Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Karcher Estates,
(CCN: 13-5110),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-11-815

Decision No. CR2632

Date: September 28, 2012

DECISION

Following a complaint survey, the Idaho Department of Health & Welfare (state agency) determined that Karcher Estates (Petitioner or facility) was not in substantial compliance with certain Medicare participation requirements, and that its noncompliance posed immediate jeopardy to the health and safety of one of its residents. Based on the state agency's findings, the Centers for Medicare & Medicaid Services (CMS) imposed a per-instance civil money penalty (CMP) of $5,000 and denied the facility's nurse aid training and competency evaluation program (NATCEP) for two years.

For the reasons explained below, I find that Petitioner was not in substantial compliance with the participation requirements at 42 C.F.R. § 483.13(b) and (c) for the period the state agency cited, and that the enforcement remedies are reasonable. I therefore sustain the per-instance CMP of $5,000 and denial of the facility's NATCEP.

I. Case Background

Petitioner is a long-term care facility in Nampa, Idaho that participates in the Medicare and Medicaid programs. At issue in this case is the care (or absence of care) provided to

a female resident of Petitioner's facility, referred to throughout these proceedings as "Resident 1" (R1). R1 suffered a stroke in early 2008 that resulted in, among other things, right hemiparesis and aphasia. She was admitted to Petitioner's facility shortly thereafter. At all times relevant to this case, R1 was not able to speak but would communicate by nodding her head, gesturing, or using a communication board. While each party characterizes the incident giving rise to the complaint survey differently, the parties do not dispute the following events: on March 21, 2011, a certified nursing assistant (CNA) observed a male acquaintance and frequent visitor of R1 with his hands under R1's shirt, on her chest and breasts, while the two were alone in the facility's dining area. The CNA immediately left the dining area without stopping the conduct. The CNA discussed her observations with other nursing staff, but did not immediately notify the facility's director of nursing (DON). Upon reentering the dining area, the CNA said "hello" to announce her presence, which prompted the acquaintance to remove his hands from R1. The CNA then notified the DON about the situation, and the DON, in turn, directed the CNA to notify the facility's social worker about the incident. Once the social worker learned of the incident, he notified R1's family. A family member then contacted the police as well as the state ombudsman and reported the incident as sexual abuse.[1]

The state agency completed a survey of Petitioner's facility on March 31, 2011, and found, among other things, that certain staff members in the facility had known of the intimate activity between R1 and her acquaintance for a substantial period, but never assessed R1's ability to consent or her actual consent to such activity in light of her aphasia and instances of confusion and difficulty with decision-making. Based on its findings, the state agency determined that Petitioner was not in substantial compliance with Medicare program requirements, including, most significantly, the abuse prevention requirements set forth at 42 C.F.R. § 483.13(b) and (c). According to the state agency, Petitioner's noncompliance posed immediate jeopardy to the health and safety of R1. The state agency also found that the facility abated the immediate jeopardy on March 31, 2011, based on the facility's corrective action plan. After a revisit survey on June 1, 2011, the state agency determined that the facility achieved substantial compliance with Medicare participation requirements as of April 27, 2011.

Based on the state agency's findings, on April 18, 2011, CMS imposed a per-instance CMP of $5,000, denied payment for new Medicare and Medicaid admissions (DPNA) effective May 3, 2011, and, as required by statute, denied approval of the facility's NATCEP for two years. CMS later rescinded its DPNA because the facility had achieved substantial compliance prior to the effective date of that enforcement remedy.

[1] The Nampa Police Department conducted a brief investigation but did not charge R1's male acquaintance with a crime or take any further action.

Petitioner requested a hearing to challenge the state agency's finding of noncompliance at an immediate jeopardy level and CMS's enforcement remedies. I held a hearing from March 5-8, 2012, in Boise, Idaho, where I admitted CMS Exhibits (CMS Exs.) 1-25 and 27-32 as well as Petitioner's Exhibits (P. Exs.) 1-37. Each party also presented testimony from several witnesses. A transcript of these proceedings (Tr.) is incorporated into the record, subject to the minor typographical changes already provided to the parties. Each party has submitted a post-hearing brief (Br.) and reply brief (Reply Br.).

II. Statutory and Regulatory Framework

The Social Security Act (Act) establishes the requirements that a long-term care facility must meet to participate in the Medicare and Medicaid programs, and authorizes the Secretary of Health and Human Services (Secretary) to promulgate regulations implementing those statutory requirements. Act §§ 1819, 1919.[2] Specific Medicare participation requirements for long-term care facilities are at 42 C.F.R. Part 483. A long-term care facility must remain in substantial compliance with program requirements to participate in Medicare. 42 C.F.R. § 483.1(b). "Substantial compliance" means "a level of compliance with the requirements of participation such that any identified deficiencies pose no greater risk to resident health or safety than the potential for minimal harm. 42 C.F.R. § 488.301. By contrast, "noncompliance" means "any deficiency that causes a facility not to be in substantial compliance." *Id.* A "deficiency" is a violation of a statutory or regulatory participation requirement. *Id.*

The Act authorizes the Secretary to impose enforcement remedies against a long-term care facility for failure to comply substantially with the federal participation requirements. The Secretary may not continue Medicare payments to a long-term care facility for more than six months after the facility is first found not to be in substantial compliance. Act § 1819(h)(2)(C). If a facility does not return to substantial compliance within three months, the Secretary must deny payments for all individuals admitted to the facility after that date – commonly referred to as the mandatory or statutory DPNA. Act § 1819(h)(2)(D).

