Department of Health and Human Services
DEPARTMENTAL APPEALS BOARD
Appellate Division

Libertywood Nursing Center
Docket No. A-11-106
Decision No. 2433
December 23, 2011

FINAL DECISION ON REVIEW OF ADMINISTRATIVE LAW JUDGE DECISION

Libertywood Nursing Center (Libertywood), a North Carolina skilled nursing facility (SNF), appeals the June 24, 2011 decision of Administrative Law Judge (ALJ) Carolyn Cozad Hughes, *Libertywood Nursing Center,* DAB CR2388 (2011) (ALJ Decision). The ALJ concluded that Libertywood failed to take adequate steps to protect its female residents from the "sexually aggressive behaviors of a demented male resident" and for that reason was not in substantial compliance with Medicare participation requirements from September 6 through December 10, 2009. The ALJ also upheld a determination by the Centers for Medicare & Medicaid Services (CMS) that the noncompliance placed Libertywood's residents in "immediate jeopardy" from September 6 through November 17, 2009. Finally, the ALJ sustained the civil money penalties (CMPs) that CMS had imposed on Libertywood for the noncompliance.

For the reasons discussed below, we affirm the ALJ Decision in its entirety.

Legal Background

In order to participate in Medicare, a SNF must comply with the participation requirements in 42 C.F.R. §§ 483.1-483.75. Compliance with these requirements is verified by nursing home surveys conducted by state health agencies. 42 C.F.R. Part 488, subpart E. Survey findings are reported in a document called a Statement of Deficiencies. *See, e.g.,* CMS Ex. 1. At issue here is the participation requirement in section 483.25(h), which, in relevant part, requires a SNF to "ensure" that each resident receives "adequate supervision . . . to prevent accidents."

CMS may impose CMPs and other enforcement "remedies" on a SNF if it determines, on the basis of survey findings, that the SNF is not in "substantial compliance" with one or more participation requirements. 42 C.F.R. §§ 488.400, 488.402(b), (c). In choosing an appropriate remedy, CMS considers the "seriousness" of the SNF's noncompliance and may consider other factors specified in the regulations. *Id.* § 488.404(a), (c). "Seriousness" is a function of "severity" (whether the noncompliance has created a

"potential" for "more than minimal" harm, resulted in "actual harm," or placed residents in "immediate jeopardy") and "scope" (whether the noncompliance is "isolated," constitutes a "pattern," or is "widespread"). *Id.* § 488.404(b); State Operations Manual (SOM), App. P – *Survey Protocol for Long Term Care Facilities*, sec. IV (available at http://www.cms.hhs.gov/Manuals/IOM/ list.asp). "Immediate jeopardy" is the highest level of severity. *See* 42 C.F.R. §§ 488.404 (setting out the levels of severity and scope that CMS considers when selecting remedies) and 488.438(a) (authorizing the highest CMPs for immediate jeopardy-level noncompliance); 59 Fed. Reg. 56,116, 56,183 (Nov. 10, 1994) (scope-and-severity grid).

A SNF may challenge a finding of noncompliance that has resulted in the imposition of a CMP or other enforcement remedy by requesting a hearing before an ALJ. *See* 42 C.F.R. §§ 488.408(g)(1), 498.3(b)(13), 498.5(b). In an ALJ proceeding, CMS has the burden of coming forward with evidence related to disputed findings that is sufficient (together with any undisputed findings and relevant legal authority) to establish a prima facie case of noncompliance with a regulatory requirement. *Evergreene Nursing Care Center*, DAB No. 2069, at 7 (2007); *Batavia Nursing and Convalescent Center*, DAB No 1904 (2004), *aff'd, Batavia Nursing & Convalescent Ctr. v. Thompson*, 129 F. App'x 181 (6th Cir. 2005). "If CMS makes this prima facie showing, then the SNF must carry its ultimate burden of persuasion by showing, by a preponderance of the evidence, on the record as a whole, that it was in substantial compliance during the relevant period." *Evergreene,* DAB No. 2069, at 7.

Case Background

From November 16 to November 18, 2009, the North Carolina Department of Health and Human Services (state survey agency) conducted a Medicare compliance survey of Libertywood; the state survey agency later issued a Statement of Deficiencies containing its survey findings. *See* CMS Ex. 1; CMS Ex. 29, at 1 ¶ 4. The survey was performed in response to a complaint about the behavior of Resident 2, an 82 year-old male with Parkinson's disease and progressive dementia. CMS Ex. 3; CMS Ex. 29, at 3 ¶ 8. The complaint alleged that on October 17, 2009, Resident 2 entered the room of a female resident and began to fondle her breast and touch her genitals. *See* CMS Ex. 5.

The state survey agency found that as early as September 6, 2009, Libertywood knew that Resident 2 was prone to engage in "sexually inappropriate" behavior. *See* CMS Ex. 1, at 1-4. The state survey agency also found that female residents had been subjected to unwanted sexual contact by Resident 2 on September 6, 2009, October 6, 2009, October 17, 2009, and November 13, 2009. *Id.* at 3, 10, 15-16. Libertywood discharged Resident 2 on November 17, 2009. *Id.* at 18.

Based on its assessment of the nursing staff's management of Resident 2, the state survey agency determined that as of September 6, 2009, Libertywood was not in substantial

compliance with 42 C.F.R. § 483.25(h). CMS Ex. 1, at 1. The state survey agency also determined that: (1) Libertywood's noncompliance with section 483.25(h) placed residents in immediate jeopardy beginning on September 6, 2009; (2) residents were in immediate jeopardy from September 6 through November 17, 2009; and (3) after November 17, 2009, Libertywood continued to be out of substantial compliance with section 483.25(h) but at a lower level of severity. *Id.*; *see also* CMS Ex. 4, at 1. A revisit survey determined that Libertywood returned to substantial compliance with section 483.25(h) on December 11, 2009. CMS Ex. 4, at 13.

CMS concurred with the state survey agency's noncompliance findings and imposed the following CMPs on Libertywood: $3,700 per day from September 6 through November 17, 2009; and $100 per day from November 18 through December 10, 2009. CMS Ex. 4, at 6-7, 14; CMS Response Br. at 1-2.

