Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Libertywood Nursing Center
(CCN: 34-5520),

Petitioner

v.

Centers for Medicare and Medicaid Services.

Docket No. C-10-388

Decision No. CR2388

Date: June 24, 2011

DECISION

Petitioner, Libertywood Nursing Center (Petitioner or facility), is a long-term care facility located in Thomasville, North Carolina, that participates in the Medicare program. The Centers for Medicare and Medicaid Services (CMS) charges that, because the facility did not take appropriate steps to protect its female residents from the sexually aggressive behaviors of a demented male resident, it was not in substantial compliance with Medicare requirements, and its deficiencies posed immediate jeopardy to resident health and safety. CMS has imposed civil money penalties (CMPs) of $3,700 per day for 73 days of immediate jeopardy and $100 per day for 23 days of substantial noncompliance that was not immediate jeopardy (total $272,400). Petitioner timely appealed CMS's determination.

For the reasons set forth below, I find that the facility was not in substantial compliance with Medicare program requirements, its deficiencies posed immediate jeopardy to resident health and safety, and the penalties imposed are reasonable.

I. Background

The Social Security Act (Act) sets forth requirements for nursing facility participation in the Medicare program and authorizes the Secretary of Health and Human Services to promulgate regulations implementing those statutory provisions. Act §1819. The Secretary's regulations are found at 42 C.F.R. Part 483. To participate in the Medicare program, a nursing facility must maintain substantial compliance with program requirements. To be in substantial compliance, a facility's deficiencies may pose no greater risk to resident health and safety than "the potential for causing minimal harm." 42 C.F.R. § 488.301.

The Secretary contracts with state survey agencies to conduct periodic surveys to determine whether skilled nursing facilities are in substantial compliance. Act § 1864(a); 42 C.F.R. § 488.20. The regulations require that each facility be surveyed once every twelve months and more often, if necessary, to ensure that identified deficiencies are corrected. Act § 1819(g)(2)(A); 42 C.F.R. §§ 488.20(a); 488.308.

Here, responding to a complaint, the North Carolina Department of Health and Human Services, Division of Health Service Regulation (State Agency) surveyed the facility from November 5-18, 2009. CMS Exs.1, 4. Based on the survey findings, CMS determined that, from September 6 through December 10, 2009, the facility was not in substantial compliance with Medicare participation requirements, specifically 42 C.F.R. § 483.25(h) (Tag F323), which addresses supervision and accident prevention. CMS also determined that, from September 6 through November 17, 2009, the facility's deficiencies posed immediate jeopardy to resident health and safety. CMS Exs. 4 at 6-7. CMS subsequently determined that the facility achieved substantial compliance on December 11, 2009. CMS Ex. 4 at 13, 14.

CMS has imposed against the facility CMPs of $ 3,700 per day for 73 days of immediate jeopardy (September 6-November 17, 2009) and $100 per day for 23 days of substantial noncompliance that was not immediate jeopardy (November 18-December 10), for a total CMP of $272,400. CMS Ex. 4 at 6-7.

Petitioner timely requested a hearing.

On September 30, 2010, I convened a hearing, via video teleconference, from the offices of the Departmental Appeals Board in Washington, D.C. Counsel for both parties appeared in Washington, D.C., Ms. Erin Shear on behalf of CMS, and Mr. Joseph Bianculli on behalf of Petitioner. Transcript (Tr.) at 7. Witness Ann Burgess testified from Boston, Massachusetts, and Witness Kristine Woodyer testified from Raleigh, North Carolina.

I admitted into evidence CMS Exhibits (Exs.) 1-30 and Petitioner's Exhibits (P. Exs.) 1-26, including P. Ex. 5A. Tr. at 8; Order Summarizing Prehearing Conference at 2 (August 20, 2010). The parties have also filed pre-hearing briefs (CMS Br.; P. Br.), post-hearing briefs (CMS Post-hrg. Br.; P. Post-hrg. Br.), and reply briefs (CMS Reply; P. Reply).

II. Issues

The issues before me are:

- From September 6 through December 10, 2009, was the facility in substantial compliance with 42 C.F.R. § 483.25(h)?

- If the facility was not in substantial compliance from September 6 through November 17, 2009, did its deficiencies then pose immediate jeopardy to resident health and safety?

- If the facility was not in substantial compliance with program requirements, were the penalties imposed – $3,700 per day for the period of immediate jeopardy and $100 per day for the remaining period of substantial noncompliance – reasonable?

III. Discussion

A. The facility was not in substantial compliance with Medicare requirements governing quality of care because it did not protect its residents from sexual assault.[1]

Program requirements. So that each resident can attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the his/her comprehensive assessment and plan of care, the "quality of care" regulation mandates that the facility "ensure" that each resident's environment remains as free of accident hazards as possible. 42 C.F.R. § 483.25(h)(1). It must "take reasonable steps to ensure that a resident receives supervision and assistance devices designed to meet his assessed needs and to mitigate foreseeable risks of harm from accidents." *Briarwood Nursing Ctr.*, DAB No. 2115 at 5 (2007); *Guardian Health Care Ctr.*, DAB No. 1943 at 18 (2004) (*citing* 42 C.F.R. § 483.25(h)(2)). The facility must anticipate what accidents might befall a resident and take steps to prevent them. A facility is permitted the flexibility to choose the methods it uses to prevent accidents, but the chosen methods must constitute an "adequate" level of supervision under all the circumstances. *Briarwood*, DAB No.

