Department of Health and Human Services
DEPARTMENTAL APPEALS BOARD
Appellate Division

Golden Living Center – Trussville
Docket No. A-17-118
Decision No. 2937
April 29, 2019

REMAND OF ADMINISTRATIVE LAW JUDGE DECISION

Petitioner Golden Living Center – Trussville, a skilled nursing facility, appeals the August 11, 2017 Amended Decision of an administrative law judge (ALJ).[1] *Golden Living Center – Trussville*, DAB CR4916 (2017) (ALJ Decision). This case involves allegations that, on October 25, 2014, Petitioner's nursing staff left residents alone with an individual who had arrived to see his mother (a resident at Petitioner's facility) apparently under the influence of alcohol. The Centers for Medicare & Medicaid Services (CMS) cited Petitioner with violations of Medicare participation requirements in 42 C.F.R. Part 483, subpart B. The ALJ granted summary judgment for CMS, concluding that: (1) Petitioner was not in substantial compliance with section 483.13, which prohibits abuse of residents and sets out requirements for facility staff treatment of residents, and section 483.75, which addresses facility administration, from October 25, 2014 until December 9, 2014; (2) CMS's determination that the noncompliance posed immediate jeopardy to resident health and safety from October 25, 2014 through November 6, 2014 was not clearly erroneous; and (3) the civil money penalties (CMPs) imposed, which included a $5,000 per-day CMP for the immediate jeopardy period, were reasonable.

Having reviewed the question of summary judgment de novo, we have determined that there are genuine disputes of material fact relating to Petitioner's compliance with the facility administration requirement at 42 C.F.R. § 483.75, whether CMS's immediate jeopardy determination was clearly erroneous, and whether the corresponding immediate jeopardy CMPs were reasonable. Accordingly, we remand this case for further development of the record, as necessary, and adjudication based on the full evidentiary record.

[1] The ALJ's August 11, 2017 decision amended his August 10, 2017 decision only to strike the erroneous reference to a different facility by name on page 21 of his earlier decision. Although Petitioner refers to the ALJ's August 10 decision in the opening paragraph of its brief in support of its request for review (RR), we assume that it is asking the Board to review the ALJ's August 11 amended decision. Our references to "ALJ Decision" herein are to the ALJ's amended decision.

I. Legal authorities

To participate in the Medicare program, a facility must be in "substantial compliance" with the participation requirements in 42 C.F.R. Part 483, subpart B.[2] 42 C.F.R. §§ 488.400, 483.1. A facility is not in substantial compliance when it has a "deficiency" – a failure to meet a participation requirement – that creates the potential for more than minimal harm to one or more residents. *Id.* § 488.301 (defining "substantial compliance"). The term "noncompliance" is synonymous with lack of substantial compliance. *Id.* § 488.301 (defining "noncompliance"). Compliance with Medicare participation requirements is verified through onsite surveys performed by state survey agencies. *Id.* §§ 488.10(a), 488.11. A state survey agency reports any deficiency it finds in a Statement of Deficiencies (SOD), Form CMS-2567. *See* CMS State Operations Manual (SOM), CMS Pub. 100-07, § 1016.

CMS may impose enforcement "remedies," including CMPs, on a facility found out of substantial compliance. 42 C.F.R. §§ 488.400, 488.402(b), (c), 488.406. When CMS elects to impose a CMP, it sets the CMP amount based on, among other things, the "seriousness" of the facility's noncompliance. *Id.* §§ 488.404(a), (b), 488.438(f). Seriousness is a function of the noncompliance's scope (whether it is "isolated," constitutes a "pattern," or is "widespread") and severity (whether it has created a "potential for" harm, resulted in "[a]ctual harm," or placed residents in "immediate jeopardy"). *Id.* § 488.404(b). The most serious noncompliance is that which puts one or more residents in "immediate jeopardy," which is "a situation in which the [facility'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." *Id.* §§ 488.301, 488.438(a) (authorizing the highest CMPs for immediate-jeopardy-level noncompliance); *Woodland Oaks Healthcare Facility*, DAB No. 2355, at 2 (2010).

[2] In October 2016, CMS issued revised requirements for long-term care facilities in Part 483, subpart B. Final Rule, *Medicare and Medicaid Programs; Reform of Requirements for Long-Term Care Facilities*, 81 Fed. Reg. 68,688 (Oct. 4, 2016); 82 Fed. Reg. 32,256 (July 13, 2017) (technical corrections). The revisions took effect on November 28, 2016, with the implementation of the revised regulations in phases, with the earliest implementation date beginning on November 28, 2016, after the surveys that formed the bases for CMS's determination of noncompliance in this case. *See* 81 Fed. Reg. at 68,688, 68,696-698. The Board applies the regulations in effect on the date of the survey and revisit survey. *See Carmel Convalescent Hosp.*, DAB No. 1584, at 2 n.2 (1996).

CMS may impose one or more remedies on noncompliant facilities, including per-day CMPs. 42 C.F.R. §§ 488.402(b), (c), 488.406, 488.408(d)(1), (e)(1), 488.430(a). CMS may impose a per-day CMP of $50-$3,000 per day for noncompliance at a level less than immediate jeopardy, and a per-day CMP of $3,050-$10,000 per day for noncompliance that poses immediate jeopardy. *Id*. §§ 488.408(d)(1)(iii), (e)(1)(iii), 488.438(a)(1). Within the applicable range, the regulations provide a number of factors to be considered by CMS in determining an appropriate CMP amount. *Id.* §§ 488.438(f)(3), 488.404. A per-day CMP may accrue from the date the facility was first out of substantial compliance until the date it is determined to have achieved substantial compliance. *Id.* § 488.440(a)(1), (b).

A facility may challenge a determination of noncompliance that has resulted in the imposition of a CMP (or other enforcement remedy) by requesting an ALJ hearing and appealing any unfavorable decision by an ALJ to the Board. 42 C.F.R. §§ 488.408(g)(1), 498.3(b)(13), 498.5(c). Also, when CMS imposes a per-day CMP, a facility may challenge CMS's determination that the noncompliance has placed residents in immediate jeopardy, but an ALJ and the Board must review that determination under a "clearly erroneous" standard. *Id.* §§ 498.3(b)(14), 498.60(c)(2). This regulatory standard means that a facility bears a heavy burden in challenging the assessment of immediate jeopardy, which, of necessity, includes an element of judgment. *Meadowwood Nursing Ctr.*, DAB No. 2541, at 14 (2013); *Britthaven of Havelock*, DAB No. 2078, at 29 (2007) (and cited cases). In addition, a facility may challenge the reasonableness of the amount of any CMP imposed. *Lutheran Home at Trinity Oaks*, DAB No. 2111, at 21 (2007).

II. Case background

This appeal centers on events that occurred in the facility on October 25, 2014. Much of what occurred that day is disputed. The undisputed core facts (discussed in more detail below) involve a male visitor observed with a shoe off in the room of two female residents. One resident (Resident 2 or R2) stated to a nurse that the visitor had been "messing with" the other resident (Resident 1 or R1).[3] CMS Ex. 1 (SOD) at 2, 3. The nurse left the room, returned shortly, and, on at least the second visit, smelled alcohol, noticed the man appeared to be holding up his unbelted pants, and found the situation strange. She left again and returned with her supervisor after at least two-three minutes. The supervisor then observed Resident 1 with her genitalia exposed and the male visitor partially undressed. The visitor was removed and later arrested by the police for public drunkenness and charged with sexual abuse and other crimes (the resolution of which is not documented in the record evidence). The facility reported the episode to the Alabama Department of Public Health, the state survey agency.

[3] The visitor proved to be Resident 1's son, although that was not known by the nurse at the time.

On November 7, 2014, the state survey agency completed a complaint survey of Petitioner, finding violations of Medicare participation requirements cited at scope and severity level "J" (isolated noncompliance that poses immediate jeopardy to resident health and safety). Those violations included the following:

42 C.F.R. § 483.13(b), (c)(1)(i) (Tag F223 – resident abuse)
42 C.F.R. § 483.13(c) (Tag F226 – abuse policies and procedures)
42 C.F.R. § 483.75 (Tag F490 – facility administration)

CMS Ex. 1; CMS Ex. 2, at 1-2.

Based on the survey results, CMS determined that Petitioner had violated participation requirements. By notice dated December 2, 2014, CMS informed Petitioner that the violations put facility residents in immediate jeopardy from October 25, 2014 through November 6, 2014. CMS Ex. 2, at 1. CMS imposed a per-day CMP of $5,000 for the immediate jeopardy period, and a per-day CMP of $100 to start on November 7, 2014, and to continue until Petitioner returned to substantial compliance or until Petitioner's Medicare participation terminated. *Id.* at 2.

