Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

In the Case of:	)	
	)	
Life Care Center of Hendersonville,	)	Date: July 22, 1998
	)	
Petitioner,	)	
	)	
- v. -	)	Docket No. C-96-105
	)	Decision No. CR542
Health Care Financing	)	
Administration.	)	
	)	

DECISION

I decide that there is no basis for the Health Care Financing Administration (HCFA) to impose a civil money penalty against Petitioner, Life Care Center at Hendersonville. Briefly summarized, my decision is as follows.

HCFA's principal assertion against Petitioner is that during the period between August 14 and November 9, 1995, Petitioner tolerated physical and mental abuse of several of its residents. HCFA asserts that several of Petitioner's residents received traumatic injuries as a result of physical abuse. Other residents, according to HCFA, were mentally abused.

HCFA asserts that Petitioner essentially did nothing to prevent abuse, mistreatment or neglect of its residents or to investigate alleged episodes of abuse, neglect, or mistreatment. HCFA contends that the alleged episodes of abuse at the facility were a consequence of inadequate staffing and of ineffective administration. According to HCFA, the level of harm to residents caused by Petitioner's alleged derelictions of care was so great as to have placed the residents in a state of immediate jeopardy. HCFA proposes to remedy Petitioner's allegedly deficient care by imposing a civil money penalty against Petitioner of $6,000 per day for each day beginning with August 14, 1995 and ending on November 9, 1995.

I conclude that none of the residents of Petitioner's facility was abused, either physically or mentally. Some of the residents did suffer from traumatic injuries. These injuries were accidental. They were a consequence of the residents' illnesses and the restraint-free operation of the facility. There is no credible evidence that any of the residents were subject to mental abuse. I find that the preponderance of the evidence in this case is that Petitioner implemented policies to prevent abuse, mistreatment, or neglect of its residents. Petitioner was not derelict in investigating or reporting suspected abuse, mistreatment, or neglect. I find no credible evidence to support assertions that Petitioner was inadequately staffed or managed.

I. BACKGROUND

A. Background facts and procedural history

Petitioner is a long-term care facility that is located in Hendersonville, North Carolina. Petitioner provides nursing services to Medicare beneficiaries and to recipients of North Carolina's Medicaid program.

Petitioner was surveyed from November 6, 1995 through November 9, 1995 by surveyors who are employed by the North Carolina Department of Human Resources, Division of Facility Services (North Carolina State survey agency). An employee of HCFA was also present at the survey. At the completion of the survey, the surveyors made findings that Petitioner was not complying substantially with five federal participation requirements governing participation of long-term care facilities in Medicare and Medicaid. HCFA Ex. 5; P. Ex. 9. These alleged deficiencies were listed in the report of the survey under headings known as "tags." Ids.

The North Carolina State survey agency sent a notice to Petitioner on November 20, 1995. HCFA Ex. 1. That notice advised Petitioner that the asserted noncompliance by Petitioner with participation requirements that the surveyors identified at the November 6 - 9, 1995 survey of Petitioner constituted immediate jeopardy to Petitioner's residents. The notice stated that the findings of immediate jeopardy arose from Petitioner's alleged noncompliance with the requirements of 42 C.F.R. §§ 483.13(b) and 483.13(c). The regulations cited in the notice conform, more or less, with the requirements cited at Tags 223, 224, and 225 of the surveyors' report of the November 6 - 9, 1995 survey. See HCFA Ex. 5; P. Ex. 9. The North Carolina State survey agency advised Petitioner that it would recommend to HCFA that HCFA impose against Petitioner a civil money penalty in the amount of $3,050 per day for each day of the period beginning on August 14, 1995 and running through November 9, 1995 to remedy Petitioner's alleged past noncompliance with participation requirements. HCFA Ex. 1 at 2.

HCFA determined to impose a civil money penalty for each day of the August 14 - November 9, 1995 period that was greater than the penalty amount which the North Carolina State survey agency had recommended to HCFA that HCFA impose against Petitioner. On November 27, 1995, HCFA notified Petitioner that it intended to impose against Petitioner a civil money penalty in the amount of $6,000 per day for each day of the period which began with August 14, 1995 and which ended on November 9, 1995. HCFA Ex. 2.

Petitioner requested a hearing from HCFA's determination and the case was assigned to me for a hearing and a decision. Shortly prior to the hearing, Petitioner filed motions which addressed various issues of law. HCFA opposed these motions. I reserved ruling on the motions and advised the parties that I would rule on them as part of my decision of this case. I rule on those motions below, at Part II of this decision.

I held an in-person hearing in Asheville, North Carolina, from November 3 - November 6, 1997. At the hearing, I received into evidence exhibits from HCFA, consisting of HCFA Ex. 1 - HCFA Ex. 17. I also received into evidence exhibits from Petitioner, consisting of P. Ex. 1 - P. Ex. 26; P. Ex. 28 - P. Ex. 31; P. Ex. 34 - P. Ex. 48.

After completion of the in-person phase of the hearing, Petitioner offered as evidence four additional exhibits, consisting of P. Ex. 49 - P. Ex. 52. HCFA offered as evidence one additional exhibit, a declaration by Cynthia L. Graunke, which I have identified as HCFA Ex. 18. HCFA did not object to my receiving into evidence P. Ex. 49 - P. Ex. 52. Petitioner did not object to my receiving into evidence HCFA Ex. 18. Therefore, I receive into evidence P. Ex. 49 - P. Ex. 52 and HCFA Ex. 18.

The witnesses whom HCFA called to testify at the hearing consisted of the following individuals:

- *Norma Duncan, R.N., L.N.P.* Tr. at 230 - 314. Ms. Duncan is an employee of the North Carolina State survey agency. Id. at 231. Ms. Duncan has more than 30 years' experience as a registered nurse. Id. Additionally, Ms. Duncan is a licensed nurse practitioner. She was the North Carolina State survey agency team leader during the survey that was conducted of Petitioner from November 6 - November 9, 1995. Id. at 239.

- *Adelaide Hoffman, R. N.* Tr. at 320 - 405. Ms. Hoffman is an employee of the North Carolina State survey agency. Id. at 320. She has approximately 30 years' experience as a registered nurse. Id. at 321. Ms. Hoffman has conducted surveys of long-term care facilities to determine the facilities' compliance with Medicare participation requirements since 1989. Id. at 325. Ms. Hoffman was a member of

the survey team which conducted the November 6 - November 9, 1995 survey of Petitioner. Id. at 326.

• *Jennifer Clark, R.N.* Tr. at 406 - 492. Ms. Clark is employed by HCFA in its Division of Provider Plans and Providers. Id. at 407. In November 1995, Ms. Clark was employed by HCFA's Survey and Certification Branch. Id. Ms. Clark participated in the November 6 - November 9, 1995 survey of Petitioner as an observer and monitor of the North Carolina State survey agency surveyors. Id. at 417 - 419. Ms. Clark also did a partial record review of the treatment records of Resident 13, one of the residents of Petitioner whose care is at issue in this case. Id. at 419.

The witnesses whom Petitioner called to testify at the hearing consisted of the following individuals:

• *David L. Jackson, M.D.* Tr. at 59 - 230. Dr. Jackson is the chief executive officer of Healthware Solutions International, a quality management company in geriatrics and is also an adjunct professor of geriatrics at the Johns Hopkins University School of Medicine. Id. at 60. He formerly served as the Commissioner of Health for the State of Ohio. Id. at 61. I accepted Dr. Jackson as an expert with respect to quality of care evaluation in long-term care facilities and also with respect to investigation and determination of the existence of abuse and neglect in long-term care facilities. Id. at 63 - 67.

• *Nancy Kuss, R.N.* Tr. at 533 - 621. Ms. Kuss is President of Professional Compliance Associates, a firm whose responsibilities include providing total quality management overviews in long-term care facilities. Id. at 535. Her experience includes being a registered nurse for nearly 30 years. Id. at 534. Her experience also includes serving as part of the faculty at Temple University, where she taught courses whose subjects included identifying, handling, and preventing resident abuse at long-term care facilities. Id. at 535. Ms. Kuss has served as a surveyor with the Pennsylvania State survey agency. Id. at 536 - 538. I accepted Ms. Kuss as an expert with respect to the evaluation of the accuracy and completeness of surveys of long-term care facilities, and also with respect to the investigation of incidents for the purpose of determining whether abuse occurred at long-term care facilities. Id. at 540 - 542.

• *Michelle Morrow.* Tr. at 626 - 686. Ms. Morrow is a social worker. Id. at 627. She has been employed at Petitioner's facility since September 27, 1994 in the capacity of social worker and admissions coordinator. Id. She was present during the November 6 - November 9, 1995 survey of Petitioner's facility, except for the

morning of November 6, 1995. Id.

• *Carolyn Link.* Tr. at 690 - 719. Ms. Link is the activities director at Petitioner's facility. Id. at 692. She worked in the facility in that capacity at the time of the November 6 - November 9, 1995 survey. Id. Ms. Link's duties as activities director include speaking with every resident daily. Id.

• *Karl Pillemer, Ph. D.* Tr. at 720 - 820. Dr. Pillemer has a Ph. D. in sociology. Id. at 721. Dr. Pillemer has served as a consultant with respect to the issue of abuse of aged individuals. Id. at 728. He is a founding member of the National Commission for the Prevention of Elder Abuse. Id. at 729. He has published two books and several articles on the topic of abuse of aged individuals. Id. I accepted Dr. Pillemer as an expert with respect to the issues of investigation and evaluation of abuse and the causes of abuse in long-term care facilities. Id. at 731.

• *Raymond Dickison, Jr.* Tr. at 821 - 844. Mr. Dickison currently is the administrator of Petitioner's facility. Id. at 822. At the time of the November 6 - November 9, 1995 survey, he was the facility's assistant administrator. Id. at 822 - 823.

• *Marie Mangino, M.S.N., C.R.N.P., C.S.* Tr. at 850 - 956. Ms. Mangino has a Master's degree in the science of nursing, is licensed in the State of Pennsylvania as a nurse practitioner, and is certified by the American Nurse's Association as a geriatric nurse practitioner. Id. at 851. Her license in Pennsylvania permits her to work within the scope of her training in collaboration with a physician to examine, assess, diagnose illnesses, prescribe medications, and treat patients. Id. at 852. Ms. Mangino's graduate education is as a gerontological nurse practitioner. Id. at 853. Presently, Ms. Mangino provides clinical and educational expertise, particularly in geriatrics, to healthcare organizations in the Philadelphia area. Id. Ms. Mangino spends the majority of her time seeing patients in seven different nursing homes. Id. at 854. She is on the clinical faculty of the University of Pennsylvania's adult nurse practitioner program. Id. I accepted Ms. Mangino as an expert with respect to the quality of care provided in long-term care facilities. Id. at 858.

B. Summary of the governing law

In order to participate in Medicare, a long-term care facility such as Petitioner's facility must comply with federal participation requirements. These requirements are set forth at sections 1819 and 1919 of the Social Security Act (Act) and in regulations that are published at 42 C.F.R. Part 483.

Sections 1819 and 1919 of the Act give the Secretary of the United States Department of Health and Human Services (Secretary) authority to impose against a long-term care facility a civil money penalty for failure by the facility to comply substantially with participation requirements. These sections state, in effect, that the Secretary's authority to impose a civil money penalty against a long-term care facility is derived from the civil money penalty authority that is conferred under section 1128A of the Act. Act, sections 1819(h)(2)(B)(ii); 1919(h)(3)(C)(ii). Both sections 1819 and 1919 state that: "The provisions of section 1128A . . . shall apply to a civil money penalty . . . [imposed under either section 1819 or 1919] in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a)." Id.

The Secretary has delegated to HCFA and the States the authority to impose remedies, including civil money penalties, against a long-term care facility that is not complying substantially with federal participation requirements. 42 C.F.R. Part 488. The Part 488 regulations provide that facilities which participate in Medicare may be surveyed on behalf of HCFA by State survey agencies in order to ascertain whether the facilities are complying with participation requirements. 42 C.F.R. §§ 488.10 - 488.28. The regulations contain special survey provisions for long-term care facilities. 42 C.F.R. §§ 488.300 - 488.325. Under the Part 488 regulations, a State or HCFA may impose a civil money penalty against a long-term care facility where a State survey agency ascertains that the facility is not complying substantially with participation requirements. 42 C.F.R. §§ 488.406, 488.408, 488.430. The penalty may be imposed for each day that the facility is out of compliance. Id.

The regulations specify that a civil money penalty that is imposed against a facility will fall into one of two broad ranges of penalties. 42 C.F.R. §§ 488.408, 488.438. The upper range of civil money penalties, of from $3,050 per day to $10,000 per day, is reserved for deficiencies that constitute immediate jeopardy to a facility's residents, and, in some circumstances, for repeated deficiencies. 42 C.F.R. §§ 488.438(a)(1), (d)(2). The lower range of civil money penalties, of from $50 per day to $3,000 per day, is reserved for deficiencies that do not constitute immediate jeopardy, but either cause actual harm to residents, or cause no actual harm, but have the potential for causing more than minimal harm to residents. 42 C.F.R. § 488.438(a)(2).

The terms "substantial compliance" and "immediate jeopardy" are defined terms in the regulations which govern participation of long-term care facilities in Medicare. "Substantial compliance" is defined to mean:

> a level of compliance with the requirements of participation such that any identified deficiencies pose no greater risk to resident health or safety than the potential for causing minimal harm.

