Department of Health and Human Services

DEPARTMENTAL APPEALS BOARD

Civil Remedies Division

Somerset Nursing & Rehabilitation Facility
(CCN: 18-5218),

Petitioner

v.

Centers for Medicare and Medicaid Services.

Docket No. C-09-313

Decision No. 2166

Date: June 24, 2010

DECISION

I sustain the determination of the Centers for Medicare and Medicaid Services (CMS) to impose remedies against Petitioner, Somerset Nursing & Rehabilitation Facility, consisting of civil money penalties of:

- $3,050 per day for each day of a period that began on May 10, 2008, and which ran through January 14, 2009;

- $150 per day for each day of a period that began on January 15, 2009, and which ran through January 29, 2009; and

- A denial of payment for new admissions for each day of a period that began on January 18, 2009, and which ran through January 29, 2009.

I. Background

Petitioner is a skilled nursing facility in Somerset, Kentucky. It participates in the Medicare program. Sections 1819 and 1866 of the Social Security Act, and its

implementing regulations at 42 C.F.R. Parts 483 and 488, govern Petitioner's participation in Medicare. 42 C.F.R. Part 498 governs Petitioner's hearing rights in this case.

Petitioner was surveyed for compliance with Medicare participation requirements in a survey ending on January 9, 2009 (January 9 Survey), and in a subsequent survey on January 26, 2009 (January 26 Survey). Eleven (11) deficiencies were identified at the January 9 Survey. Eight of the deficiencies were determined to be so egregious as to put residents of Petitioner's facility in immediate jeopardy. An "immediate jeopardy" level deficiency is one that causes, or is likely to cause, serious injury, harm, impairment, or death to a resident or residents. 42 C.F.R. § 488.301. Three deficiencies were identified at the January 26 Survey, and none of these were determined to be at the immediate jeopardy level. CMS concurred with the surveyors' findings and determined to impose the remedies that I recite in the opening paragraph of this decision.

Petitioner requested a hearing, and the case was assigned to me for a hearing and a decision. I directed the parties to file pre-hearing exchanges, which included all of their proposed evidence and briefs that addressed all of the issues in the case. The parties completed their exchanges and complied with my order. It is apparent from Petitioner's exchange that Petitioner is not challenging the non-immediate jeopardy level findings of noncompliance that were made at the January 26 Survey. Consequently, these findings, and the determination to impose civil money penalties of $150 per day for the period that ran from January 15 through January 29, 2009, are administratively final and raise no issues that I may hear and decide. All that is left for me to decide is whether Petitioner manifested immediate jeopardy level noncompliance during the period that ran from May 15, 2008 through January 14, 2009 and, if so, whether the remedies that CMS determined to impose are reasonable in duration and amount.

I held a hearing by telephone on March 22, 2010, at which several witnesses were cross examined. I received all witnesses' direct testimony as affidavits or declarations. I received into evidence forty-five (45) exhibits from CMS, which I identified as CMS Ex. 1 – CMS Ex. 45. I also received nine exhibits from Petitioner, which I identified as P. Ex. 1 – P. Ex. 9.

II. Issues, Findings of Fact, and Conclusions of Law

A. Issues

The issues in this case are whether:

1. Petitioner failed to comply substantially with Medicare participation requirements;

2. CMS's determination of immediate jeopardy level noncompliance is clearly erroneous; and

3. The remedies that CMS imposed are reasonable in duration and amount.

B. Findings of Fact and Conclusions of Law

I make the following findings of fact and conclusions of law (Findings).

1. Petitioner failed to comply substantially with Medicare participation requirements.

As I discuss above, CMS determined that Petitioner manifested 11 deficiencies as of the January 9 Survey. In this decision, I address two of them, Petitioner's noncompliance with the requirements of 42 C.F.R. §§ 483.13(b) and 483.13(c). It is unnecessary that I address additional alleged deficiencies for reasons that I explain at Finding 3 of this decision.

a. Petitioner failed to comply substantially with the requirements of 42 C.F.R. § 483.13(b).

The regulation that is at issue here provides that a resident of a skilled nursing facility has the right to be free from sexual, physical, and mental abuse, among other things. "Abuse" is defined to mean the: "willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish." 42 C.F.R. § 488.301.