[1] My findings of fact/conclusions of law are set forth, in italics and bold, in the discussion captions of this decision.

2115 at 5; *Windsor Health Care Ctr.*, DAB No. 1902 at 5 (2003); *see Burton Health Care Ctr.*, DAB No. 2051 at 9 (2006) (holding that determining whether supervision/assistive devices are adequate for a particular resident "depends on the resident's ability to protect himself from harm").

Resident 2's (R2's) aggressive behavior and the facility's responses. The parties agree on most of the critical facts in this case. R2 was an 82-year-old man, admitted to the facility on August 28, 2009. He suffered from a long list of ailments, including Parkinson's Disease and progressive dementia. He had a history of strokes. CMS Ex. 6 at 1; P. Exs. 1, 2, 3.

Immediately prior to his admission, R2 resided in another nursing home, where he had been exhibiting sexually inappropriate behaviors toward staff. According to a physician's report, dated June 18, 2009, he tried to put his hands up the shirts of some nurses, and he tried to pull people into rooms. *See* P. Ex. 3 at 1; *see also* P. Ex. 4 at 1 (reporting his history of problem behaviors, including hitting and groping staff). Not long after his admission to this facility, he began to engage in similar problematic behaviors. An evaluation, dated September 1, 2009, says that he had eloped twice over the weekend and that he displayed sexually inappropriate behavior toward the female staff. CMS Ex. 9 at 4; *see* CMS Ex. 7 at 1. A psychiatric report, dated September 8, 2009, describes episodes of agitation and sexual aggression. *See* CMS Ex. 9 at 6; *see also* P. Ex. 6 at 5.

Although he had problems with balance and required assistance with walking, R2 moved throughout the facility in his wheelchair, and, as shown by the following list of incidents, this mobility enabled him to pounce on women residents. Specifically:

- **September 6, 2009**, at 4:30 p.m. R2 rolled his wheelchair up to a woman resident and began fondling her breast. The nurse moved him to the other side of the day area, told him not to touch other residents, and wrote that she would "monitor." CMS Ex. 7 at 2; CMS Ex. 11 at 4; P. Ex. 15 at 2; *see* P. Ex. 16 at 3.[2]
  According to the incident report, the victim of his assault was unaware of his actions. CMS Ex. 13 at 2.

- **September 6, 2009**, at 5:45 p.m. The staff's "monitoring" of R2 was apparently ineffective, because he went back to the same resident, put his

[2] Petitioner suggests that R2 made only an unsuccessful attempt, stating that R2 "rolled his wheelchair near a female resident and a nurse observed him to attempt to fondle the other resident's breast through her clothing." P. Post-hrg. Br. at 9. In fact, the nurse's note reports that he successfully "began fondling her left breast." P. Ex. 15 at 2; P. Ex. 16 at 3.

hand under a blanket that was on her lap, and, according to the victim, he "was feeling all over around her diaper." She asked staff to take him away (which suggests that this resident was more aware than staff had originally credited). CMS Ex. 7 at 2; CMS Ex. 11 at 4; CMS Ex. 13 at 1; *see* P. Ex. 16 at 3.[3]

- **September 8, 2009**. A nurse's note indicates that the resident had his hand under another resident's clothing at supper. CMS Ex. 7 at 3.

Thus, from at least September 6, 2009, if not from the time of his admission, the facility was well aware of the threat R2 posed to the health and safety of its female residents.

Indeed, in a September 9, 2009 entry to R2's care plan, the facility identified as a problem R2's "increasingly aggressive" behaviors "in seeking [a] sexual relationship with others." CMS Ex. 12 at 3; P. Ex. 8 at 1. To address the problem, the plan lists multiple interventions, although some appear to be redundant and some are vague to the point of conveying no meaningful instructions. Specifically, the plan instructs staff to: 1) redirect "to situation as able," administer medications as ordered, and monitor for side effects; 2) redirect and assist him to his room when he becomes sexually aggressive; 3) one-on-one monitoring; 4) "ACT"[4] consult and evaluation to determine the effectiveness of medication in managing and decreasing behaviors; 5) provide supportive counseling intervention; 6) wanderguard to prevent elopement; 7) encourage him to participate in activities; 8) "attempt to redirect [resident] that behaviors are unacceptable and remove [him] from possible situation as needed"; 9) help the resident maintain and preserve his dignity; 10) notify the family if sexual behaviors continue or are more aggressive and if medication needs change; 11) redirect resident from making sexual advances toward visitors and/or other residents and tell him that the behaviors are not appropriate; 12) assist resident to activities "to stimulate him in a positive way and prevent him from fixating on sexual behaviors"; 13) "monitoring tool for sexual aggressive behaviors"; 14) notify his physician, responsible party, supervisor and ACT services of continued sexual behaviors/aggression.

