Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

In the Case of:	)	
	)	
Pinehurst Healthcare & Rehabilitation Center (CCN: 34-5370),	)	Date: October 8, 2008
	)	
Petitioner,	)	
	)	
- v. -	)	Docket No. C-04-555
	)	Decision No.CR1854
Centers for Medicare & Medicaid Services.	)	
	)	

DECISION

Based on my review of the entire record in this case, I find that Pinehurst Healthcare & Rehabilitation Center (Petitioner or facility) was not in compliance with 42 C.F.R. § 483.13(b)[1] at the immediate jeopardy level from April 6, 2004 to May 28, 2004. I further find that Petitioner was not in compliance with 42 C.F.R. § 483.25(h)(2) from May 28, 2004 through July 25, 2004 at the immediate jeopardy level. In addition, Petitioner was not in substantial compliance with 42 C.F.R. §§ 483.13(c)(ii), 483.13(c)(i), and 483.70(h)(4) from July 26, 2004 through August 25, 2004. It returned to substantial compliance with all program participation requirements effective August 25, 2004.

The evidence presented by the Centers for Medicare & Medicaid Services (CMS) establishes a basis for the imposition of a civil money penalty (CMP) and a denial of payment for new admissions (DPNA). I sustain CMS's imposition of a CMP of $3050 per day from April 6, 2004 through July 25, 2004. I find that CMS has established a basis to impose a CMP of $100 per day from July 26, 2004 through August 25, 2004. The evidence demonstrates, and I find, that the per day CMPs, as well as the total CMP of $300,000, are reasonable. Finally, I find that CMS has established a basis for the imposition of a DPNA for the period from July 23, 2004 through August 25, 2004.

[1] All references to the Code of Federal Regulations (C.F.R.) are to the version in effect at the time of the surveys, unless otherwise indicated.

I. Background

Petitioner, located in Pinehurst, North Carolina, is authorized to participate in Medicare as a skilled nursing facility (SNF) and in the North Carolina Medicaid program as a nursing facility (NF). On July 15, 2004, the North Carolina Department of Health and Human Services, Division of Facility Services (State Agency), completed a complaint survey of Petitioner's facility. The results of that survey were reported in a statement of deficiencies (SOD) dated July 15, 2004. The State Agency determined that Petitioner did not substantially comply with Medicare and Medicaid participation requirements at the immediate jeopardy level and recommended that CMS impose remedies. By a letter dated July 21, 2004, CMS notified Petitioner of its concurrence with the State Agency findings and recommendations and its intention to impose a CMP of $3050 per day effective April 6, 2004, until Petitioner returned to substantial compliance; a DPNA effective July 23, 2004, until Petitioner returned to substantial compliance; and termination effective August 7, 2004, if substantial compliance was not achieved before that date. Based on the results of a July 21, 2004 complaint survey, the State Agency determined that Petitioner's facility was out of compliance with federal participation requirements at the immediate jeopardy level. It recommended that CMS impose remedies. Concurring with the State Agency findings, CMS informed Petitioner, by a letter dated July 27, 2004, that it intended to impose remedies, including a continuation of a CMP of $3050 per day effective April 6, 2004, and termination effective August 7, 2004.

Following an August 3, 2004 revisit survey, the State Agency again determined that Petitioner was not substantially compliant with federal participation requirements. Agreeing with the State Agency findings, by an August 18, 2004 letter, CMS informed Petitioner that it intended to impose remedies of a CMP of $100 per day effective July 26, 2004 until compliance was achieved.

By a letter dated September 16, 2004, Petitioner requested a hearing before an Administrative Law Judge (ALJ). On September 28, 2004, the case was docketed and assigned to me for a hearing and a decision.

I held a hearing in this case on June 6-9, 2006, which was continued on December 5, 2006, in Greensboro, North Carolina. At the hearing CMS offered exhibits (CMS Exs.) 1-60; Petitioner offered exhibits (P. Exs.) 1-38. I overruled CMS's objection to P. Exs. 32-38 on grounds of relevance and received P. Exs. 1-38 into evidence. Without objection, I admitted CMS Exs. 1-60 into evidence.

State surveyors Mary Ann Sawicki, R.N., Susan Richardson, R.N., and Patrick Campbell, R.N. testified for CMS. Dr. Ann Burgess testified as an expert witness for CMS. Petitioner presented the testimony of Susan Wolfe Davidson, a social worker, and David Culbreth, Administrator of Petitioner's facility (hereinafter, Administrator Culbreth or Mr. Culbreth). Petitioner also called June Lassiter, a state surveyor who participated in the survey completed on July 21, 2004, to testify.

Each party received a copy of the hearing transcript (Tr.) and submitted a post-hearing brief (CMS Brief and P. Brief, respectively). CMS filed a response brief (CMS Reply). Both parties filed proposed Findings of Fact and Conclusions of Law.

II. Discussion

A. Issues

The issues in this case are:

> Whether Petitioner was substantially compliant with Medicare participation requirements; and
>
> If Petitioner is found not to have been in substantial compliance, whether the amount of the remedies imposed are reasonable.

B. Applicable Law

Petitioner is a long-term care facility participating in the federal Medicare program as a SNF and in the state Medicaid program as a NF. The statutory and regulatory requirements governing its participation are found at sections 1819 and 1919 of the Social Security Act (Act) and 42 C.F.R. Part 483. Sections 1819 and 1919 of the Act authorize the Secretary of Health and Human Services to impose CMPs on a long-term care facility for failure to substantially comply with federal participation requirements.

State survey agencies may survey, on behalf of CMS, facilities that participate in Medicare to determine whether they meet federal participation requirements. 42 C.F.R. §§ 488.10-488.28, 488.300-488.335. Pursuant to 42 C.F.R. Part 488, CMS may impose a per-instance CMP (PICMP) or a per-day CMP against a long-term care facility based on a state survey agency's finding of failure to substantially comply with federal participation requirements. 42 C.F.R. §§ 488.406, 488.408, 488.430. Pursuant to 42 C.F.R. Part 488, CMS also may impose other remedies based on noncompliance with such requirements.

There are two broad ranges of the amount of per-day CMPs. 42 C.F.R. §§ 488.408, 488.438. The upper range, from $3050 to $10,000 per day, is reserved for deficiencies that constitute immediate jeopardy to a facility's residents and, in some circumstances, for repeated deficiencies. 42 C.F.R. §§ 488.438(a)(1)(i), (d)(2). The lower range, from $50 to $3000 per day, is reserved for deficiencies that do not constitute immediate jeopardy, but either cause actual harm to residents or, cause no actual harm, but have the potential for causing more than minimal harm. 42 C.F.R. § 488.438(a)(1)(ii). There is a single range of PICMP from $1000 to $10,000, applicable regardless of the presence of immediate jeopardy. 42 C.F.R. §§ 488.408(d)(1)(iv), 488.438(a)(2).

The Act and regulations afford a long-term care facility assessed a CMP a hearing before an ALJ. Act, § 1128A(c)(2); 42 C.F.R. §§ 488.408(g), 498.3(b)(13). The hearing is a *de novo* proceeding. *Anesthesiologists Affiliated, et al.*, DAB CR65 (1990), *aff'd*, *Anesthesiologists Affiliated, et al. v. Sullivan*, 941 F.2d 678 (8th Cir. 1991); *Emerald Oaks*, DAB No. 1800, at 11 (2001); *Beechwood Sanitarium*, DAB No. 1906 (2004); *Cal Turner Extended Care Pavilion*, DAB No. 2030 (2006); *The Residence at Salem Woods*, DAB No. 2052 (2006). A facility has a right to appeal a "certification of noncompliance leading to an enforcement remedy." 42 C.F.R. § 488.408(g)(1); *see also* 42 C.F.R. §§ 488.330(e) and 498.3. However, the choice of remedies by CMS or the factors CMS considered when choosing remedies are not subject to review. 42 C.F.R. § 488.408(g)(2). A facility may only challenge the scope and severity level of noncompliance found by CMS if a successful challenge would affect the amount of the CMP that could be collected by CMS or approval of the facility's nurse aide training and competency evaluation program (NATCEP). 42 C.F.R. §§ 498.3(b)(14) and (d)(10)(i). CMS's determination on the level of noncompliance "must be upheld unless it is clearly erroneous." 42 C.F.R. § 498.60(c)(2). This includes CMS's finding of immediate jeopardy. *Woodstock Care Center*, DAB No. 1726, at 9, 38 (2000), *aff'd, Woodstock Care Center v. Thompson,* 363 F.3d 583 (6th Cir. 2003). The Departmental Appeals Board (Board) has long held that a provider has no right to challenge the scope and severity level assigned to a noncompliance finding, except where that finding was the basis for an immediate jeopardy determination. *See, e.g.*, *Ridge Terrace*, DAB No. 1834 (2002); *Koester Pavilion*, DAB No. 1750 (2000). An ALJ's review of a CMP is governed by 42 C.F.R. § 488.438(e).