The regulation requires a facility to ensure that its residents are not abused. It requires a facility to be vigilant in determining when possibly abusive conduct might occur and to take every reasonable step to assure that it does not occur. Put simply, a facility does not comply with the regulation's requirements simply by reacting to abuse with ad hoc interventions. If a facility knows that a possibility exists that abuse may occur, it must develop preventive measures to assure that it does not occur. It also must implement those measures.

The gravamen of CMS's allegations against Petitioner is that Petitioner failed to take meaningful actions to protect its residents from the abusive behavior of one of its residents who is identified in the January 9 Survey report as Resident # 9. That abuse consisted of numerous instances of verbal and physical violence, including several instances of sexual abuse that Resident # 9 perpetrated against other residents. CMS contends that Petitioner's efforts to protect its residents from Resident # 9 were ineffective.

The weight of the evidence supports CMS's assertions. For a period of several months, Petitioner failed to prevent Resident # 9 from engaging in verbal and physical violence against other residents and from perpetrating sexual abuse against some female residents. The interventions that Petitioner used when Resident # 9 engaged in abusive conduct were woefully ineffective in protecting other residents from Resident # 9. Petitioner's failure to protect its residents from Resident # 9 reveals a fundamental misunderstanding on the part of Petitioner and its staff of the need to take every reasonable measure to protect its residents from abuse. Petitioner's noncompliance, therefore, was not limited just to the way in which its staff dealt with Resident # 9 but was a systemic failure by Petitioner and its staff to develop an effective system for dealing with abusive residents.

Resident # 9 was an alert and oriented resident. CMS Ex. 39 at 2. He was a relatively large and robust individual, five feet 11 inches tall, who weighed about 200 pounds. CMS Ex. 7 at 19; CMS Ex. 39 at 2. He was capable of moving around Petitioner's facility in a wheelchair without the assistance of Petitioner's staff. CMS Ex. 1 at 15; CMS Ex. 7 at 5, 12, 31; CMS Ex. 39 at 2. He could walk occasionally. CMS Ex. 6 at 73, 77; CMS Ex. 8 at 37; CMS Ex. 39 at 2.

Petitioner knew, or should have known, at the time of Resident # 9's admission to the facility that the resident posed a threat to the safety and well-being of other residents. The resident had a life long history of sexually aggressive behavior. CMS Ex. 39 at 4. He had been in, and had been discharged from, several other facilities prior to his residing at Petitioner's facility. *Id.*

Resident # 9 engaged in conduct very shortly after his admission to Petitioner's facility that confirmed all that was or should have been known about his proclivities. He displayed a constellation of aggressive and violent behavior. Petitioner's administrator described him as aggressive, grouchy, and volatile. CMS Ex. 41 at 3. On numerous occasions, Resident # 9 was combative – and at times violent – in his interactions with Petitioner's staff. CMS Ex. 9 at 2, 9, 13-15, 21, 24-25, 28; CMS Ex. 6 at 62, 66, 67. The resident's combativeness included his repeated noncompliance with medical instructions and attempts to provide care to him. He ignored, or refused to comply with, restrictions on consuming fluids, and he repeatedly refused to take medication that was prescribed to him. CMS Ex. 9 at 2-4, 8-9, 13-15, 17-18, 20-22, 24-25, 27-28, 33; CMS Ex. 6 at 48, 52, 66-72, 79, 99, 106.

Resident # 9 displayed aggressive, threatening, and, at times, violent behavior towards other residents. CMS Ex. 9 at 14, 18, 20-21; CMS Ex. 6 at 104. He threatened to kill his roommate by smothering him with a pillow. CMS Ex. 9 at 9. He kicked and shoved other residents. *Id.* at 14, 18, 20-21; CMS Ex. 6 at 104. In June 2008, he shoved another resident's wheelchair causing the chair to come off the floor. CMS Ex. 9 at 18.

Resident # 9 continually sought to engage in uninvited sexual activity with Petitioner's female residents during his stay at Petitioner's facility. This activity included the following instances:

- April 2008: Resident # 9 put his hand into the shirt of a female resident and attempted to fondle her breast. When the resident rebuffed Resident # 9's advances, he attempted to persuade her to come to his room. CMS Ex. 34 at 16.

