Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Maysville Nursing and Rehabilitation,
(CCN: 18-5207)

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-15-618

Decision No. CR4859

Date: May 31, 2017

DECISION

In this case, we again consider a long-term-care facility's responsibility to protect its residents from the abusive behavior of others and to report and investigate all allegations of abuse.

Petitioner, Maysville Nursing and Rehabilitation, is a long-term-care facility, located in Maysville, Kentucky, that participates in the Medicare program. Following a complaint investigation, completed September 11, 2014, the Centers for Medicare and Medicaid Services (CMS) determined that the facility was not in substantial compliance with Medicare program requirements and that its deficiencies posed immediate jeopardy to resident health and safety. CMS imposed civil money penalties (CMPs) of $4,300 per day for 39 days of immediate jeopardy and $100 per day for 8 days of substantial noncompliance that was not immediate jeopardy.

For the reasons set forth below, I find that, from July 26 through September 10, 2014, the facility was not in substantial compliance with Medicare program requirements and that, from July 26 through September 2, 2014, its deficiencies posed immediate jeopardy to resident health and safety. The penalties imposed are reasonable.

Background

The Social Security Act (Act) sets forth requirements for nursing facilities to participate in the Medicare program and authorizes the Secretary of Health and Human Services to promulgate regulations implementing those statutory provisions. Act § 1819. The Secretary's regulations are found at 42 C.F.R. pt. 483. To participate in the Medicare program, a nursing facility must maintain substantial compliance with program requirements. To be in substantial compliance, a facility's deficiencies may pose no greater risk to resident health and safety than "the potential for causing minimal harm." 42 C.F.R. § 488.301.

The Secretary contracts with state survey agencies to survey skilled nursing facilities in order to determine whether they are in substantial compliance. Act § 1864(a); 42 C.F.R. § 488.20. Each facility must be surveyed annually, with no more than fifteen months elapsing between surveys, and must be surveyed more often, if necessary, to ensure that identified deficiencies are corrected. Act § 1819(g)(2)(A); 42 C.F.R. §§ 488.20(a); 488.308. The state agency must also investigate all complaints. Act § 1819(g)(4).

In this case, surveyors from the Kentucky Cabinet for Health and Family Services (state agency) completed a partially extended complaint investigation/survey, which began on August 18, 2014, and ended on September 11, 2014. CMS Exs. 1, 21. Based on their findings, CMS determined that the facility was not in substantial compliance with multiple program requirements:

- 42 C.F.R. § 483.10(b)(11) (Tag F157) (resident rights – notification of changes) at scope and severity level J (isolated instance of substantial noncompliance that poses immediate jeopardy to resident health and safety);

- 42 C.F.R. §§ 483.13(b) and 483.13(c)(1)(i) (Tag F223) (abuse and staff treatment of residents) at scope and severity level J;

- 42 C.F.R. §§ 483.13(c)(1)(ii)-(iii), and 483.13(c)(2)-(4) (Tag F225) (staff treatment of residents: investigate and report allegations of abuse) at scope and severity level J;

- 42 C.F.R. § 483.13(c) (Tag F226 – policies to prohibit abuse and neglect) at scope and severity level J;

- 42 C.F.R. §§ 483.10(d)(3) and 483.20(k)(2) (Tag F280 – resident assessment: coordination and comprehensive care plans) at scope and severity level J;

- 42 C.F.R. § 483.20(k)(3)(ii) (Tag F282 – resident assessment: comprehensive care plans/services provided) at scope and severity level J;

- 42 C.F.R. § 483.75 (Tag F490 – administration) at scope and severity level J; and

- 42 C.F.R. § 483.75 (*l*)(1) (Tag F514 – administration: clinical records) at scope and severity level J.

CMS Ex. 21.

Surveyors revisited the facility on December 3, 2014. Based on their findings, CMS determined that the facility returned to substantial compliance on September 11, 2014. CMS Ex. 2.

CMS imposed against the facility CMPs of $4,300 per day for 39 days of immediate jeopardy (July 26 – September 2, 2014), and $100 per day for 8 days of substantial noncompliance that was not immediate jeopardy (September 3 – 10, 2014), for penalties totaling $168,500 ($167,700 + $ 800). CMS Ex. 1 at 2.

Petitioner timely requested review.

On January 11, 2017, I convened a hearing, via video conference, from the offices of the Departmental Appeals Board in Washington, D.C. Counsel and witnesses convened in Lexington, Kentucky. Ms. Leah Epstein appeared on behalf of CMS. Mr. Robert May and Mr. David Trevey appeared on behalf of Petitioner Maysville. Transcript (Tr.) 4.

The parties filed pre-hearing briefs (CMS Br.; P. Br.) and post-hearing briefs (CMS Post-hrg. Br.; P. Post-hrg. Br.). I admitted into evidence CMS Exhibits (Exs.) 1-29 and P. Exs. 1-6. Order Summarizing Prehearing Conference at 2 (October 5, 2016); Tr. 5, 6.

