

**STATE OF MINNESOTA  
OFFICE OF ADMINISTRATIVE HEARINGS  
FOR THE COMMISSIONER OF HEALTH**

In the Matter of Texas Terrace Health  
Care Center

**RECOMMENDED DECISION**

The above matter was the subject of an informal dispute resolution meeting conducted by Administrative Law Judge Eric L. Lipman on January 9, 2007, at the Office of Administrative Hearings. The meeting concluded on that date.

Marci Martinson, Unit Supervisor, Division of Compliance Monitoring, 1645 Energy Park Drive, Suite 300, St. Paul, MN 55108-2970 represented the Minnesota Department of Health ("the Department"). Mary Cahill also attended the meeting and made comments on behalf of the Department.

Robert F. Rodè and Lynn M. Wieczorek, Voigt, Klegon & Rode, LLC, 2550 University Avenue West, Suite 190 South, St. Paul, MN, 55114 appeared on behalf of Texas Terrace Care Center ("Texas Terrace"). The following persons also attended the meeting and made comments on behalf of the Facility: Mat Bredard, Chi Chi Osuji, Eric Osoro, Lois Sipprell and Margo Vredenburg.

As detailed in the Memorandum that follows, based upon the documentary exhibits, arguments and applicable case law, the Administrative Law Judge makes the following:

**RECOMMENDED DECISION**

Neither Citation F-223, nor Citation F-225, is supported by the underlying record; and both citations should be dismissed.

Dated this 24<sup>th</sup> day of January, 2007.

s/Erick L. Lipman  
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ERIC L. LIPMAN  
Administrative Law Judge

## NOTICE

Under Minn. Stat. § 144A.10, subdivision 16 (d) (6), this recommended decision is not binding upon the Commissioner of Health. Further, pursuant to Department of Health Information Bulletin 04-07, the Commissioner must mail a final decision to the facility, indicating whether or not the Commissioner accepts or rejects the recommended decision of the Administrative Law Judge, within 10 calendar days of receipt of this recommended decision.

## MEMORANDUM

This matter arises out of a partial extended survey and complaint investigation at Texas Terrace Care Center ("Texas Terrace"), following the report of injuries of an unknown origin to "Resident 1" – a resident of Texas Terrace.<sup>1</sup> On June 8, 2006, the Minnesota Department of Health ("MDH") issued a Statement of Deficiencies designating two "F-Tags." These "tags" set forth areas in which the Department asserts that Texas Terrace fell below the federal requirements for participation in the Medicare program. If later sustained, either or both of these deficiencies could result in the application of sanctions to Texas Terrace.

### **Factual Background on the Statement of Deficiencies**

Resident 1 is an 88-year-old woman with a range of health challenges; including advanced dementia and Alzheimer's disease, and a history of cerebral vascular accidents, atrial fibrillation and bruising.<sup>2</sup>

As detailed in her care plan, Resident 1 was dependent upon staff for all of her activities of daily living: She is incontinent of bowel and bladder; non-ambulatory; unable to toilet herself or manage her incontinence independently; unable to communicate her needs; and sometimes resistive to care.<sup>3</sup>

At approximately 5:00 p.m., on May 16, 2006, Eric Orsoro, a Nursing Assistant at Texas Terrace observed that Resident 1 had bruises along her public area, groin, legs and knees.<sup>4</sup> He summoned his supervisor, Sobhana Varghese, who in turn called another more senior nurse, Chi Chi Osuji, to examine the bruises on Resident 1.<sup>5</sup> After the examinations, and consultation

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<sup>1</sup> Consistent with the protections provided in Minn. Stat §§ 13.05 and 13.384, and the Protective Order in this matter, the moniker "Resident 1" is used in lieu of the resident's given name.

<sup>2</sup> Exhibits 37 and J-1 through J-14.

<sup>3</sup> Exhibits J-3, J-4, J-5, J-6, J-11 and J-14.

<sup>4</sup> Exhibits I-1 & I-2; Remarks of E. Osoro.