Libertywood then requested an ALJ hearing to challenge the imposition of those remedies. In compliance with a pre-hearing order, the parties submitted the direct testimony of their witnesses in writing.[1] Libertywood submitted written direct testimony from the following individuals: Debbie Draughn, Libertywood's Director of Social Services; Garry W. Hoyes, a licensed nursing home administrator; Timothy Beittel, M.D., Libertywood's Medical Director during the relevant period; Ben Powers, L.P.N., a nurse who worked in Resident 2's section of the facility; and Darlene Whitley, L.P.N., Libertywood's "MDS Coordinator." CMS submitted written direct testimony from Ann W. Burgess, DNSc, a professor of psychiatric nursing at Boston College who specializes in "elder sexual abuse" and who testified as an expert witness, and surveyor Kristine Woodyer, R.N. On September 30, 2010, a hearing by videoconference was held in which Libertywood cross-examined CMS's witnesses.

The ALJ Decision

Based on her review of contemporaneous nursing records (and other evidence), the ALJ made detailed (and chronological) factual findings about Resident 2's behavior in the facility and Libertywood's response to that behavior. ALJ Decision at 4-10. The ALJ found that "from at least September 6, 2009, if not from the time of [Resident 2's] admission" in late August 2009, Libertywood "was well aware of the threat [he] posed to

[1] Libertywood contends that the ALJ violated its constitutional rights by requiring it to submit its witnesses' direct testimony in writing. RR at 5 n.2. "[T]he Board has previously upheld the discretion of the ALJ to receive direct testimony in written form, so long as the right to effective cross examination is protected and no prejudice is alleged and shown." *Golden Living Center–Frankfort,* DAB No. 2296, at 4 (2009) (internal quotation marks omitted), *aff'd, Golden Living Ctr.–Frankfort v. Sec. of Health and Human Svcs.*, No. 10-320 (6th Cir. Aug. 31, 2011), *available at http://www.ca6.uscourts.gov/opinions.pdf/11a0249p-06.pdf.* We see nothing in the record indicating that the ALJ improperly curtailed Libertywood's right of cross-examination or that Libertywood was unfairly prejudiced by the ALJ's requirement to submit direct testimony in writing.

the health and safety of its female residents." *Id.* at 5. That threat was Resident 2's unwanted and sexually inappropriate touching of female residents. *Id.*

The ALJ found that on September 6, 2009:

> [Resident 2] rolled his wheelchair up to a woman resident [Resident 5] and began fondling her breast. The nurse moved him to the other side of the day area, told him not to touch other residents, and wrote that she would "monitor."

ALJ Decision at 4. The promised post-incident monitoring was "apparently ineffective," the ALJ found, because approximately one hour after he was discovered fondling Resident 5, Resident 2 "went back to the same resident, put his hand under a blanket that was on her lap, and, according to the victim, he 'was feeling all over around her diaper.'" *Id.* at 4-5 (*citing or quoting* CMS Ex. 7, at 2; CMS Ex. 11, at 4; and CMS Ex. 13, at 1).

In Libertywood's nursing records, the ALJ found additional incidents of inappropriate behavior by Resident 2 on September 8 (resident had hand under another resident's clothing), September 15 (repeatedly told female resident that he "wanted her for tonight"), September 20 (approaching female residents and putting, or trying to put, his hands on them), September 29 (multiple attempts to be "'inappropriate'" with other residents), October 6 ("'rolled up behind a female' resident, reached over her shoulder, and 'stuck his hand down her shirt'"), and October 14 ("rolled up to another resident and asked her if she was 'ready to go to bed'"). ALJ Decision at 5-8 (*citing or quoting* CMS Ex. 7, at 4-7; CMS Ex. 12, at 3; CMS Ex. 13, at 3-4; P. Ex. 8, at 1; and P. Ex. 16, at 9).

Although Resident 2's plan of care recognized his sexually inappropriate behavior as a "problem," the ALJ found "no evidence" that the nursing staff "relied on" that plan to protect the facility's female residents. ALJ Decision at 5. In addition, the ALJ found that "between September 9 and October 17, facility staff generally limited their interventions to separating [Resident 2] from his victim and telling him not to touch her again" and that these measures were "not effective in controlling [Resident 2]'s behavior and protecting others from his advances." *Id.* at 6.

Turning to the incident on October 17, 2009, the ALJ found:

> [A]t 11:00 a.m. [Resident 2] went into the room of [Resident 1], a 29-year-old woman suffering from Friedreich's ataxia and other impairments. Freiedreich's ataxia is a rare genetic disease that causes progressive damage to the central nervous system, resulting in impaired movement and sensory functions. It does not affect cognitive function. [Resident 2] started to fondle her breast and to touch her genitals. She protested, telling him not to

> do that, but she was unable to defend herself because of her physical limitations. . . .

ALJ Decision at 9.

The ALJ found that after the October 17, 2009 incident, the nursing staff "began to supervise [Resident 2] one-on-one for part of the day (from 9:00 a.m. to 8:00 p.m.) and to make 15-minute checks the rest of the time." ALJ Decision at 9. "Unfortunately," said the ALJ, "[Resident 2] was up and about well before 9:00 a.m., which meant that he was not adequately supervised during the early morning hours." *Id.*

The next (and last) incident recounted by the ALJ occurred during the early morning hours of November 13, 2009:

> At 7:45 a.m., staff checked on [Resident 2]. He was in the dining room, sitting at his assigned seat. But he rolled himself over to another resident at the other side of the table and "had his hand up her shirt, touching her breast." Staff removed him from the area and asked him to stop touching other residents.

ALJ Decision at 9 (*citing or quoting* CMS Ex. 7, at 12-13 and CMS Ex. 13, at 5-7). After the November 13th incident, Libertywood "expanded the hours of one-on-one supervision to begin at 7:00 a.m." (according to Nurse Whitley). *Id.*

In assessing the "[e]ffectiveness of the facility's interventions," the ALJ found that Libertywood "did not have in place a coherent approach for ensuring that staff would adequately supervise [Resident 2] and protect other residents from his advances," noting that there was little evidence that staff adhered to a standard or pre-established protocol for reporting, investigating, and responding (with increased supervision) to incidents of resident misbehavior. ALJ Decision at 9-11. The ALJ further found that the nursing staff "did not even have a clear picture of the magnitude of its problems" concerning Resident 2 because its records did not capture "multiple incidents of inappropriate behavior." *Id.* at 11. In addition, the ALJ found that the supervisory measures that the nursing staff actually implemented during the relevant period "did not work." *Id.* at 9. The ALJ acknowledged that there was "some evidence of limited 15-minute checks" but found that those checks "appear to have been implemented only sporadically, were not well-documented, and, in any event, . . . proved ineffective in controlling [Resident 2's] behaviors" (unless he was confined to his bed). *Id.* at 10. The ALJ found that "one-on-one supervision . . . appears to have been the most effective intervention" but that this measure was not implemented until after the incident involving Resident 1 on October 17, 2009. *Id.*

Based on these (and other) findings, the ALJ concluded that Libertywood was not in substantial compliance with section 483.25(h) from September 6 through December 10, 2009. ALJ Decision at 3, 13. The ALJ also upheld, as not clearly erroneous, CMS's determination that Libertywood's noncompliance had placed residents in "immediate jeopardy" from September 6 through November 17, 2009. *Id.* at 15. In addition, the ALJ found that Libertywood had not "met its burden" to demonstrate that the immediate jeopardy-level noncompliance (assuming it was present) arose later than September 6, 2009 or was abated sooner than November 17, 2009. *Id.* at 15. Finally, the ALJ found that the per-day CMPs imposed by CMS for Libertywood's noncompliance were reasonable under the circumstances.