Issues

The issues before me are:

1. From July 26 through September 10, 2014, was the facility in substantial compliance with Medicare program requirements;

2. If, from July 26 through September 2, the facility was not in substantial compliance with program requirements, did its deficiencies then pose immediate jeopardy to resident health and safety; and

3. If the facility was not in substantial compliance, are the penalties imposed – $4,300 per day for 39 days of immediate jeopardy and $100 per day for 8 days of substantial compliance that was not immediate jeopardy – reasonable?

Discussion

1. The facility was not in substantial compliance with 42 C.F.R. § 483.10(b)(11) because staff did not immediately consult a resident's physician or notify his family about a significant change in his physical, mental, or psychosocial status and a need to alter his treatment significantly.[1]

42 C.F.R. § 483.10(b)(11) (Tag F157). The facility must protect and promote the rights of each resident. In this regard, it must immediately consult with the resident's physician and notify the resident's legal representative or interested family member (if known) of: 1) an accident involving the resident that results in injury that may require physician intervention; 2) a significant change in the resident's physical, mental, or psychosocial status (i.e., deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); or 3) a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences or to commence a new form of treatment). The Departmental Appeals Board has repeatedly explained that requiring staff to consult the physician "is not a mere formality"; the requirement guarantees that the resident will timely receive his treating physician's input as to the care he requires under the circumstances. *Senior Rehab. and Skilled Nursing Ctr.*, DAB No. 2300 at 7 (2010), *quoting Britthaven of Goldsboro*, DAB No. 1960 at 11 (2005).

Facility policy. The facility had in place a written policy requiring that it "promptly notify" the resident, his attending physician, and his representative of changes in his medical/mental condition and/or status. Among other requirements, the nurse supervisor or charge nurse must notify the physician when there has been a significant change in the resident's physical/emotional/mental condition; or a need to alter his treatment significantly. The policy defines "significant change" as a "decline or improvement in the resident's status" that: 1) will not normally resolve itself; 2) affects more than one

[1] My findings of fact/conclusions of law are set forth, in italics and bold, in the discussion captions of this decision.

area of the resident's health status; 3) requires interdisciplinary review and/or revision to the care plan; and 4) ultimately is based on the judgment of the clinical staff and the guidelines outlined in the *Resident Assessment Instrument* and 42 C.F.R. § 483.20(b)(ii). CMS Ex. 29 at 10. [2]

The policy requires notification within 24-hours except in medical emergencies. CMS Ex. 29 at 10. This is a problem inasmuch as "within 24 hours" is not "immediately." *See Magnolia Estates Skilled Care*, DAB No. 2228 at 8 (finding that "immediately" means "*without any intervening interval of time*") (emphasis added).

The policy also directs the nurse supervisor/charge nurse to "record in the resident's medical record information relative to [the] changes in the resident's medical/mental condition or status." CMS Ex. 29 at10; *see* CMS Ex. 29 at 2.

Finally, the policy dictates that a comprehensive assessment of the resident's condition will be conducted if a significant change in the resident's physical or mental condition occurs. CMS Ex. 29 at 11.

Resident 1(R1). R1 was a 74-year old woman, admitted to the facility in December 2013, suffering from a multitude of conditions, including Alzheimer's disease, advanced dementia, and anxiety. CMS Ex. 19; CMS Ex. 22 at 1; CMS Ex. 24 at 1, 8. She scored a zero on her mental status exam, indicating that she was severely impaired. Her verbal skills were limited. CMS Ex. 24 at 4; P. Ex. 2.

Resident 2 (R2). R2 was an 89-year-old man suffering from Parkinson's disease, depression, and other serious disorders. CMS Ex. 8 at 1, 8. He was, however, cognitively intact, at least through June 2014, when he scored 15 out of 15 on his mental status exam. CMS Ex. 8 at 4; *see also* Tr. at 35 (indicating mental acuity scores of 15 out of 15 in January and April 2014); CMS Ex. 8 at 4 (describing resident's appearance and appropriate answers to questions); CMS Ex. 11 at 1, 2 (indicating that the resident can

[2] This final item is confusing, and the facility did not explain its meaning. Consistent with federal regulations, I interpret it as requiring that clinical staff compare any perceived change with the resident's most recent assessment in order to determine whether there has been a significant change. Section 483.20(b)(ii) mandates that the resident's assessment include "customary routine." Why the facility's policy singles out that requirement among the 18 listed in section 483.20(b) (including cognitive patterns, mood and behavior, psychosocial wellbeing, medications) is a mystery.

understand and that he exhibits no behavior problems); CMS Ex. 12 at 1. Until July 26, 2014, he had not displayed any aggressive or otherwise inappropriate sexual behavior. CMS Ex. 8 at 6; CMS Ex. 12 at 2 (indicating "no behaviors noted"); CMS Ex. 26 at 38, 39, 40, 51, 56, 79, 151; P. Ex. 3 at 2 (Burkhart Decl. ¶ 11); P. Ex. 5 at 1 (indicating that "inappropriate behavior does not go back for any significant length of time"); Tr. 33-5.

