responses to allegations or episodes. After suspending and then terminating NA Robinson, the facility management should have been on notice that facility staff had not known how to respond promptly and effectively.

Lumberton further argues that the amount of the CMP for the non-immediate jeopardy period is excessive and that the ALJ failed to consider the factors set out in 42 C.F.R. § 488.438(e) in upholding the CMP of $1000 per day. Lumberton Br. at 41. Lumberton bases its argument on the ALJ's citation to section 488.408(g)(2), which bars facilities from appealing "*the choice of remedy, including the factors considered by CMS or the State in selecting the remedy, specified in § 488.404.*" ALJ Decision at 16, citing 42 C.F.R. § 488.408(g)(2) (italics in ALJ Decision). The ALJ appears to refer to this regulation in concluding that Lumberton's additional assertion that CMS failed to offer a rationale for its choice of remedies was without merit. The cited regulation prohibits ALJs from reviewing CMS's choice of remedies, and hence its rationale for making that choice. However, on the issue of the reasonableness of the amount of the CMP, which the ALJ may review, the ALJ went on to point out that the onus was on Lumberton to offer evidence to show that the amount was not reasonable. Lumberton does not,

however, proffer any evidence that suggests that the relevant regulatory factors, which are limited to those listed at 42 C.F.R. § 488.438(f), would dictate a lower CMP amount, merely repeating its already-rejected assertions that the noncompliance was either nonexistent or trivial. Therefore, even if we were to conclude as Lumberton suggests that the ALJ mistakenly understood section 488.408(g)(2) to restrict his consideration of the factors relevant to the reasonableness of the amount of the CMP (as opposed to the choice of a CMP as a remedy), we would find the error to be harmless here.

Conclusion

For the reasons explained above, we affirm the ALJ Decision and sustain the imposition of the CMPs at issue.

_____/s/_____
Judith A. Ballard

_____/s/_____
Sheila Ann Hegy

_____ /s/_____
Leslie A. Sussan
Presiding Board Member