The Board has addressed the allocation of the burden of persuasion and of going forward with the evidence in the absence of specific statutory or regulatory provisions. The Board's analysis and approach in this regard is not in dispute and is applicable here.

When a penalty is proposed and appealed, CMS must make a prima facie case that the facility has failed to comply substantially with federal participation requirements. "Prima facie" means, generally, that the evidence is "[s]ufficient to establish a fact or raise a presumption unless disproved or rebutted." *Black's Law Dictionary* 1228 (8th ed. 2004).

In *Hillman Rehabilitation Center*, DAB No. 1611, at 8 (1997), *aff'd, Hillman Rehabilitation Center v. U.S. Dept. of Health and Human Services*, No. 98-3789 (GEB), slip op. at 25 (D.N.J. May 13, 1999), the Board described the elements of a prima facie case and said that the Health Care Financing Administration (HCFA, CMS's predecessor) must identify the legal criteria to which it seeks to hold a provider. Moreover, to the extent that a provider challenges HCFA's findings, HCFA must come forward with evidence of the basis for its determination, including the factual findings on which HCFA is relying and, if HCFA has determined that a condition of participation was not met, HCFA's evaluation that the deficiencies found meet the regulatory standard for a condition-level deficiency. *Hillman Rehabilitation Center*, DAB No. 1611, at 8.

And in *Evergreene Nursing Care Center*, DAB No. 2069 (2007), the Board explained:

> CMS has the burden of coming forward with evidence related to disputed findings that is sufficient (together with any undisputed findings and relevant legal authority) to establish a prima facie case of noncompliance with a regulatory requirement. If CMS makes this prima facie showing, then the SNF must carry its ultimate burden of persuasion by showing, by a preponderance of the evidence, on the record as a whole, that it was in substantial compliance during the relevant period. [Citations omitted.]
>
> CMS makes a prima facie showing of noncompliance if the evidence CMS relies on is sufficient to support a decision in its favor absent an effective rebuttal. [Citations omitted.] A facility can overcome CMS's prima facie case either by rebutting the evidence upon which that case rests, or by proving facts that affirmatively show substantial compliance. *Tri-County Extended Care Center*, DAB No. 1936 (2004). 'An effective rebuttal of CMS's prima facie case would mean that at the close of the evidence the provider had shown that the facts on which its case depended (that is, for which it had the burden of proof) were supported by a preponderance of the evidence.' *Id.* at 4 (quoting *Western Care Management Corp.*, DAB No. 1921 (2004)).

Evergreene Nursing Care Center, DAB No. 2069, at 7-8.

Thus, CMS has the initial burden of coming forward with sufficient evidence to show that its decision to impose remedies or terminate a facility from participation is legally sufficient under the statute and regulations. To make a prima facie case of a legally

sufficient decision, CMS must: (1) identify the statute, regulation or other legal criteria to which it seeks to hold the provider; (2) proffer evidence upon which it relies for its factual conclusions that the provider disputes; and (3) show how the deficiencies it found amount to noncompliance to warrant an enforcement remedy.

C. Findings of Fact, Conclusions of Law, and Analysis

I make findings of fact and conclusion of law (Findings) to support this decision. I set forth each Finding below as a separate heading and discuss each in detail.

July 15, 2004 Survey - Tags 223, 226, 490, 497

1. Petitioner manifested an immediate jeopardy level failure to comply with 42 C.F.R. § 483.13(b) (Tag 223) from April 6, 2004 through May 28, 2004.

The July 15, 2004 survey found that Petitioner was not substantially compliant with 42 C.F.R. § 483.13(b). CMS Ex. 1, at 1-19. Section 483.13(b) provides that a resident is entitled to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.

Most deficiency allegations based on the July 15, 2004 survey (including Tags 226 and 490) stem from an incident on April 6, 2004, involving Residents 3 and 4. On April 6, 2004, Resident 3 was a 70-year-old male who was almost completely blind and could see only shadows. P. Ex. 15, at 1. He was alert, oriented, participated in activities of daily living, and was mentally competent to handle his own affairs. P. Ex. 15, at 1-5. Despite his blindness, Resident 3 was able to get around his room without assistance, but could not leave his room without the assistance of facility staff or of fellow residents. CMS Ex. 6, at 18. He was not assessed with behavioral problems. P. Ex. 15; CMS Ex. 1, at 2. He occasionally asked female facility staff for dates, "pat[ted]" them on their bottoms, or asked them for kisses. Tr. at 656-657.

CMS presented evidence that Resident 3 had a female roommate at Petitioner's facility in April 2001. CMS Ex. 6, at 11. Both residents and their respective families consented to the arrangement. CMS Ex. 28, at 6; Tr. at 658. CMS's position is that the female resident's declining cognitive state affected her ability to consent to sexual relations and, for that reason, she was moved to another room. Tr. at 170. Notably, the exhibits CMS cited do not indicate that Resident 3's female roommate was moved because she could no longer consent to sexual relations. According to Petitioner, she was placed with Resident 3 at her, and not Resident 3's, request. Tr. at 658. It defends its decision on the living arrangement, citing the residents' and their respective families' consent to the arrangement, as well as that of the state. Tr. at 658. It maintains that the female resident was moved to another room after she became disoriented and apparently was no longer

able to "recognize [Resident 3] as someone she wanted to be with anymore" (Tr. at 664) and after consultation with her family. Tr. at 664-665. Petitioner argues that while there was some presumption that Resident 3 and his female roommate were intimate, there is no evidence cited by the surveyors documenting actual sexual relations. Tr. at 170.

On April 6, 2004, Resident 4 was a 79-year-old female who had resided at the facility since December 2002. CMS Ex. 5, at 1, 22. She had a medical history of dementia with delusions and agitation. CMS Ex. 5, at 1, 10. She had both short- and long-term memory problems, and poor decision-making skills. While she was able to verbalize, much of what she said was nonsensical. CMS Ex. 5, at 23-26; Tr. at 137. She had a tendency to wander and Petitioner considered her an elopement risk. CMS Ex. 5, at 18, 24.

The medical records establish at least one previous encounter between Residents 3 and 4. Resident 4 scratched Resident 3's nose sometime in late 2003. Nurses' notes indicate that Resident 3 asserted: "[T]hat woman came into my room and hit me in my nose." A nurse did note a scratch on Resident 3's nose. CMS Ex. 6, at 7. There is no evidence that Petitioner investigated the incident or otherwise acted on it other than informing Resident 3's sister. CMS Ex. 6, at 7.

Petitioner and CMS generally agree on the basic facts as to what occurred on April 6, 2004. That day, at about 10:30 to 10:45 a.m., Resident 4 was walking down the hallway outside Resident 3's room. A registered nurse assistant heard Resident 3 say to Resident 4, "come here." Shortly thereafter, two certified nursing assistants (CNAs) heard Residents 3 and 4 talking in Resident 3's room. The CNAs went in to investigate. Resident 4 was in Resident 3's bathroom bent over with her diaper down. Resident 3 was observed standing behind Resident 4 with his pants down. Tr. at 412-413, 483. The CNAs separated the residents and notified their supervisors. Tr. at 171.

The interpretation of what each CNA reportedly saw differs. CNA Sheila Smith's written account indicates that "[Resident 3] was having sex with her [Resident 4] from behind." CMS Ex. 15. When interviewed by a surveyor during the July 15, 2004 survey, CNA Tim Martin was not as certain, as he said: "[I]t looked like his [Resident 3's] privates were between her [Resident 4's] legs from behind." He was not certain that Resident 3 had penetrated Resident 4. CMS Ex. 28, at 23-24; CMS Ex. 17.

As for Tag 223, the SOD alleges that Petitioner failed to protect Resident 4 from potential sexual abuse by Resident 3. CMS charges that the April 6, 2004 incident would not have occurred had Petitioner taken certain steps to prevent possible abuse and effectively deal with Resident 3's "sexualized behavior." CMS Ex. 1, at 1.

Interpreting 42 C.F.R. § 483.13, the Board stated: "Protecting and promoting a resident's right to be free from abuse necessarily obligates the facility to take reasonable steps to prevent abusive acts, regardless of their source." *Western Care Management Corp., d/b/a Rehab Specialties Inn*, DAB No. 1921, at 12 (2004). Based upon the Board's decision in *Western Care Management,* a facility is deficient under 42 C.F.R. § 483.13(b) if it knows, or should know, that potential abuse might occur and does nothing to prevent it. Thus, what is important under applicable regulations and case law is whether or not the facility knew, or should have known, that potential abuse might occur and failed to take reasonable preventative steps. I find Petitioner failed to take reasonable steps to protect Resident 4 from potential abuse.