Ultimately, the plan's short-comings are not relevant, however, because no evidence suggests that staff ever relied on it. According to Licensed Practical Nurse (LPN)

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[3] Petitioner claims that this incident was followed by a psychiatric consultation and cites to P. Ex. 4 at 5 and P. Ex. 12 at 2. These documents are dated September 1, 2009, five days *before* the September 6 assaults occurred.

[4] ACT is a medical group that services nursing home residents throughout North Carolina. The facility's medical director, who was also R2's treating physician, worked for ACT Medical Group. P. Ex. 24 at 1 (Beittel Decl.)

Darlene Whitley, who was also the facility's MDS (Minimum Data Set) coordinator, the facility had in place a standard protocol that staff implemented when residents exhibited undesirable behaviors: separate the residents involved and, perhaps, "have some communication with the person whose behavior is of concern to the effect that the conduct is unacceptable . . . ." Where a resident's conduct might injure someone – and LPN Whitley concedes that R2's conduct had that potential – the facility would "ordinarily implement frequent (every 15 minutes) checks of his location and demeanor. In some circumstances, the facility might implement one-on-one supervision. *See* P. Ex. 26 at 2-3 (Whitley Decl.); *see also* P. Ex. 25 (Powers Decl.). But not all staff seem to agree on the specifics of the facility's purported "standard protocol." According to Social Services Director Debbie Braughn, nursing staff "implemented the usual protocol of one-on-one supervision, followed by fifteen minute checks." P. Ex. 22 at 2 (Draughn Decl.). Petitioner has not produced a written copy of its protocol.

In any event, it seems that, between September 9 and October 17, facility staff generally limited their interventions to separating R2 from his victim and telling him not to touch her again.[5] The evidence shows that they were not effective in controlling R2's behavior and protecting others from his advances.[6]

- **September 15, 2009**. A nurse's note says that R2 repeatedly told another resident that he "wanted her for tonight." CMS Ex. 7 at 4.

- **September 20, 2009**, at 11:00 a.m. A nurse reported that R2 had been propelling himself around the hallways in his wheelchair, approaching different female residents, trying to put his hands on them. When asked to move away, he would move to another resident and put his hands on her. When staff told him to stop putting his hands on people, he said that he should wash his hands, since he had "touched everyone." He then went into his room and washed his hands. CMS Ex. 7 at 4.

A care plan entry, dated September 20, reports "touching female" as a problem and "redirected" as the intervention. CMS Ex. 12 at 3; P. Ex. 8 at 1. Another entry, dated September 22, relates elopement attempts and "fondle [resident]/staff[;] behavior noted worse during day than [at bedtime]." In response, staff should "continue to redirect; assist to activities during day for distraction." CMS Ex. 12 at 3; P. Ex. 8 at 1. If staff assisted R2 to activities, I see no record of it, with the possible exception of the 30

[5] From time to time, staff imposed 15-minute checks, which, as discussed below, were wholly ineffective in controlling R2's behaviors.

[6] I discuss below Petitioner's remarkable assertion that its interventions worked because R2 engaged in no sexually inappropriate behaviors for a full month.

minutes a day he spent in Occupational Therapy (during which the facility reported no episodes of sexual misconduct). *See* Tr. at 26-27. In fact, Petitioner ridicules a suggestion made by CMS witness, Dr. Ann W. Burgess, that R2 should have been provided activities. Dr. Burgess, DNSc, RNC, FAAN, is a professor of psychiatric nursing at Boston College, who has studied and written about sexual abuse of the elderly. CMS Ex. 27; CMS Ex. 28 at 1 (Burgess Decl. ¶4); Tr. 13. She pointed out that R2 "had too much time on his hands" and suggested that he be kept busy doing hands-focused activities with a men's group, so that he would not threaten the women residents. CMS Ex. 28 at 5 (Burgess Decl. ¶22); Tr. at 27-28.

Petitioner claims, without support, that R2's "significant physical and cognitive limitations obviously precluded 'keeping his hands occupied,' as well as continuing many of the previous interests his family apparently reported," and that R2 "would become agitated in such a setting." P. Post-hrg. Br. at 11; P. Reply at 12.[7] But, according to R2's assessment, cards/games, arts/crafts, exercise/sports, and religious activities were among R2's preferred activities. P. Ex. 5A at 2; P. Ex. 6 at 7. An assessment is supposed to take into account the resident's capabilities and interests, from which a plan can be developed. If Petitioner were not capable of performing his preferred activities, the assessment should include activities in which he could participate. According to Petitioner, however, its assessment simply listed activities that R2 was incapable of performing. P. Ex. 5A. If that were the case (and no evidence supports that conclusion), the facility was seriously out of compliance with 42 C.F.R. § 483.20, which sets forth requirements for resident assessments, including activity pursuit. 42 C.F.R. § 483.20(b)(1)(xiii).

So, the facility assessed R2 as preferring certain activities, and his care plan directs staff to help him participate in them; yet, Petitioner now argues that taking him to activities would not have been an appropriate intervention.

- **September 29, 2009**. A nursing note indicates that the resident had been redirected six times because he was "attempting to be inappropriate" with other residents "[at] different times." CMS Ex. 7 at 5; CMS Ex. 12 at 3; P. Ex. 8 at 1.