42 C.F.R. § 488.301. "Immediate jeopardy" is defined to mean:

> a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident.

Id.

A long-term care facility against which HCFA has determined to impose a civil money penalty is entitled to a hearing before an administrative law judge at which the facility may contest HCFA's determination. Act, section 1128A(c)(2); 42 C.F.R. §§ 488.408(g); 498.3(b)(12), (13); see 42 C.F.R. § 488.438(e). A relevant part of section 1128A of the Act provides that the Secretary shall not impose a civil money penalty against an individual or entity until that individual or entity has been given written notice and an opportunity for the Secretary's determination to be made on the record after a hearing at which the individual or entity is entitled to be represented by counsel, to present witnesses, and to cross-examine adverse witnesses. Act, section 1128A(c)(2). This right to a hearing under section 1128A has been interpreted uniformly to confer on a party against whom the Secretary has determined to impose a civil money penalty a right to a de novo hearing. Anesthesiologists Affiliated, et al., DAB CR65 (1990), aff'd 941 F.2d 678 (8th Cir. 1991); Tommy G. Frazier, DAB CR79 (1990), aff'd 940 F.2d 659 (6th Cir. 1991); Berney R. Keszler, M.D., et al., DAB CR107 (1990).

In a de novo hearing in a case involving a determination to impose a civil money penalty against a party, the party against whom a civil money penalty determination is made is afforded the right to contest both the determination of misconduct which is the basis for the penalty and the amount of the proposed penalty. In such a case the administrative law judge has authority to impose a penalty that is for an amount which is less than that which the agency determines to impose where the amount that is determined by the agency is not reasonable.

There are potentially two issues to be heard and decided in a case where a long-term care facility requests a hearing before an administrative law judge from a determination by HCFA to impose a civil money penalty against the facility. The first issue is whether the facility was not complying substantially with federal participation requirements on the date or dates for which HCFA determined to impose a civil money penalty. The second issue is, assuming that noncompliance is established, whether the amount of the penalty imposed by HCFA is reasonable. 42 C.F.R. §§ 488.408(g); 498.3(b)(12), (13); see 42 C.F.R. § 488.438(e). The issue of reasonableness of the penalty is not reached unless there is a finding of substantial noncompliance on which a penalty may be predicated. Id.

II. RULINGS ON PETITIONER'S MOTIONS

Petitioner styled its prehearing motions as Petitioner's motions to: (1) dismiss civil money penalties; (2) strike certain facts as a basis for imposition of immediate jeopardy; and (3) dismiss for inadequate notice. Petitioner appended documents to these motions which it labeled as exhibits and attachments. Petitioner has not moved that I receive these exhibits and attachments into evidence.

I am not receiving the exhibits and attachments into evidence, inasmuch as they appear not to be related to facts in evidence in the parties' cases-in-chief. Moreover, to receive them into evidence would be confusing, inasmuch as the exhibits and attachments to a motion bear identification numbers that duplicate identification numbers of exhibits that I have received into evidence and of exhibits and attachments that are appended to Petitioner's other motions. I am associating the exhibits and attachments with the relevant motions and they are being retained as part of the case file. They are available for review in the event that any part of my decision, including my rulings on Petitioner's motions, is appealed by either Petitioner or HCFA.

A. HCFA's overall objections to Petitioner's motions

HCFA raises two overall objections to my considering Petitioner's motions. First, HCFA asserts that the issues raised by these motions were not identified by Petitioner in its hearing request. HCFA contends, essentially, that if a party to a hearing from a determination that HCFA makes does not raise an issue in its request for a hearing, it is barred from raising that issue at a later date. Second, HCFA asserts that Petitioner's motions are untimely, inasmuch as Petitioner filed the motions close to the date of the hearing.

I do not find these overall objections to be persuasive arguments against my considering Petitioner's motions and ruling on them. First, I do not view the regulation which governs a party's hearing request as requiring a party necessarily to articulate all of its legal arguments in the initial request. Second, HCFA has not in any respect been prejudiced by Petitioner's late filing of its motions.

The regulation on which HCFA relies to assert its overall objections is 42 C.F.R § 498.40(b). Subsection (b)(1) of this regulation provides that a party that requests a hearing must identify the specific issues and findings of fact and conclusions of law with which it disagrees. Subsection (b)(2) provides that the party must specify the basis for contending that the findings and conclusions that it identifies are incorrect.

HCFA interprets the regulation as requiring that a party who requests a hearing submit a bill of particulars in its hearing request which specifies each issue of fact and law that the party intends to assert at the hearing. In HCFA's view, a party is foreclosed forever from raising issues and facts which it did not plead precisely in its hearing request.

I am not persuaded that a party that fails to articulate precisely a legal defense in a hearing request is barred forever from asserting that defense. HCFA's asserted interpretation would impinge on a party's right to due process. It ignores provisions in the Act and regulations which give the administrative law judge the flexibility to hear and decide issues and arguments that are not raised by parties in their initial notices and hearing requests. HCFA's asserted interpretation of the regulation also would impose wooden and unworkable requirements on a party who requests a hearing. It would ignore the reality that, frequently in a case, issues emerge as the case develops.

Section 1128A of the Act envisions an orderly and flexible process in which the administrative law judge manages the issues in a case with regard for each party's due process rights. What the Act plainly contemplates is that, in a case involving a hearing as to a civil money penalty determination, the administrative law judge will allow the parties to develop the issues in the prehearing phase of the case. That may include amplifying on issues that the parties have raised previously or even raising new issues as the case develops. The Act authorizes an administrative law judge to sanction a party for that party's failure to participate in an orderly prehearing process. Act, section 1128A(c)(4). These sanction authorities would have little meaning if there were not a prehearing process which included development of issues and which enabled parties who requested hearings to raise additional issues as they arose.

As I read 42 C.F.R. § 498.40(b), it requires a party who requests a hearing to identify the issues and arguments of which it is aware at the time that it requests a hearing. It does not foreclose a party from amplifying on its assertions or raising new issues as a case unfolds. In my experience, I can recall relatively few cases where new issues did not arise in the context of prehearing preparations. This likely development is acknowledged elsewhere in the regulations which govern hearings involving HCFA. Under 42 C.F.R. § 498.56, an administrative law judge specifically is authorized to hear and decide issues other than those which the parties raise in their initial notices and hearing requests.

HCFA has not identified any prejudice that it suffered as a result of Petitioner's late filing of its motions. In fact, no prejudice to HCFA has occurred. HCFA has had more than ample time to react to Petitioner's motions and to prepare its opposition to them. I reserved ruling on these motions. I gave HCFA leave to oppose the motions in its posthearing briefs. As a consequence, HCFA had approximately six months to formulate its arguments in opposition to Petitioner's motions.

B. Petitioner's motion to dismiss civil money penalties

Petitioner premises its motion to dismiss the imposition of civil money penalties against it on three arguments. The central theme which underlies each of these three arguments is that HCFA may not impose a civil money penalty against Petitioner because either HCFA, or the North Carolina State survey agency acting on HCFA's behalf, followed unlawful procedures in surveying Petitioner or in determining to impose a civil money penalty against Petitioner.

First, Petitioner asserts that the North Carolina State survey agency unlawfully failed to follow the survey requirements contained at 42 C.F.R. Part 488, Subpart C in conducting the November 6 - 9, 1995 survey of Petitioner. Second, Petitioner asserts that, in lieu of utilizing the procedures required under Subpart C, the North Carolina State survey agency unlawfully utilized procedures contained in Appendix P to the State Operations Manual. Finally, Petitioner argues that HCFA lacks authority to impose a civil money penalty against Petitioner because enforcement regulations that are codified at 42 C.F.R. §§ 488.301 et seq. were not published lawfully.

I lack authority to consider the merits of Petitioner's motion. That is because, in order to decide any of Petitioner's three arguments, I would have to decide either the lawfulness of regulations or procedures that HCFA has adopted pursuant to those regulations. The authority to decide the lawfulness of regulations or procedures has not been delegated to me.

I have the authority to interpret regulations and procedures and to decide whether HCFA has acted properly pursuant to those regulations and procedures. But, I am required to assume that regulations and procedures that the Secretary issues are legal. CarePlex of Silver Spring, DAB CR457 at 12 (1997), aff'd in part, rev'd in part, DAB No. 1627 (1997). I do not have the authority to declare that the procedures or the regulations themselves are illegal.

C. Petitioner's motion to strike certain facts as a basis for imposition of immediate jeopardy

Petitioner relies on three arguments to support its motion to strike certain facts as a basis for imposition of immediate jeopardy. First, Petitioner argues that HCFA may not base a finding of immediate jeopardy on events which transpired prior to the November 6 - 9, 1995 survey. Second, Petitioner asserts that neither the North Carolina State survey agency nor HCFA gave Petitioner any factual basis for finding that Petitioner's treatment of two residents, Residents 14 and 16, was deficient to the extent that it was a basis for a finding of immediate jeopardy. Finally, Petitioner argues that HCFA lacks authority to

impose a civil money penalty based on events that predate July 1, 1995, the effective date of the Part 488 civil money penalty enforcement regulations.

1. Petitioner's argument that HCFA may not base a finding of immediate jeopardy on events which transpired prior to the November 6 - 9, 1995 survey

Petitioner's first argument raises two issues. The first is whether evidence of noncompliance predating a survey may be the basis of a conclusion that the noncompliance continues to exist at a level of immediate jeopardy at a facility as of the date of the survey. The second is whether, as a matter of law, a civil money penalty based on findings of immediate jeopardy may be imposed retroactively to cover dates which predate a survey of the facility.

I disagree with Petitioner's argument that evidence of noncompliance predating a survey may not be the basis of a conclusion that the noncompliance continues to exist at a facility at a level of immediate jeopardy as of the date of the survey. The issue, put simply, is whether reasonable inferences may be drawn from events which occurred in the past about the current state of affairs at a facility. Whether such inferences may be drawn in a given case depends on the evidence and on the specific circumstances which prevail at a facility. But, I do not accept Petitioner's apparent argument that State survey agency surveyors and HCFA may never infer reasonably from evidence of past noncompliance that noncompliance continues to exist as of the date of the survey.

Here, the evidence that HCFA relies on consists in the main of evidence that, at dates prior to the survey, residents of Petitioner's facility suffered injuries, consisting primarily of bruises. From this evidence, the North Carolina State survey agency and HCFA concluded that residents had been abused in the past and that there was, as of the dates of the survey, a continuing likelihood that abuse might occur. At Part III of this decision, I explain why the North Carolina State survey agency's and HCFA's analysis of the evidence of the injuries that residents of Petitioner's facility incurred is flawed and why no reasonable conclusions that residents were abused or were likely to be abused may be drawn from such evidence. But, I do not find that the evidence of past injuries is irrelevant – as Petitioner contends – to the issue of whether a dangerous situation persisted at Petitioner's facility as of the dates of the survey.

I also disagree with Petitioner's argument that a civil money penalty may not be applied retroactively to address noncompliance at an immediate jeopardy level which occurred on dates prior to the dates of the survey. My ruling here is governed by the requirements of a regulation, 42 C.F.R. § 488.440(a).

The central argument that Petitioner makes with respect to retroactive application of a civil money penalty in an immediate jeopardy situation is that the purpose of a remedy in that circumstance is to deal with an ongoing situation. Petitioner argues that the Act does not permit a retroactive civil money penalty to be imposed based on survey findings that immediate jeopardy may have existed at a facility at dates which are prior to a survey.

Petitioner's arguments as to the meaning of the Act notwithstanding, the regulations expressly permit the imposition of a civil money penalty retroactively to cover deficiencies which predate a survey. I would have to find the relevant regulation to be ultra vires the Act in order to credit Petitioner's argument about the Act's reach. I have no authority to do so.

A civil money penalty may start accruing "as early as the date that the facility was first out of compliance, as determined by HCFA or the State." 42 C.F.R. § 488.440(a). On its face, the regulation permits a civil money penalty to be imposed, either for immediate jeopardy or for a lower level deficiency, retroactively, for dates which transpire prior to the dates of a compliance survey. This meaning is supported by the commentary that is contained in the preamble to the Part 488 regulations. 59 Fed. Reg. at 56206 (1994). The commentary notes that the regulation which became section 488.440(a) was revised specifically so that a penalty could begin to accrue "as early as the date that the facility was first out of compliance, as determined by HCFA or the State." Id. The preamble notes that "this revision includes the accrual of the civil money penalty for past days of noncompliance since the last standard survey *which are corrected by the time of the current survey*. . . ." Id. (Emphasis added).

2. Petitioner's argument that there is no factual basis for HCFA's findings that the care that the facility gave to Residents 14 and 16 evidenced immediate jeopardy to residents of the facility.

At the in-person hearing of this case, HCFA withdrew its allegations concerning the care that the facility allegedly gave to Residents 14 and 16. Tr. at 523 - 524. Therefore, Petitioner's motion as to whether any allegations concerning these residents are supported is moot.

3. Petitioner's argument that HCFA lacks authority to impose a civil money penalty based on events that predate July 1, 1995, the effective date of the Part 488 civil money penalty enforcement regulations

This argument relates to the care that the facility gave to Resident 16. Petitioner observes that the resident died on March 10, 1995, almost four months prior to the July 1, 1995 effective date of the civil money penalty enforcement regulations. Petitioner asserts HCFA lacks authority to impose a civil money penalty for noncompliance which predates the effective date of enforcement regulations. I find this argument to be moot, inasmuch as HCFA withdrew its allegations concerning the care that was provided to Resident 16.