On December 18, 2014, the state survey agency performed a revisit survey, finding that, as of December 9, 2014, Petitioner had corrected the deficiencies cited following the November 2014 survey. P. Ex. 2, at 1 ("The surveyors placed the citations of the November 7, 2014, survey back into compliance."), 2 (finding substantial compliance as to Tags F223, F226, and F490 on December 9, 2014). However, the state survey agency found continued noncompliance based on new noncompliance findings following a survey completed on December 23, 2014. *Id.* at 1.

On January 15, 2015, CMS issued a "Change in Remedies Notice" based in part on the December 2014 survey findings. P. Ex. 3. In that notice, CMS informed Petitioner that, in addition to the $5,000 per-day CMP imposed for the immediate jeopardy period through November 6, 2014, it was imposing revised CMPs of $100 per day for the period from November 7, 2014 through December 1, 2014, and $250 per day beginning December 2, 2014. *Id.* at 2. As noted above, the state survey agency determined that Petitioner returned to substantial compliance with respect to the deficiencies cited under Tags F223, F226, and F490 on December 9, 2014.

III. ALJ proceedings and decision

Petitioner requested a hearing before an ALJ.[4] After filing their pre-hearing exchanges (briefs, proposed exhibits, and lists of proposed exhibits and witnesses), the parties filed cross-motions for summary judgment. Each party filed written arguments opposing the other's motion.

In upholding the deficiencies cited as Tags F223 and F490, the ALJ concluded that deciding this case by summary judgment (for CMS) would be appropriate because, "even when viewed in the light most favorable to Petitioner, the evidence establishes" that:

> (1) Petitioner violated 42 C.F.R. § 483.13(b), (c)(1)(i) (and, by extension, § 483.75) by failing to take reasonable steps to protect Residents 1 and 2 from the reasonably foreseeable risk of abuse posed by Resident 1's son; (2) Petitioner's noncompliance posed a risk for more than minimal harm to Residents 1 and 2; (3) CMS's determination that Petitioner's noncompliance posed immediate jeopardy to resident health and safety is not clearly erroneous; and (4) the CMPs posed by CMS are reasonable.

ALJ Decision at 12. The ALJ rejected "what amount[ed] to several legal arguments why the evidence shows either that the risk of abuse posed by Resident 1's son was unforeseeable or, if the risk of abuse was foreseeable, it took all reasonable steps to protect Residents 1 and 2 from abuse, which, in Petitioner's view, entitle Petitioner to summary judgment." *Id.*

The ALJ set out 32 numbered facts that the ALJ stated were either undisputed, or, to the extent disputed, based on Petitioner's version of the facts as supported by the evidence. *Id.* at 7 n.6; *id.* at 7-11. We summarize below these facts.

- Petitioner had a written anti-abuse policy within its Human Resources Management Policies and Procedures Manual, CMS Ex. 16, which required Petitioner "to take appropriate steps to prevent the occurrence of abuse . . . ," *id.* at 1.

[4] In its pre-hearing brief, Petitioner stated that it was not appealing the $250 per-day CMP imposed beginning December 2, 2014 "based upon additional unrelated deficiencies" cited upon the revisit survey or the "underlying deficiencies." P. Pre-hearing Br. at 7. Thus, although the ALJ noted the issuance of the "Change in Remedies Notice," the ALJ also stated that he would not further address the $250 per-day CMP imposed for the December 2-9 period. ALJ Decision at 4-5 & 5 n.4. Before the Board, Petitioner again states that it did not appeal the $250 per-day CMP or the deficiencies on which those CMPs were based. RR at 5 n.3.

- Petitioner had a separate policy concerning the handling of intoxicated visitors to the facility. P. Ex. 13, at 4-5; P. Ex. 15, at 4. The policy, as explained by S.M.H., the Vice President of Petitioner's parent company, "is that if a staff member suspects that a visitor is intoxicated or impaired, the staff person (or staff persons, if warranted) should escort the person out, or, if needed, call 911." P. Ex. 13, at 4. According to S.M.H., the concern underlying this policy "is not necessarily that the intoxicated person is a threat to other residents, but is based upon the common knowledge . . . that intoxicated persons can be loud, disruptive, or argumentative, and could frighten residents and staff or even interfere with care." *Id.* at 4-5.

- According to J.D., Petitioner's Director of Nursing, facility nurses were trained "not to confront or argue with visitors who might be impaired, or who are being loud or aggressive, but to get a supervisor . . . ." P. Ex. 18, at 2. According to Petitioner's expert witness, registered nurse A.O., individuals who are "impaired/mentally-disturbed . . . can become very unpredictable and unmanageable." P. Ex. 17, at 13.

- Resident 1, an 83-year-old woman who was admitted to Petitioner's facility on October 14, 2014, and Resident 2, a 76-year-old woman admitted to the facility on October 23, 2014, were roommates at Petitioner's facility. R1 had a son who visited R1 at the facility on October 25, 2014. CMS Exs. 12, at 1-5 and 14, at 1; P. Exs. 16, at 1 and 9, at 1.

- In the mid-afternoon of October 25, 2014, V.E., a licensed practical nurse, went to the room shared by R1 and R2 to perform a skin assessment on R2. V.E. had not provided care to, and did not know, either resident before that day, and did not recall hearing reports of any unusual visitors or behaviors relating to either resident. V.E. knocked on the closed door, but, hearing no response, opened the door slightly and announced herself, at which time she heard the voice of a male inviting her to enter the room. Upon entering, V.E. found the room dark, with the light off, the blinds pulled, and the privacy curtain between the beds of R1 and R2 (R2's bed was located away from the door, near the window) pulled out. V.E. saw a wheelchair between the beds, and a man (whom she had not seen before) standing near R1's bed. The man sat down in the wheelchair as V.E. entered. V.E. told the man that she came to check on R2, turned the light on, and went to R2's bed. V.E. then noticed that the man's right shoe and sock were off. Immediately after V.E. reached R2, R2 said to V.E. "he's been messing with her" in a "soft, matter of fact, calm voice." V.E. asked R2 to repeat herself, and R2 repeated those same words, in the same voice, but said nothing more. P. Ex. 15, at 1-2.

- At that time V.E. did not perceive anything that seemed out of the ordinary and believed R2 might have been confused, so V.E. left the room and went to the nearby nursing station to review R2's chart to get information about R2's cognitive status. The chart revealed that R2 was moderately impaired. *Id.* at 3.

- V.E. returned to the room and saw the man standing at the end of R1's bed, appearing to hold his opened pants up. When V.E. walked in, the man quickly sat down on the wheelchair. His belt and shoe were on the floor. V.E. noticed an odor of alcohol in the room. R1 was awake, sitting up and calm. *Id.* At that point, V.E. felt uncomfortable, suspected that the man might have been drinking, and thought the situation odd. V.E. thought that if the man had been drinking, she might need help from another nurse. *Id.* at 3-4. V.E. testified that she might have told the man to step outside to the hallway because she smelled alcohol, but was not certain that she did this. *Id.* at 4.

- V.E. again left the room, and returned two or three minutes later with T.W., a registered nurse and the nurse supervisor on duty. V.E. had explained to T.W. that she had smelled alcohol in R1's room. T.W., who entered the room first, discovered R1 in her bed with the bedsheet pulled away. R1's genital area was exposed to view. T.W. covered up R1 and asked the man what was going on. The man reportedly became somewhat belligerent in response to the question and asked whether T.W. was accusing him of being a pedophile. *Id.*; P. Ex. 9, at 1; CMS Ex. 11, at 5, 7. T.W. then told the man he would have to leave and escorted him out of the room. P. Ex. 9, at 1; P. Ex. 15, at 4-5. V.E. later learned that the man in question was R1's son. P. Ex. 9, at 1.

- At some point, Petitioner's staff called 911. R1's son was arrested and removed from the facility. *Id.*; CMS Ex. 3, at 1-2, 4. He evidently was initially charged with two sexual offenses – sexual abuse by force and first degree rape – but the court records submitted by Petitioner indicate those charges were "WAIVED TO GJ," which the ALJ stated appeared to stand for "grand jury." ALJ Decision at 11 (citing P. Ex. 12). The ALJ noted that nothing in the record suggested that R1's son had been indicted by the time the parties completed briefing for cross-motions for summary judgment. *Id.* n.11.

- R1 was assessed and later transported to a hospital for alleged sexual assault. The hospital performed a rape examination.[5] CMS Ex. 11, at 6-7; P. Ex. 9, at 1.

[5] The ALJ noted that the results of the rape examination are not in the record. ALJ Decision at 11 n.10.

