Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Neighbors Rehabilitation Center, LLC
(CCN: 14-5440),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-14-1263

Decision No. CR4895

Date: July 21, 2017

DECISION

Neighbors Rehabilitation Center, LLC, (Petitioner), a skilled nursing facility (SNF), challenges the Centers for Medicare & Medicaid Services' (CMS) determination that it was not in substantial compliance with 42 C.F.R. § 483.25(h) (requirement to ensure that the resident environment remains as free of accident hazards as is possible and each resident receives adequate supervision and assistance devices to prevent accidents). Petitioner also challenges CMS's imposition of an $83,800 civil money penalty (CMP). For the reasons discussed below, I affirm CMS's determination and conclude that the CMP is reasonable.

I. Background

The Social Security Act (Act) sets forth requirements for a SNF's participation in the Medicare program and authorizes the Secretary of Health and Human Services (the Secretary) to promulgate regulations implementing those statutory provisions. 42 U.S.C. § 1395i-3. The Secretary's regulations are found at 42 C.F.R. Parts 483 and 488. To participate in the Medicare program, a SNF must maintain substantial compliance with program participation requirements. To be in substantial compliance, a SNF's

deficiencies may "pose no greater risk to resident health or safety than the potential for causing minimal harm." 42 C.F.R. § 488.301. "Noncompliance" means "any deficiency that causes a facility to not be in substantial compliance." 42 C.F.R. § 488.301.

The Secretary contracts with state agencies to conduct periodic surveys to determine whether SNFs are in substantial compliance. 42 U.S.C. § 1395aa(a); 42 C.F.R. § 488.10. The Act also authorizes the Secretary to impose enforcement remedies against SNFs that are not in substantial compliance with Medicare program participation requirements. 42 U.S.C. § 1395i-3(h)(2). The regulations specify the enforcement remedies that CMS may impose. 42 C.F.R. § 488.406. Among other enforcement remedies, CMS may impose a per-day CMP for the number of days a SNF is not in substantial compliance. 42 C.F.R. § 488.430(a). A per-day CMP may range from either $50 to $3,000 per day for less serious noncompliance, or $3,050 to $10,000 per day for more serious noncompliance that poses immediate jeopardy to the health and safety of residents.[1] 42 C.F.R. § 488.438(a). "Immediate jeopardy" exists when "the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident." 42 C.F.R. § 488.301. If CMS imposes a CMP based on a noncompliance determination, then the facility may request a hearing before an administrative law judge (ALJ) to challenge the noncompliance finding and enforcement remedy. 42 U.S.C. §§ 1320a-7a(c)(2), 1395i(h)(2)(B)(ii)); 42 C.F.R. §§ 488.408(g), 488.434(a)(2)(viii), 498.3(b)(13).

Petitioner is a SNF located in Byron, Illinois, that participates in the Medicare program. The Illinois Department of Public Health (state survey agency) conducted a "Complaint Investigation" survey that commenced on February 20, 2014, and was completed on February 26, 2014. CMS Exhibit (Ex.) 1 at 1; CMS Ex. 12 at 1; CMS Ex. 20. The surveyors detailed their findings on a Statement of Deficiencies (Form CMS-2567) form. CMS Ex. 12. The surveyors concluded that Petitioner violated 42 C.F.R. § 483.25(h) (F323) at the immediate jeopardy level (scope and severity level J)[2] because:

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[1] CMS recently increased the CMP amounts to account for inflation in compliance with the Federal Civil Penalties Inflation Adjustment Act Improvements Act of 2015, 104 Pub. L. No. 114-74, 129 Stat. 584, 599. The new adjusted amounts apply to CMPs assessed after August 1, 2016, for deficiencies occurring on or after November 2, 2015. *See* 81 Fed. Reg. 61,538 (Sept. 6, 2016). As the deficiencies alleged in this case occurred prior to November 2, 2015, the increased CMP amounts do not apply in this case.

[2] Scope and severity levels are used by CMS and state agencies when selecting remedies. The scope and severity level is designated by letters A through L, selected by CMS or the state survey agency from the scope and severity matrix published in the State Operations Manual, chap. 7, § 7400.5 (Sep. 10, 2010). A scope and severity level of A, B, or C indicates a deficiency that presents no actual harm but has the potential for minimal harm, which is an insufficient basis for imposing an enforcement remedy. Facilities with

> [Resident 1] was touching/masturbating the genitalia of [Resident 2] on 2/4/14 and 2/[8]/14.[3] [Petitioner] failed to implement safety interventions and supervise [Resident 1] to prevent contact with [Resident 2].

CMS Ex. 12 at 1.

