Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Kingsbrook Lifecare Center,
(CCN: 18-5449),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-12-647

Decision No. CR3314

Date: August 1, 2014

DECISION

I sustain the determinations of the Centers for Medicare & Medicaid Services (CMS) that Kingsbrook Lifecare Center (Petitioner or the facility) was not in substantial compliance with Medicare program requirements. Further, I do not find CMS's determinations of immediate jeopardy were clearly erroneous. I also sustain as reasonable CMS's imposition of civil money penalties (CMPs) of $4,600 per day for 27 days (December 25, 2011 through January 20, 2012) and $200 per day for 52 days (January 21, 2012 through March 13, 2012) for a total CMP of $134,600.

I. Procedural Background

Petitioner is a long-term care facility in Ashland, Kentucky. It participates in Medicare as a skilled nursing facility and the state Medicaid program as a nursing facility. On February 3, 2013, the Kentucky Division of Health (State Agency) completed a recertification and complaint investigation survey of Petitioner's facility. The State Agency found that Petitioner was not in substantial compliance with participation requirements, and its deficiencies constituted immediate jeopardy with respect to: 42 C.F.R. §§ 483.13(c) (preventing abuse and neglect), 483.15(g)(1) (providing social

services to residents), 483.20(d) and 483.20(k) (developing comprehensive care plans), 483.25(h) (supervising residents), and 483.75(administering the facility). By letter dated March 1, 2012, CMS notified Petitioner that it was accepting the State Agency's findings and imposing CMPs as a remedy.[1]

Petitioner timely requested a hearing before an administrative law judge (ALJ). Petitioner sought review for only six deficiencies cited as subjecting the facility's residents to a pattern of immediate jeopardy to their health and safety (scope and severity level K).[2] The case was assigned to me for hearing and decision. On May 3, 2012, I issued an Acknowledgment and Initial Pre-hearing Order. On December 17, 2012, I convened a prehearing conference with the parties. In that conference the parties agreed to the articulation of the issues that I would be deciding, I admitted to the record without objection CMS exhibits (Exs.) 1-19 and Petitioner's exhibits (P. Exs.) 1-25, and the parties indicated which witnesses they wished to cross-examine at a video hearing considering that I required affidavits of direct testimony be included as exhibits prior to the hearing. I convened a hearing by video teleconference on March 27, 2013, which consisted of the cross-examination of three witnesses. The parties filed pre-hearing briefs (CMS PH Br. and P. PH Br.), post-hearing briefs (CMS Br. and P. Br.), and post-hearing reply briefs (CMS Reply and P. Reply).

II. Issues Presented

1. Whether Kingsbrook failed to comply substantially with Medicare program requirements;

2. Whether CMS's determinations of immediate jeopardy to the health and safety of the Petitioner's residents were clearly erroneous; and

3. Whether CMS's determinations of CMPs are reasonable in amount and duration.

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[1] CMS also proposed termination, denial of payment for new admissions, and loss of any approved Nurse Aide Training and Competency Evaluation Program (NATCEP) if so notified by the State. CMS Ex. 7 at 15-17. On April 12, 2012, CMS notified Petitioner that it achieved substantial compliance as of March 13, 2012 and that the denial of payment for new admissions and termination action did not go into effect. CMS Ex. 7 at 21. Petitioner did not receive notification from the State with respect to any NATCEP, and therefore those remedies are not at issue here.

[2] Petitioner did not appeal the other cited deficiency findings that did not involve immediate jeopardy, and they became administratively final. *See* CMS. Ex. 1; Petitioner's Request for Hearing.

III. Statutory and Regulatory Framework

The Social Security Act (Act) sets forth requirements for participation of a long-term care facility in the Medicare program, as a skilled nursing facility, and the Medicaid program, as a nursing facility, and authorizes the Secretary of the U.S. Department of Health and Human Services (Secretary) to promulgate regulations implementing those statutory provisions. Act §§ 1819, 1919.[3] The Secretary's regulations are found at 42 C.F.R. Part 483. To participate in the Medicare program, a skilled 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 Act authorizes the Secretary to impose enforcement remedies against a long-term care facility for failure to comply substantially with the federal participation requirements. The Secretary has delegated to CMS and the states the authority to impose remedies against a long-term care facility not in substantial compliance with program participation requirements. State agencies survey facilities on behalf of CMS to determine whether the facilities comply with federal participation requirements. 42 C.F.R. §§ 488.10-.28, 488.300-.335.

CMS may impose a per-day CMP for the number of days a facility is not in substantial compliance or a per-instance CMP for each instance of the facility's noncompliance. 42 C.F.R. § 488.430(a). A per-day CMP, which CMS imposed in this case, may range from either $50 to $3,000 per day for less serious noncompliance or $3,050 to $10,000 per day for more serious noncompliance that poses immediate jeopardy to the health and safety of residents. 42 C.F.R. § 488.438(a)(2). "Immediate jeopardy" exists when "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.

If CMS imposes one or more enforcement remedies against a long-term care facility based on a noncompliance determination, the facility may request a hearing before an ALJ to challenge the noncompliance finding and enforcement remedies. Act §§ 1128A(c)(2), 1866(h); 42 C.F.R. §§ 488.408(g), 498.3(b)(13).

IV. Factual Background

This matter involves incidents between a male resident (Resident 22) and certain female residents (Residents 1, 2, and 29). All the residents were cognitively impaired and

[3] The Act, as amended, is available at http://www.ssa.gov/OP_Home/ssact/ssact.htm. On this website, each section of the Act contains a reference to the corresponding chapter and code in the United States Code.

resided on the facility's locked dementia unit. The following facts are undisputed unless otherwise noted.

Petitioner reported to the State Agency that Resident 22 had sexual contact with Resident 1 on December 25, 2011. CMS Ex. 2. The State Agency began a complaint survey on January 3, 2012 and ultimately determined that Residents 1, 2, and 29 had been subjected to potentially inappropriate contact with Resident 22.

Specifically, the first incident occurred on December 25, 2011, at around 11:30 a.m. A State Registered Nurse Aide (SRNA) found Resident 22, an 88 year-old wheelchair-bound male resident, in Resident 1's room with Resident 1 lying across her bed on her stomach with her pants and briefs pulled down past her knees. CMS Ex. 1 at 1-2. Resident 22 was between her legs, touching her genital area with his hands and mouth. CMS Ex. 2; CMS Ex. 10 at 83; CMS Ex. 14 at 1. The SRNA removed Resident 22 from the room, escorted him to the nurses' station, and informed the day shift nurse what occurred. CMS Ex. 14 at 1. The same SRNA reported to the afternoon shift nurse that later in the shift, around 4 p.m., the Licensed Practical Nurse (LPN) on the afternoon shift saw Resident 22 rubbing the upper leg of Resident 2. CMS Ex. 2; CMS Ex. 14 at 1, 15; P. Ex. 2. Neither the day shift nurse nor the afternoon shift nurse reported the incidents to anyone. CMS Ex. 14 at 1, 13, 18; P. Ex. 2.

It was not until around 10 -10:30 p.m., when the Weekend Supervisor, an LPN, was making her rounds and heard about the earlier incident with Resident 22 and Resident 1 that she notified the Assistant Director of Nursing and Social Services Manager and initiated 15 minute checks, beginning at 11 p.m. that night, for both Resident 22 and Resident 1.[4] CMS Ex. 12 at 176; CMS Ex. 14 at 13. On the morning of December 26, 2011, the facility's Administrator learned of the incident between Resident 22 and Resident 1 and initiated one on one supervision of Resident 22. P. Ex. 5 at 1. According to the Administrator, although it was not documented in "patient charts," this one on one supervision occurred and continued until December 29, 2011. P. Ex. 5 at 1.