R2's significant change. That situation changed abruptly on **July 26, 2014**. On that day, a facility visitor approached Nurse Aide Pam Jett and told her that she "might want to do something about this." The visitor then pointed to R2 and the seriously demented R1. The two residents were in wheelchairs in the hallway, and R2 had his hand in the waist band of R1's pants. CMS Ex. 26 at 57-60.[3] Nurse Aide Jett reported the incident to Licensed Practical Nurses (LPNs) Becky Jett and Kendra McCain, who, in turn, reported it to the facility administrator, Cortney Burkhart. CMS Ex. 26 at 51, 59, 60, 151; Tr. 42-43. Administrator Burkhart told staff to conduct 15-minute checks on R2 but *not* to document the incident. CMS Ex. 26 at 51, 57-60; CMS Ex. 7.[4] No one consulted R2's physician; no one notified the family or legal representative of either resident.

A nurse's note, written at 9:00 a.m. on July 26, describes R2 as "becoming slower with [wheel chair] mobility, requiring [increased] assistance more often." CMS Ex. 3 at 13.

The following day (**July 27**), R2 was trying to get into R1's room. Staff thwarted one attempt. CMS Ex. 26 at 51. But staff also reported to LPN Becky Jett that R2 had successfully entered R1's room. CMS Ex. 26 at 48. Nurse Aide Sandy Collins described the encounter: "He tried to reach [R1's] genital area [but] the over-the-bed table was in

[3] As discussed below, management directed staff *not to document these incidents* (which is, in itself, a serious deficiency). CMS Ex. 26 at 51, 52, 55, 57, 66, 68, 69, 70; *see* CMS Ex. 29 at 2 (facility policy requiring staff to document "any changes in the resident's medical or mental condition. . . ."). Because of this, the record contains no contemporaneous documentation or incident reports, and the evidence of abuse is derived from the surveyor interview notes and witness testimony – some of which is self-serving and unreliable, and much of which is not precise, especially regarding dates and times.

[4] Some evidence suggests that staff provided one-on-one supervision, although I see no documentation of it. CMS Ex. 26 at 37; *see* CMS Ex. 4 at 1. In any event, the practice was short-lived. After speaking to a consultant, who was also her mother, Administrator Burkhart directed the 15-minute checks in lieu of one-on-one supervision. *See, e.g.*, CMS Ex. 26 at 151 (indicating that staff started 15-minute checks); CMS Ex. 27 at 3; *Id.*; Tr. 46-48

the way and he could not. . . ." CMS Ex. 26 at 50, 56. Staff separated them. When they reported the incident to Administrator Burkhart, she instructed them to continue checking R2 every 15 minutes. CMS Ex. 26 at 48, 51. Again, no one consulted his physician; no one notified the family or legal representative.

On **July 28**, Nurse Aide Christian Jones reported to LPN Dianne Mitchell that R2 had put his hands under R1's shirt. LPN Mitchell reported the incident to the director of nursing (DON), Angie Brammer. CMS Ex. 26 at61, 67, 68, 69, 86-87; Tr. 52-53; *see* CMS Ex. 26 at 37. Social Service progress notes indicate that the facility administered another mental status exam that day. R2's score had dropped to 7, indicating that he was severely impaired. He was confused and forgetful. CMS Ex. 12 at 2; Tr. 24. But no one consulted his physician or notified the family/legal representative of the behaviors or the dramatic drop in his mental status score.

Petitioner offers some evidence that, on **July 29**, staff contacted R2's physician, but I don't find that evidence particularly reliable or persuasive in establishing that they *consulted* him about the resident's behavioral changes.

> The [Departmental Appeals] Board has repeatedly explained that to "consult" properly with the resident's physician, the facility must provide "all the information" the physician needs to assess properly the resident's condition and necessary treatment. "Failure to provide even one aspect of the change in a resident's condition can significantly impact whether the physician has been properly consulted."

River City Care Ctr., DAB No. 2627 at 8 (2015), *quoting Magnolia Estates Skilled Care*, DAB No. 2228 at 8-9 (2009).

Administrator Burkhart told surveyors that "Dr. Wallingford was "~~notified~~ updated of [R2's] inappropriate sexual behavior" on **July 29,** although she conceded that the facility *did not document* that it had notified him. CMS Ex. 26 at 36 (strikeout in original). A physician order for that date says that R2 may have psychiatric services "as needed." CMS Ex. 6 at 6; *see* CMS Ex. 26 at 161. But I see no evidence that staff explained the nature of R2's problem to his physician. To the contrary, progress notes simply say that his physician authorized a psychiatric exam "as needed." CMS Ex. 10. This does not suggest that staff consulted Dr. Wallingford about R2's sexual acting-out. Indeed, as discussed below, we know that, when staff reported the behaviors to Dr. Wallingford on the following day, he ordered immediate hospitalization and testing, which shows that he considered the changes significant. The contrast between Dr. Wallingford's July 29 and his July 30 orders indicates that he was not fully informed of the problem until July 30.

For his part, Dr. Wallingford told the surveyors that he first learned about R2's "change in behavior" on July 30 when he sent the resident out for a psychiatric evaluation. CMS Ex. 26 at 160.