- April 10, 2008: Resident # 9 brushed up against another resident – a severely cognitively impaired individual – in the hallway of Petitioner's facility. CMS Ex. 27 at 1.

- May 10, 2008: Resident # 9 was discovered in a female resident's room, Resident # 25, touching that resident's body ("feeling of her"). CMS Ex. 9 at 14; Petitioner's Pre-Hearing Brief at 3.

- May 18, 2008: Resident # 9 was observed touching another resident, Resident # 21, at several places on her body. CMS Ex. 6 at 67; CMS Ex. 27 at 1; CMS Ex. 1 at 16.

- May 22, 2008: Resident # 9 was observed in a hallway making inappropriate sexual advances towards Resident # 21. The resident failed to cease making advances when Resident # 21 asked him to stop. CMS Ex. 6 at 69; CMS Ex. 27 at 1.

- May 28, 2008: Resident # 9 was observed in a hallway making sexual advances towards an unidentified female resident. He continued making advances despite several efforts by Petitioner's staff to redirect him. CMS Ex. 6 at 69.

- May 28, 2008: After the first reported incident on May 28, 2008, and despite redirection, Resident # 9 made two attempts to go into a female resident's room, or to get that resident to go to Petitioner's break room with him. CMS Ex. 6 at 102.

- May 29, 2008: Resident # 9 was found in the room of a female resident, Resident # 26. Resident # 26 complained that Resident # 9 had attempted to touch her inappropriately. CMS Ex. 6 at 102; CMS Ex. 27 at 1; CMS Ex. 1 at 16.

- May 30, 2008: Resident # 9 was observed in a hallway making sexual advances towards an unidentified female resident. CMS Ex. 6 at 69.

- June 18, 2008: Resident # 9 was overheard making sexually suggestive comments to an unidentified female resident. CMS Ex. 9 at 17.

- July 8, 2008: Resident # 9 was seen in a hallway kissing and fondling the breasts of Resident # 21. CMS Ex. 1 at 16-17; CMS Ex. 9 at 21.

- July 12, 2008: Resident # 9 was observed making sexual comments to another unidentified resident. CMS Ex. 9 at 21.

- August 21, 2008: Resident # 9 forcefully pinched or grabbed the right breast of Resident # 15 after Resident # 9 stopped her in the hallway. CMS Ex. 1 at 6, 17.

- August 22, 2008: Resident # 9 was found in an unidentified female resident's room sitting beside her bed. CMS Ex. 9 at 24.

- August 22, 2008: Resident # 9 was found holding on to the shirt of an unidentified female resident. The shirt had become partially undone. *Id*.

- August 23, 2008: At 9:30 A.M., Resident # 9 was found reaching for an unidentified female resident's breast. *Id*.

- August 23, 2008: At 2:45 P.M., Resident # 9 was found in the doorway of an unidentified female resident's room. *Id*.

- October 16, 2008: Resident # 9 grabbed the breasts of a female resident, Resident # 10. CMS Ex. 6 at 108; CMS Ex. 9 at 29; CMS Ex. 27 at 2; CMS Ex. 34 at 17.

- December 10, 2008: Resident # 9 invited an unidentified female resident who was passing by his room to come in and visit him. The female resident declined. CMS Ex. 9 at 33.

Resident # 9's conduct was flagrant and outrageous. It is not an exaggeration to say that, for a period of several months, this resident terrorized other residents and, in particular, some of Petitioner's female residents, such as Resident # 15 and Resident # 21. The situation called for Petitioner to take drastic measures to protect other residents from Resident # 9's predatory conduct. However, interventions that Petitioner implemented had a half-hearted and tepid quality to them that was totally inappropriate to the situation that Petitioner, its staff, and the residents confronted. Petitioner contends that it:

> did take reasonable efforts to protect female residents and to prevent Resident 9 from further instances of inappropriate sexual behaviors. . . . Many of these interventions worked for a significant period of time. When

> Resident 9 exhibited new episodes of inappropriate behavior, the facility took additional measures to address those behaviors and protect other residents.