The surveyors further concluded that:

> [Petitioner] failed to closely supervise [Resident 1] who was exhibiting hypersexual behaviors on the Dementia Unit. This failure contributed to [Resident 2] seeking out a female resident [Resident 3] and fondling her breasts on 2/11, 2/19, and 2/20/14.

CMS Ex. 12 at 1.

On February 27, 2014, the state agency sent Petitioner a copy of the Statement of Deficiencies and a notice informing Petitioner that the state agency directed Petitioner to perform in-service training to its employees by March 23, 2014, on abuse prevention, recognition, and identification. CMS Ex. 1 at 1-2. Further, the state agency recommended that CMS impose a per-day CMP on Petitioner. CMS Ex. 1 at 2.

In an April 3, 2014 initial determination, CMS noted the findings and conclusions by the state agency and imposed a $5,150 per day CMP for 16 days from February 4, 2014 through February 19, 2014, and a $100 per day CMP commencing on February 20, 2014, and continuing until Petitioner returned to substantial compliance. CMS Ex. 6 at 1-2.

On April 8, 2014, the state agency conducted a revisit survey at Petitioner's facility and determined that Petitioner had returned to substantial compliance with Medicare

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deficiencies of a level no greater than C remain in substantial compliance. 42 C.F.R. § 488.301. A scope and severity level of D, E, or F indicates a deficiency that presents no actual harm but has the potential for more than minimal harm that does not amount to immediate jeopardy. A scope and severity level of G, H, or I indicates a deficiency that involves actual harm that does not amount to immediate jeopardy. Scope and severity levels J, K, and L are deficiencies that constitute immediate jeopardy to resident health or safety. The matrix, which is based on 42 C.F.R. § 488.408, specifies which remedies are required and optional at each level based upon the frequency of the deficiency.

[3] The original text provides the date as "2/7/14"; however, the team leader for the survey team, Robin Conley, RN, testified that the correct date was "2/8/14." CMS Ex. 38 at 2.

participation requirements on March 6, 2014. CMS calculated the total CMP to be $83,800, consisting of 16 days of a $5,150 per day CMP and 14 days of a $100 per day CMP. CMS Ex. 8 at 1.

Petitioner timely requested a hearing before an ALJ. Petitioner disputed CMS's determination that Petitioner was not in substantial compliance with 42 C.F.R. § 483.25(h) and that such noncompliance resulted in immediate jeopardy for residents. Petitioner also contested the imposition of a CMP. Following receipt of Petitioner's hearing request, I issued an Acknowledgment and Initial Pre-hearing Order (Pre-hearing Order). In that order, I directed the parties to file written direct testimony for all witnesses they wanted to present.

In compliance with my Pre-hearing Order, CMS filed a pre-hearing brief and 39 proposed exhibits. One of the proposed exhibits was the written direct testimony for CMS's witness (CMS Ex. 38), a state surveyor who was the team leader for the complaint survey that ended on February 26, 2014. Petitioner filed its pre-hearing brief (P. Pre-hearing Br.) along with six proposed exhibits, which included written direct testimony from three witnesses (P. Exs. 1, 2, 6). Petitioner requested to cross-examine CMS's witness and CMS requested to cross-examine one of Petitioner's witnesses, Petitioner's Director of Nursing (P. Ex. 6). CMS did not object to any of Petitioner's proposed exhibits; however, Petitioner objected to CMS Exs. 21 and 22. Based on these submissions, I set a hearing date, overruled Petitioner's objections to CMS's proposed exhibits, and admitted CMS Exs. 1-39 and P. Exs. 1-6 into the record. Notice of Hearing at 1-2; *see also* Hearing Transcript (Tr.) at 8-9.

On May 25, 2016, I held a video teleconference hearing at which I heard testimony on cross-examination from the state surveyor and Petitioner's Director of Nursing. Tr. at 4, 13-37, 38-59. After the hearing, CMS and Petitioner filed posthearing briefs (CMS Br., P. Br.) and reply briefs (CMS Reply; P. Reply).

II. Issues

The issues presented are:

1. Whether Petitioner was in substantial compliance with Medicare participation requirements at 42 C.F.R. § 483.25(h) from February 4, 2014 through March 5, 2014.

2. If Petitioner was not in substantial compliance, was CMS's determination that immediate jeopardy existed from February 4, 2014 through February 19, 2014 clearly erroneous.

3. If Petitioner was not in substantial compliance with program requirements, is the penalty imposed on Petitioner reasonable.

III. Findings of Fact

Resident 1

1. Resident 1 was a male born in 1933 who was first admitted to Petitioner's facility on October 15, 2012. CMS Ex. 23 at 5.

2. Resident 1's diagnoses included "Dementia, unspec[ified] w/ behav[ioral] disturb[ance] (Primary) . . . bipolar, atypical depressive . . . ." CMS Ex. 23 at 5, 70.