<sup>5</sup> Exhibit 12; Remarks of E. Osoro.

with the on-call nurse practitioner, it was agreed that Resident 1 would be transferred to North Memorial Hospital for further evaluation. The staff was concerned that a sexual assault may have occurred.<sup>6</sup>

Following Resident 1's arrival at North Memorial Hospital, a Sexual Assault Resource Service (SARS) nurse was summoned and, at approximately 2:00 a.m. on Sunday, May 14, 2006, the nurse undertook an examination of Resident 1.<sup>7</sup> The SARS nurse noted that obtaining a "vaginal swab was difficult because victim did not want to spread legs far enough for speculum, however labia was spread and swabs were held at introitus (the opening/entrance into the vagina) for [approximately] 10 seconds...labia was extremely bruised and swollen. Introitus was red and swollen. Bruising consistent with sexual assault."<sup>8</sup>

Still early in the morning on Sunday, May 14, Texas Terrace Administrator, Mat Bedard, was informed of the discovery of bruising on Resident 1 and of her transfer to North Memorial Medical Center for further evaluation. Mr. Bedard began his investigation of the events surrounding Resident 1's injuries by identifying the staff that had contact with Resident 1, conducting interviews of with those employees and completing a Common Entry Point Report regarding the suspected abuse.<sup>9</sup>

Resident 1 was discharged from North Memorial Hospital, back to Texas Terrace, on the morning of Sunday, May 14, 2006. The emergency Department Nursing record from North Memorial Medical Center concluded with a diagnosis of "Sexual Assault."<sup>10</sup> Pursuant to Texas Terrace's pre-existing safety plan, upon Resident 1's return to Texas Terrace the facility undertook 30 minute checks and her care was assigned to female nurse aides.<sup>11</sup>

On the following Tuesday, May 16, 2006, investigators from the Minnesota Department of Health's Office of Health Facility Complaints ("OHFC") began their inquiries into the injuries to Resident 1. The inquiries continued over the course of the following weeks – with investigators interviewing Texas Terrace staff and health care providers who were familiar with Resident 1's condition and injuries.<sup>12</sup> Likewise, investigators made a thorough review of available records.<sup>13</sup>

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<sup>6</sup> Exhibits K-1; Remarks of E. Osoro; Remarks of C. Osuji.

<sup>7</sup> Exhibits K-5 and L.

<sup>8</sup> Exhibit L-3.

<sup>9</sup> Exhibit N; Remarks of M. Bedard.

<sup>10</sup> Exhibit K-4.

<sup>11</sup> Exhibit 15.

<sup>12</sup> See, e.g., Exhibits N and O through X.

<sup>13</sup> *Id.*

As the agency's investigation proceeded apace, Texas Terrace's staff maintained their own parallel inquiry and investigations. This included interviews with staff, reviewing relevant records, and conducting examinations of Resident 1, in order to determine the causes of her injuries.<sup>14</sup>

On May 26, 2006, OHFC investigators undertook a follow-up interview with Employee J – a Texas Terrace employee who worked as a nurse aide providing care to Resident 1. As the investigators uncovered inconsistencies with, and variations from, his earlier statements, Employee J became a key person of interest in the abuse investigation.<sup>15</sup>

In the early afternoon of May 26, 2006, OHFC officials declared that residents of the facility were in "Immediate Jeopardy"<sup>16</sup> – a designation that has a specialized meaning. "Immediate Jeopardy" is defined as a situation in which a provider's noncompliance with regulatory standards "has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident."<sup>17</sup>

Less than 4 hours after Immediate Jeopardy was declared by state health officials, the designation was lifted. Officials from Texas Terrace and the Department had conferred, and agreed upon, the following action plan to protect the residents of Texas Terrace:

- Employee J would be immediately suspended;
- The checks that nursing staff were completing as to Resident 1, would be extended, at 30-minute intervals, to include all female residents on the Garden Terrace unit;
- Staffing was arranged so that any male employee who worked with Resident 1 on May 12<sup>th</sup> or 13<sup>th</sup> would have either a female staff member provide care for female residents, or at a minimum, be accompanied by a female staff member while care was performed for female residents;
- Female staff who worked with Resident 1 on May 12<sup>th</sup> or 13<sup>th</sup> would not float to another unit;
- Texas Terrace agreed to maintain the staffing plan and that adjustments to the plan would only be made by the facility's Director on Nursing;
- Staff were to be re-educated regarding abuse prevention prior to providing care; and,

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<sup>14</sup> Exhibits 26 and N; Remarks of M. Bedard and M. Vredenburg.