Petitioner's Pre-Hearing Brief at 10. According to Petitioner, these interventions included: ongoing discussions with Resident # 9; involvement of the resident's family; diversionary activities; increased monitoring and supervision; educating staff on dealing with inappropriate sexual behaviors in general, and the resident's behaviors in particular; checking the resident at 15-minute intervals; and involvement of the resident's physicians. *Id.*

But, what is apparent – and what ought to have been apparent to Petitioner and its staff – is that these interventions, individually and in combination, were singularly ineffective in protecting other residents from Resident # 9. The persistence of the resident's abusive conduct, despite the interventions that Petitioner described, makes this conclusion evident. For example, Resident # 9 was observed to be engaging in sexually predatory behavior on five occasions within three days in August 2008, notwithstanding Petitioner's claims of effective intervention.

It does not appear that Petitioner even considered the possibility that the resident needed to be kept under continuous observation while he was in the presence of female residents. Nor did Petitioner's staff ever consider the possibility that the resident needed to be segregated from the facility's female population. Petitioner did not finally decide to transfer Resident # 9 out of its facility until November 2008. CMS Ex. 6 at 6, 8.

The interventions that Petitioner claimed appear to be particularly tepid and half-hearted when they are scrutinized closely. Resident # 9 was not placed on 15-minute checks until July 7, 2008, many months after he began to engage in sexually abusive behavior. P. Ex. 1 at 160. Moreover, these checks were not begun in response to the resident's abusive behavior but were begun due to the fact that resident had attempted to elope Petitioner's premises. *Id.*; Petitioner's Pre-Hearing Brief at 6 n.1. In the weeks after the checks were implemented, the resident perpetrated multiple episodes of sexual abuse. Petitioner never considered intensifying the resident's supervision or restricting his movement, however. Resident # 9 continued to enjoy freedom of movement throughout Petitioner's facility during his stay there, and he took advantage of that freedom of movement to perpetrate abuse.

Petitioner has not presented any detailed explanation of when its staff's asserted ongoing discussions with Resident # 9 occurred and what was said to the resident. Petitioner has not pointed to any evidence showing that the resident responded to what was said to him, or how these discussions modified his behavior. What is obvious, however, is that direct communications between Petitioner's staff and Resident # 9 were singularly ineffective.

Petitioner knew, or should have known, that involvement of Resident # 9's family in attempts to curb the resident's aggression would be an exercise in futility. No evidence exists that family involvement helped to curb the resident's conduct. Indeed, family involvement could only have served to put Petitioner on notice that it had an extremely dangerous situation on its hands. The resident's family placed Resident # 9 in skilled nursing care *because of* his history of sexually abusive behavior at home, which he directed against his demented wife. CMS Ex. 39 at 4.

Petitioner's care plan was amended on September 1, 2008 to say that the resident should be monitored frequently for inappropriate sexual behavior. CMS Ex. 8 at 30. However, Petitioner has offered no evidence to show how it and its staff implemented this amendment. In fact, Petitioner did not make any concerted effort to implement the amendment. Several of Petitioner's staff told surveyors that they were not aware that Resident # 9 would be subjected to increased monitoring and supervision. CMS Ex. 39 at 2-3; CMS Ex. 17 at 6-8.

Petitioner has not offered persuasive evidence that it involved Resident # 9's physicians in a comprehensive effort to eliminate the resident's abusive behavior. As of the January 9 Survey, Petitioner's medical director was unaware of the resident's abusive behavior. CMS Ex. 41 at 3-4. The resident's primary physician made no entries in his progress notes between March and December 2008, concerning the resident's sexually abusive behavior. CMS Ex. 6 at 9-14. The resident was seen on May 16, August 22, and November 22, by a psychiatric physician's assistant, but that provider did not evaluate the resident's sexually abusive conduct. CMS Ex. 1 at 31; CMS Ex. 6 at 25-27; CMS Ex. 38 at 5-6. No record exists of anyone ordering medication for Resident # 9 that was intended to curb his abusive behavior.

b. Petitioner failed to comply substantially with the requirements of 42 C.F.R. § 483.13(c).

In relevant part, the applicable regulation states that a facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents. CMS alleges that Petitioner contravened this regulation's requirements, because it failed to implement its written abuse policy in dealing with the repeated episodes of sexual abuse that Resident # 9 perpetrated. The evidence strongly supports CMS's assertion.

