**Department of Health and Human Services**

**DEPARTMENTAL APPEALS BOARD**

**Civil Remedies Division**

Qualicare Nursing Home,
(CCN: 23-5622),

Petitioner,

v.

Centers for Medicare & Medicaid Services.

Docket No. C-11-630

Decision No. CR2665

Date: November 16, 2012

# DECISION

Following a complaint investigation survey, the Michigan Department of Licensing and Regulatory Affairs (state agency) determined that Qualicare Nursing Home (Petitioner or facility) failed to protect one of its residents from sexual assault. Based on this finding, the Centers for Medicare and Medicaid Services (CMS) determined Petitioner was not in substantial compliance with Medicare participation requirements for a long-term care facility and imposed a $2,500 per-instance civil money penalty (CMP). Petitioner appeals.

For the reasons explained below, I find that Petitioner was not in substantial compliance with Medicare participation requirements and that the CMP imposed is reasonable.

## I. Case Background and Procedural History[1]

Petitioner is a long-term care facility located in Detroit, Michigan that participates in the Medicare and Medicaid programs. The victim of the incident giving rise to this case was

[1] Unless otherwise noted, the facts recited in this section of the decision are undisputed.

a 65-year-old female resident of Petitioner's facility. The resident, referred to as "Resident 201" (R201) during the survey and these proceedings, was admitted to the facility following a stroke, was in a persistent vegetative state, and was totally dependent upon facility staff for all of her needs. The facility placed R201 with a roommate, referred to as "Resident 202" (R202). R202 had been admitted to the facility with a history of a stroke and schizophrenia. At all times relevant to this case, R202 was alert, though not always reliable or consistent with her answers to questions from facility staff or investigators.

On April 17, 2011, R202's brother (the perpetrator) came to visit R202 at the facility at approximately 4:45 p.m. During the visit, a licensed practical nurse (LPN1), a member of the facility's nursing staff, noticed that the perpetrator repeatedly left the residents' room to go to the vending machine in the dining area of the facility. The perpetrator went back-and-forth between the room and dining area two or three times within a 30-minute period. At approximately 6:45 p.m., on her regular rounds, LPN1 observed the curtain around R201's bed had been closed, obstructing the view of R201.[2] LPN1 entered the room, reopened the curtain, and told the perpetrator that the privacy curtain around R201 had to remain open at all times so that the staff could monitor R201. The perpetrator did not deny that he closed the curtain.

When she returned to the room at approximately 7:00 p.m., LPN1 again observed the curtain around R201's bed was drawn. She briefly discussed the closed curtain with another staff member, and then she quietly entered the room. She looked behind the privacy curtain around R201's bed and saw R201's breasts exposed and the perpetrator with his mouth on R201's right breast. LPN1 immediately stopped the perpetrator and ordered him to leave. She then alerted the director of nursing, who, in turn, notified the police, the facility administrator, and R201's family. The police arrived shortly thereafter, apprehended the perpetrator nearby, and charged him with fourth-degree criminal sexual conduct. A forensic nurse examined R201 at the facility. Emergency medical service personnel then transported R201 to a local hospital for evaluation and treatment for potential sexually transmitted diseases.

The facility administrator initiated an internal investigation of the assault and reported the incident to the state agency. The state agency then conducted a survey that concluded April 26, 2011. The state agency found that the facility was not in substantial compliance with certain Medicare participation requirements for long-term care facilities:

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[2] Petitioner disputes that the curtain around R201 was pulled at 6:45 p.m. P. Reply Br. at 4. However, as set forth in Part IV below, the evidence submitted and adduced at the hearing demonstrates that the curtains were pulled around both R201 and R202 at that time.

- 42 C.F.R. § 483.13(b), which requires that each resident be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion; and

- 42 C.F.R. § 483.13(c)(1)(i), which requires that the facility must not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion.[3]

The state agency cited the facility at a scope and severity level of "G," meaning that the surveyors found an isolated instance of actual harm that was not immediate jeopardy. On July 20, 2011, CMS imposed a per-instance CMP of $2,500 based on the state agency's survey findings.