On January 5, 2012, a State Agency surveyor observed Resident 22 rubbing Resident 29's left hand on his upper right thigh, and kissing up and down the length of Resident 29's arm and hand. CMS Ex. 1 at 18, 39; CMS Ex. 12 at 187. A staff member was present when this occurred and within direct view of the incident, but she did not intervene. CMS Ex. 1 at 18; CMS Ex. 12 at 188. Later that same day, the State Agency surveyor observed Resident 22 rubbing Resident 29's thigh and then pulling Resident 29 backwards by her arms while she was sitting in a geriatric (geri) chair, an upholstered recliner on wheels that can be pushed around like a wheel chair. CMS Ex. 1 at 39. The

[4] According to Resident 22's care plan, the 15-minute checks were discontinued on January 3, 2012. CMS Ex. 12 at 46.

surveyor made the staff member aware of this activity by clearing her throat to get her attention, and the staff member then separated the residents. CMS Ex. 1 at 39; P. Ex. 4. Later that day Resident 22 transferred to River Park Hospital, a psychiatric hospital, for evaluation because he was "acting out physically and sexually." CMS Ex. 12 at 121, 123.

According to the psychiatric hospital's admission records, the facility transferred Resident 22 "due to worsening physical agitation and showing sexual behaviors to staff and other residents. He reportedly has been wandering in and out of other resident's rooms while redirection has been quite difficult" and performance of his activities of daily living "have been difficult" as "he often became combative . . . trying to hit and kick the helping staff." CMS Ex. 12 at 123. He was readmitted to Petitioner's facility on January 16, 2012. CMS Ex. 12 at 131; P. Ex. 5.

Resident 22 was initially admitted to Petitioner's facility on September 13, 2010, with diagnoses including senile dementia, anxiety disorder, psychotic disorder, and psychosis. CMS Ex. 12 at 5, 20. Petitioner assessed Resident 22 as having "severely impaired" cognitive skills for daily decision making. CMS Ex. 12 at 12.

Resident 22 was 6 feet, 2 inches tall and weighed 202 pounds at the time of his admission to the facility. CMS Ex. 12 at 24. The record suggests he had a history of making sexual comments and gestures to staff and had exposed himself to staff prior to December 25, 2011. Tr. 186; P. Ex. 5 at 2 (Affidavit of the facility's Administrator)("[I] am aware of the fact that he [Resident 22] occasionally made sexual comments to female staff members"); CMS Ex. 1 at 13 (from State Agency surveyor interviews with facility staff, "SRNA #5 revealed that she cared for Resident 22 since 2010" and "[he] always made sexual comments"; LPN #1 "recalled Resident #22 unzipping [his] pants and exposing [himself] . . .;" SRNA #1 "revealed when she provided care for Resident #22, [he] was often 'touchy feely'"; SRNA #3 "revealed when she cared for Resident #22 [he] made sexual statements and gestures"; and LPN #3 "revealed that she had heard Resident #22 making sexual remarks and hand gestures (as though [he] was touching [his] genitals)"); CMS Ex. 14 at 4-5, 19, 52, 58.

While facility staff coded Resident 22 as needing extensive assistance with locomotion, nursing notes (discussed below) documented R22's ability to move throughout the dementia unit in his wheelchair without assistance. CMS Ex. 12 at 16. Within two months of his admission to the facility, nursing notes indicated Resident 22 showed signs of agitation. He would wander into the rooms of female residents and wake them while they slept. CMS Ex. 12 at 152. Staff could not redirect him, and he would repeatedly

wander through the hallways cursing, yelling, and attempting to hit and kick at residents and staff.[5]

- On November 16, 2010, nurses' notes indicated that Resident 22 was entering female residents' rooms in his wheelchair and going up to their beds and waking them. CMS Ex. 12 at 152.
- On November 23, 2010, the notes stated that Resident 22 was agitated and wanted to go out; that he was in and out of residents' rooms, kicking the door and screaming to go out and get his truck, and that he attempted to hit with his fist one of the SRNAs. *Id.* at 154.
- Later that day Petitioner noted that Resident 22 was fighting and combative with staff. *Id.* at 154.
- On January 10, 2011, nurses' notes stated that Resident 22 was verbally arguing with another resident in the hallway, he repeatedly went to the door wanting to go home, and he was yelling at intervals. *Id.* at 189.
- On January 11, 2011, Resident 22 attempted to go off the unit. The nurses' notes stated that he was having increased aggression but he was able to be redirected. "No sexual behavior noted at this time." *Id.* at 189.
- On January 12, 2011 at 4 a.m. The nurses' notes indicated no incidents of sexually aggressive behavior that shift, but Resident 22 did require redirection out of both male and female peers rooms numerous times. *Id.* at 189.
- On January 12, 2011, nurses' notes stated that Resident 22 had not had any sexual behavior that day, but that he had had an increase in aggression toward other male residents. *Id.* at 189.
- On January 14, 2011 at 1:30 am, nurses' notes state that when Resident 22 was being changed he stated, "That pad felt food against my [blank]." He then proceeded to ask the SRNA to give him a kiss and to climb in bed with him. *Id.* at 190.
- On January 14, 2011, nurses' notes indicated that Resident 22 was having increased aggression towards the SRNA, claiming that the SRNA had his car and the keys. Nurses' notes also stated that Resident 22 was upset that the SRNA was taking care of other male residents. The Notes indicated that Resident 22 was also attempting to hit the SRNA. *Id.* at 190.
- On January 15, 2011, the nurses' notes indicated Resident 22 had increased agitation. *Id.* at 190.
- On January 18, 2011, nurses' notes indicated he was noncompliant in his wheelchair use and verbally inappropriate to the SRNA. *Id.* at 190.

[5] The facility's social service progress notes for March 11, 2011, August 25, 2011, November 10, 2011, indicate that Resident 22 was "verbally abusive" toward staff, combative at times and resisted care. CMS Ex. 12 at 163.

- On January 24, 2011, nurses' notes indicate that new orders were received after the physician's visit to increase Resident 22's current Depakote order because resident continued to have sexual behaviors. *Id.* at 190.
- On February 1, 2011, nurses' notes stated that at 1 a.m., Resident 22 was combative, hitting at the SRNAs, cursing, in and out other resident rooms, chasing the SRNAs in his wheelchair, opening the parlor door, and he could not be redirected. *Id.* at 190.

Resident 22's aggressive behaviors continued.[6]

- On May 2, 2011, a late nursing note entry after 11 p.m. indicated that Resident 22 was yelling and hitting at staff, he was up and down out of his wheelchair every few minutes, and he was going in and out of female residents' rooms yelling and cursing at staff. CMS Ex. 12 at 155.
- On June 11, 2011 at 5 p.m., nurses' notes stated that Resident 22 was agitated and yelling, and when the SRNA attempted to help feed him, Resident 22 started yelling and picked up his chicken and threw it at a male resident sitting at his table. *Id.* at 157.
- Later at 5:10 p.m., nurses' notes stated that Resident 22 was raising his fist and threatening to hit the nurse. *Id.* at 157. At 6:15 p.m., a nurse and SRNA were attempting to pull Resident 22 up in his wheelchair, when Resident 22 began to swing his fists, attempting to hit the nurse in face, kicking his legs and trying to kick the SRNA and the nurse. *Id.* at 157.
- On June 15, 2011, Resident 22 was noted as being up all evening, combative, kicking, and trying to bite and hit. *Id.*at 158.
- On June 17, 2011, nurses' notes indicate that Resident 22 was given a shot in his right deltoid and that he was extremely combative, kicking, hitting, fighting other staff and residents. *Id.* at 158.
- On June 23, 2011, nurses' notes indicate that Resident 22 was combative and hitting, kicking, cursing at the SRNA, yelling, "Cry! Cry! Go ahead, I'll make you cry." *Id.* at 159.