Based on the above facts the ALJ said were undisputed, or, to the extent disputed, viewed most favorably to Petitioner, the ALJ concluded:

> The undisputed fact that a member of Petitioner's staff left [R1 and R2] alone with a man she did not know for at least two minutes even after she (1) smelled alcohol and suspected the man had been drinking; (2) was told by [R2] that the man had been "messing with" [R1]; (3) witnessed the man in a state of partial undress; and (4) felt uncomfortable enough to seek out her supervisor and even to possibly tell the man to leave the room support a conclusion that Petitioner was not in substantial compliance with 42 C.F.R. §§ 83.13(b), (c)(1)(i) (Tag F223) and 483.75 (Tag F490).

ALJ Decision at 12.[6] The ALJ also determined that the violations of sections 483.13(b) and (c)(1)(i) (Tag F223) and 483.75 (Tag F490) "had the potential to cause more than minimal harm to Petitioner's residents; therefore, Petitioner was not in substantial compliance with those regulatory requirements." *Id.* at 18. The ALJ further found CMS's immediate jeopardy determination "not clearly erroneous," *id.* at 19, and upheld the CMPs as imposed as reasonable, *id*. at 21-22.

IV. Standard of review

We review whether summary judgment is appropriate de novo, construing the facts in the light most favorable to the non-moving party (or, here, Petitioner, the party that did not prevail before the ALJ on summary judgment) and giving that party the benefit of all reasonable inferences. *See Pearsall Nursing & Rehab. Ctr.*, DAB No. 2692, at 5 (2016) (citing *Livingston Care Ctr*., DAB No. 1871, at 5 (2003), *aff'd*, *Livingston Care Ctr. v. U.S. Dep't of Health & Human Servs*., 388 F.3d 168, 172-73 (6th Cir. 2004)); *Brightview Care Ctr*., DAB No. 2132, at 2, 9 (2007). Drawing factual inferences in the light most favorable to the non-moving party does not require that a reviewer draw unreasonable inferences or accept the non-moving party's legal conclusions. *Brightview* at 10; *Cedar Lake Nursing Home*, DAB No. 2344, at 7 (2010). Inferences based on speculation are not reasonable. *Dumas Nursing & Rehab., L.P.*, DAB No. 2347, at 18 (2010).

[6] Before the ALJ, CMS stated that, in addition to Tags F223, F226, and F490 set out in the SOD, it was also citing Tag F225, alleging that Petitioner failed to thoroughly investigate the incident involving R1's son in violation of section 483.13(c)(3). ALJ Decision at 5 (citing CMS Br. to ALJ at 8, 10-12). The ALJ stated that he need not address the alleged violations with respect to Tags F225 or F226 because the alleged deficiencies that he was addressing (Tags F223 and F490) "support both the imposition of enforcement remedies, including a CMP, and the reasonableness of the CMPs imposed by CMS." *Id*. at 6 n.5. Petitioner raises an argument about this aspect of the ALJ's decision, which we will address later.

Our standard of review on a disputed conclusion of law is whether the ALJ's decision is erroneous. *Guidelines – Appellate Review of Decisions of Administrative Law Judges Affecting a Provider's Participation in the Medicare and Medicaid Programs*, https://www.hhs.gov/about/agencies/dab/different-appeals-at-dab/appeals-to-board/guidelines/participation//index.html.

V. Discussion

As we explain below, we concur with the ALJ's determination that the undisputed facts alone suffice to establish that Petitioner was not in substantial compliance with section 483.13. However, based on our de novo review, we also determine that there are genuine disputes of material fact which require this case to be adjudicated on the full evidentiary record. A remand of this case will allow fact-finding based on a full assessment and discussion of the evidence to determine the events, actions of the staff, and surrounding circumstances and, in particular, whether CMS clearly erred in determining that Petitioner's noncompliance did or was likely to cause serious harm to one or more residents and thus warranted immediate jeopardy CMPs.

A. Sections 483.13(b) and (c)(1)(i) – Tag F223

1. *The issue as to the deficiency cited under sections 483.13(b) and (c)(1)(i) is whether Petitioner failed to take reasonable steps to protect its residents from reasonably foreseeable risks of abuse by a visitor to the facility.*

Section 483.13, captioned "Resident behavior and facility practices," provides in part:

> (b) *Abuse*. The resident has the right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion.
> (c) *Staff treatment of residents*. The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.
> (1) The facility must—
> (i) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion. . . .

"Abuse" is the "willful infliction or injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish." 42 C.F.R. § 488.301.

Petitioner asserts that the ALJ erred in concluding (based on the facts the ALJ stated were undisputed or, to the extent disputed, viewed most favorably to Petitioner) that it was not in substantial compliance with sections 483.13(b) and (c)(1)(i). Petitioner asserts that, because CMS alleged that Petitioner violated these regulations by failing "*to prevent the actual sexual abuse of a specific resident*" (RR at 3, Petitioner's emphasis), the ALJ was required to determine whether CMS made its prima facie case of noncompliance based on *that* precise allegation. *Id.* at 2, 3. According to Petitioner, no sexual assault of R1 has been established and therefore no proof of violation of the abuse regulations in the manner CMS alleged exists. Accordingly, says Petitioner, the "subsidiary citations" also fail. *Id.* at 27. Petitioner's argument runs as follows: "Petitioner believes that Section 483.13 must be applied in this case in light of the evidence that relates to the allegation of noncompliance CMS actually made – that is, . . . [Petitioner's] alleged failure *to protect [R1] against sexual abuse*. If CMS failed to establish a prima facie case of noncompliance on that specific allegation, the case should have ended, and the ALJ should have gone no further." *Id*. at 29 (Petitioner's emphasis).

Also, according to Petitioner, rather than determining whether CMS had proof that R1's son sexually assaulted R1, the ALJ instead "took a much broader view" of section 483.13. *Id*. at 3. Petitioner argues that the ALJ wrongly held Petitioner to his own "iteration" of the regulations, which Petitioner portrays as prohibiting a facility from ever leaving any visitor who might be under the influence of alcohol alone with residents, even for a few minutes, because such a visitor "*might*" abuse someone. *Id.* (Petitioner's emphasis). It says that the ALJ thereby "created a new and completely unworkable standard of resident and visitor supervision" and "how a nurse 'should have' responded to an apparently intoxicated visitor." *Id.* at 3-4 and 27 ("[T]he implication is that the ALJ could not find any plausible way to sustain the citation on the grounds CMS actually advanced, and so he substituted – on summary judgment – an alternative basis for the CMP."); Reply Br. at 3 (asserting that the ALJ "created an alternative theory of the case"). Petitioner takes the position that the "specific scenario at issue here – sexual abuse of an elderly nursing facility resident by a family member – actually is so rare that there are no studies or statistics at all that directly address that specific issue," RR at 9-10, implying that R1's son sexually assaulting R1 was not something its staff could possibly be expected to foresee. *Id.* at 9-11, 27-28, 29.

Petitioner misstates the issue and misreads the ALJ's conclusions. Petitioner mistakenly assumes that the issue of whether it violated section 483.13 turned only on whether or not sexual abuse of R1 by her adult son actually occurred or whether that precise form of abuse was reasonably foreseeable. Sections 483.13(b) and (c)(1)(i) do indeed prohibit sexual (and physical) abuse of residents, and evidence of actual occurrence of sexual or

physical abuse would certainly be relevant to determining whether a facility violated section 483.13. However, as explained below, under section 483.13 a facility is responsible for keeping residents free from sexual or other types of abuse and could be found in violation if its staff failed to take reasonable precautions in a situation that made the possibility of abuse reasonably foreseeable, whether or not the abuse materialized, was of the type foreseen, or was ultimately provable. The pertinent issues here are whether some risk of abuse to residents posed by R1's son was reasonably foreseeable under the circumstances found and, if so, whether Petitioner acted appropriately to protect its residents from that risk.