<sup>15</sup> See, Exhibits H-11 through H-13.

<sup>16</sup> *Id.*

<sup>17</sup> See, 42 C.F.R. § 488.301 (2005); Exhibit C-1.

- The staff supervisor would conduct random audits, at least two times each work shift, in order to assure that female staff are present during the provision of care to female residents.<sup>18</sup>

On May 30, 2006, Texas Terrace submitted to the Office of Health Facility Complaints, its own conclusions as to the source of Resident 1's injuries. Texas Terrace concluded that the injuries followed from a "failed transfer" of Resident 1 from the toilet to a nearby wheelchair, and that as a result, Resident 1 "fell backward onto the grab bars...and was subsequently hoisted by using her incontinence product and pants...to a standing position to prevent the resident from falling on the floor."<sup>19</sup>

When presented with Texas Terrace's explanation for Resident 1's injuries, the SARS nurse who examined Resident 1 on May 14 offered the following assessment: Although it was possible that Resident 1's injuries could have been caused by diaper hoisting, she doubted that the injuries from such an action would be as deep as they had been in the case of Resident 1.<sup>20</sup>

By way of a Statement of Deficiencies dated June 8, 2006, the Department issued two deficiencies to Texas Terrace: Tag F-223, alleging that the facility failed to ensure that residents are free from abuse; and F-225, alleging that the facility failed to safeguard residents from further potential abuse during the internal investigation.

While he had been earlier suspended on May 26, Texas Terrace formally terminated Employee J on June 28, 2006.<sup>21</sup> The facility asserted that safety rule violations were the basis for the termination.<sup>22</sup>

On November 1, 2006, the Office of Health Facility Complaints issued a revised report of its abuse investigations. In the revised report, OHFC remarked:

Conclusion: In preparation for a maltreatment hearing regarding a finding of sexual abuse, SARS nurse (M) indicated that although resident #1's injuries were consistent with sexual assault, the injuries could also be consistent with an incident in which the resident may have fallen on to an object (such as a grab bar) or could have been pulled to a standing position by her incontinence product. SARS nurse (M) could not conclusively state that resident #1's injuries were the result of sexual assault. In addition, employees (G, H, and K) no longer support their

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<sup>18</sup> Exhibit H-25.

<sup>19</sup> Exhibit H-11.

<sup>20</sup> Exhibits T-2 and T-5.

<sup>21</sup> Exhibit 33.

<sup>22</sup> *Id.*

initial statements that the resident's injuries appeared to be sexual in nature.

As a result of this information, sexual abuse is inconclusive. However, the preponderance of the evidence establishes that neglect of health care did occur as it relates to resident #1's unexplained injuries.<sup>23</sup>

### **Statutory and Regulatory Background**

Participation requirements for skilled nursing and other long-term care facilities in the Medicare program are set forth in 42 C.F.R. Part 483, Subpart B. Provisions governing the surveying of long-term care facilities and enforcement of their compliance with participation requirements are in 42 C.F.R. Part 488, Subparts E and F.

Federal Medicare and Medicaid authorities assure compliance with the participation requirements through regular surveys by state agencies. The survey agency reports any "deficiencies" on a standard form called a "Statement of Deficiencies."<sup>24</sup>

A "deficiency" is a failure to meet a participation requirement in 42 C.F.R. Part 483.<sup>25</sup> Deficiency findings are organized in the Statement of Deficiencies under alpha-numeric "tags," with each tag corresponding to a regulatory requirement in Part 483.<sup>26</sup> The facts alleged under each tag may include a number of survey findings, which (if upheld) would support the conclusion that a facility failed to meet the regulatory standards.

A survey agency's findings also include a determination as to the "seriousness" of each deficiency.<sup>27</sup> The seriousness of a deficiency depends upon both its "scope" and its "severity."<sup>28</sup>

When citing deficiencies, state surveyors use the CMS "Chart of Enforcement Remedies" (otherwise known as the "Scope and Severity Grid" or "the Grid"). The level of deficiency and the enforcement action to be taken is set out on each square of the Grid. Each square on the Grid has a letter

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<sup>23</sup> Exhibit 40 at 7 (emphasis and parenthetical notation in original).