The Secretary has delegated to CMS and the states the authority to impose remedies against a long-term care facility not in substantial compliance with program participation requirements. State agencies survey facilities on behalf of CMS to determine whether the facilities comply with federal participation requirements. 42 C.F.R. §§ 488.10-.28, 488.300-.335. The regulations specify the enforcement remedies that CMS may impose

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

if a facility is not in substantial compliance with Medicare requirements. 42 C.F.R. § 488.406.

CMS may impose a per-day CMP for the number of days a facility is not in substantial compliance or a per-instance CMP for each instance of the facility's noncompliance. 42 C.F.R. § 488.430(a). A per instance CMP, which CMS imposed in this case, may range from $1,000 to $10,000, and the range is not affected by the scope and severity of the facility's noncompliance. 42 C.F.R. § 488.438(a)(2).

A long-term care facility may request a hearing before an administrative law judge (ALJ) to challenge a noncompliance finding and enforcement remedies. Act §§ 1128A(c)(2), 1866(h); 42 C.F.R. §§ 488.408(g), 498.3(b)(13). The hearing before an ALJ is *de novo*. *The Residence at Salem Woods*, DAB No. 2052 (2006); *Cal Turner Extended Care*, DAB No. 2030 (2006); *Beechwood Sanitarium*, DAB No. 1906 (2004); *Emerald Oaks*, DAB No. 1800 (2001); *Anesthesiologists Affiliated*, DAB CR65 (1990), *aff'd*, 941 F.2d 678 (8th Cir. 1991). A facility may appeal a "certification of noncompliance leading to an enforcement remedy." 42 C.F.R. § 488.408(g)(1); 42 C.F.R. §§ 488.330(e), 498.3. However, the choice of remedies, or the factors CMS considered when choosing remedies, is not subject to review. 42 C.F.R. § 488.408(g)(2). A facility may only challenge the scope and severity level of noncompliance if a successful challenge would affect the range of the CMP that may be imposed or impact the facility's authority to conduct a NATCEP. 42 C.F.R. § 498.3(b)(14), (d)(10)(i).

The standard of proof, or quantum of evidence required, is a preponderance of the evidence. CMS has the burden of coming forward with the evidence and making a *prima facie* showing of a basis for imposition of an enforcement remedy. Petitioner bears the burden of persuasion to show by a preponderance of the evidence that it was in substantial compliance with participation requirements or any affirmative defense. *Batavia Nursing & Convalescent Ctr.*, DAB No. 1904 (2004), *aff'd*, 129 F. App'x. 181 (6th Cir. 2005); *see Hillman Rehab. Ctr.*, DAB No. 1611 (1997), *aff'd*, No. 98-3789, 1999 WL 34813783 (D.N.J. May 13, 1999).

III. Issues

The issues before me are:

1. whether Petitioner was in substantial compliance with the abuse prevention requirements at 42 C.F.R. § 483.13(b)-(c);

2. if Petitioner was not in substantial compliance, whether its noncompliance posed immediate jeopardy to the health and safety of its residents; and

3. if Petitioner was not in substantial compliance, whether the enforcement remedies imposed are reasonable.

As discussed below, I find that Petitioner did not comply substantially with 42 C.F.R. § 483.13(b) and (c) because it failed to implement its abuse prohibition policy to assess certain residents for the potential risk of abuse and did not intervene in any way after observing R1 — aphasic with inconsistent communication skills and levels of cognitive ability — and a male acquaintance engaging in intimate activity over a prolonged period. Petitioner's noncompliance based on these deficiencies is a sufficient basis for the enforcement remedies imposed. I need not and therefore do not address the issue of whether R1's male acquaintance did, in fact, abuse R1 sexually on March 21, 2011 or whether R1 consented to that intimate activity.

IV. Findings of Fact, Conclusions of Law, and Discussion

I make five findings of fact and conclusions of law (FFCL) to support this decision. Each FFCL is set forth as a separate heading in bold and italic type, followed by a discussion for that FFCL.