Resident 22's behavior became progressively more agitated (*see, e.g.*, CMS Ex. 12 at 162-166), and on December 4, 2011, he hit another male resident with a closed fist and kicked him in both legs. CMS Ex. 12 at 166.[7] His records continued to show numerous

[6] CMS apparently did not provide all of the nurses' notes for the time Resident 22 was in Kingsbrook so there are gaps in the time periods. Petitioner only provided the nurses' notes for Resident 22 beginning with February 2, 2012 and ending on February 24, 2012, a period after the relevant period upon which CMS based the CMP. P. Ex. 7.

[7] Due to the increase in Resident 22's behaviors, Petitioner on December 5, 2011 ordered an evaluation at a psychiatric hospital, but his son refused the evaluation. CMS Ex. 12 at

incidents of agitation both before and after the relevant incidents on December 25, 2011 and January 5, 2012. CMS Ex. 12 at 168.

- On December 5, 2011, Resident 22 was noted as yelling and threatening to hit residents and staff, going in and out of residents' rooms, kicking at staff and yelling, "I'll hit you." *Id.* at 168.
- On December 8, 2011, Resident 22 was noted to be very agitated and combative. *Id.* at 169.
- On December 16, 2011, nurses' notes stated that Resident 22 continued to be combative and yell. *Id.* at 170.
- On December 18, 2011, nurses' notes stated that Resident 22 was screaming, kicking at residents and staff, kicking the locked door, and yelling 'I'll kill you, I'll beat you up' to several other residents. *Id.* at 171.
- On December 21, 2011, nurses' notes indicated that Resident 22 was "up in" his wheelchair, whistling a lot, yelling a lot, kicking locked doors, attempting to go out the parlor doors. He refused to eat all of his meal and then was noted cursing and kicking at the nurse and SRNA. He rolled over to a cart and tried to take the used meal trays. He threw two trays across the table. He then proceeded to go up and down the hallway in his wheelchair. The nurses' notes indicated that staff would continue to monitor Resident 22 closely and to keep him away from other residents. *Id.* at 174-75.
- On December 26, 2011, the nurses' notes indicated that a nurse spoke to Resident 22's son regarding the physician's visit with the resident. The nurse stated she discussed the physician's concern for the safety of the other residents because the Resident's behaviors continued even with the medication adjustments. The notes indicate a suggested referral to neurology and to River Park for evaluation. *Id.* at 177.
- On December 31, 2011, nurses' notes state that Resident 22 was yelling, kicking the locked main door, cursing, and trying to hit a female resident as she ambulated past, but he was unable to do so. The SRNA redirected him to a hallway away from others. *Id.* at 182.
- On December 31, 2011, nurses' notes indicate that Resident 22 was given an injection of Haldol due to his agitation and behaviors. *Id.* at 183.
- On January 1, 2012, Resident 22 was noted to be combative with care, kicking, hitting and yelling as well as yelling out at times and whistling. *Id.* at 183.
- On January 2, 2012, the nursing staff noted that Resident 22 was hitting the door and trying to go out. He was also yelling and whistling a lot and rolling around in his wheelchair. *Id.* at 184-85.

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164. However, after the incident on December 25, 2011, the family agreed to the psychiatric evaluation. *Id.* The facility, however, did not transfer Resident 22 for evaluation at the psychiatric hospital until January 5, 2012. CMS Ex. 12 at 121, 123.

- Later he was noted as lying in his bed whistling, and yelling, "Help, Momma!" He was also combative with care, trying to climb out of bed. *Id.* at 185.
- On January 3, 2012 at 1:30 a.m., Resident 22 was noted to be combative with care, screaming, kicking and trying to punch SRNAs with his fist. *Id.* at 185.
- In the evening on January 3, 2012, nurses' notes stated that Resident 22 went into two other residents' rooms by himself and pulled out two emergency lights. The nurse stated that redirection was helpful only for a few minutes and that the male SRNA and female SRNA attempted to take resident back to his room to put him to bed, but Resident 22 started shouting. Resident 22 then rolled his wheelchair backwards very forcibly into the female SRNA who was pushing him into his room and almost knocked her down. Resident was reportedly upset because he could not stay in a female's room he had just rolled into. *Id.* at 185.
- A short time later, Resident 22 was found in his room in the closet pulling out his clothes. *Id.* at 185.
- At around 9:10 p.m. that same night, the nurses' notes stated that Resident 22 was yelling out of his room, "Hello! Hello!" *Id.* at 186.
- At 9:40 p.m. nurses' notes state that Resident 22 was put to bed by two SRNAs, and he was yelling and kicking at the SRNAs. *Id.*
- On January 5, 2012, Resident 22 was observed rubbing Resident 29's left hand on his upper right thigh during an activity with an Activity Aide in the room. *Id.* at 187-88.

Later that day, Petitioner transferred Resident 22 to the psychiatric hospital where he stayed until his readmission to Kingsbrook on January 16, 2012. CMS Ex. 12 at 121. On January 16, 2012, Petitioner readmitted Resident 22 from the psychiatric hospital. Resident 22's aggressive behaviors continued upon his readmission. CMS Ex. 12 at 193.

- On January 17, 2012, Resident 22 was noted to be yelling very loudly, "Get away, get away!" *Id*. at 193. Resident was pulling at brief and stating, "help me help me." *Id.* The SRNA who was in his room sitting with resident attempted to check resident's brief to see if the resident was wet, and Resident 22 started yelling, "Damn you Damn you!" *Id.* He pulled his penis out and started shaking it at the SRNA, yelling again, "damn you, damn you." *Id.*
- The nursing notes state that a nurse and another SRNA went to room to see why Resident 22 was yelling so much and changed the resident's brief. *Id.*

Resident 1, the female resident with whom the SRNA found Resident 22 having sexual contact, was admitted to the facility on February 10, 2010, with diagnoses including senile dementia, Alzheimer's disease, hypertension and hypothyroidism. CMS Ex. 10 at 5. Resident 1 had a court-appointed guardian. CMS Ex. 10 at 6-7. Resident 1's Brief Interview for Mental Status (BIMS) score was 3, indicating severely impaired cognitive ability, and her verbal communication was also seriously impaired. CMS Ex. 10 at 9.

She had episodes of combative behavior. CMS Ex. 10 at 13, 33, 42. Resident 1 sometimes exhibited socially inappropriate behavior including wandering into other residents' rooms and urinating and having bowel movements on the floor of her room or in other residents' rooms. CMS Ex. 10 at 81-82, 35.

Resident 2, the female resident who the SRNA observed Resident 22 touching and kissing, was admitted to the facility on August 24, 2009. CMS Ex. 11 at 6. She had short and long-term memory problems, and her cognitive skills for decision making were moderately impaired. CMS Ex. 11 at 8, 32, 39. Resident 29, the female resident whom the State Agency nurse surveyor observed Resident 22 pull while in her geriatric chair, was admitted to the facility on March 7, 2008, with diagnoses of Alzheimer's disease, hypertension, arthritis, and hypercholesterolemia. CMS Ex. 13 at 6. She was totally dependent on staff for her care due to impaired physical mobility and decreased cognition. CMS Ex. 13 at 12, 22. She was at high risk for falls, and she relied on her geriatric chair for mobility. CMS Ex. 13, at 23. Her decision-making skills were severely impaired, and her assessments showed short and long-term memory problems. CMS Ex. 13 at 12, 36. She also had impaired verbal communication. CMS Ex. 13 at 32.