Moreover, in granting summary judgment for CMS, the ALJ did not necessarily have to conclude that every CMS allegation was proven based on the undisputed facts alone. The ALJ's role in evaluating the cross-motions for summary judgment was to determine whether the undisputed facts, viewed in the light most favorable to the party against whom the ALJ would decide, demonstrated noncompliance as a matter of law (or demonstrated the contrary). We find no authority supporting Petitioner's novel concept that summary judgment is precluded unless the undisputed facts substantiate every factual allegation raised in the SOD or CMS briefing.[7]

[7] Petitioner asserts that the ALJ erred in not determining whether CMS established a prima facie case based on the specific allegations raised by CMS. According to Petitioner, if CMS failed to establish a prima facie case of noncompliance based on its allegations, then "the ALJ should have gone no further." RR at 29. The ALJ did not err. The ALJ could have separately articulated that CMS had made a prima facie showing of Petitioner's noncompliance in concluding that Petitioner was not entitled to summary judgment, but was not required to do so. Here, CMS established a prima facie case of noncompliance with section 483.13 requirements based on the evidence of record, including evidence presented by CMS that the petitioner disputes. *See Evergreene Nursing Care Ctr.*, DAB No. 2069, at 7 (2007), *appeal dismissed per consent motion to dismiss with prejudice*, *Evergreene Nursing Care Ctr. v. Leavitt*, No. 3:07cv00024 (W.D. VA, Charlottesville Div. June 16, 2008) (CMS has the burden to go forward with evidence related to disputed findings that, together with any undisputed findings and relevant legal authority, is sufficient to establish a prima facie case of noncompliance; once CMS makes its prima facie case, the facility must carry its ultimate burden to show by a preponderance of the evidence, based on all of the record evidence, that it was in substantial compliance) (and cited cases). Under the summary judgment standard, the ALJ must determine whether there is any genuine dispute about a fact material to the outcome of the case such that the moving party – who has the initial burden to demonstrate that there is no genuine issue of material fact for trial – is entitled to judgment as a matter of law. Once the movant carries that burden, the nonmoving party must come forward with specific facts showing that there is a genuine issue for trial. *Southpark Meadows Nursing & Rehab Ctr.*, DAB No. 2703, at 5 (2016) (and cited cases); *Senior Rehab. & Skilled Nursing Ctr.*, DAB No. 2300, at 3 (2010), *aff'd*, *Senior Rehab. & Skilled Nursing Ctr. v. Health & Human Servs.*, 405 F. App'x 820 (5th Cir. 2010) (and cited cases).

The ALJ correctly framed and resolved the pertinent issue, stating as follows:

> "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." *Pinehurst Healthcare & Rehab Ctr.*, DAB No. 2246 at 6 (2009) (quoting *Western Care Mgmt. Corp., d/b/a Rehab Specialties Inn*, DAB No. 1921 at 12 (2004) (internal quotation marks omitted). Actual abuse need not occur for a facility to violate 42 C.F.R. § 483.13(b) and (c)(1)(i). *See Holy Cross* [*Village at Notre Dame*,] DAB No. 2291 at 7 [(2009)] (citation omitted). "It is sufficient for CMS to show that . . . the facility failed to protect residents from reasonably foreseeable risks of abuse." *Id.* (citing *Western Care Mgmt.*, DAB No. 1921 at 15). In order to demonstrate that Petitioner violated 42 C.F.R. 483.13(b), (c)(1)(i), CMS must show that (1) there was a reasonably foreseeable risk of abuse and that (2) Petitioner failed to take reasonable steps to prevent abuse from occurring. Even when viewing the evidence in the light most favorable to Petitioner, CMS has made a sufficient showing as to both of these requirements.

ALJ Decision at 13.

In other words, the issue is not whether R1's son actually abused his mother sexually or whether Petitioner's staff had or should have anticipated the possibility of sexual abuse of R1 by her son. Although both section 483.13(b) and section 483.13(c)(1)(i) expressly refer to sexual abuse as one of multiple forms or types of abuse (to include verbal, physical, mental, corporal punishment, involuntary seclusion) and the nature of the October 25, 2014 incident reasonably raises the possibility of sexual abuse of a resident, that does not then mean that sexual abuse of R1 or another resident by R1's son specifically must have been foreseeable. It certainly does not mean that sexual abuse actually must have in fact occurred for CMS's enforcement action to stand. Instead, the ALJ properly asked whether a man who was found partially clothed and appeared to be under the influence of alcohol, in a room with two women with cognitive and physical limitations under the circumstances presented (including the expression of some concern by one of the women) should have raised red flags of risks (whether of sexual, physical, or verbal abuse or other forms of abusive behavior) to those residents and possibly other facility residents, and whether leaving him alone in the room with the residents was a reasonable response.

"The goal of section 483.13(b) is to keep residents free from abuse. This goal cannot be achieved if a facility could be found in compliance even though it failed to take reasonable steps to protect residents from potentially injurious acts which it knew or should have known might occur and which might be willful . . . ." *Honey Grove Nursing Ctr.*, DAB No. 2570, at 3 (2014) (quoting *Western Care Mgmt.*, DAB 1921, at 14), *aff'd, Honey Grove Nursing Ctr. v. Dep't of Health & Human Servs.*, 606 F. App'x 164 (5th Cir. 2015). The goal would be meaningless if section 483.13(b) is not read as imposing an obligation to prevent the risk of abuse.

"CMS is not required to establish, and the ALJ is not required to find, that actual abuse occurred" to establish a violation of section 483.13(b). *Holy Cross Village at Notre Dame*, DAB No. 2291, at 7. "It is sufficient for CMS to show that the facility failed to protect residents from reasonably foreseeable risks of abuse." *Id.*; *see also Lakeport Skilled Nursing Ctr.*, DAB No. 2435, at 5 (2012) (Proof that a deficiency resulted in actual harm is unnecessary; CMS need only show that a deficiency created a "potential" to cause more than minimal harm in order to find a facility out of substantial compliance.). The facility's responsibility to protect its residents from abuse also encompasses the responsibility to protect them from the potential for abuse by family members and visitors. *See Singing River Rehab. & Nursing Ctr.*, DAB No. 2232, at 7 (2009); *see also Western Care Mgmt.*, DAB No. 1921, at 12-13 (discussing facility's duty to take reasonable steps to prevent abusive acts against residents, regardless of source).

Accordingly, the ALJ did not have to find that R1's son sexually assaulted his mother, or even that that specific type of abuse was reasonably foreseeable, to conclude that a section 483.13 deficiency was established as a matter of law.[8] We reject the argument that the ALJ committed legal error or held Petitioner to some standard of the ALJ's own creation not consistent with the applicable authorities.

[8] Not only is the proposition that actual abuse is required to support a section 483.13 deficiency incompatible with the regulation's underlying purpose (that is, to prevent abuse from occurring in the first place by taking appropriate action responsive to reasonably foreseeable risks), it is inconsistent with the regulations for another reason. It is conceivable that a resident could experience mental anguish even if a perpetrator does not actually make physical contact with him or her (whether to sexually assault or to perpetrate some other type of physical abuse). Mental abuse is itself a form of abuse for which a facility may be cited. 42 C.F.R. §§ 483.13(b) and (c)(1)(i) (a resident has the right to be free from mental abuse; the facility must not use such abuse), 488.301 (defining "abuse" to include "mental anguish").

2. *The deficiency cited as Tag F223 for a violation of section 483.13 requirements should be evaluated on the full evidentiary record.*

We agree with the ALJ that even the undisputed facts identified by the ALJ establish that Petitioner was not in substantial compliance with section 483.13. The undisputed facts as set out by the ALJ establish that there was a potential to cause more than minimal harm to residents and that V.E.'s response to the situation she had encountered was not reasonable. However, having determined that there is a genuine dispute of material fact relating to CMS's immediate jeopardy determination, as discussed below, we have determined that Petitioner's noncompliance with section 483.13 should be evaluated based on review of the full record in light of the fact-intensive nature of the episode, rather than on only a narrow set of undisputed facts. We discuss some of the evidence here, but, on remand, the ALJ may further develop the record and make assessments including determinations on witness credibility (such as that about V.E., whose varying accounts of the episode the ALJ noted but said he could not evaluate on summary judgment, ALJ Decision at 8-9 n.7). The ALJ may also consider what weight to accord evidence in the record and what inferences should be drawn from it (without the constraints of the summary judgment standard), and make factual findings and conclusions.

Nurse V.E.'s accounting of the events on October 25 (even ignoring, as did the ALJ for purposes of summary judgment, any inconsistencies in her various statements) establishes a potential for more than minimal harm to residents. As the ALJ noted, and we agree, even accepting that V.E. might not have had a reason to think that either R1 or R2 could be at risk of abuse when she first left the room to check R2's chart, the situation *upon her return* should have alerted her to that potential risk. Upon her return, V.E. found the man, someone she did not know, standing near R1's bed, appearing to hold his pants up, with his shoe and belt on the floor. ALJ Decision at 9 (facts 16, 21). At that point, even in the version of her account most favorable to Petitioner, V.E. admitted that she noticed an odor of alcohol in the room and suspected that the man might have been drinking. She described the situation as odd and felt that she might need help to deal with a man apparently under the influence of alcohol. *Id.* at 9-10 (facts 21, 22). Yet she left

him alone with the residents while she went to look for a supervisor. *Id.* at 10 (fact 23). That, as the ALJ observed, is strong evidence of V.E.'s recognition of the potential risk of abuse of R1 posed by the situation V.E. encountered.[9] *Id.* at 9-10 (facts 21-25), 13-14, 15 ("[E]ven if Petitioner's staff had no reason to suspect [R1's] son might be abusing [R1] before [V.E.] entered the room, [V.E.] certainly had reason to suspect such abuse might occur based on her testimonial account of the incident."). We further agree with the ALJ that V.E.'s leaving the residents alone with R1's son the second time not only posed a risk of more than minimal harm to R1, but also to her roommate R2 and other residents, given the son's apparent intoxication and state of undress, since R1's son easily could have left the room. *Id.* at 14, 15, 19 (citing P. Ex. 15, at 2 and noting that given the close proximity of R1's son, the son could have heard R2's statement to V.E. that the son had been "messing with" his mother (R1) but that V.E. nevertheless made R2 repeat herself and questioned R2 about her statement within earshot of the son).