Libertywood then filed a request for review, claiming that it had adequately supervised Resident 2 and was in substantial compliance with section 483.25(h) "at all times" during the period at issue (September 6 through December 10, 2009). *See* Request for Review (RR) at 39. Libertywood does not challenge the ALJ's conclusion that the per-day CMP amounts were reasonable.

Standard of Review

The Board's standard of review on a disputed finding of fact is whether the decision is supported by substantial evidence on the record as a whole. *Appellate Review* of *Decisions* of *Administrative Law Judges Affecting* a *Provider's Participation in the Medicare and Medicaid Programs, available at* http://www.hhs.gov/dab/divisions/appellate/guidelines/index.html. The Board's standard of review on a disputed conclusion of law is whether the ALJ's decision is erroneous. *Id.*

"Substantial evidence" is "more than a mere scintilla. It means such relevant evidence as a reasonable mind might accept as adequate to support a conclusion." *Richardson v. Perales,* 402 U.S. 389, 401 (1971), *quoting Consolidated Edison Co. v. NLRB*, 305 U.S. 197, 229 (1938). Under the substantial evidence standard, the reviewer must examine the record as a whole and take into account whatever in the record fairly detracts from the weight of the evidence relied on in the decision below. *Universal Camera Corp. v. NLRB*, 340 U.S. 474, 488 (1951).

Discussion[2]

1. *Substantial evidence the record as a whole supports the ALJ's conclusion that Resident 2 received inadequate supervision.*

[2] Although we do not expressly address all of the arguments and assertions contained in Libertywood's appeal briefs, we have, in fact, considered them all and determined that none warrant a reversal or modification of the ALJ Decision under the applicable standard of review.

Section 483.25(h) requires a SNF to "ensure" that each resident receives "adequate supervision." "Ensuring" adequate supervision involves (among other things): (1) identifying safety hazards or risks of harm in a resident's environment; (2) devising and implementing a plan of supervision to minimize the hazards or risks; and (3) monitoring and assessing the effectiveness of a supervision plan on an ongoing basis. *See* SOM, App. PP (guidelines for F371) (noting certain elements of adequate supervision in the section entitled "Intent").

In applying section 483.25(h), the Board has held that a SNF's supervision of a resident must "meet the resident's assessed needs" and "reduce known or foreseeable accident risks to the highest practicable degree, consistent with accepted standards of nursing practice." *Century Care of Crystal Coast*, DAB No. 2076, at 6-7 (2007), *aff'd, Century Care of the Crystal Coast v. Leavitt*, 281 F. App'x 180 (4th Cir. 2008). A SNF has flexibility to choose the methods of supervision so long as the chosen methods are adequate under the circumstances to protect the resident from known or foreseeable risks of harm. *Liberty Commons Nursing and Rehab – Almance,* DAB No. 2070, at 3 (2007).

Libertywood takes no issue with the ALJ's findings of historical fact, which reveal that the nursing staff first became aware of Resident 2's sexually inappropriate behavior no later than September 6, 2009. Libertywood also does not dispute that such behavior posed a risk of harm to female residents,[3] although it argues that the potential harm was not as serious as CMS assumed. And Libertywood concedes that section 483.25(h) required its nursing staff to take "all reasonable steps" to shield residents from unwanted sexual contact and other sexually inappropriate behavior.[4] Reply Br. at 2; *see also Briarwood Nursing Center*, DAB No. 2115, at 11 (2007) (stating that the focus of a section 483.25(h) inquiry is "whether the facility took all reasonable steps to ensure that a resident receives supervision and assistance devices that . . . mitigate foreseeable risks of harm from accidents"). As the Board has stated, section 483.25(h) places an "affirmative duty [on facility staff] to intervene and supervise . . . behaviorally impaired residents in a manner calculated to prevent them from causing harm to themselves and each other." *Vandalia Park*, DAB No. 1940, at 18 (2004), *aff'd, Vandalia Park v. Leavitt*, No. 04-4283 (6th Cir. Dec. 8, 2005), available at http://www.ca6.uscourts.gov/opinions.pdf/05a0957n-06.pdf.

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[3] One of Libertywood's witnesses, Nurse Darlene Whitley, effectively conceded that Resident 2's conduct had the potential to harm other residents, calling "unwanted touching" of another resident "unacceptable." P. Ex. 26, at 2-3 (further stating that the nursing staff implements "frequent" checks of a resident's location and demeanor "[i]f, *as in this case,* a resident is acting in a way that potentially might injure someone else" (italics added)).

[4] In its reply brief, Libertywood stated that it "agree[d] with CMS'[s] expert witness Ann Burgess that nursing facilities must take all reasonable steps to protect residents against unacceptable behaviors by fellow residents, no matter what their conditions or ailments." Reply Br. at 2.

The September 6 incidents, in which a female resident was victimized twice by Resident 2 in the span of 75 minutes, plainly show that he needed to be watched closely by the nursing staff when he was in the presence of female residents. *See* CMS Ex. 1, at 5 (noting that an "incident report" of the September 6 incident recommended that Resident 2 be observed "closely"). Based on the evidence before her, which we now discuss, the ALJ reasonably concluded that Libertywood did not institute close – or effective – supervision in the wake of the September 6 incidents.[5]