The evidence advanced by CMS establishes that Petitioner failed to effectively deal with Resident 3's "sexualized behavior" and that Resident 4's cognitive impairment and inability to communicate coherently, combined with her tendency to wander, placed her at unreasonable risk of abuse. Petitioner failed to take reasonable steps to prevent that risk.

Petitioner was well aware that on April 6, 2004 Resident 4: (1) was cognitively impaired; (2) wandered constantly; (3) had poor decision-making skills; (4) could not appreciate potential dangers; (5) had unsteady gait and a risk for falls; (6) could not communicate meaningfully; and (7) frequently wandered the facility seemingly without regard for her own safety. She had both short- and long-term memory problems and, therefore, could not recall the location of her own room or the names of staff, and was not oriented to date, time, and place. She had poor judgment and, thus, required frequent re-direction and cuing. She was known for being flirtatious and affectionate. CMS Exs. 28, at 1; 5, at 10-12, 16-18, 22-25, 32, 34; Tr. at 170, 491-493. Despite knowledge of such risks, Petitioner allowed Resident 4 to regularly wander about the facility without supervision or adequate intervention. She was extraordinarily vulnerable to possible abuse given her diminished cognitive ability, poor judgment, and inability to communicate effectively. The potential perils she faced are obvious and the likelihood of serious injury, harm, or death resulting from failure to prevent her constant wandering, too, are apparent.

Petitioner was also aware that Resident 4 had a previous encounter with Resident 3, an alert, oriented, and mentally competent resident able to handle his own affairs and who, despite his visual limitations, participated in activities of daily living. Resident 3 sustained a scratch on his nose and alleged that Resident 4 entered his room and hit him on his nose. Resident 4 could not dispute this claim because she could not communicate meaningfully. Petitioner did not investigate this incident. Thus, if Resident 3's allegations were true, Petitioner did not address the possibility that Resident 4 posed a threat to Resident 3 and, potentially, to other residents. At a minimum, Petitioner was

aware of a previous encounter between Residents 3 and 4 that resulted in physical injury to Resident 3. Administrator Culbreth testified under cross-examination that he would have had concerns about a confused female resident entering a cognitively-intact male resident's room unsupervised. Tr. at 492-93.

Petitioner argues that it could not have foreseen that Resident 3 might attempt to sexually abuse Resident 4 and, therefore, it should not be held liable for Resident 3's conduct. Specifically, Petitioner notes that although Resident 3 occasionally patted female staff members' bottoms and asked them for kisses, he was not observed behaving aggressively toward other female residents and that there is no evidence that Resident 3 had a prior history of inappropriate sexual behavior with any female resident during his five years at the facility. Tr. at 657-658, 777. Petitioner also maintains that facility staff had talked to Resident 3 regarding his behavior, letting him know that it was inappropriate, and that there had been no escalation in his behavior. Tr. at 657. However, Petitioner did not provide documentation to show that staff had actually "talked to Resident 3" about his behavior.

CMS offered Dr. Ann Burgess' testimony to support its argument that Petitioner knew Resident 3 might abuse female residents. CMS Brief at 13. Dr. Burgess holds advanced degrees in psychiatric nursing (master's) and nursing science (doctorate), and is a professor of psychiatric nursing, and I deemed her qualified, without objection from Petitioner, as an expert on the prevention, identification and treatment of elder abuse, and on elder sexual abuse generally. Tr. at 206, 220, 244; CMS Ex. 34. Dr. Burgess testified that facility staff's failure to address what she called "sexualized language" (i.e., "give me a kiss") and "sexualized behavior" (i.e., "patting on the butt") of Resident 3 (Tr. at 247) encouraged him to "try to do more and more and more because he is getting away with it." Tr. at 248. Dr. Burgess also testified that Petitioner's failure to effectively respond to Resident 3's sexualized behavior made it more likely that the behavior would escalate or continue, leading to an incident such as that on April 6, 2004. Tr. at 248.

Petitioner presented the testimony of Susan Davidson, the social worker employed by Petitioner on April 6, 2004. Ms. Davison earned a bachelor's degree in Psychology and a minor in Gerontology. Tr. at 623. Petitioner urges me to give Ms. Davidson's testimony greater weight than that of Dr. Burgess based on Ms. Davidson's educational background and over 20 years of nursing home experience. Ms. Davidson testified that it was "very common" for residents to want to hold hands and "fairly common" for a resident to ask for a kiss. Tr. at 624. She further testified that such conduct was not indicative of sexual predation and that social workers are encouraged to show residents affection. Tr. at 624-625. Ms. Davidson also testified that she immediately went to Resident 4 after the April 6, 2004 incident, but noted the resident was her "usual self" at that time, and that she did not see anything "adverse psychologically." Tr. at 625-626. Also, she testified that she saw Resident 4 the next day but did not note any ill effects of the incident. Tr. at 626.

According to Ms. Davidson, she saw Resident 4 daily, but did not see any change in mood or behavior after April 6, 2004. Tr. at 633.

I find CMS expert Dr. Burgess' testimony more persuasive and, for that reason, assign it greater weight. While Petitioner argues that Dr. Burgess lacked familiarity with, and experience in, a nursing home environment, Petitioner did not object to her qualifications as an expert on the prevention, identification and treatment of elder abuse, and on elder sexual abuse generally. Dr. Burgess' opinion that Petitioner failed to address what she characterized as Resident 3's "sexualized language" and "sexualized behavior" and that that failure effectively encouraged Resident 3 to continue engaging in or escalating such behavior (Tr. at 248-249), is compelling. That opinion was not based upon ongoing or incomplete studies, but rather, was squarely within the realm of expertise for which Dr. Burgess was qualified to possess in this case. Petitioner should have more effectively responded to Resident 3's behavior to set clear limits that his conduct towards staff and other residents was unacceptable and would not be tolerated. Most significantly, Petitioner should have taken action to keep wandering, cognitively-impaired residents away from a resident exhibiting sexualized behavior, including Resident 3. As previously noted, Resident 4 was extraordinarily vulnerable to possible abuse given her diminished cognitive ability, poor judgment, and inability to communicate meaningfully. If she had in fact been sexually assaulted - and, in Dr. Burgess's opinion, she was (Tr. at 250) - she would have been unable report a complaint or describe the abuse. CMS also established, through Mr. Culbreth's testimony, that the facility had other cognitively-impaired female residents who were known wanderers. Tr. at 550.

Both parties focused on the issue of whether or not Resident 3 "abused" Resident 4 on April 6, 2004. Petitioner argues that there was insufficient evidence to establish that Residents 3 and 4 had sex and that Resident 4 seemed "unharmed and in good spirits" immediately after the April 6, 2004 incident. CMS Ex. 5, at 15. CMS argues that sexual assault and "abuse" occurred. CMS Brief at 16-17.

On this issue CMS introduced evidence concerning an incident involving Resident 8.[2] A record of complaint and progress notes dated April 7, 2004, and a resident review worksheet dated April 15, 2004, indicated that Resident 8 reported that on April 7 she was "raped" at nighttime by a tall, thin, light-skinned man who got into her bed, but left when she tried to push him away. CMS Ex. 29, at 11, 13, 20-21. The record of complaint further indicated that the corrective action called for a psychological

[2] CMS requested to introduce the testimony of Resident 8's daughter to rebut Petitioner's allegation that Resident 8 was delusional. Tr. at 785. Resident 8 was not the subject of the survey in issue and no citation was issued based on her allegation after a state investigation. I therefore denied the request by a November 20, 2006 Order.

evaluation. The evaluation concluded that the complaint of assault was the result of delusional thought. CMS Ex. 29, at 13. CMS contends that Petitioner failed to appropriately investigate Resident 8's complaint and dismissed it as a product of delusion. CMS also argues that Petitioner mischaracterizes the complaint, noting that Resident 8's care plan does not note delusional thinking. CMS Ex. 29, at 22-27. By introducing evidence on Resident 8 CMS apparently wanted me to infer that Resident 3 might have attacked Resident 8, to further bolster its position that Resident 4 was at high risk of abuse by a sexually-aggressive Resident 3.

