Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Poplar Point Health & Rehabilitation,
(CCN: 44-5150),

Petitioner

v.

Centers for Medicare & Medicaid Services.

Docket No. C-16-255

Decision No. CR4995

Date: December 19, 2017

DECISION

Petitioner, Poplar Point Health & Rehabilitation (Petitioner or "the facility"), is a long-term care facility that participates in the Medicare program. Based on a partial extended survey related to a complaint investigation that was completed on October 29, 2015, the Centers for Medicare & Medicaid Services (CMS) determined that Petitioner was not in substantial compliance with multiple Medicare participation requirements. I uphold the penalties imposed against Petitioner, to include a civil money penalty (CMP) of $6,450 per day for 77 days of immediate jeopardy noncompliance, effective August 13, 2015 through October 28, 2015, for a total of $496,650, and a CMP of $150 per day thereafter.

1. Background

The Social Security Act (Act) sets requirements for skilled nursing facility (SNF) participation in the Medicare program. The Act authorizes the Secretary of the United States Department of Health & Human Services (Secretary) to promulgate regulations

implementing those statutory provisions. Act § 1819 (42 U.S.C. § 1395i-3). The Secretary's regulations are found at 42 C.F.R. part 483.[1]

A facility must maintain substantial compliance with program requirements in order to participate in the program. To be in substantial compliance, a facility's deficiencies may pose no greater risk to resident health and safety than "the potential for causing minimal harm." 42 C.F.R. § 488.301.

The Secretary contracts with state agencies to conduct periodic surveys to determine whether SNFs are in substantial compliance with the participation requirements. Act § 1864(a) (42 U.S.C. § 1395aa(a)); 42 C.F.R. §§ 488.10, 488.20. The Act and its implementing regulations require that facilities be surveyed on average every twelve months, and more often if necessary, to ensure that identified deficiencies are corrected. Act § 1819(g)(2)(A) (42 U.S.C. § 1395i-3(g)(2)(A)); 42 C.F.R. §§ 488.20(a), 488.308.

Petitioner is an SNF that operates in Memphis, Tennessee. The West Tennessee Regional Office of Health Care Facilities (state agency) completed a partial extended survey of Petitioner's facility as part of a complaint investigation on October 29, 2015, at which time the state agency determined that the facility was not in substantial compliance with Medicare participation requirements and the conditions constituted immediate jeopardy.[2] CMS Exs. 1 at 2; 25 at 2. CMS determined that, between August 13, 2015 and October 28, 2015, the facility was not in substantial compliance with the following participation requirements, and that the noncompliance was at the "K" level of scope and severity[3] that constituted substandard quality of care:[4] 42 C.F.R. §§ 483.13(b),

---

[1] Federal nursing home regulations substantially changed effective November 28, 2016. 81 Fed. Reg. 68,688 (October 4, 2016). Based on the date of the survey, which preceded the regulatory revisions, I refer to the regulations that were in effect at the time of the survey.

[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." *See* 42 C.F.R. § 488.301.

[3] Scope and severity levels are used by CMS and state survey agencies when selecting remedies. As relevant here, a scope and severity level of "K" indicates a pattern of a deficiency that poses immediate jeopardy to resident health or safety. Pub. 100-7, State Operations Manual, § 7400.5.1 (Factors That Must be Considered When Selecting Remedies), "Assessment Factors Used to Determine the Seriousness of Deficiencies Matrix" (table), *https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/som107c07.pdf* (last visited December 1, 2017); *see* 42 C.F.R. § 488.408. Based on the aforementioned authorities, a scope and severity level of D, E, or F indicates a deficiency that presents no actual harm but has the potential for more than minimal harm that does not amount to immediate jeopardy.

483.13(c)(1)(i)) (cited as Tag F223 (right of residents to be free from abuse/involuntary seclusion)); 42 C.F.R. § 483.13(c)(1)(ii)-(iii), (c)(2)-(4)) (cited as Tag F225 (facility requirement to investigate and report allegations of abuse); and 42 C.F.R. § 483.75(o)(1) (cited as Tag F520 (regarding quality assurance meetings and quarterly plans)).[5] CMS Ex. 1. Noncompliance with these participation requirements continued at the "E" level of scope and severity beginning on October 29, 2015, and continued to an unspecified date thereafter.[6] The survey also found noncompliance with the following participation requirements:

- 42 C.F.R. § 483.15(a) (cited as Tag F241 at the "D" level of scope and severity);
- 42 C.F.R. § 483.20(g)-(j) (cited as Tag F278 at the "D" level of scope and severity);
- 42 C.F.R. §§ 483.20(d), 483.20(k)(1) (cited as Tag F279 at the "D" level of scope and severity);
- 42 C.F.R. §§ 483.20(d)(3), 483.10(k)(2) (cited as Tag F280 at the "D" level of scope and severity);
- 42 C.F.R. § 483.20(k)(3)(ii) (cited as Tag F282 at the "E" level of scope and severity);
- 42 C.F.R. § 483.25 (cited as Tag F309 at the "D" level of scope and severity);
- 42 C.F.R. § 483.25(a)(3) (cited as Tag F312 at the "E" level of scope and severity);
- 42 C.F.R. § 483.25(d) (cited as Tag F315 at the "D" level of scope and severity);
- 42 C.F.R. § 483.25(g)(2) (cited as Tag F322 at the "D" level of scope and severity);
- 42 C.F.R. § 483.25(h) (cited as Tag F323 at the "D" level of scope and severity);

---

[4] Substandard quality of care, as applicable here, "means one or more deficiencies related to participation requirements under . . . § 483.13, Quality of life . . . which constitute . . . immediate jeopardy to resident health or safety . . . ." 42 C.F.R. § 488.301.

[5] As mentioned above, CMS subsequently cited 42 C.F.R. § 483.13(c) (Tag F226, Develop/Implement Abuse/Neglect Policies) as an additional deficiency in its brief. CMS Brief (Br.) at 7.

[6] The parties have not submitted any documentation establishing the date that CMS determined Petitioner returned to compliance, and Petitioner has not submitted any argument alleging the date it returned to compliance.

- 42 C.F.R. § 483.60(b), (d), (e) (cited as Tag F431 at the "E" level of scope and severity);
- 42 C.F.R. § 483.65 (cited as Tag F441 at the "D" level of scope and severity); and
- 42 C.F.R. § 483.75(l)(1) (cited as Tag F514 at the "E" level of scope and severity).

CMS Ex. 1. By letter dated November 18, 2015, CMS imposed a CMP in the amount of $6,450 per day effective August 13, 2015 through October 28, 2015, and a CMP in the amount of $150 per day effective October 29, 2015.[7] CMS Ex. 2 at 2.

Petitioner, through counsel, filed a timely request for hearing on January 15, 2016, in which it contended that "[i]mmediate jeopardy did not exist at Poplar Point, and the facility should not have been cited at immediate jeopardy." Petitioner "dispute[d] the scope and severity of all immediate jeopardy and substandard quality of care tags, the findings of immediate jeopardy, the factual findings regarding the dates and duration the facility is alleged to have been out of compliance, and the remedies imposed by CMS."[8]

On February 12, 2016, I issued an Acknowledgment and Pre-Hearing Order (Pre-Hearing Order) establishing a briefing schedule. In its brief, Petitioner limited its challenges to the three deficiencies cited at the immediate jeopardy level and the penalties associated with those deficiencies. Petitioner focused its attention to the following three deficiencies that were cited at the "K" level of scope and severity for deficiencies that posed a pattern of noncompliance that caused immediate jeopardy to resident health or safety: 42 C.F.R. § 483.13(b), (c)(2)(i) (cited as Tag 223); 42 C.F.R. § 483.13(c)(1)(ii)-(iii), (c)(2)-(4) (cited as Tag F225), and 42 C.F.R. § 483.75(o)(1) (cited as Tag F520). In addition to the three aforementioned deficiencies, CMS cited, for the first time in its

[7] Petitioner asserts, without citation to supporting evidence, that a "$600,000 fine" was imposed for its deficiencies. Petitioner Brief (P. Br.) at 14.