Petitioner's policy governing sexual abuse defines "sexual abuse" as including sexual harassment, sexual coercion, or sexual assault. CMS Ex. 24 at 9. The policy draws no distinction between abuse involving physical contact and abuse that is verbal. It lays out a protocol for staff to report and investigate alleged or observed abuse. *Id.* at 9-10. Any member of Petitioner's staff who observes an incident of actual or suspected resident abuse must immediately report what he or she observes to a charge nurse and Petitioner's

director of nursing and administrator. *Id.* at 10. The report must contain the names of the perpetrator and the victim. Upon receiving the report of abuse, the charge nurse must immediately examine and interview the possible victim and record the findings of the examination and interview in the possible victim's medical record. *Id.* The staff is obligated to notify the physician and family of any possible victim and to refer the possible victim to social services in any case of suspected abuse. *Id.* at 8, 11.

CMS offered evidence that proved that Petitioner's staff failed to follow this protocol in several instances in which Resident # 9 was observed to be engaging in sexually abusive behavior. There were, as I have discussed, several instances in which Petitioner's staff failed even to identify the victim of Resident # 9's aggression. In other instances, the staff did not examine and interview the victim nor did it notify the victim's family or the victim's treating physician. That was the case with instances of abuse involving Residents #s 10, 15, 25, and 26. None of these residents' treatment records contain any documentation showing that Petitioner's staff followed the requisite protocol. None of the incidents at issue were investigated by Petitioner nor were they reported to the relevant Kentucky State agency with the exception of the incident occurring on August 21, 2008, in which Resident # 9 pinched Resident # 15's breast. CMS Ex. 39 at 5.

Petitioner denies that it contravened the requirements of 42 C.F.R. § 483.13(c), arguing primarily that the behaviors by Resident # 9 that Petitioner's staff documented were "questionably inappropriate but did not constitute sexual harassment, sexual coercion, or sexual assault and therefore did not require implementation of . . . [Petitioner's abuse investigation and reporting policy]." Petitioner's Pre-Hearing Brief at 11. I do not agree with Petitioner's characterization of Resident # 9's behavior. Some of his acts may have been on the borderline between what was merely offensive and what was abusive. But, many of the acts that Resident # 9 perpetrated clearly were abusive. On multiple occasions, the resident fondled, or attempted to fondle, female residents. He made sexually suggestive comments to many of them. His behavior was persistent and repetitive. Petitioner has not argued that any of this conduct was consensual, and, in fact, no evidence exists that would support a finding of consensual sexual conduct between Resident # 9 and other residents. To the contrary, the victims of Resident # 9's aggression tended to be debilitated and sometimes demented individuals. Individuals who reside in nursing facilities are individuals who are generally helpless to deal with life's problems, including uninvited sexual advances. Petitioner should have recognized the helplessness of Resident # 9's victims and acted accordingly.

2. CMS's findings of immediate jeopardy level noncompliance were not clearly erroneous.

The evidence that CMS offered establishes that Petitioner's failure to protect residents against abuse, and its failure to carry out its own policies concerning abuse, created a likelihood of serious injury, harm, impairment, or death to residents of Petitioner's facility. Petitioner did not prove CMS's determination to be clearly erroneous.

The probability of serious psychological or physical injury resulting from Resident # 9's unchecked sexual aggression was very high. As I have discussed, the resident's victims were frail, elderly individuals, and some of them suffered from dementia. They were helpless to defend themselves from Resident # 9, a physically large and relatively robust individual. Moreover, at least one of Resident # 9's victims, Resident # 15, suffered from a medical condition that made her vulnerable to severe injury if Resident # 9 succeeded in groping her breast again, as he did on August 21, 2008. Resident # 15 had a history of cancer therapy for her right breast, including a lumpectomy and radiation treatments, and she was at risk of developing lymphedema. CMS Ex. 13 at 5, 134-35; CMS Ex. 41 at 2. The right side of this resident's body needed to be protected against injury. Pinching her breast, as Resident # 9 had done, posed a grave threat for Resident # 15.