Petitioner objected to the introduction of evidence concerning Resident 8 as evidence of non-conformity with the cited deficiencies because the allegations regarding Resident 8 were neither cited as deficiencies, nor were grounds for the cited deficiencies. Further, Petitioner argues that it was denied adequate notice that the allegation regarding Resident 8 would be at issue at the hearing. It maintained that the first mention of Resident 8 was in CMS's pre-hearing brief. P. Brief at 19. Moreover, Petitioner cites the fact that the state investigated the handling of Resident 8's allegation on April 19, 2004 and determined that Petitioner had performed appropriately. Petitioner was not cited for any deficiencies relative to Resident 8's allegations. Finally, Petitioner argues that Resident 8's allegations are not additional evidence of inappropriate behavior by Resident 3 because Resident 8 described her assailant as "light-skinned," and Resident 3, as a dark-skinned man. Furthermore, Petitioner's investigation found no evidence of a "light-skinned" intruder at the facility. P. Brief at 20.

CMS's arguments are unavailing. First, the evidence indicates that Petitioner adequately investigated and documented Resident 8's complaint. CMS Ex. 29, at 13. Second, progress notes indicate that, on March 3, 2008, Resident 8 complained that she noticed a $7000 check from Oprah Winfrey was missing. CMS Ex. 29, at 20. There is no evidence that Resident 8 had received a check from Oprah Winfrey, and this claim alone reasonably supports a conclusion that Resident 8 was delusional. Third, given Resident 8's delusional state, and that her description of the perpetrator did not match anyone at the facility, it was reasonable for Petitioner to conclude that the complaint was based on a delusion and that there was insufficient evidence to conclude an assault had occurred.

Finally, and of most import, the State Agency investigated Resident 8's complaint and did not find a deficiency. CMS counsel de-emphasizes the state investigation, but all the while argues that the fact that the investigation took place is evidence of failure to have an effective sexual abuse prevention system. Essentially, CMS argues that I should ignore an on-site investigation of a complaint of potential sexual abuse, which resulted in no citation, and instead, find, based on the very same evidence, that the facility failed to protect Resident 8 from sexual abuse. CMS also argues that the investigation by Petitioner and the State Agency focused on a charge of "rape" when in fact the complaint was that Resident 8 said she awoke to find a man atop her attempting to assault her. CMS

maintains that Petitioner was dismissive of the complaint, merely attributing it to delusion. To prove that Petitioner and the state investigation were essentially wrong, CMS did not propose to call state surveyors to establish flawed investigations, but instead, attempted to call Resident 8's daughter to rebut allegations that Resident 8 was delusional. I requested that CMS file a brief addressing the relevance of such testimony and the legal authority to use the evidence from another State survey which found Petitioner to be in compliance with participation requirements to prove Petitioner was not in compliance relative to the same specific facts. CMS provided no persuasive legal, precedential, or factual basis upon which I could find the proposed testimony relevant. I therefore denied CMS's motion to conclude the testimony of Resident 8's daughter as irrelevant.

Ultimately, I am not persuaded by Petitioner's argument that given Resident 3's visual problems, background, history at the facility, and isolated nature of the April 6, 2004 incident, it was not foreseeable that Resident 3 could sexually abuse female residents. I find the record inconclusive on whether Residents 3 and 4 actually had sexual contact. What is clear is that a cognitively-intact resident called a cognitively-impaired, non-communicative resident incapable of consenting into his room and they were found engaged in a position suggestive of actual or imminent sexual contact.

Based on the foregoing, I conclude that Petitioner failed to demonstrate that it took reasonable steps to effectively address Resident 3's "sexualized behavior" and to protect Resident 4 from potential abuse. Petitioner, therefore, was not in compliance with participation requirements of 42 C.F.R. § 483.13(b) at the immediate jeopardy level.

Duration of the immediate jeopardy citation.

CMS argues that immediate jeopardy was present from April 6, 2004 through May 28, 2004, based on a failure to take adequate steps to protect Resident 4 and other residents from Resident 3's sexually aggressive behavior. CMS Brief at 14-18.

Petitioner argues that the evidence warrants fully setting aside the entire CMP. It also argues, alternatively, that the noncompliance at the immediate jeopardy level for the April 6, 2004 incident ceased on April 6, 2004. P. Brief at 35. It asserts that it appropriately acted after April 6, 2004, listing specific actions taken thereafter. P. Brief at 9. CMS counters each, alleging that the actions were insufficient to abate the immediate jeopardy. I address the actions in dispute and which have an impact on my decision in this case.

Petitioner maintains that it immediately separated Residents 3 and 4 after finding them together. But CMS argues, persuasively, that Petitioner should not have allowed Resident 4 to enter Resident 3's room at all. CMS Reply at 7. Separating the residents did not abate the immediate jeopardy.

Petitioner also asserts that staff conducted a head-to-toe assessment of Resident 4 to determine whether there were any signs of trauma. CMS maintains that Resident 4 should have been sent to an emergency room for a possible examination for sexual assault. CMS persuasively argues that had such an examination been conducted, evidence of physical abuse, if any, would have been identified and preserved. CMS notes that the facility's administrator instead insisted that Resident 4 be examined at the facility. The nurse asked to conduct the examination refused to do so, but she subsequently agreed to witness the examination conducted by another nurse. Tr. at 255-270.

Petitioner prepared a report of the April 6, 2004 incident. But CMS cites the fact that while an incident report was prepared, it neither included critical factual descriptions, nor identified eyewitnesses to the event. The incident was not recorded in the incident report log. It was recorded in the 24 Hour Report the facility sent to the State of North Carolina. However, that report omitted a critical factual, physical description of the event; it did not discuss cognitive competence of the residents involved. CMS also argues that the police should have been called to investigate the incident and to obtain and preserve pertinent evidence. Administrator Culbreth maintains that he did not call the police because "nothing happened." CMS Ex. 28, at 2; CMS Reply at 8-9 (footnote 10). I find Mr. Culbreth's testimony on this point unconvincing.

The facility argues that staff called Resident 4's physician for guidance on how to handle the April 6, 2004 incident. CMS points out that there are no contemporaneous notes corroborating this assertion. There were no contemporaneous nurses' notes concerning the incident. The first reference to it was a late entry written over three months after the event. P. Ex. 14, at 2-5. Two incident reports prepared by Petitioner do not mention contact with Resident 4's physician. The state interviewed Dr. Ward Patrick, Petitioner's Medical Director and Resident 4's physician, who indicated that he could not recall the incident because he was not given details about the incident. CMS Ex. 28, at 8. Petitioner did not dispute the validity or credibility of Dr. Patrick's statement.

Petitioner maintains that Ms. Davidson, a trained social worker with significant experience working with the elderly, assessed Resident 4 for mental trauma and behavioral changes. As CMS argues, the social worker admitted on cross-examination that she has no specialized counseling or training on handling elderly sexual-abuse victims. Tr. at 733.

Petitioner asserts that Administrator Culbreth called Adult Protective Services (APS) and the local ombudsman concerning the April 6, 2004 incident. APS did not initiate an investigation that prompted Mr. Culbreth to call again to ask whether an investigation would be conducted. CMS points out that Mr. Culbreth did not provide APS with accurate information that could affect the conduct of the investigation and any conclusions to be derived therefrom. Mr. Culbreth told the APS investigator that

Resident 4 had attacked Resident 3, but he also said that both residents willingly participated in the incident. As for contacting the ombudsman CMS argues that that action did not protect Resident 4 or any other vulnerable resident from abuse.

Resident 4's husband was informed of the incident involving his wife and Resident 3. According to Petitioner, Resident 4's husband assessed his wife himself and did not believe that sexual assault had occurred. CMS maintains that with all due respect to Resident 4's husband he does not have the training to make such a medical-legal determination.

Petitioner maintains that the staff, Mr. Culbreth, and the facility social worker counseled Resident 3 regarding his behavior after the incident. CMS maintains that the facility imposed no consequences on Resident 3, who denied any wrongdoing. CMS Ex. 6, at 14. Further, CMS argues that there is no evidence that Resident 3 was restricted in any way immediately after the event. He was later supervised one-on-one, but only after a survey was conducted months after the fact.

According to Petitioner, Resident 4 was monitored one-on-one to ensure her safety after the incident. However, Petitioner does not dispute CMS's assertion that one-on-one supervision lasted only a week, after which time Resident 4 was apparently allowed to wander alone as she was permitted to do before April 6, making her once again vulnerable to abuse. Mr. Culbreth himself testified that the facility had other cognitively-impaired and/or wandering female residents during the immediate jeopardy period. Tr. at 550. They, too, were vulnerable to abuse from April 6 through May 28, 2004.