[8] Petitioner specifically identified three immediate jeopardy deficiencies in its request for hearing, but did not provide any bases in support as required by 42 C.F.R. § 498.40(b) (directing that a request for hearing must identify the specific issues and the findings of fact with which the affected party disagrees, and that a party must specify the basis for contending that the findings and conclusions are incorrect). Nonetheless, as CMS did not challenge the adequacy of the request for hearing, I need not further address this issue. Further, while Petitioner's request for hearing includes a blanket statement, with no further elaboration, that it has appealed "all deficiencies," Petitioner later clarified that "the [August 12, 2015] event is the only issue giving rise to the CMP and the only one that needs to be addressed by the Court in order to resolve the removal of immediate jeopardy and the removal [of] all CMP[s]." P. Br. at 24. Therefore, I will not address any deficiencies that are not related to the incident on August 12, 2015.

brief, noncompliance with "42 C.F.R. § 4813.13(c)(Tag 226) [sic]" without addressing the level of scope and severity, associated penalties (if any), and duration.[9] CMS Br. at 7-8.

In accordance with Sections 4 through 6 of my Pre-Hearing Order, the parties submitted evidence, in the form of exhibits, along with their respective pre-hearing exchanges. CMS submitted 26 exhibits (CMS Exs. 1 to 26), and Petitioner submitted 13 exhibits (P. Exs. 1 to 13). I admitted all exhibits at the hearing, with the exception of P. Ex. 9 (which was withdrawn by Petitioner). Transcript (Day One) (T1) at 11-12. I also explained that I would admit all submitted written witness testimony so long as each witness presented for cross-examination. T1 at 11-12; *see* Pre-Hearing Order, § 9 (discussing that the parties have a right to cross-examine any witness who submitted written direct testimony). CMS submitted CMS Ex. 27 at the hearing (Transcript (Day Two) (T2) at 111-112), and filed a motion for leave to submit that exhibit after the hearing. Petitioner has not filed an objection to the submission of CMS Ex. 27. I admit CMS Exs. 1 to 27 and P. Exs. 1-8 and 10-13 into the record.

I convened a hearing via video teleconference on September 13-14, 2016 for the purpose of allowing the parties an opportunity to cross-examine the witnesses who submitted written direct testimony. Witnesses Marsha Morris, Susan Dannels, Kenna Todd, Dr. James Powers, Vicki Sherrard, and Dr. Angela Watson appeared for cross examination. T1 at 3; T2 at 3. Following the hearing, the parties submitted briefs (CMS Post-Hrg Br. and P. Post-Hrg Br.) and reply briefs. The record is closed and the case is ready for a decision on the merits.

For the reasons set forth below, I sustain the determination that substantial noncompliance posed immediate jeopardy to resident health and safety from August 13, 2015 through October 28, 2015, along with the per-day remedies imposed by CMS.

II. Issues

The following issues are before me:

1) Whether Petitioner failed to comply substantially with Medicare participation requirements.

2) Whether CMS's finding that Petitioner's substantial noncompliance posed immediate jeopardy to resident health and safety was clearly erroneous.

---

[9] I will not address this newly raised deficiency because it would not change the remedies. *See Claiborne-Hughes Health Ctr. v. Sebelius,* 609 F.3d 839 (6th Cir. 2010)*; Carrington Place of Muscatine,* DAB No. 2321 at 20-21 (2010).

3) Whether CMS's determination regarding the duration of the period of immediate jeopardy and noncompliance was clearly erroneous.

4) Whether the CMP that CMS imposed is reasonable.

III. Findings of Fact and Conclusions of Law[10]

A. Factual Background, facility policies, and relevant law

Resident # 22

Resident # 22, who was born in 1957, has diagnoses that include intracerebral hemorrhage, cerebral thrombosis with cerebral infarction, end stage renal disease (ESRD), total visual impairment of better and lesser eyes, primary cerebellar degeneration, encephalopathy, difficulty in walking, aphasia due to cerebrovascular disease, generalized anxiety disorder, depressive disorder not elsewhere classified, and unspecified persistent mental disorder due to conditions classified elsewhere. CMS Ex 8 at 1, 49. Resident # 22 was first admitted to the facility on May 11, 2012. CMS Ex. 8 at 4. A May 21, 2015 Brief Interview for Mental Status (BIMS) evaluation determined that Resident # 22 had a score of 13/15, which correlates to a "cognitively intact" individual. CMS Ex. 8 at 7; *see* Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual, Chapter 3, Section C0050 (Summary Score), *https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/NursingHomeQualityInits/Downloads/MDS-30-RAI-Manual-V113.pdf* (herein referred to as "BIMS Summary Score Criteria") (last visited December 1, 2017).

Resident # 22 had a care plan that addressed his numerous medical impairments and potential complications related to those medical impairments, along with other focuses such as his risk for falls, participation in the facility's weekly happy hour, a desire to smoke, and episodes of "cursing/yelling at staff, resist[ing] care and refusing appointments."[11] CMS Ex. 8 at 35-51. On August 17, 2015, the facility updated

[10] My findings of fact and conclusions of law are set forth in italics and bold.

[11] Although Resident # 22 kicked another resident on July 17, 2015, Resident # 22's care plan does not address his physical aggression with other residents; in fact, the complaint that precipitated the complaint investigation involved an incident of resident-on-resident abuse initiated by Resident # 22. *See* CMS Ex. 3 at 1 (Petitioner's self-report of a July 17, 2015 incident in which Resident # 22 "reportedly kicked another resident after he accidentally bumped into the resident in his wheelchair.") The state agency's complaint explained, in part, that "[w]hile investigating [the July 17, 2015 complaint] involving [Resident # 22] an incident involving Resident # 25 on 8/13/15 was identified. On

Resident # 22's care plan to include his desire to have sex.[12] CMS Ex. 8 at 45. Ms. Reeder, in an August 17, 2015 entry, and Social Services Director Towanda R. Stephen-Swims, in an October 29, 2015 update, discussed a history of "sexually offensive behaviors related to [diagnoses] of anxiety, depressive disorder, mental disorders due to physiological condition and has displayed sexual[ly] inappropriate behaviors." CMS Ex. 8 at 50-51. The care plan stated that Resident # 22 "will not engage in non-consensual sexual activity" and "will verbalize his understanding of [the] need to control sexual/physical/aggressive behavior . . . ." CMS Ex. 8 at 50.

A search of the national and Tennessee state sexual offender registries reveals that Resident # 22 is a registered sex offender as a result of a conviction for "Sexual Battery."[13] CMS Ex. 13. Resident # 22's status as a registered sex offender is not addressed in his care plan, and the facility contends it was unaware of Resident # 22's status as a registered sex offender until it was notified of this by the survey team. *See* T2 at 54 (testimony of Vicki Sherrard, the Chief Operating Officer of Vanguard Health Services, LLC (herein "Vanguard") that she first became aware that Resident # 22 is a convicted sex offender during the complaint survey; *see* T1 at 7 and T2 at 9, 22 (testimony that Vanguard is Petitioner's parent company)); T1 at 242-243 (testimony of Petitioner's Activities Director, Kenna Todd, that she did not know Resident # 22 was a registered sexual offender until the October 2015 survey).