Although Petitioner does not generally contest that there were interactions and contacts between Resident 22 and Residents 1, 2, and 29, it does contest that these interactions constituted abuse. Petitioner also contests that Resident 22's misconduct can be characterized as sexual misconduct. P. Reply at 1.

V. Findings of Fact and Conclusions of Law

1. Petitioner was not in substantial compliance with 42 C.F.R. § 483.13(c) because it did not immediately report and appropriately investigate suspected abuse.

Program Requirement. The lead-in language in section 483.13(c), captioned "*Staff treatment of residents*," states: "The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property." Section 483.13(c)(1)(i) states that the facility must "[n]ot use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion[.]" Subsections 483.13(c)(2)-(4) state:

> (2) The facility must ensure that all alleged violations involving . . . abuse . . . are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).

> (3) The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.

The facility administrator's written direct testimony states that he was not informed of the December 25, 2011 incident between Resident 22 and Resident 1, which occurred around 11:30 a.m., until the morning of December 26, 2011. P. Ex. 5 at 1. There is no mention in his affidavit that he was informed of the second incident on the afternoon of December 25th between Resident 22 and Resident 2. The regulation clearly states that the any alleged violation involving mistreatment, neglect or abuse must be reported "immediately" to the administrator. Petitioner admittedly did not do so here.

As soon as the SRNA removed Resident 22 to the nurses' station and reported the incident between Resident 22 and Resident 1 to the day shift nurse, the facility staff immediately should have reported the incident to its administrator and should have begun to implement their policies and procedures with respect to an alleged incident of abuse. Petitioner contends that while it is true that Resident 22 and Resident 1, two severely cognitively impaired residents, had sexual contact, there is no support that this contact was forced on Resident 1 or that Resident 1 suffered any injury. This argument, however, is irrelevant to the issue of whether, when faced with a suspected incident of abuse, the facility employees implemented the appropriate policies and procedures. At the time of the incident, the facility staff had no information about the incident other than what the SRNA observed and, therefore, the staff was under an obligation pursuant to the regulatory requirements to treat the incident as a suspected incident of abuse, to report it immediately to its administrator, to begin an investigation, and to do whatever necessary to protect its residents from any further potential abuse while the investigation is in progress. 42 C.F.R. § 483(c)(2) and (3).

Moreover, under Petitioner's own policy interpretation this incident could be considered "sexual abuse" because it was "contact in which the individual is used for sexual gratification by another . . .[t]he individual may or may not be a willing partner to the interaction." CMS Ex. 5 at 9. However, Petitioner took no action to investigate the alleged incident thoroughly or to separate Resident 22 from the rest of the residents so as to protect them from further potential abuse while the investigation was in progress until almost 10 hours after the alleged incident occurred. If the facility did separate Resident 22, the facility could have prevented the suspected abusive incident between Resident 22 and Resident 2.

Petitioner also never assessed Resident 2, 29, or any other resident for that matter, to determine if they had suffered any harm from Resident 22. This is particularly troublesome considering the Physician's Order Sheet and Progress Notes dated December 26, 2011, the day after the incidents with Resident 1 and 2, which noted that Resident

22's behaviors were "scaring other residents" and that he was "still having sexual behaviors." P. Ex. 15 at 22.

2. Petitioner was not in substantial compliance with 42 C.F.R. § 483.13(c) because it did not comply with its abuse prevention policies.

Clearly it is not enough that a facility simply have written policies and procedures in place -- a facility may also be found out of compliance with the regulatory requirement if it fails to implement its developed policies and procedures. *Mississippi Care Ctr. of Greenville*, DAB No. 2450 (2012) at 9, *aff'd*, *Mississippi Care Ctr. of Greenville, v. United States Dept. of Health & Human Servs.*, No. 12-60420 (5th Cir. 2013); *Liberty Health & Rehab. of Indianola, LLC*, DAB No. 2434 (2011).

Although Petitioner developed policies and procedures to help prevent abuse, I find Petitioner failed to implement those policies and procedures regarding immediate reporting of abuse, thorough investigations of allegations of abuse, and prevention of further potential abuse while an investigation is pending.

a. Petitioner's policy and procedures

Kingsbrook's Social Services Policy, Section 14, requires that all reports of resident abuse, neglect and injuries of unknown source be promptly and thoroughly investigated by facility management. CMS Ex. 4 at 1. That policy's procedures require the Administrator and Social Services Director to investigate the alleged incident. *Id.* The procedures also provide that while the investigation is being conducted, an accused individual "not employed by the facility will be denied unsupervised access to residents." CMS Ex. 4 at 1.

Section 14.2 of Petitioner's policy, Reporting Abuse to Facility Management, requires employees to "promptly" report any suspected incident of resident abuse to facility management. CMS Ex. 4 at 3. The procedures to implement Section 14.2 provide that Kingsbrook will not condone resident abuse by anyone including other residents; that employees, facility consultants and attending physicians must report any suspected abuse or incident of abuse to the director of nursing and director of social services; that sexual abuse is defined as, but is not limited to, sexual harassment, sexual coercion, or sexual assault; any individual observing an incident of resident abuse or suspecting resident abuse must promptly report such an incident to a member of the nursing staff or management; upon receiving reports of physical or sexual abuse, a licensed nurse or physician shall immediately examine the resident. CMS Ex. 4 at 3. Findings of the examination must be recorded in the resident's medical record. CMS Ex. 4 at 3-4.

Section 14.4 of Petitioner's policy, Protection of Residents During Abuse Investigations, requires the facility to protect is residents from harm while an investigation is in process.

If the alleged abuse involves another resident, that resident will not be permitted to make visits to other resident rooms unattended. CMS Ex. 4 at 5.

Section 14.6 of Petitioner's policy, Recognizing Signs and Symptoms of Abuse/Neglect, provides that all personnel are "to report any signs and symptoms of abuse/neglect to their supervisor or to management immediately." CMS Ex. 4 at 7. The procedures further provide that when in doubt if something is a sign or symptom, personnel should report it. *Id.*

Section 14.8 of Petitioner's Social Service Policy for Resident-to-Resident Abuse also provides that "[a]ll forms of abuse, including resident-to-resident abuse, must be reported immediately to the nursing supervisor, the director of nursing and/or the administrator." CMS Ex. 4 at 10. The procedures for this policy requires, among other things, that the resident "observed/accused" of abusing another resident should be separated from the other residents until a plan of care can be developed to meet the needs of the resident. CMS Ex. 4 at 10. Petitioner's policy uses both "promptly" and "immediately" to describe when incidents of suspected abuse must be reported.[8]

b. Petitioner failed to implement its policy and procedures

The day shift nurse admittedly failed to report the alleged incidents on December 25, 2011 to the facility's director of nursing, administrator, or director of social services, or even her supervisor, as required by Petitioner's Social Services policies and procedures. As a result, there was no separation or increased supervision of Resident 22 to protect the other residents in the locked dementia unit. In fact, he continued to freely move about the unit. Yet, section 14.4 of Petitioner's Social Service Policy, Protection of Residents During Abuse Investigation, requires the facility to protect residents from harm during investigations of abuse allegations. The procedures require that if the alleged abuse involves another resident, the accused resident's representative will be informed of the alleged abuse incident and that the accused resident will not be permitted to make visits to other resident rooms unattended. If necessary the accused resident's family members may be asked to provide assistance in meeting this requirement. CMS Ex. 4 at 5. No such steps were taken here and, as a result, the second suspected abusive incident involving Resident 22 and Resident 2 occurred within five hours after the first incident involving Resident 22 and Resident 1.