1. *The facility had policies and procedures prohibiting abuse of its residents, but did not implement those policies and procedures in its care of R1.*

Section 483.13 requires that the facility develop a written abuse prohibition policy. 42 C.F.R. § 483.13(c). Consistent with this requirement, the facility developed "A Guide to Abuse Prevention," which includes policies and procedures prohibiting abuse and also establishing report and investigation procedures. *See* CMS Ex. 14.[3] The facility policy states, in relevant part, that "[r]esidents at greater risk for abuse and neglect will be assessed by the facility." CMS Ex. 14, at 4. Under the policy, the facility will also evaluate residents with specified characteristics to determine "the potential to be at greater risk for abuse and neglect." *Id.* at 4 ¶ 2. Among the stated characteristics are "[n]onverbal residents or other sensory deficits." *Id.* The policy further states that "[g]reater risk residents will be identified through the RAI [resident assessment instrument] process." *Id.* at 4 ¶ 3. By regulation, a comprehensive assessment using the RAI must include, among other things, a "cognitive pattern" evaluation, and the facility

[3] CMS did not challenge any substantive provisions of the facility's abuse prohibition policy. Accordingly, I accept for the purposes of this decision that the policy sufficiently complies with regulatory requirements.

must perform an RAI-based assessment once each year.[4] 42 C.F.R. § 483.20(b). The comprehensive assessment utilizing the RAI must be used for a resident's plan of care. *Id.* § 483.20(d).

The facility policy also states that certain "staff advocates," specifically social services, "will be assigned to monitor and identify resident abuse or the potential for abuse and neglect." CMS Ex. 14, at 4 ¶ 5. In addition, the policy requires staff to report any instance of abuse or suspected abuse to the DON. *Id.* at 12 ¶¶ 2, 4. The DON, in turn, must "immediately examine the resident following notification of the incident." *Id.* at 12 ¶ 6.

The parties do not dispute that R1 was a "nonverbal resident" for all times relevant to this case. CMS Br. 10; P. Br. 2. By its own policy, the facility had to evaluate R1 for the potential to be at greater risk for abuse. CMS Ex. 14, at 4 ¶ 2. The facility's records, however, do not show that it ever performed such an evaluation prior to the March 21, 2011 incident. In addition, Petitioner does not cite any contemporaneous clinical notes showing the facility performed such an evaluation during the RAI process. Rather, Petitioner offers an empty claim by its DON, years after the fact, that its staff evaluated R1 during R1's initial RAI process in 2008 and determined that she was not at greater risk for abuse. *See* Tr. 879-80. But without any clinical notes supporting its evaluation or determination, the self-serving testimony that the facility carried out its policy is not sufficient evidence that the facility performed the evaluations as its policy required. *See Western Management Corp.*, DAB No. 1921 at 52 (2004) ("[A] factfinder is not obligated to indulge in such speculation and is entitled to assume, absent contrary evidence, that a resident's medical records accurately reflect the care and services provided (or not provided).").

Moreover, the DON testified that she determined during the RAI process, albeit without documenting, that R1 was not at greater risk for abuse based on R1's ability to "make her needs known" and having "the capability of moving away from the visitor, anytime she wanted to." Tr. 880. The DON's testimony, however, places the burden on R1 to protect herself (by "moving away from the visitor") and act as her own advocate (by "making her needs known") if she was being abused. In doing so, the DON upends the role of the facility to protect R1 from abuse in the first instance. *See* 59 Fed. Reg. 56,116, 56,130 (Nov. 10, 1994) ("Our obligation is to protect the health and safety of every resident, including those that are incapable of perception or are unable to express themselves."). Participation requirements make the facility more than a passive entity waiting for R1 to come forward with reports of abuse and, meanwhile, protect herself from potential abuse.

[4] The facility must also assess each resident on a quarterly basis using the "quarterly assessment instrument" specified by the state agency. 42 C.F.R. § 483.20(c). Here, it appears that the facility used the RAI during the quarterly assessments as well as the annual assessments of R1. *See generally* CMS Ex. 23 (collected assessment records).

See 42 C.F.R. § 483.13(c) (requiring facility to develop and implement policies that prohibit abuse, and not merely respond to reports of abuse).

This record also shows that facility staff had to "anticipate needs" for R1, to which she would nod affirmative or negative responses. CMS Ex. 18, at 1-59. But nothing shows that staff anticipated any needs related to the intimate activity between R1 and her male acquaintance, including determining whether she could consent or even whether she needed privacy. It is disingenuous, therefore, for the DON to assert that R1 could "make her needs known" and so was not at greater risk of abuse because, presumably, she could alert the DON to potential abuse. *See* Tr. 880. There is a significant difference between R1 making her needs known as it relates to hunger, thirst, pain, sleep, and so on — her basic activities of daily living — and to express her needs related to potential abuse.[5] *See* CMS Ex. 30, at 2-3 (declaration of expert witness describing communication skills needed to convey consent to intimate activity). Alternatively, R1 could not spontaneously tell the nursing staff that she wanted privacy to engage in the intimate activity. *See* CMS Ex. 30, at 4.