As updated on September 9, 2009, Resident 2's plan of care, prepared by MDS Coordinator Darlene Whitley, identified several "interventions" intended to manage or reduce Resident 2's "increasingly aggressive" sexual behavior. P. Ex. 8, at 1; CMS Ex. 12, at 3. The interventions specified in the plan included medication (if found to be appropriate and effective), "redirecting" Resident 2 away from situations in which he was acting or threatening to act inappropriately, and encouraging him to participate in activities as a way to channel his mind and energy away from female residents. CMS Ex. 12, at 3. The plan did not call on the staff to segregate Resident 2 completely from female residents (and the ALJ did not find that such a measure was necessary).[6] However, the plan is unclear about how the staff intended to monitor Resident 2 when he was in the presence of female residents (but not engaged in diversionary activities), or when he was moving about the facility in a way that made it likely he would encounter female residents. The only listed intervention that entailed visual monitoring by the staff was "one-on-ones with [resident] monitoring to prevent any sexual behaviors towards [residents] only if occurs." CMS Ex. 12, at 3. We are unsure precisely what this means, and none of Libertywood's witnesses, including Nurse Whitley, who was responsible for coordinating care planning by the interdisciplinary team, provided an explanation.[7] *See* P. Ex. 26. Assuming that "one-on-ones" meant continuous monitoring by a staff member

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[5] Although Libertywood broadly contends that CMS did not make out a "prima facie case" of noncompliance, it did not provide any additional argument supporting this contention. In any event, as the Board has held, once a SNF submits evidence for the record, the issue is whether a preponderance of the evidence shows substantial compliance. *Jennifer Matthew Nursing & Rehabilitation Center*, DAB No. 2192, at 21 n. 12 (2008) (*citing Oxford Manor*, DAB No. 2167 (2008)); *Hillman Rehabilitation Center*, DAB No. 1663, at 9-10 (1998), *aff'd, aff'd, Hillman Rehabilitation Ctr. v. U.S. Dep't of Health and Human Servs.*, No. 98-3789 (GEB) (D.N.J. May 13, 1999).

[6] Another version of the plan of care called on the nursing staff to supervise Resident 2 by moving him away from the targeted resident, explaining to Resident 2 that his behavior was unacceptable, encouraging him to exercise or go to activities, obtaining a psychiatric consultation, explaining to him the legal possible consequence of behavior, and *"[a]ttempt[ing] to keep [him] separated* from female residents." P. Ex. 8, at 19. There is no indication in this version of the care plan – or in the other evidence of record – *how* the staff intended to keep Resident 2 "separated" from female residents, assuming that separation was the care plan's goal.

[7] The words "only if it occurs" suggests that staff would not implement one-on-one supervision until after another incident of sexually aggressive behavior by Resident 2.

assigned to watch Resident 2 at all times, there is no evidence in the record that the nursing staff implemented that measure in response to the September 6 incidents.

During the survey, Libertywood produced a "resident monitoring record" showing that Resident 2 was placed on "15 minute checks for behaviors" beginning on September 6. CMS Ex. 1, at 4; *see also* CMS Ex. 14, at 1-8. However, these checks stopped on September 8 (CMS Ex. 1, at 4), even though Resident 2 was seen inappropriately touching another resident on that day (CMS Ex. 7, at 3), and even though it was plain that two of the interventions called for by the care plan – redirection and on-the-spot counseling or admonishment – did not prevent a second incident of unwanted sexual contact on September 6.[8] Libertywood's witnesses offered no explanation for the decision to stop 15-minute checks on September 8, and Libertywood does not challenge the ALJ's finding that those checks were ineffective. *See* ALJ Decision at 10. We note also that Libertywood's Director of Nursing admitted in a survey interview that 15-minute checks were an inadequate response to Resident 2's misconduct. CMS Ex. 1, at 6.

In her survey interview, Nurse Whitley reportedly stated that one-on-one supervision should have been instituted for 72 hours after the September 6 incidents. CMS Ex. 1, at 7. She did not disavow that statement in her written direct testimony or explain why one-on-one supervision was not instituted. P. Ex. 26, at 2-3. Furthermore, none of the Libertywood employees who testified explained how the staff kept track of Resident 2's movements and behavior after the 15-minute checks were stopped.

CMS's expert witness, Professor Burgess, testified that staff education and training were necessary to prevent and respond effectively to Resident 2's behavior and that all staff "should have been alerted to keep Resident 2 away from female residents." Tr. at 58; CMS Ex. 28, at 6-7. At Libertywood, the nursing "unit managers" were responsible for alerting staff to changes in the plan of care. CMS Ex. 1, at 7. There is, however, no evidence that unit managers systematically alerted the nursing staff to the September 9 care plan update, which first identified Resident 2's "sexually aggressive" behavior as a "problem." Assuming the update was communicated, it is not clear what the staff was told to do.

Professor Burgess also testified that Libertywood should have considered or implemented certain measures to curb Resident 2's sexually aggressive behavior. For example, she testified that Resident 2 could have been evaluated to determine if he was a candidate for Depo-Provera or some other comparable drug that reduces sexual aggression. CMS Ex. 28, at 4-5; Tr. at 42-43. She further testified that the nursing staff should have provided (but did not provide) "structured diversionary activities" and "written a very specific care

[8] It is undisputed that Resident 2 returned to his victim a second time on September 6 *after* being moved away from the resident and told that what he had done was wrong. *See* CMS Ex. 13, at 2.

plan detailing how his day would be managed to prevent him from victimizing residents." CMS Ex. 28, at 5. In addition, Professor Burgess testified that Libertywood "should have involved [Resident 2's] family to find out specifics about his past behaviors and what interventions worked and did not work for him." *Id.*

These statements by Professor Burgess were not rebutted by Libertywood's witnesses or undercut by cross-examination. *See* Tr. at 10-58. Dr. Beittel, Libertywood's Medical Director, testified that he adjusted Resident 2's medications after September 6 (P. Ex. 24, at 3), but Professor Burgess made it clear that the medications that Resident 2 was taking were not appropriate to treat sexual aggression (CMS Ex. 28, at 4-5). Dr. Beittel also testified that drugs were "of limited use" in preventing sexually aggressive behavior but did not address the potential efficacy of Depo-Provera or claim that he considered and ruled out the use of that drug. P. Ex. 24, at 3. As for Professor Burgess's recommendation of "structured diversionary activities," Resident 2's plan of care called for the staff to provide Resident 2 with unspecified out-of-room ("oor") activities (CMS Ex. 12, at 3), but there is no evidence that the staff devised a subsidiary plan to achieve that goal or that staff, upon due consideration, decided that diversionary activities were likely to be ineffective in keeping Resident 2 away from female residents. Debbie Draughn, Libertywood's Social Services Director, expressed no opinion about whether Resident 2 could have been successfully diverted in that way, and her "social service progress notes" contain no entries about Resident 2's inappropriate behavior until October 17, 2009. P. Ex. 17, at 1.