<sup>24</sup> See, 42 C.F.R. § 488.325 (a) (2005); CMS State Operations Manual, Appendix P, Section IV.

<sup>25</sup> See, 42 C.F.R. § 488.301 (2005).

<sup>26</sup> CMS State Operations Manual, Appendix P, Section IV.

<sup>27</sup> See, 42 C.F.R. § 488.404 (2005).

<sup>28</sup> Exhibit C-1.

designation. “A” is the least serious designation and “L” is the most serious designation.<sup>29</sup>

A facility becomes subject to remedial action under the participation agreement when it is not in “substantial compliance” with one or more regulatory standards.<sup>30</sup> A facility is not in substantial compliance with a participation requirement if there is a deficiency that creates at least the “potential for more than minimal harm” to one or more residents.<sup>31</sup>

If a facility is found not to be in “substantial compliance,” CMS may either terminate the facility's provider agreement or allow the facility the opportunity to correct the deficiencies pursuant to a plan of correction.<sup>32</sup> Further, CMS may, based upon the severity of the deficiencies, impose an intermediate remedy, such as a monetary penalty, for each day in which the facility was not in substantial compliance with the terms of the participation agreement.<sup>33</sup>

Lastly, Minnesota Statutes §144A.10, Subdivision 16, establishes a process for independent and informal resolution of disputes between survey agencies and health care providers with a participation agreement. In this request for Informal Dispute Resolution, Texas Terrace challenges the June 8, 2006 findings and submits two F-Tags for review.

### **Tag F-223 – Resident 1’s Right to Be Free From Abuse**

The surveyors found a violation of 42 C.F.R. 483.13 and assigned a severity and scope level of “J” – meaning that the deficiency was one that “results in immediate jeopardy to resident health and safety,” but was “isolated” in its scope.<sup>34</sup> The deficiency alleges that Texas Terrace failed to safeguard Resident 1 from “significant, unexplained injuries that were consistent with sexual assault.”<sup>35</sup>

Texas Terrace, for its part, replies that the bruising to Resident 1 followed from the isolated negligence of a now-terminated employee, who failed to follow facility procedures when transferring Resident 1 from the toilet to a wheelchair.<sup>36</sup>

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<sup>29</sup> Exhibit C-4.

<sup>30</sup> See, 42 C.F.R. § 488.400 (2005).

<sup>31</sup> See, 42 C.F.R. § 488.301 (2005).

<sup>32</sup> See, 42 C.F.R. §§ 488.402, 488.406 and 488.412. (2005).

<sup>33</sup> See, 42 C.F.R. §§ 488.406, 488.408 and 488.440 (2005).

<sup>34</sup> Exhibit C-4.

<sup>35</sup> Exhibit H-2.

<sup>36</sup> Exhibit 6 and H-11.

Nursing homes are required to comply with the standards set out in 42 C.F.R. § 483.13, which states:

The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.<sup>37</sup>

While the term “abuse” is not separately defined in 42 C.F.R. Part 483 (relating to the “Requirements for States and Long Term Care Facilities”), the term is defined in a related part; the Survey, Certification and Enforcement Procedures of Part 488. In analogous cases, the Departmental Appeals Board of the U.S. Department of Health has held that this definition should be used in interpreting the term “abuse” in section 483.13 (b).<sup>38</sup> In Part 488, “abuse” is defined to mean “the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish.”<sup>39</sup>

The Department’s argument as to this tag falters because there is no evidence in the record that the injuries sustained by Resident 1, presumably at the hands of Employee J,<sup>40</sup> followed from willful misconduct. In that way, this case differs markedly from cases in which an F-223 tag has been sustained; cases where there was some deliberate misconduct – a slap, kick or other overreaching – to a vulnerable adult.<sup>41</sup>

While both CMS, and its predecessor HCFA, have argued in other cases that the term “abuse” is broad enough to include injuries that follow from negligent conduct by facility employees, the Departmental Appeals Board has not sustained this interpretation of the regulations.<sup>42</sup> A similar result seems fitting in

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<sup>37</sup> See, 42 C.F.R. § 483.13 (b) (2005) (“Abuse”).