Relevant clinical notes also show that R1 did not always understand facility staff, that staff could not always understand R1, and that her responses to questions were "inconsistent" and "not reliable." *See* CMS Ex. 23, at 98 (quarterly minimum data set (MDS) showing R1 was "sometimes understood" and "usually understands"); CMS Ex. 19, at 5 (notes of social worker, stating that R1's "yes/no responses" were "inconsistent" and "not reliable."); *see also id.* at 3 (same). In addition, many RAI-based assessments showed that R1 had "moderately impaired" cognitive skills for daily decision-making. *See* CMS Ex. 23, at 63, 75, 87, 97. The facility's roster-sample matrix listed R1 as having "cognitive impairment." CMS Ex. 21, at 2. Also, the social worker noted that it was "diff[icult] to accurately assess cog[native] status [secondary to] having aphasia . . . ." CMS Ex. 19, at 3; *see id.* at 4 ("Not able to accurately assess knowledge of place, [or the] complete date."). R1 also had a prolonged history of urinary tract infections

[5] R1's medical record shows she would respond by nodding when the staff anticipated her needs. *See, e.g.*, CMS Ex. 18, at 3 ("[R1] able to make needs known by pointing to things she wants - or answering by nodding head to yes/no questions."). The record also shows R1 could use a communication board to convey her needs to facility staff. CMS Ex. 19, at 3. But nothing in the record shows that R1 had the ability or necessary tools to communicate the much more subtle notions involved in determining whether she was in an intimate relationship and whether she was a willing or unwilling participant.

(UTIs), which contributed, at times, to "some confusion" and "processing problems." *See* CMS Ex. 18, at 2, 26-32.[6]

The DON testified that there "has to be other areas of concern, not just being hard of hearing or non-verbal" to be at "greater risk" for abuse. Tr. 879. Being "moderately impaired" for daily decision-making, having difficulty understanding caretakers, having difficulty being understood by others, and having a history of UTIs associated with "confusion" should have been additional "areas of concern" that the DON considered in her evaluation, but no documentation or testimony shows that she did. Thus, the DON's basis for determining that R1 was not at greater risk for abuse, even if it had been documented, was haphazard and incomplete.[7] Accordingly, the facility staff failed to evaluate R1 in accordance with its abuse prohibition policy.

The required evaluations became even more critical once facility staff knew that R1 and her male acquaintance were engaging in intimate activity. The exact date of when the intimate activity began is not material because, as is clear from the record, the activity had been going on with staff knowledge for a "long time," at least one year prior to the March 21, 2011 incident. CMS Ex. 20, at 8-13. At the point the intimate activity began, the situation had potential for actual abuse. R1 was vulnerable because of her communication deficiencies and impaired decision-making abilities, which made it difficult for staff to assess her cognitive status. *See* CMS Ex. 19, at 3-5. There was no apparent manner by which R1 could have communicated complex and intimate needs and desires related to her activity with her male acquaintance. Moreover, her responses to simple questions were "inconsistent" and "not reliable," adding to the uncertainty of her

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[6] Petitioner argues that R1 only had UTIs early on in her stay at the facility, and the UTIs were resolved by the time R1 began the intimate activity with the male acquaintance. P. Br. 3. Petitioner overlooks the progress note of "chronic UTI" on July 30, 2010, which was within the time the intimate activity was occurring, and reasonably shows that staff were still cognizant that R1's history of UTIs remained an area of concern. CMS Ex. 18, at 2. In any event, the abuse prohibition policy was not triggered upon the intimate activity beginning, but upon R1 being a resident of the facility, and R1's history of UTIs and confusion was another warning sign the facility overlooked in recognizing the potential for abuse, even before R1 began the intimate activity with the acquaintance.

[7] Petitioner also argues that the nurses' daily interaction with R1 gave them foundation to determine whether she was at greater risk for abuse. P. Reply Br. 2. Again, nothing in R1's medical record prior to March 21, 2011 documents the scope of the interaction (from an assessment perspective) or shows exactly *how* the nurses' interaction with R1 provided an appropriate evaluation of whether R1 was at greater risk for abuse. I do not give any weight to assertions of facility staff made during the pendency of this case that have no support in the medical records contemporaneous with the incident at issue.

consent absent some level of evaluation. *Id.* at 5. While the MDS noted that R1 was "moderately impaired" for decisions related to daily activities (CMS Ex. 23, at 63, 75, 87, 97), it is reasonable that R1 would have also been impaired in making more complex decisions, such as the decision to engage in intimate activity. The facility certainly should have recognized that being cognitively impaired for decisions related to her activities of daily living might also mean that R1 was impaired for decision-making in other areas of her life as well. Petitioner's attempt now to downplay the importance of the MDS by arguing that it did not provide enough information to determine whether R1 could consent (P. Br. 10) actually underscores the need for the facility to provide a thorough evaluation of R1's cognitive status in light of the information revealed in the MDS, the other clinical notes showing R1's mental and communication deficiencies, and knowledge of R1's intimate activity with her male acquaintance. As Petitioner concedes, the MDS alone, and therefore the RAI process alone, could not be a sufficient basis to determine whether R1 consented to the intimate activity with her acquaintance. It is therefore inconsistent for Petitioner to claim that it evaluated R1 during the RAI process and determined she was not at greater risk for abuse (Tr. 880), but argue that the MDS, which documents the RAI process, is not sufficient to conclude whether R1 could and did consent to the intimate activity (P. Br. 10). Whether R1 could consent to intimate activity was critical to whether R1 was at greater risk for abuse. Accordingly, Petitioner's position on these issues is not persuasive.