Although not mentioned in the nurses' notes, an October 5, 2009 notation in R2's care plan says "hand down female shirt" and "redirected [and] monitored behaviors." Again, the plan directs staff to "assist to activities for distraction" and "cont[inue] to redirect,"

[7] Petitioner also claims, without citation to the record, that R2 was incapable of hand work because he "actually was paralyzed on one side." P. Reply at 12. According to R2's assessment, he experienced no loss of voluntary movement to his hands, including wrists or fingers. P. Ex. 6 at 6.

but nothing in the record shows that staff assisted him to any activities. CMS Ex. 12 at 4; P. Ex. 8 at 2.

- **October 6, 2009**, at 8:00 a.m. R2 "rolled up behind a female" resident, reached over her shoulder, and "stuck his hand down her shirt." Staff moved the resident away, notified the physician and left a message for R2's responsible party.[8] Staff also told R2 that he could not touch others. Someone recommended that staff implement 15-minute checks in response, but nothing in R2's record indicates that the facility did so at that time. CMS Ex. 7 at 6; CMS Ex. 13 at 3-4; P. Ex. 16 at 9.

A care plan entry for the day reflects that R2 "continues to touch female [residents]/staff" and says that staff should "continue to divert [and] redirect [resident's] attention from female [residents and] staff." CMS Ex. 12 at 4; P. Ex. 8 at 2. A note written in the care plan suggests that R2's medication (Ativan) might cause him to become sexually aggressive, but another note says the medication was given in response to his behaviors. CMS Ex. 12 at 4. Staff reported the incidents to Timothy Beittel, M.D., the facility's medical director and R2's attending physician, who wrote "ok" under the "instructions/orders" section of the reporting form. P. Ex. 12 at 4.

- **October 14, 2009**. A note written at 1:00 p.m. says that R2 rolled up to another resident and asked her if she was "ready to go to bed." Staff removed him from the area. CMS Ex. 7 at 6-7.

The weekly nurse's summary says that, at 1:00 p.m. on October 14, staff caught R2 with his hand on a female resident's breast. P. Ex. 16 at 11.

So, for well over a month, staff responded to R2's sexual aggression by separating him from his victim and telling him not to do it again. In response, he often returned to that victim or moved on to someone else.

- **October 17, 2009**, at 11:00 a.m. R2 went into the room of a newly-admitted resident (R1), a 29-year-old woman suffering from Friedreich's ataxia and other impairments. Friedreich's ataxia is a rare genetic disease that causes progressive damage to the central nervous system, resulting in impaired movement and sensory functions. It does not affect cognitive function. R2 started to fondle her breast and to touch her genitals. She protested, telling him not to do that, but she was unable to defend herself because of her physical limitations. Facility staff notified R2's

[8] No evidence suggests that the facility informed the victims' responsible parties of these incidents.

> "responsible party." Thereafter, someone also spoke to the facility's administrator and director of nursing, and staff began to supervise R2 one-on-one for part of the day (from 9:00 a.m. to 8:00 p.m.) and to make 15-minute checks the rest of the time. CMS Ex. 7 at 7; CMS Ex. 12 at 4; CMS Ex. 15 at 4-5; P. Ex. 8 at 2; P. Ex. 21 at 9 *et seq.*; P. Ex. 26 at 3 (Whitley Decl.).

Unlike other victims of R2's advances, this resident was not wholly dependent on facility staff to protect her. She was coherent and able to complain. She reported the incident, and her husband called the police. CMS Ex. 15 at 4-5. Stating that she no longer felt safe, she immediately transferred to the hospital pending placement at another facility. CMS Ex. 15 at 5.

Because R2 could not get out of bed without assistance, facility staff reasoned that 15-minute checks would provide sufficient supervision for much of the evening, night, and early morning hours. Unfortunately, R2 was up and about well before 9:00 a.m., which meant that he was not adequately supervised during the early morning hours.

- **November 13, 2009**, at 7:45 a.m. At 7:45 a.m., staff checked on R2. He was in the dining room, sitting at his assigned seat. But he rolled himself over to another resident at the other side of the table and "had his hand up her shirt, touching her breast." Staff removed him from the area and asked him to stop touching other residents. CMS Ex. 7 at 12, 13; CMS Ex. 13 at 5-7.

According to LPN Whitley, the facility thereafter expanded the hours of one-on-one supervision to begin at 7:00 a.m. P. Ex. 26 at 3 (Whitley Decl.); CMS Ex. 13 at 6.

Effectiveness of the facility's interventions. Review of these facts leads to the inevitable conclusion that the facility did not have in place a coherent approach for ensuring that staff would adequately supervise R2 and protect other residents from his advances. No facility witness claims that staff were guided by the instructions in R2's care plan. Instead, they say they relied on a protocol that was not individualized, not necessarily consistent with the care plan, and does not even appear to have been in writing; at least, Petitioner has produced no written copy. Staff do not even agree on the particulars of that protocol.

Moreover, staff's responses did not work. No one argues that asking R2 to stop his behaviors had any realistic possibility of succeeding as an intervention. So, it seems that "redirect" was the facility's primary (if not only) intervention until the October 17 incident.