3. On January 27, 2014, Petitioner's staff noted in his care plan that Resident 1 would yell at staff and make "inappropriate comments." CMS Ex. 23 at 64.

4. Resident 1's January 28, 2014 Minimum Data Set shows he had: the highest score for "Cognitive Patterns" (i.e., a Brief interview for Mental Status (BIMS) score of 15); no problems with "Mood"; limited "Behavior" concerns (no hallucinations or delusions), although his behavior was considered worse since the prior assessment; answered all questions regarding his "Preferences for Customary Routine and Activities" without assistance; few limitations with his "Functional Status"; and "Active Diagnoses" that included non-Alzheimer's dementia and depression (other than bipolar). CMS Ex. 23 at 13-22, 24-25.

5. In a January 29, 2014 entry into Resident 1's care plan, Petitioner's staff decided that Resident 1 "would benefit from residing on the dementia care unit," but noted that he is "higher functioning." CMS Ex. 23 at 61.

Resident 2

6. Resident 2 was a male born in 1948 who was first admitted to Petitioner's facility on January 17, 2014. CMS Ex. 24 at 5.

7. Resident 2's diagnoses included Alzheimer's disease (primary diagnosis); dementia, unspecified with behavioral disturbance; amnesia, transient global; and loss of hearing. CMS Ex. 24 at 5.

8. Resident 2's January 24, 2014 Minimum Data Set shows he had: highly impaired hearing; unclear speech; the ability to understand others sometimes; moderately impaired vision; a BIMS score of 99 due to inability to complete the interview; short-term and long-term memory problems; moderately impaired ability to make

decisions; disorganized or incoherent thinking; a severity score of 99 for the Resident Mood Interview due to inability to complete interview; physical and verbal behavioral symptoms directed at others that could significantly intrude on the privacy or activities of others; wandered, and the wandering significantly intruded on the privacy and activities of others; the need for extensive assistance for transfers, mobility in bed, moving around his unit of Petitioner's facility, dressing, toileting, and personal hygiene; balance and stability problems and used a wheelchair; and "Active Diagnoses" that included Alzheimer's disease, Non-Alzheimer's dementia, amnesia, and hearing loss. CMS Ex. 24 at 12-15, 17-18, 21-22, 24-25, 42.

9. On January 31, 2014, Petitioner's staff was able to determine that Resident 2's BIMS score was a 3 out of 15. CMS Ex. 32 at 11.

Resident 3

10. Resident 3 was a female born in 1936 who was first admitted to Petitioner's facility on January 11, 2007. CMS Ex. 25 at 5.

11. Resident 3's diagnoses included Alzheimer's disease as a primary diagnosis. CMS Ex. 25 at 5.

12. Resident 3's January 14, 2014 Minimum Data Set shows she had: highly impaired hearing; the ability to sometimes understand what others are saying; a BIMS score of 0 out of 15; wandered, and the wandering significantly intruded on the privacy or activities of others, and was worse than the prior assessment; the need for limited assistance for transfers, walking in her room, and bed mobility, but needed extensive assistance for dressing, toilet use, and personal hygiene; and "Active Diagnoses" that included Alzheimer's disease and depression. CMS Ex. 25 at 12-13, 18, 21, 24-25.

Incidents Involving Residents 1, 2, and 3

13. Resident 1 could access Resident 2's room through a bathroom that they both shared. CMS Ex. 21 at 8.

14. On February 4, 2014, a CNA observed Resident 1 "masturbating" Resident 2 in Resident 2's room, but noted that the resident "was quiet and made no signs of object[ing]." CMS Ex. 23 at 47; CMS Ex. 24 at 49. In response to Petitioner's inquiry into the matter, Resident 1 stated that he did not have any kind of a

relationship with Resident 2 and Resident 2 stated that he could not recall any incident with Resident 1.[4] CMS Ex. 29 at 1.

15. At some time before February 5, 2014, Petitioner placed Resident 1 on 15 minute checks. CMS Ex. 23 at 47.

16. On February 5, 2014, Resident 2 indicated to a CNA at Petitioner's facility that "I've heard theres [sic] rumors going around about me that im [sic] homosexual, I am not a homosexual, im [sic] married and have a wife." CMS Ex. 24 at 49.

17. On February 8, 2014, one of Petitioner's nurses found Resident 1 in Resident 2's room "stroking" Resident 2's penis. Resident 2 was quiet. The nurse told Resident 1 to leave Resident 2's room, which Resident 1 did. CMS Ex. 23 at 47; CMS Ex. 24 at 52. In response to Petitioner's inquiry into the matter, Resident 1 stated that he did not have any kind of a relationship with Resident 2 and Resident 2 stated that he could not recall any incident with Resident 1. CMS Ex. 29 at 2.

