Department of Health and Human Services
DEPARTMENTAL APPEALS BOARD
Appellate Division

Somerset Nursing & Rehabilitation Facility
Docket No. A-10-88
Decision No. 2353
December 23, 2010

FINAL DECISION ON REVIEW OF ADMINISTRATIVE LAW JUDGE DECISION

Somerset Nursing & Rehabilitation Facility (Somerset) appealed the June 24, 2010 decision of Administrative Law Judge (ALJ) Steven T. Kessel sustaining the determination of the Centers for Medicare & Medicaid Services (CMS) that Somerset was not in substantial compliance with Medicare participation requirements. Somerset Nursing & Rehabilitation Facility, DAB CR2166 (2010) (ALJ Decision). The remedies sustained by the ALJ consisted of a civil money penalty (CMP) of $3,050 per day beginning May 10, 2008 and continuing through January 14, 2009, during which period, CMS determined, Somerset's deficiencies placed its residents in immediate jeopardy; a CMP of $150 per day from January 15, 2009 through January 29, 2009; and a denial of payment for new admissions from January 18, 2009 through January 29, 2009.

On appeal, Somerset challenged the deficiencies which the ALJ upheld at the level of immediate jeopardy, both of which involved a single male resident who engaged repeatedly in sexually aggressive behavior toward female residents. Somerset contended that the ALJ imposed an unreachable standard on the facility to prevent all episodes of sexually inappropriate behavior. Somerset further argued that the ALJ's factual findings ignored evidence favoring its position and thereby exaggerated the number and severity of the incidents and undervalued the measures by which the facility attempted to intervene.

For the reasons explained below, we conclude the ALJ Decision is supported by substantial evidence and free from legal error.

Applicable Law

The Social Security Act (Act) and federal regulations provide for state agencies to conduct surveys of Medicare skilled nursing facilities (SNF) and Medicaid nursing facilities (NF) to evaluate their compliance with the Medicare and Medicaid participation requirements. Sections 1819 and 1919 of the Act; 42 C.F.R. Parts 483, 488, and

498.[1] The participation requirements are set forth at 42 C.F.R. Part 483, subpart B. A facility's failure to meet a participation requirement constitutes a "deficiency." 42 C.F.R. § 488.301. "Substantial compliance" means a level of compliance such that "any identified deficiencies pose no greater risk to resident health or safety than the potential for causing minimal harm." *Id*. "Noncompliance" is defined as "any deficiency that causes a facility to not be in substantial compliance." *Id*.

Surveyor findings are reported in a statement of deficiencies (SOD), which identifies each deficiency under its regulatory requirement. 42 C.F.R. § 488.404; *State Operations Manual* (SOM), CMS Pub. 100-07, App. P -- Survey Protocol for Long Term Care Facilities (available at http://www.cms.hhs.gov/ Manuals/IOM/list.asp), sec. V. A deficiency's scope and severity is designated in the SOD by a letter (A-L). SOM, Ch. 7, at § 7400.5.1.

A long-term care facility determined to be not in substantial compliance is subject to enforcement remedies, including CMPs. 42 C.F.R. §§ 488.402(c), 488.406, 488.408. A per-day CMP may accrue from the date the facility was first out of compliance until the date it achieved substantial compliance. 42 C.F.R. § 488.440(a)(1), (b). For noncompliance determined to pose less than immediate jeopardy to facility residents, CMS may impose a per-day CMP in an amount ranging from $50-$3,000 per day. 42 C.F.R. § 488.408(d)(1)(iii). For noncompliance determined to pose immediate jeopardy to facility residents, CMS may impose a per-day CMP in an amount ranging from $3,050-$10,000 per day. 42 C.F.R. § 488.408(e)(1)(iii).

Regulations provide that a resident in a nursing home "has the right to be free from verbal, sexual, physical and mental abuse . . . ." 42 C.F.R. § 483.13(b). Furthermore, the facility "must develop and implement written policies and procedures that prohibit mistreatment, neglect and abuse of residents . . . ." 42 C.F.R. § 483.13(c). All alleged violations involving abuse must be immediately reported to the facility administration and to state authorities and must be thoroughly investigated, with any further potential abuse prevented during the investigation and the results of the investigation reported to the state as well. 42 C.F.R. § 483.13(c)(2).

Case Background

Somerset is a skilled nursing facility located in Kentucky. Surveys to assess Somerset's compliance with Medicare participation requirements were completed on January 9, 2009 and again on January 26, 2009. The surveyors cited 11 deficiencies at the January 9th

[1] The current version of the Social Security Act can be found at http://www.socialsecurity.gov/ OP_Home/ssact/ssact.htm.

survey, of which eight were identified as posing immediate jeopardy. The surveyors cited three deficiencies at the January 26th survey, none posing immediate jeopardy. Somerset requested a hearing before the ALJ.

The ALJ decided that Somerset's submissions made clear that Somerset did not challenge the deficiency findings from the January 26th survey and that the resulting $150 per-day CMP from January 15 through January 29, 2009 is therefore "administratively final." ALJ Decision at 2. The ALJ chose to address only two of the 11 deficiencies found at the January 9th survey. ALJ Decision at 3. He found it unnecessary to address the remaining deficiencies because he concluded that those he upheld constituted immediate jeopardy and the CMP imposed based on the January 9th survey was set at the minimum CMP amount provided by law for an immediate jeopardy deficiency. ALJ Decision at 11. The ALJ received direct testimony in writing and cross-examination by telephone and admitted exhibits from both parties.

ALJ Decision

The deficiencies addressed by the ALJ both relate to the facility's handling of one resident (referred to as Resident # 9) and his behavior toward other residents. The ALJ concluded that the weight of the evidence supported CMS's allegations that Somerset "failed to take meaningful actions to protect its residents from the abusive behavior" of Resident # 9 which included "several instances of sexual abuse" against other residents. ALJ Decision at 3. The ALJ further concluded that the interventions attempted by Somerset were so "woefully ineffective" as to show a "fundamental misunderstanding . . . of the need to take every reasonable measure to protect its residents from abuse" resulting in a "systemic failure . . . to develop an effective system for dealing with abusive residents." *Id.* at 4.

The ALJ described Resident # 9 as alert, oriented, "large and robust," using a wheelchair although able to "walk occasionally." *Id.* (record citations omitted throughout this summary). The ALJ found that Somerset knew or should have known when it admitted the resident that he was a threat due to a history of sexually aggressive behavior and repeated discharge from other facilities. *Id*. The resident displayed combative and aggressive behavior toward staff and was noncompliant with medical instructions. *Id*. The resident's behavior toward other residents, according to the ALJ, included threats and violent episodes. *Id*. Furthermore, the ALJ found that Resident # 9 "continually sought to engage in uninvited sexual activity" with female residents, citing 19 instances between April 2008 and December 10, 2008. *Id.* at 5-6. The instances described ranged from being "found in the doorway" of a female resident's room, to uninvited sexual comments, to brushing up against or "feeling of" residents' bodies, to the most serious

finding that he "forcefully pinched or grabbed the right breast of Resident # 15," who had a history of cancer in that breast. *Id*. at 5-6, 10.

The ALJ noted that Somerset reported various measures to address Resident # 9's inappropriate behavior, including discussions with the resident and his family, activities to divert the resident, and consultation with a psychiatric professional. *Id.* at 6-7. The ALJ concluded that the facility's efforts "had a half-hearted and tepid quality" in the face of "flagrant and outrageous" conduct and were "singularly ineffective in protecting other residents from" Resident # 9's persistent abusive actions. *Id*. In particular, the ALJ stated that 15-minute checks were not begun until July 7, 2008, were adopted in reaction to an elopement attempt by Resident # 9 rather than in response to his abusive behavior, and were followed by multiple instances of continuing sexual misconduct. *Id*. at 7. The ALJ also noted that Somerset did not provide any evidence that talks with the resident or attempts to involve his family had any effect on his behavior. *Id*. at 8. The ALJ found that the evidence did not show meaningful involvement of physicians responsible for Resident # 9's care. *Id*. The facility amended Resident # 9's care plan on September 1, 2008 to require more frequent monitoring for inappropriate sexual behavior, but the ALJ found no evidence that this measure was implemented or that staff were aware of it. *Id*.