[8] Considering the very serious nature of a suspected incident of abuse and the regulatory requirement under section 42 C.F.R. § 483.13(c)(2) that such suspected incidents must be reported "immediately," I do not accept that Petitioner's use of the word "promptly" means required reporting under the policies and procedures should be anything less than "immediate" in order to comply with Medicare requirements.

Petitioner's policy interpretation and implementation with respect to abuse requires that the investigation process involve an examination of the alleged victim to determine any resident injury, requires social services to "assess and monitor the residents' feelings concerning the incident," and interview other residents who may be affected. CMS Ex. 5 at 5. The only indication in the medical records that an assessment was made of Resident 1 is a nursing note from December 25, 2011, apparently entered at 10:30 p.m. by the Weekend Supervisor, that "female resident assessed with no problems or injuries noted." CMS Ex. 10 at 83. No record exists of how the Weekend Supervisor made this assessment and what criteria she used to establish her conclusion. No one apparently documented any physical or psychological clinical evaluations of the other residents in the unit to determine if they too suffered any harm considering Resident 22's unfettered access to them.

It was not until some ten hours after the first incident that anyone actually reported the two incidents to the Social Services Manager and the Assistant Director of Nursing (ADON) so that the investigatory process could be initiated. Petitioner's post-hearing brief states that the Weekend Supervisor was advised of the incident at approximately 8:30 p.m. on December 25, 2011, however the facility's contemporaneous medical records state that she learned of the incident at 10 p.m. and notified the physician, the Social Services Manager, and the ADON at approximately 10:45 p.m. P. Br. at 4; CMS Ex. 12 at 176. Moreover, there is no evidence that the Weekend Supervisor reported the second incident which occurred on December 25th between Resident 22 and Resident 2. Despite the fact that the SRNA reported the incident in her written statement, dated December 26, 2011, the facility investigation did not mention this incident, nor was it included in the Self-Reported Incident Form sent by Petitioner to the Kentucky Cabinet for Health and Family Services. P. Ex. 15 at 4, 14, 27; P. Ex. 14. There is also no record of any facility assessment of Resident 2 to determine her physical or mental condition as a result of Resident 22's potentially unwanted and very personal contacts.

While the second incident in comparison to the first, may have seemed more benign and insignificant to the facility staff, considering the previous incident with Resident 22, facility staff should have been keenly alert to any incidents of physical contact between this resident and the female residents especially because no investigation of the incidents had yet been initiated and little information was available to indicate whether these incidents were in fact abuse. A principal purpose of requiring abuse policies and procedures is to immediately investigate suspected incidents while protecting residents and preventing any further incidents. *See Grace Healthcare of Benton*, DAB No. 2189 at 8 (2008)("the regulations require an investigation of an allegation of abuse not only to protect a resident who may already have been abused . . . but also to prevent other residents from being abused."). While Petitioner generally contends that its actions were generally compliant with its policies, I find that the evidence shows just the opposite-- the day shift nurse and the afternoon shift nurse failed to properly implement its procedures for reporting incidents of suspected abuse. The significant delay between the time of the

incident between Resident 22 and Resident 1 and when the incident was finally reported up the supervisory chain left the other residents at significant risk.

Furthermore, the failure of Petitioner's charge nurse to immediately report the incident demonstrates, at the very least, that not all of Petitioner's employees were sufficiently trained in how to properly implement the facility's policy and procedures with respect to such an incident. Petitioner in fact disciplined the charge nurse from the morning shift for her failure "to notify her supervisor/administration of incident reported and witnessed by staff." P. Ex. 15 at 28. It is well settled that a facility cannot disown the acts and omissions of its own staff, not even an isolated error by a single employee, to immunize itself from a finding of noncompliance. As the Board stated in *Cal Turner Extended Care Pavilion*--

> [a facility cannot] avoid responsibility by blaming one nurse for the failure of multiple systems. . . a facility "cannot disown the consequences of the inadequacy of the care provided by the simple expedient of pointing the finger at her fault, since she was the agent of her employer empowered to make and carry out daily care decisions." *Emerald Oaks*, DAB No. 1800, at 7, n.3 (2001); *see also Cherrywood Nursing and Living Center*, DAB No. 1845 (2002) and *Ridge Terrace*, DAB No. 1834 (2002).

DAB No. 2030, at 15 (2006); *see also Life Care Center of Gwinnett*, DAB No. 2240, at 12-13 (2009).

3. Petitioner was not in substantial compliance with 42. C.F.R. § 483.25(h) because its staff did not adequately supervise Resident 22.

Program Requirement. Section 483.25(h) requires facilities to "ensure that – (1) The resident environment remains as free of accident hazards as is possible; and (2) Each resident receives adequate supervision and assistance devices to prevent accidents." This provision is part of the quality of care regulation at section 483.25 requiring that "[e]ach resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being in accordance with the comprehensive assessment and plan of care."

The facility must "take reasonable steps to ensure that a resident receives supervision and assistance devices designed to meet his assessed needs and to mitigate foreseeable risks of harm from accidents." *Briarwood Nursing Ctr.*, DAB No. 2115 at 5 (2007); *Guardian Health Care Ctr.*, DAB No. 1943 at 18 (2004). The facility must anticipate what accidents might befall a resident and take steps to prevent them. A facility is permitted the flexibility to choose the methods it uses to prevent accidents, but the chosen methods must constitute an "adequate" level of supervision under all the circumstances. *Windsor Health Care Ctr.*, DAB No. 1902 at 5 (2003).

a. It was foreseeable that Resident 22 would harm other residents if he was not adequately supervised.

As documented above, the facility was on notice that Resident 22 often exhibited aggressive, abusive, and sexually inappropriate behaviors. Petitioner's records show that within months of Resident 22's admission, the facility was aware that he wheeled himself into female residents' rooms and approached their beds to wake them from their sleep. Resident 22 would also wander through the hallways, cursing and yelling, and would strike out at residents and staff. The following examples were recorded in some of the facilities nursing notes:

- On November 16, 2010, Resident 22 entered female residents' room, and going up to bed in his wheelchair and waking them. He wanders through the hallway cursing, and trying to hit other residents and staff. CMS Ex. 12 at 152.
- On November 23, 2010, Resident 22 was agitated and wanted to go out. He was going in and out of other residents' rooms, kicking the door and screaming to go out and get his truck. He also attempted to hit the SRNA. *Id.* at 154.
- On May 2, 2011, after 11 p.m., Resident 22 was yelling and hitting at staff, in and out of his wheelchair, going in and out of female residents rooms, yelling and cursing at staff. *Id.* at 155.
- On June 11, 2011, Resident 22 was swinging his fists and attempting to hit the nurse. *Id.* at 157.
- On June 15, 2011, Resident 22 was up all evening, combative, kicking and trying to bite and hit. *Id.* at 158.
- On June 23, 2011, Resident 22 was combative, hitting, kicking and cursing at the SRNA. *Id.* at 159.
- On July 25, 2011, Resident 22 was very agitated. *Id.* at 161.
- On July 31, 2011, Resident 22 was agitated, yelling, and trying to get out the parlor door three times, rolling up his fists and trying to hit someone, screaming and out of control. *Id.* at 162.
- On November 19, 2011, Resident 22 was yelling out and cursing at the SRNA when he moved into the dining room for his meal. Two SRNAs put Resident 22 to bed, and he was kicking and yelling, attempting to bite one of the SRNAs. *Id.* at 165.
- On November 28, 2011, Resident 22 was progressively agitated all shift, whistling loudly, yelling out loud, combative, trying to bite, kick, grab, and pinch. Resident 22 was in his wheelchair. Another male resident passing in his wheelchair got close to this resident's wheelchair, and Resident 22 hit the other resident in the arm twice with closed fist and kicked the other resident in both legs. *Id.* at 166.