On July 22, 2011, Petitioner requested a hearing before an administrative law judge (ALJ) to contest the survey findings and enforcement remedies. The case was assigned to me for a hearing and decision. Following prehearing briefing and submissions, I held a prehearing conference on March 12, 2012, where I admitted CMS Exhibits (CMS Exs.) 1-16 and Petitioner Exhibits (P. Exs.) 1- 3 over the objection of CMS counsel. I directed the parties to obtain and submit a copy of the police report regarding the incident, which Petitioner did on April 17, 2012. The police report has been admitted into the record as ALJ Ex. 1. On April 27, 2012, I held a hearing by video teleconference. A transcript of those proceedings (Tr.) has been incorporated into the record. Following the hearing, CMS filed a motion to supplement its exhibits and a copy of CMS Ex. 17, which contained medical records of R202. Petitioner responded by filing its own motion to supplement its exhibits and a copy of P. Ex. 4. The submitted exhibit contained additional medical records of R202 that were not included with CMS's submission. Neither party objected to the opposing party's submission. Therefore, I admit both CMS Ex. 17 and P. Ex. 4 into the record. The parties also submitted post-hearing briefs (CMS Br. and P. Br.) and post-hearing reply briefs (CMS Reply Br. and P. Reply Br.).

## II. Statutory and Regulatory Framework

The Social Security Act (Act) establishes the requirements that a long-term care facility must meet to participate in the Medicare and Medicaid programs and authorizes the Secretary of the U.S. Department of Health and Human Services (Secretary) to

[3] The state agency cited Petitioner for only one deficiency, though the "F-Tag" used to cite the deficiency encompasses both regulatory provisions cited above. Here, the Statement of Deficiencies actually cited 42 C.F.R. § 483.13(b)(1)(i), though no such regulatory provision exists. In any event, the language of Tag F-223, used here, is consistent with the two regulatory provisions cited above, and therefore provided Petitioner adequate notice of the alleged deficiency. *See Illinois Knights Templar Home*, DAB No. 2369, at 2 n.2 (2011). Moreover, the parties have correctly referred to section 483.13(c)(1)(i) in their submissions.

promulgate regulations implementing those statutory requirements. Act §§ 1819, 1919.[4] Specific Medicare participation requirements for long-term care facilities are at 42 C.F.R. Part 483. A long-term care facility must remain in substantial compliance with program requirements to participate in Medicare. 42 C.F.R. § 483.1(b). "Substantial compliance" means "a level of compliance with the requirements of participation such that any identified deficiencies pose no greater risk to resident health or safety than the potential for minimal harm. 42 C.F.R. § 488.301. By contrast, "noncompliance" means "any deficiency that causes a facility not to be in substantial compliance." *Id.*

The Act authorizes the Secretary to impose enforcement remedies against a long-term care facility for failure to comply substantially with the federal participation requirements. The Secretary has delegated to CMS and the states the authority to impose remedies against a long-term care facility not in substantial compliance with program participation requirements. State agencies survey facilities on behalf of CMS to determine whether the facilities comply with federal participation requirements. 42 C.F.R. §§ 488.10-.28, 488.300-.335. The regulations specify the enforcement remedies that CMS may impose if a facility is not in substantial compliance with Medicare requirements. 42 C.F.R. § 488.406.

CMS may impose a per-day CMP for the number of days a facility is not in substantial compliance or a per-instance CMP for each instance of the facility's noncompliance. 42 C.F.R. § 488.430(a). A per instance CMP, which CMS imposed in this case, may range from $1,000 to $10,000. 42 C.F.R. § 488.438(a)(2). A long-term care facility may request a hearing before an ALJ to challenge a noncompliance finding and enforcement remedies. Act §§ 1128A(c)(2), 1866(h); 42 C.F.R. §§ 488.408(g), 498.3(b)(13).