The ALJ found that Somerset did not comply with its own written anti-abuse policy which required all alleged or observed sexual abuse (with no distinction between physical and verbal abuse) to be investigated and reported to the administration and state authorities, the victim examined and interviewed, and the physician and family of any victim notified. *Id*. at 8-9; CMS Ex. 24, at 9. The only incident fully investigated and reported was the one in which Resident # 9 pinched the breast of Resident # 15, according to the ALJ. *Id*. at 9. The ALJ found that in other instances either the records of the events did not identify the victim at all, or the victims were not examined or interviewed, or their families or physicians were not notified, or more than one element was lacking. *Id*. No other incident was reported to the state authorities. *Id*.

The ALJ found that the probability of "serious psychological or physical injury resulting from Resident # 9's unchecked sexual aggression was very high" in light of Resident # 9's mobility, persistence and relative strength and the vulnerability of many of the female residents who were frail and in some cases demented. *Id*. at 9-10. In particular, he found, Resident # 15 was at risk of lymphedema from her breast cancer treatment and needed protection from injury to that part of her body. *Id*. at 10. The ALJ found that the failure to follow abuse procedures in every instance where any allegation or observation occurred put residents at jeopardy of serious abuse and that the absence of serious actual harm was fortuitous and did not disprove the likelihood of serious harm occurring from Resident # 9's conduct. *Id*.

Based on this analysis, the ALJ made the following findings of fact and conclusions of law (FFCLs):

> 1. Petitioner failed to comply substantially with Medicare participation requirements.
>
> a. Petitioner failed to comply substantially with the requirements of 42 C.F.R. § 483.13(b).
>
> b. Petitioner failed to comply substantially with the requirements of 42 C.F.R. § 483.13(c).
>
> 2. CMS's findings of immediate jeopardy level noncompliance were not clearly erroneous.

ALJ Decision at 3, 8, 10.

Standard of Review

The Board's standard of review on a disputed conclusion of law is whether the ALJ decision is erroneous. The Board's standard of review on a disputed finding of fact is whether the ALJ decision is supported by substantial evidence on the record as a whole. *Guidelines – Appellate Review of Decisions of Administrative Law Judges Affecting a Provider's Participation in the Medicare and Medicaid Programs*, http://www.hhs.gov/dab/divisions/appellate/guidelines/prov.html; *Batavia Nursing and Convalescent Inn*, DAB No. 1911, at 7 (2004), *aff'd, Batavia Nursing & Convalescent Ctr. v. Thompson*, 143 F. App'x 664 (6th Cir. 2005).

Analysis

Somerset excepted to all of the ALJ's FFCLs. Somerset Br. at 1. Somerset's arguments took two forms. First, Somerset asserted that the ALJ Decision would require nursing facilities to take extreme and unreasonable interventions. Second, Somerset alleged that the ALJ's factual findings were not supported by substantial evidence because the ALJ failed to address material contrary evidence in the record.

A. The procedures and legal standards applied by the ALJ are not erroneous and do not have the implications claimed by Somerset.

1. Somerset's procedural arguments lack merit**.**

Somerset claims that it was denied an opportunity to respond to testimony by CMS's witnesses on cross-examination. Somerset Br. at 5. This objection is based on the

procedure adopted by the ALJ under which both parties were required to file the complete direct testimony of any proposed witness in the form of an affidavit or sworn declaration and then to produce in person at the hearing any witness whom the opposing party sought to cross-examine. ALJ Order (March 20, 2009). CMS did not elect to cross-examine any of Somerset's witnesses. Somerset now complains that it was thereby precluded from having those witnesses respond to material that emerged during Somerset's cross-examinations of CMS's witnesses. This objection is without merit. Somerset points to no evidence that it ever asked to present any of its witnesses in person. (The ALJ Order merely states that the ALJ will "[g]enerally" accept written direct testimony as "a statement in lieu of in-person testimony," but does not preclude exceptions. *Id*. at 3.) Nothing in the ALJ Order denies either party the ability to present rebuttal evidence if new material emerges on cross-examination requiring a response. Furthermore, even in its brief to us, Somerset fails to identify any specific new material requiring additional testimony from any of its witnesses.

Somerset also objects that the ALJ "instructed" Somerset "not to confront CMS witnesses with documentary evidence that contradicted their testimony during the hearing" but only to "point out any impeachment evidence in its post-hearing brief." Somerset Br. at 5, citing Tr. at 64. Somerset does not fairly represent the nature or context of the ALJ's remarks. A CMS witness was testifying by telephone and indicated that she did not have copies of the exhibits in the room with her. Tr. at 62-63. Counsel for Somerset asserted that he had understood that the witnesses would have the exhibits (without explaining the basis for his understanding). Tr. at 63. The ALJ agreed that it "probably would be better if they did," but then commented that the proceeding "is not a jury trial, and showing the witness something in a document that might contradict a witness' written direct testimony, is not all that much benefit to me," noting that he "would much rather you simply point it out in your post-hearing brief." Tr. at 64. The ALJ also referenced his earlier statement at the beginning of the hearing that "asking witnesses questions about documents is certainly legitimate," but asking witnesses "to tell me what documents say is not legitimate." Tr. at 5. Counsel for Somerset responded to the ALJ's comments by stating, "I'll move on, Your Honor." Tr. at 64. Although the ALJ thus stated a preference that inconsistencies between what is stated in a document and what is contained in testimony be presented in briefing, he certainly did not preclude Somerset from proceeding to cross-examine CMS witnesses about documents or dictate that any "impeachment evidence" should only be pointed out in the brief. Counsel for Somerset did not object to the ALJ's statement at the time, did not request any steps be taken to provide any particular documents to the witness (such as, for example, faxing the relevant pages to the witness's location), and has identified no prejudice from the manner in which the hearing proceeded.

We therefore reject Somerset's procedural objections.

2. Somerset mischaracterizes the legal standards applied by the ALJ.

Somerset argues that the ALJ Decision set out standards that would cause the following "devastating" results to Medicare facilities and residents:

- Nursing facilities will refuse to admit residents who have demonstrated even one instance of inappropriate behaviors in the past;

- Residents will be subject to indefinite isolation or immediate discharge at the first instance of behavioral problems (also causing the facility to violate other regulations that govern discharge and residents' rights);

- Facilities will be required to complete so much paperwork that resident care will be jeopardized; and

- The state licensing agencies will be bombarded with trivial allegations, resulting in the likelihood that dangerous incidents with significant consequences will be overlooked or missed altogether.

Somerset Br. at 34-35 (emphasis added). We find nothing in the ALJ Decision that would result in any of the consequences imagined by Somerset.

Nowhere does the ALJ suggest, for example, that Somerset should have refused to admit Resident # 9 because of a single instance of inappropriate behavior in the past. The ALJ found that Resident # 9 came to Somerset with a "life long history" of sexual aggression, that he was repeatedly discharged from other facilities, and that he was placed in skilled nursing "because of his history of sexually abusive behavior at home, which he directed against his demented wife." ALJ Decision at 4 and 8, citing CMS Ex. 39, at 4. The ALJ also found that the facility was, or should have been, aware of these proclivities at the time of admission and, in any case, observed volatile and violent behavior soon after admission. *Id*. at 4. Despite these findings, the ALJ does not hold that Somerset should not have admitted Resident # 9. Instead, the ALJ concluded that Somerset failed to plan adequately or implement adequate supervision to manage the resident's behavioral problems or to institute effective interventions to protect other residents. *Id.* at 7-8. This conclusion amounts only to the regulatory requirements that, having accepted the resident, Somerset must both care plan to meet his needs and act to protect the other residents for which it was responsible. 42 C.F.R. §§ 483.13(b), (c); 483.20(k); 483.25; *see, e.g., Columbus Nursing & Rehabilitation Center*, DAB No. 2247, at 9 (2009) (facility's duty of care "breached where a facility fails to take action to prevent foreseeable aggressive conduct by mentally impaired residents that impacts other

residents"); *Woodland Village Nursing Center*, DAB No. 2172, at 24 (2008) (facility "cannot simply avoid its duty to care for and protect a resident" where it failed to consider feasible interventions to address known risks).

We address later in this decision Somerset's arguments that some of the factual findings on which the ALJ based his conclusions are not supported by substantial evidence. Here, however, we conclude that Somerset does not accurately represent the legal conclusions that the ALJ drew based on the facts as he found them.