The record includes some evidence of limited 15-minute checks, but those appear to have been implemented only sporadically, were not well-documented, and, in any event, unless R2 was confined to his bed, they proved ineffective in controlling his behaviors. The facility produced records of 15-minute checks immediately following the first incident on September 6. Comparing these records to the nursing notes and incident reports shows how ineffectual the 15-minute checks were. According to the record of 15-minute checks, at 4:30 p.m. on September 6, R2 was "in room." CMS Ex. 14 at 2. But the incident report says that he was in the "day area" of Wing I, molesting a resident at that time. CMS Ex. 13 at 2. The record of 15-minute checks says that he ate supper at 5:15 p.m. and was in his room at 5:30 p.m. Staff initialed checking on him at 5:45 p.m. but left blank the space for recording an observation. CMS Ex. 14 at 2. At 5:45 p.m., R2 was back in the day area of Wing I, molesting the same woman he had attacked at 4:30. CMS Ex. 13 at 1. The monitoring record for what appears to be September 8 (staff was not careful about dating these sheets) records that, from 5:00 p.m. until 5:45 p.m., R2 was "eating supper." CMS Ex. 14 at 8. We know from the nurse's note that, during this time, he put his hand under the clothing of another resident. CMS Ex. 7 at 3.[9]

The record thus supports the finding that R2 required close supervision and that one-on-one supervision, which was not implemented until after the October 17 incident, appears to have been the most effective intervention. *See, e.g.*, P. Ex. 25 at 2 (Powers Decl.) (acknowledging that one-on-one supervision was "more effective."). The November 13 incident occurred when staff were not providing that level of supervision. I therefore reject Petitioner's claim that R2's behavior could not be controlled by means other than extreme measures, such as chemical or physical restraint. Petitioner also argues that one-on-one supervision might further agitate a resident, but nothing in this record suggests that R2 became agitated when closely supervised.[10] If a resident requires one-on-one monitoring to prevent him from abusing others, the facility must implement it regardless of whether the facility deems it impractical or expensive, or lacks sufficient staff. *Pinehurst Healthcare*, DAB No. 2246 at 13 (2009).

Documenting, reporting, and investigating the incidents. Petitioner maintains, again without citation to the record, that the facility protocol required all staff immediately to report unusual resident behavior to the charge nurse, who was supposed to "intervene immediately." The charge nurse then reported to the Director of Nursing (DON), who "discusse[d] the matter with the interdisciplinary care planning team no later than the

[9] Facility records also show 15-minute checks made from August 29-31 and on September 28, apparently in response to R2's attempted elopements. P. Ex. 21 at 1-8.

[10] In an earlier case involving this facility, Petitioner also argued that one-on-one supervision would only further agitate an already volatile resident. The Administrative Law Judge (ALJ) there characterized the argument as "not consistent with the evidence." *Libertywood Nursing Ctr.*, DAB CR1945 at 16 (2009).

next morning." P. Post-hrg. Br. at 6. Petitioner offers no copy of said protocol. For the most part, none of Petitioner's witnesses even refer to these procedures. *See* P. Exs. 22 (Draughn Decl.), 24 (Beittel Decl.), 25 (Powers Decl.). Only LPN Whitley alludes generally to any reporting requirements. According to her declaration, staff must report the incident to the charge nurse, who "implements appropriate supervision per an established protocol," informs the DON and the facility administrator, and "whatever the issue may be is discussed at the 'stand up' meeting the following morning." P. Ex. 26 at 1-2. I see little evidence that staff adhered to these procedures.

Petitioner provides what purports to be a "behavior/intervention monthly flow record" for the month of October. P. Ex. 11. But, according to this document, R2 engaged in no sexually inappropriate behaviors on October 6, 14, or 17, 2009, even though, based on the nurses' notes, we know that significant behaviors occurred on those days. According to this document, he engaged in only one such behavior, on October 2, during the 3-11 shift. Staff intervened by redirecting him, and the intervention was successful. P. Ex. 11 at 1. Thus, staff did not record multiple incidents of inappropriate behavior. Because its monitoring records were inaccurate, the facility did not even have a clear picture of the magnitude of its problems.

Petitioner's defenses. Petitioner bases much of its defense on the false premise that its initial interventions were successful because R2 was not sexually aggressive for a full month following the September 6 incidents. P. Post-hrg. Br. at 10-11 (claiming that, following the September 6 incidents, "no further touching of fellow residents occurred for about a month"); P. Post-hrg. Br. at 11, 19; P. Reply at 7.[11] This assertion is simply false. As discussed above, and, as amply supported by the facility's own records, multiple additional incidents occurred between September 6 and October 6. CMS Ex. 7 at 3 (September 8); CMS Ex. 7 at 4 (September 15); CMS Ex. 7 at 4 (noting multiple attacks on September 20); CMS Ex. 12 at 3; P. Ex. 8 at 1; CMS Ex. 7 at 5 (setting forth six incidents on September 29); CMS Ex. 12 at 4; P. Ex. 8 at 2.