## III. Issues

The issues before me are:

(1) Whether, on April 17, 2011, the facility was in substantial compliance with the participation requirements at 42 C.F.R. § 483.13(b) and (c)(1)(i); and

(2) If the facility was not in substantial compliance, whether the per-instance CMP imposed was reasonable.

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

## IV. Findings

My findings of fact and conclusions of law are set forth below in the discussion captions of this decision.

### A. *Facility staff observed behaviors of the perpetrator that demonstrated a reasonable potential for resident abuse.*

The perpetrator visited R202 once per week for three weeks prior to April 17, 2011, including one occasion (the perpetrator's first visit to the facility) where facility staff denied him access because he was unable to provide R202's married name. Tr. 46; CMS Ex. 8, at 5. The perpetrator returned to the facility with a police officer to verify that he was the brother of R202 and only then did facility staff permit him access to the facility. During an April 10, 2011 visit, the perpetrator wanted to take R202 outside, but the facility did not allow him to do so because staff considered him a new visitor to the facility. CMS Ex. 8, at 14.

One week later, on April 17, 2011, the perpetrator returned to the facility. During the visit, LPN1 noticed that the perpetrator was walking back-and-forth between the facility's dining area and the residents' room. CMS Ex. 8, at 1, 11; P. Ex. 1, at 2 ¶ 11; Tr. 48, 51. R202 remained in bed during that time. CMS Ex. 9, at 9. LPN1 later told the facility administrator during an internal investigation that she thought the back-and-forth behavior was "suspicious." CMS Ex. 8, at 1, 11; P. Ex. 1, at 2 ¶ 11. In her written declaration and during the hearing, LPN1 clarified that she was concerned about the perpetrator drinking alcohol or buying harmful candy for R202, not that she was concerned about the perpetrator possibly assaulting a resident. P. Ex. 1, at 2 ¶ 12; Tr. 49-52.

Petitioner relies heavily on LPN1's explanation about why she was concerned about the perpetrator's back-and-forth behavior, arguing that she was not suspicious of any possible abuse prior to the incident. P. Br. 8-9. Petitioner thus implies that the facility did not need to take any steps to prevent an unforeseeable assault. *See* P. Br. 11. Petitioner's position, however, overlooks the critical point: LPN1 was concerned about the behavior and found it unusual. Tr. 48-51. LPN1 should have been concerned about the perpetrator's back-and-forth behavior. He was unaccompanied, moving in-and-out of a shared-resident room, bringing potentially harmful items to R202 (based on LPN1's perception of the behavior), or drinking alcohol in the shared-resident room. Tr. 49; P. Ex. 1, at 2 ¶ 12. Moreover, the perpetrator was still a "new" visitor (*see* CMS Ex. 8, at 14; P. Reply Br. 3) whose behavior should have been subject to more scrutiny. Regardless of the reasons she found the back-and-forth behavior concerning or unusual at the time, LPN1 never questioned or otherwise approached the perpetrator when it was occurring. Tr. 59. She also did not check the room at the time of the perpetrator's repeated trips through the facility to determine whether the perpetrator was providing

R202 with candy or drinking alcohol. Ultimately, while LPN1 conceded that the perpetrator's behavior was concerning (Tr. 49-50), she did not take any immediate measures to follow up on her concern.