Libertywood now contends that Resident 2, given his cognitive and physical limitations, was incapable of participating in the types of activities suggested by Professor Burgess (namely, "hands-focused activities in occupational therapy or recreational therapy"). CMS Ex. 28, at 5; RR at 18 n.12, 19. This argument has little support in the record, as the ALJ found. Moreover, it appears Professor Burgess was merely providing examples of broad categories of activities that might serve to divert a person like Resident 2, rather than expressing an opinion about what Resident 2 could, in fact, have done given his clinical status. *See* Tr. at 27. The important point, which the ALJ made, is that Libertywood apparently failed to assess how Resident 2's day might be structured to limit his contact with female residents. Moreover, if medication and diversionary activities were likely to be ineffective, as Libertywood claims, then it is logical to assume that robust visual monitoring was critical to ensuring that Resident 2 was adequately supervised. As indicated, the record is silent about how, logistically, the staff performed (or intended to perform) such monitoring after 15-minute checks were stopped on September 8.

All of these facts and circumstances amply support the ALJ's general finding that <u>from the outset</u>, Libertywood lacked – and made little visible effort to devise and implement – a coherent and coordinated plan, communicated to and understood by the entire staff, for managing Resident 2's aggressive behavior.

Daily nursing notes indicate that on September 15, 20, and 29, Libertywood's nursing staff "redirected" Resident 2 when he appeared to be acting inappropriately toward female residents. *See* CMS Ex. 7, at 4-5. According to Libertywood, these interventions demonstrate that, for at least one month after Resident 2's proclivities became known, the nursing staff's supervision was adequate to protect female residents from unwanted sexual contact. *See* RR at 33-34. For the following reasons, the ALJ was not unreasonable in rejecting that argument. First, it is not clear from the nursing notes that, in each instance, the nursing staff intervened before Resident 2 made unwanted physical contact with another resident. CMS Ex. 7, at 4 (indicating that after being redirected four times on September 20, Resident 2 stated that he had "touched everyone").

Second, it is unclear whether the nursing staff's interventions were the result of coordinated monitoring or were merely fortuitous. There are no details in the notes about how the staff became aware of Resident 2's threatening behavior on September 15, 20, and 29. In other words, it is unclear from the nursing notes whether the staff directly observed Resident 2's aggressive behavior or whether residents simply alerted the staff to the threats. The frequency, intensity, and scope of the nursing staff's monitoring is nowhere specified in the daily notes from September 2009. A note for September 19 states that Resident 2 was wheeling himself in and out of out of other resident's rooms (CMS Ex. 7, at 4), behavior that would have temporarily put him beyond the vision of nursing staff, yet it is not clear how the staff sought to prevent – or closely observe – that movement. (The October 17th incident occurred in a resident's room.)

Third, it is reasonable to weigh the purportedly successful interventions during mid and late September against the staff's failure to prevent the unwanted sexual contact that occurred on October 6. *See* CMS Ex. 13, at 3 (indicating that Resident 2 reached over a female resident's shoulder and put his hand down her shirt). Libertywood offers no explanation for that failure other than to say that the October 6th incident represented an "escalation" of Resident 2's behavior, and that there was no "clear trigger" for that behavior and "no realistic way to predict or prevent that manifestation of his dementia." RR at 34. This argument is unpersuasive. To begin, there is no evidence that Libertywood's nursing staff recognized the October 6th incident as an "escalation" or otherwise as increasing the threat of harm to female residents. If in fact the nursing staff recognized at the time that the incident was an escalation, then there should be some evidence – there is none, in fact – that the nursing staff carefully investigated the incident and assessed the adequacy of its supervision. *Residence at Kensington Place,* DAB No. 1963, at 9 (2005) (holding that if a SNF knows or has reason to know that its supervision is substantially ineffective, it must "determine the reasons for the ineffectiveness and . . .

consider – and, if practicable, implement – more effective measures"). Instead, the staff responded with measures that it had already tried for a month without success.[9]

Moreover, it is simply not credible to suggest, as Libertywood does, that its nursing staff was powerless to deal with Resident 2's seeming unpredictability. Professor Burgess gave unrefuted testimony that the nursing staff should have documented and assessed Resident 2's behavior patterns to help identify the circumstances that triggered his sexually aggressive behavior. CMS Ex. 28, at 6. We see no evidence in the record that the nursing staff documented Resident 2's behavior patterns in September 2009 with that goal in mind, and the documentation it did keep was, as the ALJ found, seriously flawed. In addition, Libertywood does not explain precisely how Resident 2 was being monitored on October 6 or claim that, because of unusual or unforeseen circumstances, the unwanted touching occurred despite the nursing staff's best efforts to supervise him. Under the circumstances, the ALJ could reasonably find that the October 6th incident exposed the inadequacy of Resident 2's supervision instead of supporting the facility's claim of substantial compliance during September 2009. *Cf. Lake Park Nursing and Rehabilitation Center*, DAB No. 2035, at 9 (2006) (finding that the circumstances surrounding the resident's injuries and the facility's inability to explain how the resident sustained them supported a finding of inadequate supervision).

Libertywood makes various other contentions, none of which persuade us that substantial evidence is lacking to support the ALJ's finding of noncompliance. Libertywood complains, for example, that the ALJ "never identified the clinical standard that [the nursing staff] should have met for" Resident 2's supervision and how it failed to live up to that standard. RR at 2-3, 31-32. Libertywood asserts that "[t]he only specific intervention the ALJ discusses at all – one-to-one monitoring – actually *was* implemented by Petitioner's staff for a period of several weeks, but neither the ALJ nor any witness identified any standard of care that would support a finding that it should have been implemented earlier than it was." RR at 31-32 (italics in original).

This argument is without merit because the applicable compliance standard is the one established by section 483.25(h) – namely, supervision that is adequate under the circumstances to deal with a risk or threat of harm. The ALJ expressly applied that standard in evaluating the evidence, finding that the circumstances demanded "close supervision" of Resident 2. *See* ALJ Decision at 3-4, 9-10. It is also fair to say that Libertywood's own witnesses addressed the applicable compliance standard. In their

[9] In the box labeled "recommended steps to prevent recurrence," the "incident report" for the October 6th incident states that Resident 2 would be redirected and counseled, and that 15-minute checks would be instituted. CMS Ex. 13, at 3. However, there is no evidence that 15-minute checks continued beyond October 8. *See* CMS Ex. 14. A written summary of an October 7 "P.A.R." meeting states, after briefly mentioning incidents on September 20 and October 6, that Resident 2 "must be closely monitored." P. Ex. 18, at 1. The document does not indicate what "close monitoring" entailed under the circumstances or discuss what the nursing staff concluded after the October 6 incident about the need for additional supervision.