Petitioner also argues that it should not be accountable for R2's behaviors because it "had no prior notice of the Resident's behaviors," a claim that is both unsupported and

[11] Petitioner relies on surveyor notes that purport to record what the facility's then DON said at the time of the survey. CMS Ex. 20 at 9. Petitioner did not produce the DON as a witness. I accept that she made statements to the surveyors, but that does not establish that her statements were accurate. She may have deliberately attempted to deceive the survey team. More likely, she was not aware of the extent of the problem, which suggests that staff were not reporting the incidents to her as required by the facility's unwritten protocol.

irrelevant. P. Post-hrg. Br. at 3.[12] Prior to his admission, R2 was evaluated by a registered nurse named Cynthia Norman. P. Ex. 22 at 1 (Draughn Decl.). Yet, Petitioner offers no statements from her as to what she knew about the resident's behaviors. Plainly, documentation of R2's behavior problems was available. Dr. Beittel admitted that, when he examined R2 the day after he was admitted, "I noted reports that the Resident had a history of touching staff at the facility where he had lived . . . ." P. Ex. 24 at 2 (Beittel Decl.). For this reason, I am skeptical of Dr. Beittel's simultaneous claim that "the nature of [R2's] behaviors was not fully disclosed at the time [of his admission]. . . ." P. Ex. 24 at 2 (Beittel Decl.). Moreover, R2's initial assessment, dated and signed August 31, 2009, affirms that, within the preceding week, the resident engaged in physically abusive behaviors and socially inappropriate/disruptive behaviors. P. Ex. 6 at 5. On the same day, staff asked that he be referred for a psychological and psychiatric evaluation "for aggression [and] elopement." P. Ex. 12 at 1. Thus, in the unlikely event that the facility did not know about R2's problems at the time it admitted him, it learned of the problems almost immediately thereafter and was charged with developing a plan to protect him and the facility's other residents from those problematic behaviors.[13]

Moreover, no one suggests that a facility may not accept a resident with R2's behaviors, but, having accepted the resident, it must take all reasonable steps to protect R2 and the facility's other residents.

Next, Petitioner trivializes the sexual abuse of its demented residents. First, Petitioner claims, without any reliable support, that inappropriate touching is simply a common behavior in nursing homes. Dr. Burgess disagrees: "I would say it's unusual . . . . I have not seen any literature that says that's a common behavior." Tr. at 22.

In Petitioner's view, sexual assaults are "undesirable" but not particularly dangerous, at least not as dangerous as other behaviors exhibited by nursing home residents. Petitioner's witnesses then recount other, purportedly more terrible behaviors, both real and hypothetical, that have occurred at the facility and in other nursing homes. In a

[12] Petitioner maintains that CMS "concedes" that Petitioner had no prior notice. P. Post-hrg. Br. at 3. I see nothing to suggest that CMS concedes this (or any of the other issues that Petitioner characterizes as CMS concessions). Rather, CMS considers the question irrelevant because Petitioner was on notice at least as early as August 29 that R2 required a higher level of supervision.

[13] Petitioner made the same argument in its earlier appeal. *Libertywood Nursing Ctr.*, DAB CR1945 (2009). The facility has now twice identified as its underlying problem its practice of accepting residents without knowing whether it was capable of meeting their needs. If, in fact, its admissions practices have caused the facility's significant problems with resident supervision, the facility should long ago have addressed and corrected the inadequacies in its pre-admission screening.

particularly remarkable and disturbing bit of testimony, Social Services Director Debbie Draughn[14] argues that "behavior that otherwise would be considered unacceptable or offensive is not unusual in nursing facilities" and that unwanted touching "is nowhere as serious as some situations I have faced." She then describes admitting a resident, without knowing that he had a history of violence, who "engaged in a course of terrorizing staff and other residents for several weeks . . . ." *See* P. Ex. 22 at 2-3;[15] *see also* P. Ex. 24 at 3 (Per Dr. Beittel: "[W]e commonly face more serious behavioral issues in nursing facilities that do pose much greater potential for harm to residents."); P. Ex. 25 at 2 (Per LPN Ben Powers: "[N]othing about the behaviors or their responses struck me as particularly dramatic at the time.").

That staff have such a casual attitude toward the sexual abuse of its residents may explain why they allowed R2's behavior to continue with such minimal intervention. In any event, subjecting residents to weeks of terror does not set the standard against which we measure facility compliance. The standard is whether the environment allows a resident "to attain or maintain his/her highest practicable physical, mental and psycho-social well-being."

Finally, I recognize that R2 was seriously demented and not responsible for his behaviors. But that only increases the facility's obligation to protect him from himself, as well as to protect the women he preyed upon. Protecting vulnerable residents from foreseeable sexual assault is hardly part of "some hypothetical or idealized health care system," as Petitioner suggests. P. Post-hrg. Br. at 2. I consider it the facility's absolute minimum responsibility. As the evidence establishes, the facility failed to do this and was therefore not in substantial compliance with 42 C.F.R. § 483.25(h).

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[14] Although referred to as "Social Worker Draughn," no evidence suggests that Social Services Director Draughn was educated or licensed as a social worker. In fact, she is conspicuously silent with regard to her professional qualifications except to say, "I am not a clinician so I am not involved in matters such as referral to mental health practitioners, medication changes, and the like . . . ." P. Ex. 22 at 2 (Draughn Decl.).