In the meantime, the facility's social services department was arranging a psychiatric consult. Yet, the social work progress notes say "no behaviors at this time," which was patently false and undermines Petitioner's suggestion that staff accurately described R2's behaviors to Dr. Wallingford or anyone else. CMS Ex. 12 at 2-3.

As of **July 30**, R2 was continuing to stalk R1. LPN Sue Zapf pulled DON Brammer out of a staff meeting to report R2's behavior. Petitioner has been deliberately vague as to what R2's behaviors entailed, suggesting that nothing untoward occurred, which I find unlikely. CMS Ex. 3 at 14; CMS Ex. 26 at 51-52, 55. Whatever R2's actions that day, they caused the facility finally to consult Dr. Wallingford about the behavioral changes, describing increased confusion and "inappropriate behaviors" toward another resident. Dr. Wallingford ordered that R2 be tested for a urinary tract infection and that he be transferred to the hospital for psychiatric evaluation. Administrator Burkhart also finally notified R2's family member (his daughter-in-law, who was also Administrator Burkhart's aunt) of the behavioral changes. CMS Ex. 3 at 14-15; CMS Ex. 6 at 7; CMS Ex. 26 at 36, 52, 87; P. Ex. 5; Tr. 41.

Prior to the transfer, staff administered another mental status exam; R2 scored 10, indicating moderate impairment. CMS Ex. 26 at 161; Tr. 23.

Referring to physician reports from 2012, in which R2's physician lists "dementia" as an "impression," Petitioner argues that R2 did not undergo a significant change because he was already suffering from dementia. P. Cl. Br. at 8; P. Ex. 1 at 3, 4. Although R2 had Parkinson's disease, I see no objective evidence to support the proposition that he was demented prior to July. Even if he were, there are many levels of dementia, and, as of June 2014, the facility's own testing showed that his mental status was intact. CMS Ex. 8 at 4. Most important, everyone agrees that he had never exhibited behavioral issues before. The change in behavior and increased confusion represented significant changes.

Further, when R2's physician learned of the new behaviors, he ordered hospitalization, a psychiatric evaluation, a mental status examination, and that R2 be tested to rule out a urinary tract infection (which can cause behavioral changes). CMS Ex. 26 at 87. This represents a need to alter treatment significantly. That an appropriate diagnosis or treatment may ultimately have eluded the medical professionals does not relieve the facility of its responsibility to consult and report.

Finally, R2's situation falls squarely within the facility's own definition of "significant change." His sudden changes in behavior and dramatic deterioration in mental acuity could not normally be expected to resolve itself and represented a significant change

from his latest assessment. The changes required interdisciplinary review and a change to his care plan (see discussion below). CMS Ex. 29 at 10.

Thus, a previously mentally competent resident suddenly began to engage in sexually inappropriate behaviors with an incompetent resident and was unable to explain why. His mental acuity dropped sharply. Staff described him as "confused," which he had not been previously. He required hospitalization and testing. This represented a significant change in his mental, psychosocial, and, perhaps, physical status, as well as a need to alter treatment significantly. Facility staff were therefore obligated to consult immediately his physician and notify his family of the change. Because they failed to do so, the facility was not in substantial compliance with 42 C.F.R. § 483.10(b)(11).

2. ***The facility was not in substantial compliance with 42 CFR §§ 483.13(b) and (c) and 483.75 (l)(1) because its administration and staff did not follow the facility's policies and procedures for preventing abuse, and they did not immediately report or thoroughly investigate instances of abuse or potential abuse. In fact, the facility attempted to conceal the abuse by failing to maintain records of the incidents.***

42 C.F.R. § 483.13(b) and (c) (Tags F223, 225, and 226). The regulation governing resident behavior and facility practices mandates that each resident "has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion." 42 C.F.R. § 483.13(b). Abuse is defined as "the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish." 42 C.F.R. § 488.301.

In order to keep residents free from abuse, facilities must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents. Among other requirements, the facility must ensure that all alleged violations are reported immediately to the facility administrator and appropriate state officials. 42 C.F.R. § 483.13(c). The facility must have evidence that all alleged violations are thoroughly investigated, and it must prevent further potential abuse while the investigation is in progress. The results of all investigations must be reported to the administrator (or designated representative) and to the appropriate state officials within five working days of the incident. If the violation is verified, the facility must take appropriate action. 42 C.F.R. § 483.13(c)(2), (3), and (4).

Facility policies – abuse: The facility had in place a written policy and procedures for reporting abuse. The policy requires that "all personnel promptly report any incident or suspected incident of resident abuse." CMS Ex. 29 at 3. The policy adopts the regulatory definition of abuse ("the willful infliction of injury, unreasonable confinement,

intimidation, or punishment with resulting physical harm, pain or mental anguish.") and further defines sexual abuse "as, but is not limited to, sexual harassment, sexual coercion, or sexual assault." CMS Ex. 29 at 3, 8.

According to the policy, the facility does "not condone resident abuse by anyone," including other residents. To prevent abuse:

- Staff are required to report immediately to the charge nurse and the administrator or DON any allegation of abuse. CMS Ex. 29 at 3, 4.