18. On February 11, 2014, Petitioner's staff discussed with Resident 1 the possibility of changing his room. CMS Ex. 23 at 47.

19. On February 11, 2014, Resident 2 fondled the breasts of Resident 3. CMS Ex. 14 at 1; CMS Ex. 21 at 6. Staff separated Residents 2 and 3. CMS Ex. 21 at 6. However, when Petitioner's staff reported this incident to supervisors, staff were informed not to intervene unless a resident was resisting. CMS Ex. 14 at 1; *see also* CMS Ex. 21 at 6; Tr. 58.

20. Resident 2 sexually touched Resident 3 several times between February 11 and 20, 2014, including one incident when he touched Resident 3's vagina. CMS Ex. 12 at 1, 4-7; CMS Ex. 13 at 1-2; CMS Ex. 14 at 1; CMS Ex. 21 at 6, 9; CMS Ex. 22 at 1-2.

21. On February 17, 2014, Resident 2 stated to a CNA while she was preparing him for bed to "stick your hand down there and feel around so you can help me," to which the CNA responded that Resident 2 should not talk to her like that. CMS Ex. 24 at 53; Tr. 47-48.

22. On February 18, 2014, Petitioner's staff observed Resident 2 to have been "inappropriately touching female residents and staff for entire shift." CMS Ex. 24 at 57. Also on that date, Resident 2 "asked a CNA to close the door behind her so

[4] Although the Administrator of Petitioner's facility learned of this incident on February 11, 2014, the Administrator did not investigate the incident until February 20, 2014. CMS Ex. 14 at 1; *see also* CMS Ex. 12 at 6; P. Reply at 10.

they can kiss, and was trying to rub another CNA's leg." CMS Ex. 24 at 53; Tr. 47.

23. On February 18, 2014, Petitioner's staff noticed Resident 3 hugging and kissing another resident in the hallway. CMS Ex. 25 at 6.

24. On February 19, 2014, Petitioner's staff observed that Resident 2 was "making inappropriate sexual comments to staff and other res[idents]. Res[ident 2] asking to touch breast, kiss areas that aren't lips and asking staff to touch him." Petitioner's staff requested that a nurse practitioner see Resident 2. CMS Ex. 24 at 57; *see also* Tr. 46.

25. On February 20, 2014, Petitioner's staff noted that Resident 2 was "trying to touch staff in an inappropriate manner and also trying to kiss staff when they get close. Staff explained to him that that he was being inappropriate and he needed to stop." A nurse practitioner indicated to staff that changes to Resident 2's medications would be made. CMS Ex. 24 at 57.

26. In Resident 1's care plan, Petitioner noted on February 20, 2014, two "Problems" which started on February 10, 2014: 1) Resident 1 "has developed a close friendly relationship with another male resident . . . . They have been observed in a bed laying [sic] next to each other"; and 2) "[Resident 1] has physical behavioral symptoms toward others (touching others private areas)." One "Approach" identified by Petitioner was to place Resident 1 on 15 minute checks "to assure safety." CMS Ex. 23 at 51, 54.

27. In Resident 2's care plan, Petitioner noted on February 20, 2014, that a "Problem" started on February 17, 2014: "Resident has socially inappropriate/disruptive behavioral symptoms as evidenced by asking staff to do sexual acts to him during care times." One "Approach" identified by Petitioner was to "[a]ssess whether the behavior endangers the resident and/or others. Intervene if necessary." CMS Ex. 24 at 58.

IV. Conclusions of Law and Analysis

My conclusions of law are in italics and bold.

1. Petitioner was not in substantial compliance with 42 C.F.R. § 483.25(h).

CMS asserts that Petitioner violated 42 C.F.R. § 483.25(h), which states:

> (h) Accidents. The facility must ensure that—
>
> > (1) The resident environment remains as free of accident hazards as is possible; and
> > (2) Each resident receives adequate supervision and assistance devices to prevent accidents.

CMS alleges that Petitioner failed to adequately supervise three cognitively-impaired residents, Residents 1, 2, and 3, resulting in multiple incidents of resident-on-resident aggressive sexual behavior. CMS also asserts that Petitioner did not reassess the residents, update their care plans to instruct staff about possible interventions, and did not inform the residents' families. Therefore, Petitioner did not comply with 42 C.F.R. § 483.25(h), when it allowed Resident 1 to sexually intrude upon Resident 2, and when it allowed Resident 2 to sexually intrude upon Resident 3.