Petitioner also argues that the length of R1's relationship with her male acquaintance should be considered, and, if it is considered, that it demonstrates that there was no potential for abuse. P. Br. 13. But Petitioner's argument overlooks that even long-standing friends can be abusive and R1 may have, at any time, determined she no longer wanted to engage in such activity with her male acquaintance. In fact, shortly after the March 21, 2011 incident, the social worker noted that R1 "was consistent" that she no longer wanted to engage in intimate activity with her male acquaintance.[8] CMS Ex. 19, at 6; *see also* CMS Ex. 13, at 13 (statement of R1's daughter, explaining that when told she would be given privacy, R1 "adamantly shook her head in a negative response," and that "each response indicated that it was not her wish to be left alone with [her male

[8] Notes from other facility staff state that R1 told one of her daughters that the activity was consensual and that she wanted to still receive visits from her male acquaintance. *See, e.g.*, CMS Ex. 13, at 22 (statement from DON describing conversation with R1's daughter wherein R1 conveyed to her daughter that "she did want [her male acquaintance to continue to visit her"); *but see id.* at 29 (psychiatric evaluation report, stating that R1 "indicates this was clearly her choice to engage in such activity . . . . She is also clear that if [her son] does not want her to see [her male acquaintance] anymore, that this will be okay with her."). The facility prohibited the male acquaintance from further visits with R1, showing that the staff understood R1 no longer wanted the activity to continue. *See* CMS Ex. 20, at 4-5.

acquaintance]"). Because the facility continually failed to follow its abuse prohibition policy, it could not have otherwise known of R1's desire to stop the intimate activity.

Moreover, Petitioner summarily concludes that the situation prior to March 21, 2011 was not abusive. Even if that is true, the facility had to recognize, under its own policy, situations that had to the *potential* for abuse, and the circumstances here — intimate activity involving a nonverbal resident with inconsistent responses to simple questions, trouble understanding others, and, at times, "moderate impairment" in decisions for daily activities — certainly raised that potential. *See* CMS Ex. 14, at 4 ¶ 5. Prior to the March 21 incident, however, the facility failed to recognize the situation as having the potential for abuse. The facility's nursing staff stated that they were embarrassed about walking in on R1 and her male acquaintance, and would immediately leave the room if they happened upon the two engaged in intimate activity. CMS Ex. 20, at 9. The nursing staff's bashfulness related to the intimate activity involving a resident with severe communication deficiencies and difficulty making decisions related to her daily activities, let alone intimate activity, does not meet the standard of care the facility should have provided, and shows another failure to follow the facility's abuse prevention policy.

Also under its policy, the facility "staff advocates" were obliged to monitor R1 and identify the potential for abuse and neglect. CMS Ex. 14, at 4 ¶ 5. The policy states that "social services" represents the "staff advocates," but it is not clear whether social services is the only staff advocates or not. In any event, the social worker at the facility, Ronald Tryon, noted repeatedly in his progress notes that R1 was "inconsistent [with] nodding head, comm[unication] board," that staff had to anticipate R1's needs, and that staff had to offer R1 choices when appropriate. CMS Ex. 19, at 3-6. These notes certainly do not represent a clinical evaluation of R1's cognitive function, but they nevertheless show that R1 was not effective with her communication and suggest that there may have been cognitive impairment. *See, e.g.*, *id.* at 5 ("Needs reminders, cuing; family helps [with] dec[ision] making."); *see also* Tr. 821 ("To be able to take in and comprehensively solve problems in these situations, could be challenging for [R1]."). Intimate activity, when coupled with the social worker's documented knowledge of R1's possible cognitive impairment should have been identified as a situation with the potential for abuse. The social worker did not document R1's intimate activity with her acquaintance until after the March 21, 2011 incident. In fact, the social worker acknowledged that he did not know about the intimate activity before the incident occurred. Tr. 809, 815. But as the facility's "staff advocate" the social worker should have been aware of the situation soon after it started, and certainly well before the March 21, 2011 incident. *See* Tr. 792 (testimony of social worker, stating "[p]art of my job description is to know what's going on with all my residents"). The facility policy placed that obligation squarely on social services; knowledge of the situation was not based on a clinical evaluation or other medical assessment, but rather on an understanding of the circumstances of R1's daily life that could have led to the potential for abuse. The social worker even discussed R1 with nursing staff, who had knowledge of the intimate activity,

on a regular basis. Tr. 662. Despite these discussions, knowledge of the intimate activity never left a small group of CNAs (Tr. 644), marking a systemic failure in effective communication and calling into question the accuracy of the social worker's knowledge of R1's psycho-social status. There can be no doubt that engaging in intimate activity with a male acquaintance is certainly within the purview of social situations about which the social worker should have known. By not carrying out the duties of the "staff advocate," the social worker failed to identify the intimate activity along with R1's communication and cognitive issues as a situation that was potentially abusive, and, in turn, failed to implement the facility policy.

Petitioner adamantly argues that the situation did not have the potential to be abusive because R1 consented to the activity and facility staff understood the intimate activity as consensual.[9] Petitioner's argument is not persuasive. Petitioner relies on assessments, medical determinations, and staff assertions made after the March 21, 2011 incident. The central issues before me, however, relate to the facility's inaction prior to that incident. While these later assessments may show that R1 consented to the intimate activity, it does not absolve the facility from its failure to perform those evaluations when it first learned of the intimate activity, as its own policy required. *See* CMS Ex. 14, at 4 ¶¶ 3, 5.