written testimony, Nurse Whitley and Social Services Director Debbie Draughn indicated that when a resident engaged in undesirable or potentially harmful behavior, the nursing staff ordinarily followed a specific protocol.[10] *See* P. Ex. 26, at 2-3; P. Ex. 22, at 2. Although these witnesses differed or were unclear about the elements of the protocol, they agreed that it included structured or coordinated visual monitoring of the resident, such as one-on-one supervision, 15-minute checks of a resident's location and demeanor, or a combination of those measures. *Id.*; *see also* CMS Ex. 1, at 7 (discussing the state survey agency's interview of the "MDS nurse"). Furthermore, the ALJ did not expressly find that one-on-one monitoring should have been in place sooner than October 17. Although she found that such monitoring was – among the interventions mentioned in the plan of care or used by the nursing staff – the "most effective," the ALJ did not rule out the possibility that sufficiently "close supervision" could have been achieved by other means (or a combination of other means). In any event, Libertywood failed to prove that it was providing "close supervision," under any reasonable definition of that term, prior to October 17, and it does not challenge the ALJ's finding that it ineffectively implemented one-on-one supervision after that date. *See* ALJ Decision at 9 (finding that staff did not adequately supervise Resident 2 during the early morning hours after October 17).

Furthermore, the ALJ reached her ultimate conclusion based on more than a finding that Libertywood failed to implement particular interventions (such as one-on-one supervision). She also found that the nursing staff had deficient processes for "ensuring" that Resident 2 received appropriate supervision. In particular, she found, and Libertywood does not dispute, that the nursing staff failed: (1) to devise and follow a coherent plan of supervision; (2) to keep accurate records of Resident 2's behavior; and (3) adhere to established incident reporting and evaluation protocol. ALJ Decision at 5, 9, 10-11. These types of failures prevent a SNF from ensuring that decisions about the appropriate level of supervision are based on informed professional judgment, which is precisely what section 483.25(h) requires a SNF to exercise. *Josephine Sunset Home*, DAB No. 1908, at 14-15 (2004) (stating that "[w]hat is . . . required of facilities is not prescience but reason and professional judgment in assessing what can be done to make residents (given their special needs) safe, through removing accident hazards, providing appropriate devices, and ensuring adequate supervision").

Libertywood contends that the ALJ improperly applied a theory of "strict liability" in that she held it responsible for whatever "behavior" Resident 2 exhibited. RR at 1, 2. The evidence for this, says Libertywood, is the fact by the ALJ "found noncompliance from the first instance of inappropriate touching by [Resident 2] and further found that the

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[10] According to the Statement of Deficiencies, Nurse Whitley informed surveyors that "if Resident # 2 exhibited sexually inappropriate behaviors, one-on-one monitoring should be instituted for *a minimum* of 72 hours to prevent recurrence of the behavior." CMS Ex. 1, at 7 (italics added).

noncompliance extended for several weeks afterward, despite the fact that Petitioner's interventions to prevent recurrence were "completely *effective* in preventing the targeted behavior[.]" RR at 2 (italics in original). According to the facility, the ALJ drew "no useful distinction between *the Resident's behaviors,* and *Petitioner's* responses thereto, including Petitioner's efforts to protect other residents." RR at 9 (italics in original).

The record contradicts Libertywood's claim that its supervision was "completely effective." To the contrary, it was plainly ineffective because Resident 2 succeeded in physically laying his hands on at least four female residents from September 6 through the date of his discharge (November 17). Moreover, we see nothing in the ALJ Decision to support Libertywood's claim that the ALJ applied a theory of "strict liability," a tort concept that is inapplicable in this proceeding. *Briarwood*, DAB No. 2115, at 11 n.8. The issue here is not tort liability but compliance with a regulatory standard of "adequate supervision." *See id.* In concluding that Libertywood was noncompliant with section 483.25(h), the ALJ focused on the adequacy of Resident 2's supervision and, thus, did not rely solely on Resident 2's behavior in reaching her conclusion. *See, e.g.*, ALJ Decision at 9 (finding that the facility lacked a "coherent approach" to supervising Resident 2 and that the measures actually implemented to supervise that resident "did not work").

Finally, Libertywood asserts that it "was impossible to prevent [Resident 2's] behaviors even with close supervision." RR at 34. However, section 483.25(h) does not require a SNF to achieve perfection in preventing adverse outcomes. It requires the SNF to take all reasonable measures calculated to protect its residents from harm, consistent with resident rights and accepted standards of nursing care.

Accordingly, we conclude that the ALJ's finding that Libertywood did not take all reasonable and timely measures to protect its female residents from the harm posed by Resident 2's sexually aggressive behavior is supported by substantial evidence in the record as a whole.

2. *Substantial evidence in the record as a whole supports the ALJ's finding that Libertywood's noncompliance began on September 6, 2009 and continued through December 10, 2009.*

a. Onset date of the noncompliance

Libertywood contends that its noncompliance did not begin on September 6, 2009, as CMS and the ALJ found, because the incidents involving Resident 2 on that date were, in its view, "sudden and unexpected" and because the nursing staff's "initial interventions seemed to be effective for weeks thereafter[.]" RR at 37. We find no merit in this argument. The September 6th incidents clearly notified the nursing staff that Resident 2 needed close supervision, including visual monitoring by staff when he was in the

presence of female residents. Hence, as of September 6, 2009, Libertywood was in noncompliance with section 483.25(h)(2) unless and until it devised and implemented an effective supervision plan to ensure that female residents were safe from Resident 2's advances. As discussed earlier, substantial evidence supports the ALJ's finding that Libertywood failed to devise and implement such a plan after the September 6th incidents. We therefore find no basis to disturb the ALJ's finding (*see* ALJ Decision at 15) that Libertywood's noncompliance began on September 6, 2009.

b. Continuation of noncompliance after September 6

When a SNF is found to be noncompliant on a particular date, there is a rebuttable presumption that the SNF remains in a state of noncompliance afterward until sufficient corrective action is taken:

> Longstanding Board precedent holds that the regulatory scheme governing noncompliance assumes that any deficiency that has a potential for more than minimal harm is necessarily indicative of problems in the facility which need to be corrected. Thus, a facility's noncompliance is deemed to be corrected or removed only when the incidents of noncompliance have ceased and the facility has implemented appropriate measures to ensure that similar incidents will not recur.