<sup>38</sup> See, e.g., *Vandalia Park v. CMS*, U.S. Dep’t of Health and Human Services, Departmental Appeals Board No. 1939 (2004) (<http://www.hhs.gov/dab/decisions/dab1939.html>); *Pathfinder Healthcare, Inc. v. CMS*, U.S. Dep’t of Health and Human Services, Departmental Appeals Board No. CR-958 (2002) (<http://www.hhs.gov/dab/decisions/cr958.html>); *Beverly Health and Rehabilitation Center v. HCFA*, U.S. Dep’t of Health and Human Services, Departmental Appeals Board No. 1748 (2000) (<http://www.hhs.gov/dab/decisions/dab1748.html>).

<sup>39</sup> See, 42 C.F.R. § 488.301 (2005) (“Definitions”).

<sup>40</sup> Compare, Exhibit 40 at 7.

<sup>41</sup> Compare, e.g., *Britthaven, Inc., d/b/a/ Britthaven of Smithfield v. CMS*, U.S. Dep’t of Health and Human Services, Departmental Appeals Board No. CR-1259 (2004) (<http://www.hhs.gov/dab/decisions/CR1259.htm>); *Valley Oaks Camden v. CMS*, U.S. Dep’t of Health and Human Services, Departmental Appeals Board No. CR-1257 (2004) (<http://www.hhs.gov/dab/decisions/CR1257.htm>).

<sup>42</sup> See, *Beverly Health and Rehabilitation Center v. HCFA*, U.S. Dep’t of Health and Human Services, Departmental Appeals Board No. 1748 (2000) (<http://www.hhs.gov/dab/decisions/dab1748.html>).

this case. Without at least some evidence that Resident 1's injuries followed from intentional conduct, as opposed to a negligent lapse in judgment, assignment of an F-223 Tag is inappropriate.

### **Tag F-225 – Texas Terrace's Obligation to Prevent Abuse to Residents Pending Its Investigation of Resident 1's Injuries**

When urging support for the F-255 Tag, the Department argues that abuse prevention procedures like those which followed the declaration of Immediate Jeopardy, should have been instituted by Texas Terrace at an earlier point in time. The Department points to the fact that upon Resident 1's return to Texas Terrace, from the hospital, the facility had a report from the hospital with a diagnosis of sexual assault and the resident had "injuries consistent with sexual assault."<sup>43</sup> In the view of the Department, had the types of procedures which were applied after May 26, been instituted following Resident 1's May 14 return, the other residents of the unit would have been protected against the potential for further abuse.

For its part, Texas Terrace asserts that Resident 1's fellow residents were safe from abuse. It argues that the increase in monitoring checks for Resident 1, the increase in presence of supervisory and survey staff on the unit during the parallel investigations and the changes made to staffing arrangements, all contributed to greater scrutiny of the care that was being delivered and to the prevention of further abuse.<sup>44</sup>

A few points deserve emphasis. First, the Department makes clear that neither the regulations, the State Operations Manual nor other regulatory guidance establish a specific set of nursing home responses following the allegation of abuse. The facility's regulatory obligation is to guard against the potential for future abuse – even if the regulations, or surveyors, are silent as to the precise steps that are needed to meet that obligation.

Perhaps a better description of the law is that the statutes, regulations and participation agreement all invest the facilities with discretion; the facility is permitted to choose, among a range of possible alternatives, in meeting its abuse prevention obligations. Thus, even in cases where the state surveyors prefer the use of one regulatory response over another, provided that the facility's chosen course of action is reasonable under the circumstances, it will be deemed to have substantially complied with the terms of the law and the participation agreement.<sup>45</sup>

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<sup>43</sup> See, Texas Terrace Care Center Partial Extended Survey Exit, at 13.

<sup>44</sup> See, e.g., Remarks of Margo Vredenburg.

<sup>45</sup> Compare, Remarks of M. Martinson with *Western Care Management Corp., D/B/A Rehab Specialties Inc. v. CMS*, DAB No. 1921 (2004) ("[p]rotecting and promoting a resident's right to be

In this case, it is clear that the Department's surveyors did have a preference: They preferred the abuse prevention procedures which followed the Immediate Jeopardy designation on May 26 – as opposed to the ones that were implemented earlier by Texas Terrace on May 14. Yet, this preference alone does not render Texas Terrace's chosen methods inadequate. As noted above, the question in this case is whether Texas Terrace met its regulatory obligations with the procedures it did apply.