- On December 5, 2011 Resident 22 was yelling and threatening to hit other residents and staff. Resident 22 going in and out of residents' rooms, kicking at staff and yelling "I'll hit you." *Id*. at 168.

Also, in April 2011, a doctor ordered Tagamet for Resident 22 "for sexual behavior."[9] CMS Ex. 12 at 112, 114. On December 4, 2011, he hit another male resident with a closed fist and kicked the resident in both legs. CMS Ex. 12 at 166. By December 5, 2011, Resident 22's behavior and actions towards staff and residents had become increasingly belligerent and aggressive. He yelled and threatened staff and residents, and he would enter uninvited into other residents' rooms, particularly female residents' rooms. CMS Ex. 12 at 168. Because of the increase in his behaviors, on December 5, 2011, a doctor ordered an evaluation at a psychiatric hospital. CMS Ex. 12 at 167. However, it appears the facility deferred to Resident 22's family, who refused the psychiatric evaluation. CMS Ex. 12 at 168.

Resident 22's aggressive behavior continued. In fact, on December 18, 2011, he became so agitated, kicking and screaming at residents and staff, the nursing staff determined to provide him with one on one supervision from two SRNAs and to separate him from other residents until he calmed down as staff were "afraid resident will try to kick + hit other residents." CMS Ex. 12 at 171 and 174. His aggressive behaviors continued on December 21, 2011 when he was discovered yelling and kicking locked doors. CMS Ex. 12 at 174-75. He later became agitated at meal time and threw trays across the table. CMS Ex. 12 at 174-75. Again, the LPN decided that due to his increased agitation, one on one supervision should be given so as to monitor him closely and to keep him away from other residents. CMS Ex. 12 at 175. Due to his elevated behaviors, Resident 22's doctor increased his Tagamet dosage to 400 mg. daily his Seroquel to 50 mg. every 12 hours, and Depakote to 750 mg. every 12 hours on December 22, 2011. CMS Ex. 12 at 175.

b. Petitioner did not mitigate the foreseeable risks of harm.

i. Resident 22's care plan did not address his potential to harm other residents.

Despite these behaviors, and until the incident on December 25, 2011, Resident 22's care plan, dated June 8, 2011 (and reviewed on September 1, 2011 and November 22, 2011), only addressed as problems his episodes of combative behavior towards staff and his resistance to care from staff. CMS Ex. 12 at 58, 59, and 61-62. Resident 22's care plan

[9] Apparently, the State Agency documented that a facility Medical Director first prescribed 300 mg. of Tagamet to Resident 22 on November 16, 2010, shortly after his admission, due to the resident being "very sexually aggressive." CMS Ex. 1 at 27.

interventions for his episodes of combative behavior provided that the following approaches or interventions should be used:

1. Identify trigger stimuli and educate staff to avoid as much as possible;
2. Approach in quiet non-threatening manner;
3. At the time of episode explain firmly but gently that this behavior is not acceptable;
4. Leave resident alone for a few minutes when episode occurs; return later to continue with care giving;
5. Avoid commands using "don't" or "no." Use positive terms such as "do" or "let's"
6. Observe closely for signs of increased frustration and/or anxiety. Change caregiving approach or activity as necessary. Observe resident's response.
7. Reduce distractions and negative environmental stimuli as much as possible (e.g. loud voices, multiple conversations, bright lights, shiny floors).

CMS Ex. 12 at 61-62. Nothing in Resident 22's care plan, however, addressed his aggressive behavior towards other residents including his wandering into female residents' rooms and approaching their beds and waking them. Resident 22 apparently had no limitations on wandering unsupervised around the locked floor, which had 32 residents. Not only was he able to enter other residents' room and approach their beds to wake them, but he often did so without being detected until the resident woke up. CMS Ex. 12 at 152, 154, 168. On December 25, 2011, Resident 22 apparently entered Resident 1's room during the late morning hours completely undetected until the SRNA entered the room for a completely unrelated reason (to help Resident 1's roommate) and found Resident 22 engaged in a sexual act with Resident 1. P. Ex. 1 at 1.

Although the Physician's Order for April 25, 2011 ordered 300 mg. of Tagamet for Resident 22 to decrease his sexual behavior, there is nothing in the nurses' notes, or in the submitted medical records to further explain why this change was necessary. CMS Ex. 12 at 112. Yet, the doctor again ordered Tagamet for him in May 2011 with the cursory explanation that it was ordered to address sexual behaviors. CMS Ex. 12 at 114. Resident 22's records indicate he was still receiving the 300 mg. of Tagamet daily in December 2011, but the dosage was increased to 400 mg. on December 22, 2011, three days before his suspected abuse of Residents 1 and 2. CMS Ex. 12 at 94, 95. Apparently the doctor wished to address some sort of sexual behaviors that Resident 22 was exhibiting, but Petitioner did not come forward with any reasonable explanation of what prompted the doctor's orders to decrease his sexual behaviors. P. Ex. 6 (Medical Director's affidavit has no explanation as to why he or another facility physician prescribed Tagamet to Resident 22 for "sexual behaviors" or why this medication was ordered).

Until the sexual contact between Resident 22 and Resident 1 occurred on December 25th, Petitioner had not implemented any interventions or monitoring of Resident 22 to deal with his increasingly aggressive and agitated behaviors. It was not until some almost ten hours after the alleged sexual abuse occurred that Petitioner even began to institute some interventions to monitor Resident 22. CMS Ex. 12 at 176, 64. The evidence supports the need for earlier interventions regarding more supervision because potentially abusive interactions with other residents were foreseeable.

ii. Resident 22 was not adequately supervised when he had potentially abusive contacts with Residents 1, 2, and 29.

Given Resident 22's aggressive and agitated behaviors and that potentially abusive interactions were foreseeable, Petitioner was obligated to take all reasonable steps to ensure that Resident 22 received adequate supervision and assistance devices to mitigate any foreseeable risks of harm from his behaviors. Resident 22's practice of entering female residents' rooms and waking them, the fact that his doctor had prescribed medication for him as early as April 2011 for his "sexual behaviors," and that he also would curse, kick, yell, hit, and grab at other residents were all serious behaviors about which the facility should have been more concerned.

Despite his aggressive behaviors towards other residents, Petitioner failed to devise any interventions to address these behaviors and supervise Resident 22 to prevent abusive contacts with other residents. The record supports the finding that Resident 22 required close supervision but no such interventions were established in his care plan. In fact, due to his increased agitation on December 18 and later on December 21, 2011, the LPN on her own initiative determined that one on one supervision was necessary for a short time. CMS Ex. 12 at 171-72, 174-75. The facility did not institute any actual interventions for one on one supervision in Resident 22's care plan until January 5, 2012 and that was not until after the two December 25th incidents, when 15 minute checks were instituted, and then on December 26th when one on one supervision began. CMS E. 12 at 46.