Similarly, the ALJ does not imply that Somerset should have responded to the first sign of a behavior problem by instituting indefinite isolation of Resident # 9 or discharging him immediately in violation of his rights. The ALJ does point out that Somerset never documented any consideration of "intensifying the resident's supervision or restricting his movement" or of separating him from the female population of the facility even after "Resident # 9 was observed to be engaging in sexually predatory behavior on five occasions within three days in August 2008 . . . ." ALJ Decision at 7. The emphasis here is that, in the ALJ's view, the facility failed to even consider alternatives after the failure of less intrusive interventions to ensure the safety of other residents. The ALJ does not suggest that the facility should have even considered "indefinite isolation." The ALJ also notes that Somerset "did not finally decide to transfer Resident # 9 out of its facility until November 2008." *Id.* By November 2008, according to the ALJ's findings, Resident # 9 was involved in 19 sexually inappropriate incidents and numerous other incidents of violent or combative behavior. *Id.* at 4-6. The point made by the ALJ is not that Resident # 9 should have been discharged immediately (and certainly not that he should have been discharged in a manner out of compliance with resident's rights in the discharge process) but rather that, having demonstrated its inability to safely meet Resident # 9's needs while protecting other residents, the facility also failed to act with any alacrity to admit that inability and discharge him to another setting. *Cf. Woodstock Care Center*, DAB No. 1726 (2000), *aff'd, Woodstock Care Ctr. v. Thompson*, 363 F.3d 583 (6th Cir. 2003) . We agree, especially since Somerset itself first raised the possibility of discharge in May 2008 but did not initiate the process until five months later.

The last two claims on Somerset's list essentially argue that facilities should be allowed to decide which allegations and observations of abusive actions toward their residents are worth investigating and reporting so as not to overburden their staff or state authorities. The regulations expressly demand that "all alleged violations involving mistreatment, neglect or abuse" must be "reported immediately" to both the administration of the facility and to state officials and thoroughly investigated, and the facility "must prevent further potential abuse while the investigation is in progress," and report its results. 42 C.F.R. § 483.13(c)(2)-(4)(emphasis added). The ALJ did not impose any new requirement in this regard but merely reiterated the express requirements of the

regulations. Moreover, Somerset's own policy requires that "all personnel promptly report any incident or suspected incident of resident abuse" and that "reports of abuse be promptly and thoroughly investigated." CMS Ex. 24, at 6, 9. The ALJ explained that one reason for the requirement to investigate and report all allegations, even if ultimately unsubstantiated, is the potential for conflict of interest arising from a facility's concern about its own reputation if a finding of abuse is substantiated. ALJ Decision at 10. As far as state agencies dealing with reports of abuse allegations, Somerset gives us no reason to presume that they are incapable of setting their own priorities and managing their own resources to address reports of abuse allegations from facilities in their jurisdiction consistent with federal law.

Somerset contends that no requirement to investigate or report is triggered unless the facility found the female victim showed signs of harm or intimidation. Somerset Reply Br. at 3. We find no such requirement in the law. Somerset points to the definition of abuse at 42 C.F.R. § 488.301 as the "willful infliction of injury . . . with resulting physical harm, pain, or mental anguish." Somerset Br. at 6. This definition applies to whether an allegation is substantiated as constituting abuse. The determination of whether a sexual assault caused physical pain or psychological anguish, however, is part of the investigation not a prerequisite to conducting an investigation.

We thus conclude that Somerset has not shown any error in the ALJ's application of regulatory standards to the facts as he found them. We turn next to Somerset's arguments that the factual findings made by the ALJ are not supported by substantial evidence in the record as a whole.

B. The ALJ's conclusion that Somerset was not in substantial compliance with sections 483.13(b) and 483.13(c) is supported by substantial evidence.

As discussed earlier, the ALJ based his conclusion on factual findings about numerous incidents involving Resident # 9's sexual aggression toward female residents over the course of eight months. The ALJ reviewed the interventions attempted by Somerset to deal with this persistent problem and found them collectively inadequate to protect female residents from being repeatedly victimized, as well as inconsistent with Somerset's own policy for responding to reports of suspected abuse. Thus, the ALJ concluded that Somerset failed in its responsibility to develop and implement appropriate "preventive measures" to protect its residents from the possibility of abuse resulting from the behavior of a resident known to the facility to be violent and sexually inappropriate in dealing with staff and other residents. ALJ Decision at 3. In making his factual findings as to the incidents and the interventions, the ALJ relied heavily on contemporaneous facility records prepared by staff charged with caring for the residents involved.

In its appeal, Somerset challenges those findings largely on the grounds that the ALJ relied on evidence that was taken out of context and disregarded contradictory evidence in the record without explanation.[2] Somerset contends that many of the incidents on which the ALJ relied in assessing Resident # 9 as a hazard to other residents either did not occur as he found or consisted merely of the resident reaching from his wheelchair toward another resident before being successfully redirected. Somerset also contends that the record as a whole shows that, contrary to the ALJ's findings, the facility took "appropriate and reasonable measures to protect its residents," based on its view of the evidence. Somerset Br. at 6. We discuss below why we conclude that, although the ALJ did not discuss every item of evidence to which Somerset points as undercutting his findings as to each incident or intervention, his findings are supported by the evidence in the record as a whole in all material respects.

1. The ALJ findings that Resident # 9 engaged in repeated incidents of sexually aggressive behavior directed against female residents are supported by substantial evidence.

Somerset contends that the timeline of sexual abuse instances in the ALJ Decision inaccurately characterizes the incidents and sometimes counts the same incident multiple times. *Id.* According to Somerset, only one incident (on August 21, 2008) can "even conceivably be defined as abuse." *Id.* at 7. We discuss that incident first, both because the parties and the ALJ treated it as the most serious and because the ALJ particularly referenced it in relation to upholding the immediate jeopardy determination. We then discuss in chronological order Somerset's arguments about the evidence relating to the other incidents in order to clarify the record as to the scope and seriousness of Resident # 9's behavior; we discuss in the following section the evidentiary disputes about what steps Somerset undertook in response.

The ALJ found that, on August 21, 2008, Resident # 9 "forcefully pinched or grabbed the right breast of Resident # 15 after Resident # 9 stopped her in the hallway." ALJ Decision at 6, citing CMS Ex. 1, at 6, 17. Somerset states that Resident # 15 reported, to her husband, to a charge nurse, and to the Administrator that Resident # 9 pinched her breast. Somerset Br. at 13, citing P. Exs. 7, at 3; 8; and CMS Ex. 33, at 113-16. The Administrator considered Resident # 15's report that Resident # 9 pinched her breast and that she "slapped Resident # 9's hand away" to be an "allegation of sexual abuse." P. Ex.

[2] Somerset frames much of its discussion about the record around its claim that the evidence to which it cites "conclusively establishes that Resident # 9's behaviors did not meet the definition of 'abuse.'" Somerset Br. at 6. Here again Somerset wrongly frames the issues. Properly applying the regulatory standard, the focus is not on whether particular episodes of behavior by Resident # 9 met the definition of abuse, but whether the resident's known behavior and history of sexual aggression and abuse posed a risk of abuse to other residents sufficient that the facility should have adopted protective measures.

7, at 4. It is undisputed that this is the only incident that was formally investigated, reported to family and physician, and reported to the proper state agency in accordance with the facility's abuse policy. ALJ Decision at 8-9; CMS Ex. 24, at 6-11.

Somerset also does not deny in its brief that the pinching episode occurred, although the Administrator in her statement asserts that she was "unable to substantiate" the report. Somerset Br. at 13-14; P. Ex. 7, at 4. Somerset minimizes the seriousness of the event, asserting that Resident # 15 denied any pain or injury when questioned during the investigation. Somerset Br. at 13, citing CMS Ex. 33, at 113 and P. Exs. 6 and 7. Surveyor Brock testified, however, that a facility nurse (Dawn Brooks) reported observing the August 21st incident and later receiving complaints of "tenderness of breast" from Resident # 15. CMS Ex. 39, at 3. The ALJ found that Resident # 15 was particularly vulnerable to injury from trauma due to the grabbing or pinching of her right breast because she had undergone lumpectomy and radiation to treat cancer in that breast, creating a risk of lymphedema. ALJ Decision at 10, citing CMS Ex. 13, at 5, 134-35 and CMS Ex. 41, at 2.

Surveyor Candido interviewed Resident # 15 herself and found her alert, oriented and credible. Surveyor Candido provided the following account of the conversation:

> [S]he was still upset about the situation that had occurred in August 2008. She said she was still afraid of Resident # 9 and remained in her room with the door closed most of the time. She was aware of the location of Resident # 9's room and avoided traveling on that hall. She became agitated and upset as she retold the story about the inappropriate touching. Furthermore, Resident # 15 was worried about her right breast and talked to me about it non-stop. Resident # 15 said she was told to always protect her right breast ever since she had the lumpectomy performed for her breast cancer. In fact, there was a sign posted in her room stating "No Lab Sticks or BP Checks on Right Side." To Resident # 15, the incident of Resident # 9 pinching her breast real hard was more than a sexual assault; it was a medical assault because of the medical history on her right breast. She felt violated medically as well as psychologically.