On this latter point, the case of *Life Care Center of Hendersonville v. CMS*, is instructive. In that case, CMS and the nursing home facility differed sharply as to what procedures should have followed the discovery of bruises on the inner thighs of "Resident 13," a nursing home resident with a history of dementia and Alzheimer's disease. In urging the application of an F-225 Tag, CMS asserted that the discovery of these bruises – which may have been associated with a sexual assault – should have prompted the facility to make inquiries as to whether *other residents* may have been abused. The facility, by contrast, maintained that its reports and detailed inquiries regarding Resident 13's injuries satisfied the regulatory standards. In that case, the federal Administrative Law Judge found that the facility "complied fully with applicable requirements," where the facility had: sent the allegedly abused resident to the hospital with a specific request that the resident be evaluated for the possibility of sexual abuse; notified the resident's treating physician; prepared incident reports that were reviewed by the facility administrator and director of Nursing; filed a report with the appropriate state agency reciting the nature and extent of the resident's injuries and the facility's investigative steps; instituted hourly checks of the resident; and interviewed staff members who cared for the resident.<sup>46</sup>

While the state surveyors' deficiency claim was slightly different in *Life Care Center of Hendersonville*, than it is in this case, the principle is identical: Notwithstanding the clear preference that the state surveyors have for a particular set of practices following a report of alleged abuse, the facility may meet its regulatory obligations through other, similarly reasonable methods. Moreover, Texas Terrace's responses in this case were the same or greater than the facility responses in *Life Care Center of Hendersonville*, upon very similar facts. It stands to reason, therefore, that a like result should apply to these Tags.

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free from abuse necessarily obligates the facility to take reasonable steps to prevent abusive acts, regardless of their source") (<http://www.hhs.gov/dab/decisions/dab1921.html>) and *Windsor Health Care Center*, U.S. Dep't of Health and Human Services, Departmental Appeals Board No. 1902 (2003), *aff'd*, *Windsor Health Center v. Leavitt*, 127 Fed. Appx. 843 (6th Cir. 2005) ("A facility is permitted the flexibility to choose the methods it uses to prevent accidents, but the chosen methods must constitute an 'adequate' level of supervision under all the circumstances") (<http://www.hhs.gov/dab/decisions/dab1902.html>).

<sup>46</sup> See, *Life Care Center of Hendersonville v. CMS*, U.S. Dep't of Health and Human Services, Departmental Appeals Board No. CR542 (1998) (<http://www.hhs.gov/dab/decisions/cr-542.html>).

Further, it bears mentioning that state surveyors were at the facility for a period of 10 days before any mention was made of the scope of spot checks for other residents; a fact that mildly suggests that the procedures being used by Texas Terrace before the declaration of Immediate Jeopardy were not woefully inadequate. Likewise, the fact that Texas Terrace implemented the list of upgrades sought by Department officials within 4 hours of the declaration of Immediate Jeopardy, indicates that the facility staff were attentive and responsive to their regulatory obligations.

In this respect, this case does not appear to be like others in which the Departmental Appeals Board has found that the facility's response falls short of "substantial compliance." Unlike the facilities in these other cases,<sup>47</sup> Texas Terrace was attentive to its reporting requirements, duty to investigate and obligations to guard against potential misconduct.

Because the factual record does not support the citations and the negative resident outcome was unavoidable, it is therefore recommended that the Commissioner dismiss Tags F-223 and F-225,

E.L.L.

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<sup>47</sup> Compare, e.g., *Britthaven, Inc., d/b/a/ Britthaven of Smithfield*, DAB CR1259 (2004) (the Statement of Deficiency was sustained where the facility failed completely to report or investigate a resident's unexplained injuries) (<http://www.hhs.gov/dab/decisions/CR1259.htm>); *Spring Meadows Health Care Center v. CMS*, U.S. Dep't of Health and Human Services, Departmental Appeals Board No. CR1063 (2003), *aff'd*, DAB No. 1966 (2005) (the Statement of Deficiency was sustained where facility staff noted an injury and suspected abuse, but did not timely report the incident, speak with staff members about the incident, or reeducate staff as to preventing potential abuse) (<http://www.hhs.gov/dab/decisions/CR1063.html>).