Resident # 25

Resident # 25, who was born in 1953, was admitted to the facility in July 2009 following her discharge from an acute care hospital. CMS Ex. 7 at 17. Resident # 25's diagnoses include ill-defined cerebrovascular disease, unspecified cerebral artery occlusion with infarction, hemiplegia affecting her dominant side, disorder of bone and cartilage,

---

8/13/15 a facility staff member observed [Resident # 22] engaged in a sexual act with [Resident # 25] a cognitively impaired resident." CMS Ex. 3 at 3; *see* CMS Ex. 3 at 1.

[12] "Michelle R. Reeder (Admissions/Marketing/SW)" authored the care plan entry. Ms. Reeder, who computer entries identify as the Director of Social Services, provided written direct testimony at P. Ex. 7. She does not list any professional licensure credentials in either her care plan entry or her written direct testimony (CMS Ex. 8 at 50; P. Ex. 7), and Petitioner does not otherwise provide any credentials for Ms. Reeder. *See* Petitioner's List of Proposed Exhibits and Petitioner's List of Proposed Witnesses. Petitioner's witness, Dr. James Powers, identified Ms. Reeder as a social worker in his testimony (T1 at 74), as did Dr. Watson (T2 at 86).

[13] A date of "12/04/1979" is listed on the state registry report (CMS Ex. 13 at 1); it is unclear whether this date is the date of the offense or the date of the conviction.

aphasia, congestive heart failure, anxiety state, and depressive disorder. CMS Ex. 7 at 1, 100; P. Ex. 1 at 6.

Resident # 25 was assessed as having a BIMS score of 0 (out of a scale of 0 to 15) during Minimum Data Set (MDS) assessments on March 24, 2013, June 17, 2014, September 15, 2014, December 8, 2014, March 2, 2015, June 2, 2015, and September 2, 2015, which corresponds to "severe impairment." CMS Ex. 7 at 3-9; *see* BIMS Summary Score Criteria. According to the BIMS assessments, a BIMS score of 0 indicates that Resident # 25 could not provide correct responses to any of the BIMS assessment questions that asked her to repeat three different words, report the month, year, and day of the week, and recall the three words that were given at the outset of the interview. CMS Ex. 7 at 3-9. Further, the BIMS assessment forms indicate that a BIMS assessment should *not* be administered if the resident is "rarely/never understood," and that a score of 99 should be reported if the resident is "unable to complete the interview."[14] CMS Ex. 7 at 3-9; *see* BIMS Summary Score Criteria. None of the BIMS scores contained in the evidentiary record are scored as "99." *See* CMS Ex. 7 at 3-9; P. Ex. 3 at 11-12.

A May 6, 2015 activity note reports that Resident # 25 "is alert with impaired cognition," that her "speech is impaired," and that she "uses gestures and nods to communicate." P. Ex. 1 at 10.

A June 26, 2015 progress note reporting on a care plan meeting documents that Resident # 25 "is not able to converse" and is "[u]nable to communicate wants and needs clearly." P. Ex. 1 at 11.

A June 2, 2015 MDS assessment reported that Resident # 25 had unclear speech, was "sometimes understood" and was "limited to making concrete requests." CMS Ex. 7 at 19. The June 2, 2015 MDS assessment also reported that Resident # 25 required extensive assistance with transfers, dressing, toilet use, and personal hygiene, and limited assistance with bed mobility and eating. CMS Ex. 7 at 28.

---

[14] Dr. Watson testified that because Resident # 25's "speech is garbled, she scores very poorly on BIMS because over [sic] her difficulty communicating, not because she cannot understand what is being said and formulate thoughts and opinions." P. Ex. 4 at 1. However, I point out that the BIMS assessment does not test an individual's "thoughts and opinions." *See* BIMS Summary Score Criteria. Regardless, if Resident # 25 could not participate in BIMS testing due to communication difficulties, the facility should have marked as score of 99 or administered the alternative test. *See* P. Post-Hrg Brief at 9 (Petitioner's statement that "according to the RAI manual, the MDS coordinator should have chosen "Code 99 – unable to complete interview," rather than a "0," which indicates an inability to recall).

The facility's investigative file contains a BIMS assessment, dated June 26, 2015. P. Ex. 3 at 11-12. The staff member who conducted the assessment, Ms. Reeder, determined that a BIMS assessment could be conducted because Resident # 25 is not "rarely/never understood" and that she did not need to administer the alternative "Staff Assessment for Mental Status." P. Ex. 3 at 12. The report documents that Ms. Reeder provided three words, and Resident # 25 could not "tell [her] the three words." P. Ex. 3 at 11. Ms. Reeder asked Resident # 25 the year, month, and day of the week, and Resident # 25 was not able to give a correct answer to any of those questions. P. Ex. 3 at 11. At the end of the interview, Resident # 25 could not recall any of the three words, even with cueing. P. Ex. 3 at 12. As a result, a score of 0 (on a scale of 0 to 15) was given. P. Ex. 3 at 12. The instructions directed Ms. Reeder to assign a score of 99 if Resident # 25 could not complete the interview, and Ms. Reeder assigned a score of 0 based on the responses to the assessment. P. Ex. 3 at 12.

Resident # 25's care plan addressed her impaired speech and "difficulty expressing her needs and understanding what i[s] said to her at times." CMS Ex. 7 at 77. A care plan intervention included asking "yes/no type questions" and encouraging her to "continue to use gestures to make need[s] and wants known and feelings knowns [sic]." CMS Ex. 7 at 77. The care plan reported that Resident # 25 has a "[c]ommunication/speech impairment which frustrates the resident and cognition impairments that fluctuate related to expressive aphasia." CMS Ex. 7 at 98. With respect to Resident # 25's medical impairments, the care plan addressed her deficits with activities of daily living and self-care due to right-sided hemiplegia, to include her need for staff assistance with toileting, transfers, and bed mobility, and that assistance was necessary "to reposition and turn in bed." CMS Ex. 7 at 91-92.

A care plan entry, dated August 17, 2015, indicated that Resident # 25 wanted to have sex and that she "[g]esture[d] to the question from police t[ha]t she is going to have sex."[15] CMS Ex. 7 at 90. The plan indicated that she "will have safe sex." CMS Ex. 7 at 90. The care plan interventions included that "caregivers to provided [sic] a safe and private environment" and "will educate on safe sex and pro[s] and con[s] of unsafe sex." CMS Ex. 7 at 90.

Dr. Angela Watson provided written direct testimony that Resident # 25 "is competent to make decisions about her life, her activities, and her sexual companion but cannot always articulate her decisions because of a stroke she suffered." P. Ex. 4 at 1.

[15] The facility's notes of the encounter with the police reflect that the police officers "spoke with" her and she "stated" her responses, and there is no reference to Resident # 25 making gestures in response to questions. P. Ex. 3 at 4, 39.

August 12-13, 2015

On August 12, 2015, a facility employee, Christopher Johnson, CNA, prepared a statement in which he reported that he witnessed two residents having sexual intercourse at approximately 10:15 pm that same evening, stating the following:

> When I was walking back down the hall I saw 306 door was closed. When I walked in the room I saw the two having intercourse. [Resident # 22's] pants were down and he was on top of [Resident # 25]. I could see his naked rear end. I went to my nurse but she was in the middle of giving medicine to a patient. I told her I would tell her when she came out of the room. I then went to the desk to tell the other nurse who was sitting there for the other half of the hall. I then went back to check on the patient. I saw a tear running down her eye so I wasn't sure if it was consented sex or not. I also told my nurse and she reported it to her supervisor.