CMS Ex. 41, at 2. This testimony strongly contradicts Somerset's portrayal of the assault on Resident # 15's breast as non-abusive, involving no fear, pain or injury on the part of the victim. *See* Somerset Br. at 14, 16-17.

Somerset does not deny that it failed to timely notify Resident # 15's physician of the incident (as required under its own policy as well as the regulations), although it sent Resident # 15 for a consultation with a psychiatric physician's assistant (PA). Somerset

Br. at 13-14. Thus, even in the case of the one incident that Somerset itself recognized as constituting an allegation of abuse and which it investigated and reported, Somerset admittedly failed to comply with applicable requirements.

Turning to the remaining incidents listed on the timeline in the ALJ Decision, we note that Somerset agrees with the ALJ that on **April 10, 2008** Resident # 9 "was observed brushing up against a female in a hallway" of the facility. Somerset Br. at 7; *see* ALJ Decision at 5; CMS Ex. 27, at 1. Somerset does not dispute the ALJ's characterization of the female as a "severely cognitively impaired" resident. Somerset Br. at 7. Somerset asserts that the resident explained he was just "pushing the female Resident's wheelchair down the hallway." *Id*. Although Somerset argues that the episode was "neither identified nor described as a sexual incident," Somerset's documentation of the incident shows that the Social Services Director counseled Resident # 9 that day that he needed to respect other residents, that brushing against someone might make them feel he was "invading their space," and that he should turn to staff "if he has any problems with other residents." CMS Ex. 33, at 37; see also CMS Ex. 27, at 1. Somerset's own records thus support a conclusion that the incident involved physical contact with a female resident incapable of consent that was perceived as inappropriate and problematic by staff and do not support the Resident's claim to have been "simply pushing" another person's wheelchair.

The ALJ also found that, on another occasion in **April 2008**, Resident # 9 "put his hand into the shirt of a female resident and attempted to fondle her breast," trying to talk her into entering his room when she "rebuffed [his] advances." ALJ Decision at 5. Somerset argues that this finding was mistaken because the ALJ relied on the decision of the state discharge hearing on Resident # 9 at which Somerset's Administrator says she "inadvertently testified in the state discharge hearing that the incident with Resident 15 occurred in April. In fact, the incident to which I was referring was actually the August, 2008 incident." P. Ex. 7, at 2; CMS Ex. 34, at 16. CMS did not cross-examine the Administrator; and the ALJ did not discuss the claim that this was a duplication of the August 21st event. No contemporaneous documents were cited as recording a separate incident in April. We therefore do not give weight to this as a separate episode in evaluating whether the record as a whole contains substantial evidence to support the ALJ's findings, but we conclude that any error in this regard was not material given the other findings supported on the record.

The ALJ found that, on **May 10, 2008**, Resident # 9 physically touched a female resident, based on a behavioral log notation that he was "in women's room feeling of her," whereupon he was "directed to his own room & given verbal direction." ALJ Decision at 5; CMS Ex. 9, at 14. Somerset argues that its internal investigation "confirmed that no physical contact was observed" and that the surveyor (and the ALJ) should not have

relied on the behavioral log without interviewing the staff who wrote the note or others who were present or on duty. Somerset Br. at 7-8, citing CMS Ex. 33, at 28-29. The internal investigation notes (like all of those discussed below in relation to later episodes)[3] are handwritten, signed only by the Administrator and Director of Nursing (DON), and have no date showing when they were prepared or signed. CMS Ex. 33, at 28-35. Their evidentiary value is particularly diminished given that the three staff members involved did not sign the investigative notes, provided no written statements, and were not called as witnesses by Somerset. Somerset's allegations about whether the surveyor should have conducted additional interviews do not undercut the ALJ's reliance on the resident's behavioral log in light of Somerset's failure of to produce the eyewitnesses who allegedly disagreed with the written records. The ALJ could reasonably give more weight to the specific details recorded by the staff at the time that interaction was observed than to facility investigative notes stating that three staff members told the DON that they "did not observe direct contact." CMS Ex. 33, at 28-29.[4]

We also reject Somerset's argument that the surveyor was required to interview the persons mentioned in the investigative reports. First, since the reports were not produced at the time of the survey, it is not clear that the surveyors would have known the identity of all staff members who witnessed incidents involving Resident # 9. Second, Somerset points to no authority that requires surveyors to interview all staff who witnessed an incident before relying on the facility's contemporaneous records of the event.

The ALJ found that on **May 18, 2008** Resident # 9 "was observed touching another resident, Resident # 21, at several places on her body." ALJ Decision at 5. The ALJ cited nurse's notes which read as follows:

---

[3] The ALJ did not address each of these documents denominated as investigative reports or explain specifically why he did not accord weight to their account of various episodes. At one point, he stated that none "of the incidents at issue were investigated" by Somerset except the August 21st episode, but he did not make clear if he rejected the authenticity of these documents or merely concluded that they did not constitute full investigations with all the elements required by facility policy. ALJ Decision at 9. The surveyors testified that, "before the survey team left the facility on January 7, 2009," the Administrator was asked "repeatedly" for all investigative reports and produced only the one for the August 21st episode, while admitting that "no other incidents were investigated or reported." CMS Ex. 39, at 5. The ALJ did not resolve the question thus raised about when the documents produced as investigative reports of other incidents were created and we make no conclusions about their authenticity now.

[4] Somerset also denies that Resident # 25, who was the female involved, was harmed, because she "was unable to describe what had occurred" when interviewed by the DON and she was not noted to have any adverse effects in regular assessments that day or the following week or month. Somerset Br. at 8, citing CMS Exs. 33, at 28; 15, at 12, 15. The ALJ made no finding of actual harm in relation to Resident # 25, so we see no relevance to Somerset's assertion that the ALJ failed to consider the surveyor's testimony that he did not see evidence of her suffering intimidation or actual harm as a result of the episode. *Cf.* Somerset Br. at 8, citing Tr. at 56-57.

> 9 AM & 1:30 /p & 3:15/p res is in w/c [wheelchair] talking to another res touches her in sev [a side note attributed to the DON suggests this appears to mean several] areas of her body Staff keeps redirecting her and other res away from each other they keep going back to each other.

CMS Ex. 6, at 67. The facility agrees that Resident # 21 "has a moderately impaired cognitive status" and does not claim she was capable of consent. CMS Ex. 1, at 17.

Again, Somerset asserts that the ALJ should have given weight to an internal investigative report that states that, at 3:15 PM on May 18, 2008, staff observed Resident # 9 "reaching toward" Resident # 21's "arms, chest and abdomen areas," but that interviews with the residents and staff did not substantiate that "contact occurred between [the] residents." CMS Ex. 33, at 30; Somerset Br. at 9. This report too is signed only by the DON and Administrator, and Somerset did not provide statements or testimony from any of the staff members allegedly interviewed. CMS Ex. 33, at 30. The report also does not make clear whether the interviews included all staff that observed the interactions which, according to the nurse's notes, took place at three different times.[5] CMS Ex. 6, at 67. While Somerset stresses that the surveyors did not interview any of the eyewitnesses, the ALJ again could reasonably discount claims by Somerset that their testimony would have contradicted the contemporaneous written record of the events, especially since the eyewitnesses were within Somerset's control but not called as witnesses. It might again have been preferable for the ALJ to explain why he did not find the investigative reports credible or persuasive, but the evidence which he cites in the nurse's note supports his finding and the evidence adduced to the contrary is not sufficient to undercut that finding under a substantial evidence test.

The ALJ found that on **May 22, 2008** Resident # 9 was seen "making inappropriate sexual advances towards Resident # 21," and not ceasing even "when Resident # 21 asked him to stop." ALJ Decision at 5, citing CMS Exs. 6, at 69; 27, at 1. Somerset does not deny these findings but states that, although Resident # 9 was "reaching toward" Resident # 21, he was "unable to reach her." Somerset Br. at 10. This statement is not inconsistent with the ALJ's finding. Somerset also denies that Resident # 21 was harmed, citing another investigative report stating that the resident was assessed by the Social Services Director "noting no adverse psychosocial outcome." *Id.*, citing CMS Ex. 33, at 31. The ALJ made no finding of actual harm with regard to this incident. We note, however, that Somerset's own investigative notes state that the facility immediately began "attempting to arrange a room change" for Resident # 21 "to assist in this matter"

[5] The investigative report states that a Daniel Jones called the DON at home to report the issues, and the nurse's note appears to be signed by him, but the investigative report does not list Daniel Jones among the staff members interviewed. CMS Ex. 33, at 30.