Furthermore, Petitioner's staff did not take reasonable action in response to the situation even on these undisputed facts. V.E. did seek out help from a supervisor, which, the ALJ commented, was not "inherently faulty." *Id.* at 15. Contrary to Petitioner's reading of the ALJ's analysis, however, the ALJ did not determine that V.E.'s decision to leave the room to get help rather than remain there and call for help "ipso facto was so unreasonable as to constitute a regulatory violation." RR at 24. Rather, the ALJ noted that in so doing V.E. left two residents alone with a partially undressed man V.E. did not know, but suspected might have been drinking, for at least two minutes. That action, the ALJ stated, and we agree, was a "manifestly unreasonable" response (ALJ Decision at 15), particularly where V.E. had available at least one option (i.e., summoning any needed help while remaining in the room, either by calling out or using a phone or call light) that would have been reasonable under the circumstances and which, if taken, would not have left two vulnerable elderly residents alone in a situation that V.E. evidently was not comfortable confronting alone. Moreover, in our view, the ALJ rightly rejected Petitioner's argument that V.E.'s actions were nevertheless reasonable because

[9] We have already stated that foreseeability here does not mean that staff is expected to be prescient in anticipating something Petitioner says is so rare as sexual abuse of a parent by an adult child. We have also rejected the argument that the deficiency stands or falls based on whether R1's son actually assaulted his mother sexually. However, even assuming that this type of abuse is an extremely rare occurrence, V.E. maintained that she did not learn that the man in question was R1's son until sometime after the incident. If V.E. did not know that fact, then she could not have based her decision to leave the room on some certainty that a son would not sexually assault his mother. Moreover, if V.E. did not know the identity of the man, as she has said, then she left a stranger who appeared under the influence of alcohol and was partially undressed alone with two residents, even after one of the residents said that the man had been "messing with" the other resident. That, we agree with the ALJ, was not a reasonable or responsible reaction.

she left the lights turned back on and the door open when she left to get her supervisor. *Id.* at 15-16. These measures were inadequate (or unreasonable under the circumstances) because the man "could easily have turned off the lights or closed the door, or both, in the time [V.E.] took to find her supervisor and return." *Id.* at 16. The ALJ also aptly observed that, "even with the lights on and the door open, [R1's] son could have (and indeed may have) acted abusively toward" R1 or R2 while he was left alone with the residents. *Id.*; *id.* n.16 (ALJ questioning the "efficacy" of such "minimal protective steps" since R1's son's judgment might have been impaired from drinking).[10]

Petitioner takes issue with the ALJ's determining that it was "manifestly unreasonable" for V.E. to leave the room under the circumstances, asserting that while V.E. could have stayed in the room and called for help as the ALJ stated (ALJ Decision at 15), V.E. nevertheless made an appropriate judgment call to leave and that V.E.'s decision to leave the room was consistent with facility policy. RR at 24. According to Petitioner, its staff members were told not to confront a potentially disruptive visitor alone, but to seek help from a supervisor. *Id.* at 12. This argument appears to be based on the testimony of J.D., Petitioner's Director of Nursing, who stated, in part, that the nurses were trained "not to confront or argue with visitors who might be impaired, or who are being loud or aggressive, but to get a supervisor . . . ." P. Ex. 18, at 2. But V.E. need not have confronted R1's son directly or engaged in an argumentative exchange with him to have called for help from the room.[11] Petitioner has not shown that such an action would have been inconsistent with the policy to get help rather than confront someone who appeared to be impaired, alone. Furthermore, Petitioner's written visitor policy, as explained by

[10] The ALJ recognized, too, the risk that abuse occurred in the form of nonconsensual exposure of R1's genitals to public view that was noted by the time V.E. and her supervisor T.W. returned, but stated that he could not find on summary judgment that R1's son exposed R1's genitals, much less that he did so without consent. ALJ Decision at 19 n.18. Although we are inclined to agree with the ALJ that the "*possibility* that [the son] did so illustrates vividly" the risk of abuse posed by leaving him alone (*id.*, ALJ's emphasis), we note that on remand the ALJ would be able to review the full record to make any finding, if he determines appropriate, on whether the son exposed R1's genitals.

[11] V.E. did not, for instance, describe a situation that made her fear for her own safety. Nor does V.E.'s accounting of the situation leading up to the time she left to get her supervisor T.W. reveal that the son was loud, aggressive, confrontational with V.E., or otherwise exhibiting behavior that reasonably could explain why at that very moment V.E. might have felt she had to leave the room.

S.M.H. (Vice President of Petitioner's parent company), contemplates taking actions appropriate to the circumstances in dealing with impaired or disruptive visitors, such as calling 911 or escorting such a person out of the facility. P. Ex. 13, at 4-5.[12] Thus, the policy does not contemplate that the *only* appropriate staff response to an impaired or disruptive visitor, under every possible set of circumstances, requires leaving residents alone to deal with the situation while looking for a supervisor.

In addition, relying on section 483.10(j)(1)(vii), Petitioner asserted below that its choices for dealing with the risk of abuse were constrained by the requirement to allow its residents immediate access to immediate family members or relatives. The ALJ observed, however, that, first, Petitioner in fact had allowed R1's son access to his mother because he was visiting her when V.E. noticed something was amiss and left to get her supervisor. Second, and more important, the ALJ said, once R1's son began to pose a reasonably foreseeable risk of abuse, Petitioner's duty to protect its residents "trumped" R1's right to visit with her son. ALJ Decision at 16. Lastly, the ALJ said, V.E. indicated that she was not aware that the person in question was R1's son and her testimony "manifests no concern over the man's right to visit" R1 and, therefore, section 483.10(j)(1)(vii) "presented no barrier to" V.E. *Id.*

Petitioner takes issue with the ALJ's reasoning, asserting that the ALJ assumed that nurses "*must* suspect unknown individuals of nefarious intent at least in some circumstances," which is "contrary to the plain intent of [the] regulation" on residents' right to have access to family members. RR at 11-12 (Petitioner's emphasis). In the same vein, Petitioner suggests that the ALJ somehow drew an inappropriate inference, arguing that the facility cannot simply remove or monitor a visitor, impinging on residents' visitation rights, merely because the visitor appears "suspicious" or "sketchy." *Id.* at 28-29; Reply Br. at 18. We disagree that the ALJ made any inappropriate judgment about the son based only on the son's "suspicious" appearance as Petitioner suggests, or that he determined Petitioner failed to comply with any requirement merely because it did not remove or monitor R1's son based only on such an appearance. We read the ALJ's rationale to mean that a facility's responsibility to protect its residents must be balanced with the residents' right to have access to their families, but that once a visitor, including a family member, poses a reasonably foreseeable risk of abuse to residents, the facility is responsible for taking protective action appropriate to the circumstances. We agree with the ALJ's rationale and reject Petitioner's suggestion (RR at 11-12) that the protection of residents is somehow never a reason for restricting visits by immediate family, as though

[12] Indeed T.W., the supervisor who returned to the room with V.E., told the man he would have to leave and escorted him from the room. ALJ Decision at 10 (fact 28), 16 n.17. This action appears to be consistent with facility policy and suggests that T.W. understood on October 25, 2014 that this action would be permissible under the policy.

the right to visit with family is an absolute one that the facility may not limit in any way. Indeed, Petitioner's abuse policy requires its staff to take appropriate steps to prevent the occurrence of abuse regardless of who the perpetrator is. CMS Ex. 16, at 1. And, the very fact that Petitioner has a policy on handling intoxicated visitors (e.g., escort such a visitor out, P. Ex. 13, at 4) contemplates the potential for risk posed by such visitors whether or not such visitors belong to a resident's family.