At approximately 6:45 p.m. that evening, LPN1 observed that the privacy curtains around both R201 and R202 were closed.[5] CMS Ex. 6, at 3; P. Ex. 1, at 1 ¶ 6; Tr. 53. In her written declaration, LPN1 claimed that she "did not find [the closed curtains] at all suspicious or unusual." P. Ex. 1, at 1 ¶ 7. LPN1 testified at hearing, however, that the closed curtains concerned her because she was unable to monitor R201. Tr. 53-54. The LPN also adjusted her normal two-hour rotation and returned to R201's room 15 minutes later:

> [CMS Counsel:] You had conducted initial rounds at 6:45 p.m. and then you came back in the room 15 minutes later.
>
> [LPN1:] Yes.
>
> [CMS Counsel:] And you said that was unusual, right?
>
> [LPN1:] Yes.
>
> [CMS Counsel:] *So the reason that you came back was because you were suspicious that something was amiss in the room*?
>
> [LPN1:] *Correct*.

Tr. 42-43 (emphasis added). Thus, her own testimony at hearing and her actions following the observation at 6:45 p.m. undercut LPN1's written declaration that she was not suspicious of the closed curtains the first time she saw them. In any event, LPN1 acknowledged it was unusual for someone to close the privacy curtain around the bed of a resident who the person was not visiting. Tr. 54-55. Certainly, for the perpetrator to close the privacy curtain around R201, who could not speak or move and with whom he was not visiting, was not only brazen and illogical, but it should have been concerning to facility staff. The perpetrator was also in a position at the head of R202's bed where he

[5] Petitioner argues that only the privacy curtain surrounding R202's bed was closed at 6:45 p.m. *See* P. Br. 6; P. Reply at 4-5. But Petitioner's own exhibit contradicts its argument (P. Ex. 1, at 1 ¶ 6), and the record amply supports that the curtains around both R201 and R202 were closed when LPN1 observed them at 6:45 p.m. *See* CMS Ex. 6, at 3 (the facility's incident report stating "[a]round 6:45 pm charge nurse on duty observed *both residents in room 208 with curtain pulled* and visitor was instructed not to pull the curtain of [R201]" (emphasis added).); Tr. 53 (testimony of LPN1 that curtain was closed around both beds at 6:45 p.m.).

could move between the beds (and surrounding areas) of R202 and R201 and not be subject to staff observation. *See* CMS Ex. 13, at 2 ¶ 8; Tr. 67.

Finally, at 7:00 p.m., LPN1 abbreviated her normal rounds and returned to the nurses' station, directly across from R201's and R202's room. Tr. 42-43, 58. From there, LPN1 observed that the privacy curtain around R201 was closed again, and she could not see R201 or the perpetrator. P. Ex. 1, at 1 ¶ 8; CMS Ex. 9, at 9. LPN1 acknowledged that this also made her suspicious because she had reopened the privacy curtain 15 minutes earlier and directed the perpetrator to keep it open. P. Ex. 1, at 2 ¶ 13. LPN1 briefly conferred with a certified nursing assistant about the closed curtain around R201. Tr. 56, 59. Acting on her suspicions at that point, LPN1 quietly entered the room, looked around the privacy curtain, and observed the perpetrator sexually assaulting R201. Tr. 61; CMS Ex. 9, at 9.

Collectively, the perpetrator's behaviors on April 17, 2011, demonstrated the reasonable potential for resident abuse. Based on R201's defenseless condition, the nursing staff should have recognized that the perpetrator reasonably had the potential to impose resident harm. The perpetrator was an unaccompanied visitor who facility staff still considered a new visitor (CMS Ex. 8, at 14), who had exhibited unusual behavior during his visit, and who screened off a vulnerable resident using a privacy curtain behind which he had unmonitored access to that resident. Even if the facility staff could not have foreseen that the perpetrator would have assaulted R201 in the manner he did, staff should have recognized the very real potential for harm to R201 while she could not be visually monitored and in the presence of a new and relatively unknown male visitor. LPN1 acknowledged that the inability to see R201 was concerning because she needed constant monitoring and "she couldn't call for help" if needed. Tr. 54.