D. Petitioner's motion to dismiss for inadequate notice

Petitioner asserts that the November 27, 1995 notice which HCFA sent to Petitioner, along with the accompanying statement of deficiencies, inadequately informs Petitioner of both the basis for HCFA's findings of deficiencies and the civil money penalty that HCFA determined to impose against Petitioner. Consequently, Petitioner urges that the determination to impose a civil money penalty in this case be dismissed.

1. Adequacy of HCFA's notice of deficiencies

Petitioner notes that, in a prehearing order dated May 27, 1997, I afforded HCFA the opportunity to supplement its notice to Petitioner. In that order I advised the parties that I would not receive evidence concerning an allegation by HCFA if I concluded that Petitioner had not received adequate notice of that allegation. Petitioner observes that, in a letter dated August 20, 1997, HCFA declined to provide additional statements to supplement its notice to Petitioner.

My May 27, 1997 prehearing order did not constitute a finding that HCFA's notice to Petitioner was inadequate. Rather, it afforded HCFA the option of supplementing its notice to Petitioner if HCFA determined that it wished to offer evidence or arguments at the hearing which were not subsumed within the notice it had given to Petitioner previously. HCFA concluded that its notice to Petitioner was adequate and that supplementation was unnecessary.

I do not find that the statement of deficiencies which HCFA sent to Petitioner is, on its face, inadequate. See HCFA Ex. 5; P. Ex. 9. To the contrary, I find that, for the most part, it informs Petitioner of the basis for HCFA's allegations that Petitioner was not complying substantially with participation requirements. There are, however, some portions of the statement of deficiencies that are ambiguous. I find this to be so,

particularly, with the allegations that are made under Tags 224 and 225. HCFA Ex. 5 at 10 - 15; P. Ex. 9 at 10 - 15. HCFA declined to explain or supplement these allegations. In light of that, I have done my best to interpret the allegations that were made under Tags 224 and 225. I have elected to interpret them consistent with the evidence that HCFA offered and the arguments it made in its posthearing brief. I discuss my interpretations in detail below at Findings 3 and 4.

Additionally, at the hearing of this case, I found that some of the allegations that HCFA raised on the record of the hearing went beyond the ambit of the statement of deficiencies that HCFA had sent to Petitioner. I ruled that I would not consider these allegations, inasmuch as they exceeded the boundaries of the notice that HCFA gave to Petitioner, and inasmuch as HCFA had declined the opportunity I had afforded to it to supplement its allegations. Tr. at 424 - 428. The evidence which I ruled to be out of bounds consisted of testimony as to whether Petitioner's investigation of possible abuse at the facility comported with alleged HCFA requirements governing how an investigation into possible abuse is to be conducted by a facility. I discuss this issue in more detail below at Finding 4.

2. Adequacy of HCFA's notice as to how it determined the amount of the civil money penalty

Petitioner asserts that HCFA's November 27, 1995 notice letter does not give Petitioner adequate notice of how HCFA arrived at its determination to impose a civil money penalty against Petitioner in the amount of $6,000 per day for each day that Petitioner allegedly failed to comply with participation requirements. As Petitioner notes correctly, the notice merely states that HCFA considered certain factors in arriving at the amount of the penalty without identifying the evidence that HCFA relied on and without explaining how these factors were weighed. It is fair to characterize the language of the November 27, 1995 notice to Petitioner as being boilerplate language which simply restates those factors which regulations permit HCFA to consider in determining the amount of a civil money penalty.

I find Petitioner's motion to be moot. It is unnecessary for me to decide whether the notice failed to adequately apprise Petitioner of HCFA's reasons for determining to impose a $6,000 per day civil money penalty against Petitioner. That is because there is no basis to impose a civil money penalty against Petitioner in this case. At Part III of this decision, I find that Petitioner complied substantially with applicable participation requirements.

III. ISSUES, FINDINGS OF FACT AND CONCLUSIONS OF LAW

A. Issues

The issue in this case is whether there is a basis for HCFA to impose a civil money penalty against Petitioner.

Both HCFA and Petitioner in their respective briefs addressed issues which pertain to the amount of a civil money penalty that may be imposed against a noncompliant long-term care facility. I do not decide those issues here, inasmuch as I find no basis to impose a civil money penalty against Petitioner. For the record, I note that the issues raised by the parties which I do not hear and decide in this case include the following:

- Whether a civil money penalty in the immediate jeopardy range of from $3,050 - $10,000 would be appropriate in this case had I found that Petitioner was not complying substantially with one or more participation requirements. Petitioner argued that, even if there were some deficiencies, none of them fell within the immediate jeopardy range.

- Whether any civil money penalty in the lower range of from $50 - $3,000 per day would be authorized had I found no immediate jeopardy, but had I found Petitioner not to be complying with one or more participation requirements at less than the immediate jeopardy level. Petitioner asserted that no penalty would be authorized under the unique circumstances of this case. According to Petitioner, that is so because at the time of the survey, HCFA had placed a moratorium on imposing civil money penalties for deficiencies that were at less than the immediate jeopardy level.

- Whether HCFA established a prima facie case to show the presence of requisite criteria governing the amount of a civil money penalty. Petitioner asserted that HCFA offered no evidence concerning how it determined the $6,000 per day civil money penalty that HCFA sought to impose. From this, Petitioner asserted that no civil money penalty could be imposed even if it were shown that Petitioner had failed to comply substantially with one or more participation requirements.

- Whether I have authority to consider de novo evidence which relates to the factors which govern the amount of a civil money penalty. HCFA argued that my review authority in a civil money penalty case is extremely narrow on the issue of the amount of the penalty. It asserted that I lacked authority to consider de novo evidence which relates to many of the factors that the Act and regulations identify as being relevant to deciding the amount of a civil money penalty.

B. Findings of fact and conclusions of law

I make findings of fact and conclusions of law (Findings) to support my decision that there is no basis for HCFA to impose a civil money penalty against Petitioner. I state each Finding below, as a separate heading. I discuss each Finding in detail.

1. The preponderance of the evidence is that residents of Petitioner's facility were not abused.

Central to HCFA's case against Petitioner is HCFA's contention that Petitioner tolerated physical and mental abuse of its residents. The basis for the conclusion that Petitioner was deficient under Tag 223 in the report of the November 6 - 9, 1995 survey of Petitioner is the surveyors' assertion that residents of Petitioner's facility were abused. HCFA Ex. 5 at 3; P. Ex. 9 at 3. The assertion that residents were abused is also a significant component of each of the alleged deficiencies listed at Tags 224, 225, 353, and 490 of the statement of deficiencies. HCFA. Ex. 5 at 11, 15, 17, 19; P. Ex. 5 at 11, 15, 17, 19. The residents whom the surveyors found were abused are Residents 12, 13, 14, 16, 20, and 21 (all allegations with respect to two of these residents, Residents 14 and 16, were later withdrawn by HCFA), plus three residents whom the surveyors interviewed. HCFA Ex. 5 at 3; P. Ex. 9 at 3.

The preponderance of the evidence is that none of these residents was abused. HCFA's case that some residents were abused physically is missing necessary evidence of a critical element of abuse. HCFA failed to offer any evidence that any resident of Petitioner's facility was injured willfully. For the most part, HCFA's case is premised merely on the *presence* of injuries without any evidence that some individual caused those injuries intentionally. Similarly, HCFA's assertion that some residents of Petitioner's facility were the victims of mental abuse is unsupported by any credible assertions by these residents or other evidence that the residents were the victims of willful acts.

Moreover, there is affirmative evidence which establishes a reasonable explanation other than abuse for all of the bruises and injuries on which HCFA bases its allegations of physical abuse. The weight of the evidence is that the physical injuries sustained by Residents 12, 13, 20, and 21 were accidental in nature. And, there is affirmative evidence that proves that residents of Petitioner were not abused mentally.

In part, I base my conclusions for this Finding and for my other Findings as well on the testimony of Petitioner's expert witnesses, Dr. Jackson, Ms. Kuss, Dr. Pillemer, and Ms. Mangino. Petitioner's expert witnesses gave persuasive and credible explanations for their opinions that residents of Petitioner's facility were not abused. On balance, the

testimony of these experts was far more persuasive than was the testimony that was offered by HCFA's witnesses in explaining their reasoning for finding that residents had been abused.

HCFA asserts that the opinions of the experts that Petitioner called as witnesses are impeached by the fact that the experts based their opinions on reviews of residents' treatment records and not on in-person interviews of the residents or of the persons who gave care to the residents. I disagree with HCFA's assertion that, somehow, the experts' opinions become less credible because they are based in part on reviews of treatment records and not on interviews. I am puzzled in some respect by HCFA's argument inasmuch as it is apparent to me that the North Carolina State survey agency surveyors relied on record reviews for many of their own conclusions, including their conclusions that Residents 12, 13, 20, and 21 had been abused.

The experts whom Petitioner relied on drew their conclusions not just from the treatment records they reviewed, but from their expertise and years of experience in their respective fields. The experts thoroughly reviewed the records of the care that Petitioner gave to the residents in question. I am persuaded from the testimony of Petitioner's expert witnesses that their review of the records was more thorough than that which was done by the surveyors who conducted the November 6 - 9, 1995 survey.

In fact, as was apparent from the testimony that the surveyors gave at the hearing, the surveyors badly misread or overlooked entirely substantial and significant parts of the residents' records. The analytical errors that the surveyors made contributed to their erroneous conclusions that residents of Petitioner had been abused.

I find additional support for my conclusions that no resident of Petitioner's facility was abused from the residents' treatment records which were offered into evidence by Petitioner. Also, I draw my conclusions from the testimony of Ms. Morrow and Ms. Link. These witnesses had first hand knowledge about Resident 19, whom the surveyors accused of abusing mentally three residents. Ms. Morrow and Ms. Link also had knowledge of these three residents who alleged they had been subjected to mental abuse and of evidence which impeached the credibility of these residents.

a. What constitutes "abuse"

The regulation under which Tag 223 is cited is 42 C.F.R. § 483.13(b). This section provides that a resident of a long-term care facility has a right to be free from abuse. "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."

HCFA's internal guidelines to surveyors, including the individuals who conducted the November 6 - 9, 1995 survey of Petitioner, define "abuse" to be:

> the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm or pain or mental anguish, or deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical, mental, and psychosocial well-being.

P. Ex. 34 at 317.

HCFA's definition of "abuse" is consistent with the plain meaning of the word. A necessary element of abuse is *willfulness*. There can be no abuse absent the willful infliction of harm. Accidentally inflicted injury is not abuse.

Evidence that a resident at a long-term care facility has sustained an injury is not by itself dispositive proof that the resident was abused. There must also be proof that the injury was inflicted willfully. It may be possible to infer from the nature of the injury or the circumstances which attend the injury that an injury was caused by abuse. But, an inference that an injury is the product of abuse does not flow automatically from the mere fact that an injury occurred. Otherwise, every injury could be attributed to abuse. Leaping to the conclusion that an injury is caused by abuse without evidence of willful infliction of injury would be reading the necessary element of willfulness out of the definition of the word "abuse".

That a willful cause may not be attributed automatically to an injury that is sustained by a resident of a long-term care facility is made evident by the types of individuals who are residents in long-term care facilities. The individuals who reside in long-term care facilities do so because they are unable to sustain themselves in an unprotected environment. Residents of long-term care facilities often manifest medical problems, such as dementia, unsteadiness, and weakness, which render them far more prone to accidental injuries than is the general population. Elderly individuals have blood vessels and tissue that are more fragile than are the blood vessels and tissue of individuals living in the general population. Tr. at 862. Residents of long-term care facilities are far more likely to sustain accidental bruises than is the general population. Id. at 862 - 863. Incidences of bruising in long-term care facilities occur with such frequency that it is not possible for a facility to record all of the observed bruises or to investigate all of them. Id. at 863.

In fact, as Ms. Mangino attested to, most bruises that are sustained in long-term care facilities are not caused by abuse. Tr. at 882. Falls and related trauma are the major cause of bruising sustained by elderly residents of long-term care facilities. Id.

Moreover, and somewhat paradoxically, efforts by long-term care facilities to afford residents the maximum possible freedom to attain the highest possible state of emotional well-being may actually increase the possibility that some residents will sustain accidental injuries. A facility which seeks to minimize the use of restraints in caring for its residents increases the residents' freedom of movement but it also increases the risk that residents will sustain accidental falls that cause bruises. Tr. at 69; 863 - 864. Residents of a facility, such as Petitioner's facility, which minimizes the use of restraints, are much more likely to sustain accidental injuries than are residents of a facility which employs restraints. Id. at 69.

b. Resident 13

It is apparent from the statement of deficiencies that the surveyors prepared after the November 6 - 9, 1995 survey of Petitioner's facility and from the testimony of the surveyors who conducted the survey that the surveyors believed that the alleged facts that they cited concerning Resident 13 comprise the strongest evidence that a resident of Petitioner's facility was abused physically. The statement of deficiencies contains an extensive recitation of alleged facts which the surveyors contended demonstrated that Resident 13 was abused. HCFA Ex. 5 at 3 - 6; P. Ex. 9 at 3 - 6. The statement of deficiencies asserts that the Resident sustained severe traumatic injuries on numerous occasions. It attributes all of these injuries to abuse. It suggests, without stating so explicitly, that abuse ultimately caused Resident 13's death. Ids. at 6.