Petitioner's failure to investigate and to report allegations of abuse also put residents at immediate jeopardy. There is a reason why any allegation of abuse must be reported immediately by a facility to responsible State authorities, even if it is ultimately established that no abuse occurred. A conflict of interest exists between a facility and its residents any time that abuse is alleged. It is in the facility's interest that no abuse be found, because a finding of abuse could, at the least, damage the facility's reputation and, more than that, subject the facility to remedies. For that reason, it is absolutely necessary that *every* possibility of abuse be reported and thoroughly investigated. Failure to comply with this requirement puts residents at jeopardy, because it leaves them unprotected from possibly serious or even lethal abuse.

Petitioner argues that no one actually was seriously injured as a result of Resident # 9's actions. But, the absence of serious harm does not serve as a defense to a finding of immediate jeopardy level noncompliance. In this case, a *likelihood* of serious harm existed even if no serious harm actually occurred. That Resident # 9 did not seriously injure one or more of his victims, either physically or psychologically, may have been fortuitous, but there was a high probability that he would inevitably do so given his proclivities.

There is evidence at least one of Petitioner's residents, Resident # 15, did suffer serious harm as a result of Resident # 9's predatory activity. This resident clearly manifested signs of psychological harm. At the time of the January 9 Survey, more than four and one-half months after Resident # 9 sexually assaulted her, Resident # 15 continued to express fear of Resident # 9. The resident told surveyors that she remained in her room with the door closed most of the time due to her fear. CMS Ex. 41 at 2; CMS Ex. 1 at 6.

Furthermore, the likelihood of actual harm to specific residents does not define the limit of the risk to residents that Petitioner's noncompliance posed. Petitioner's lack of recognition of its obligations to protect its residents, coupled with the manifest ineffectiveness of the interventions it developed to protect residents from Resident # 9, convinces me that Petitioner, at bottom, lacked any comprehension of the ambit of its responsibility to protect its residents. That put all of Petitioner's residents in jeopardy from future instances of abuse, whether or not Resident # 9, or someone else, perpetrated them.

3. CMS's remedy determinations are reasonable.

This case involves two civil money penalty determinations and a denial of payment for new admissions. I have held that, as a matter of law, CMS's determination to impose penalties of $150 per day against Petitioner for the period running from January 15 through January 29, 2009 is reasonable. That leaves only the issue of whether immediate jeopardy level penalties of $3,050 per day for the period running from May 10, 2008 through January 14, 2009 are reasonable.

The immediate jeopardy penalty amounts are reasonable as a matter of law. The minimum immediate jeopardy level civil money penalty that CMS may impose is $3,050 per day. 42 C.F.R. § 488.438(a)(1)(i). Even one instance of immediate jeopardy level noncompliance justifies the minimum amount as a matter of law. In this case, I have found the presence of two immediate jeopardy level deficiencies. It is unnecessary that I find the presence of others, because CMS determined to impose the minimum penalty amount.

What remains to be determined is the issue of duration. CMS determined that the beginning date for imposition of immediate jeopardy level penalties is May 10, 2008. That date is amply justified by the evidence showing that Resident # 9 began his sexually abusive activity at Petitioner's facility in April 2008. Indeed, I likely would have sustained an earlier starting date for immediate jeopardy level noncompliance had CMS made such a determination.

The duration of Petitioner's immediate jeopardy level noncompliance, through January 14, 2009, is also amply supported by the evidence. Resident # 9 continued to perpetrate abusive acts through December 10, 2008. However, there is no evidence that Petitioner corrected its deficiencies – its failure to develop and implement policies to protect residents against abuse – prior to January 14, 2009 and after completion of the January 9 survey. That Resident # 9 did not engage in abusive behavior after December 10, 2008, may have been fortuitous. But, the likelihood of immediate jeopardy level noncompliance persisted so long as Petitioner and its staff failed to implement actions that protected residents against abuse, either abuse that Resident # 9 or other residents perpetrated. Resident # 9 remained in the facility until January 9, 2009. Petitioner did not implement corrective actions designed to assure enforcement of its abuse policy prior to January 14, 2009.

Finally, CMS's determination to impose a denial of payment for new admissions is reasonable as a matter of law. CMS has discretionary authority to impose a denial of payment for new admissions for each day that a facility is noncompliant with Medicare participation requirements. 42 C.F.R. § 488.417(a)(1). Consequently, I sustain denial of payment for new admissions for each day of a period that began on January 18, 2009, and which ran through January 29, 2009.

/s/
Steven T. Kessel
Administrative Law Judge