Petitioner instituted interventions for "episodes of inappropriate sexual behavior" in Resident 22's care plan on December 27, 2011. CMS Ex. 12 at 64. The approaches were: tell resident calmly and firmly that this behavior is not acceptable, separate from peers if behavior becomes offensive to them, take to room and provide privacy, teach resident about acceptable behavior (discontinued on January 13, 2012), be non-judgmental when confronting negative behavior, establish consistent staff approaches to problem, and provide one on one supervision until assessed by physician (added on January 16, 2012 and continued on January 19, 2012). CMS Ex. 12 at 64.

As soon as the facility discontinued its temporary one on one supervision of Resident 22 on January 3, 2012, a State Agency surveyor observed Resident 22 rubbing Resident 29's left hand on his upper right thigh and kissing up and down Resident 29's arm and hand.

CMS Ex. 1 at 18, 39, 64; CMS Ex. 12 at 187. Later that same day, the State Agency surveyor also observed Resident 22 able to approach Resident 29 and pull her backwards by her arms while she was sitting in a geriatric chair. CMS Ex. 1 at 39. Further, staff failed to use or implement any of the existing interventions in Resident 22's care plan when this incident of inappropriate touching occurred.

iii. Petitioner did not follow its policies to immediately report suspected abuse incidents and to prevent abuse pending a thorough investigation.

As previously discussed, Resident 22 was allowed access to Resident 2, hours after the suspected abuse of Resident 1. A SRNA reported to the LPN on the afternoon shift that around 4 p.m. that she saw Resident 22 rubbing the upper leg of Resident 2. CMS Exs. 2; 14 at 1, 15; P. Ex. 2. If Petitioner had followed its policies, which outline foreseeable steps to prevent further potential harm during a pending investigation, the suspected abuse between the residents would not have occurred.

Petitioner's failure to take immediate action to report the incident when it found Resident 22 and Resident 1, and its failure to otherwise implement its abuse policy and procedures at the time of the occurrence of the incident allowed Resident 22 to continue to have unfettered access to the residents in the locked dementia ward. As a result the other residents were left unprotected. In addition, the facility did not assess other residents to determine whether Resident 22 had harmed them in any way.

Petitioner was under an obligation then to protect Resident 22 from himself as well as to protect the other residents from his behaviors by providing Resident 22 with adequate supervision. As the evidence establishes, the facility failed to do this and therefore was not in substantial compliance with 42 C.F.R. § 483.25(h).

4. Petitioner was not in substantial compliance with 42 C.F.R. § 483.75 because it did not follow its abuse prevention policies and did not adequately supervise Resident 22.

Program Requirement. A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.

The Board has held that where a deficiency finding under section 483.75 is derivative, that is, it is "based on the surveyors' identification of other deficient practices," the existence of those separately identified deficiencies "may constitute a prima facie case that a facility has not been administered efficiently or effectively as required by section 483.75." *Odd Fellow & Rebekah Health Care Facility*, DAB No. 1839 (2002); *Cross Creek Health Care Ctr.*, DAB No. 1665, at 19 (1998); *Asbury Ctr. at Johnson City*, DAB

No. 2088 (2007). Here, in support of the allegations associated with its findings of noncompliance with respect to section 483.75, CMS relies on the same set of facts that form the basis for the deficiencies cited for sections 483.13(c) and 483.25(h).

I have determined that Petitioner was not in substantial compliance with sections 483.13(c) and 483.25(h) at the immediate jeopardy level of noncompliance. The facility's failures to implement its policies and procedures with respect to suspected abuse placed the well-being of every resident in the locked unit at risk for the likelihood of serious harm. Similarly, Petitioner's failure to provide Resident 22 with necessary care and services, particularly adequate supervision to protect himself and other residents from his aggressive behaviors, is sufficient to establish that Petitioner was not being administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental and psychosocial well–being of each resident. Accordingly, I find that Petitioner was not in substantial compliance with section 483.75.

5. CMS's determinations of immediate jeopardy to resident health and safety are not clearly erroneous.

a. CMS's determination of the level of noncompliance as immediate jeopardy was not clearly erroneous.

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 held consistently 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. 1962 at 11 (2005) (citing *Florence Park Care Ctr.*, DAB No. 1931 at 27-28 (2004)).

Petitioner disputes CMS's findings of immediate jeopardy claiming that there is no evidence that any residents suffered physical harm and that if CMS is basing its finding on the "psychological or mental insult to the 'victim' that occurs as a result of sexual abuse . . . the only examples of supposed sexual abuse—an episode of apparently oral sex that was not foreseeable, and in which the other resident appeared to cooperate, an episode of touching on the leg, and an episode of possible arm-grabbing or kissing – simply do not suggest an injury of the magnitude of immediate jeopardy even in the worst case." P. Reply at 19- 20.

A determination of immediate jeopardy does not require actual harm but the *likelihood* of serious injury or harm. *Lakeport Skilled Nursing Ctr.*, DAB No. 2435 at 8 (2012). I also do not find Petitioner's argument persuasive that Resident 1 may have been a "willing participant." P. Reply at 9. Resident 1 was adjudged incompetent and was not capable of consent. CMS Ex. 10 at 6-7. I do not find that Petitioner sufficiently assessed the residents involved in the three incidents as well as the residents whose rooms he entered without permission and awoke for signs and symptoms of distress from these events. Without a sufficient assessment, it is easier for the facility to argue there was no actual serious harm. *See Libertywood Nursing Ctr. v. Sebelius*, 2013 WL 719786 (4th Cir. 2013) (finding, where Petitioner failed to assess for signs and symptoms of distress the elderly and demented residents who were subjected to aggressive and sexual behaviors of another resident, Petitioner cannot be allowed to benefit from such a disregard for the welfare of its vulnerable residents).

CMS's determinations reflect record evidence of serious physical threats to residents' health and safety, including biting, kicking, punching and throwing objects. Petitioner's staff did not provide residents with adequate security if they allowed Resident 22 to move about unfettered and unsupervised, especially after the December 25, 2011 incident. *See* P. Ex. 15 at 22 (Physician's Order Sheet and Progress Notes for Resident 22 which states Resident's "behaviors scaring other residents still having sexual behaviors"). Resident 22 could have likely also caused serious physical harm to Resident 29, a known fall risk, when he pulled her arms backward as she sat in a geriatric chair, as the State Agency surveyor herself witnessed. CMS Ex. 1 at 39; CMS Ex. 13 at 23.

Considering the copious facility documentation of Resident 22's persistent, long-term, and aggressive behavioral misconduct, the ineffectual nature of the facility's interventions, the non-adherence to its many abuse policies, and the lack of urgency in managing Resident 22's behaviors, the facility demonstrated a lack of comprehension of its duty to protect its residents. Such failures implicate danger to all residents from the likelihood of serious harm, whether from Resident 22 or someone else. Therefore I do not find CMS's determinations of immediate jeopardy in clear error here.

b. CMS's determination as to the duration of the period immediate jeopardy is not clearly erroneous.

The Board has explained previously that CMS's determination that a skilled nursing facility's ongoing compliance remains at the level of immediate jeopardy during a given period constitutes a determination about the "level of noncompliance" and, therefore, is subject to the clearly erroneous standard of review under section 498.60(c)(2). *See, e.g.*, *Brian Ctr. Health & Rehab./Goldsboro*, DAB No. 2336, at 7-8 (2010). Here, CMS determined that the immediate jeopardy began on December 25, 2011, the day of the incidents involving Resident 22, and Residents 1 and 2, and continuing through January 20, 2012.