P. Ex. 3 at 9.

Ms. Brenda Robbins, who is identified as an agency nurse in the facility's records, reported at 12:53 am on August 13, 2015 that Resident # 25 "denied the incident happened." P. Ex. 3 at 1.

A "Plan of Care Note" created by Ms. Robbins at 1:52 am on August 13, 2015, with an effective date and time of August 12, 2015 at 10:40 pm, reports the following:

> CNA C.J. reported he observed another resident on top of [Resident 25] apparently having sex. The CNA stated that the resident had tears in her eyes. He said they stopped when he entered the room. Resident examined for injuries and none noted. When asked about the incident resident denied to me and supervisor (L.H.) that this did not happen. Vital signs taken BP 109/53 P-74 R-20. [Assistant Director of Nursing] notified by supervisor. Family notified . . . .

P. Ex. 3 at 10. Ms. Robbins authored a similar note for Resident # 22 at 12:30 am on August 13, 2015, stating:

> CNA C.J. reported he observed this resident on top of [Resident 25] apparently having sex. CNA stated they stopped when he entered the room. Resident examined for injuries and none noted. When asked about the incident resident denied to me and supervisor (L.H.) that this did not happen. Vital signs taken BP 183/108 P-87 R-20. [Assistant Director of Nursing] notified by supervisor. [Responsible Party] notified . . . Dr.

> Watson[16] notified of BP at 10:30 pm due to CNA reporting incident at 10:40 pm. Supervisor notified (LH).

P. Ex. 3 at 23. On August 13, 2015, the Assistant Director of Nursing (ADON), Director of Nursing (DON), and Quality Improvement Coordinator interviewed Mr. Johnson. Deborah Beard, the ADON, prepared the following report of Mr. Johnson's statement:

> CNA opened door and witnessed [Resident # 22] on top of [Resident # 25] with his pants [and] his bottom exposed. [Resident # 25] had her brief pulled to the side. [Resident # 22] jumped up and got back in his wheelchair [and] left the resident[']s room. CNA states he noticed one tear on [Resident # 25's] face and she looked sad. CNA went to notify nurse and nurse was in another [room] so he went to desk to notify another nurse [and] nurse responded "she is a whore and she always does this."[17] CNA states this nurse also told another nurse the same comment that the resident was a whore. CNA states he continued to tell the nurses about [Resident 25] crying and that's when the nurse got up from desk and went into [Resident # 25's] room. CNA stated he went to change Resident # 25's brief but she was dry. CNA does not know what happened after this.

CMS Ex. 10 at 2. After reviewing the statement, Mr. Johnson added the following information:

> CNA also states he noticed [Resident # 22] jumping up and down (motion) on [Resident # 25] [and] that [Resident # 22's] genitals were exposed but he saw no sign of semen present.

CMS Ex. 10 at 2.

---

[16] A facility log documents that the attending physician, Dr. Watson, was notified at 10:30 pm, but the nursing note indicates that the notification was triggered due to Resident # 22's elevated blood pressure reading. P. Ex. 3 at 41. Although not recorded in Resident # 25's treatment record, Dr. Watson testified that she was notified of the incident "at the time it happened . . . so [she] could meet with [her] patient and help decide the best course for her." P. Ex. 4 at 1. The record does not evidence that Dr. Watson met with Resident # 25 prior to August 30, 2015, and Petitioner does not claim otherwise. P. Exs. 1 at 5; 4 at 2.

[17] Although Petitioner does not concede that its nurse made this comment, it contends this nurse's employment "ended between the event and the survey." P. Post-Hrg Br. at 14. Surveyor notes identify this nurse as an agency nurse. CMS Ex. 3 at 8.

Ms. Reeder, the facility social worker, interviewed Resident # 25 on August 13, 2015. Ms. Reeder recorded the following questions and responses from the interview:[18]

> Did a man come into your room last night? Yes.
> Did you have sex? Yes.
> Did you give consent? No.
> Did you say stop or no? Yes.

P. Ex. 3 at 5.

The DON and ADON interviewed Resident # 25 at approximately 9:30 am on August 13, 2015, and reported that "Resident aphasic, but shook head and denied any male intimate contact."[19] P. Ex. 1 at 12.

On August 13, 2015, Ms. Reeder interviewed Resident # 22 and drafted the following statement by Resident # 22: "I did not have sex with that lady I visited with my friend." P. Ex. 3 at 21.

The ADON called Resident # 25's son at approximately noon on August 13, 2015. P. Ex. 1 at 12. The ADON reported that "he stated he was notified of allegation of sexual encounter with his mom." P. Ex. 1 at 12. Ms. Beard stated that she told Resident # 25's son that the "facility would be sending her out for a medical examination and we will notify him with any additional information." P. Ex. 1 at 12. Yet, there is no evidence in the record indicating that the facility sent Resident # 25 for such an examination. P. Ex. 1 at 12; *see* P. Post-Hrg Br. at 18 (Petitioner's argument that "A Rape Kit was not Appropriate and Would Have Been Traumatic for the Resident.").

The facility's investigative file contains an unsigned and typed document prepared by an unidentified employee memorializing that police officers investigated a suspected assault

---

[18] Dr. Watson, the treating physician for both Resident # 22 and Resident # 25, testified that she received a call on the morning of August 13, 2015 informing her that the social worker had spoken to Resident # 25 "and she did alert [her] to the fact by this time, the social worker had spoken with the resident which prompted . . . the Director of Nursing to speak with the residents and that's when [she] was notified that there could be some differences in her statements to them and to the social worker." T2 at 86. Dr. Watson testified that she believed that the DON interviewed Resident # 25 after Resident # 25 had been interviewed by the social worker. T2 at 87. Although Ms. Reeder submitted written direct testimony (P. Ex. 7), she did not reference her interview with Resident # 25 that revealed the allegation of sexual assault.

[19] Ms. Sherrard addressed this discrepancy in her testimony, stating that Resident #25 "first said it was rape and then denied that anything happened." T2 at 90.

on August 13, 2015.[20] P. Ex. 3 at 39; *see* P. Ex. 3 at 4 (handwritten notes). The document states that "[a]fter police spoke [with] [Resident # 25] she stated it was not rape and she would do it again if she wants too [sic]." P. Ex. 3 at 39. The report stated that "Officer Cobb stated that a police report is not needed after they spoke [with] [Resident # 25]," and "Officer Supervisor also came to facility and agreed w[ith] officer decision of no police report because she . . . want [sic] to have sex." P. Ex. 3 at 39. There is no indication that the police questioned the alleged abuser, Resident # 22, as the facility's notes do not report that he had been interviewed. *See* P. Ex. 3 at 4, 39; T2 at 95 (testimony of Dr. Watson that she did not know why the police did not interview Resident # 22).[21]

An August 13, 2015 mental and behavioral health treatment record documents that Resident # 25 did not appear stressed and was in good spirits and smiling. P. Ex. 3 at 18.

An August 13, 2015 mental and behavioral health treatment record documents that Resident # 22 "[d]enies being in the room of a female resident." He said that he was not

---

[20] Another report documents that personnel from the Memphis Police Department arrived at 1:42 pm and departed at 2:45 pm on August 13, 2015. P. Ex. 3 at 46.