Also, Petitioner dismisses any possible deficiencies in R1's cognitive abilities through conclusory assertions. There is no evidence showing R1 actually consented or had the ability to consent to the intimate activity prior to March 21, 2011. Petitioner relies on the statements of nursing staff that observed R1 grabbing the male acquaintance's hand when he removed it from her chest, placed her hand on the male acquaintance's thigh, and, at other times, "seemed to be" consenting. *See* CMS Ex. 20, at 8, 10, 11. Appearances — especially when those appearances manifest themselves in settings of intimacy, potential embarrassment, and unclear communications — can be deceiving, and without fulfilling its obligation to protect R1 from potential abuse by evaluating R1 and the situation as a whole, the facility could not summarily dismiss the activity as consensual. *See* CMS Ex. 14, at 4 ¶ 5 (requiring facility to "monitor and identify . . . the potential for abuse and neglect"). Here, the lack of any clinical evaluation or notes means there was simply no way of concluding with any certainty prior to March 21, 2011, whether R1 had the cognitive ability, communication skills, and intent to consent to intimate activity with the male acquaintance.

Moreover, the manner in which the facility handled the March 21, 2011 incident also highlights a breakdown in implementing its abuse prohibition policy. The CNA that

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[9] Petitioner's position implies that whether R1 considered herself abused is relevant to whether the facility had to protect R1 from a potentially abusive situation. However, the regulatory drafters rejected such a position many years ago. *See* 59 Fed. Reg. at 56,130. The facility's obligation to prevent abuse of vulnerable residents applies without regard to a resident's perception of the activity. *Id.*

observed the intimate activity in the dining room that day immediately left without stopping the activity. CMS Ex. 20, at 8; Tr. 639. Had the CNA been properly trained to recognize potentially abusive situations — per facility policy — she should have promptly reported the incident to the DON. *See* CMS Ex. 14, at 12 ¶ 4. Rather, the CNA discussed the incident with other CNAs, and, only after fifteen minutes had passed, she reported it to the DON. Tr. 627. After the DON learned of the incident, she took no immediate action, even though she acknowledged that she was unsure whether it was abuse or not. Tr. 869. The DON directed staff to notify the social worker, but never attempted to stop the activity. By policy, the DON had to "immediately examine [R1] following notification of the incident." CMS Ex. 14, at 12 ¶ 6. Whether or not the CNA reported the incident as potential abuse was not the "trigger" of the DON's responsibility under the policy and regulations to recognize the potential for abuse. Also, because she was unsure whether R1 was being abused at that moment, and based on her knowledge of R1, the DON should have recognized the situation as having the potential for abuse. Tr. 869; CMS Ex. 14, at 7. Instead, the DON took no action other than to refer the situation to the social worker, contrary to the facility policy on handling reported instances of possible abuse. CMS Ex. 14, at 12.

In sum, the facility repeatedly failed to carry out several provisions of its abuse prohibition policy. The facility staff reached conclusory determinations about R1, and ignored or completely failed to recognize a situation with the serious potential for abuse. Even when a CNA reported the situation to facility administrators, they were uncertain of the course of action the facility policy mandated to ensure the safety of R1.

2. *The facility was not in substantial compliance with 42 C.F.R. § 483.13(c) because it did not implement its abuse prohibition policies.*

Section 483.13 requires that the facility "implement" its policy prohibiting abuse. 42 C.F.R. § 483.13(c); *Columbus Nursing & Rehab. Ctr.*, DAB No. 2247 at 11 (2009). The Board has said that, when reviewing the implementation of a facility's abuse prohibition policy, the focus is on "whether the facts . . . surrounding each instance demonstrates an underlying breakdown in the facility's implementation of the provisions" of the anti-neglect and anti-abuse policies. *Oceanside Nursing & Rehab. Ctr.*, DAB No. 2382 at 11 (2011) (citing *Columbus Nursing*, DAB No. 2247 at 27).

Here, as discussed above, Petitioner did not implement its abuse prohibition policy after many opportunities to do so. Facility staff never evaluated R1 for the potential to be at greater risk for abuse even though she was "nonverbal," and the facility policy required an evaluation for such residents. CMS Ex. 14, at 4 ¶ 2. R1 was a resident of Petitioner's facility for approximately three years before the March 21, 2011 incident occurred; the number of RAI-based assessments was significant. *See* CMS Ex. 23 (providing 11 completed MDS forms). Yet, the facility never determined with certainty whether R1 was or was not at greater risk for abuse based on her aphasia and cognitive impairments

related to her daily activities. Also, at least one year passed since the facility had become aware of the intimate relationship with R1 and her male acquaintance and the March 21, 2011 incident, but the facility staff still did not evaluate R1 for the potential to be at greater risk for abuse, and even failed to recognize during that time that the situation had the potential for abuse, contrary to facility policy. CMS Ex. 14, at 4 ¶¶ 2, 5. Providing vague testimony years later that the facility followed its policy despite there being no contemporaneous documentation to that effect, as Petitioner does here (P. Br. 18-19 (*citing* Tr. 879-80)), does not show compliance with the facility policy, especially when records show a vulnerable resident, specifically identified in the policy as a resident needing an evaluation of her abuse risk, engaged in repeated intimate activities while staff intentionally turned their backs. The staff knew of the situation, knew of R1's status, and did nothing. The facility policy clearly requires that the facility do *something* with a resident in R1's situation — "evaluate," "identify," "monitor," "assess" — and doing *nothing*, *i.e.*, recording no evaluation, no identification, no monitoring, no assessment, shows an underlying breakdown in the implementation of that policy.