Petitioner argues that it did not violate 42 C.F.R. § 483.25(h) and the "key question involved is whether or not residents with dementia have the right and ability to consent to relationships and intimate touching." P. Pre-hearing Br. at 7. Petitioner argues that "a diagnosis of dementia does not remove a resident's right to consent to intimate behavior." P. Pre-hearing Br. at 8. Petitioner contends that none of the three residents were so impaired that they lacked the ability to consent to intimate, consensual relationships with each other. According to Petitioner, staff was aware of their relationships and closely monitored them and intervened when necessary. Petitioner argues that if a violation did occur, it did not rise to the level of immediate jeopardy

Resident 1's BIMS score of 15 in January 2014 meant that he was cognitively intact. Tr. 25; P. Ex. 6 at 2 (Resident 1 "had higher functioning dementia."). Resident 1 was mobile and allowed to freely move around the dementia unit. CMS Ex. 23 at 61; *see* CMS Ex. 21 at 8; P. Reply at 4. Significantly, Resident 1 could access Resident 2's room through a bathroom that they both shared. CMS Ex. 21 at 8.

Resident 2's BIMS score was a 3 in January 2014 (CMS Ex. 32 at 11), which means that he had severe cognitive impairment. Tr. 26-27, 46. He also had mobility limitations and significant hearing loss.

On February 4, 2014, a CNA observed that Resident 1 was in Resident 2's room, standing over Resident 2, who was lying in his bed. Resident 2's covers had been pulled back and Resident 1 was "masturbating" Resident 2, and Resident 2 was quiet while this was happening. The CNA took no action because Petitioner's policy was only to intervene in a situation such as this if a resident protested at the actions of the other resident. CMS Ex. 21 at 8-9; CMS Ex. 23 at 47; CMS Ex. 24 at 49.

When Petitioner's staff inquired into this situation, Resident 1 denied having any relationship with Resident 2, but, importantly, Resident 2 could not recall any incident with Resident 1. CMS Ex. 29 at 1. However, by February 5, 2014, rumors had spread that Resident 2 was homosexual, which Resident 2 denied to a CNA, indicating that he was married with a wife. CMS Ex. 24 at 49. Resident 2's statement that he was heterosexual appears consistent with all reports of his inappropriate sexual behavior (discussed below), which was directed exclusively at female staff and residents. CMS Ex. 21 at 1, 6, 8-9 ("[Resident 1] mostly goes after men. [Resident 2] – women."); CMS Ex. 24 at 53.

Despite Resident 2's statement to Petitioner's staff that he was not homosexual, Petitioner took meager action to determine whether Resident 2 had in fact consented when Resident 1 touched him sexually on February 4, 2014. *See* Tr. 30. Resident 2's response to the inquiry from Petitioner's staff, that he could not recall any incident with Resident 1, was only consistent with Resident 2's Alzheimer's and amnesia diagnoses, and did not mean Resident 2 consented.[5] Further, Resident 1's response should have caused Petitioner further concern as to whether Resident 2 consented to sexual contact with Resident 1 since his response was, at best, misleading. Although Petitioner had placed Resident 1 on 15 minute checks by at least February 5, 2014, these checks did not provide sufficient supervision of Resident 1 since Resident 1's conduct on February 4 was not considered problematic. CMS Ex. 23 at 47 (February 5, 2014 Progress Note states "Continues on Q 15 minute checks, no adverse behaviors observed."). Rather, Petitioner's policy required Resident 2 to overtly object to Resident 1's sexual actions before Petitioner would consider Resident 1's behavior to be adverse.

On February 8, 2014, Resident 1 was again in Resident 2's room touching Resident 2's genitals. CMS Ex. 23 at 47; CMS Ex. 24 at 52. One of Petitioner's nurses observed this and made Resident 1 stop. However, because Petitioner's policy was not to stop sexual contact between residents unless one of the residents was objecting, Petitioner's Director of Nursing counseled the nurse for breaching the policy since Resident 2 was silent while Resident 1 was touching him. Tr. 58-59. This, despite the fact that Petitioner's belated inquiry into the matter once again revealed that Resident 2 could not even remember the incident and Resident 1 again denied having any kind of relationship with Resident 2.

Petitioner primarily asserts that Resident 2 regularly let staff know when he did not want to be touched, and that Resident 2 did not resist Resident 1. Tr. 52; P. Ex. 6 at 2-3. Further, Petitioner says that Residents 1 and 2 had become friends. P. Ex. 6 at 2. Petitioner also states that Resident 2 could consent to sexually intimate contact. P. Br. at 8, 10; P. Reply at 6; *see* P. Ex. 6 at 3.