Life Care Center of Elizabethton, DAB No. 2367, at 16 (2011) (emphasis in original, citations and quotations omitted); *see also Taos Living Center*, DAB No. 2293, at 20 (2009) (discussing the "presumption of continued noncompliance"). "The Board has made it clear," moreover, "that the facility bears the burden of showing that it returned to substantial compliance on a date earlier than that determined by CMS and has rejected the idea that CMS must establish a lack of substantial compliance during each day in which a remedy remains in effect." *Owensboro Place and Rehabilitation Center*, DAB No. 2397, at 12 (2011). That precedent is based on the statutory and regulatory scheme designed to protect vulnerable residents and to provide facilities with incentives to correct noncompliance.

Libertywood contends that a "blanket finding of 'continuing noncompliance'" after September 6, 2009 was unjustified because Resident 2's inappropriate behavior "wax[ed] and wan[ed]" and because the nursing staff responded appropriately to each incident of such behavior.[11] RR at 37-38. Given these circumstances, says Libertywood,

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[11] In support of this contention, Libertywood cites *Guardian Health Care Center*, DAB No. 1943 (2004) and the ALJ decisions in *Libertywood Nursing Center*, DAB CR1945 (2009) and *Wesley Nursing & Rehabilitation Center*, DAB CR1530 (2006). We carefully reviewed those decisions and conclude that the supervision issues they presented are not factually analogous to the supervision issue in this case.

> the ALJ should have broken down the period of alleged noncompliance into specific segments of incidents and responses rather than simply relying on sweeping generalizations about Petitioner's staff's supposed incompetence and indifference. . . . [I]t makes no sense to assert that Petitioner should have reacted to the first incidents of touching on September 6 with the same arsenal of responses that it employed after the incident involving Resident #1 more than a month later. . . . [E]ven CMS's witnesses agreed that one-to-one monitoring or consideration of involuntary discharge was not appropriate for the first incident.

RR at 38.

The apparent factual premise of this argument is that the nursing staff practiced prudent incrementalism, timely ratcheting up the intensity or scope of Resident 2's supervision whenever his problematic behavior resurfaced or the risk of harm posed by that behavior increased. We see no evidence, however, that such an approach was actually contemplated, planned, or implemented. Indeed, the nursing staff's apparent failure to reassess its supervision of Resident 2 after the October 6 incident is compelling evidence that the staff simply ignored gaps or a breakdown in supervision despite the persistence of Resident 2's advances on female residents (as documented in the September 2009 nursing notes). In addition, we do not see anything in the testimony of CMS's witnesses that could be read as expressing agreement with the view that it would have been "inappropriate" to implement one-on-one supervision sooner than October 17.[12]

Libertywood also contends that the ALJ had no basis to find that its noncompliance continued after November 17, 2009, the day Resident 2 was discharged from the facility. RR at 37. According to Libertywood, his discharge assured residents' safety because there were no other residents who exhibited sexually inappropriate behavior. RR at 37, 39.

The ALJ rejected that contention for the following reasons:

> Here, the facility's problems went beyond the actions of one "uncontrollable" resident. They included poor documentation, poor care planning, poor supervision, and behavior tracking records that were plainly

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[12] Surveyor Woodyer testified that Dr. Beittel told her in a November 16th interview that one-on-one supervision was the only effective way to prevent Resident 2 from touching other residents. CMS Ex. 29, at 3 ¶ 12. Dr. Beittel did not disavow that reported statement in his written direct testimony or assert that one-on-one supervision was unnecessary in the immediate wake of the September 6 incidents. *See* P. Ex. 26. Although he indicated that one-on-one supervision was "extremely difficult" and that "staying too close to a resident can cause him or her to get agitated," *id.* at 3-4, Dr. Beittel did not state that those concerns precluded such supervision of Resident 2 in this case.

> false. These are not the types of problems resolved by discharging one resident (although CMS determined that [Resident 2]'s discharge alleviated the immediate jeopardy). Indeed, the facility's plan of correction shows that its problems were not corrected with the November 17, 2009 discharge. Staff were disciplined for insufficiently monitoring the resident; nursing staff received inservice training on the resident's care plan; incident/accident reports were reviewed; admissions practices were changed so that the admissions committee would review a potential resident's history for inappropriate sexual behavior; the facility developed a list of interventions to address behavior problems, including immediate one-on-one supervision. Measures were also instituted to improve completion and review of incident/accident reports.

ALJ Decision at 16. We agree with the ALJ that CMS could reasonably conclude that steps such as those instituted by Libertywood after November 17, 2009 were necessary to establish that substantial compliance had been achieved.[13] Furthermore, Libertywood does not offer a credible or convincing response to the just-quoted findings. *See* RR at 37-39. Instead, it claims only that CMS never alleged or proved that there were any "systemic" problems that contributed to its deficient supervision of Resident 2 and that would have survived his discharge on November 17, 2009. *Id.* at 38-39. This claim, however, is contradicted by the record. *See, e.g.*, CMS Ex. 29, at 4 ¶ 15 (testimony by Surveyor Woodyer, a CMS witness, that Libertywood's Director of Nursing admitted in a survey interview that "staff were not filling out behavior monitoring forms correctly so that they could be used to inform nurse supervisors and herself that further investigation of behaviors was needed . . . ."). Moreover, the burden was not on CMS to prove that Libertywood's noncompliance persisted after November 17 because of systemic problems in supervising residents. *Owensboro* at 12-13. Instead, the burden was on Libertywood to prove that the measures necessary to enable it to achieve substantial compliance – such as staff training or re-training – had been completed sooner than CMS found. *Id.* Libertywood did not make this showing by, for example, proving that it had fully implemented its CMS-approved plan of correction prior to December 11, 2009. Accordingly, we affirm the ALJ's finding that Libertywood did not come back into substantial compliance earlier than December 11, 2009. *Cf. Somerset Nursing and*

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[13] We note that the ALJ cites section 488.456 and the Board's decision in *Hermina Traeye* for the proposition that, to end a remedy, a facility must prove that it was in substantial compliance and "capable of remaining in substantial compliance." ALJ Decision at 15. The language the ALJ used, however, comes from section 488.454. Section 488.454(b)(1), which applies only to "State monitoring and denial of payment imposed for repeated substandard quality of care," provides that those remedies continue not only until substantial compliance is achieved, but until CMS or the State determines the facility "is capable of remaining in substantial compliance." In *Hermina Traeye*, the Board quoted from section 488.454(e), which mentions this standard, but only as a showing required "if necessary," that is, if section 488.454(b)(1) applies. DAB No. 1810, at 12. Here, that standard does not apply, but that does not matter because Libertywood did not even show that it achieved substantial compliance at an earlier date.

Rehabilitation Facility, DAB No. 2353, at 26 (2010) (affirming the ALJ's finding that a period of immediate jeopardy did not end when a resident who had engaged in sexually inappropriate behavior was discharged because the facility had not completed corrective action to abate the jeopardy).