### B. *The facility was not in substantial compliance with Medicare participation requirements because it did not take all reasonable steps to address the perpetrator's suspicious behavior and thus prevent the abuse of R201.*

Medicare participation requirements provide each resident with the "right to be free from verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion." 42 C.F.R. § 483.13(b). A long-term care facility cannot use any measures involving abuse, corporal punishment, or involuntary seclusion. *Id.* § 483.13(c)(1)(i).[6] The applicable regulation defines "abuse" as "the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish." *Id.* § 488.301. In addition, the Board has explained that

[6] While the language of section 483.13(c)(1)(i) appears directed to prevent abuse by facility staff, the Board has found noncompliance with that section when a facility did not protect a resident from abuse by another resident. *Sunshine Haven Lordsburg*, DAB No. 2456, at 25-27 (2012).

"[p]rotecting and promoting a resident's right to be free from abuse necessarily obligates the facility to take reasonable steps to prevent abusive acts, regardless of their source." *Pinehurst Healthcare & Rehab. Ctr.*, DAB No. 2246, at 6 (2009) (*quoting Western Care Mgmt.*, DAB No. 1921, at 12 (2004)) (quotation marks omitted).

It is undisputed that the perpetrator subjected R201 to abuse on April 17, 2011. But the fact that a resident actually suffered abuse is not always dispositive about whether the facility took all reasonable steps to prevent that abuse. It is certainly possible that even if the facility takes reasonable steps to prevent abuse, the abuse may still have occurred. Therefore, the focus here must be on whether the facility took reasonable steps to prevent the abuse in the time leading up to the abuse, and not on the actual abuse itself. *See Cedar View Good Samaritan*, DAB No. 1897 (2003) (affirming ALJ's analysis of whether the facility took reasonably necessary steps to prevent a potentially abusive event from occurring without focusing on the actual abuse that a staff member perpetrated).

As explained above, the facility knew or should have known that the perpetrator posed a potential risk of harm to R201 based upon his unusual behavior. Making multiple trips back-and-forth from the residents' room and the dining room was suspicious behavior and caused LPN1 to take notice of the behavior. Tr. 49-51. LPN1 described the action as "suspicious" to the facility administrator, and even if she only believed the perpetrator was secretly providing his sister with candy or that they were drinking alcohol, she had a duty to do more than ignore the behavior. At that point, even if not suspecting potential sexual abuse, LPN1 or another staff member should have intervened by approaching the perpetrator, questioning his behavior, and ensuring that he was not, in fact, harming any resident by providing her with items she should not have, or drinking alcohol in the residents' room.[7] The facility has the duty of protecting the health and safety of its residents. Therefore, any behavior by a visitor that seemed suspicious or unusual should have been challenged by staff, not merely observed without confrontation.

In addition, after the perpetrator closed the privacy curtain around R201, facility staff had an opportunity to do more than tell him to keep the curtain open. LPN1 could have notified other staff members about the situation and established closer monitoring of the situation in the room by more than just one staff member. The facility also could have implemented a "one-on-one" monitoring of R201 for as long as the perpetrator remained in the room. Alternatively, staff could have directed that R202 and the perpetrator visit in

[7] Petitioner characterizes stopping the perpetrator while he was going back-and-forth as a potential improper interrogation. P. Br. 11. Facility staff could have asked the perpetrator if he needed assistance or whether he was, in fact, providing R202 with candy without staff having to "stop and interrogate" the perpetrator. Simply asking, "Can I help you with something?" would not have been an interrogation in the manner Petitioner implies but may have alerted the perpetrator that staff was vigilant and more closely monitoring his behavior.

another social area of the facility in order to allow closer monitoring of R201's condition. Facility staff may have also tried to move R201 temporarily to an area where she could be monitored without any potential interruption from a visitor. All of these represent some – but not all – of the reasonable steps the facility could have taken to prevent the abuse of R201 but did not do so.