- The charge nurse must "immediately examine and interview the [affected] resident." CMS Ex. 29 at 4.

- Upon receiving a report of abuse, the DON or administrator must "immediately report the incident" to the state Division of Licensing and Regulation, Adult Protective Services, and other agencies, as appropriate. CMS Ex. 29 at 4.

- The charge nurse must complete an incident report and obtain a written, signed, and dated statement from the person reporting the incident. CMS Ex. 29 at 5. A completed copy of the incident report and any written statements must be provided to the administrator "immediately." An investigation will ensue and the findings will be provided to the administrator within five days. The results of the investigation must be faxed to the state licensing agency. CMS Ex. 29 at 5.

- These reporting procedures must be followed in situations of resident-on-resident abuse or suspected abuse. CMS Ex. 29 at 3.

- When informed of abuse or potential abuse, the DON will ask someone from the social services department to "monitor the [affected] resident's feelings" about the incident as well as the resident's reactions to her involvement in the investigation. The representative must document "any concerns and conversations." CMS Ex. 29 at 5.

A separate policy addresses abuse investigations. According to that policy, *all* reports of resident abuse must be "promptly and thoroughly investigated by facility management." CMS Ex. 29 at 6. The facility administrator or her designee investigates all incidents or suspected incidents of abuse. At a minimum, the investigator:

- reviews the completed documentation;

- reviews the resident's medical record to determine the events leading up to the incident;

- interviews the person reporting the incident;
- interviews any witnesses;
- interviews the resident (as medically appropriate);
- consults the resident's attending physician to determine the resident's current level of cognitive function and medical condition;
- interviews staff members on all shifts who have had contact with the resident at the time of the alleged incident;
- interviews the resident's roommate, family members, and visitors; and
- reviews all events leading up to the alleged incident.

CMS Ex. 29 at 6. Witness reports will be in writing, signed, and dated. CMS Ex. 29 at 6.

The administrator or her designee notifies the ombudsman that an abuse investigation is underway and invites the ombudsman to participate in the review. CMS Ex. 29 at 6.

The administrator will keep the resident or her representative informed of the investigation's progress. The results of the investigation will be recorded on approved forms. The administrator will inform the resident or her representative of the investigation's results and corrective action. CMS Ex. 29 at 6. Finally, within five working days of the reported incident, the administrator must provide to the state agency, the local police department, the ombudsman, and others (as required by law) copies of a written investigative report. CMS Ex. 29 at 7.

Facility noncompliance: abuse. It is difficult to overstate the level of Petitioner's noncompliance with sections 483.13(b) and (c). First, the facility did not keep R1 free from sexual abuse. As discussed above, on July 26, R2 began molesting or attempting to molest her. Over a period of four days he stalked and harassed her, sometimes managing to lay hands on her. This meets the regulatory definition of abuse, as well as the facility's own definition of sexual abuse, which includes sexual harassment, coercion, and assault. 42 C.F.R. § 488.301; CMS Ex. 29 at 3, 8; *see* CMS Ex. 15; CMS Ex. 17 at 2 (reporting that R2 has been "acting out sexually" and "putting his hands between the legs of a [nonconsenting] female resident"); CMS Ex. 26 at 36 (describing R2's behavior as "inappropriate sexual behavior"); CMS Ex. 26 at 60 (describing R2's behavior as "sexually inappropriate").

Petitioner denies that R1 was sexually abused and, in fact, congratulates itself on not "jumping to the conclusion" that R2's behavior was sexual and "shaming him" when his cognition was evidently impaired. P. Post-hrg. Br. at 2. According to Petitioner, the "inappropriate touching" does not "rise to the level of sexual abuse "due to the cognitive status of the residents in question." P. Ex. 2 at 3 (Burkhart Decl. ¶ 10).

Petitioner's argument is flawed in multiple ways. First, no one has suggested that R2 should have been "shamed"; in fact, doing so would have violated multiple regulations. *See, e.g.*, 42 C.F.R. § 483.10; 483.13; 483.15(a). But both R2 and R1 required a level of protection that the facility should have provided without "shaming" or punishing any of its residents.

Second, because of R2's deteriorating mental status, he may not have been able to control or fully understand the implications of his actions. But so long as his actions were "deliberate" rather than accidental or inadvertent, they are considered "willful" within the meaning of the regulation. *Merrimack County Nursing Home*, DAB No. 2424 at 5 (2011); *Britthaven, Inc., d/b/a Britthaven of Smithfield*, DAB No. 2018 at 4 (2006); *cf. Singing River Rehab. & Nursing Ctr.*, DAB No. 2232 at 13 (2009) (suggesting that, so long as a mentally ill resident did not act "by accident," his conduct was abusive).

Third, I reject as disingenuous and plainly false Petitioner's claim that the alleged abuse was limited to one isolated incident, after which staff began 15-minute checks, effectively preventing further problems. P. Post-hrg. Br. at 12. In making this claim, the facility has absolutely no credibility inasmuch as – at management's direction – staff did not document any incidents. CMS Ex. 26 at 36, 51, 52, 55, 57, 66, 68, 69, 70. This was not an oversight, but management's deliberate attempt to conceal abuse, which effectively renders suspect all of the facility's records. Thus, the facility can hardly argue, based on the absence of documentation, that incidents did not occur.