[21] Petitioner argues that the police sent a "CIT" certified police officer to the facility, which means that the responding officer was on the department's crisis intervention team. P. Br. at 9 (It is very important to note that Officer Cobb was on the Crisis Intervention Team ("CIT")). CIT is a training program for police officers to react appropriately in situations involving mental illness or developmental disability."); *but see, e.g.*, *https://www.nami.org/Law-Enforcement-and-Mental-Health/What-Is-CIT* (last visited December 1, 2017) ("A Crisis Intervention Team (CIT) program is a model for community policing that brings together law enforcement, mental health providers, hospital emergency departments and individuals with mental illness and their families to improve responses to people in crisis," and "CIT gives officers more tools to do their jobs safely and effectively. It helps keep people with mental illness out of jail, and gets them into treatment, where they are more likely to get on the road to recovery.") Despite Petitioner's repeated suggestions, Petitioner has presented no evidence that crisis intervention training prepares police officers to investigate reports of sexual assaults, nor has Petitioner demonstrated, contrary to its suggestions, that CIT training enabled the police officer to elicit full-sentence verbal communication from an aphasic victim whose predominant impairments do *not* involve mental illness. *See* T1 at 45 (Petitioner's counsel's questioning of a witness that "if you had looked up what CIT stood for to understand that training that is specifically to deal with crisis involving a mental health -- person with mental health issues"); *but see, e.g.,* Trauma Informed Sexual Assault Investigation Training program, *http://www.theiacp.org/Trauma-Informed-Sexual-Assault-Investigation-Training* (last visited December 1, 2017) (example of specialized training for law enforcement officers who perform sexual assault investigations).

in bed with her – he cannot even see." P. Ex. 3 at 28. An August 14, 2015 mental health treatment record reported that "[Resident # 22] was accused of being in a female patient's room engaging in sexual activity. He has anger issues, blindness from stroke." P. Ex. 3 at 34. The record also documents that he "has had anger issues at times and altercations with residents." P. Ex. 3 at 35.

An undated Quality Assurance Performance Improvement Investigation Report by the Director of Nursing reported the following result of an investigation: "Consensual Sexual Relationship." P. Ex. 3 at 45. The report provides no rationale for this conclusion, and indicates that the facility did not report the incident to the state agency. P. Ex. 3 at 45.

As explained previously, the facility updated Resident # 22 and Resident # 25's care plans on August 17, 2015 because they each "[want] to have sex," and further updated each care plan on October 29, 2015. CMS Exs. 7 at 90; 8 at 45. The October 29, 2015 update to Resident # 25's care plan peculiarly states that she "will not engage in non-consensual sexual activity . . . ."[22] CMS Ex. 7 at 96-97.

The facility first learned during the survey that Resident # 22 was a registered sex offender. T2 at 54.

The state agency determined that the August 12, 2015 incident and the facility's handling of that incident posed immediate jeopardy to resident health and safety, and that immediate jeopardy existed from August 13 through October 28, 2015. CMS Ex. 1 at 2. The surveyors determined that immediate jeopardy was abated on October 29, 2015. CMS Exs. 1 at 2; 2 at 1.

Petitioner's Abuse Policies

Section 5 of Petitioner's "Abuse Prevention Standard" includes a "Resident-to-Resident Abuse Policy" that provides "it is the policy of this facility to take all steps reasonable and necessary to protect the residents from harm at all times, including protection from physical and verbal abuse form [sic] other residents." CMS Ex. 9 at 4. The policy instructs that "if a resident-to-resident incident occurs, staff should intervene immediately," and "the investigation protocol must be implemented and a report given to the appropriate agencies as specified by law and regulations." CMS Ex. 9 at 4. The procedures further require that "[a]ll incidents are to be documented in the resident's

[22] I interpret this care plan focus to mean that the facility placed the burden on Resident # 25, an individual with dominant-sided hemiplegia and aphasia, to fend off nonconsensual sexual activity. It is unclear how not engaging in nonconsensual sex could be a legitimate care plan goal for a suspected victim of a sexual assault, and such a care plan focus evokes a "blame the victim" attitude on the part of Petitioner.

medical record with intense monitoring to continue for at least 72 hours. The resident's care plan is to be updated to reflect interventions to reduce the risk of reoccurrence of this behavior." CMS Ex. 9 at 4.

Section 7 of Petitioner's Abuse Prevention Standard outlines the responsibilities of the facility's administrator, which include:

> Administrator shall take the following actions to address issues of resident care raised by suspected abuse:
>
> 1. If the incident has resulted in an injury or suspected sexual assault, the resident will be transferred to the hospital emergency room. The physician and family will be notified of the transfer.
>
> 2. If rape or sexual assault is suspected, the following steps should be taken by the facility:
>
>   1. requests and examination of the resident by the Attending Physician;
>   2. do not change the resident's clothes;
>   3. do not bathe the resident;
>   4. administer first aid as indicated.

CMS Ex. 9 at 8. The facility's policy requires "[a]ny complaint, allegation, observation or suspicion of resident abuse, mistreatment, or neglect . . . is to be thoroughly reported, investigated and documented in a uniform manner . . . ." CMS Ex. 9 at 6. The policy further mandates:

> ***Reporting –*** All employees are required to immediately notify the administrative or nursing supervisory staff that is on duty of any complaint, allegation, observation or suspicion of resident abuse, mistreatment or neglect so that the resident's needs can be attended to immediately and investigation can be undertaken promptly:
>
> > 42 C.F.R. [§] 483.13(c)(2) The facility must ensure that all allegations involving mistreatment, neglect or abuse, including injuries of unknown source and misappropriate of resident property are reported immediately to the administrator of the facility and to their officials in accordance with State law through established procedures (including to State survey and certification agency).

CMS Ex. 9 at 7-8.

Pertinent regulations

42 C.F.R. § 483.13(c)(2)-(4):

> (2) The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property 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.
>
> (4) The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.

B. A suspected sexual assault occurred at the facility on August 12, 2015, and the facility was not in substantial compliance with 42 C.F.R. §§ 483.13(c)(2)-(4) because its administration and staff did not follow the facility's written policies and procedures for preventing abuse and did not immediately report or thoroughly investigate an allegation of potential abuse.

Petitioner argues that Resident # 22 and Resident # 25 had consensual sex with each other, and therefore, it was unnecessary to immediately report it as suspected abuse or investigate it in accordance with its policies. [23] The pertinent regulation, 42 C.F.R. § 483.13(c), and the facility's own policies require the facility to report immediately and to investigate thoroughly *all alleged* violations. The reporting requirements are triggered

[23] Petitioner's failure to investigate and report an allegation of sexual assault in accordance with 42 C.F.R. § 483.13(c)(2)-(4), alone (which is the deficiency cited as Tag 225 at CMS Ex. 1 at 13-22), supports the penalties imposed. It is unnecessary for me to find that Resident # 25 was sexually abused, nor must I address whether the facility failed to ensure that its quality assessment and assurance committees appropriately addressed the August 12, 2015 incident, because the remedies were appropriate based on the facility's failure to investigate and report suspected abuse, alone. *Claiborne-Hughes Health Ctr.*, 609 F.3d at 847; *Carrington Place of Muscatine*, DAB No. 2321 at 20-21.

by any *allegation* of abuse, whether or not it is recognized as such by the facility. *Ill. Knights Templar Home*, DAB No. 2369 at 11, 12 (2011). As I previously explained, Petitioner's own policy mandates that "[a]ny *complaint*, *allegation*, observation or *suspicion* of resident abuse, mistreatment, or neglect . . . is to be thoroughly reported, investigated and documented in a uniform manner . . . ." CMS Ex. 9 at 6 (emphasis added); *see* 42 C.F.R. § 483.13(c)(2). In addition to investigating and reporting abuse, section 483.13(c)(3) requires that the facility must prevent further potential abuse while the investigation is in progress.