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[5] Resident 2's Minimum Data Set indicates that he had memory problems and could not recall staff names and faces, location of his room, or the current season. CMS Ex. 24 at 14

Petitioner's argument fails because Petitioner does not show that it took appropriate action to supervise the residents. Resident 2, a resident with severe cognitive decline, nearly no hearing, and who was only mobile when in his wheelchair, was being sexually touched while lying in bed by a mobile, cognitively intact resident who had access to Resident 2's room through an adjoining bathroom. This situation alone should have caused Petitioner to fully inquire as to whether Resident 2 consented to these actions, but instead only brought about some cursory questioning of the residents involved almost two weeks after the incidents. However, the answers received from the residents to that questioning should not have satisfied anyone that Resident 2 consented to Resident 1's actions. It did confirm that Resident 2 was very cognitively-impaired since he could not remember anything and that Resident 1 dissembled about his conduct, both of which should have prompted further investigation. Further, on February 5, Resident 2 told one of Petitioner's employees that rumors had surfaced related to the February 4 incident and that Resident 2 was not homosexual. At the least, this statement shows the possibility that Resident 2 did not consent to Resident 1's sexual touching.[6] Merely saying that Resident 2 did not protest while being sexually touched is insufficient for me to conclude that Petitioner correctly determined that Resident 2 had consented to the February 4 incident. Consent is not assumed simply because a victim of a sexual assault does not object while the assault is taking place, especially where, as here, the victim has severe cognitive deficits. A review of the record shows that Petitioner did not know what precipitated the February 4 incident. Tr. 30.

Petitioner's failure to properly determine whether Resident 2 consented to Resident 1's actions meant that Petitioner did not change the care plans of either resident to effectively supervise them. This resulted in the February 8, 2014 incident where Resident 1 again was found fondling Resident 2 while Resident 2 was immobile in his bed. A nurse who witnessed this stopped Resident 1 and told him to leave; however, Petitioner disciplined this nurse for improper conduct on the assumption that Resident 2 consented to Resident 1's actions. *See* Tr. 58-59. Petitioner's actions certainly had the potential to pose more than minimal harm to Resident 2 and other residents.

Petitioner also failed to properly supervise Residents 2 and 3. Although Resident 2 was severely cognitively-impaired and immobile when not in his wheelchair, he freely wandered around the facility in his wheelchair. Tr. 48. Resident 3, however, was significantly more impaired than Resident 2, with a BIMS score of 0, which included an inability to repeat words or have temporal orientation, and no ability to hear. Tr. 34-35, 49-51.

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[6] Although Resident 2 told Petitioner's staff that he was heterosexual, even if Resident 2 had been homosexual, Petitioner could not have assumed consent based on that alone.

Resident 2 was admitted to Petitioner's facility in January 17, 2014 and, by January 31, 2014, Petitioner's staff observed that Resident 2 "makes inappropriate statements toward staff and others . . . . Many times he makes sexual remarks to staff during care . . . . Staff do not do his care alone." CMS Ex. 32 at 11.

On February 11, 2014, Resident 2 fondled the breasts of Resident 3. CMS Ex. 14 at 1; CMS Ex. 21 at 6. Staff separated Residents 2 and 3. CMS Ex. 21 at 6. However, when Petitioner's staff reported this incident to supervisors, staff were informed not to intervene unless a resident was resisting. CMS Ex. 14 at 1; *see also* CMS Ex. 21 at 6. However, the staff member who separated Residents 2 and 3 stated the following:

> I intervened because [Resident 3] can't hear [Resident 2], she doesn't understand what he wants[.] It was for her own safety. [Resident 2 is] very suggestive. Behaviors increasing.

CMS Ex. 21 at 7. Resident 2 sexually touched Resident 3 several times between February 11 and 20, 2014, including one incident when he touched Resident 3's vagina. CMS Ex. 12 at 1, 4-7; CMS Ex. 13 at 1; CMS Ex. 14 at 1; CMS Ex. 21 at 6, 9; CMS Ex. 22 at 1-2. During the February 26, 2014 survey, state surveyor Robin Conley, RN, observed Resident 2 next to Resident 3 with no supervision. CMS Ex. 38 at 5.

Petitioner's position, as it was with regard to Residents 1 and 2, is that Resident 3 consented to Resident 2's sexual touching. Petitioner asserted that Resident 3 would yell, push, and hit if she did not want to be touched. Tr. 52-53; P. Ex. 1 at 3.

However, as Nurse Conley testified:

> In my opinion as a nurse and surveyor, [Petitioner] failed to realize that R[esident] 3 could not protest given her cognitive impairments, and this also prevented her from making a conscious decision to consent to engage in sexual behavior with other residents. As a result, [Petitioner] failed to investigate these incidents, the residents were not assessed, and their care plans were not adequate and timely revised and updated to instruct staff regarding possible interventions. Also, R[esident] 3's family was not informed. In my opinion as a nurse and a surveyor, [Petitioner] did not provide the requisite supervision and, as a result, [Petitioner] allowed R[esident] 2 to essentially sexually intrude upon R[esident] 3.