[15] With respect to that incident, CMS found that the facility was not in substantial compliance and that its deficiencies posed immediate jeopardy to resident health and safety. CMS imposed a penalty of $3,050 per day. The ALJ agreed that the facility was not in substantial compliance and that its deficiencies posed immediate jeopardy to resident health and safety. *Libertywood Nursing Ctr.*, DAB CR1945 (2009); CMS Ex. 30.

B. CMS's determination that the facility's deficiencies posed immediate jeopardy to resident health and safety is not clearly erroneous.

Immediate jeopardy exists if a facility's noncompliance has caused or is likely to cause "serious injury, harm, impairment, or death to a resident." 42 C.F.R. § 488.301. CMS's determination as to the level of a facility's noncompliance (which would include an immediate jeopardy finding) must be upheld unless it is "clearly erroneous." 42 C.F.R. § 498.60(c). The Departmental Appeals Board has observed repeatedly that the "clearly erroneous" standard imposes on facilities a "heavy burden" to show no immediate jeopardy, and has sustained determinations of immediate jeopardy where CMS presented evidence "from which '[o]ne could reasonably conclude' that immediate jeopardy exists." *Barbourville Nursing Home*, DAB No. 1931 at 27-28 (2004) (*citing Koester Pavilion*, DAB No. 1750 (2000)); *Daughters of Miriam Ctr.*, DAB No. 2067 at 7, 9 (2007).

Unfortunately, the facility does not seem to have assessed, for signs and symptoms of distress, the elderly and demented residents who were subjected to R2's attacks. The facility can hardly be allowed to benefit from such a disregard for the welfare of its vulnerable residents. Moreover, I do not doubt that any woman who has been the victim of a sexual assault has suffered serious harm, regardless of her mental capacities. Dr. Burgess, who has studied the issue extensively, testified that sexual abuse affects profoundly those victimized by it and that the elderly are particularly susceptible to injury because of their frailty and cognitive status. The damage can be permanent. CMS Ex. 28 at 2 (Burgess Decl. ¶ 8); Tr. 23. Even Dr. Beittel acknowledged "the distress such groping can cause victims and their families . . . ." P. Ex. 24 at 2-3 (Beittel Decl.).

One of the victims was neither elderly nor demented, and she was fully capable of articulating her fear and anxiety. By all accounts, R1 was significantly distressed and refused to remain in the facility. She told staff that "she did not feel safe." CMS Ex. 15 at 5.

Finally, as CMS points out, the regulation does not require actual harm, but the *likelihood* of serious injury or harm. That an unsupervised male resident sexually assaults elderly women who are unable to defend themselves creates such a likelihood. *See* P. Ex. 26 at 3 (Whitley Decl.) (acknowledging that R2 was acting "in a way that potentially might injure someone else"). CMS's immediate jeopardy determination is therefore not clearly erroneous.

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

Here, the facility should have known about R2's need for close supervision at the time of his admission and should have planned accordingly. Certainly evidence of his behaviors was available to staff at the time of his admission. Had there been any question, the danger he posed was demonstrated at 4:30 p.m. on September 6, when he first assaulted a facility resident, so, from that point on, facility staff were put on notice of the problem. Staff's response ("monitor") was inadequate, and R2 was able to attack the same woman again an hour later. A third attack took place within two days. These facts more than justify CMS's setting September 6, 2009 as the onset date of its noncompliance at the immediate jeopardy level of scope and severity.

With respect to the date the facility's deficiencies no longer posed immediate jeopardy to resident health and safety (November 8, 2009) and the date it returned to substantial compliance (December 11, 2009), the facility has not met its burdens of establishing that it alleviated the immediate jeopardy any earlier nor that it returned to substantial compliance any earlier.

Substantial compliance means not only that the facility corrected the specific cited instances of substantial noncompliance, but also that it implemented a plan of correction *designed to assure that no additional incidents would occur* in the future. Once a facility has been found to be out of substantial compliance (as Petitioner was here), it remains so until it affirmatively demonstrates that it has achieved substantial compliance once again. *Life Care Ctr. of Elizabethton*, DAB No. 2367 at 16-17 (2011); *Premier Living and Rehab Ctr.*, DAB No. 2146 at 23 (2008); *Lake City Extended Care*, DAB No. 1658 at 12-15 (1998). The burden is on the facility to prove that it has resumed complying with program requirements, not on CMS to prove that deficiencies continued to exist after they were discovered. *Asbury Ctr. at Johnson City*, DAB No. 1815 at 19-20 (2002). A facility's return to substantial compliance usually must be established through a resurvey. 42 C.F.R. § 488.454(a). To be found in substantial compliance earlier than the date of the resurvey, the facility must supply documentation "acceptable to CMS" showing that it "was in substantial compliance and *was capable of remaining in substantial compliance*" on an earlier date. 42 C.F.R. § 488.456(e) (emphasis added); *Hermina Traeye Mem'l Nursing Home*, DAB No. 1810 at 12 (*citing* 42 C.F.R. §488.456(a) and (e)); *Cross Creek Care Ctr.*, DAB No. 1665 (1998).