We therefore conclude that even the bare facts here, i.e., that V.E. left the two residents alone with an unknown man who smelled of alcohol, appearing to hold his pants up and with his belt and shoe on the floor, and about whom one of the residents expressed some concern (however ambiguous) while going to get help rather than remain with them and summon such aid, do establish a lack of substantial compliance with 42 C.F.R. § 483.13. However, on remand, the ALJ is not constrained to base his determination on the section 483.13 deficiency on this narrow set of undisputed facts related to V.E.'s accounting of the episode on October 25, 2014. The ALJ may consider on remand additional evidence bearing on the reasonable foreseeability of risk. Among the other evidence in the record potentially relevant to this determination, we note facility records suggesting the facility was aware from the date of admission of R1 that the person in question was R1's son and that he had been seen to be drunk prior to V.E.'s observations. *See, e.g.*, P. Ex. 5 and CMS Ex. 12, at 79 (various documents related to R1's October 14, 2014 admission into Petitioner's facility, bearing what appear to be the son's signatures as R1's legal representative and responsible party); P. Ex. 9, at 4 (October 20, 2014 nursing notes discussing a meeting with "son sponsor" of R1 and referring to him as R1's "caregiver"); CMS Ex. 9, at 46-47 (staff report that R1's son arrived around 1:30 p.m. on October 25, 2014, and smelled of alcohol). Moreover, during the survey, some staff members indicated awareness that the man found in the room shared by R1 and R2 on October 25 had previously visited the facility, apparently in an intoxicated state. CMS Ex. 9, at 16, 34, 43, 64; CMS Ex. 19, ¶ 13. One staff member told the surveyor that she had seen the son visit previously and described the son as loud and aggressive. CMS Ex. 9, at 38. Thus, there is record evidence which the ALJ might view as showing that staff had reason to know before V.E. entered the room on October 25 that R1's son's visits could raise red flags about the potential for more than minimal harm to residents.[13]

[13] Despite acknowledging that R1's son had visited the facility "about six times" between October 14, 2014, the date of R1's admission into Petitioner's facility, and October 25, 2014, Petitioner takes the position that its staff had no reason to think R1's son could pose a real risk of harm based on the prior visits. RR at 16-18. On remand, however, the ALJ may consider the conflicting evidence and determine whether the facility had prior notice that R1's son presented elevated concerns for intoxication and/or aggressive behavior that might affect residents. The ALJ may also consider on remand the significance, if any, of the disputed evidence concerning events after R1's son was removed from the facility.

The ALJ also may consider on remand additional evidence concerning the situation V.E. encountered on October 25, 2014, and the facility's response to that situation, to make findings of facts about which there is much dispute between the parties. The ALJ may consider, among other things, the variations between V.E.'s initial accounting of the situation (that she smelled alcohol when she first entered the room) and subsequent accounting in her sworn testimony (that she did not smell alcohol when she first entered the room) (ALJ Decision at 8-9 n.7) and whether V.E. took more than two or three minutes to return to the room (*id.* at 10 n.9), and how V.E. should or could have responded to the situation upon her return to the room after checking R2's chart. On remand, the ALJ, unencumbered by the constraints of the summary judgment standard, may make all appropriate determinations on the credibility of witnesses, assign appropriate weight to evidence, and draw reasonable inferences when finding facts.

In conclusion, the legal arguments made by Petitioner which we have rejected earlier are settled. We find, however, that the record as a whole presents a much broader picture of the context, events and aftermath surrounding the episode at issue. Since we remand, as explained below, to allow the ALJ to reconsider the immediate jeopardy determination, we find it more prudent to also provide the ALJ an opportunity to make findings of fact regarding the incident based on all of the evidence, evaluating weight and credibility, and drawing appropriate inferences. We therefore vacate the ALJ's decision and remand for further action by the ALJ consistent with this decision.

B. Section 483.75 – Tag F490

1. *A determination that a facility was noncompliant with section 483.75 (Tag F490) may, in appropriate circumstances, be derived from facts establishing noncompliance with section 483.13 abuse-prohibition requirements (Tag F223).*

"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." This is the overarching requirement governing facility administration set out in the introductory paragraph of section 483.75.

The ALJ determined that Petitioner violated section 483.75 requirements based on "[t]he same undisputed facts that support[ed]" the section 483.13 "noncompliance finding." ALJ Decision at 17-18 (citing *Stone Cnty. Nursing & Rehab. Ctr.*, DAB No. 2276, at 15 (2009); *Asbury Ctr. at Johnson City*, DAB No. 1815, at 11 (2002)[14]; *Odd Fellow & Rebekah Health Care Facility*, DAB No. 1839 (2002)). The ALJ wrote:

[14] The U.S. Court of Appeals for the Sixth Circuit affirmed DAB No. 1815. *Asbury Ctr. at Johnson City v. Dep't of Health & Human Servs.*, 77 F. App'x 853 (6th Cir. 2003). In *Asbury Center*, the Board stated: "[W]here a facility has been shown to be so out of compliance with program requirements that its residents have been placed in immediate jeopardy, the facility was not administered in a manner that used its resources effectively to attain the highest practicable physical, mental, and psychosocial well-being of each resident." DAB No. 1815, at 11 (as quoted in the ALJ Decision at 17).

> Any failure of management that adversely affects a resident constitutes a violation of § 483.75. I have already found that Petitioner violated . . . [sections] 483.13(b), (c)(1)(i), and, as I conclude later in the decision, CMS's determination that Petitioner's noncompliance posed immediate jeopardy to resident health and safety is not clearly erroneous. The same undisputed facts that support that noncompliance finding [Tag F223] also support my conclusion that Petitioner violated the administration requirement at 42 C.F.R. § 483.75. In addition, [V.E.'s] unreasonable response to the situation she found in [R1's] room reflects a failure of Petitioner's management to ensure direct care staff was trained to respond appropriately to such a situation, particularly one involving an intoxicated visitor.

Id. at 17-18.

Before the Board, Petitioner alludes to the ALJ's determination on section 483.75 by using the words "subsidiary citations" and states, "Since neither CMS nor the ALJ even purported to describe how [Petitioner's] administration failed, the basis for that citation is completely unclear." RR at 27 & 27 n.18. We understand Petitioner to be asserting that the ALJ did not explain specifically how the section 483.13 deficiency finding also supports a finding that Petitioner failed in its section 483.75 administration responsibilities.

The "Board has held that, in appropriate circumstances, a finding that a [facility] was noncompliant with section 483.75 may be derived from findings of noncompliance with other participation requirements." *Life Care Ctr. of Tullahoma,* DAB No. 2304, at 45 (2010), *aff'd, Life Care Ctr. Tullahoma v. Sec'y of U.S. Dep't of Health & Human Servs.*, 453 F. App'x 610 (6th Cir. 2011) (citing *Stone Cnty.*, DAB No. 2276, at 15-16); *see also Odd Fellow & Rebekah Health Care Facility*, DAB No. 1839, at 16 (stating that the existence of other deficiencies "may constitute a prima facie case that a facility has not been administered efficiently or effectively as required by section 483.75"). Such other deficiencies can arise from a variety of situations not limited to those involving physical abuse of residents, as several recent Board decisions show. *See, e.g., Madison Cnty. Nursing Home*, DAB No. 2895, at 12-13 (2018) (upholding on summary judgment a section 483.75 deficiency for supervisory and administrative lapses over time based on undisputed facts establishing noncompliance with sections 483.10(c)(2) and 483.13(c) for employee misappropriation of resident property); *Rockcastle Health & Rehab. Ctr.*, DAB No. 2891, at 20 (2018) (upholding a section 483.75 deficiency based on section 483.13

abuse violation and section 483.10(b)(4) violation for forced administration of medication posing immediate jeopardy); *Maysville Nursing & Rehab.*, DAB No. 2874, at 10-16 (2018) (upholding, in part, a section 483.75(*l*)(1) deficiency for failure to maintain clinical records on residents related to abuse violations under sections 483.13(b) and (c)); *Countryside Rehab. & Health Ctr.*, DAB No. 2853, at 23 (2018) (upholding a section 483.75 deficiency based on a violation of section 483.13(b) related to a failure to protect residents from unwanted sexual advances of a resident, as well as violations of sections 483.20(d) and 483.20(k)(2) for failure to revise the perpetrator-resident's plan of care in response to his inappropriate sexual behavior); *Fireside Lodge Retirement Ctr., Inc.*, DAB No. 2794, at 13 (2017) (upholding section 483.75 noncompliance determination on summary judgment based on same undisputed facts establishing facility's noncompliance with section 483.13(c) related to reporting and investigation of a fracture injury).