CMS Ex. 38 at 5; *see also* Tr. 35 (testifying that all residents are not capable of consenting to relationships). I credit Nurse Conley's testimony and opinion, and find that it is consistent with the record in this case.

The facts in this matter are similar to those in *Karcher Estates*, DAB CR2632 (2012). In that case, the ALJ provided the following analysis pertinent to the present case:

> 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 . . . . 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 . . . . 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.

Karcher, DAB CR2632 at 11 (internal citations omitted).

I agree with the ALJ's analysis and conclude that Petitioner failed to properly supervise its residents because it failed to identify whether Resident 2's sexual touching of Resident 3 was consensual and, indeed, whether Resident 3 could even consent to that touching given her low cognitive abilities.

Therefore, based on the evidence of record, I conclude that Petitioner was not in substantial compliance with 42 C.F.R. § 483.25(h).

2. CMS's determination that Petitioner's deficiencies posed immediate jeopardy was not clearly erroneous.

Immediate jeopardy exists when a facility's noncompliance "has caused, or is likely to cause, serious injury, harm, impairment, or death to a resident." 42 C.F.R. § 488.301. CMS's determination that a deficiency constitutes immediate jeopardy must be upheld unless the facility shows that the determination is clearly erroneous. 42 C.F.R. § 498.60(c)(2); *see also Beverly Health Care Lumberton*, DAB No. 2156 at 5 (2008), *citing Woodstock Care Ctr.*, DAB No. 1726 at 39 (2000), *aff'd*, *Woodstock Care Ctr. v. Thompson*, 363 F.3d 583 (6th Cir. 2003). The "clearly erroneous" standard means that CMS's immediate jeopardy determination is presumed to be correct, and the burden of

proving the determination clearly erroneous is a heavy one. *See, e.g., Owensboro Place & Rehab. Ctr.*, DAB No. 2397 at 9-10 (2001), *citing Azalea Court*, DAB No. 2352 at 16-17 (2010), *aff'd, Azalea Court v. HHS*, 482 F. App'x 460 (11th Cir. 2012).

In the present case, CMS alleges that Petitioner's violation of 42 C.F.R. § 483.25(h) was at the scope and severity level of "J," constituting immediate jeopardy to resident health and safety. As discussed above, the evidence in this case supports a conclusion that Petitioner violated 42 C.F.R. § 483.25(h). The record also shows that CMS's immediate jeopardy determination was not clearly erroneous. Immediate jeopardy does not require actual harm, but, as the regulatory definition indicates, only a likelihood of serious harm. *Dumas Nursing & Rehab., L.P.*, DAB No. 2347 at 19 (2010), *citing Life Care Ctr. of Tullahoma*, DAB No. 2304 at 58 (2010), *aff'd, Life Care Ctr. of Tullahoma v. Sebelius*, 453 F. App'x 610 (6th Cir. 2011).

There is no question that Petitioner placed Resident 2's and Resident 3's health in immediate jeopardy, because Petitioner failed to take appropriate action to determine whether they consented, or even had the capacity to consent, to sexual touching from others. Even though staff tried to intervene in some instances, Petitioner's policy was not to intervene unless there was an express objection from a resident to the touching. This not only led to multiple instances where Residents 2 and 3 were sexually touched, but generally put the resident population at risk because Petitioner would only stop a sexual incident between residents if one were actively objecting. Under Petitioner's misguided policy, all residents, especially those with severe cognitive or other deficits which may have adversely impacted their ability to actively protest or object, were potentially vulnerable and unprotected from being victimized in such situations.

3. CMS's determination of the amount of CMP is reasonable.

In determining whether the CMP amount imposed here is reasonable, I apply the factors listed in 42 C.F.R. § 488.438(f). 42 C.F.R. § 488.438(e)(3). These factors include: (1) the facility's history of compliance; (2) the facility's financial condition; (3) the factors specified at 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 at 42 C.F.R. § 488.404 include: (1) the scope and severity of the deficiency; (2) the relationship of the deficiency to other deficiencies resulting in noncompliance; and (3) the facility's prior history of noncompliance in general and specifically with reference to the cited deficiencies. Unless a facility contends that a particular regulatory factor does not support the CMP amount, the ALJ must sustain it. *Coquina Ctr.*, DAB No. 1860 at 32 (2002).