(CMS Ex. 33, at 31), which suggests that the staff at the time was indeed concerned about the impact on Resident # 21.

The ALJ found that on **May 28, 2008** Resident # 9 was seen "making sexual advances towards an unidentified female resident" and persisting despite staff attempts at redirection and later trying twice to get into a female resident's room or persuade her to go with him to the break room. ALJ Decision at 5, citing CMS Ex. 6, at 69, 102. Furthermore, the ALJ found that, on **May 29, 2008**, Resident # 9 was found in the room of Resident # 26, who "complained that Resident # 9 had attempted to touch her inappropriately." ALJ Decision at 5, citing CMS Exs 6, at 102; 27, at 1; 1, at 16. Somerset alleges that these incidents were not "three separate occurrences" and did not involve "unidentified female residents," but rather "were actually one event which occurred on one day and was investigated on the following day" involving only Resident # 26. Somerset Br. at 11. Somerset characterized the event as involving Resident # 9 "making inappropriate remarks" to an "alert & verbal" resident." *Id*.

Nurse's notes on Resident # 9, cited by the ALJ, report that at 2 PM on May 28, 2008 he was in the hallway "making sexual advances toward" a female resident not named in the notes and that, despite several efforts to redirect him, he "continues to make sexual advances." CMS Ex. 6, at 69. A social services note from the same day, also cited by the ALJ, notes that staff reported that Resident # 9 "had inappropriate sexual contact with a female resident," was redirected and left the area, but then "has made 2 attempts to go into female res room or get her to go to the break-room with him." CMS Ex. 6, at 102. These records clearly support the ALJ's finding that more than one episode occurred on May 28, 2008. The ALJ made no finding as to whether the female resident involved in each was the same individual or different, and we do not see that it alters the analysis in any case. The note for May 29, 2008 states that Resident # 9 was found "in room with female resident <u>that he had been re-directed away from yesterday</u>," that he was again redirected, and that the female resident stated "to staff <u>at this time</u> that res. had tried to touch her inappropriately." CMS Ex. 6, at 102 (emphasis added). The ALJ reasonably relied on this contemporaneous facility record in finding that the episode on May 29, 2008 was yet another separate event, even though it may have involved the same female resident who was the target of Resident # 9's behavior in at least one of the episodes on the prior day.[6] The ALJ's finding that Resident # 26 complained that Resident # 9 was in her room trying to touch her in a sexually-inappropriate manner on May 29th is also

[6] The typed log prepared by the Administrator for the surveyors states that on May 29, 2008 Resident # 9 tried to get a female resident to accompany him into a room, but fails to report any event on May 28, 2008. CMS Ex. 27, at 1. This account is inconsistent both with the contemporaneous records and with Somerset's assertion on appeal that the only episode occurred on May 28, 2008 with an investigation the next day. The investigative report of the May 28th incident is not dated so it does not support Somerset's claims that the investigation occurred on May 29th and that no other incident happened on May 29th. CMS Ex. 33, at 33.

supported by the nurse's note and contradicts the claim in Somerset's brief that the encounter merely involved "inappropriate remarks." Even if the behavior were verbal rather than physical, Somerset's own policy includes verbal abuse involving "any use of oral, written or gestured language" to disparage a resident regardless of ability to comprehend and also includes sexual harassment as well as sexual coercion or assault. CMS Ex. 24, at 12.

The ALJ further found that Resident # 9 was seen on **May 30, 2008** "making sexual advances" to a female resident not identified by name in the nurse's notes and overheard on **June 18, 2008** "making sexually suggestive remarks" to a female resident again not identified in the behavior log notes.[7] ALJ Decision at 5, citing CMS Exs. 6, at 69; 9, at 17. Somerset does not deny in its brief the multiple staff observations of Resident # 9 behaving inappropriately in attempting to touch female residents, particularly in the chest area, during May 2008. Somerset Br. at 7-12. Somerset nevertheless asserts without any citation to evidence in the record, that after May 29, 2008, the "interventions initiated by the facility were effective in preventing any further behaviors until July 8, 200[8]." Somerset Br. at 12. The Administrator's own timeline of events, however, claims that facility "interventions [were] effective until [the] last week of June" without explaining what occurred during the last week of June. CMS Ex. 27, at 2. Social services notes state that Resident # 9 was "verbally & physically abusive" to another resident on June 2, but does not indicate if the abuse was sexual in nature. CMS Ex. 6, at 104. In any case, the claim that incidents stopped (or went unobserved) for several weeks, even if it were supported on the record, would not undermine the ALJ's findings about the many recorded incidents based on substantial evidence in the record.

The ALJ described the **July 8, 2008** observation of Resident # 9 "in a hallway kissing and fondling the breasts of Resident # 21." ALJ Decision at 6, citing CMS Exs 1, at 16-17; 9, at 21. Somerset relies on investigative notes to argue that the residents were having a "conversation with sexual content," during which Resident # 9 pursed his lips

---

[7] Somerset's Administrator testified as follows about the events of May 2008:

> Staff suspected that Resident 9 began exhibiting episodes of sexually inappropriate behaviors in May, 2009. However, no staff member actually observed any inappropriate behaviors during this time, and no resident was able to describe what had occurred. These behaviors were reported to me and the [DON], and we followed up by interviewing those individuals who made the reports and the residents involved.

P. Ex. 7, at 2-3. The claim that no inappropriate behavior was observed by staff or described by residents is inconsistent with undisputed contemporary documentation as well with the statement that these behaviors were reported and investigated. Possibly, the Administrator means that her investigations did not substantiate that physical contact was actually seen by staff during the episodes, but, if so, she does not explain why physical contact would be a prerequisite to recognizing sexual advances as inappropriate, especially where cognitively-impaired victims were involved.

and reached toward Resident # 21's chest, but did not make contact. Somerset Br. at 12, citing CMS Ex. 33, at 34. While arguing that the ALJ should have credited the investigative report, Somerset ignores the contemporaneous behavior log prepared by its staff and on which the ALJ relied. That log states that Resident # 9 was "fondling a female resident" and was observed "kissing another res then started feeling of her breasts." Somerset Br. at 12-13; CMS Ex. 9, at 21. Somerset also argues that Resident # 21 suffered no physical harm or mental anguish because her regular nursing assessments and behavior log record no untoward changes, and her regular visit by a psychiatric PA on July 18, 2008 revealed no mood problems. Somerset Br. at 13. The ALJ made no finding of actual harm in relation to Resident # 21. The investigative report states that Resident # 21 could provide no information about the incident "due to cognitive status," but that she was "taken to Activities for her protection and monitoring." CMS Ex. 33, at 34-35. Thus, the facility was clearly aware that the resident was unable to report the effect of the sexual conduct on her and that she needed to be protected from Resident # 9.

It is notable that, despite Somerset's minimizing the significance of this and prior episodes, the facility notified Resident # 9 and his family in both May and July that he would face discharge unless he ceased such behavior. Somerset Br. at 11, 13.

The ALJ listed four occasions on **August 22 and 23, 2008** on which Resident # 9 was found in or entering the rooms of female residents, holding on to a partially opened shirt of one female resident and reaching for the breasts of another female resident. ALJ Decision at 6, citing CMS Ex. 9, at 24. None of the women were named in the behavior log notes. CMS Ex. 9, at 24. Somerset did not dispute these episodes in its brief and submitted no investigative reports following up on the incidents.

Somerset also admits that, as the ALJ found, Resident # 9 "was witnessed grabbing Resident # 10's breast" on **October 16, 2008**. Somerset Br. at 14-15; ALJ Decision at 6, citing CMS Exs. 6, at 108; 9, at 29;, 27, at 2; 34, at 17. A facility nurse testified at the discharge hearing that Resident # 10 had dementia, with little verbal ability, and "was not capable of consent," when Resident # 9 was found with his hand inside her shirt. CMS Ex. 34, at 17. Somerset contends that Resident # 10 had "a history of being tearful, sad and crying," and that she showed no distress or fear and was found in a psychiatric consult to be "calm, pleasant, and to have a bright affect." Somerset Br. at 14-15, citing CMS Exs. 11, at 2; 29, at 8; 33, at 111; P. Ex. 9. The ALJ made no finding of actual harm to Resident # 10.