The Board has also repeatedly held that CMS's determination that a facility's ongoing noncompliance remains at the level of immediate jeopardy during a given period "is subject to the clearly erroneous standard of review under [42 C.F.R. §] 498.60(c)(2)." *Life Care Ctr. of Elizabethton*, DAB No. 2367 at 16 (*quoting Brian Ctr. Health and Rehab.*, DAB No. 2336 at 7-8 (2010)).

Here, the facility's problems went beyond the actions of one "uncontrollable" resident. They included poor documentation, poor care planning, poor supervision, and behavior tracking records that were plainly false. These are not the types of problems resolved by discharging one resident (although CMS determined that R2's discharge alleviated the immediate jeopardy). Indeed, the facility's plan of correction shows that its problems were not corrected with the November 17, 2009 discharge. Staff were disciplined for insufficiently monitoring the resident; nursing staff received inservice training on the resident's care plan; incident/accident reports were reviewed; admissions practices were changed so that the admissions committee would review a potential resident's history for inappropriate sexual behavior; the facility developed a list of interventions to address behavior problems, including immediate one-on-one supervision. Measures were also instituted to improve completion and review of incident/accident reports. CMS Ex. 1 at 1-11. But the promises of such changes, by themselves, are not sufficient to ensure that the cited deficiencies will not recur. As I have noted in similar cases, the facility must also follow-up with staff to verify that they understand and have implemented the necessary changes, and that the changes, in fact, correct the problem. *Premier Living and Rehab. Ctr.*, DAB CR1602 (2007), *aff'd* DAB No. 2146 (2008).

Such follow-up is particularly important here, where, as I discuss below, the facility had a history of substantial noncompliance, followed by its implementing short-lived corrective action and then almost immediately returning to substantial noncompliance (even immediate jeopardy).

D. The penalties imposed are not unreasonably high.

I next consider whether the CMPs are reasonable by applying the factors listed in 42 C.F.R. § 488.438(f): 1) the facility's history of noncompliance; 2) the facility's financial condition; 3) 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 in 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.

In reaching a decision on the reasonableness of the CMP, I 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 deficiencies 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 Ctr.*, DAB No. 1848 at 21 (2002); *Cmty. Nursing Home*, DAB No. 1807 at 22 *et seq*. (2002); *Emerald Oaks*, DAB No. 1800, at 9 (2001); *CarePlex of Silver Spring*, DAB No. 1638 at 8 (1999).

CMS has imposed penalties of $3,700 per day, which is at the low penalty range for situations of immediate jeopardy ($3,050-$10,000), and $100 per day, which is at the low end of the penalty range for per-day CMPs ($50-$3,000). 42 C.F.R. §§ 488.408(d), 488.438(a)(1).

In light of the facility's dismal history, I find these penalty amounts surprisingly low. Since at least 2006, the facility has consistently failed to maintain substantial compliance with 42 C.F.R. § 483.25(h), the regulation at issue here, and other requirements. As mentioned above, a December 2006 complaint investigation/survey revealed immediate jeopardy deficiencies under section 483.25(h), based, in significant part, on the facility's failure to supervise a resident who threatened the safety of others. *Libertywood Nursing Ctr.*, DAB CR1945 (2009). The penalties then imposed – $3,050 per day for the period of immediate jeopardy and $50 per day for the period of noncompliance that was not immediate jeopardy – were not sufficient to ensure corrective action that would endure. Within six months the facility's annual survey (completed in June 2007) revealed multiple deficiencies, the most serious cited at scope and severity levels E (pattern of noncompliance with no actual harm, but the potential for more than minimal harm) and G (actual harm that is not immediate jeopardy). The facilities deficiencies under section 483.25(h) were cited at scope and severity level D. CMS Ex. 26 at 1.

Following a July 2008 annual survey, CMS again found that the facility was not in substantial compliance with multiple requirements, the most serious cited at scope and severity level E. Its deficiencies under section 483.25(h) were cited as Level E deficiencies. CMS Ex. 26 at 1.

Immediately prior to the complaint investigation survey that is the subject of this proceeding, the facility's annual survey was completed on July 23, 2009. Again, the facility was not in substantial compliance with multiple requirements, including section 483.25(h), which was cited at the immediate jeopardy level. The facility then claimed to have corrected its deficiencies by September 10, 2009, four days after R2 started molesting facility residents. CMS Ex. 26 at 1.

By itself, the facility's history would justify CMPs significantly higher than those imposed here.

With respect to the remaining factors, Petitioner does not claim that its financial condition affects its ability to pay the penalties. I consider the severity of the deficiencies significant enough to warrant this penalty. That facility staff, by their own admissions, did not consider the sexual assault of elderly and demented women particularly dangerous or "dramatic" evidences indifference and disregard for resident care, comfort and safety, and I therefore consider the facility culpable in failing to protect its most vulnerable residents.

For these reasons, I find that the penalties imposed are not unreasonably high.

IV. Conclusion

From September 6 through December 10, 2009, the facility was not in substantial compliance with 42 C.F.R. § 483.25(h); from September 6 through November 17, 2009, its deficiencies posed immediate jeopardy to resident health and safety; and I affirm the penalties imposed.

/s/
Carolyn Cozad Hughes
Administrative Law Judge