A deficiency that could affect resident safety and quality of life is of particular concern when determining whether that deficiency also implicates a failure of the facility's management and administration responsibilities. *Western Care Mgmt.*, DAB No. 1921, at 79 ("[A] finding of noncompliance under section 483.75 may be based on evidence of other deficient practices, especially those practices that affect a resident's safety, quality of life, and quality of care."). A deficiency that exposed residents to possible physical and as well attendant psychological and emotional abuse (as the deficiency under 42 C.F.R. § 483.13 described above certainly could) undoubtedly is one that could adversely affect resident safety and quality of life.

Therefore, we reject Petitioner's contention that the legal basis for the management deficiency finding is unclear or improperly derivative.

2. *The deficiency cited as Tag F490 for a violation of section 483.75 should be evaluated on the full evidentiary record.*

The issue as to the section 483.75 deficiency as derivative of the section 483.13 deficiency is whether the latter is indicative or a manifestation of a failure by Petitioner's management and administration to provide adequate training, supervision, and direction to staff (including V.E., who provided direct care to residents) concerning abuse of residents and handling of visitors. A facility provides such training, supervision, and direction by establishing facility resident care policy, educating its staff on that policy, and ensuring that the policy is implemented and followed.

The ALJ identified certain facts based on undisputed evidence of the facility's written abuse prevention policy, contained within its Human Resources Management Policies and Procedures Manual, a policy for dealing with intoxicated visitors, and related testimony proffered by Petitioner of S.M.H. (Vice President of Quality for Petitioner's parent company) and J.D. (the facility's Director of Nursing Services) about how facility nurses were trained to deal with visitors who might be impaired. ALJ Decision at 7 (facts 1-6) (citing CMS Ex. 16; P. Ex. 13, at 4-5; P. Ex. 15, at 4; P. Ex. 18, at 2). However, the discussion in pages 17-18 of the ALJ Decision in which the ALJ addressed the section 483.75 deficiency does not tie the policies and related testimony that were the subject of facts 1-6 to the ALJ's conclusion that the undisputed facts that establish the section 483.13 deficiency also establish the derivative section 483.75 deficiency. Moreover, although the ALJ correctly stated that a section 483.75 deficiency may be based upon deficiency findings on other program requirements that put residents in immediate jeopardy (ALJ Decision at 17), the ALJ did not explain, as we have said elsewhere, how the narrow set of undisputed facts concerning the section 483.13 deficiency that were the basis for his also finding a section 483.75 deficiency supported immediate jeopardy.

The record includes evidence bearing on the gaps between policy and staff performance that would be relevant to determine whether the section 483.13 findings demonstrate a related management failure in violation of section 483.75, but which the ALJ did not address. We note, in particular, a section of the Manual that addresses reporting and investigation of alleged abuse, headed "Prevention," requires the facility to identify, intervene in, and correct situations in which abuse is likely to occur and, its staff, to report such situations as soon as they are identified. CMS Ex. 16, at 4. A section headed "Protection" requires the facility to take all appropriate measures "immediately" to secure residents' safety and well-being in situations involving visitors and states that "[s]aid measures may include disallowing contact between the resident and alleged perpetrator while an investigation is conducted." *Id.* at 4-5. The ALJ may consider whether the referenced policy language or other relevant provisions bear on the issue of whether Petitioner met its administrative responsibilities.

Also important to the administration issue is evidence of relevant training, supervision, and direction of staff. We note that Petitioner submitted its abuse training materials headed "Preventing Resident Abuse" as Petitioner's exhibit 4, pages 1-5. There is also evidence that J.D., Director of Nursing Services, gave a "Lecture/In-Service" training on abuse, evidently on October 13, 2014. CMS Ex. 17, at 33-35. However, Petitioner's exhibit 4 on its face does not indicate exactly when the materials were used to train its

staff, or include specific language concerning the handling of situations involving visitors who may be impaired. As for the October 13, 2014 training materials, they likewise do not include content specific to handling impaired visitors, though V.E. signed her name on October 13, 2014 to indicate her attendance. CMS Ex. 17, at 34. (The signature dates of other attendees vary. *Id.* at 33-35.)

On remand, the ALJ may determine whether and how well Petitioner had trained its staff before the incident and also whether the staff nevertheless failed to follow the policy, evidencing a lapse in management's responsibility to ensure effective and consistent implementation of the established policy.[15] *See Life Care Ctr. of Gwinnett*, DAB No. 2240, at 12-13 (2009), *appeal dismissed on Petitioner's motion*, No. 09-12843-C (11th Cir. Apr. 6, 2010) (Facilities execute their responsibilities for meeting the Part 483 requirements "in part through their selection, training and supervision of their staff."). The failure by staff to implement established policy concerning a visitor who staff had reason to know could pose a risk of harm to residents may thus implicate a failure by management to ensure, by training and supervision, that the staff follow that policy.

C. Immediate Jeopardy

The ALJ determined, based on the undisputed facts and viewing the evidence in the light most favorable to Petitioner, that the deficiencies cited as Tags F223 and F490 not only "had the potential to cause more than minimal harm to Petitioner's residents" thus establishing noncompliance with sections 483.13(b), (c)(1)(i), and 483.75, but that CMS did not clearly err in concluding that the noncompliance posed immediate jeopardy to resident health and safety. ALJ Decision at 18-21. The ALJ reasoned that V.E.'s leaving R1 and R2 alone with the person who V.E. later learned was R1's son "for at least two minutes and possibly three (not 'a few moments')," even with the lights on and the door open, exposed R1 and R2 to "a variety of possible risks of harm," only one of which was "a risk of sexual abuse in the form of nonconsensual exposure of a resident's genitals to public view." *Id.* at 18-19; *id.* at 20 (similar discussion, citing P. Ex. 15, at 4-5). Also, noting that when nurse T.W. questioned R1's son about his conduct he reportedly became somewhat belligerent, the ALJ reasoned that the risk was not limited to R1. R1's son also posed a risk to R2, the roommate, who had told nurse V.E. that R1's son was

[15] The record includes training materials specific to sexual abuse, dated October 27, 2014. CMS Ex. 17, at 1-3. On November 6, 2014, the Director of Nursing Services trained staff, V.E. among them, on protecting residents against suspected perpetrators of abuse. *Id.* at 9. The latter training included instructions to "immediately" "secure the safety and well being of the resident"; "[r]emove the perpetrator from the victim" by asking that person "to leave the room"; "[u]se call light to render for help"; "[h]oller down the hall for assistance"; and "DO NOT leave the resident alone in room with the perpetrator." *Id.* Thus, there is evidence that, *after* the incident, Petitioner trained staff on handling visitors who could harm residents. That training included specific instructions to use a call light to get help and not to leave the resident alone in the room with the perpetrator.

"messing with" his mother, as well as other residents, because R1's son "easily could have left the room through the (now conveniently open) door in that two-minute window and roamed the facility still intoxicated and partially undressed." *Id.* at 19 (citing P. Ex. 15, at 2, 4), 20. The ALJ also observed that later "[s]omeone even thought it appropriate to call 911," which we understand to mean that the ALJ noted that staff appreciated the risk of harm posed by the situation. *Id.* at 20 (citing P. Ex. 18, at 2).

The ALJ rejected Petitioner's "conclusory" arguments concerning CMS's immediate jeopardy determination as unpersuasive. *Id.* at 20. The ALJ stated, "I cannot say that even when viewing the evidence in the light most favorable to Petitioner I am 'left with the definite and firm conviction' that CMS made a mistake in determining that Petitioner's noncompliance was at least likely to cause serious harm to Petitioner's residents." *Id.* at 20 (quoting *Easley v. Cromartie*, 532 U.S. 234, 242 (2001) ("In applying [the clearly erroneous] standard, . . . a reviewing court must ask whether, 'on the entire evidence,' it is 'left with the definite and firm conviction that a mistake has been committed.'")). The ALJ went on to state, "To the contrary, one could reasonably conclude from the evidence, even when viewed in Petitioner's favor, that [V.E.'s] actions gave rise to an immediate jeopardy situation, at least with respect to [R1 and R2], if not to all the residents who might have been harmed by [R1's] son when he was left alone for two minutes while intoxicated and partially undressed." *Id.* at 20-21.