Apparently, Somerset's contention is that permitting Resident # 9 to grope Resident # 10's breast under her shirt did not meet the definition of abuse because a negative change in Resident # 10's emotional state could not be traced to the episode. As

discussed earlier, however, it is not necessary for CMS to show that every improper interaction by Resident # 9 with a female resident led to physical or emotional harm or constituted abuse for the ALJ to conclude that these episodes demonstrated Somerset's failure to effectively protect its female residents from abusive behavior.

Somerset concedes that the October 16th incident triggered the abuse policy requirement to investigate and report abuse to the appropriate state agency, even in the absence of a showing of actual harm, and that it failed to follow that policy in regard to the Resident # 10. Somerset Br. at 24, 26; Somerset Reply Br. at 9. Somerset suggests that its failure to notify the appropriate state agency should be excused, however, because Somerset initiated discharge proceedings soon after the incident about which the state agency would receive notice. Somerset identifies nothing in the regulations supporting its apparent theory that its obligations to provide timely notice of alleged abuse and of the results of its investigation of that alleged abuse to the state agency are obviated where the state agency would learn of the abuse through discharge proceedings.

The ALJ also included on the list of Resident # 9's continual efforts to "engage in uninvited sexual activity" with female resident a **December 10, 2008** incident when Resident # 9 invited a female resident to enter his room but she declined. ALJ Decision at 5-6. The episode is included in Resident # 9's behavior log. CMS Ex. 9, at 33. Somerset states that no "further incidents of inappropriate sexual behaviors occurred after October 16, 200[8]," denying that the December 10, 2008 incident was "sexual" in nature. Somerset Br. at 15, 22 n.8. The Administrator testified that this and other incidents such as Resident # 9 reaching out for female residents were documented only because of the close monitoring of Resident # 9 and would normally not be perceived as inappropriate. P. Ex. 7, at 4. These incidents did not occur in a vacuum, however, but in the context of Resident # 9's repeated attempts to sexually assault female residents and of repeated warnings to, and agreements by, Resident # 9 not to go into the rooms of female residents. *See, e.g,* CMS Ex. 6, at 102-108. While Resident # 9's "invitation" was declined by the female resident without reported difficulty, we see no error in the ALJ including the solicitation as part of Resident # 9's pattern of advances toward multiple female residents, many of whom were incapable of consenting to or declining them.

Somerset argues that its female residents were not subjected to sexual abuse by Resident # 9 because CMS did not prove that Resident # 9 acted willfully or that the victims suffered physical harm, pain or mental anguish. Somerset Br. at 15-16. We have rejected similar arguments about resident-on-resident abusive behavior in past cases. *See, e.g., Singing River Rehab. & Nursing Center*, DAB No. 2232 (2009); *Western Care Management Corporation, d/b/a Rehab Specialties Inn*, DAB No. 1921 (2004). Contrary to Somerset's suggestion that Resident # 9 must be proven to have "intended to injure or intimidate" the victims but could not have formed such intent with a diagnosis of

dementia, the Board has recognized the nonaccidental actions of a compromised resident as potentially abusive to other residents and sufficient to impose a duty of protection, investigation and reporting on the facility. *Singing River* at 11.

We have already found substantial evidence in the record to support the ALJ's finding that at least one resident did suffer actual harm. Somerset contends that the ALJ failed to make any finding of mental anguish as to any of the other residents. Somerset Br. at 17. The ALJ pointed out, however, that in many cases Somerset failed to conduct proper investigations with prompt examination by physicians or other staff, or even to identify the specific residents, so that any consequences of the nonconsensual groping, fondling, sexual comments and other behaviors for the targeted residents cannot be ascertained after the fact. ALJ Decision at 9. The more important point, however, is that every instance of inappropriate behavior by Resident # 9 need not have been substantiated as full-blown abuse to have put the facility on notice that its female residents require protection from his behavior in order for the facility to satisfy the female residents' right to be free from abuse. As we discuss further later in this decision, moreover, no showing of actual harm is necessary to establish that the facility's failure to protect its female residents exposed them to immediate jeopardy, where, as here, the circumstances demonstrated a likelihood of serious harm occurring. *See, e.g., Daughters of Miriam Center*, DAB No. 2067 (2007).

We next consider the ALJ's findings about Somerset's response to Resident # 9's behaviors and the danger they posed to other residents.

2. The ALJ's findings that facility interventions to protect residents from abuse were ineffective are supported by substantial evidence.

Somerset contends that it took graduated measures to deal with Resident # 9's behaviors, that these steps were successful for long periods and that it reasonably increased its interventions when the behaviors recurred. Somerset Br. at 18-24. Somerset keys its explanations of the interventions taken to its version of the timeline of events, which we have generally rejected above and will not repeat here. We therefore address below Somerset's arguments about the effectiveness and reasonableness of its efforts.

Somerset first asserts that it had "no knowledge" of Resident # 9's propensity to sexually inappropriate behavior until the "relatively minor event" of May 10, 2008. Somerset Br. at 19. The ALJ found that Somerset "knew, or should have known, at the time of Resident # 9's admission" that he "posed a threat to the safety and well-being of other residents." ALJ Decision at 4. The ALJ cited testimony by Surveyor Brock. Surveyor Brock reported that, in an interview, the Social Services Director, Jennifer Davis, informed her that the same psychiatric PA had been seeing Resident # 9 before his

admission to Somerset and "may even [have] sent some of his past notes on Resident # 9 to Somerset." CMS Ex. 39, at 3-4. Ms. Davis stated that this PA told her that Resident # 9's "sexual aggression had been his lifelong problem and he had been in seven different facilities." *Id.* at 4. Ms. Davis provided testimony stating that she learned this history only after Resident # 9's admission, beginning with conversations with the resident's daughter on May 22, 2008, and that the resident "did not begin to exhibit inappropriate sexual behaviors immediately upon his admission." Pet. Ex. 5, at 2. The surveyor's testimony did not specify when the facility learned of Resident # 9's prior history and the ALJ did not address why he rejected Ms. Davis's statement that her first information about it was received in May 2008, by which time Resident # 9 had already begun displaying inappropriate behavior at the facility. Other evidence in the record to which the ALJ did not refer does support the ALJ's finding, however. The state long-term care ombudsman testified at the state discharge hearing that she did inform the facility about Resident # 9's "history of sexualized behavior." CMS Ex. 34, at 15. In any case, this finding is not material to the outcome of our decision, since there is ample evidence in the record that the facility was aware of Resident # 9's sexually aggressive and inappropriate behavior toward female residents by at least May 10, 2008 when the CMP period begins.

The interventions to which Somerset refers in its brief to us include "teachable moments" conducted with some staff members after some of the incidents (Somerset Br. at 9, 14-15, citing CMS Ex. 33, at 29, 71, 72, 75); a psychiatric consult for Resident # 9 in May 2008 (Somerset Br. at 9, citing CMS Exs. 27, at 1; and 33, at 9); and discussions by social services staff with Resident # 9 and his family (*id*. at 10, citing CMS Ex. 33, at 31). Somerset asserts that a meeting was held on May 31, 2008 with Resident # 9 and his daughter, warning that he would be "discharged if behaviors did not cease," and resulting in involving Resident # 9 in "diversionary activities" such as gardening. Somerset Br. at 11-12. According to Somerset, these measures were reflected in an updated care plan. *Id.* at 12, citing CMS Ex. 33, at 43-44, 61, 66, 69. Somerset states that, after the August 21, 2008 episode, Resident # 9 was again seen by the psychiatric PA and began weekly meetings with social services. *Id*. at 14, citing CMS Ex. 6, at 76; and P. Exs. 2 and 7. A "teachable moment" was held on August 22, 2008 to instruct staff "to monitor Resident 9 and keep him away from female residents at all times" and staff specifically assigned to conduct checks every 15 minutes to avoid elopement were "advised to continue monitoring Resident 9 for behaviors and additionally, to monitor his location and redirect Resident 9 from females' rooms." *Id*. at 14, citing CMS Ex. 6, at 115. After the October 16, 2008 episode, Somerset began the discharge process but Resident # 9 was not actually discharged until January 9, 2009. *Id*. at 15. By that time, the PA had informed the Director of Social Services that he could not imagine any intervention that would succeed in resolving Resident # 9's behaviors. P. Ex. 5, at 2.