Petitioner contends, however, that if there was any immediate jeopardy, it was removed earlier, as of December 26, 2011, the date when one on one supervision was initiated for Resident 22 or, at the most, by January 5, 2012, when Resident 22 transferred to the psychiatric hospital. Petitioner also contends that it abated the immediate jeopardy long before the State Agency accepted its Allegation of Compliance and argues it fully implemented its Resident Abuse Policy on the evening of December 25, 2011 when it made the appropriate reports and it took the appropriate measures. P. Br. at 19-20. Petitioner also contends that the State Agency required Petitioner to submit six versions of its Allegation of Compliance until it could demonstrate that a facility-wide assessment of all the residents could be completed, even for those residents who resided outside the locked unit. P. Br at 20-21.

The duration of the immediate jeopardy is based on Petitioner's Allegation of Compliance and the dates it established for taking the actions necessary to remove the immediate jeopardy to its residents. CMS Ex. 8. Petitioner's Allegation of Compliance set forth ten actions it would take with a completion date for each action. *Id.* Its assessment of all residents was only one of the actions set forth, and Petitioner set a completion date of January 18 for the physical assessments and January 19 for the completion of the psycho-social assessment. There were also several other actions with the completion date of January 19, 2012: notification of residents on the locked unit and their family members, or healthcare representatives, about the potential safety issues and their corrective measures; updating Resident 22's care plan to address his current needs; revising policies and procedures for reporting and investigating abuse; and creating a rapid response protocol called CODE PROTECT, which would actually separate potential abusers from other residents.

January 20, 2012 was also the date Petitioner stated for its completion of the last of those actions: special education for its administrative staff and clinical leadership on the impact of mental capacity and the determination of abuse; and the competency testing of all staff with a score of 100 percent on its new CODE PROTECT policy and procedure. CMS Ex. 8 at 5-6. Thus, CMS has accepted January 20, 2012, as the last date of the period of immediate jeopardy. Petitioner has not established that all the actions it determined necessary to address and remove the immediate jeopardy were completed prior to January 20, 2012.

The burden is on the facility to show that it timely completed the implementation of the plan of correction, and "[i]t is not enough that some steps have been taken, but rather the facility must prove that the goal has been accomplished." *Lake Mary Health Care*, DAB No. 2081 at 29 (2007); *see also Cal Turner Extended Care Pavilion*, DAB No. 2030 at 19 (2006) (rejecting facility's "claim that steps short of those which the facility itself identified as necessary for it to correct the problems found (and to achieve substantial compliance) should nevertheless be accepted as adequate to require lifting the remedies

imposed"). I do not find Petitioner has shown that CMS made a clear error when it determined that the facility had not abated the immediate jeopardy prior to January 20, 2012, and I sustain CMS's determination as to the duration of the period of immediate jeopardy from December 25, 2011 through January 20, 2012.

6. The CMPs that CMS imposed are reasonable.

CMS must consider several factors when determining the amount of a CMP, which an ALJ considers de novo when evaluating the reasonableness of the CMP that CMS imposed: (1) the facility's history of noncompliance; (2) the facility's financial condition, *i.e.*, its ability to pay the CMP; (3) the severity and scope of the noncompliance, (4) the "relationship of the one deficiency to other deficiencies resulting in noncompliance," (5) the facility's prior history of noncompliance; and (6) the facility's degree of culpability, which includes neglect, indifference, or disregard for resident care, comfort or safety. 42 C.F.R. §§ 488.438(f), 488.404(b), (c). A CMP that is imposed against a facility on a per day basis will fall into one of two ranges of penalties. 42 C.F.R. §§ 488.408; 488.438. The upper range of a CMP, $3,050 per day to $10,000 per day, is reserved for deficiencies that pose immediate jeopardy to the health and safety of a facility's residents and, in some circumstances, for repeated deficiencies. 42 C.F.R. §§ 488.438(a)(1)(i), 488.438(d)(2). The lower range of CMP, $50 to $3,000 per day, is reserved for deficiencies that do not pose immediate jeopardy, but either cause actual harm to residents, or cause no actual harm but have the potential for causing more than minimal harm. 42 C.F.R. § 488.438(a)(1)(ii).

In assessing the reasonableness of a CMP amount, an administrative law judge looks at the per day amount, rather than the total accrual. *Kenton Healthcare, LLC*, DAB No. 2186, at 28 (2008). The regulations leave the decision regarding the choice of remedy to CMS and the amount of the remedy to CMS and the ALJ, requiring only that the regulatory factors at 42 C.F.R. §§ 488.438(f) and 488.404 be considered when determining the amount of a CMP within a particular range. 42 C.F.R. §§ 488.408; 488.408(g)(2); 498.3(d)(11); *see also* 42 C.F.R. § 488.438(e)(2); *Alexandria Place*, DAB No. 2245, at 27 (2009); *Kenton Healthcare, LLC*, DAB No. 2186, at 28-29.

Unless a facility contends that a particular regulatory factor does not support the CMP amount that CMS imposed, the ALJ must sustain it. *Coquina Ctr.*, DAB No. 1860, at 32 (2002). CMS determined to impose a per day CMP in this case. I found immediate jeopardy level noncompliance not to be clearly erroneous here. Thus, the minimum CMP I am required to sustain is $3,050 per day.

Petitioner argues that CMS did not demonstrate the facility's history of noncompliance, the seriousness of the deficiency, the facility's financial condition, and the facility's degree of culpability. P. Br. at 23-24. Conversely, however, I find Petitioner did not carry its burden to demonstrate that a reduction is necessary. First, Petitioner did not

dispute that its financial condition affected its ability to pay the CMP imposed. Next, while Petitioner contends that it had an excellent record of compliance, the record shows Petitioner had a notable history of noncompliance. CMS Ex. 19; P. Ex. 24. In its November 2010 re-licensure survey, it was not in substantial compliance with numerous requirements. In fact, in 2010, there were numerous deficiencies for which they were again found non-compliant in the present survey: section 483.13(c) at a scope and severity level of D, sections 483.20(d) and 483.20(k)(1) at a scope and severity level of D, section 483.25(c) at a scope and severity level of G, section 483.25(h) at scope and severity level of D, and section 483.65 at a scope and severity level of D. P. Ex. 24 at 82, 84, 108, 113, 119. Similarly, Petitioner was not in substantial compliance with numerous requirements during its December 2009 survey. P. Ex. 24 at 6-45.

As to the seriousness of the deficiencies, Petitioner minimizes the seriousness and argues there was no actual harm to any resident, and, to the extent there was a deficiency, it was isolated. P. Br. at 19. However, I find Petitioner's noncompliance to be very serious. Petitioner's own records show how often aggressive Resident 22's behavior was; however, Petitioner's staff did not adequately supervise or monitor his movements around the locked dementia ward. They also did not follow the facility's many procedures for reporting or investigating suspected abuse and did not limit Resident 22's access to other residents, even after a suspicion of abuse. Petitioner is highly culpable for the relevant deficiencies because it could have easily prevented them if it provided more supervision for this one resident and actually followed its many relevant policies and procedures.

I sustained three of the deficiencies cited at the immediate jeopardy level and do not discuss the others because these three more than amply supported the CMP that CMS imposed. The CMP of $4,600 per day is at the lower range for situations of immediate jeopardy ($3,050-$10,000). I further conclude that the CMP of $200 per day, for the periods constituting non-compliance not involving immediate jeopardy risks, is reasonable considering the many other deficiencies cited at a scope and severity levels of D, E, and F for which Petitioner did not request review. *See supra* n.2.

VI. Conclusion

Petitioner was not in substantial compliance with Medicare program participation requirements for abuse prevention, adequate supervision of residents, and effective and

efficient administration. I also find that CMS's determination of immediate jeopardy was not clearly erroneous. Further, I sustain as reasonable CMS's imposition of CMPs.

/s/
Joseph Grow
Administrative Law Judge