We do not disagree with the ALJ's analysis concerning possible harm to which facility residents were exposed by R1's son. The ALJ correctly stated that Petitioner has a heavy burden because section 498.60(c)(2) requires the ALJ and the Board to defer to CMS's immediate jeopardy determination absent clear error. *Id.* at 19-20. Nevertheless, the ALJ's analysis is not fully consistent with the standard for immediate jeopardy, which requires the *likelihood of serious harm.* "Immediate jeopardy" is a "situation in which the [facility's] noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident." 42 C.F.R. § 488.301. Immediate jeopardy need not be based on the occurrence of actual harm but, rather, requires only the "likelihood" that serious harm may result from the noncompliance. *Crawford Healthcare & Rehab.*, DAB No. 2738, at 17 (2016); *see also Franklin Care Ctr.*, DAB No. 2869, at 9 (2018) (An immediate jeopardy deficiency is one that creates more than a "potential" for or possibility of serious harm or death; it must have either "caused" actual serious harm, impairment, or death, or have been "likely to cause" that result.); *Daughters of Miriam Ctr.*, DAB No. 2067, at 10 (2007) (The term "likely" means "probable" and "reasonably to be expected," and suggests that the degree of probability that an event may occur is greater than "possible" or "potential."); *Innsbruck HealthCare Ctr.*, DAB No. 1948, at 5 (2004) ("[M]ere risk" or possibility of harm is not equivalent to a likelihood of harm.).

The ALJ did not specifically articulate what serious harm was likely to occur and what made such an outcome likely. The ALJ did articulate a *potential or risk for more than minimal harm* posed by a person who apparently was under the influence of alcohol and partially undressed, left alone for a brief period in a room with two vulnerable, elderly residents. There is no question in our minds that a potential or risk for more than minimal harm to R1 and R2 and possibly other facility residents existed based on these facts. Nevertheless, the ALJ's immediate jeopardy analysis does not sufficiently address how *only* the narrow set of undisputed facts on which the ALJ rendered his decision demonstrated a *likelihood* (that is, the probability, as opposed to mere possibility) of *serious* harm. As we stated earlier, the parties do dispute the facts concerning what transpired on October 25, 2014, and the ALJ's findings on those disputed factual issues could bear on the immediate jeopardy question.

We therefore vacate the summary judgment ruling so that the ALJ may: (1) consider and evaluate all of the record evidence, make all appropriate credibility and weight determinations, draw appropriate inferences, and make factual findings to determine whether the violations of sections 483.13(b), 483.13(c)(1)(i), and 483.75 should be upheld; (2) if he upholds them, determine whether the immediate jeopardy determination may be upheld as not clearly erroneous, applying the correct standard and evaluating the likelihood of serious harm; and (3) if he determines that the immediate jeopardy determination was not clearly erroneous, assess the reasonableness of the CMPs as imposed.

Lastly on this issue, Petitioner states that "it is not at all clear how the 'possibility' of abuse constitutes 'immediate jeopardy' noncompliance for an extended period." RR at 33. We have already considered this statement in the full context of Petitioner's arguments concerning foreseeability of abuse and actual harm. We have rejected the arguments that actual harm must be shown to support the deficiency and that the only relevant question on foreseeability is the likelihood that the precise scenario of incestuous sexual abuse could or would occur. Petitioner appears to conflate his argument about actual (as opposed to possible) harm for purposes of determining whether the cited deficiency should stand with his argument about whether any such deficiency upheld posed immediate jeopardy. Of course, evidence that abuse actually occurred is relevant to (though as we said not necessary for) determining whether a deficiency should be cited. And, if a deficiency involving actual abuse is cited, the fact of actual abuse could affect a determination on the "seriousness" (scope and severity) of the noncompliance. *See* 42 C.F.R. § 488.404(b) ("[A]ctual harm" is one factor considered to determine the "seriousness" of a violation.). No actual harm is required to establish immediate jeopardy – the focus instead is on whether harm was likely to occur and, if so, if that harm was likely to be serious in nature.

CMS made its immediate jeopardy determination based on the full picture of what transpired and the ALJ is to reverse that determination only if he finds clear error – a highly deferential standard. On remand, the ALJ may consider whether his findings based on review of the entire record demonstrate clear error in finding a likelihood of serious harm to any resident.

D. Tags F225 and F226

CMS cited three immediate jeopardy level deficiencies – Tags F223, F226, and F490 – based on the November 7, 2014 state survey results. CMS determined that the deficiencies posed immediate jeopardy from October 25 through November 6, 2014. It determined that Petitioner had abated immediate jeopardy but remained out of substantial compliance with the cited deficiencies as of November 7, 2014. Based on a December 18, 2014 revisit survey, the state agency found Petitioner had completed corrective actions to the November 7, 2014 citations on December 9, 2014. P. Ex. 2. The ALJ addressed Tags F223 and F490, but not Tag F226. ALJ Decision at 6 n.5 (stating that those allegations of noncompliance he was addressing supported the imposition of enforcement remedies, including the CMPs and the reasonableness of the CMP amounts).

During the ALJ proceedings, CMS asserted that the survey results supported another deficiency, Tag F225, not cited in the SOD, for a violation of the requirement to investigate abuse under section 483.13(c)(3). CMS asserted that it may raise a new deficiency before the ALJ so long as Petitioner is given adequate notice of the factual basis for the citation. CMS Pre-hearing Br. at 8 n.3. The ALJ did not address Tag F225 in his decision.

Petitioner states that CMS "alleged for the first time" in its prehearing brief that Petitioner violated section 483.13(c)(3), but "described no separate evidentiary or legal basis for adding" Tag F225. RR at 9. Also, stating that the ALJ did not address Tag F225 "as well as certain other 'tags' that CMS cited and Petitioner appealed," Petitioner asserts that the U.S. Court of Appeals for the Ninth Circuit has held that where CMS "has not correlated parts of the CMP to specific citations – that is, where the CMP may reflect cumulative weight of all of the citations (as CMS' own CMP calculation tool expressly provides) – an ALJ must decide every appealed citation, since setting aside some may demand that the CMP be reduced." *Id.* at 5-6 n.4 (citing *Plott Nursing Home v. Burwell*, 975 F.3d 975 (9th Cir. 2015)). Petitioner asserts that "[t]hat result plainly is applicable here." *Id.* at 6 n.4.

We do not construe the vague words "as well as certain other 'tags' that CMS cited and Petitioner appealed" (*id.* at 5-6 n.4) as sufficient to raise a dispute specific to the ALJ's determination not to address certain deficiencies, including, namely, Tag F226, which was cited and appealed below.[16] In any case, in *Plott*, the sole authority Petitioner invokes, the Ninth Circuit reversed in part *Plott Nursing Home*, DAB No. 2426 (2011), in which the Board held that the ALJ was not required to uphold or set aside every deficiency finding that Plott (a California facility) had appealed. The court in *Plott* held that if a facility appeals a deficiency, the deficiency must either be dismissed or reviewed. *Plott*, 779 F.3d at 985-989. The Board is not bound to follow *Plott* in this case, which involves a facility in Alabama, within the Eleventh Circuit. *See Rockcastle*, DAB No. 2891, at 23-24 (rejecting a similar argument relying on *Plott* by a facility in Kentucky, within the Sixth Circuit) and cited cases.

Moreover, unlike Plott, which had "argue[d] not that immaterial determinations must nevertheless be reviewed, but rather that the unreviewed determinations were, in fact, material" (*Plott*, 779 F.3d at 986), Petitioner here merely hints that a separate analysis of Tag F225 and/or Tag F226 could have somehow resulted in a reduction of the CMPs. RR at 5-6 n.4 (asserting that where, as here, CMS "has not correlated parts of the CMP to specific citations . . . an ALJ must decide every appealed citation, since setting aside some may demand that the CMP be reduced"). We note, however, that Petitioner did not appeal that part of CMS's deficiency determination concerning the $250 per-day CMP, the duration for which that CMP was imposed, or the deficiencies on which that CMP was predicated. Nor has Petitioner specifically raised any argument before the ALJ or the Board concerning the duration of immediate jeopardy, or the duration of noncompliance below the immediate jeopardy level, or the CMP amounts imposed ($5,000 per day for the immediate jeopardy period; $100 per day from November 7 through December 1, 2014). Accordingly, to date, Petitioner has not given any reasoned explanation of whether and how addressing either Tag F225 or Tag F226 could or would have reduced its CMP liability. Nevertheless, since we are remanding this case for adjudication based on the full record, a determination of whether additional analysis of Tag F225 and/or Tag F226 is warranted will be for the ALJ to make.

[16] On appeal, a petitioner "must specify the issues, the findings of fact or conclusions of law with which the party disagrees" and, also, "the basis for contending that the findings and conclusions are incorrect." 42 C.F.R. § 498.82(b); *see also Guidelines*, "Starting the Review Process" at ¶ (d) (similar language). Moreover, on appeal, the Board does not consider issues not raised in the request for review, or issues which could have been presented to the ALJ but were not. *Guidelines*, "Completion of the Review Process" at ¶ (a).

Conclusion

We vacate the ALJ Decision and remand this case for further ALJ actions consistent with the foregoing discussion.

/s/
Leslie A. Sussan

/s/
Constance B. Tobias

/s/
Susan S. Yim
Presiding Board Member