Petitioner argues that Resident 3's therapy with ACT, a psychiatrist group, continued after April 6, 2004. CMS aptly points to lack of documentary evidence on how often and when ACT evaluated, treated, or observed Resident 4. Petitioner did not provide any records to document that ACT was addressing the potential psychological impact of the incident, or that ACT was even aware of it. There is evidence that Resident 4's anti-psychotic medication was increased, but not documentation of the reasons for an increase.

A physician examined Resident 4 on April 9, 2004, and his progress note bearing that date indicated that Resident 4 "constantly" wandered about the facility and that ACT had recommended an increase in Resident 4's anti-psychotic medication. CMS Ex. 5, at 11. But it does not discuss the April 6 event, or that any medical examination or treatment was administered to specifically address the effects of the incident.

Petitioner argues that facility staff were "in-serviced" regarding the need to keep Resident 4 away from Resident 3's hallway and to keep Resident 3 on the other side of the building at all times. In support of this assertion, Petitioner presented the testimony of Ms. Davidson, who said that after April 6, Resident 3 was monitored to ensure that he did not

leave his room alone. Petitioner does not dispute the assertion that Resident 3 was not on one-on-one supervision until the facility was surveyed. Additionally, during the survey, Resident 3 was observed leaving his room without a staff escort. He left with another male resident. CMS Ex. 28, at 9 (surveyor notes worksheet).

Further, Ms. Davidson testified that after the April 6 incident the staff were "hyper-vigilant" to keep wandering residents away from Resident 3's room and to remain where there were supposed to be. Tr. at 776-777. She also testified that staff were "in-serviced" regarding keeping wandering residents away from Resident 3's hall. Tr. at 776-777. Petitioner provides no evidence to document that various "in-services" were provided, when they were provided, who attended the "in service," and what specifically was discussed. Moreover, Petitioner has not established what specific measures it implemented after April 6, 2004 to prevent Resident 3 from behaving sexually inappropriate with other wandering female residents in rooms near Resident 3. Administrator Culbreth testified that there was no formal sign-in sheet for the "in-services"; nor did he hear of anyone "in-servicing" any staff new to the facility from May to July 2004. Tr. at 542-543. And, he admitted under cross-examination that staff were not informed specifically about the April 6, 2004 incident; nor were they told to monitor Resident 3 one-on-one. Tr. at 543-544. Thus, if the "in-services" or intervention specifically responsive to the April 6, 2004 event were actually provided as was alleged, then those staff members who were allegedly in-serviced were provided insufficient information. Petitioner has not explained why staff at the alleged in-services were provided only limited information.

CMS established that problems with wandering residents, including vulnerable female residents, persisted even after the alleged in-servicing. Resident 7, a confused female resident and known wanderer, wandered into another resident's room on July 1, 2006. CMS Ex. 31, at 8. CMS also provided evidence in the form lists of wanderers (CMS Exs. 26 and 41), many of whom are females. Moreover, nursing notes indicate that less than three weeks after April 6, 2004, the facility's activities director observed Resident 4 outside the activity room where she had fallen and sustained injuries. CMS Ex. 5, at 8. Thus, it is evident that Resident 4 was not monitored at the time of her fall.

Based on the forgoing, Petitioner's arguments that if immediate jeopardy existed at all, it existed but for one day, on April 6, 2004, is not persuasive. CMS has established that an immediate jeopardy condition existed on April 6, 2004, and continued, as to Tag 223, until May 28, 2004. Petitioner has not met its burden to prove by a preponderance of the evidence that it abated the immediate jeopardy associated with Resident 3's actions on April 6, 2004, or any time before May 28, 2004.

2. Petitioner was not in compliance with 42 C.F.R. § 483.13(c)(1)(i) (Tag 226).

A facility must develop and implement written policies and procedures that prohibit mistreatment, neglect and abuse of residents, and misappropriation of resident property. 42 C.F.R. § 483.13(c). More specifically, a facility must not use verbal, mental, sexual or physical abuse, corporal punishment or involuntary seclusion in its care of residents. *Id.*

The SOD for the July 15, 2004 survey alleges that Petitioner failed to comply with 42 C.F.R. § 483.13(c)(1)(i). However, it is obvious from the text of the survey report that the allegations of noncompliance relate more to general provisions of 42 C.F.R. § 483.13(c) than to the narrower provisions of 42 C.F.R. § 483.13(c)(1). CMS Ex. 1, at 20-41. Petitioner is charged, essentially, with failure to implement its anti-abuse policy. The April 6, 2004 event regarding Residents 3 and 4 as discussed above is the basis for Tag 226.

Petitioner maintains that CMS has failed to establish a prima facie case that Petitioner did not develop and appropriately implement its abuse policies and procedures. Alternatively, Petitioner asserts that it had in place and implemented appropriately its abuse policies and procedures. P. Brief at 21. It maintains it had a resident abuse policy dated March 2004, which defined and addressed sexual abuse, and which had both prevention and reporting components. P. Exs. 28 and 29.

As of April 6, 2004, Petitioner's written anti-abuse polices mandated certain steps upon observation of possible abuse. Relevant language therefrom included the following:

> (a) The staff member who witnesses a possible violation of the facility policy shall immediately report the incident to their supervisor. If their supervisor is not available, the report shall be made to the charge nurse for the alleged victim. The nursing staff will take appropriate actions to protect the alleged victim, and insure that he or she suffers no further harm. These actions will include immediate separation from the alleged perpetrator . . . .
>
> (b) The supervisor and/or charge nurse shall immediately complete an incident report listing the residents or staff involved, date, time, location, witnesses, and a summary of the event. The report shall immediately be given to the Administrator and the resident's family and attending physician shall be notified. The Administrator shall provide the Director of Nursing and Social Worker with a copy of the report.

> (c) The facility will timely conduct an investigation of the report. The facility investigation shall include the Social Worker and Director of Nursing and any other appropriate personnel. The conclusion of the investigation will be forwarded to the Administration for review.
>
> (d) The facility, upon receipt of the initial incident report, will contact other agencies, including Adult Protective Services and Law Enforcement as necessary or required. If the alleged perpetrator is a resident, his or her family will also be notified.

P. Ex. 29, at 6.

CMS concedes that Petitioner's staff immediately separated Residents 3 and 4 and notified their supervisors of the incident. CMS argues that Petitioner nonetheless failed to implement its anti-abuse policy in numerous ways.

First, CMS argues that Petitioner failed to act appropriately to protect the alleged victim and prevent further harm to her. Petitioner maintains that Resident 4 was monitored one-on-one after April 6, which CMS demonstrated lasted merely a week and after which time she apparently was allowed to wander the facility as she had before April 6. Further, nursing records show that Resident 4 suffered a fall merely weeks after April 6 - an incident suggesting no one-on-one supervision. CMS Ex. 5, at 8.

As for protecting Resident 3 and potentially other vulnerable residents from similar abuse by Resident 4, Petitioner maintains that its staff, administrator, and social worker counseled Resident 3 about his inappropriate behavior. CMS has established that the facility imposed no consequences on Resident 3, who denied any wrongdoing. Petitioner did not place Resident 4 on one-on-one supervision until the July 15, 2004 survey. Additionally, a surveyor observed Resident 3 leaving his room without a staff escort, but rather, with another male resident. CMS Ex. 28, at 9.

Petitioner's policy requires that the supervisor and/or charge nurse immediately complete an incident report listing the names of residents or staff involved, date, time, location, witnesses, and a summary of the event. P. Ex. 29, at 6. CMS maintains that while an incident report was prepared, it did not include critical factual discussion about exposure of both residents' genitalia; nor did it name eyewitnesses to the incident. Thus, anyone reading the incident report would not be fully informed as to either what had actually occurred, or that it was actually witnessed. The April 6 event was not recorded in the incident report log. Furthermore, the 24 Hour Report the facility sent to the State of North Carolina omitted critical factual, physical description of the event and did not discuss the cognitive competence or incompetence of the residents involved.

Petitioner's policy also provides that the incident report shall be given immediately to the administrator and that the residents' family and attending physician(s) shall be notified. There is no documentation that an incident report was provided to any such individual other than Mr. Culbreth. Petitioner argues that staff called Resident 4's physician for guidance on how to handle the matter, but CMS established the lack of contemporaneous corroborating notes. In fact, there were no contemporaneous nurses' notes concerning the April 6, 2004 incident. As previously noted, the first reference to the April 6 event was a late entry dated July 15, 2004, the date of the state survey, over three months after the fact. P. Ex. 14, at 2-5. There was no mention of the contact with Resident 4's physician in two incident reports prepared by Petitioner. Petitioner maintains that Resident 4's physician examined her on April 9, 2004. While there is a physician progress note bearing that date, that note does not mention the April 6 incident, but indicates that ACT recommended adding an anti-psychotic to Resident 4's medication, which her physician did not administer due to the risk of falls. The note indicates that Resident 4 did wander. CMS. Ex. 5, at 11. The state interviewed Dr. Patrick, the facility's Medical Director for some fifteen years, and who treated Residents 3 and 4. Dr. Patrick indicated that he was unaware of the details of the April 6, 2004 event. He further indicated that he would have ordered Resident 4 sent to the emergency room for an examination if he had known the details of the incident. CMS Ex. 28, at 8.