3. *CMS's finding that Libertywood's noncompliance was at the immediate jeopardy level of severity from September 9, 2009 through November 17, 2009 was not clearly erroneous.*

"Immediate jeopardy" is defined as "a situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident." 42 C.F.R. § 488.301. Actual harm is not a prerequisite for an immediate jeopardy finding; immediate jeopardy may exist when the noncompliance is "likely to cause" serious injury, harm, impairment, or death. 42 C.F.R. § 488.301; *Life Care Center of Tullahoma*, DAB No. 2304, at 58 (2010), *aff'd, Life Care Center of Tullahoma v. Sebelius*, No. 10-3465 (6th Cir. December 16, 2011), *available at* http://www.ca6.uscourts.gov/opinions.pdf/11a0852n-06.pdf.

CMS determined that Libertywood's noncompliance was at the immediate jeopardy level from September 6 through November 17, 2009. *See* CMS Ex. 1, at 1. That finding "must be upheld unless it is clearly erroneous." 42 C.F.R. § 498.60(c)(2); *Maysville Nursing & Rehabilitation Facility*, DAB No. 2317, at 11 (2010). The Board has held that that "under the clearly erroneous standard, the harm or threatened harm caused by the noncompliance is presumed to be serious, and the facility 'has the burden to rebut the presumption with evidence and argument showing that the harm or threatened harm did not meet any reasonable definition of 'serious.'" *Yakima Valley School*, DAB No. 2422, at 8 (2011) (*quoting Daughters of Miriam Center*, DAB No. 2067, at 9 (2007)). "The Board has further recognized that serious harm or injury can be psychological as well as physical in nature, and that serious psychological harm can result from one resident's unrestrained acts of intimidation or sexually aggressive behavior towards another resident." *Id.* (citing authorities).

Libertywood objects to the immediate jeopardy finding on three grounds, none of which persuades us that the finding was clearly erroneous.[14] First, Libertywood suggests that residents were neither harmed nor at risk of serious harm, asserting that "most of the female residents who were the subjects of [Resident 2's] unwanted attention also were confused, were not frightened, and did not recall the incidents; that none suffered any physical injury; and that only one even expressed any complaint." RR at 2. Libertywood further asserts that there is "*no evidence at all* that Resident #2's behaviors

[14] Libertywood does not challenge the ALJ's finding that it failed to meet its burden of showing that the immediate jeopardy was removed earlier than November 17, 2009.

even potentially were dangerous, and [that] CMS's witnesses understandably declined to speculate that [Resident 2's behaviors] could escalate to dangerous behavior." RR at 35, 36 n.25 (italics added). According to Libertywood, Dr. Beittel "testified that exactly the opposite is true." *Id.* at 35 (citing P. Ex. 24, at 2); *see also* RR at 14.

This argument is unpersuasive because it overlooks the declaration of Professor Burgess, who gave uncontradicted testimony that unwanted sexual contact has the potential to cause "serious trauma" to the victim; that the elderly are "more likely to be harmed by abuse or harassment due to frailty and cognitive status"; and that "[a] resident with cognitive deficits can still experience trauma from sexual abuse."[15] *See* CMS Ex. 28, at 2, 5-6 ¶¶ 8, 25. The ALJ identified other sound reasons, which we need not repeat, for rejecting Libertywood's suggestion that Resident 2's behavior did not pose a risk of serious harm. *See* ALJ Decision at 14. Moreover, whether the female residents victimized by Resident 2's behavior actually experienced psychological trauma is, for present purposes, immaterial because the occurrence of actual harm is not a prerequisite for an immediate jeopardy finding.

Second, Libertywood contends that there was no "causal connection" between its noncompliance and any threat of harm to female residents. RR at 8-9. "[W]hile it certainly is conceivable that one or more Residents suffered some degree of psychological distress from [Resident 2]'s behavior," says Libertywood, "such distress would have been caused *by [Resident 2]'s behavior*, and not by any noncompliance by Petititioner." RR at 36 (italics in original). To the extent that this argument rests on the assumption that Resident 2's victims were harmed, it is unpersuasive because, as we just indicated, a finding of immediate jeopardy does not require evidence of actual harm. Furthermore, we disagree that there was no "causal connection" between the noncompliance and the risk or threat of harm. The noncompliance in this case was Libertywood's failure to meet its regulatory duty to protect residents from Resident 2's sexually aggressive behavior. Had its nursing staff properly supervised Resident 2, the threat or risk of harm to female residents from that behavior would have been eliminated or substantially reduced. It is therefore reasonable to conclude that Libertywood's noncompliance was, at minimum, a contributing cause of the threatened harm. *See Black's Law Dictionary* (9th ed. 2009) (defining "contributing cause" as "[a] factor that – though not the primary cause – plays a part in producing a result").

Finally, Libertywood complains that the ALJ "redefined [Resident 2's] problem behavior as 'sexual assault' in order to compel the conclusion that serious harm necessarily results." RR at 35. Libertywood "respectfully suggests that while groping by a demented

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[15] In connection with its "causation" argument, which we address next, Libertywood admits that "it certainly is conceivable that one or more Residents suffered some degree of psychological stress from [Resident 2]'s behavior[.]" RR at 36.

elderly man obviously is distasteful, it trivializes more serious assaults to suggest that all instances of unwanted touching or nasty remarks have serious impacts on victims, or to speculate that even residents who appear not to be alarmed or harmed by the Resident's behavior might have some latent or delayed psychological response." RR at 35-36. We disagree. There is absolutely no indication in the ALJ's decision that she sought to "redefine" Resident 2's conduct in order to buttress CMS's immediate jeopardy finding. *See* ALJ Decision at 15. The ALJ also gave sound reasons in rejecting Libertywood's apparent suggestion that Resident 2's "groping" was, in the long-term care setting, too commonplace or not dangerous enough to warrant the facility's attention and deployment of resources. *See id.* at 12-13; *see also* P. Ex. 24, at 2-3 (testimony by Dr. Beittel acknowledging "the distress such groping can cause victims and their families"). In any event, there was at least one resident – Resident 1 – who, the evidence shows, found Resident 2's conduct more than merely "distasteful." *See* CMS Ex. 1, at 12 (describing Resident 1 as "agitated" and "very upset" after the October 17th incident).

Conclusion

For the reasons outlined above, we affirm the ALJ Decision in its entirety.

/s/
Judith A. Ballard

/s/
Leslie A. Sussan

/s/
Stephen M. Godek
Presiding Board Member