My review of the reasonableness of the CMP is de novo and based upon the evidence in the record before me. I am not bound to defer to the CMS determination of the

reasonable amount of the CMP to impose, but my authority is limited by the regulations. The limitations as set forth in the regulations are: (1) I may not set the CMP at zero or reduce it to zero; (2) I may not review the exercise of discretion by CMS in selecting to impose a CMP; and (3) I may only consider the factors specified by 42 C.F.R. § 488.438(f) when determining the reasonableness of the CMP amount. I am to determine whether the amount of any CMP proposed is within reasonable bounds considering the purpose of the Act and regulations. *Emerald Oaks*, DAB No. 1800 at 10 (2001); *CarePlex of Silver Spring*, DAB No. 1683 at 14-18 (1999); *Capitol Hill Cmty. Rehab. & Specialty Care Ctr.*, DAB No. 1629 (1997).

In the present case, CMS imposed a total CMP of $83,800, consisting of 16 days of a $5,150 per day CMP and 14 days of a $100 per day CMP. CMS Ex. 8 at 1.

Petitioner has a history of noncompliance with Medicare program participation requirements. A November 25, 2013 survey revealed a number of deficiencies at the D, E, and F level of scope and severity. CMS Ex. 36. More significantly for this case, Petitioner also had a G level deficiency (actual harm that is not immediate jeopardy) for a deficiency under F223 (Resident's right to be free from abuse or involuntary seclusion), as well as D and E level deficiencies under F323 (i.e., the deficiency cited in this case). CMS Ex. 36 at 1.

Petitioner's financial condition is one that Petitioner asserts is a basis for a reduction in the CMP. Petitioner's Chief Financial Officer (CFO), who is a certified public accountant, testified that "a CMP of $83,800 would have a drastic effect on the facility that could potentially affect its continued operation or modifications planned to improve the quality of life in the facility." P. Ex. 2 at 1, 3. The CFO testified that the financial statements submitted by Petitioner in this proceeding were accurate. P. Ex. 2 at 2. The CFO explained that the balance on a loan from Petitioner's owners was $130,000 and that Petitioner already had reached its maximum bank credit line amount. P. Ex. 2 at 2. The CFO further testified that total liabilities were $1,269,918, but total current assets were $1,092,054. P. Ex. 2 at 2; P. Ex. 4 at 5-6. The CFO also testified that although Petitioner had net income of $146,640, $79,564 of that was from a prior year adjustment and interest income related to late payments made to Petitioner; therefore, current income was really $67,076. P. Ex. 2 at 2; P. Ex. 4 at 7. The CFO opined that "a fine that represents more than the facility's net income could have a crippling effect on the facility's ability to continue to operate" and to borrow money to make needed repairs and upgrades that have already been planned. P. Ex. 2 at 2-3.

Although CMS did not cross-examine the CFO, CMS argues that the CFO's testimony is not an accurate reflection of Petitioner's financial condition because the financial statement provided by Petitioner expressly states it is not a consolidated statement with Petitioner's variable interest entity (Neighbors Property, LLC), as normally required

under generally accepted accounting principles in the United States. CMS Br. at 17-18; P. Ex. 4 at 3. Petitioner did not respond to CMS's argument in its reply brief.

I am concerned that Petitioner's financial report does not appear to comply with standard accounting principles and that the CFO's testimony may not accurately reflect Petitioner's financial situation. However, even accepting Petitioner's financial report that Petitioner had $74,122 in cash and net income before taxes of $146,640 (CMS Ex. 37 at 57, 59; P. Ex. 4 at 5, 7), I conclude that the total CMP in this case is not sufficiently large to warrant reducing it.

I also conclude that Petitioner is very culpable. As indicated above, Petitioner failed to properly assess Residents 2 and 3 to determine if they consented, or were capable of consenting, to sexual touching by other residents. Some of Petitioner's staff members were concerned for these residents, but Petitioner did not take heed of its employees, even counseling one for stopping the February 8, 2014 incident involving Residents 1 and 2.

In regard to the scope and severity of the deficiency, as indicated above, I agree that CMS properly determined that Petitioner's deficiency was at the immediate jeopardy level. I also believe that CMS properly continued to penalize Petitioner at a non-immediate jeopardy level.

I conclude that the CMP that CMS imposed is reasonable. I note that the $5,150 per day CMP that CMS imposed for 16 days for an immediate jeopardy level deficiency is in the lower half of the CMP range ($3,050 per day to $10,000 per day). 42 C.F.R. § 488.438(a)(1)(i), (d)(2). Further, I find that the $100 per day CMP for 14 days of noncompliance after Petitioner abated immediate jeopardy is near the bottom of the CMP range ($50 per day to $3,000 per day). 42 C.F.R. § 488.438(a)(1)(ii).

V. Conclusion

I affirm CMS's determination and conclude that the CMP imposed on Petitioner was reasonable.

/s/
Scott Anderson
Administrative Law Judge