As for the facility policy provision mandating timely investigation of such events, CMS maintains that Petitioner failed conduct such an examination specific to the April 6, 2004 event. Petitioner asserts that staff conducted a head-to-toe assessment of Resident 4 to ascertain signs of trauma, if any, from the April 6 incident. CMS maintains that Resident 4 should have been sent to an emergency room for a sexual assault examination. CMS asserts that the facility administrator insisted that Resident 4 be examined at the facility. Nurse Sylvia Kelly informed the state surveyor that Mr. Culbreth asked her to examine Resident 4, but she refused to perform a vaginal exam on Resident 4 and questioned Mr. Culbreth whether Resident 4 should be sent to the emergency room. Nurse Kelly subsequently agreed to witness the examination of Resident 4 conducted by Nurse Marion Jones at 1:00 to 1:30 p.m. on April 6. CMS Ex 28, at 7. There are no contemporaneous notes of that examination. CMS Ex. 28, at 7. The facts are clear that both residents were found with their genitalia exposed; Resident 3 was standing behind Resident 4 in a manner suggesting that he was engaging in, had engaged in, or was about to engage in, sexual intercourse with a cognitively-impaired Resident 4. Dr. Burgess testified that these circumstances would reasonably require a sexual assault examination. In addition, Nurse Kelly believed that Resident 4 should have been sent to a hospital emergency room for an examination, but refused to conduct the examination herself. Finally, Resident 4's treating physician Dr. Patrick indicated that had he been informed of the details of the incident, he would have ordered Resident 4 transferred to an emergency room for an examination.

Petitioner's policy provides that the facility must contact other agencies, including APS and law enforcement, as necessary. Petitioner asserts that Administrator Culbreth called APS and the local ombudsman concerning the April 6 incident. CMS established that Mr. Culbreth told the APS investigator, Ms. Kate Walton, that "the female" (Resident 4) had attacked "him" (Resident 3). An interview with Ms. Walton also reveals that Mr. Culbreth told her that both residents willingly participated. CMS Ex. 28, at 25. Thus, APS conducted its investigation based on false information. CMS also argues that contacting the local ombudsman did nothing to protect any vulnerable resident from potential abuse.

CMS argues that local law enforcement should have been called to investigate immediately after the April 6 incident, but was not so called until July 15, 2004. The resulting police report indicates that Mr. Culbreth had reported that both parties were "not in their right minds" and there was no need for the police to talk to them. CMS Ex. 14, at 2. The evidence the police obtained was presented to the Assistant District Attorney, but the matter was not prosecuted due to insufficient physical evidence. CMS Ex. 14, at 1-3. On July 23, 2004, Mr. Culbreth called the police again and informed them that the original report was inaccurate. Mr. Culbreth indicated that "the reporting officer misunderstood that both the victim . . . and the suspect . . . were both mentally incoherent . . . [Resident 4] is suffering from a mental disorder and is incoherent most of the time but that [Resident 3] is coherent and able to understand and answer questions." CMS Ex. 14, at 4. Petitioner provides no information as to how the reporting officer "misunderstood" the two materially different statements. As CMS points out Mr. Culbreth asked the police to conduct another investigation, but police declined due to lack of evidence. Captain Ronnie L. Davis informed Mr. Culbreth that "the Police Department should have been notified at the time of the incident. That no medical evidence was obtained by social services and by the time we were notified if there had been any medical evidence it was gone by that time." CMS Ex. 14, at 4-5. Mr. Culbreth has indicated that he did not call the police because, in his view, "nothing happened" on April 6, 2004. CMS Ex. 28, at 2.

Based on the evidence presented relative to this citation, I find that Petitioner was not in compliance with participation requirements at 42 C.F.R. § 483.13(c)(1)(i). While Petitioner did have an anti-abuse policy in place on April 6, 2004, CMS has established that Petitioner did not properly or completely implement it. Petitioner did not sustain its burden of proving that it was in compliance with this participation requirement.

3. Petitioner was not in compliance with 42 C.F.R. § 483.75 (Tag 490).

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. 42 C.F.R. § 483.75.

Again, the allegations of noncompliance stem from the April 6, 2004 incident between Residents 3 and 4. The SOD alleges, in part, that:

> staff failed to implement their abuse policy related to identification, reporting, prevention/protection and training, failed to involve the interdisciplinary care plan team as described in their abuse policy . . .

P. Ex. 1, at 44. CMS relies on essentially the same set of facts here that it used in its claim that Petitioner failed to implement its anti-abuse policy.

The gravamen of this deficiency is a facility's failure to have a protocol or procedure in place, and not merely the failure of staff to follow the protocol in a specific instance. As I have indicated above, I find that CMS has established a prima facie case that Petitioner failed to satisfactorily implement its anti-abuse policies and, therefore, was not in compliance with 42 C.F.R. § 483.75. Petitioner has failed to meet its burden of proving by a preponderance of the evidence that it was in compliance with 42 C.F.R. § 483.75.

4. Petitioner was not in compliance with 42 C.F.R. 483.75(e)(8) (Tag 497).

A facility must complete a performance review of every nurse aide at least once every 12 months and in-service training must be no less than 12 hours per year and sufficient to insure continuing competence of nurse aides. 42 C.F.R. § 483.75(e)(8). The SOD alleges that when surveyors asked Petitioner for proof that six sampled nurse aides had received in-service hours, the administrator was unable to show that a system tracking in-service hours was present. CMS Ex. 1, at 50-51. Petitioner did not challenge this allegation.

I find that the evidence is sufficient to establish a prima facie case of noncompliance with 42 C.F.R § 483.75(e)(8). Petitioner did not prove by a preponderance of evidence that it was in compliance with this participation requirement.

July 21, 2004 Survey - Tags 278 and 324

5. Petitioner manifested an immediate jeopardy level failure to comply with 42 C.F.R. § 483.25(h)(2) (Tag 324) from May 28, 2004 through July 25, 2004.

The "quality of care" regulation in 42 C.F.R. § 483.25(h)(2) requires a facility to ensure that each resident receives adequate supervision and assistance devices to prevent accidents. The SOD alleges that Petitioner failed to provide adequate supervision to

prevent elopement by Residents A and B.[3] CMS Ex. 35, at 3. CMS alleges that Residents A and B eloped and were found outside the facility, thereby placing them in immediate jeopardy. CMS Ex. 35, at 3-12.

Resident A was diagnosed with dementia, hypertension, and combative behavior, and was assessed as an elopement risk. CMS Ex. 38, at 1; Tr. at 42. The nurses' notes for Resident A reveal multiple elopements or attempted elopements in May-July 2004:

> May 28, 2004 at 4:00 a.m. Resident A was found outside the facility by the local police department and returned;
>
> May 29, 2004 at 12:00 p.m. Resident A attempted to leave the facility twice;
>
> June 23, 2004 at 1:00 a.m. Resident A attempted to leave the facility repeatedly;
>
> July 4, 2004 at 10:30 p.m. Petitioner's staff on the 7:00 a.m. to 3:00 p.m. shift reported that Resident A "got outside on day shift."

CMS Ex. 38, at 26-29.

Similarly, Resident B eloped from the facility on July 3, 2004, in a wheelchair, attempting to roll the chair up a hill. A CNA found him and returned him to the facility. CMS Exs. 35, at 8; 39, at 7-8. On July 4, 2004, Resident B again left the facility briefly and was escorted back inside. Tr. at 58-59. CMS argues that these repeated elopements and attempted elopements by Residents A and B demonstrate that Petitioner failed to provide adequate supervision and assistance devices.

Petitioner admits that Residents A and B did elope or attempt to elope from the facility on the dates and times documented. However, Petitioner argues that it was monitoring residents and taking appropriate responsive actions, including: (1) securing the doors; (2) alarming the front doors; (3) implementing a missing resident procedure; (4) increasing resident monitoring; (5) focusing on redirecting residents; and (6) providing additional in-services to staff regarding resident elopements. P. Brief at 7-8.

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[3] In the July 21, 2004 SOD (CMS Ex. 35) these residents were identified as Residents 4 and 5. These numbers were used in the July 15, 2004 SOD to identify other residents. To avoid confusion, I refer to Residents 4 and 5 as Residents A and B, respectively.