The first time LPN1 observed the closed privacy curtain around R201, she did take a reasonable step toward preventing potential abuse by reopening the curtain and telling the perpetrator not to close it again. CMS Ex. 9, at 9; P. Ex. 1, at 1 ¶ 6. But, when additional reasonable steps are apparent and can be readily taken to prevent abuse, the facility must take those reasonable steps to comply substantially with the applicable participation requirement. The participation requirement places a significant obligation on the facility to protect a resident's right to be "free from abuse." *See* 42 C.F.R. § 483.13(b). Making a single effort to prevent abuse, when many other reasonable steps should have been taken, is simply not enough to comply with the regulatory standard. Here, the facility did not take all reasonable steps necessary to prevent abuse of R201. This had the potential for more than minimal harm to the resident, and therefore Petitioner did not substantially comply with the applicable Medicare participation requirement.

Petitioner argues that finding the facility was not in substantial compliance "compounds the crime by further demeaning the staff who cared for [R201] and who were subjected to the threatening and degrading behavior of the perpetrator while trying to protect the resident." P. Br. 1-2. There is no doubt that LPN1 stopped a serious sexual assault from progressing and placed herself in danger by confronting the perpetrator. However, the facility is responsible for promoting the highest possible level of resident health and safety, especially for residents such as R201, who are dependent upon facility staff for *all* needs. Determining that facility staff did not take the reasonable steps necessary to prevent the abuse, even when a staff member interrupts an abusive act, does not "compound the crime," but merely holds the facility to the regulatory standards it agreed to follow.

### C. *The per-instance CMP that CMS imposed is reasonable.*

The factors listed in 42 C.F.R. § 488.438(f) guide whether the CMP imposed here is reasonable. Those factors include: (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, including neglect, indifference, or disregard for resident care, comfort or safety. Among the factors specified in section 488.404 are the scope and severity of noncompliance, the relationship of one deficiency to another deficiency resulting in noncompliance, and the facility's history of noncompliance generally as well as with reference to the cited deficiencies. 42 C.F.R. § 488.404(b)-(c). In addition, the "absence of culpability is not a mitigating circumstance in reducing the amount of the penalty." 42 C.F.R. § 488.438(f)(4).

Unless a facility contends that a particular regulatory factor does not support the CMP amount, the ALJ must sustain it. *Coquina Ctr.*, DAB No. 1860 (2002). Here, Petitioner has not alleged or offered evidence that its financial condition affects its ability to pay the CMP.

CMS imposed a $2,500 per-instance CMP, which is in the lower end of the applicable range. *See* 42 C.F.R. § 488.408(d)(1)(iv) (providing a range from $1,000 to $10,000 for a per-instance CMP based on a finding of noncompliance that caused isolated actual harm that is not immediate jeopardy). Despite prior findings of noncompliance, CMS has never imposed an enforcement remedy against Petitioner prior to the one at issue, but the state agency imposed a CMP in 2005. CMS Ex. 3, at 4.

This case is one of a serious, though isolated, instance where the facility did not meet participation standards. Petitioner did not take all reasonable steps to prevent the abuse to R201, which left her even more vulnerable than she already was because of her defenseless medical condition. Although facility staff intervened and stopped the abuse after it began, it does not mitigate the facility's noncompliance *prior* to the abuse occurring. Thus, even though the facility and LPN1 prevented the sexual assault from becoming worse than it was, the facility was nevertheless deficient in its protection of R201, and the relatively low CMP is not unreasonably harsh to the facility.

In light of all of these circumstances, I find that the $2,500 per-instance CMP imposed here, which is in the lower end of the allowable range, is reasonable and well-supported by the record before me.

## V. Conclusion

For all of the foregoing reasons, I find that Petitioner did not take the reasonable steps necessary to prevent abuse of R201 and was therefore not in substantial compliance with 42 C.F.R. § 483.13(b) and (c)(1)(i). I also find that the CMP that CMS imposed is reasonable. Accordingly, I sustain the determination that Petitioner was not in substantial compliance and the enforcement remedy imposed.

/s/
Joseph Grow
Administrative Law Judge