Despite management's efforts at concealment, the record contains evidence sufficient to establish ongoing abuse and the facility's inadequate response to it. In addition to the July 26 (hands-in-pants) incident, we have evidence of R2 stalking R1, entering her room, attempting to touch her, and putting his hands under her shirt. *See, e.g.*, CMS Ex. 26 at 50, 56 (describing R2's attempt to reach R1's genital area). Petitioner dismisses the July 28 (hands-under-the-shirt) incident by lamenting that "[w]e do not have the benefit of an eye-witness account" so cannot know what actually happened. But staff unquestionably witnessed and reported the event. CMS Ex. 26 at 56, 67-69 We have no eye-witness *account* because neither the administrator, her designee, nor anyone else bothered to interview the witnesses, much less prepare written, signed and dated witness reports, as required by the facility's policy and federal regulations. CMS Ex. 29 at 6.

Facility noncompliance: failure to report and investigate. Ultimately, I need not find that R2 abused R1 in order to find that the facility was not in substantial compliance with section 483.13. The regulation and the facility's own policies require the facility to report immediately and to investigate thoroughly *all alleged* violations. The reporting requirements are triggered by any *allegation* of abuse, whether or not it is recognized as such by the facility. *Illinois Knights Templar Home*, DAB No. 2369 at 11, 12 (2011).

Here, facility staff dutifully reported the abuse to the facility administrator, but, as Petitioner concedes, Administrator Burkhart did not report the incidents to the appropriate state officials; she did not investigate the violations; indeed, at her direction, no incident reports were prepared. P. Post-hrg. Br. at 4, 14-15; CMS Ex. 26 at 36-38; P. Ex. 3 (Burkhart Decl. ¶¶ 7, 8, , and 10).

Petitioner justifies its inaction by arguing that no resident was harmed as a result of R2's actions. It cites staff claims that R1 "did not appear" to be upset. P. Post-hrg. Br. at 14-15; Ex. 26 at 59. But the facility did not assess properly R1's reaction to the abuse. Its policies required someone from the social services department to monitor the victim of the abuse or possible abuse. CMS Ex. 29 at 5. Because R1 was so cognitively impaired, she required careful observation by someone who knew her well. CMS Ex. 5 at 3 (Foster Decl. ¶ 12). The longer the delay, the more difficult it is to assess the mental and emotional impact of the abuse. CMS Ex. 9 at 3 (Miles Decl. ¶ 13). No one from social services or any other department carefully observed R1. I do not consider sufficient the curt physician report, generated after R1 had been admitted to the hospital and days after the abuse began (July 31). CMS Ex. 22 at 1. Because the facility did not properly assess R1's condition, it cannot now claim that she suffered no harm. *See Libertywood Nursing Ctr. v. Sebelius*, 512 F. App'x 285; 2013 WL 729786 (4th Cir. 2013), *quoting Libertywood Nursing Ctr.*, DAB CR2388 (2011) (The facility "can hardly be allowed to benefit from such disregard for its vulnerable resident[].")

In any event, whether R2's behavior caused R1 actual harm is not material. Because the facility failed to protect her "from reasonably foreseeable risks of abuse," it was not in substantial compliance. *Holy Cross Village at Notre Dame, Inc.*, DAB No. 2291 at 7 (2009).

The facility was required to keep its residents free from abuse. 42 C.F.R. § 483.13(b). Section 483.13(c)(1)(i) puts the onus on it to protect its residents by developing and implementing policies that prevent resident-to-resident abuse. *See, e.g., Martha and Mary Lutheran Servs.*, DAB No. 2147 at 12-13 (2008) (finding substantial noncompliance with section 483.13(c) where facility staff failed to implement facility policies and procedures to prevent resident-to-resident abuse). Because the facility here did not keep its residents free from abuse and did not implement its own policies for preventing abuse, it was not in substantial compliance with sections 483.13(b) and 483.13(c).

42 C.F.R. § 483.75(*l*)(1) (Tag F514). In accordance with professional standards and practices, the facility must maintain clinical records on each resident that are complete, accurate, readily accessible, and systematically organized. 42 C.F.R. § 483.75(*l*)(1).

Facility policies – clinical records. As noted above, the facility's policies dictate that the nurse supervisor/charge nurse "record in the resident's medical record information relative to [the] changes in the resident's medical/mental condition or status." CMS Ex. 29 at10; *see* CMS Ex. 29 at 2. The facility policy for preventing abuse (including resident-on-resident abuse or suspected abuse) also requires the charge nurse to complete an incident report and obtain a written, signed, and dated statement from the person reporting the incident. CMS Ex. 29 at 5. Witness reports must be in writing, signed, and dated. CMS Ex. 29 at 6.