The surveyors and HCFA base their conclusion that Resident 13 was abused on an inaccurate recitation of the evidence pertaining to the resident and on a flawed analysis of the evidence. Essentially, the allegation that the resident was abused is premised on the assertion that the resident was injured frequently and on the reasoning that the alleged frequency of injuries to the resident establishes abuse as the likely cause of those injuries.

HCFA offered no evidence to show that abuse may be inferred solely from a resident's history of frequently sustaining injuries. In fact, Resident 13 was not injured nearly so frequently as the surveyors and HCFA allege. Moreover, the surveyors and HCFA omitted to consider evidence which gives a far more persuasive explanation than abuse of the few injuries that Resident 13 did experience. The weight of the evidence concerning Resident 13 is that the resident was injured in a few falls – and not from abuse – that were the consequence of her physical and emotional state. The injuries sustained by the resident were exacerbated by the resident's underlying medical conditions.

HCFA asserts that, between August 30, 1995 and November 3, 1995, Resident 13 sustained 11 separate episodes of traumatic injuries which were caused by physical abuse of the resident. HCFA Ex. 5 at 3 - 6; P. Ex. 9 at 3 - 6; see Tr. 242. The 11 allegedly separate episodes of injury that the surveyors contend Resident 13 sustained are:

- On August 30, 1995, a two centimeter skin tear to the resident's left hand accompanied by bruising on the right forearm extending to the upper arm with a large hematoma on the forearm, and bruising to the resident's left knee and buttock;

- On August 31, 1995, a tennis ball sized knot with blue discoloration from just above the resident's (apparently right) elbow to her wrist, a five centimeter circular blue discolored area on her left hip and buttock, bruising on the left mid thigh towards the outside and back, and a quarter size contusion to the resident's left knee;

- On September 6, 1995, bilateral bruising to Resident 13's upper leg, hip area and perineum, subsequently documented on that same day as massive bruising to the resident's groin and upper inner thighs, and an impacted Colles fracture to the resident's left wrist;

- On September 7, 1995, a bruise on the resident's upper right chest;

- On September 16, 1995, a bruise on the lateral side of Resident 13's left knee, along with a bruise to the resident's upper back;

- On October 28, 1995, two skin tears of the resident's left arm, a bruise on the left side of her forehead, and an abrasion of the resident's right shin;

- On October 31, 1995, a large bruise on Resident 13's right temple and eyebrow, along with a bruise on her right leg;

- On November 1, 1995, bruising on the resident's inner upper thigh and side of perineum;

- On November 2, 1995, at 12:00 am, bruising on the resident's right hip and down her leg to her knee, bruising on her right inner thigh to her perineum, and a bruise to the resident's left hip;

- On November 2, 1995, at 9:00 pm, deep bruising on the lateral side of the resident's right femur, accompanied by medial bruising (apparently also to the

right leg);

• On November 3, 1995, at 3:00 am, increased bruising on the resident's right inner thigh, radiating around to her backside, buttocks, and sacrum.

HCFA Ex. 5 at 3 - 6; P. Ex. 9 at 3 - 6.

I am not persuaded that the evidence would show Resident 13 to have been abused even if she had been injured as frequently as the surveyors contend. HCFA has not offered any evidence to establish a connection between frequency of injuries and a likelihood that abuse is the cause of those injuries. But, it is manifest from the record that Resident 13 was in fact injured on only a few occasions, and not many times, as the surveyors assert to be the case.

The record establishes only a few episodes of injuries to the resident and not the 11 disconnected episodes that the surveyors depict in their statement of deficiencies. Thus, HCFA's principal basis for asserting that the resident was abused – the alleged frequency with which she sustained injuries – is not supported by the weight of the evidence in this case.

The references in the resident's treatment records to bruises and injuries depict evolving injuries that progressed over time. A series of entries in the records over a period of days which describe an evolving bruise – for example, the resident's right thigh – may not be read as documenting separate and unconnected episodes of bruising. I do not mean to suggest that the resident's injuries were less significant than they are depicted as being in the treatment records. This resident suffered some serious traumatic injuries. However, the surveyors simply were incorrect to assert that Resident 13 was injured – or, as the surveyors contended, injured as a consequence of abuse – on 11 separate occasions.

The bruises that were recorded in Resident 13's records on August 30 and 31, 1995 are a record of an evolving injury that the resident incurred on August 29, 1995. Tr. at 89 - 91; 877 - 878; 903 - 904. The injuries that were recorded in Resident 13's records on September 7, 1995 describe evolving injuries that the resident incurred on September 6, 1995. Id. at 894 - 895. The bruises and associated injuries that were recorded beginning on October 28, 1995, and the bruises and injuries that were reported on October 31, November 1, November 2, and November 3, 1995 constitute one evolving event which began with an injury the resident sustained on October 28, 1995. Id. at 898 - 903.

Neither the surveyors nor HCFA made any effort to investigate possible causes of injury to the resident other than abuse that might have provided a more reasonable explanation than abuse for the resident's injuries. Indeed, the surveyors compounded their inaccurate

reading of the record of the resident's injuries by failing to take into consideration evidence that causes other than abuse explain the injuries that the resident incurred. The statement of deficiencies omits any meaningful reference to the resident's underlying physical and mental state. See HCFA Ex. 5 at 3 - 6; P. Ex. 9 at 3 - 6. Resident 13's physical and mental state is a much more logical contributing cause of her injuries than is abuse.

The weight of the evidence is that each of the documented episodes of injuries incurred by Resident 13 was caused by an accident and was not caused by abuse of the resident. Resident 13 was an individual who was highly prone to experience traumatic accidental injuries of the very type that she sustained. The evidence plainly shows that the resident's injuries were, essentially, caused by falls experienced by the resident as a consequence of her multiple physical and mental illnesses. And, the evidence establishes that the seriousness of the injuries that the resident sustained from her falls was exacerbated by the resident's underlying medical problems.

Resident 13 was a frail, very thin individual. Tr. at 869 - 870. Resident 13 suffered illnesses which made her a likely candidate for traumatic injuries, including bruising and fractures. She had an unsteady gait. Id. at 74. Resident 13 had a documented history of falling. Id. She had multiple diagnoses of serious illnesses, including congestive heart failure. Tr. at 74; 871. The resident had sustained a stroke with consequent seizures. Ids. Resident 13 suffered from osteoporosis, with severe kyphosis, a bowing of her spine. Id. at 871. Resident 13 had documented early Alzheimer's disease and dementia. Id. at 74; 871. She had short term memory problems. Id. at 871. The resident had difficulty with simple concepts. Id. at 871-872. She was emotionally inappropriate at times. Id. at 872. She suffered from an anxiety disorder. Id. at 74; 872. Furthermore, this resident was an accident-prone individual. She resisted care and preventive measures, such as the use of bed siderails, that were designed to protect her. See id. at 91 - 92, 899 - 900.

Resident 13 suffered from thrombocytopenia. Tr. at 77 - 78; 872. This is a condition in which the resident had an inadequate amount of platelets in her blood. Ids. The condition progressed significantly through the latter months of the resident's life. Id. at 872. As a consequence, Resident 13 was more likely to bruise as a result of an injury. Id. at 77 - 78; 872.

HCFA argues that Resident 13's low platelet count does not explain the episodes of bruising that the resident sustained. HCFA asserts that there is no correlation between episodes of below-normal platelet levels in Resident 13 and the dates when the resident sustained bruises. It is not necessary, however, to find a precise correlation between the episodes of bruising and a below-normal platelet count in Resident 13 to conclude that her thrombocytopenia may have at least contributed to the degree of bruising that the

resident sustained. As Ms. Mangino pointed out in her testimony, the resident's platelet count always was at the lower end of what is considered to be acceptable, and towards the end of her life, dipped well below normal. Tr. at 885. I am persuaded from the experts' testimony that Resident 13's low platelet count contributed to the extensive bruising that the resident experienced even if it did not constitute the principal cause of her bruises. See Tr. at 901 - 902.

The most reasonable explanation of the bruising and injuries that Resident 13 was documented as sustaining on August 30 and 31, 1995 was a fall that the resident experienced on August 29, 1995. Tr. at 877 - 881. The injuries to the resident that were documented on August 30 and 31, 1995 are entirely consistent with the resident having fallen. Id. The resident herself attributed the injuries she sustained to a fall. Id. at 880. Her recollection of what happened to her was corroborated by a member of Petitioner's staff. Id. at 877.

The injuries to Resident 13 that were documented on September 6 and 7, 1995, with the exception of a chest bruise sustained by the resident, can best be explained as injuries that the resident sustained as a result of a fall. Tr. at 98; 887 - 896. They are entirely consistent with the resident's history of falls, her unsteady gait, and her tendency to bruise. Id. at 887 - 888. In the days which immediately preceded the September 6, 1995 injury, the facility's staff explicitly noted the resident's unsteady gait. Id. at 91. The chest bruise that the resident is documented having sustained on September 7, 1995 is the kind of injury that an elderly individual might experience while strapped to a gurney. Id. at 895. It is consistent with Resident 13 being transported to a hospital emergency room by ambulance on September 6, 1995. Id.

The Colles fracture that the resident sustained on September 6, 1995 is the kind of fracture that elderly individuals sustain when they attempt to break a fall. Id. at 888 - 889. A Colles fracture is a classic injury resulting from a fall. Id. at 97. A Colles fracture resulting from falls is the second most common type of fracture that elderly individuals sustain. Id. at 888 - 889.

The opinions of Petitioner's experts that the injuries that the resident incurred on September 6, 1995 were not caused by abuse is corroborated by independent practitioners who reviewed the resident's case contemporaneously with giving her treatment for the injuries she sustained. An investigation of the injuries that Resident 13 sustained on September 6, 1995 was conducted by the hospital to which the resident was sent for treatment. The hospital's staff concluded that the resident had not been abused sexually. Tr. at 94 - 96.

HCFA argues that the hospital may not have been well-equipped to investigate whether the resident was sexually abused. I find this argument to be speculative. Moreover, I find that the staff at the hospital certainly was at least as well-equipped to consider the issue of abuse as were the surveyors who reviewed Resident 13's records. And, these practitioners had the advantage of examining the resident first hand.

The most reasonable explanation for the injuries that Resident 13 sustained on October 28, 1995 is that she fell at least once on that date. Most probably, the resident fell while extracting herself from the roll belt and climbing over the side rails of her bed. Tr. at 897 - 900. Treatment records of the resident for October 28, 1995 show that she was in an agitated state. P. Ex. 3 at 583. At 3:45 p.m. on October 28, 1995, the resident was found seated in a chair, disoriented, with a skin tear on her right hand. Tr. at 121; 898; P. Ex. 10 at 49. The facility's staff attempted to put the resident to bed with a roll belt in order to keep Resident 13 from wandering. Tr. at 898; P. Ex. 10 at 49. However, two hours later, the resident was found on the floor of the facility's hallway. Tr. at 121, 898; P. Ex. 10 at 50.

c. Resident 12

The surveyors assumed that Resident 12 was abused based entirely on evidence that the resident experienced several episodes of bruising or skin tears. The statement of deficiencies essentially lists the occasions when injuries to the resident were detected by Petitioner's staff. HCFA Ex. 5 at 7 - 9; P. Ex. 9 at 7 - 9. The statement of deficiencies offers no explanation as to why the surveyors believed that these injuries were caused by physical abuse of the resident. Ids.

HCFA failed to establish even a prima facie case that Resident 12 was abused. As I find above, at subpart a. of this Finding, the mere presence of injuries to a resident of a long-term care facility is not usually by itself sufficient evidence on which to predicate a finding that the resident has been abused. Here, HCFA has offered merely the fact that the resident was injured, without attempting to show how or why the injuries it identified were caused by abuse of the resident.

The weight of the evidence establishes affirmatively that Resident 12 was not abused at Petitioner's facility. Petitioner's facility most likely had no connection with most of the injuries that the resident sustained. Many of the injuries that the surveyors identified in their statement of deficiencies were most likely caused by a single episode which predated the resident's admission to Petitioner's facility. The bruising of Resident 12 that the facility's staff recorded on September 20, September 26, and October 2, 1995, appears to relate back to an old injury that predates the resident's stay at Petitioner's facility. See Tr. 912 - 913. That stay began on September 18, 1995 when the resident

was admitted to Petitioner's facility from the hospital. What the statement of deficiencies omits to mention is that the bruises that were first recorded in the nurses' notes on September 20, 1995 were described as being yellow at the edges. P. Ex. 8 at 77. Such discoloration is evidence that a bruise is old rather than of recent origin. Tr. at 912.

The fact that many of the bruises may be traced to a single injury that predated Resident 12's admission to Petitioner's facility also is made somewhat evident by the surveyors' summary of events pertaining to the resident in the statement of deficiencies. The statement of deficiencies lists episodes of bruising to the resident that were recorded by Petitioner's staff on September 20, September 26, and October 2, 1995. It also notes that the staff observed that all bruises were "first recorded on 9/22/95." HCFA Ex. 5 at 8; P. Ex. 9 at 8; See P. Ex. 8 at 75.

Resident 12 suffered from illnesses that made the resident prone to falls and injuries. The surveyors failed to take any of the resident's history and medical condition into account in asserting that the resident had been abused. Resident 12's history and medical condition is strong evidence that accidents and not abuse most likely caused the bruising and related injuries that the resident sustained.