Mr. Johnson walked in on what he believed could have been a sexual assault in progress, reporting that he "saw a tear running down her eye so [he] wasn't sure if it was consented sex or not." P. Ex. 3 at 9. Petitioner's own investigative file reveals that the nurse who received the report of the possible sexual assault of Resident # 25, a vulnerable and aphasic individual with hemiplegia who is dependent on staff for activities as basic as repositioning herself in bed, stated that she "is a whore and always does this." CMS Ex. 10; *see* CMS Exs. 3 at 8; 7 at 28. Petitioner's records document that the nurse only took action after Mr. Johnson persisted by explaining that Resident # 25 was crying. CMS Ex. 10 at 2.

Ms. Robbins, the nurse who purportedly expressed her belief that Resident # 25 was a "whore,"[24] questioned both residents. P. Ex. 3 at 10, 23. Both residents denied that any such incident happened, even though Mr. Johnson had reported that he "saw the two having intercourse." P. Ex. 3 at 9. Thus, in denying that the incident happened, it is apparent that both residents almost certainly provided an inaccurate response to Ms. Robbins' inquiry. P. Ex. 3 at 10, 23. Owing to Ms. Robbins' stated viewpoint that Resident # 25 is a "whore," it is not surprising that Resident # 25 would deny having engaged in sex when questioned by this nurse.

Despite the fact that Mr. Johnson suspected that Resident # 25 may have been the victim of a sexual assault at approximately 10:15 pm, Petitioner neither followed its abuse policy nor made any effort to protect Resident # 25 or its other residents from a suspected sexual predator during the overnight and early morning hours. Even though the facility's policy instructs that "the resident will be transferred to the hospital emergency room" in the event of a *suspected* sexual assault, the facility's records do not indicate that the facility called Dr. Watson to request a transfer to the hospital. CMS Ex. 9 at 8. Further, even though the facility directs that a resident should not have her clothes changed or be bathed if a sexual assault is *suspected*, the facility's records contain no evidence that the

[24] Interestingly, despite facility staff's apparent belief that Resident # 25 has engaged in sexual activity in the facility prior to August 12, 2015, Resident # 25's care plan did address sexual activity prior to August 17, 2015. CMS Ex. 7 at 90; *see* T1 at 54 (testimony of Dr. Powers explaining that residents have a right to have sexual relationships and it should be part of a care plan).

facility made any attempt whatsoever to preserve evidence of a potential sexual assault despite this policy.[25] CMS Ex. 9 at 8. Likewise, although 42 C.F.R. § 498.13(c)(3) mandates that a facility "must prevent further potential abuse while the investigation is in progress," there is no evidence that Resident # 22 was closely monitored to protect other residents from abuse during the overnight hours.

After an overnight of allowing a suspected sexual abuser to roam freely and not otherwise adhering to its own policy, the facility developed more evidence of a potential sexual assault in the morning. First, the facility's social worker conducted a one-on-one interview with Resident # 25, questioning her with the type of "yes/no type questions" that are dictated by her care plan. P. Ex. 3 at 5; *see* CMS Ex. 7 at 77. Resident # 25 answered "Yes" in response to a question asking if she had sex the night before. She then responded "No" in response to a question asking if she gave consent, and she answered "Yes" in response to a question asking whether she told Resident # 22 to stop. P. Ex. 3 at 5. Resident # 22, even though he had been observed to be having sex with Resident # 25, informed the same social worker that "[he] did not have sex with that lady [he] visited with [his] friend." P. Ex. 3 at 21.

In addition to Resident # 25's clear allegation that she had been the victim of a sexual assault, the facility received additional information from Mr. Johnson indicating that a sexual assault may have occurred. CMS Ex. 10 at 1-2. The DON, ADON, and Quality Improvement Coordinator questioned Mr. Johnson on August 13, 2015, at which time Mr. Johnson explained that he witnessed Resident # 22 "jumping up and down" on Resident # 25, with Resident # 22's genitals and "bottom" exposed, and with Resident # 25's brief pulled to the side. CMS Ex. 10 at 1-2. He also observed a tear on Resident # 25's face, and reported that "she looked sad." CMS Ex. 10 at 2. Mr. Johnson explained that when he received a dismissive response from Ms. Robbins in which she remarked that Resident # 25 "is a whore and she always does this," he persisted by explaining to the nurse that Resident # 25 had been "crying." CMS Ex. 10 at 2. Upon hearing Mr. Johnson's account, neither the DON nor ADON took action to closely monitor Resident # 22 to prevent abuse of Resident # 25 and other residents.[26] Despite the fact that Resident # 25, herself, alleged that she had been the victim of a sexual assault, and Mr. Johnson graphically explained an encounter of sexual intercourse and his observation that Resident # 25 looked sad and was crying, Petitioner opted not to comply with its own policy and applicable regulatory authorities. Even though the

[25] Mr. Johnson stated that "he went to change [Resident # 25's] brief but she was dry." CMS Ex. 10 at 2.

[26] For example, Resident # 22 (who had already been convicted of committing sexual battery in the past) would have had an opportunity to ask Resident # 25 to deny that she had been assaulted, and he would have had an opportunity to intimidate her so she would not make a report.

facility was on notice of a suspected sexual assault, based on both Resident # 25's own statement and the observations of its own employee, Mr. Johnson, Petitioner did not transfer Resident # 25 to the hospital, make efforts to preserve evidence that could be used in a criminal prosecution, or report the suspected sexual assault to the state agency.

Apparently not satisfied with the clear "yes/no" type responses that Resident # 25 provided to the social worker alleging that she had been sexually assaulted, the DON and ADON interviewed Resident # 25 again.[27] P. Ex. 1 at 12. At that time, Resident # 25 was "aphasic" and shook her head to "den[y] any male intimate contact." P. Ex. 1 at 12. The DON and ADON were apparently satisfied that Resident # 25 was responsive to their questioning, even though she is capable of saying "yes" and "no" in response to questions and is not limited to non-verbal communication. *See* P. Ex. 3 at 5 (interview with the social worker that same morning); CMS Ex. 7 at 77 (care plan intervention for "yes/no type questions"); T1 at 66 (Activities Director's testimony that Resident # 25 can speak words "like yes, no, u-huh . . ."). Resident # 25's denial of *any* sexual contact, by shaking her head, was unquestionably untrue; after all, an employee had walked in on Resident # 25 with a male resident on top of her committing sexual intercourse, and Resident # 25 had already claimed that she had been sexually assaulted through her responses to the social worker's questions. CMS Ex. 10; P. Ex. 3 at 5, 9.[28]

Thus, even though an employee reported that he had seen another resident on top of Resident # 25 having sexual intercourse, Resident # 25 had been observed with a tear on her face, looked sad, had been crying, and the Resident, herself, alleged that she had been the victim of sexual assault, the facility refused to follow its own policy that required it to transfer Resident # 25 to an emergency room and to preserve evidence of a potential crime. And even though the ADON called Resident # 25's son at approximately noon the day following the suspected sexual assault and informed him that she *would* be sent out for a medical examination, the facility did not send her for an examination.

Petitioner eventually called the police at approximately 1:00 pm on August 13, 2015, more than 14 hours after suspected sexual assault. P. Ex. 3 at 4, 39. In the more than 14 hours, Resident # 22 had not been put on close observation to protect Resident # 25 and

---

[27] There is no evidence that the DON and ADON have training or certification in sexual assault investigations. Had Resident # 25 been brought to the hospital, as required by the facility's policy, she likely would have been interviewed and examined by a health care professional who is trained in examining and caring for victims of sexual assault. Further, she would have been questioned in a safe environment away from the suspected offender.