Petitioner did not "implement" its abuse prohibition policy with regard to its care of R1, and therefore was not in substantial compliance with 42 C.F.R. § 483.13(c).

3. *The facility was not in substantial compliance with 42 C.F.R. § 483.13(b) because it did not timely ensure R1 was free from abuse.*

A facility must ensure that its residents are free from abuse of any kind. *See* 42 C.F.R. § 483.13(b). The Board has explained that actual abuse need not occur in order to show that the facility failed to protect and promote a resident's right to be free from abuse. *Western Care Management*, DAB No. 1921 at 13. As explained above, Petitioner did not identify the potential for abuse with regard to R1's intimate activity with her male acquaintance. R1 had serious deficiencies in her communication abilities, and her mental status was not consistent. CMS Ex. 23, at 98; CMS Ex. 19, at 3-5. By regulation, the facility had to ensure that R1 was not being abused in any way, including by her acquaintance. 42 C.F.R. § 483.13(b); *Holy Cross Village at Notre Dame, Inc.*, DAB No. 2291 at 7 (2009) (concluding that a facility violated section 483.13(b) if it "failed to protect residents from reasonably foreseeable risks of abuse"). Even though staff observed R1 and her male acquaintance as smiling when engaged in what "seemed to be consensual" intimate activity (CMS Ex. 20, at 8-11), the facility did nothing to ensure that R1 was not subject to abuse and could, at any time, be free from unwanted contact with her male acquaintance. The facility had no system in place for R1 to convey to staff that she no longer wanted to be involved in the intimate activity with the male acquaintance, in part because the facility failed to recognize the potential for abuse. Certainly, a non-verbal resident with uncertain cognitive function, difficulty understanding others, and who engaged in intimate activity created a "reasonably foreseeable risk of abuse" that the facility had to address and ensure was not, or did not become, actual abuse. *Holy Cross Village*, DAB No. 2291 at 7; *see also Western Care*

Management, DAB No. 1921 at 15. Because Petitioner failed to recognize the potential for abuse, it had no way of ensuring that R1 was free from abuse and did not substantially comply with 42 C.F.R. § 483.13(b).

Petitioner argues that this case is similar to *Meadville Convalescent Home*, DAB CR1434 (2006), wherein I determined that the facility was in substantial compliance with section 483.13(b) because the record did not support CMS's claim that a resident lacked the cognitive ability to consent to sexual activity with another resident. But in *Meadville*, CMS concluded that the resident did not have the capacity to consent based solely on the MDS form. DAB CR1434 at 8-9. Here, however, CMS did not reach a conclusion about R1's actual capacity to consent, but demonstrated that the facility took no steps to ensure that the intimate activity was consensual or that R1 could even consent to it, contrary to regulatory standards. CMS also relies on clinical documentation and notes other than the MDS, though the MDS is still relevant here. Also in *Meadville*, the facility immediately stopped the sexual activity, following its policy and contributing to its overall substantial compliance. DAB CR1434 at 13. But here, as stated above, the facility did nothing to intervene even when its own policy required it. Therefore, I do not find my prior decision in *Meadville* to be persuasive to the outcome of the case currently before me.

4. *The immediate jeopardy determination was not clearly erroneous*.

By regulation, an immediate jeopardy determination must be upheld unless it is clearly erroneous. 42 C.F.R. § 498.60(c)(2). Under this standard, CMS's determination of the scope and severity of the facility's noncompliance is presumed to be correct, and Petitioner's burden to prove it is clearly erroneous is a "heavy one." *Mississippi Care Ctr. of Greenville*, DAB No. 2450 at 15 (2012) (citing *Maysville Nursing & Rehab. Facility*, DAB No. 2317 at 11 (2010)).

The facility's policy, as required by regulation, must prohibit abuse of residents, not just provide means of reacting to instances of abuse. *See* 42 C.F.R. § 483.13(c); CMS Ex. 14, at 4. As explained above, the facility did not evaluate R1 for the potential to be at greater risk of abuse, which violated its abuse prohibition policy. Had R1 not been involved in intimate activity with a male acquaintance, the failure to evaluate R1 may have been a less severe level of noncompliance. Certainly, repeatedly not evaluating R1, who had a characteristic indentified as needing an at-risk assessment, was serious, especially when the resident had other factors contributing to her overall risk of abuse. But Petitioner's failure to implement its policy became critical when facility staff observed R1 and her male acquaintance involved in intimate activity, but did nothing in response. The staff did not even communicate with the appropriate members of the facility for more than one year that R1 was engaging in such activity. The likelihood of R1's suffering serious harm by way of repeated sexual abuse was very apparent, and certainly "reasonably foreseeable," but the facility never conclusively determined whether R1 was a knowing and willing participant in the activity. The facility staff reached assumptions about R1's

consent based on their brief observations of the activity. But the facility never broached the subject with R1, and certainly never assessed R1 to determine whether she could even comprehend the nature of what she was doing. Moreover, the facility repeatedly failed to monitor R1 and identify the situation as one that had the potential for abuse.