Resident 12 was known to have an unsteady gait and a history of having fallen on multiple occasions. Tr. at 151 - 152, 155; P. Ex. 8 at 202; See P. Ex. 8 at 261. Resident 12 was observed to have frequent loss of balance. Id. at 154; P. Ex. 8 at 202. The resident was at the low end of functioning in terms of her ability to stand. Tr. at 155. Resident 12 was noncompliant with the facility's treatment regime. Resident 12 had a tendency to get out of her roll belt and climb over bed rails. Tr. at 608.

d. Resident 20

I find that HCFA failed to establish even a prima facie case that Resident 20 was abused. HCFA's assertions of abuse rest entirely on the fact that the resident was bruised. HCFA Ex. 5 at 6 - 7; P. Ex. 9 at 6 - 7. The surveyors cited no facts to show that abuse was the likely cause of the resident's bruises.

It is not necessary for me to make additional fact findings about Resident 20. That being said, I find that the evidence that Petitioner offered concerning the resident's injuries shows persuasively that these injuries were more likely the consequence of: the resident's physical resistance to receiving care; combative behavior; and, self-inflicted harm than they were the product of some other cause.

The statement of deficiencies creates a highly misleading picture of Resident 20. The statement of deficiencies notes that the staff of Petitioner's facility attributed the resident's injuries to the fact that the resident was combative at times. HCFA Ex. 5 at 7; P. Ex. 9 at 7. The surveyors then challenge the staff's credibility by averring that: "Review of the nurses notes failed to document any combative behavior." Ids.

In fact, the treatment records of Resident 20 are replete with evidence that the resident was a highly combative individual who physically resisted care. Tr. at 133 - 135; P. Ex. 10 at 82 - 84. The evidence depicts a clear picture of an individual who was so resistant to receiving care that the bruises that were reported likely were the consequence of her resistance and hostility.

Resident 20's own physician described the resident as being cantankerous and almost hateful in her interactions with the physician and the facility's staff. P. Ex. 10 at 81. I infer from Resident 20's records that the resident was so combative that her physician ordered that she be administered medication to address the resident's behavior. See Tr. at 136; see P. Ex. 10 at 82.

The evidence shows that there were episodes of combative behavior exhibited by Resident 20 that occurred in close proximity to the dates of the bruises that were recorded in the resident's records. For example, the surveyors note that on August 14, 1995, the nurses found bruises on both sides of the resident's neck. HCFA Ex. 5 at 6; P. Ex. 9 at 6. In fact, in the days prior to the reporting of these bruises, the resident was reported to exhibit hostility to receiving care. P. Ex. 2 at 78 - 80. On August 10, 1995, four days prior to the reporting of neck bruising in Resident 20, the facility's staff reported that the resident was easily upset, frequently hostile, and that she interfered with the providing of care to her. Id. at 115.

Finally, the resident's records show also that the resident at times inflicted injuries to herself. Tr. at 592; P. Ex. 2 at 84. She had a history of pinching her face, causing it to become red and swollen. Id.

e. Resident 21

The surveyors' allegation that Resident 21 was abused once again is based solely on the fact that the resident experienced bruising. In this instance, the allegation is based on a single episode of bruising. HCFA Ex. 5 at 7; P. Ex. 9 at 7. I find that HCFA failed to establish a prima facie case that Resident 21 was abused. Here, as in other instances, HCFA relies only on the fact that the resident was bruised to support its allegation that the resident was abused. HCFA has offered no evidence to show that the bruising was caused by a willful act.

Moreover, Resident 21's records provide an explanation for the bruise that the resident sustained – which was not considered by the surveyors – but, which I find to be a far more reasonable explanation for the bruise than is the surveyors' unsupported allegation that the resident was bruised as a consequence of abuse. The most likely cause of the resident's bruise is an injury that resulted from lifting or positioning Resident 21 in the course of providing care to her.

Resident 21's treatment records describe her essentially to be helpless. She was paralyzed on her left side with limb contractures. She was unable to position herself. Tr. at 145 - 146. She manifested very poor skin turgor. Id. at 146 - 147; P. Ex. 6 at 84. As a consequence, she was at a risk to sustain bruises. Tr. at 146 - 147.

Resident 21 was receiving physical therapy to increase her range of motion in an attempt to increase the resident's physical functioning. Tr. at 146; see P. Ex. 6 at 230. Her spasticity and weakness made it difficult to position Resident 21. Id. at 146.

The record of Resident 21 is consistent with her having sustained a bruise as a consequence of her being lifted during the course of providing care to her. Resident 21 was an individual who required considerable lifting and manipulation to position her. Tr. at 148. The bruising that the surveyors noted in the statement of deficiencies involved the vicinity of the resident's chest and arm. HCFA Ex. 5 at 7; P. Ex. 9 at 7. It is the kind of bruising that is seen frequently in a patient who is lifted by placing hands underneath the patient's arms and lifting upward. Tr. at 148.

f. Residents who were allegedly subjected to mental abuse by Resident 19

The surveyors who conducted the November 6 - 9, 1995 survey alleged that three of Petitioner's residents were subjected to mental abuse by a fourth resident, Resident 19. HCFA Ex. 5 at 9 - 10; P. Ex. 9 at 9 - 10. The allegations are that: on numerous occasions, Resident 19 wandered into other residents' rooms, where he would agitate, upset, and attempt to hit other residents; that he frequently entered specific residents' rooms and on one occasion picked up a bedstand and threw it on a resident's bed, nearly hitting the resident; and, that he entered the room of and approached the bed of another resident, thereby frightening that resident.

The preponderance of the evidence establishes Resident 19 did not perpetrate mental abuse against any residents of Petitioner's facility. I base my conclusion on the following evidence and considerations.

The surveyors' allegations about the abuse that Resident 19 allegedly perpetrated are based entirely on statements that the surveyors attribute to three residents. The surveyors made no attempt to verify independently whether these attributed statements were accurate. They made no serious efforts to observe Resident 19's behavior. See Tr. at 365 - 366. The surveyors appear not to have thoroughly examined the medical records of the three residents who complained of mental abuse to determine whether these residents were credible witnesses. Nor did they interview Petitioner's staff concerning the mental acuity and credibility of the three residents who complained of mental abuse.

The statements that the three allegedly abused residents made about Resident 19's behavior are critical to HCFA's allegations of mental abuse in light of the surveyors' failure to obtain any evidence that corroborated the residents' assertions. The statements attributed to the three allegedly abused residents are not credible. It is evident from a review of the residents' records and testimony of Petitioner's staff that all three of the residents who complained of being abused mentally by Resident 19 suffered from medical problems which severely affected their credibility as witnesses. I find that the residents' complaints of mental abuse to be so lacking in credibility as to render the surveyors' allegations about the abuse which Resident 19 allegedly perpetrated to be allegations without substance.

The three residents whose accounts are mentioned in the statement of deficiencies as providing evidence of Resident 19's alleged abuse are identified by Petitioner by their initials as Residents G.K., B.S., and L.O. According to the statement of deficiencies, Resident G.K. accused Petitioner of coming into her room every afternoon and night. HCFA Ex. 5 at 9; P. Ex. 9 at 9. It is this resident who related that Resident 19 had picked up a bedstand and thrown it on her bed. Ids.

The statement of deficiencies reports Resident G.K. to be alert and oriented. Ids. The impression that the surveyors certainly intended to convey by this statement is that Resident G.K. credibly asserted that she had been abused mentally by Resident 19. In fact, the weight of the evidence is that Resident G.K. suffered from medical impairments that make her attributed assertions concerning Resident 19 on balance not credible.

First, Resident G.K. could not have seen Resident 19 well enough to identify him. Resident G.K. was legally blind as of the dates of the survey. Tr. at 376, 570, 705. Her blindness was such that she perceived only light, colors, and shapes. Id. at 376 - 377. Resident G.K. was unable to recognize individuals except by voice identification. Id. at 381 - 382. Ms. Link testified credibly that, although Resident G.K. knew Ms. Link well, Ms. Link would have to come within a foot and one-half to two feet of the resident before the resident would recognize her. Id. at 705 - 706.

Second, the surveyors' description of Resident G.K. as "alert and oriented" begs the question of whether the resident had the cognitive ability to remember events clearly and to describe them accurately. The fact that Resident G.K. was described as being alert and oriented does not mean that the resident was competent to recall the events that she alleged recalling. An alert and oriented person means that the individual is aware of his or her surroundings. It does not mean that the individual necessarily is free from memory problems or is able to recall events accurately. Id. at 574 - 576. In fact, treatment records for Resident G.K. show that she suffered from mental confusion on occasion. Tr. at 382, 570.

Third, the account of Resident 19's behavior that the surveyors attribute to Resident G.K. is unbelievable in light of Resident 19's severe physical impairments. The assertion which the surveyors attribute to Resident G.K. has Resident 19 picking up a bedstand that weighed 23.7 pounds and throwing it across Resident G.K.'s bed. See Tr. at 709. That would not be an easy feat for a healthy individual to accomplish. But, as I discuss below, Resident 19 was a wheelchair bound individual who suffered from advanced diabetes. I do not believe that Resident 19, given his physical impairments, would have been capable of picking up a 23.7 pound object from a seated position and throwing that object across another resident's bed.

Resident B.S. was the roommate of Resident G.K. The surveyors assert that Resident B.S. agreed with Resident G.K.'s account by shaking her head. HCFA Ex. 5 at 9; P. Ex. 9 at 9. I find that Resident B.S. was not capable of corroborating Resident G.K. credibly. Resident B.S. suffered from a number of medical conditions which undermine the credibility of any account that is attributed to her.

The medical conditions which affected Resident B.S. and which, in my judgment, impeach irretrievably any account that is attributed to her included: delirium, cognitive loss, dementia, mood swings, confusion with disorientation, short term memory impairment, and expressive and receptive aphasia. Tr. at 386 - 388. "Expressive aphasia" is the inability to communicate and to be understood. Id. at 572. "Receptive aphasia" is the inability to process information correctly. Id.

Resident L.O. was reported in the statement of deficiencies to be an alert and oriented individual. HCFA Ex. 5 at 9; P. Ex. 9 at 9. This resident was reported to have said that he was "scared to death" on occasions when Resident 19 entered Resident L.O.'s room and came up to the resident's bed. Ids. at 10. However, the surveyors failed to take into account facts about Resident L.O. which show the resident to be an unreliable reporter and which render his assertions to be not credible.

Resident L.O. was a cognitively impaired individual. He suffered from post-alcoholic dementia. Tr. at 393, 580. And, Resident L.O. had a history of prevaricating. Id. at 579 - 580. For example, the resident had made repeated unverified complaints that other individuals, including Resident 19 and Resident L.O.'s roommate, had hit or kicked him in the stomach, causing him to suffer from internal bleeding. Id. at 394 - 398, 577 - 579; P. Ex. 12 at 25.

The affirmative evidence offered by Petitioner about Resident 19 squarely rebuts the allegations the surveyors made concerning the abuse that Resident 19 allegedly perpetrated. Resident 19 was not capable of perpetrating abuse. Resident 19 was unable to engage in the willful activity that is a necessary element of abuse. The records of Resident 19 establish that he was a wheelchair bound individual who suffered from dementia caused by advanced diabetes. Tr. at 164; HCFA Ex. 5 at 9; P. Ex. 9 at 9. His actions, including his tendency to enter other residents' rooms and his periodic agitation, were a product of his diabetes and his dementia, and were not willful acts. Tr. at 548.

It is true that on a few occasions Resident 19 entered other residents' rooms without invitation by those residents. Tr. at 566. The resident's records show that his residence at Petitioner's facility had been interrupted by a hospital stay. When he returned to the facility, only a few days before the November 6 - 9, 1995 survey, he was placed in a room other than the room he had occupied previously. Id. at 566 - 567. Resident 19 would attempt to return to his old room as a consequence of his dementia. Id. at 566. His entry into other residents' rooms was most likely motivated by his efforts to find his old room and not by malice towards other residents. Id.

It is also true that Resident 19 would become agitated at times. His agitation was particularly apparent when his blood sugar became unstable. Tr. at 549 - 551; see Tr. at 566. When agitated, the resident would at times strike out at care givers. However, there is no evidence that the resident habitually struck out at other residents. See id. at 564 - 565. Nor is there evidence that Resident 19 engaged in planned or willful aggressive acts. His striking out was an unthinking reaction most likely caused by his diabetes.

2. Petitioner complied substantially with the participation requirement that the surveyors cited at Tag 223 of the statement of deficiencies.

The central premise of the surveyors' assertion and HCFA's determination under Tag 223 is that Petitioner tolerated the abuse of its residents. HCFA argues that this alleged toleration of abuse comprises a failure by Petitioner to comply substantially with the participation requirement stated in 42 C.F.R. § 483.13(b).

At Finding 1 of this decision, I conclude that none of the residents whose cases are cited in the statement of deficiencies were abused. For that reason, I conclude that Petitioner did not tolerate the abuse of its residents. I find that Petitioner complied substantially with the participation requirements stated in 42 C.F.R. § 483.13(b). No deficiency exists under Tag 223.

3. Petitioner complied substantially with the participation requirement that the surveyors cited at Tag 224 of the statement of deficiencies.