A close review of Petitioner's actions reveal that it failed to take adequate steps to protect its residents. For example, Resident A's nurses' notes and accompanying surveyor resident review worksheets indicate that after Resident A exited the facility on May 28, 2004, Petitioner installed an alarm on the front door. CMS Exs. 38, at 26-27; 40, at 7-8; and Tr. at 45-46. However, CMS surveyor Patrick Campbell observed that the front door alarm was a magnetic personal alarm (Tr. at 46), which, according to Mr. Campbell, was inadequate to alert Petitioner of possible resident elopement as it was designed for residents that attempt to get out of bed unassisted or out of a wheelchair unassisted, and not fully ambulatory residents that attempt to elope through facility doors. Tr. at 45-46. Mr. Campbell further testified that Administrator Culbreth indicated that the alarm was not on 24 hours a day and, in fact, was turned off at 9:00 p.m. Tr. at 46. The record shows that as late as July 4, 2004, Resident A was allowed to elope through a dining room door outside the parking lot where there was vehicular traffic. CMS Ex. 38, at 29; Tr. at 58-59. There was no door lock or alarm present and the entrance keypad on the dining room door which led out to a yard and parking lot was not operational. CMS Ex. 40, at 7; Tr. at 58-59.

After several successful elopements and attempted elopements by Residents A and B, in May and June 2004, Petitioner was clearly on notice that these residents were likely to attempt elopement and required intervention. Despite this, as late as July 4, 2004, Petitioner failed to take basic preventative steps, such as locking and alarming the dining room doors and placing more appropriate alarms on the facility entry and exit doors. The regulations require Petitioner to regularly evaluate, modify, and adjust interventions as needed. The record clearly shows that Petitioner failed to do so.

The dangers these cognitively impaired residents faced by being allowed to leave Petitioner's facility unsupervised are obvious. Both were allowed to elope out into the street or parking lot and were exposed to vehicular traffic and the elements. That the residents were not seriously injured or even killed was fortuitous. Clearly, the residents' exposure to the elements and to vehicular traffic, coupled with their physical and cognitive limitations, created a high probability that they would suffer extreme adverse consequences in the course of any elopement on and after May 28, 2004. Based on my review of all of the evidence before me, I find that Petitioner failed to substantially comply with 42 C.F.R. § 483.25(h)(2) at the immediate jeopardy level.

The record shows that Petitioner's residents continued to be in immediate jeopardy from May 28, 2004 through July 25, 2004 because Petitioner failed to take adequate measures to prevent resident elopement. In late May and early July Petitioner took steps to protect and assess wandering residents after Resident A left the facility on May 28, 2004. Petitioner increased monitoring of residents and facility staff focused on redirecting wandering residents. However, it was not until sometime after the July 21 survey, but

before the August 3 survey, that Petitioner finally installed and tested a Wanderguard system to better prevent resident elopement. Tr. 28-30. Thus, I am satisfied that beginning July 26, 2004 Petitioner had abated the immediate jeopardy.

6. CMS has failed to prove a prima facie case that Petitioner was not in substantial compliance with 42 C.F.R. § 483.20(g) (Tag 278).

The regulation at 42 C.F.R. § 483.20(g) provides, in part, that resident assessments must accurately reflect the residents' status.

At the completion of the July 21, 2004 survey Petitioner was assessed at a "D" level deficiency based on an allegation that Petitioner failed to maintain accurate Minimum Data Set (MDS) records in 1 of 6 residents reviewed. P. Ex. 3, at 3. In its May 15, 2006 pre-hearing memorandum, at 6, footnote 1, CMS indicated that it would present evidence that Tag F278 constituted immediate jeopardy. Petitioner objects to CMS changing the level of the deficiency in the findings identified in the July 21, 2004 SOD. Petitioner was placed on notice of the "D" level deficiency in CMS's July 27, 2004 notice letter. Petitioner maintains that CMS has no authority to change the level of deficiency in this case almost two years after the survey occurred. P. Brief at 24, citing *Highland Manor of Elko*, DAB CR1517 (2006).

CMS did not respond to Petitioner's challenge to its authority to change the level of deficiency cited in the SOD and to provide legal notice thereof in a footnote in CMS's pre-hearing memorandum. Thus, I find that CMS has not demonstrated that it has the authority to change the level of the deficiencies, or that it is sufficient legal notice to convey such a substantial change through a footnote in a pre-hearing memorandum prepared by CMS counsel.

As for the merits of Tag 278 as cited in the July 21, 2004 SOD, I find that CMS has not sustained its burden of proving a prima facie case that Petitioner was out of compliance. CMS based its findings on allegations that the MDS dated June 8, 2004 for Resident 4 was not coded to indicate that he was a wanderer. CMS failed to include a copy of the June 8, 2004 MDS as an exhibit and has failed to specifically present a prima facie case that the MDS was not correctly completed. Even if CMS had presented the actual document in issue as an exhibit, Petitioner would still prevail as it has established by a preponderance of the evidence that it was in compliance with participation requirements as to this Tag. Specifically, CMS alleges that a June 2, 2004 care plan prepared by Petitioner's staff indicated that Resident A exhibited behaviors which suggest he was a wanderer. However, a MDS form prepared by Petitioner's staff on June 28, 2004 did not reflect coding which indicated Resident A was a wanderer. P. Ex. 3, at 3-4. Petitioner does not dispute that the June 28, 2004 MDS form is not coded to indicate Resident A is a wanderer. However, Petitioner points out that the June 2, 2004 care plan

for Resident A indicated that he "wanders in other patients's rooms and has left the facility." P. Ex. 3, at 4. Thus, Petitioner argues that Resident A's records were updated to indicate his propensity to wander and that the facility intervened to reduce wandering, e.g., monitoring hallways. Tr. at 455.

The intent of 42 C.F.R. § 483.20(g) is to insure that residents are accurately assessed to reflect their status, needs, and strengths. I find that Petitioner demonstrated by a preponderance of the evidence that its records accurately reflected Resident A's status, i.e., his tendency to wander, consistent with this regulation.

7. CMS's attempt to plead and prove 42 C.F.R. § 483.25(h)(1) (Tag 324) is denied.

A facility must ensure that residents' environment remain as free from accident hazards as is possible. 42 C.F.R. § 483.25(h)(1).

Tag 324 was not included as a deficiency finding for any of the surveys conducted on July 15, 2004, July 21, 2004, or August 3, 2004. CMS initially notified Petitioner of the deficiency in a footnote in CMS's May 15, 2006 pre-hearing brief, and of its intent to plead and prove Tag 324, along with Tags 278 and 323. This notice was submitted approximately three weeks before the scheduled start of the hearing on June 6, 2006, and after pre-hearing exchanges (i.e., exhibits, witness lists, etc.) had been completed.

I will not allow CMS to add Tag 324 as a deficiency allegation under the circumstances of this case for two reasons. First, allowing CMS to plead and prove Tag 324 at this late date deprives Petitioner of its due process rights. CMS's delayed notice of its intention to add a deficiency left Petitioner with less than three weeks to prepare for this additional immediate jeopardy allegation. Additionally, pre-hearing exchanges had already been completed, placing Petitioner at a strategic disadvantage. CMS's failure to timely make its intentions known and provide Petitioner sufficient notice substantially prejudiced Petitioner. Second, CMS could have easily eliminated this problem by filing a motion requesting permission to add an additional deficiency Tag. *See* 42 C.F.R. § 498.56(c). This would have allowed me an opportunity to postpone the hearing and give Petitioner additional time to defend the new allegations, thereby eliminating the prejudice to Petitioner. But CMS did not do so. Therefore, I will not consider any evidence regarding deficiency allegations on Tag 324.

August 3, 2004 Survey - Tags 225, 226, 469

8. Petitioner failed to comply with 42 C.F.R. § 483.13(c)(1)(ii) (Tag 225).

The regulation at 42 C.F.R. § 483.13(c)(1)(ii) provides, in relevant part, that the facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source, are reported immediately to the administrator. The August 3, 2004 SOD alleges, in part, that based on a record review and interviews with facility staff, Petitioner failed to investigate and follow up on an allegation that a nurse aide slapped Resident 8, and that facility staff spoke harshly to Resident 9. CMS Ex. 45, at 1-11.