Facility noncompliance – failing to maintain complete and accurate records. No one disputes that standard nursing practice requires nursing staff to document, in nursing notes and incident reports, all instances of abuse or suspected abuse. CMS Ex. 5 at 3 (Foster Decl. ¶ 15); CMS Ex. 9 at 3 (Miles Decl. ¶ 17). The facility violated the regulations and its own policies because, as discussed above, its administrator directed the nursing staff *not* to document the incidents of abuse or suspected abuse and not to prepare incident reports. CMS Ex. 26 at 36, 51, 52, 55, 57, 66, 68, 69, 70.

3. The facility was not in substantial compliance with 42 C.F.R. § 483.20 because its administration and staff did not revise a resident's care plan based on a comprehensive assessment of his change in condition.

42 C.F.R. §§ 483.10(d)(3) and 483.20(k)(2) and (3) (Tags 280 and 282). Initially and periodically, the facility must conduct a "comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity" and must use the results of those assessments to develop, review, and revise the resident's comprehensive care plan. 42 C.F.R. § 483.20. After each assessment, a team of qualified persons must review and revise the plan. 42 C.F.R. § 483.20(k)(2). Services provided or arranged by the facility must be provided by qualified persons in accordance with the resident's written plan of care. 42 C.F.R. § 483.20(k)(3).

Facility policies – care plans. The facility had in place a policy for developing individualized care plans. The policy generally echoes the requirements of the regulations to base each resident's plan on his or her assessment. According to the policy, assessments are ongoing and care plans are to be revised "as information about the resident and the resident's condition changes." An interdisciplinary team is responsible for updating care plans when "*there has been a significant change in the resident's condition*." CMS Ex. 29 at 1. Emphasis added.

Facility noncompliance: assessments and care plans. Petitioner claims that it updated R2's care plan "after every verified incident." P. Post-hrg. Br. at 16. Review of the care plan shows that this is not so. An undated entry to the care plan refers vaguely to the resident's "inappropriate behavior." An entry dated July 26, 2014 reads "redirected from [R1's] room" and "15 minute checks." CMS Ex. 4 at 1.[5] As the above discussion shows, that intervention was ineffective, yet the facility made no changes to R2's care plan. *See Deltona Health Care*, DAB No. 2511 at 19 (2013) (finding that the facility violated section 483.20 because it waited four days before updating interventions that had proved ineffective).

R2 was admitted to the hospital on July 30 and released to the facility on August 4. P. Ex. 5. Upon his readmission, the facility made no changes to his care plan but continued directing staff to conduct 15-minute checks. CMS Ex. 4 at 1. It seems unlikely that the intervention would have been any more effective than it was previously, but that question is purely academic since staff did not implement the care plan directions. They did not check on R2 every 15 minutes as required. CMS Ex. 26 at 41. Not surprisingly, following his return from the hospital, R2's abusive behavior did not stop. CMS Ex. 26 at 36, 63 (reporting that his hand was in R1's pants, "you could see it clearly").

CMS also points out that the facility failed to review and revise R1's care plan as required. Because of her dementia, R1 had a tendency to disrobe. P. Ex. 3 at 2 (Burkhart Decl. ¶ 12). Yet R1's care plan does not even mention the behavior, much less instruct staff on how to address it. CMS Ex. 18 at 4.

4. The facility was not in substantial compliance with 42 C.F.R. § 483.75 because the facility was not governed in a manner that enabled it to use its resources effectively to attain or maintain the highest practicable physical, mental, and psychosocial well-being of its residents.

42 C.F.R. §§ 483.75 and 483.75(*l*)(1) (Tags 490 and 514). The facility must be governed 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.

Facility noncompliance: administration. A finding of substantial noncompliance in the facility's administration may derive from findings of substantial noncompliance in other areas.

[5] No evidence suggests that an interdisciplinary team devised the new intervention, as required by the regulation. It seems that Administrator Burkhart acted on her own in directing the 15-minute checks. CMS Ex. 26 at 51.

> [W]here a facility has been shown to be so out of compliance with program requirements that its residents have been placed in immediate jeopardy, the facility was not administered in a manner that used its resources effectively to attain the highest practicable physical, mental, and psychosocial well-being of each resident.

Asbury Center at Johnson City, DAB No. 1815 at 11 (2002); *Odd Fellow and Rebekah Health Care Facility*, DAB No. 1839 at 7 (2002); *Stone County Nursing and Rehab. Ctr.*, DAB No. 2276 at 15-16 (2009). As discussed below, I find that the facility's deficiencies posed immediate jeopardy to resident health and safety, which, by itself, justifies the finding that the facility was not in substantial compliance with 42 C.F.R. § 483.75.

Moreover, as the above discussion establishes, the failures here were directly attributable to administrative failures. The facility's administration disregarded facility policies when it failed to investigate and report timely allegations of resident abuse. Indeed, it affirmatively prevented staff from documenting instances of abuse. The administration also fell short in protecting R1 from a potential abuser. The facility was therefore not administered in a manner that used its resources effectively to attain or maintain the highest practicable physical, mental, and psychosocial well-being of its residents and was not in substantial compliance with 42 C.F.R. § 483.75.

5. CMS's determination that the facility's substantial noncompliance posed immediate jeopardy to resident health and safety is not clearly erroneous.