Under Tag 224, the surveyors concluded that Petitioner was not complying with the participation requirement that is contained in 42 C.F.R. § 483.13(c)(1)(I). HCFA Ex. 5 at 11; P. Ex. 9 at 11. The requirement in 42 C.F.R. § 483.13© is that a long-term care facility must develop and implement written policies and procedures that prohibit abuse, mistreatment or neglect of its residents and misappropriation of resident property. At subsection (c)(1)(I), the regulation states additionally that a long-term care facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion in its care of residents.

The preponderance of the evidence is that Petitioner complied substantially with the requirement that is cited under Tag 224. The allegations that Petitioner failed to comply are essentially allegations without substance. As the surveyors and HCFA acknowledge, Petitioner had a written policy designed to prevent the abuse, mistreatment or neglect of its residents. See HCFA Ex. 5 at 11; P. Ex. 9 at 11. There were no episodes of abuse at Petitioner's facility from which a failure to implement that policy may be inferred. The surveyors identified one instance in which the care of a resident was neglected. I do not find from this isolated instance that there was an overall failure by Petitioner to implement a policy designed to prevent the abuse, mistreatment or neglect of its residents. Indeed, the evidence which relates to the care of this resident shows that the resident was neglected *despite* Petitioner's implementation of its policy against abuse, mistreatment or neglect of residents.

a. What is alleged under Tag 224

The surveyors alleged that Petitioner failed to implement policies and procedures that prohibited abuse, mistreatment or neglect of 10 of the residents at Petitioner's facility. HCFA Ex. 5 at 11; P. Ex. 9 at 11. These residents included the same nine residents whose cases were cited under Tag 223. Id. The tenth resident, whose case the surveyors cited under Tag 224, but not Tag 223, is Resident 17.

The statement of deficiencies does not precisely define the nature of Petitioner's alleged noncompliance. The statement is vague in that it is unclear whether the surveyors made

alternative findings that the residents who they cited under Tag 223 as having been abused were mistreated or neglected if they were not abused.

HCFA made no supplementation or addition to the statement of deficiencies which explained whether it was contending that the residents who were cited under Tag 223 were mistreated or neglected if they were not abused. HCFA offered no evidence to show why Petitioner's care of the residents who were cited under Tag 223 would constitute mistreatment or neglect of those residents assuming that the residents were not abused. At the inception of the hearing I advised counsel for HCFA that I was concerned about the ambiguity of the allegations made under this tag and other tags. I advised counsel that, if HCFA did not explain in its posthearing brief precisely the nature of the alleged noncompliance of Petitioner under each tag, then I was likely to define the alleged noncompliance in my decision based on my reading of the relevant regulations and the allegations in the statement of deficiencies. Tr. at 21 - 24. HCFA neither stated nor suggested in its posthearing brief that it was contending that these residents had been mistreated or neglected if they were not abused.

Petitioner interpreted the statement of deficiencies to mean that the surveyors and HCFA were contending that Petitioner failed to implement policies and procedures that prohibited the *abuse* of the residents who were cited under Tag 223 and the *abuse, mistreatment* or *neglect* of Resident 17. The entire thrust of Petitioner's posthearing brief is to address these allegations in this manner. Petitioner's posthearing brief at 3; 43 - 48. If HCFA disagreed with this interpretation it could have said so in its reply brief. It did not.

The inclusion of subsection (c)(1)(I) in the citation to 42 C.F.R. § 483.13 strongly implies that the surveyors, and HCFA, relied primarily on allegations that residents were abused at Petitioner's facility as their basis for their citation under Tag 224. Otherwise, there would have been no need to include this subsection in the citation under the tag.

I interpret Tag 224 as saying that Petitioner failed to implement policies and procedures that prohibited the abuse of the residents who were cited under Tag 223 and the abuse, mistreatment or neglect of Resident 17. I have evaluated the evidence in light of my interpretation of Tag 224. However, I have also looked at the possibility that Petitioner failed to prevent the mistreatment or neglect of the nine residents whose cases are cited under Tag 223. Although I do not make detailed findings as to this issue, I conclude that Petitioner was not derelict with respect to these nine residents with respect to implementing its policy to prevent abuse, mistreatment or neglect.

b. A long-term care facility's obligations under 42 C.F.R. § 483.13(c)

It is necessary to define the obligations of a long-term care facility under 42 C.F.R. § 483.13(c) before addressing the question of whether Petitioner complied substantially with the requirements that are stated in the regulation. The regulation requires a long-term care facility to develop and implement written policies and procedures that prohibit abuse, mistreatment or neglect of residents. In evaluating a long-term care facility's compliance with the regulation, the questions that must be answered are: (1) has the facility developed written policies and procedures that prohibit abuse, mistreatment or neglect of residents; and (2) have those policies been implemented?

The surveyors acknowledged that Petitioner had developed a written policy to prohibit abuse, mistreatment or neglect of residents. HCFA Ex. 5 at 11; P. Ex. 9 at 11. Therefore, the question that must be resolved in deciding whether Petitioner complied with the obligations that are recited under Tag 224 is whether Petitioner implemented that policy.

The issue of whether a facility has implemented a policy to prevent abuse, mistreatment or neglect of residents must be resolved by looking at evidence to see whether a facility has done whatever is within its control to prevent abuse, mistreatment or neglect. That question may not be answered simply by identifying random episodes of abuse, mistreatment or neglect which may have occurred at a facility. A conclusion that a facility has failed to implement anti-abuse, mistreatment or neglect policies does not follow necessarily from evidence of an isolated episode or episodes of abuse, mistreatment or neglect. A facility may be found to have implemented the required policy even if an isolated instance of abuse, mistreatment or neglect occurs at the facility despite the facility's best efforts.

That is underscored by the guidance which HCFA gives to State survey agency surveyors. The State Operations Manual provides that:

> The intent of . . . [42 C.F.R. § 483.13(c)] is to assure that the facility has in place an effective system that . . . prevents mistreatment, neglect and abuse of residents . . . . However, *such a system cannot guarantee that a resident will not be abused; it can only assure that the facility does whatever is within its control to prevent mistreatment, neglect, and abuse of residents* . . . .

P. Ex. 34 at 319 (emphasis added).

c. HCFA's attempt to base its assertion that Petitioner failed to implement a policy to prevent abuse, mistreatment or neglect of a resident on the allegations of abuse that were made under Tag 223

A principal basis for the surveyors' and HCFA's assertion that Petitioner failed to implement a policy to prevent the abuse, mistreatment or neglect of residents is that many of Petitioners' residents allegedly were abused. This assertion is based on the allegations of abuse described under Tag 223 of the statement of deficiencies. HCFA Ex. 5 at 11; P. Ex. 9 at 11. The reasoning which underlies this assertion is that the alleged abuse of many residents of Petitioner proves that Petitioner was ineffective in implementing a policy that prevented abuse, mistreatment or neglect of its residents.

As I discuss above, the mere presence of episodes of abuse, mistreatment or neglect at a facility does not on its face answer the question of whether the facility implemented a policy to prevent abuse, mistreatment or neglect. It might be possible to infer a failure to implement a policy from repeated episodes of abuse or a pattern of abuse at a facility. However, there is no evidence in this case that there were even isolated episodes of abuse, let alone a pattern of abuse. As I find at Findings 1 and 2, the preponderance of the evidence is that none of the residents whose case is cited under Tag 223 was abused. Consequently, there is no credible evidence to support HCFA's assertion that, based on the presence of an alleged pattern of abuse at Petitioner's facility, Petitioner failed to implement its anti-abuse, mistreatment and neglect policy.

In addition to relying on evidence of an alleged pattern of abuse at Petitioner's facility, the surveyors alleged that Petitioner failed to report to its administrator, to relevant State agencies, and to law enforcement officials, episodes of suspected abuse of residents. Additionally, the surveyors asserted that Petitioner's administrator failed to document episodes of suspected abuse. HCFA Ex. 5 at 11 - 12; P. Ex. 9 at 11 - 12.

These alleged derelictions of responsibility by Petitioner are not evidence of failure by Petitioner to implement its anti-abuse policy. Petitioner had no reason to investigate "suspected" abuse or to report "suspected" abuse where no evidence existed to demonstrate even a reasonable probability that a resident was abused. There is no evidence that would lead a reasonable person even to suspect the presence of abuse in the cases of residents other than Resident 13. The evidence shows that Petitioner was diligent in reporting and investigating the possibility that Resident 13 was abused. I discuss below at Finding 4 Petitioner's efforts to assure that the case of Resident 13 was investigated thoroughly.

d. Petitioner's implementation of its policy to prevent abuse, mistreatment or neglect of its residents in the case of Resident 17

The only episode in which the surveyors correctly identified an incident in which a resident of Petitioner was neglected is the case of Resident 17. The evidence of neglect of Resident 17 describes an isolated incident and does not show that Petitioner failed to implement its policy to prevent abuse, mistreatment and neglect of its residents. The evidence establishes that Petitioner did whatever was in its control to prevent the neglect of Resident 17. See P. Ex. 34 at 319.

Summarized, the surveyors' findings with respect to Resident 17 are as follows:

> • On September 3, 1995, the resident was moved from her bed to a gerichair. The resident complained of acute left shoulder pain, evidently during or shortly after this procedure. X-rays were made of the resident's shoulder which showed abnormal findings that might be associated with a remote injury.
>
> • On a later date the resident again was moved. The resident protested being moved without the use of an assistive device, a Hoyer lift, but was moved without the use of the lift. The resident was injured as a result of this maneuver.

HCFA Ex. 5 at 12 - 13; P. Ex. 9 at 12 - 13.

It is unclear from these findings whether the surveyors and HCFA are asserting that the conduct described in the findings constitutes abuse, mistreatment, or neglect of Resident 17. I conclude that these findings and the evidence that HCFA offered at the hearing fail to show even a prima facie case that the resident was abused or mistreated. There is no evidence in the record of this case to show that Resident 17 was abused during the described episodes. There is not even a suggestion of proof that the conduct described by the surveyors was willful infliction of injury to the resident.

Furthermore, there is no evidence that the conduct that the surveyors described is "mistreatment" of Resident 17. The word "mistreatment" is not defined in the regulations. However, the common and ordinary meaning of "mistreatment" is that it involves some willfully injurious act. To "mistreat" is to treat badly or abusively. The Random House College Dictionary (1973). Mistreatment is generally considered to be a synonym for abuse. Id. The absence of proof that Resident 17 was abused also is an absence of proof that the resident was mistreated.

I do not find that the conduct that occurred on September 3, 1995 constituted neglect of Resident 17. The surveyors' allegations concerning the events of September 3, 1995 fail on their face to make out a case of neglect. The fact that the resident may have been injured during the course of being moved by a member of Petitioner's staff is not in and of itself proof that the employee was derelict in caring for the resident. The surveyors and HCFA offered no evidence to show that the employee handled Resident 17 roughly or improperly on that date. They offered no evidence to suggest that the injury the resident sustained on September 3, 1995 might have been avoidable had the employee used more care in moving the resident. Indeed, it is unclear from the resident's record that the resident actually was injured on September 3, 1995, inasmuch as the x-ray that was taken of the resident on that date attributes the findings possibly to a "remote" injury. HCFA Ex. 5 at 12; P. Ex. 9 at 12.

The evidence does show that the needs of Resident 17 were neglected on September 14, 1995. On that date, a nurse's aide whose services had been contracted for by Petitioner lifted the resident without making use of a prescribed Hoyer lift. Tr. at 186. A Hoyer lift is a mechanical lift with a sling that helps lift a patient and transport that patient. Id. The failure by the nurse's aide to use the Hoyer lift was a mistake. This error by the aide was neglect of Resident 17, because it constituted a failure by the aide to use the Hoyer lift notwithstanding explicit instructions by Petitioner to its staff that the patient not be lifted without the use of a Hoyer lift. Id. at 185 - 186.

However, this isolated episode of error does not establish that Petitioner failed to implement its policy to prevent abuse, mistreatment or neglect of its residents. To the contrary, the evidence which relates to this episode shows that Petitioner was doing all that it could reasonably be expected to do to assure that the needs of Resident 17 were not neglected. Petitioner had given express instructions to its staff concerning how the resident was to be cared for. Prior to the episode of September 14, 1995, Petitioner had posted a sign in the resident's room that instructed its staff not to move Resident 17 without the use of a Hoyer lift. Tr. at 185; 935. When Petitioner discovered the treatment error, it assured that the nurse's aide who provided the erroneous care to the resident no longer provided any services at Petitioner's facility. Id. at 186, 936. Neither the surveyors nor HCFA stated or suggested what more Petitioner might have done to prevent the neglect of Resident 17.

The efforts that Petitioner made in order to assure that Resident 17 received the correct care establish that Petitioner was not deficient in enforcing its anti-abuse, mistreatment or neglect policy with respect to this resident. I am not trying to suggest that incorrect care by Petitioner of Resident 17 may not arguably be a deficiency under the regulations. HCFA might have alleged that the failure to care for Resident 17 on September 14, 1995 constituted at least an isolated failure by Petitioner to comply with the quality of care

requirements stated at 42 C.F.R. § 483.25. It did not make this allegation.

4. Petitioner complied substantially with the participation requirement that the surveyors cited at Tag 225 of the statement of deficiencies.