Somerset's basic argument is that the measures it undertook each worked until they stopped working at which point new steps were added. *See, e.g., id*. at 2-3. Somerset further alleges that Resident # 9's behaviors "never escalated in frequency or in their severity" and in fact "became less frequent over time." Somerset Br. at 30. This allegation relies on Somerset's claim that no incidents of inappropriate sexual behavior occurred between August 21 and October 16, 2008 or after October 16, 2008. *Id*. We have explained above that the record supports the ALJ's findings about four additional episodes later in August 2008, episodes that Somerset did not dispute on appeal. Furthermore, Somerset's claim to us is inconsistent with its social service notes, which reflect that the Administrator and DON discussed Resident # 9's "escalating sexual aggression" with him and his family on May 31, 2008. CMS Ex. 6, at 103 (emphasis added). During the period between the August and October incident, Somerset's records show counseling with Resident # 9 on September 1, 2008 relative to "a conversation he had with the DON and Administrator r/t inappropriate behavior towards a female resident;" on September 11, 2008 relative to "interaction with female residents;" on September 19 and 25, 2008 regarding "personal space" and "inappropriate" social behaviors; and on October 10, 2008 to remind him "to keep his hands to himself around all females including residents, staff, and visitors." *Id.* at 105-07. These entries all evidence an ongoing problem with Resident # 9's behavior toward women. Furthermore, staff testified at the discharge hearing that "problems persisted" with Resident # 9 "throughout September." CMS Ex. 34, at 17. On November 5, 2008, a social services note records a meeting with Resident # 9 about the discharge letter and documents that the resident "has not responded to interventions" by his physician, his family or the staff "in regards to inappropriate behaviors." CMS Ex. 6, at 109. We therefore conclude that the ALJ's finding that Somerset's interventions with Resident # 9 were "singularly ineffective" is supported by substantial evidence in the record as a whole.

The essential problem highlighted in the ALJ Decision is that, whatever the merits of various efforts at helping Resident # 9, insufficient attention was paid to protecting the female residents from his abusive behaviors. The Director of Social Services testified that it appeared to her that Resident # 9's "inappropriate sexual behaviors" might have "related to his frustration in losing control of his life, and not being at home with his wife," and that the facility sought to address this through the psychiatric consults, the call for more family involvement, and the effort to distract him into other activities," in the belief that such intervention might change his behavior. P. Ex. 5, at 2. Somerset knew, however, that Resident # 9 was resistant and noncompliant with staff requests to the point of violence, that he had threatened to kill his roommate and had kicked and shoved other residents, and that he was, as the Administrator described him to a surveyor, "aggressive, grouchy, and volatile."[8] ALJ Decision at 4, and record citations therein. The ALJ points

[8] Somerset asserts that it was error for the ALJ to refer to "Resident # 9's history of noncompliance with (Continued. . .)

out that, while waiting to see if Resident # 9's behavior improved, Somerset did not ensure that he was watched when he was around vulnerable female residents. ALJ Decision at 7. The ALJ recognized that Resident # 9 was placed on a list for specific staff to perform 15-minute location checks only after an elopement incident in July 2008. *Id*. Somerset did not identify anything in the record to contradict the ALJ's findings that this measure was not adopted to control Resident # 9's sexual predation and that it did not stop continued sexual behaviors directed at female residents.

While the ALJ did not discuss the "teachable moments" in detail, he included the facility's attempts at educating staff to deal with "inappropriate sexual behaviors in general, and the resident's behaviors in particular" as among the interventions that the Somerset should have known were ineffective in light of the persistence of the abusive conduct. *Id*. The ALJ recognized that the resident's care plan was amended but found no evidence that the plan for frequent monitoring for sexual behaviors was ever systematically implemented or that the gardening had any effect on his behaviors. *Id.* at 8. While Somerset asserts that its staff was aware of the need to watch for inappropriate behavior and would step in to protect residents from harm, the ALJ was entitled to give more credit to the testimony of the surveyors that many staff members whom they interviewed were not aware of any need to provide any special supervision or monitoring to Resident # 9. *Compare* Somerset Br. at 9-10 *with* CMS Ex. 39, at 2-4. Substantial evidence in the record also supports the ALJ's conclusion that attempts to increase family involvement were not likely to be beneficial, since the facility learned from Resident # 9's daughter that he was placed in skilling nursing due to his history of sexually abusing his demented wife. ALJ Decision at 8, citing CMS Ex. 39, at 4; P. Ex. 5, at 2.

Further, the ALJ found that, despite Somerset's claim that Resident # 9's physicians were involved in an effort to curb his sexualized behavior toward female residents, the record shows no evidence that his primary physician or the facility medical director were aware of or treating him for this problem. ALJ Decision at 8, and record citations therein. The ALJ noted that Resident # 9 was seen three times by the psychiatric PA but his evaluation forms do not reflect any review for sexual aggression. *Id*. Somerset has not identified any record evidence showing medical interventions addressing these behaviors.

(Continued. . .)

staff and medication, as well as his use of threatening language toward other residents," because these incidents were not cited as deficiencies. Somerset Br. at 18 n.6. We disagree. The ALJ did not rely on this history as an independent basis for finding noncompliance but rather as context showing both that the resident's sexual aggression should have been taken seriously and that the inadequacy of "discussions" with him as an intervention should have been apparent quite early. Somerset did not dispute the accuracy of the ALJ's description of Resident # 9's history of noncompliance with caregivers or use of threatening language.

Somerset argues that facilities "must be allowed to determine what is reasonable" in light of its particular circumstances, even though "such discretion will also mean that the facility cannot guarantee that future incidents will not occur." Somerset Br. at 24. The regulations indeed take an outcome-oriented approach in many regards – setting out the minimum conditions that must be met to serve the residents but permitting facilities the flexibility in electing the means to meet those conditions. 54 Fed. Reg. 5316, 5332 (Feb. 2, 1989); *see also Virginia Highlands Health Rehabilitation Center*, DAB No. 2339, at 4 (2010) and *Lake Mary Healthcare*, DAB No. 2081, at 17 (2007). The means chosen, however, must be adequate to achieve the required ends. *Windsor Health Care Center*, DAB No. 1902, at 5 (2003), *aff'd*, *Windsor Health Care Ctr. v. Thompson*, No. 04-3018 (6th Cir. Apr. 13, 2005). In particular, the right of all residents to be free from abuse and the obligation of the facility to ensure that all allegations of abuse are reported and thoroughly investigated and further potential abuse prevented are critical outcomes that cannot be achieved by measures fairly characterized by the ALJ here as "tepid and half-hearted when they are scrutinized closely." ALJ Decision at 7.

C. We uphold the ALJ's conclusion that CMS's immediate jeopardy determination was not clearly erroneous.

Previous Board cases have explained the high bar set by regulation to overturn a determination by CMS that a facility's noncompliance presents an immediate jeopardy to its residents. In *Brian Center*, the Board reiterated that a determination that immediate jeopardy is present is a determination about the level of noncompliance, and the regulations provide that "CMS's determination as to the *level* of noncompliance of an SNF or NF must be upheld unless it is clearly erroneous." *Brian Center Health and Rehabilitation/Goldsboro*, DAB No. 2336, at 6 (2010), quoting 42 C.F.R. § 498.60(c); *see also Fairfax Nursing Home, Inc.*, DAB No. 1794, at 17 (2001) *aff'd, Fairfax Nursing Home v. Dep't of Health & Human Servs.*, 300 F.3d 835 (7th Cir. 2002), *cert. denied*, 537 U.S. 1111 (2003); *Rolling Hills Rehab Center*, DAB No. 2119, at 7 (2009); *Harlan Nursing Home*, DAB No. 2174, at 9-13 (2008). Under the clearly erroneous standard, CMS's determination is presumed to be correct, and the facility bears a heavy burden to demonstrate clear error. This standard logically applies to CMS's determination as to the duration of the immediate jeopardy as well. *Brian Center* at 7.

Somerset does not dispute that the ALJ was correct in applying the clearly erroneous standard but argues that CMS did not offer "any evidence or meaningful argument" to show immediate jeopardy, and "certainly no basis for determining that immediate jeopardy existed as far back as May 10, 2010. Somerset Reply Br. at 10-11. Somerset acknowledges that immediate jeopardy does not depend on the occurrence of actual harm but rather on the likelihood that the noncompliance will cause serious harm to one or

more resident. Somerset Br. at 28-30. Somerset argues that the ALJ was wrong in determining that Resident # 15 suffered any actual harm. *Id.* at 29-30.