[28] I find it interesting that the DON and ADON re-questioned Resident # 25, who clearly alleged a sexual assault, but did not question Resident # 22, even though he denied having *any* sexual contact with Resident # 25.

other vulnerable residents, Resident # 25 had not been examined by her primary care physician, much less brought to a hospital for an examination, and the facility had not preserved evidence as required by its policy. Even though Resident # 25 was aphasic and could only shake her head hours earlier in response to questions by the DON and ADON (P. Ex. 1 at 12), her care plan directed "yes/no type questions" and encouraged her to use gestures to make her wants, needs, and feelings known (CMS Ex. 7 at 77), and both her doctor and the activities coordinator testified that her speech made it difficult for her to communicate with anything more than gestures and nods (P. Ex. 1 at 10, P. Ex. 4 at 1), the facility documented that the police "*spoke with*" Resident # 25 and she "*stated*" that she "was not rape[d]" and would do it again if she wants to, and that she wants to have sex. P. Ex. 3 at 4, 39 (emphasis added). All this information, of course, is not recorded in a police report, but rather, in an unsigned document created by the facility. P. Ex. 4, 39. Further, there is no evidence that the police interviewed Resident # 22, who had previously been untruthful when he denied multiple times that he had engaged in sex with Resident # 25. Had the police investigated Resident # 22 as a potential abuser, they likely would have identified him as a registered sex offender. Although the police opted not to make an arrest based on their hour-long investigation, Petitioner has failed to show how the police department's failure to make an arrest and seek prosecution is dispositive of whether abuse occurred.[29]

Petitioner's version of events is that Resident # 22 and Resident # 25 had a romantic interlude. Petitioner, and its witness, Dr. Powers, are correct that nursing home residents have a right to engage in sex, and that care planning should address a resident's desire to engage in consensual sex. However, Petitioner knew immediately upon discovering the residents having intercourse, that the sex may not have been consensual. Resident # 25 has severe physical impairments that prevent her from even positioning in bed independently, and her speech is limited. Further, Resident # 25's care plan reported that she has "cognition impairments" (CMS Ex. 7 at 98), which is evidenced by her multiple BIMS score assessments of 0 on a scale of 0 to 15. CMS Ex. 7 at 3-9; P. Ex. 3 at 11-12. Petitioner has an abuse prevention policy, and its policy, in conjunction with the Secretary's regulations, should ensure that its residents are protected from abuse and that any abuse will be reported and investigated. The facility did not abide by its own policy;

[29] As the parties recognize, the burden of proof in securing a conviction in a criminal matter is higher than the burden of proof in a civil matter. While I cannot speak for the actions of the Memphis Police Department in this matter, it is unclear what, if anything, the facility told responding officers about the nature of the suspected offense for which they were called to the facility. After all, facility records document that at least one nurse felt that Resident # 25 was a "whore." Accepting Petitioner's statements and evidentiary submissions as true, the Memphis Police Department, in the span of an hour, investigated and closed a sexual assault investigation involving the suspected sexual assault of an aphasic and hemiplegic woman by a registered sex offender, and did not create a written report of its investigation.

these failures may prevent us from knowing with any certainty whether Resident # 25 was a victim of a sexual assault. If Resident # 25 had promptly been sent to the hospital as soon as sexual assault was suspected, or as soon as Resident # 25, herself, alleged she had been sexually assaulted, she would have been examined and interviewed by a trained professional. Further, Resident # 25 would have been removed from a potentially threatening situation and separated from the offender, and she would have been able to speak to medical and law enforcement professionals without fear of retaliation or harm by Resident # 22. And if the facility had followed its policy, it would have preserved her clothes and undergarments, in the event that physical evidence would be necessary for criminal prosecution.

Resident # 25, an individual who Petitioner assessed as having "cognition impairments" and multiple BIMS scores of 0 (CMS Ex. 7 at 3-9, 98), provided three different responses to questioning: She told the nurse who purportedly thought she was a whore that she did not have sex, and she likewise "nodded" that she did not have any sexual contact when questioned by the DON and ADON. When questioned by three law enforcement officers, she supposedly "stated" that she would have sex anytime and would do it again, even though her doctor and the activities director testified that could not verbally communicate in such a sophisticated manner. And finally, when questioned by an individual social worker in a manner consistent with her care plan, she reported that she was sexually assaulted. Petitioner's in-house determination that the sexual encounter was consensual was supported about as well as a decision based on the outcome of a coin flip; Petitioner made no effort to reconcile Resident # 25's clear allegation that she was sexually assaulted (which is corroborated by Mr. Johnson's account) with her other responses to questioning. For instance, no one from the facility, such as the social worker to whom she reported the allegation of sexual assault, asked Resident # 25 to reconcile her different responses or further explain why she had answered that she had been sexually assaulted.[30]

Petitioner's own policy requires that "if a resident-to-resident incident occurs, staff should intervene immediately," and "the investigation protocol must be implemented and a report given to the appropriate agencies as specified by law and regulations." CMS Ex. 9 at 4. Petitioner failed to comply with its own policy that it fully investigate and report suspected abuse.[31] P. Ex. 4 at 9. Not only did the facility fail to transfer Resident # 25 to a hospital as required by its policy, but it failed to, in accordance with its policy, request

[30] In fact, it is possible that Resident # 25 felt safe when she spoke with the social worker, but was not comfortable speaking to uniformed police officers.

[31] I acknowledge the irony that the abuse complaint that triggered the investigation involved an allegation that Resident # 22 kicked another resident, which Petitioner self-reported to the state agency. Yet, the facility did not report a far more serious suspected sexual assault to the state agency.

"an examination of the resident by the Attending Physician." P. Ex. 4 at 8; *see* P. Exs. 1 at 5; 4 at 2 (reporting examination by primary physician, Dr. Watson, on August 30, 2015). Regardless of the results of any investigation by law enforcement, Petitioner is obligated to fully investigate and report suspected abuse pursuant to 42 C.F.R. § 483.13(c)(2)-(4). The reporting requirements are triggered by any *allegation* of abuse, whether or not it is recognized as such by the facility. *Ill. Knights Templar Home*, DAB No. 2369 at 11, 12. Petitioner failed to comply with its own policies, and also failed to comply with 42 C.F.R. § 483.13(c)(2)-(4); *see, e.g.*, *Martha and Mary Lutheran Servs.*, DAB No. 2147 at 12-13 (2008) (finding substantial noncompliance with section 483.13(c) where facility staff failed to implement facility policies and procedures to prevent resident-to-resident abuse).

C. CMS's determination of immediate jeopardy is not clearly erroneous.

CMS asserts that Petitioner's deficiency constituted immediate jeopardy (at the "K" scope and severity level) to resident health and safety from August 13, 2015 through October 28, 2015. Petitioner argues that any noncompliance does not constitute immediate jeopardy. P. Br. at 1, 18-24.

As I previously discussed, 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. The regulation does not require that a resident *actually* be harmed. *Lakeport Skilled Nursing Ctr.*, DAB No. 2435 at 8 (2012). I must uphold CMS's determination as to the level of a facility's substantial noncompliance (which includes an immediate jeopardy finding) unless it is "clearly erroneous." 42 C.F.R. § 498.60(c). The Board directs that the "clearly erroneous" standard imposes on a facility 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." *See, e.g.*, *Barbourville Nursing Home*, DAB No. 1962 at 11 (2005) (*citing Florence Park Care Ctr.*, DAB No. 1931 at 27-28 (2004)).