Under Tag 225 the surveyors concluded that Petitioner was not complying with the participation requirement that is contained in 42 C.F.R. § 483.13(c)(1)(ii). HCFA Ex. 5 at 15; P. Ex. 9 at 15. In fact, this is a misstatement by the surveyors of their findings. As is apparent from the remainder of the tag, the surveyors found that Petitioner was not complying with the participation requirements that are stated at 42 C.F.R. §§ 483.13(c)(2), (3), and (4).

42 C.F.R. §§ 483.13(c)(2), (3), and (4) require that a long-term care facility must: immediately report to the facility's administrator and State authorities in accordance with the requirements of State law all alleged violations involving abuse, mistreatment or neglect of a resident; have evidence that all alleged violations are thoroughly investigated; prevent further potential abuse while an investigation is in process; and report the results of all investigations to the facility's administrator and to State authorities in accordance with the requirements of State law.

a. What is alleged under Tag 225

The surveyors and HCFA allege specifically that Petitioner did not comply with the requirement that suspected abuse, mistreatment or neglect be investigated and reported in that Petitioner failed to conduct in-house investigations of mistreatment, neglect or abuse of ten residents. HCFA Ex. 5 at 15; P. Ex. 9 at 15. These ten residents are the same residents whose cases are cited under Tag 224. These include the nine residents whose cases are cited under Tag 223 plus Resident 17.

Although the tag's allegations are stated in terms of Petitioner's alleged failures to investigate possible instances of abuse, mistreatment, or neglect of residents, it is apparent, both from the evidence that HCFA presented at the hearing and from its posthearing brief, that the surveyors' findings, as adopted by HCFA, are that Petitioner failed to investigate the possibility that the residents whose cases are cited under Tag 224 had been *abused.* HCFA has not offered any argument to suggest that Petitioner should have conducted investigations into the possibility that any of these residents was mistreated or neglected, if the resident was not abused. See HCFA's posthearing brief at 7 - 19. Petitioner interpreted HCFA's allegations as being allegations that Petitioner had failed to investigate the cases of the ten residents who are cited under Tag 224 for the possibility that the residents had been abused. Petitioner's posthearing brief at 43 - 48. HCFA did not assert in its reply brief that Petitioner had incorrectly framed the issue.

In any event, I have looked at the cases of the residents whose cases are cited under the tag to decide whether Petitioner should have conducted investigations into the possibility that any of them was abused, mistreated or neglected and reported its concerns to appropriate authorities.

b. Petitioner's compliance with investigation and report requirements

The conclusions that the surveyors reached under Tag 225 rest for the most part on the premise that the residents whose cases were cited were abused. From this premise the surveyors and HCFA contend that Petitioner had a duty to investigate and report these asserted episodes of abuse. A problem with this analysis is that none of these residents were abused. Findings 1, 2, 3.

Not only were the residents not abused but, with the exception of Resident 13, there is no evidence that would trigger a suspicion in a reasonable person that any of the residents was abused. Petitioner was under no duty to investigate and report injuries where no reasonable suspicion of abuse was raised by those injuries when they were viewed in their proper contexts.

HCFA seems to be asserting that the mere fact that a resident sustained a bruise or a related injury is in and of itself sufficient to trigger a duty on Petitioner's part to report the bruising to State authorities and to conduct an elaborate abuse investigation. I disagree that Petitioner is under such an obligation. The regulation does not require a facility to report and investigate every bruise. It imposes the reporting and investigation obligation on a facility only where there is evidence that would lead a reasonable person to suspect that the bruise or related injury was caused by abuse, mistreatment or neglect.

As I hold above, at Finding 1, the mere presence of an injury in a frail, elderly resident of a long-term care facility is insufficient evidence in and of itself to signal that abuse may be the cause of that injury. I am guided in this conclusion by the persuasive and unrebutted testimony of the expert witnesses who testified on behalf of Petitioner. As Ms. Mangino testified, bruising in elderly residents of long term care facilities is:

> Very common. So much so that you can't possibly be recording all of the bruises that happen, investigating all of the bruises that happen. It's just an unrealistic expectation.

Tr. at 863.

And, as Dr. Jackson testified, an injury to a resident is not per se evidence that the resident was abused, mistreated or neglected. See Tr. at 85 - 86. A bruise to a resident is not meaningful evidence of abuse when considered outside of the context of the resident's underlying medical condition or the overall conditions in the facility where the resident lives. See id.

The evidence of bruises and related injuries that Residents 12, 20, and 21 sustained does not suggest that the residents were abused, mistreated or neglected when that evidence is viewed in the context of the residents' overall conditions. As I discuss above at Finding 1, the total evidence pertaining to each of these residents provides a logical explanation for the resident's bruises and injuries other than abuse, mistreatment or neglect.

In the case of Resident 13, there was evidence of bruising that raised the possibility that the resident had been abused, although abuse ultimately was ruled out as the cause of the bruising. The injuries that Resident 13 sustained on September 6, 1995, included bruising to the inner part of the resident's thighs. Tr. at 94. As Dr. Jackson observed, the location and description of such bruising suggested the possibility that the resident had been abused sexually. Id. This injury put Petitioner on notice of the possibility that Resident 13 was the victim of sexual abuse and imposed on Petitioner a duty pursuant to 42 C.F.R. §§ 483.13(c)(2), (3), and (4) to report and investigate the injury.

Petitioner took several aggressive measures to address the possibility that Resident 13 had been abused. Petitioner sent Resident 13 to the hospital, both to have the injury treated, and also to have the hospital staff investigate the resident for the possibility that the resident may have been abused sexually. Tr. at 94. The resident's referral to the hospital emergency room included a specific request that the resident be evaluated for the possibility of sexual abuse. Id. The resident was accompanied to the hospital by a police detective and by a representative of a social service agency. Id. Petitioner also notified Resident 13's attending physician of her injuries. Id. at 96 - 97.

Petitioner prepared incident reports, not only of the September 6, 1995 injury, but of other injuries sustained by Resident 13. P. Ex. 10 at 49 - 54. These reports were reviewed by the facility's administrator and by its director of nursing, as is confirmed by their initials on each report. Id. at 49 - 53.

On September 8, 1995, Petitioner made a report of the September 6, 1995 incident to the North Carolina State survey agency's Licensure Section. P. Ex. 10 at 44. The report recited the nature and extent of Resident 13's injuries and the steps Petitioner had taken to investigate these injuries. Id. It also recounted some of the injuries that the resident had sustained previously. Id. It contained the incident reports that Petitioner had completed in connection with the injuries sustained by Resident 13. It noted that, as a precautionary

measure, the facility had instituted hourly checks of the resident. Id. In response to Petitioner's report, the Licensure Section failed to conclude that the resident had been abused, although it concluded there was some evidence the resident was neglected. HCFA Ex. 9.

Petitioner conducted an internal investigation of the injuries sustained by Resident 13. The investigation included structured interviews of the staff members who had cared for Resident 13. Tr. at 99 - 100. The questions that the staff members were asked addressed not only the events which surrounded the September 6, 1995 injuries, but addressed events occurring on dates going back as far as August 28, 1995. P. Ex. 10 at 59; See Tr. at 100-101. Petitioner interviewed at least six members of its staff. Id. at 60 - 65. It obtained additional written statements from three staff members. Id. at 67 - 70. Finally, Petitioner obtained a statement from the resident's attending physician. Id. at 71.

Ms. Duncan is the surveyor on whose testimony HCFA relies to support its assertions that Resident 13 was abused and that Petitioner failed to report and investigate abuse of Resident 13. Ms. Duncan testified that she was unable to find evidence that Petitioner had completed incident reports of the injuries sustained by Resident 13. Tr. at 244; See Tr. at 242. She testified, additionally, that Petitioner's administrator was not aware of the extensive bruising that the resident had experienced on September 6, 1995. Id. at 244.

I do not conclude that Ms. Duncan was less than truthful in her testimony. But, I conclude that her assertion that Petitioner failed to investigate the injuries sustained by Resident 13 is belied squarely by the record of this case. P. Ex. 10 at 49 - 54. So also is her assertion that the administrator of Petitioner's facility was not aware of the injuries that were sustained by the resident. Id. I conclude that Ms. Duncan must have overlooked relevant evidence in the course of conducting the survey, or may have misunderstood the significance of this evidence. There would have been no reason for Petitioner to withhold the evidence from Ms. Duncan.

The efforts that Petitioner made to investigate and report the possible abuse of Resident 13 complied fully with applicable requirements. The investigation was a thorough investigation of abuse as is required by 42 C.F.R. §§ 483.13(c)(2), (3), and (4). And, it comported with applicable standards that govern abuse investigations.

First, the evidence establishes that Petitioner aggressively and thoroughly investigated the possibility that the resident was abused. Dr. Pillemer, Petitioner's expert on the investigation of abuse in long-term care facilities, testified that the applicable standard of care which governs a facility's duty to investigate an incident of possible abuse requires the facility to perform a comprehensive investigation. Tr. at 756. Such an investigation should include examining the incident itself, but should also include interviews with staff,

and contacts with family members and appropriate medical personnel. Id. Dr. Pillemer's credible opinion was that Petitioner's efforts to investigate possible abuse of Resident 13, which I have discussed above, met this standard of care. Id. at 756 - 757.

Petitioner's efforts to investigate the circumstances relating to Resident 13's injuries included requesting that an outside source – the hospital emergency department – investigate the resident for possible evidence of sexual abuse. HCFA argues that this was an ineffective action by Petitioner. It speculates that the emergency department was ill-equipped to perform such an investigation. At Finding 1, I explain why I find this argument to be without merit.

Second, the evidence establishes that Petitioner reported its suspicions of abuse to the appropriate authorities. These included the police, the local hospital, relevant State agencies, and Petitioner's administrator and director of nursing. HCFA argues that the initials of Petitioner's administrator and director of nursing on incident reports pertaining to Resident 13 merely shows that these individuals signed off on the incident reports. It asserts that the managers' initials do not prove that they actually reviewed the reports. I disagree. The fact that these individuals signed the reports is evidence that they reviewed them. Moreover, the fact that Petitioner conducted an aggressive and comprehensive investigation into the possible abuse of Resident 13 and reported its suspicions to outside authorities is strong evidence that Petitioner's management, including its administrator and director of nursing, knew what was going on concerning the resident. I find it to be improbable that such elaborate investigation and reporting efforts could have been conducted without the knowledge – if not the direction and control – of Petitioner's management.

Finally, the evidence establishes that Petitioner undertook protective efforts to assure that Resident 13 was not abused during the pendency of the investigation into possible abuse of the resident. These included instituting hourly checks of the resident.

HCFA asserts that whatever efforts Petitioner may have made to investigate the possibility that Resident 13 was abused, these efforts failed to comprise a sufficiently comprehensive investigation. HCFA's posthearing brief at 10 - 11. This assertion is based on the testimony delivered at the hearing by Ms. Clark on behalf of HCFA. Tr. at 436. According to Ms. Clark, the investigation conducted by Petitioner was deficient in that Petitioner failed to expand its investigation to include residents other than Resident 13 who were likely targets of abuse. Id.

This assertion that Petitioner's abuse investigation failed to include a necessary element was not made in the statement of deficiencies. Nor is there anything in 42 C.F.R. § 483.13(c)(2), (3), and (4) which describes the elements of an investigation that HCFA

now asserts to be necessary. The regulation requires only that allegations of abuse be "thoroughly investigated." 42 C.F.R. § 483.13(c)(3). HCFA made its assertion for the first time at the in-person hearing that Petitioner's investigation was inadequate because it failed to include residents other than Resident 13. It did so notwithstanding that I gave HCFA the opportunity prior to the hearing to explain and supplement its allegations of deficiency and HCFA declined to do so.

HCFA made untimely its assertion that Petitioner's abuse investigation into the case of Resident 13 was inadequate. For that reason, I do not evaluate the sufficiency of Petitioner's evaluation pursuant to HCFA's asserted criteria as attested to by Ms. Clark. Moreover, I find that Dr. Pillemer's description of the applicable standards governing abuse investigations is more credible than that which was given by HCFA's witnesses, including Ms. Clark. I conclude that Petitioner's investigation of possible abuse in the case of Resident 13 met the standard for such investigations that was attested to credibly by Dr. Pillemer.

HCFA did not allege specifically that Petitioner was deficient for failing to investigate the possibility that Resident 17 was neglected. See HCFA Ex. 5 at 14 - 15; P. Ex 9 at 14 - 15. However, I have considered whether Petitioner ought to have made a thorough investigation into the possibility that the resident was neglected. I conclude that such an investigation was unnecessary. The incident which occurred in the care of Resident 17 on September 14, 1995 was not an "alleged" or suspected case of neglect which triggered a duty on Petitioner's part to conduct an investigation. See 42 C.F.R. § 483.13(c)(2). The incident plainly was caused by neglect. No investigation was needed to determine what happened to Resident 17 on that date. As I discuss above, at Finding 3, the incident occurred despite Petitioner's preventive measures. Petitioner immediately corrected the cause of the incident by refusing to continue to use the services of the nurse's aide who was negligent in caring for the resident.

5. Petitioner complied substantially with the participation requirement that the surveyors cited at Tag 353 of the statement of deficiencies.