Somerset claims that, when Resident # 15's physician was made aware of the incident, "he stated that the pinch to her breast would not be a medical concern as she said there were no bruises." *Id*. at 14, citing CMS Ex. 21, at 19. This claim distorts the record. The medical director was "made aware" of the incident only the day before he was interviewed by Surveyor Candido. CMS Ex. 21, at 19. The surveyor asked him if he should have been notified and the medical director expressed "disappointment" that he was not notified. *Id*. The surveyor then asked whether the resident's breast would be a medical concern. *Id*. His response was: "she said there were no bruises. I think they do a good job here. I believe her. How do you find a place for him?" *Id*. The antecedent of "she" is not clear in the notes, so it is uncertain whether it was the patient herself or a staff member who told the medical director in January 2009 that there were no bruises on Resident # 15's breast. Since Somerset identifies no record of a physical medical examination of Resident # 15, it is also unclear what basis the staff had for telling the medical director that no bruises resulted from the pinching. The medical director's statement to the surveyor is not based on his personal knowledge. Moreover, he is not reported as stating that pinching this resident's breast did not raise medical concerns or raised them only if bruising resulted, but merely that he believed the assertion that bruising had not resulted.[9] Somerset did not present any statement or testimony from the medical director to expand on or clarify his interview with the surveyor, so the ALJ was not obliged to read into the notes of the interview the interpretation now proposed by Somerset. In any case, the ALJ did not rely on his findings about the risk of lymphedema as a basis for finding that actual physical injury occurred but, rather, that a "grave threat" existed to her from Resident # 9 physically impacting this breast. ALJ Decision at 10; *see* CMS Ex. 43; Tr. at 77.

The ALJ did find that Resident # 15 "clearly manifested signs of psychological harm," based on her statement to surveyors that she continued to fear Resident # 9 and kept her door closed as a result. *Id*. at 11. Somerset argues that Resident # 15's husband provided a statement that his wife kept her door closed before the episode and after Resident # 9's discharge.[10] Somerset Br. at 17; P. Ex. 8, at 2-3. Surveyor Candido was cross-examined on the latter point and testified that –

[9] Thus, Somerset's further assertion, without record citation, that Resident # 15 must have suffered no serious harm because her primary care physician was "not concerned" and made "no recommended changes to her treatment" when he was notified of the incident is unpersuasive given the belated notification. Somerset Br. at 30.

[10] In an earlier statement, Resident # 15's husband averred that his wife sometimes sought attention (through suicide threats) but that he had "no doubt" in his mind that the "molestation" took place, although her "statement of her breast hurting for a week" could be exaggerated, as he did "not recall her mentioning it hurting for

(Continued. . .)

> Staff told us she kept her door closed. She said that she kept her door closed. She liked it to be warm and she wanted to be safe, and not be bothered, and to be sure that Resident No. 9 did not come into her room.

Tr. at 73. The ALJ could thus reasonably conclude that the husband's testimony that Resident # 15 had always kept her door closed was not inconsistent with the resident's own statement to the surveyor that she did so for multiple reasons, including protection from Resident # 9. *See* P. Ex. 8, at 3. Resident # 15's husband also denied that his wife demonstrated any fear of Resident # 9, reporting instead that she told her husband that "she would 'knock him out' if tried to touch her again." *Id.* at 2-3. While her statement leans to anger over fear, it does not suggest equanimity or lack of concern about the risk of further assaults by Resident # 9. We do not find that this evidence detracts from the evidence supporting the ALJ's finding that Resident # 15 showed signs of psychological distress persisting even at the time of the survey, months after the incident.

Somerset also argues that no likelihood of serious harm existed because, at the time of each incident, Resident # 9 "was in his wheelchair – a fact overlooked by the ALJ." Somerset Br. at 29. We are aware of no basis to assume that a resident mobile in a wheelchair lacks the ability to inflict serious emotional and even physical harm by sexually harassing or abusing female nursing home residents. Furthermore, far from overlooking the resident's use of a wheelchair, the ALJ expressly described Resident # 9's independent mobility in his wheelchair and his physical size and robustness, so that it is clear the ALJ took the evidence relating to Resident # 9's capabilities in arriving at his findings about the likelihood of serious harm to female residents if the resident continued his sexually aggressive behavior with no effective check on his actions.[11] ALJ Decision at 4, 10-11. The ALJ's findings upheld above about the persistence of Resident # 9's sexual misconduct and the ineffectual nature of the facility's interventions support his conclusions that the behavior would likely continue and that serious harm was likely to occur eventually to one or more victims. We further find no error in the ALJ's conclusion that the likelihood of actual harm may be assessed based not only on the specific threat from Resident # 9 abusing specific residents but based on the finding that

---

(Continued. . .)

that long." CMS Ex. 33, at 120. This assertion implies that injury with pain did occur at the time of the incident, although physical pain may not have persisted as much as a week.

[11] Furthermore, Somerset's descriptions of Resident # 9's capabilities are not supported by the facility's own documents. For example, Somerset alleges that Resident # 9 "required extensive assistance of staff to propel himself long distances in his wheelchair." Somerset Br. at 3. The resident assessment report to which Somerset cites, however, states that the resident used a wheelchair "as primary mode of locomotion on & off units self propelled [with] staff assisting as needed." CMS Ex. 7, at 36.

the facility's ineffectuality and lack of urgency in managing Resident # 9's behaviors manifested a lack of comprehension by the facility "of the ambit of its responsibility to protect its residents." *Id.* at 11. Such a failure, as the ALJ stated, implicates danger to all residents from abuse whether by Resident # 9 or someone else. *Id.*

Somerset also contends that, even if we uphold the ALJ's conclusion that noncompliance existed at the level of immediate jeopardy (as we have), we should find that it did not begin as early as May 10, 2008. Somerset Br. at 31. Somerset reiterates its contentions that no evidence of Resident # 9's proclivities came to its attention prior to that date and that the facility immediately responded by meeting with Resident # 9 after the events of May 10, 2008. *Id*. We have concluded above that the ALJ's contrary findings are supported by substantial evidence. *See* ALJ Decision at 11.

For similar reasons, we reject Somerset's position that any finding of immediate jeopardy prior to October 16, 2008 or after November 3, 2008 (when the discharge notice was sent) must be clearly erroneous. In the alternative, Somerset argues that, on January 7, 2009, one-on-one monitoring of Resident # 9 was implemented and that any risk to female residents was eliminated at that point.[12] The fact that such monitoring was not implemented until months after the facility had determined that Resident # 9's behaviors could not be managed supports the ALJ's conclusion that the likelihood of serious harm was broader than the specific threat from Resident # 9's behavior and represented a systemic failure to appreciate the importance of protecting its residents from abuse and of pursuing all allegations or observations of possible abuse existed. The ALJ concluded that, although Resident # 9 left the facility on January 9, 2009, the facility did not complete corrective actions until January 14, 2009. ALJ Decision at 12. The record supports this finding. We therefore do not find clearly erroneous CMS's determination that immediate jeopardy persisted until January 14, 2009.

Finally, Somerset argues that the total CMP of $761,550 was disproportionate to the noncompliance alleged. Somerset Br. at 33-34. The amount of the immediate jeopardy per-day CMP is set at $3,050, the minimum amount permitted by regulation. The total amount is not subject to review on appeal where the per-day amount is at the minimum of the applicable range. As the Board has explained, "[o]nce we determine that a legal basis existed for CMS to impose a CMP within one of the regulatory penalty ranges, we have no authority to reduce the CMP amount below the minimum amount specified by the applicable penalty range." *Magnolia Estates Skilled Care*, DAB No. 2228, at 27-28 (2009), citing 42 C.F.R. § 488.438(e)(1), (2); Final Rule, *Medicare and Medicaid Programs; Survey, Certification and Enforcement of Skilled Nursing Facilities and*

[12] The fact that Somerset did eventually implement one-on-one monitoring belies its claim that it was unable to provide such supervision. *Cf.* Somerset Br. at 22.

Nursing Facilities, 59 Fed.Reg. 56,116, 56206 ("[W]hen the administrative law judge or State hearing officer (or higher administrative review authority) finds noncompliance supporting the imposition of the civil money penalty, he or she must remedy it with some amount of penalty consistent with the ranges of penalty amounts established in § 488.438."); and *Century Care of Crystal Coast*, DAB No. 2076, at 26 (2007). The ALJ therefore did not err in concluding that the amount is reasonable as a matter of law.

Conclusion

For the reasons explained above, we affirm the ALJ Decision.

/s/
Sheila A. Hegy

/s/
Constance B. Tobias

/s/
Leslie A. Sussan
Presiding Board Member