Immediate jeopardy. Immediate jeopardy exists if a facility's noncompliance has caused or is likely to cause "serious injury, harm, impairment, or death to a resident." 42 C.F.R. § 488.301. CMS's determination as to the level of a facility's noncompliance (which would include an immediate jeopardy finding) must be upheld unless it is "clearly erroneous." 42 C.F.R. § 498.60(c). The Board has observed repeatedly that the "clearly erroneous" standard imposes on facilities a "heavy burden" to show no immediate jeopardy and has sustained determinations of immediate jeopardy where CMS presented evidence "from which '[o]ne could reasonably conclude' that immediate jeopardy exists." *Barbourville Nursing Home*, DAB No. 1931 at 27-28 (2004), *citing Koester Pavilion*, DAB No. 1750 (2000); *Daughters of Miriam Ctr.*, DAB No. 2067 at 7, 9 (2007).

In challenging the immediate jeopardy determination, Petitioner repeats its arguments that it was in substantial compliance and that no resident suffered harm.

I have discussed in detail above why the facility was not in substantial compliance.

I have also observed that, because the facility did not properly assess R1's condition, it is not in a position to claim that she suffered no injury. *See Libertywood Nursing Ctr. v. Sebelius*, 512 F. App'x 285; 2013 WL 729786 (4th Cir. 2013), *quoting Libertywood Nursing Ctr.*, DAB CR2388 (2011) (The facility "can hardly be allowed to benefit from such disregard for its vulnerable resident[]."

In any event, I need not find that the facility's noncompliance caused actual harm or injury to a resident. So long as the deficiencies are *likely* to cause serious injury or harm, they pose immediate jeopardy. Here, R2 suddenly began to engage in sexually aggressive behavior while his cognitive function dropped dramatically (from essentially normal to severely impaired). No one knew why. Yet no one consulted his physician or notified his family, errors that are likely to cause serious injury or harm to both R2 and the victim of his sudden aggression.

Moreover, by their very nature, incidents of sexual abuse and harassment are likely to cause serious injury or harm. Beyond that, management's refusal to investigate and report allegations of abuse – indeed its deliberate attempt to cover-up the incidents – creates a dangerous situation for all of the facility residents.

CMS's determination that the deficiencies posed immediate jeopardy to resident health and safety is therefore not clearly erroneous.

6. The penalties imposed are reasonable.

To determine whether the CMPs are reasonable, I apply the factors listed in 42 C.F.R. § 488.438(f): 1) the facility's history of noncompliance; 2) the facility's financial condition; 3) factors specified in 42 C.F.R. § 488.404; and 4) the facility's degree of culpability, which includes neglect, indifference, or disregard for resident care, comfort or safety. The absence of culpability is not a mitigating factor. The factors in 42 C.F.R. § 488.404 include: 1) the scope and severity of the deficiency; 2) the relationship of the deficiency to other deficiencies resulting in noncompliance; and 3) the facility's prior history of noncompliance in general and specifically with reference to the cited deficiencies.

I consider whether the evidence supports a finding that the amount of the CMP is at a level reasonably related to an effort to produce corrective action by a provider with the kind of deficiencies found, and in light of the above factors. I am neither bound to defer to CMS's factual assertions, nor free to make a wholly independent choice of remedies without regard for CMS's discretion. *Barn Hill Care Ctr.*, DAB No. 1848 at 21 (2002); *Community Nursing Home*, DAB No. 1807 at 22 *et seq.* (2002); *Emerald Oaks*, DAB No. 1800 at 9 (2001); *CarePlex of Silver Spring*, DAB No. 1638 at 8 (1999).

Here, CMS imposes a penalty of $4,300 per day for each day of immediate jeopardy, which is at the very low end of the range for the applicable per day CMP ($3,050-$10,000). 42 C.F.R. §§ 488.408(e)(1)(iii); 488.438(a)(1)(i). For the period of substantial noncompliance that was not immediate jeopardy, CMS imposes a penalty of $100 per day, also at the very low end of the applicable penalty range ($50-$3,000). 42 C.F.R. § 488.408(d)(1)(iii); 488.438(a)(1)(ii). Considering the relevant factors, these penalties are reasonable.

CMS does not argue that the facility's history justifies a higher CMP. Petitioner does not claim that its financial condition affects its ability to pay the CMP.

Applying the remaining factors, the facility's administration deliberately disregarded the policies in place to protect residents from abuse. It declined to investigate and report allegations of abuse. Even worse, it disregarded professional standards of practice and directed its nursing staff not to document instances of abuse and alleged abuse. The facility is culpable for these very serious failings.

For these reasons, I find that the relatively modest CMPs are reasonable.

Conclusion

From July 26 through September 10, 2014, the facility was not in substantial compliance with Medicare program requirements and, from July 26 through September 2, 2014, its deficiencies posed immediate jeopardy to resident health and safety. The penalties imposed – $4,300 per day for 39 days of immediate jeopardy and $100 per day for eight days of substantial noncompliance that was not immediate jeopardy – are reasonable.

/s/
Carolyn Cozad Hughes
Administrative Law Judge