Under Tag 353 the surveyors concluded that Petitioner was not complying with the participation requirements contained in 42 C.F.R. §§ 483.30(a)(1) and (2). HCFA Ex. 5 at 16; P. Ex. 9 at 16. These requirements are that a long-term care facility must have sufficient nursing staff on duty to provide nursing and related services so that residents may attain their highest practicable physical, mental, and psychosocial well-being. Additionally, these requirements are that a long-term care facility must provide services by sufficient numbers of designated personnel so as to provide nursing care to all residents in accordance with the residents' care plans.

a. A facility's obligations under 42 C.F.R. §§ 483.30(a)(1) and (2)

42 C.F.R. §§ 483.30(a)(1) and (2) do not directly address the quality of life that residents of a facility are entitled to receive or the quality of care that a facility must give to its residents. Those issues are addressed directly under other participation requirements, at 42 C.F.R. §§ 483.15 and 483.25. What is addressed directly under 42 C.F.R. §§ 483.30(a)(1) and (2) is the requirement that a facility have on duty adequate numbers of nursing staff and other personnel in order to provide the quality of life and care that is required under other regulations.

The staffing at a facility must be looked at directly in order to decide whether the staffing is adequate. The issue of whether a facility has adequate numbers of care-givers on its staff may not be decided by looking only at the quality of care provided by the staff or at the quality of life that is given to residents. That is because there may be more than one explanation for a facility's not providing care of a good quality or an acceptable quality of life to its residents. A facility may have adequate numbers of staff on board and may be providing inadequate care and an inadequate quality of life. By the same token, a facility may have inadequate numbers of staff on board and these individuals may be providing an excellent quality of care and life to the facility's residents.

I do not conclude that an inference may never be drawn that a facility is inadequately staffed from evidence that the facility is providing its residents with inadequate care or an inadequate quality of life. Such evidence would certainly support direct evidence of inadequate staffing and would buttress any finding that a facility is inadequately staffed. But, I conclude that a prima facie case of noncompliance with the staffing requirements cannot be based *entirely* on evidence that a facility is providing inadequate care or an inadequate quality of life. That is because there can be many other reasons other than inadequate staffing which would explain inadequate care or poor quality of life at a facility.

b. HCFA's failure to establish a prima facie case that Petitioner did not comply substantially with the requirements that are cited at Tag 353 of the statement of deficiencies

HCFA failed to present a prima facie case of noncompliance by Petitioner under Tag 353. HCFA did not present sufficient evidence so that I could find, based solely on that evidence, that Petitioner failed to comply with the requirements of 42 C.F.R. §§ 483.30(a)(1) and (2).

HCFA failed to offer any direct evidence that Petitioner was inadequately staffed. Rather, HCFA relied on the surveyors' allegations that Petitioner provided care of a poor quality and failed to give its residents an acceptable quality of life. Assuming the surveyors' allegations under Tag 353 to be true, they do not establish a nexus between asserted inadequate care and quality of life and allegedly inadequate staffing. The surveyors developed no persuasive evidence to link the inadequate care and inadequate quality of living that they alleged to a failure by Petitioner to have adequate staff. HCFA offered no evidence by which I could measure objectively whether Petitioner had inadequate numbers of staff. HCFA offered no evidence to show how many employees or contract workers Petitioner had and no evidence to show what the ratio of these individuals to residents may have been. And, most importantly, HCFA did not attempt to define any standard by which the adequacy of Petitioner's staff might be measured.

The surveyors described Petitioner's alleged noncompliance with the requirements of 42 C.F.R. §§ 483.30(a)(1) and (2) to be as follows:

> Based on medical record reviews, resident and staff interviews it was determined that the facility *failed to provide nursing and related services* to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care.

HCFA Ex. 5 at 16; P. Ex. 9 at 16 (emphasis added). It is apparent from the face of this allegation that the surveyors focused on the perceived poor quality of care and poor quality of life at Petitioner's facility. This allegation asserts only that the *services* that Petitioner provided were inadequate. It says nothing about whether Petitioner had adequate numbers of staff on duty at the facility.

The surveyors' fixation on the care that was delivered at the facility -- as opposed to the adequacy of the facility's staffing -- is made more evident by the specific examples that the surveyors cited as evidence to support their deficiency finding under Tag 353. Some of the allegations that the surveyors made to support their conclusion that staffing at the facility was inadequate do not, on their face, appear to have anything to do with inadequate staffing. These include allegations that residents had unexplained bruises and that the facility failed to have an incontinence program in place to deal with the continence problems of certain residents. HCFA Ex. 5 at 17; P. Ex. 9 at 17. Assuming the allegations to be true, they show only deficiencies in the quality of care and life at Petitioner's facility. None of these allegations explain why allegedly deficient services that Petitioner provided were the product of inadequate staffing.

The surveyors made additional allegations which do not provide evidence of inadequate staffing at Petitioner's facility. These additional allegations are that: there was a high turnover in the facility's director of nurses position; the facility used primarily nursing assistants who were contract personnel rather than employees of the facility; and that nursing assistants were given inadequate instructions concerning the care that they were to provide to residents. HCFA Ex. 5 at 17 - 18; P. Ex. 9 at 17 - 18. On their face, these allegations have nothing to do with the staffing levels at Petitioner's facility. They address, respectively, issues of morale, organization, and the quality of supervision that was being given. None of these issues is addressed by 42 C.F.R. §§ 483.30(a)(1) and (2).

The surveyors did make three allegations which, on their face, seem to address whether Petitioner had an adequate number of staff. These are that: call lights were not being answered promptly; bathing at Petitioner's facility had to be done at the convenience of Petitioner's staff because help was not always available to assist in bathing; and residents of Petitioner's facility could not always go to bed when they wanted to because there was not enough staff to assist these residents. HCFA Ex. 5 at 17; P. Ex. 9 at 17.

These last allegations fail also to establish a prima facie case that Petitioner was deficient under the staffing requirements. The allegations merely speculate why the problems described in the allegations existed at Petitioner's facility. The allegations appear to be based entirely on interviews done by the surveyors with unnamed residents and other individuals. Ids. I am not satisfied that the unattributed assertions by residents or other individuals of inadequate care due to inadequate staff is sufficiently reliable evidence to enable me to find that Petitioner lacked adequate staff to provide care, even if the assertions that inadequate care was provided are true.

A principal problem with these allegations is that, even if they accurately depict inadequate care by Petitioner's staff, they do not establish with any credibility that the inadequate care was due to inadequate staffing. The allegations that call lights were not being answered, that residents were being bathed at the convenience of Petitioner's staff, and that residents could not always go to bed when they wanted to could be as well explained by poor staff performance as they might be explained by staffing inadequacies at Petitioner's facility.

The surveyors made no effort to determine whether these allegations were in fact supported by evidence of inadequate staffing, inadequate allocation of personnel to assigned tasks, or alternatively, failures by staff to carry out assignments. There is no evidence that the surveyors made independent observations to ascertain whether the allegations were credible. Nor did the surveyors check the facility's duty rosters or employee records to verify whether inadequate staffing was, in fact, the basis for the complaints that the surveyors recorded.

In fact, all of the allegations that the surveyors made under Tag 353 -- assuming that they are true -- could as easily be explained by poor staff performance as they could be explained by inadequate numbers of staff. That precisely illustrates the point that I make above about the need to develop direct evidence of staffing patterns at a facility before concluding that the facility's staffing is inadequate. And, it explains why, in the absence of such evidence, I find that HCFA failed to make out a prima facie case under the tag of noncompliance by Petitioner.

c. Evidence which Petitioner offered that rebutted the allegations of noncompliance

Petitioner was not obligated to prove affirmatively that it complied with the staffing requirements of 42 C.F.R. §§ 483.30(a)(1) and (2). A party does not have to present affirmative proof in rebuttal where HCFA fails to establish a prima facie case to support its allegation of noncompliance.

However, Petitioner presented affirmative proof of compliance with the staffing requirements as an alternative to its assertion that HCFA failed to establish a prima facie case of noncompliance under Tag 353. The unrebutted evidence that Petitioner offered is that its staffing levels complied with applicable State requirements. I find this to be persuasive evidence that Petitioner's staffing levels were adequate in the absence of proof that there exists any federal staffing standard that would supersede State requirements.

Unlike HCFA, Petitioner offered affirmative evidence as to the staffing standard which applied to Petitioner's facility and as to Petitioner's compliance with that standard. Mr. Dickison testified credibly that, as of November, 1995, the State of North Carolina required a nursing facility such as Petitioner to provide its residents with 2.1 hours of nursing care per resident per resident day. Tr. at 835. Mr. Dickison testified that the hours of nursing care per resident per resident day figure is calculated by taking the total number of hours worked by a facility's nursing staff during a 24-hour period and dividing that number by the number of residents at the facility. Id. Mr. Dickison's unrebutted testimony was that, during the period between August 14, 1995 and November 9, 1995, Petitioner maintained a nursing care hours per resident day ratio of 2.36, thus exceeding the minimum staffing standard of the State of North Carolina. Id. at 836 - 837.

Furthermore, Petitioner proved that many of the surveyors' findings which the surveyors relied on as grounds for concluding that Petitioner was inadequately staffed are either factually incorrect or are based on faulty logic. Thus, these findings by the surveyors would not serve to establish inadequate care or an inadequate quality of life at Petitioner's facility even were I to find them to be relevant to the issue of adequacy of staffing.

I find the surveyors' allegations that residents at Petitioners' facility sustained unexplained bruises to be without merit. I have discussed in detail, at Finding 1, my reasons for concluding that reasonable explanations exist for all of the bruising that the surveyors observed.

I also find to be without merit the surveyors' allegations that Petitioner provided deficient care because it failed to have a formalized incontinence program to deal with the needs of residents who were not continent. As was testified to persuasively by Ms. Kuss, an "incontinence program" is a special program that a facility uses to train a resident who is not continent to become continent. Tr. at 594. A prerequisite for instituting an incontinence program with a resident is that the resident have the cognitive abilities to be able to learn how to become continent. Id. Only a relatively small percentage of residents of a facility who are incontinent would qualify to participate in continence training. Id. at 594 - 595. It is not necessary for a facility to develop a formalized continence program as a program that is separate from the individualized care plan that the facility develop for each of its residents. Id. Often, continence training is specified in a resident's care plan. Id.

Here, the surveyors limited their analysis to asserting that Petitioner lacked a *formalized* incontinence program to deal with the needs of more than 30 incontinent residents. The surveyors failed to consider that only a small percentage of the total number of incontinent residents likely would have benefitted from continence training. The surveyors failed to determine which, if any, of these residents would benefit from continence training. They failed to determine whether the residents' individual care plans included special instructions for continence training. In fact, as Ms. Kuss attested to, at least some of the residents' care plans contained special instructions for continence training. Tr. at 595.

I find to be unsupported by credible evidence the surveyors' assertions that call lights were not being answered promptly, that residents were not being assisted in bathing, and that residents could not go to bed when they chose to. These allegations are based entirely on unverified complaints. There is nothing in the record which would allow me to ascertain the credibility of the complaints. Indeed, there appears to be no way to determine who the complainants are so that their credibility may be tested. Moreover, the surveyors failed to adduce any corroborating evidence that these allegations are true. The surveyors made no observations of the response time to call lights, nor did they observe residents being bathed or put to bed.

I find to be unsubstantiated the surveyors' assertion that there existed a high turnover rate in Petitioner's director of nurses position. It is unclear from the statement of deficiencies what the surveyors meant when they asserted that there was a "high turnover" in the

position. HCFA offered no evidence to show how frequently the position was filled and vacated at Petitioner's facility or why the rate of turnover in the position would have been "high."

The surveyors' assertion that Petitioner's certified nursing assistants were "primarily 'agency' staff" is inaccurate in addition to being irrelevant. See HCFA Ex. 5 at 17; P. Ex. 9 at 17. Petitioner established that it did not utilize "primarily" agency personnel to provide care. The credible and unrebutted testimony of Mr. Dickison is that the percentage of nursing hours at Petitioner's facility provided by agency personnel ranged from thirty to approximately forty-two percent of total hours. Tr. at 830 - 831. Furthermore, there is no credible evidence that the care that agency personnel provided at Petitioner's facility was of a poor quality.

6. Petitioner complied substantially with the participation requirement that the surveyors cited at Tag 490 of the statement of deficiencies.

Under Tag 490 the surveyors concluded that Petitioner was not complying with the participation requirement that is contained in 42 C.F.R. § 483.75. HCFA Ex. 5 at 18 - 19; P. Ex. 9 at 18 - 19. This requirement is that a long-term care 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.

The allegations that the surveyors made under Tag 490 derived directly from the allegations that the surveyors made under Tags 223, 224, 225 and 353. HCFA Ex. 5 at 19; P. Ex. 9 at 19. Their reasoning was that, if Petitioner was deficient under these other tags, then as a matter of logic it must not have been administered effectively and efficiently. Neither the surveyors nor HCFA cited any evidence apart from the evidence that they relied to support their allegations under Tags 223, 224, 225 and 353 to support their assertions that Petitioner was deficient under Tag 490.

I have found that Petitioner was in substantial compliance with all of the requirements stated under Tags 223, 224, 225 and 353. Therefore, there is no basis for me to find that Petitioner was deficient under Tag 490.

7. There is no basis in this case for HCFA to impose a civil money penalty against Petitioner.

There is no basis for HCFA to impose a civil money penalty against Petitioner. Under section 1128A of the Act and the regulations contained at 42 C.F.R. Part 488, a civil money penalty may not be imposed against a long-term care facility that is in substantial compliance with participation requirements. Here, I have found that Petitioner was complying substantially with all of the participation requirements that HCFA alleged that Petitioner had failed to comply with.

/s/

Steven T. Kessel
Administrative Law Judge