Here, CMS's finding of immediate jeopardy is not "clearly erroneous." Resident # 25, an aphasic woman with multiple BIMS scores of 0, provided inconsistent responses when questioned various times, but unquestionably alleged that she had been sexually assaulted. P. Ex. 3 at 5. Despite this allegation of sexual assault, Resident # 22, a registered sex offender, was permitted to move freely throughout the facility without close supervision until one-on-one supervision was initiated on October 29, 2015 (CMS Ex. 8 at 50, 52-54), subjecting all of the facility's residents, particularly the female

residents, to the risk of sexual abuse for a period of 77 days following the suspected sexual assault.[32]

D. CMS's determinations as to the duration of the periods of noncompliance and immediate jeopardy are consistent with statutory and regulatory requirements.

Petitioner does not dispute the length of noncompliance, as its arguments focus on its mistaken belief that it was in substantial compliance. Substantial compliance means not only that the facility corrected the specific cited instances of substantial noncompliance but also that it implemented a plan of correction designed to assure that no additional incidents would occur in the future. Once a facility is found to be out of substantial compliance, it remains so until it affirmatively demonstrates that it has achieved substantial compliance once again. *Premier Living and Rehab. Ctr.*, DAB No. 2146 at 23 (2008); *Lake City Extended Care*, DAB No. 1658 at 12-15 (1998). The burden is on the facility to prove that it is compliant with program requirements, and not on CMS to prove that deficiencies continued to exist after they were discovered. *Asbury Ctr. at Johnson City*, DAB No. 1815 at 19-20 (2002). Noncompliance found during a survey is "presumed to continue until the facility demonstrates it has achieved substantial compliance." *Taos Living Ctr.*, DAB No 2293 at 20 (2009).

Immediate jeopardy was abated on the date of completion of the survey on October 29, 2015, at which time the facility implemented a number of corrective measures, most significantly that Resident # 22 would be subject to on one-on-one observation until Petitioner transferred him to another facility. CMS Ex. 8 at 50, 52-53. Petitioner does not argue that it returned to compliance prior to October 29, 2015. I sustain CMS's determination regarding the duration of immediate jeopardy and have no reason to disturb any determination regarding the duration of noncompliance thereafter.

E. The penalty imposed is reasonable

I examine whether the amount of a CMP is reasonable by applying the factors listed in 42 C.F.R. § 488.438(f): 1) the facility's history of noncompliance; 2) the facility's financial condition; 3) the factors specified in 42 C.F.R. § 488.404; and 4) the facility's degree of culpability, which includes neglect, indifference, or disregard for resident care, comfort, or safety. The absence of culpability is not a mitigating factor. The factors listed in 42

[32] It is important to note that, based on Resident # 25's aphasia and well-discussed communication difficulties, it would have been difficult for her to report to facility staff that she had been sexually assaulted. Therefore, if Mr. Johnson had not discovered the suspected sexual assault while it was in progress, it may never have been reported to anyone. Petitioner has an obligation to protect vulnerable residents such as Resident # 25.

C.F.R. § 488.404 include: 1) the scope and severity of the deficiency; 2) the relationship of the deficiency to other deficiencies resulting in noncompliance; and 3) the facility's prior history of noncompliance in general and specifically with reference to the cited deficiencies.

The regulations specify that a CMP that is imposed against a facility on a per-day basis will fall into one of two ranges.[33] 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 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, the per-day amount, rather than the total accrued CMP, is at issue. *See Kenton Healthcare, LLC*, DAB No. 2186 at 28 (2008). Pursuant to 42 C.F.R. § 488.408(g)(2), a facility cannot appeal CMS's choice of a remedy, and an appeal of a CMP is limited to review based on the regulatory factors set forth at 42 C.F.R. §§ 488.438(f) and 488.404(a)-(c). *See, e.g., Senior Rehab. & Skilled Nursing Ctr.*, DAB No. 2300 at 19-20 (2010), *aff'd, Senior Rehab. & Nursing Ctr. V. Health & Human Servs.*, 405 F. App'x 820 (5th Cir. 2010).

I must sustain a CMP unless a particular regulatory factor does not support the CMP amount imposed by CMS. *Coquina Ctr.*, DAB No. 1860 at 32 (2002). CMS imposed a $6,450 per-day CMP, and I previously determined that the facility's substantial noncompliance posed immediate jeopardy for 77 days from August 13, 2015 through October 28, 2015. The per-day CMP of $6,450 is in the middle of the $3,050 to $10,000 range for penalties imposed for deficiencies constituting immediate jeopardy. 42 C.F.R. § 488.438(a)(1)(i). Petitioner failed to properly investigate and report a serious allegation of sexual assault, and the deficiency amounted to immediate jeopardy exposing a number of residents to potential harm by a suspected sexual abuser.[34] Further, the failure to properly report and investigate a suspected sexual assault may have ultimately prevented

[33] CMP amounts increased, effective February 3, 2017, for violations occurring *after* November 2, 2015. *See* 82 Fed. Reg. 9,174 (February 3, 2017). I apply the CMP amounts that were in effect at the time of the survey in October 2015.

[34] Had the facility reported the suspected sexual abuse to the state agency in a timely manner, it is possible that the complaint investigation would have been completed sooner and immediate jeopardy would have been abated earlier, resulting in fewer days of immediate jeopardy and a lower CMP.

criminal prosecution of a sexual assault.[35] A much harsher penalty at the high end of the range would have been justified based on the severity of this deficiency, and a mid-range penalty of $6,450 is reasonable. CMS also imposed a penalty of $150 per day effective October 29, 2015, for thirteen non-immediate jeopardy level deficiencies, amounting to a CMP at the very low end of the penalty range. 42 C.F.R. § 488.438(a)(1)(ii); CMS Exs 1, 2. I find that a $150 per day CMP for a combined 13 additional deficiencies is reasonable. 42 C.F.R. § 488.438(a)(1)(ii).

Petitioner argues that it "simply cannot pay the fine," but it does not provide support for this statement. P. Br. at 24. Petitioner submitted an exhibit reflecting that Vanguard, its parent company, filed a bankruptcy petition seeking reorganization pursuant to Chapter 11 of the United States Bankruptcy Code. P. Ex. 13. Petitioner has not shown that Vanguard's bankruptcy petition would render it insolvent and unable to pay a CMP, nor has it argued that payment of the CMP would compromise the health and safety of its residents. In fact, the bankruptcy filing shows estimated assets of $100 million to $500 million, and $50 million to $100 million in estimated liabilities, which suggests that Petitioner has significantly more assets than liabilities. P. Ex. 13 at 3; *Van Duyn Home & Hosp.*, DAB No. 2368 (2011); *Gilman Care Ctr.*, DAB No. 2357 (2010). To meet the standard for reducing a CMP based on financial condition, claims must be supported by compelling financial documentation. *In Guardian Care Nursing & Rehabilitation Center*, DAB No. 2260 (2009). Petitioner has not shown, nor even alleged, that the payment of the CMP would affect its ability to stay in business, and the evidence does not otherwise warrant reduction of the CMP based on Petitioner's financial condition.

IV. Conclusion

For the reasons discussed above, I find that CMS imposed reasonable penalties for Petitioner's substantial noncompliance with Medicare requirements.

/s/
Leslie C. Rogall
Administrative Law Judge

[35] If Resident # 25 had been transferred to a hospital for an examination and been interviewed by health care providers and police at the hospital, it is possible that such an investigation may have led to a different outcome.