The implementation of the facility's policies broke down in a serious and systematic way, creating a situation that had the likelihood of serious harm to R1 and residents in her situation. Petitioner has come forward with evidence showing that R1 may have consented to the intimate activity, but none of this evidence addresses the facility's response (or lack thereof) to the activity during the year it was occurring. To ignore a situation for that long, then offer evidence after the fact that it was acceptable does not mitigate the severity of failing to implement the policy in the first place. Petitioner's "no harm, no foul" position cannot support an argument that CMS was clearly erroneous in its determination of immediate jeopardy. The facility inexplicably took no action while the reasonable likelihood of abuse existed and was known, though not understood, by staff. Moreover, "immediate jeopardy" does not require actual harm, but only the likelihood of serious harm, which was certainly present while Petitioner ignored the intimate activity between R1, a clearly a vulnerable resident, and her male acquaintance for more than one year.

5. *The enforcement remedies imposed are reasonable.*

To determine whether the enforcement remedies, including the $5,000 per-instance CMP and NATCEP denial are reasonable, I apply the factors listed in 42 C.F.R. § 488.438(f): (1) the facility's history of noncompliance; (2) the facility's financial condition; (3) factors specified in 42 C.F.R. § 488.404; and (4) the facility's degree of culpability, which includes neglect, indifference, or disregard for resident care, comfort, or safety. The absence of culpability is not a mitigating factor. The factors listed in 42 C.F.R. § 488.404 include: (1) the scope and severity of the deficiency; (2) the relationship of a 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.

In reaching a decision on the reasonableness of the CMP, I must consider whether the evidence supports a finding that the amount of the CMP is at a level reasonably related to an effort to produce corrective action by a provider with the kind of deficiency found, and in light of the above factors. I am neither bound to defer to CMS's factual assertions, nor free to make a wholly independent choice of remedies without regard for CMS's discretion. *Barn Hill Care Center*, DAB No. 1848, at 21 (2002).

The per-instance CMP of $5,000 is at the middle penalty range for any scope and severity level of noncompliance. *See* 42 C.F.R. § 488.438(a)(2) (stating the range for per-instance CMPs is $1,000 to $10,000). Overall, the per-instance CMP is modest when considering

the possible penalty CMS could have imposed. Petitioner has not presented evidence of any financial hardship limiting is ability to pay the CMP imposed. While Petitioner has a history of noncompliance, none are at an immediate jeopardy level, and CMS has never imposed an enforcement remedy against Petitioner. CMS Ex. 10. The highest scope and severity level of noncompliance in these prior incidents was "G," meaning isolated harm that was not immediate jeopardy. CMS cited Petitioner at a G level on four prior occasions. CMS Ex. 10, at 2, 4.

I find that the facility here is culpable for the deficiency because it did not follow its own policy to recognize a situation that had the potential for abuse, and because it failed to take any action upon learning R1, a vulnerable resident, was involved in an intimate relationship with a male acquaintance. The facility's conduct and corresponding inaction show indifference to the safety of R1, who had well-documented difficulty communicating, understanding, and making decisions related to daily living. Staff intentionally avoided the situation and failed to recognize that it had the potential for serious actual harm by way of abuse. As explained above, the severity in the likelihood of harm to R1 because of the facility's failure to take any action when required was certainly immediate jeopardy, and shows a complete breakdown in the staff understanding and implementing abuse prevention policy and procedures. Based upon the severity of Petitioner's noncompliance and the fact that the situation would not have been recognized or addressed, as well as the facility's culpability by being indifferent to the situation ripe for abuse, the mid-range CMP is reasonable. Also, denial of Petitioner's NATCEP is mandatory when a CMP is $5,000 or above, meaning that I have no authority to reverse or otherwise modify that enforcement remedy. *See* Act § 1819(f)(2)(B). I therefore find the penalties imposed are reasonable.

V. Conclusion

For all of the foregoing reasons, I find that Petitioner failed to implement its written abuse prohibition policies and procedures, and was therefore not in substantial compliance with 42 C.F.R. § 483.13(c). I also find that Petitioner did not recognize the situation that had a reasonable potential for abuse, did not ensure its resident was free from abuse, and therefore was not in substantial compliance with 42 C.F.R. § 483.13(b). Petitioner failed to meet its heavy burden of showing that CMS was clearly erroneous in its determination of immediate jeopardy. Finally, the enforcement remedies that CMS imposed are reasonable. Accordingly, I sustain CMS's determinations and enforcement remedies.

/s/
Richard J. Smith
Administrative Law Judge