Resident 8 complained that she was slapped in February 2004 and, again, in July 2004. CMS Ex. 47, at 5-6. There is no documentation indicating that Petitioner immediately investigated Resident 8's allegation. In fact, Petitioner's staff initiated an investigation only after surveyor Susan Richardson brought the failure to investigate to Administrator Culbreth's attention during the survey. Tr. at 105-109. Similarly, Petitioner completed a 24-hour report and a 5-day report regarding Resident 9's allegations after being prompted by surveyor Richardson's inquiry on August 2, 2004. Tr. at 105-109; CMS Ex. 45, at 1. A facility must investigate all allegations of abuse and report the results promptly consistent with 42 C.F.R. 483.13(c)(1)(ii), but Petitioner did not do so. Furthermore, it did not sustain its burden to establish that it was in compliance with this participation requirement.

9. Petitioner failed to comply with 42 C.F.R. § 483.13(c)(1)(i) (Tag 226).

A facility must develop and implement written policies and procedures that prohibit mistreatment, neglect and abuse of residents, and misappropriation of resident property. 42 C.F.R. § 483.13(c)(1)(i). The SOD alleges that Petitioner failed to follow its own policy and procedure by not reporting allegations of abuse of Residents 8 and 9. CMS Ex. 45, at 11. The specific facts surrounding Residents 8 and 9 allegations of abuse are the same as those for Tag 225. Resident 8 complained that she was slapped by a nurses aide and Resident 9 reported that a facility staff member spoke harshly to her.

Here Petitioner did not follow its anti-abuse policy (P. Ex. 29), which provides, in part, that Petitioner shall immediately complete an incident report listing the residents or staff involved, date, time, location, etc., and timely investigate a reported incident. P. Ex. 29, at 5-6. It did not investigate the allegations of abuse of Residents 8 and 9 until weeks after the incidents allegedly occurred, and neglected to promptly complete an incident report. Tr. at 109; P. Ex. 22, at 1-2; CMS Ex. 45, at 3-4. I find that Petitioner failed to comply with its own policies and procedures in violation of 42 C.F.R. § 483.13(c)(1)(i).

10. Petitioner failed to comply with 42 C.F.R. § 483.70(h)(4) (Tag 469).

A facility must maintain an effective pest control program so that the facility is free of pests and rodents. 42 C.F.R. § 483.70(h)(4). The survey findings allege that roaches were observed in the facility's kitchen sink and on the floor. Several dead roaches were observed behind the stove, oven, warmer, and microwave. CMS Ex. 45, at 19-21.

Petitioner argues, and I agree, that the facility did in fact have a pest control policy in place. *See* P. Brief at 34. However, the regulations require an *effective* pest control policy. Surveyor Richardson observed roaches throughout Petitioner's kitchen. Tr. at 109-112. Her testimony is credible and persuasive. Thus, I find that Petitioner failed to implement an effective pest control policy in violation of 42 C.F.R. § 483.70(h)(4).

11. CMS's determination to impose CMPs of: (a) $3050 per day for each day Petitioner was not in substantial compliance at the immediate jeopardy level from April 6, 2004 through July 25, 2004; and (b) $100 per day for each day Petitioner was not in substantial compliance from July 26, 2004 to August 25, 2004, are reasonable.

The regulations prescribe the range of CMPs that may be imposed for deficiencies deemed immediate jeopardy level deficiencies. The minimum daily CMP for an immediate jeopardy level deficiency is $3050. The minimum daily CMP for a substantial, but non-immediate jeopardy level, violation is $50. 42 C.F.R. § 488.438(a)(1)(i), (ii).

Immediate jeopardy exists when deficiencies cause serious injury, harm or death to a resident or, when a resident is not harmed by a deficiency, but where there is a *likelihood* of harm. CMS has a burden to prove, prima facie, that noncompliance is at the immediate jeopardy level. If it succeeds in doing so, then the burden shifts to a facility to prove that a determination of immediate jeopardy is clearly erroneous. 42 C.F.R. § 498.60(c)(2). I conclude that CMS proved in this case that there was a likelihood, and not just a possibility, that Resident 4 would suffer harm from constant wandering throughout the facility unsupervised. I also conclude that Petitioner's failure to address Resident 3's sexualized behavior created an immediate jeopardy situation. I also find Residents A and B could have suffered serious injury, harm, or death, from continued elopements. Petitioner did not sustain its burden to prove that CMS's determinations as to the immediate jeopardy conditions was clearly erroneous.

Petitioner contends that the testimony and documentation submitted at the hearing warrant fully setting aside the CMP of $300,000, and that there is no basis for finding immediate jeopardy from April 6, 2004 through July 25, 2004 as CMS urged. P. Brief at 35. It further argues that any alleged immediate jeopardy noncompliance with respect to

Resident 3 ceased on April 6, 2004, and that any alleged noncompliance as to Residents A and B based on the July 21, 2004 survey should be a single PICMP.

CMS imposed the minimum daily immediate jeopardy CMP amounts for the period during which Petitioner was not in compliance. Petitioner did not sustain its burden of proving that CMS's determination of immediate jeopardy was clearly erroneous. Therefore, I must find these CMP amounts reasonable as a matter of law without regard to the Petitioner's ability to pay. For the reasons I previously articulated herein I find that immediate jeopardy existed at Petitioner's facility from April 6, 2004 through July 25, 2004.

The CMP that requires further consideration is the $100 per-day CMP from July 26, 2004 through August 25, 2004. In determining whether the CMP is reasonable, the following factors in 42 C.F.R. § 488.438(f) must be considered: (1) the facility's history of non-compliance, including repeated deficiencies; (2) the facility's financial condition; (3) the seriousness of the deficiencies as set forth at 42 C.F.R. § 488.404; and (4) the facility's degree of culpability. Neither party has contended that a penalty amount should be impacted by Petitioner's compliance history. There is no evidence showing that Petitioner has a history of noncompliance other than that found during this survey cycle. Petitioner argues that its financial condition would be severely impacted by such a large fine, and has provided financial statements to support its claim that it has operated at a financial loss for the last three years. P. Exs. 32-38. The term "financial condition" is not defined in the regulations, but the plain meaning of the term is that a facility's "financial condition" is its overall financial health. The relevant question on whether financial condition would permit a facility to pay CMPs is whether the penalty amounts would jeopardize its ability to survive as a business entity. *Capitol Hill Community Rehabilitation and Specialty Care Center*, DAB CR469 (1997), *aff'd*, DAB No. 1629 (1997).

First, the $3050 CMP imposed at the immediate jeopardy level is the lowest allowed under the regulations. I must find it reasonable as a matter of law, without regard to Petitioner's ability to pay. Second, the $100 CMP for deficiencies that do not cause immediate jeopardy, but either cause actual harm to residents or, cause no actual harm, but have the potential for causing more than minimum harm, is at the low range of the statutory minimum of $50.

Even severe financial losses are not sufficient to establish a provider's inability to pay. *See, e.g., Wellington Specialty Care & Rehabilitation Center*, DAB CR548 (1998). In *Wellington*, the ALJ determined that a facility's profits or losses may rise and fall over short periods of time depending on several factors, but short-term profits and/or losses may not accurately reflect a facility's overall financial condition. In Petitioner's most recent balance sheet as submitted and dated March 31, 2006, its current ratio - that is, the

ratio of current assets to current liabilities - exceeds $100,000. P. Ex. 38, at 40-41. The current ratio is considered a good measure of whether or not an entity can meet its short-term obligations. Petitioner's current ratio of $473,005 in current assets and $372,062 in current liabilities indicates that the facility can meet its short-term obligations and, therefore, is in satisfactory overall financial health. Additionally, while Petitioner indicated that it would be severely impacted by paying the CMP, it did not assert that paying it would put the facility out of business. Therefore, I find the CMP of $100 per day from July 26, 2004 through August 25, 2004 for the non-immediate jeopardy deficiencies is reasonable.

III. Conclusion

Based on my review of all of the evidence of record, I find that Petitioner was not in substantial compliance with participation requirements at the immediate jeopardy level, as well as at the non-immediate jeopardy level. I find that Petitioner has not proven by a preponderance of evidence that it was in compliance with participation requirements, or that CMS's determination of immediate jeopardy was clearly erroneous. Therefore, I conclude that there is a basis for the imposition of a CMP and a DPNA. I further find that a CMP of $3050 per day for the period from April 6, 2004 through July 25, 2004 is reasonable as a matter of law. I also find that the CMP of $100 from July 26, 2004 through August 25, 2004 is reasonable. A DPNA for the period from July 23, 2004 through August 25, 2004, too, is reasonable. Finally, the loss of Petitioner's NATCEP was mandatory by operation of law, triggered by the imposition of the DPNA. By regulation, the State Agency had no choice but to deny or withdraw NATCEP approval for a period of two years after the July 2004 survey. 42 C.F.R. § 483.151(b)(2) and (e)(1).

/s/
Alfonso J. Montaño
Administrative Law Judge